AYUSHMAAN BHARAT: MAKING RURAL HEALTH UNIVERSAL

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'Ayushman Bharat' program, announced in the union budget 2018-19, is a big ticket initiative and a potential 'game-changer' for Indian healthcare system. It has irreversibly placed health higher on political agenda and public discourse and has brought the attention back on strengthening primary healthcare and continuum of care. The newly proposed National Health Protection Scheme (NHPS) targets a broader base of vulnerable and deprived population; and designed to fulfil the legitimate expectations of people from any functioning health system, accessibility, affordability and appropriate care. The successful implementation of 'Ayushman Bharat' program, supplemented by a few complementary initiatives can help achieving targets set in National Health Policy (2017) of India. This program could be as much about delivering health services in short term, as much it is about preparing Indian health systems for making health coverage universal.

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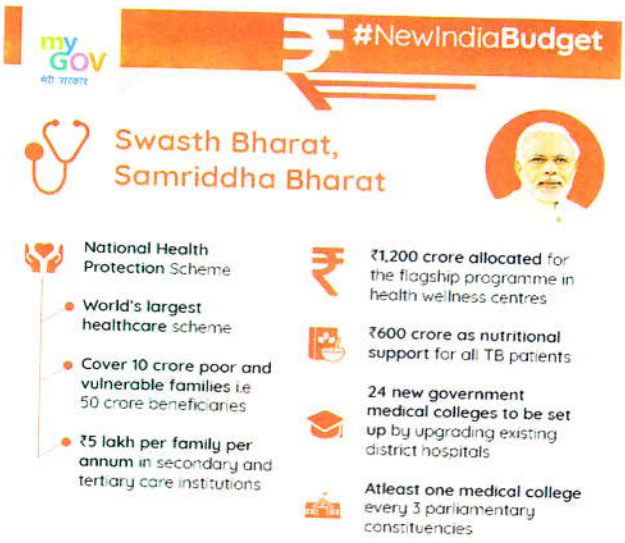


In the Union Budget 2018-19, the allocation to health[1] sector has been increased by 12 per cent from Rs. 50,280 Crore in 2017-18 to Rs. 56,226 Crore (Budgetary estimates). A number of schemes have been announced for health sector (Box 1), including 'Ayushman Bharat' program, encompassing two major components. The first initiative - Health and Wellness Centres (HWCs) aims at provision of comprehensive primary healthcare services closer to the community. Second initiative- the National Health Protection Scheme or NHPS -aims to provide financial protection of up to Rs. 500,000 per family per year, for 10 crore families, for secondary and tertiary care hospitalization related expenditure. The NHPS is being considered as one of the biggest policy announcements in the recent years. An initial financial allocation of total Rs. 3,200 crore has been made, for these two initiatives.

Proposed Health and Wellness Centres (HWC):

At present, Health Sub-Centres (HSCs) are the first point of contact between people and Indian healthcare system. Each HSC caters to 5,000 population in plains and 3,000 population in hilly, tribal and backward areas. The health services provided at each HSC are of limited range: mother and child care; treatment of common illnesses & implementation of national health programs. The health services required to tackle some of the emerging health challenges, i.e. non communicable diseases, are not offered through HSCs yet. Though, there are more than 150,000 HSC in India, their functioning and utilization has been suboptimal[2]. In the financial year 2018-19, a target of making 11,000 HWCs functional has been set and an allocation of Rs.1,200 crore has been made[3]. HWCs would be created by upgrading existing HSCs to provide a

comprehensive package of primary healthcare services, including preventive, promotive, curative and rehabilitative services and free essential drugs and diagnostic services (Box 2).

Proposed National Health Protection Scheme-2018:

The newly announced NHPS-2018[3] would replace the existing Rashtriya Swasthya Bima Yojana (RSBY)[4]. After full scale roll-out, NHPS-2018 would cover over 100 million poor and vulnerable families (approximately 500 million beneficiaries). This will be equivalent to 40 per cent of total population in India. The NHPS has been labeled as 'the largest

Box 1:

Union Budget 2018-19:Key health sector and related announcements

Financial allocation of Rs 52,800 crore to Dept. of Health and Family Welfare.

