Placing Health Care at the Centre Stage

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The Union Budget of 2018 places health in the centre-stage of public discourse. However, the success of the ambitious initiatives that have been proposed depends on a sizeable and progressive increase in financial resources allocated to health in both central and state budgets from now on and a concerted effort to build wide-ranging capacity in the health system

In the past decade, media reports of pre-budget expectations and post-budget reactions of public health advocates on union budgets could have been scripted using the same words year after year. Hopes would be initially expressed that the allocation for health would rise substantially, followed by reactions of regret and remonstration that the budget failed to do so. The last time the budget brought some cheer to the health sector was when the National Rural Health Mission (NRHM) was announced, followed soon by the Rashtriya Swasthya Bima Yojana (RSBY) under the Labour Ministry. Otherwise, health remained on the margins in budget presentations.The budget of 2018 proved to be different, as it created a flurry of excitement among health professionals, media and the public with a package of major initiatives. That also sparked debates on whether and how health care will benefit overall from these ambitious proposals.

Two of these initiatives were packaged together under the evocative label of Ayushman Bharat programme A scheme to promote Comprehensive Primary Health Care (CPHC) was heralded by the proposal to transform 1,50,000 health sub- centres into Health and Wellness Centres (HWCs). The other twin in the programme is the National Health Protection Scheme (NHPS) which assures 10 crore poor and vulnerable families of financial coverage, up to ₹5,00,000 per annum, for hospitalisation costs of secondary or tertiary care.

CPHC builds upon the platform established by the NRHM, in aiming to strengthen primary health service delivery. While NRHM was focused on maternal and child health services, the National Health Policy (NHP) of 2017 calls for the National Health Mission (NHM) to become the vehicle for comprehensive, continuous primary care. This requires expansion of services to cover hitherto unattended areas like non-communicable diseases (NCDs) and mental health disorders. Ultimately, NHM has to become the unifying platform for primary health services related to maternal and child health, communicable and non-communicable diseases apart from advancing health promotion efforts in the community.

Continuity of care requires that long term care of chronic diseases is enabled through efficient follow-up at primary care level which also has reliable bi- directional referral and return linkages with advanced care at

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secondary and tertiary levels. Though primary care has had elements of continuous care underlying antenatal follow-up visits and monitored treatment of tuberculosis and HIV-AIDS, services had been mostly configured for acute, episodic care. With the growing need to provide long term care for chronic conditions like hypertension, and mental health disorders, primary care has to be reconfigured to assure continuity of care. Health promotion, through community level health education as well as individual counselling at the healthcare facility level, is an important activity that has been largely neglected in primary care so far. Just as healthy diets and regular physical activity must be advocated in communities, missed opportunities for assisting tobacco cessation must be minimised in primary healthcare facilities.

The proposal to transform sub-centres into HWCs gives shape to comprehensive primary care and enables continuity. It also brings basic health services closer to the homes of people in rural areas. Apart from facility based care, community outreach would also strengthen health promotion and disease prevention. Augmented by induction of non-physician healthcare providers such as nurse practitioners, in addition to the existing staff, the HWC will provide essential drugs and basic diagnostics free of cost. Various vertical disease control programmes will find convergence at this delivery point. With appropriate use of information technology, HWCs can generate real time data for disaggregated estimates and monitoring of various health indicators. Judicious use of telemedicine and mobile phone technologies can help improve the delivery of healthcare at HWC, through engagement of distant doctors.

While the activation of HWCs is welcome, efforts to strengthen primary health services must extend also to primary and community health centres. The budgetary allocation to the National Health Mission does not reflect that commitment. It has come down by 2.1 per cent from the revised estimate of the preceding year. It is also disappointing to see that the Urban Health Mission component of NHM has been virtually ignored in the budget. Urban primary healthcare has been far too long neglected in both design and delivery. With increasing rural to urban migration, and the growth of urban slums and low income communities, primary health services in cities and towns acquires great urgency. HWCs will be needed for urban populations too. The sum of ₹1200 crores allotted for HWCs will need to be increased as the effort is scaled up.

The major challenge for developing fully functional HWCs is the shortage of human resources. While PHCs have suffered from non-availability of doctors, HWCs will be staffed by non-physician healthcare providers only.

Ayushman Bharat for a New India -2022

The Government announced two major initiatives in health sector, as part of Ayushman Bharat programme. The initiatives are as follows:-

Health and Wellness Centre:- The National Health Policy, 2017 has envisioned Health and Wellness Centres as the foundation of India's health system. Under this, 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. The Budget has allocated Rs.1200 crore for this flagship programme. Contribution of private sector through CSR and philanthropic institutions in adopting these centres is also envisaged.