- Ayushman Bharat Program with two initiatives has been allocated Rs 3,200 crore.
- A total of Rs 600 crore for cash assistance of Rs 500 per month for tuberculosis patient for the duration of treatment.
- 24 district hospitals will be upgraded to medical colleges, to ensure at least 1 Medical College for every 3 Parliamentary Constituencies and at least 1 government medical college in each state of India.
- The 3 per cent 'education cess' has been changed to 4 per cent 'Health and education cess', estimated to generate an additional revenue of Rs 11,000 crore in the financial year.
- Initiative to control air pollution by supporting the farmers in Haryana, Punjab, Uttar Pradesh and National Capital region of Delhi for the in-situ disposal of crop waste.
- Expansion of Ujjwala scheme (to provide free 'Liquefied Petroleum Gas' connection to rural women) from 50 million to 80 million women in India. Allocation of Rs 3200 crore.
- Continuation of Swachch Bharat Mission with target of building additional 20 million toilets.
- Allocation to National Nutrition Mission has been doubled to Rs 3000 crore.
- Increase of nearly 10 per cent for Jan Aushadhi Yojana, Swachch Bharat Mission-Rural and Aanganwadi Services.

Box 2:

Comprehensive primary healthcare : Health and Wellness Centres

The comprehensive primary healthcare (through HWCs) in India focuses upon the provision of package of 12 essential services. In addition, the HWCs are proposed to be linked to Block level Primary Health Centres (PHC as first referral point). The approach includes expanding the workforce to create a Primary Health Care Team, which would have a mid-level healthcare provider or MLHP, improving availability of drugs for chronic diseases and point of care diagnostic, developing IT systems to strengthen continuum of care, monitoring, innovations in service delivery, capacity Building of care providers and Health promotion.

Twelve packages of proposed services:

1. Care in pregnancy and child-birth.
2. Neonatal and infant health care services
3. Childhood and adolescent health care services.
4. Family planning, Contraceptive services and Other Reproductive Health Care services.
5. Management of Communicable Diseases: National Health Programs.
6. General Out-patient care for acute simple illnesses and minor ailments.
7. Screening and Management of Non-Communicable diseases.
8. Screening and Basic management of Mental health ailments.
9. Care for Common Opthalmic and ENT problems.
10. Basic Dental health care.
11. Geriatric and palliative health care services.
12. Trauma Care (that can be managed at this level) and Emergency Medical services.

The proposed essential Staff at HWC (one each)are as follows:

- ANM/health worker- Female.
- Health assistant – Male.
- Counsellor.
- Mid-Level healthcare provider (Community Health Officer/ Nurse/AYUSH).

government funded health (insurance/assurance) programme in the world'. An initial allocation of Rs. 2,000 crore has been made in the union budget 2018-19. The specifics of NHPS-2018 are being further detailed out by the officials in the Ministry of Health and Family Welfare and NITI Aayog, the Government of India (Box 3).

Can 'Ayushman Bharat' address key health challenges in India?

The key health system challenges in India are largely well known. Though, there is a vast network of primary healthcare system (around 156,000 HSC and 25,000 primary health centres), these facilities provide only 11 per cent of total health services in India. While experience shows that a well-functioning 'primary healthcare system' can cater up to 80 per cent- 90 per cent of all health needs of any population. Similarly, as nearly 80 per cent of all out-patient consultations and 60 per cent of all hospitalization happens in private sector, majority of Indian population (poor included) attend either unqualified providers (quality of care known and poor) or qualified private healthcare providers (quality largely undocumented and unknown). In both cases, they often have to pay from their pocket, beyond their paying capacity. There are reports that people often have to sell assets or

Box 3:

Proposed design and implementation plan for NHPS-2018

The design of NHPS-2018 is still being worked out by senior policy makers in Government of India, in consultation with various stakeholders including state governments.

- Some of the background work was done following announcement of NHPS-2016. The benefit packages, rates, empanelment criteria, basic information on IT platform, and outline of national and state health authorities was worked out; however, would require revision, in light of revised package.
- The 'deprivation data' from socio-economic and caste census (SECC) of 2011 will be used for eligibility of beneficiaries. The enrolment and identification will be linked with Aadhaar number.
- A premium of Rs1,082 per family has been estimated under NHPS-2018.The government would pay the entire premium, for the targeted beneficiaries, with no contribution or co-payment by the beneficiaries.
- The full scale implementation of NHPS (for 10 crore families) would cost approx. Rs 12,000 crore per year including administrative and other costs.
- The premium will be shared between union and state governments, at 60-40, 80-20 or 90-10 formula, as applicable for other centrally sponsored schemes (CSS). The state government would have to contribute around Rs. 4,330 crore per annum and remaining around Rs 7,600 crore would come from the Union Government.
- The state government would be free to choose between trust or insurance model for the implementation of the scheme. There would be freedom to the states for appropriate harmonization of ongoing state specific insurance/assurance schemes with NHPS.
- As per information available from various sources, "data preparation and revision of package rates." "Preparation of IT systems" and "setting up of institutions at national and state level" and "preparation of guidelines and documents." is planned for coming months to be completed by June 2018. The public awareness would be started after that. Thereafter, the states would float tenders to invite proposals from private insurers (July 2018), the government hopes to see states prepared with their tenders.
- Once the process is completed, the NHPS would be implemented possibly from 15 Aug 2018 and not later than 02 Oct 2018.
- NHPS likely to be implemented by 5-7 states of India in the first year, with additional states onboarding in the following years.

borrow to pay healthcare bills. It is estimated that in India annually, 63 to 80 million people either get into poverty or fall deeper into poverty (if already below poverty line) due to health related expenditures. These expenditures on health grossly undermine the elaborate efforts by the union and state governments in India to reduce poverty. The unhealthy workforce leads to absenteeism and reduced productivity which also affects economic growth of country.

'Ayushman Bharat', National Health Policy 2017 and Universal Health Coverage

'Ayushman Bharat' program received instant public and media attention. This announcement follows up the proposals in National Health Policy of India (NHP-2017). The stated goal of NHP 2017 is in full alignment and echoes with the concept of Universal Health Coverage (UHC) at global level. Universal Health Coverage (UHC) is defined that 'all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services'. The NHP 2017 goal could be considered the most explicit 'statement of intent' by the Indian government to advance UHC in the country, which was further re-affirmed by the Union Finance Minister in his budget speech, when he said that "The government is steadily but surely progressing towards the goal of universal health coverage." Through 'Ayushman Bharat', two policy prescriptions of NHP 2017- strengthening primary healthcare and reducing financial burden on the people while accessing to health services, have been given 'implementable programmatic form' and can help India to make stride towards UHC.

Making 'Ayushman Bharat' program a Success:

A few steps could facilitate the implementation of 'Ayushman Bharat' program as follow:

Detailed planning and sustained engagement with stakeholders: There is a need for developing a detailed plan and time bound road-map for implementation. This would ensure the success of these initiatives from the early stage and to nudge additional states to join. The government should fully utilize available expertise within government and amongst the stakeholders at all levels.

Engage the state governments earnestly: Health is a state subject in India and atleast 24 Indian states have their own health insurance/assurance schemes with various degree of financial protection. There might be some reluctance amongst states to transition from their existing schemes. Moreover, under NHPS-2018, the state governments need to contribute financial resources. These contributions might be reasonably big for a few states such as UP and Bihar. Similarly, for HWC, the states have to take initiatives to train and depute mid-level health care providers in a time bound manner. Lack of availability of trained mid-level providers could be a rate limiting factor in setting up HWCs, and alternative mechanisms need to be explored for

Box 4:
Ayushman Bharat Program: Possible Considerations

Will it be helpful to prioritize implementation of NHPS in high focus states? There is 'supply deficiency' (of health services) in many states of India such as North Eastern States and also on the large Indian states ranked low in NITI Aayog's State Health Index-2018. Even with state willingness, in these states, the implementation of NHPS-2018 is likely to be a challenge. There are a number of Indian states which have broad range of health insurance scheme, approaching financial coverage slightly less than offered in NHPS and with good administrative capacity for insurance schemes, i.e., Chhattisgarh, Karnataka, Andhra Pradesh, Himachal Pradesh and Rajasthan. These states could also be prioritized for early adoption and implementation of NHPS.

Can 'Ayushman Bharat' replace National Health Mission? The National Health Mission (NHM) which has made a lot of difference in health services, however, is still perceived as a program for maternal and child health. It has been only partially successful in making health services integrated service delivery and reducing out of pocket. April 2020 onwards, 'Ayushman Bharat' program could be a suitable platform for transitioning from NHM to a more comprehensive system of health services for Indian citizen.

rapid availability of 150,000 such providers in next 3-4 years. All of these would require commitment and early engagement of political leadership of states.

Strengthen administrative regulatory and capacity at all levels: The state capacity to implement large scale insurance scheme (to design a benefit package, negotiate the cost with providers or monitor the implementation) is limited. Insurance scheme should not lead to induced care and state would have to ensure that care is appropriate to the need. In this context, the capacity of state governments to regulate health providers and health insurance sectors would take time to develop. The supply deficiency (specially in north eastern states and some central Indian states) could be an implementation challenge and need to be given a due importance.

Build on the learnings from past and other ongoing schemes: Though, in the past, Universal Health Insurance Scheme (2002), National Rural Health Mission (2005), Rashtriya Swasthya Bima Yojana(2008), National Urban Health Mission (2013) and NHPS- 2016 have been announced and success has been mixed. The free medicine and diagnostics schemes by various state governments and free dialysis program by union government have struggled to reach the targeted beneficiaries. These schemes need to be studied and lessons derived.

Sustain the top level of political commitment: The apparent high level of political commitment- starting from Prime Minister, Finance Minister, NITI Aayog and Ministry of Health and Family Welfare for Ayushman Bharat should be used to accelerate the implementation. The public and media attention received by the scheme could bring desired accountability.

Optimizing Implementation:

The epidemiological profile of the population changed in the last few decades, as reported in the 'State of the Health in India' report released in Nov 2017. The Indian health system needs to change to the need of people and not vice versa. The opportunity provided by Ayushman Bharat program can be best utilized to strengthen and re-design health systems in India in a more integrated and people centric fashion.

Strengthen primary healthcare and referral linkage: A stronger primary healthcare system (beyond HWCs) and continuum of care through functional referral linkage will be required to achieve UHC. Between basic healthcare closer to community (delivered through HWCs) and hospitalization (secondary care) there is role and definitive need for availability of physicians to provide out-patient consultations. Therefore, in addition to HWCs, the primary health centres and community health centres, also need to be strengthened.

Consider progressive universalization: First, the expansion of NHPS beyond 10 crore families, till entire population is covered, should be part of mid-term roadmap. While premium for poor can be paid by government, the non-poor[5] can join on basis of payment (preferably mandatory contribution). Second, NHPS is a good opportunity to integrate all health insurance schemes in Indian states, for creating a bigger and single pool at state

Box 5:

What would achieving UHC mean to an ordinary citizen of India?

What would it mean to a citizen of India to achieve universal health coverage in the country? Let's understand from the perspective of a poor, elderly widow living in a remote tribal village of India. To her, UHC would mean that she would have access to desired health services within acceptable distance and time frame. Her decision to seek healthcare services and choice to select a health facility would not depend upon her health problem or her place of living, or her income level. She would have enough choices on providers. When she would need specialized care, it would be facilitated by the first level of providers. When attending the health services from licensed providers, she would not have to worry about the quality. She would have reasonable assurance that government would have mechanisms in place that she receives good quality services. She would have sufficient confidence that access to services would be within her financial affordability and the use of health services would not make her poor. The day when elderly tribal widow in a faraway remote village in India would not have to worry about access and utilization of health services, that would be the day Indian government can claim to have achieved Universal Health Coverage.

level. Third, the expenditure on out-patient care and medicines and diagnostics constitutes nearly 2/3 of Out of pocket expenditures in India. The out-patient consultation should be included in NHPS packages.

Strengthen health care regulation: The Economic survey 2018 reported that in private sector, the cost of most laboratory investigation is highly variable. For example, the cost of Liver Function Tests (LFTs) in Indian cities ranges from Rs 90- to Rs 7,100. Clearly, there is need for controlling the price of healthcare. NHPS (through benefit package and pricing) supplemented by regulatory strengthening could bring the cost of healthcare down. Indian states do not need new regulation and effective implementation of existing regulatory mechanism can deliver a lot more.

Increasing government investment in health: Full functioning of HWCs including establishing of additional HWCs (especially in urban areas) would require an initial expenditure of around Rs. 30,000 crore and then annual recurrent expenditure of Rs. 20,000 crore. Full scale (100 per cent population coverage in future) and universal implementation of two schemes under 'Ayushman Bharat' would require around Rs 50,000 crore per annum. This is in alignment with stated NHP-2017 proposal to increase union government expenditure to the range of 2.5 per cent of Gross Domestic Product (GDP) by the year 2025.

In summary, there are a few possibilities that emerged after the Union Budget and it is up to the union and state governments to optimize the outcome. This could also be an opportunity to transition National Health Mission, April 2020 onwards (Box 4).

The Game-Changer in Making:

'Ayushman Bharat' program is a big ticket initiative and a potential game-changer. It has irreversibly placed health higher on political agenda and public discourse. Second, successful implementation world ensure that health challenges are addressed more holistically with focus on all levels of care (primary, secondary and tertiary care systems), covering prevention and health promotion as well. Third, it has brought attention back on strengthening primary healthcare and continuum of care. Fourth, the NHPS approach to target vulnerable and deprived population is a major policy shift from the traditional approach of targeting social sector programs on poor only. This single step has nearly doubled the target beneficiaries. Fifth, the launch of NHPS would formally introduce the concept of separation of provision and 'financing/purchasing function' and introduce 'strategic purchasing' in Indian states. Sixth, the linkage between good health and economic growth is being explicitly acknowledged[5]. Finally, the program appears to meet the legitimate expectations of people from any functioning health system: accessibility, affordability and appropriate care. It can provide an important milestone towards India's aspiration to achieve UHC (Box 5).

Conclusion:

For countries aiming to march towards Universal Health Coverage, there is no 'one size fits all' approach or solution. The strategies and pathways have to be locally developed and implemented. Every approach would have 'pros and cons' and the key would be to build upon strengths and minimize limitations. 'Ayushman Bharat' Program appears to be one such approach and is as much about delivering health services in short term as it is about preparing Indian health systems for making health coverage universal.For new India by 2022, effective implementation of 'Ayushman' (blessed with long life) Bharat program can ensure 'Niramaya' (healthy) Bharat as well. This would be possible when transition from 'policy and budgetary announcements' to 'on the ground implementation' is accelerated.

Footnotes

1. The health allocation referred here is the combined total of allocation made to Dept. of Health and Family welfare, Department of Health

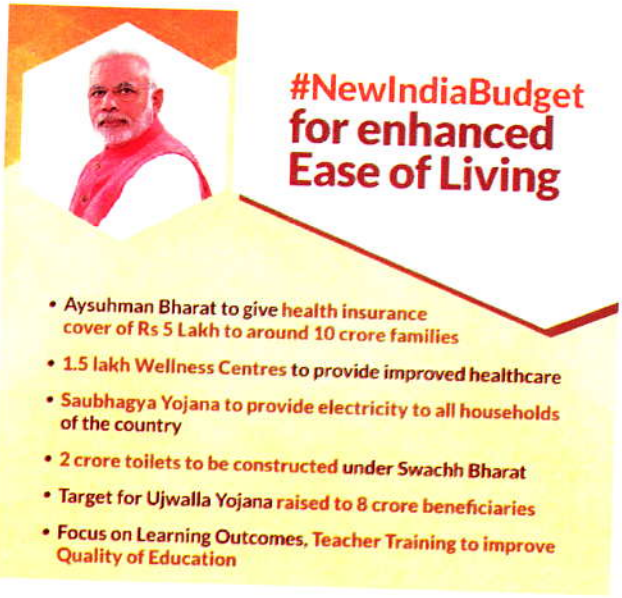
Research and Ministry of AYUSH. The figures are budget estimates (BE) for 2017-18 and 2018-19.

2. More specifically, the health sub-centres in India suffer from poor infrastructure, under-staffing and lack of equipment and medicines. Of 156,231 HSC as on 31 March 2017; only 17,204 or 11 per cent meet the Indian Public Health Standards (IPHS) set under National Health Mission. About one fifth of HSCs are without regular water supply and another one fourth without electricity. Over 6,000 HSC did not have an Auxiliary Nurse Midwife/health worker (female). The posts of health worker (male) are vacant at almost two-third of all (~100,000) HSC in India

3. Converting HSC into HWC will cost Rs. 17 Lakh per facility. In the year 2018-19, a total of 11,000 HSCs are proposed to be converted into HWCs. The total funds needed would be around Rs. 1,900 crore. However, centre's share provide 60 per cent of this amount, with remaining coming from state governments.

4. The acronym NHPS-2018 has been used in this article, to differentiate it from the scheme of similar name announced in union budget 2016-17. The NHPS- 2016 had proposed to provide financial cover of up to Rs. 100,000 per family per year with additional cover of Rs. 30,000 for every elderly member in the family. The NHPS-2016 was aimed to provide health cover to nearly 60 million families. Only elderly component of NHPS-2016 was immediately implemented and full scheme was awaiting approval by the union cabinet, when NHPS 2018 was announced.

5. Rashtriya Swasthya Bima Yojana or RSBY: This scheme was launched in year 2008 under Ministry of Labour and Employment and aimed to cover nearly 4 crore BPL families. The scheme provided insurance coverage of upto 30,000 to five members of families. In late 2014, the scheme was transferred to Ministry of Health and family Welfare, Government of India.



6. As poor & vulnerable often lack voice needed to get quality services from a government system, a scheme for poor and vulnerable only, has inherent risk of being implemented sub-optimally or offering poor quality of services. There is imperative that over period of time, non-poor are part of any government scheme.

7. The Union Finance Minister in his budget speech 2018-19 said "Only 'Swasth Bharat' can be 'Samridha Bharat'. India cannot realize its demographic dividends without its citizen being healthy.' and "Ayushman Bharat Programme will build a New India 2022 and ensure enhanced productivity, well-being and avert wage loss and impoverishment. These Schemes will also generate lakhs of jobs, particularly for women"

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