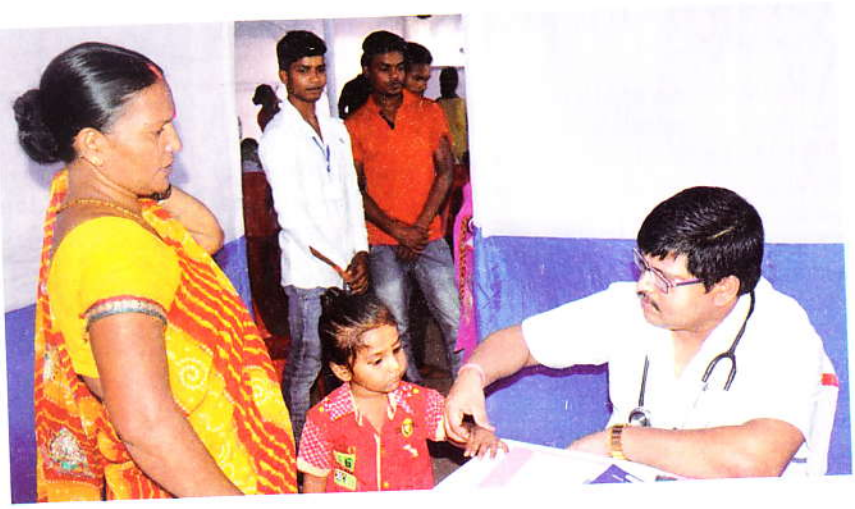
National Health Protection Scheme:- The second flagship programme under Ayushman Bharat is National Health Protection Scheme, which will cover over 10 crore poor and vulnerable families (approximately 50 crore beneficiaries) providing coverage upto 5 lakh rupees per family, per year for secondary and tertiary care hospitalization. This will be the world's largest government funded health care programme. Adequate funds will be provided for smooth implementation of this programme.

The Finance Minister said that in order to further enhance accessibility of quality medical education and health care, 24 new Government Medical Colleges and Hospitals will be set up, by up-grading existing district hospitals in the country. This would ensure that there is at least one Medical College for every 3 Parliamentary Constituencies and at least one Government Medical College in each State of the country.

However, there is need to create mid-level healthcare providers like nurse practitioners and community health assistants who have gone through a three year degree programme which is tailored to primary health care needs. The proposal to deploy AYUSH graduates (trained in traditional systems of medicine), with bridge course orientation to allopathic medicine, is controversial. Ideally, AYUSH practitioners should be placed in HWCs to provide expertise in the traditional systems of healing and health promotion wherein they have been trained. Apart from two Auxiliary Nurse Midwives, a male multi-purpose worker also would be needed. A laboratory technician cum drug dispenser would also be needed. Creating the human resource pool needed for HWCs will require a major effort but will also result in job creation for many young people. Most importantly, it will build the defenses of health and portals of healthcare close to the community.

NHPS builds on the experience and lessons of RSBY. While the poor gained increased access to secondary health care through RSBY, the coverage was limited to ₹30,000 annually per family. It had to compete in some states with state-funded health insurance schemes which offered annual coverage between ₹ 1-3 lakhs per family. More importantly, it failed to provide financial protection against out of pocket health expenditure, catastrophic expenditure or healthcare induced impoverishment. The ability to engage both public and private providers and creation of strong information technology platforms have been gains from the RSBY experience. The disconnect from primary care has minimised the impact of these central and state health insurance schemes on population health indicators.

NHPS offers ₹ 5,00,000 cover per annum for 10 crore poor and vulnerable families, to support hospitalised care. This substantial raise from RSBY will probably reduce the levels of catastrophic health expenditure but will not impact out of pocket expenditure, since outpatient care is not covered. HWCs and other primary care



strengthening efforts should provide relief in that area. Efficient primary care services will also be required to reduce the need for secondary and tertiary care services and act as a prudent gatekeeper for referral to advanced care. In the absence of effective primary health services, the uncontrolled demand for NHPS will drain the health budget and, in turn, reduce the funds available for primary care and public sector hospital strengthening.

Though only ₹2000 crores have been allotted this year, as the scheme will only be launched in October 2018, the funding requirement would rise at least five to six fold when NHPS becomes fully operational. State governments are expected to contribute 40 per cent of the cost and will be encouraged to merge state funded health insurance schemes with NHPS. Apart from expanding the resource pool and widening the 'risk pool' of population to be covered, such merger will also ensure portability of coverage to persons who move across state borders. However, this calls for consensus across different political parties in governance across the country.

Strategic purchasing is the process by which NHPS proposes to judiciously purchase services from empanelled public and private hospitals. This requires a careful choice of the diseases, tests and treatments to be covered, development and adoption of evidence based standard clinical management guidelines, setting and monitoring of cost and quality standards and measurement of health outcomes. Fraud detection and grievance redressal mechanisms too need to be developed. Public awareness of the benefits offered under NHPS ('insurance literacy') must be promoted, to increase enrolment and guide appropriate utilisation. If all of these safeguards are not in place, there will be danger of induced demand (unnecessary tests and treatments) escalating costs.

The administration of NHPS will be through a trust or an insurance company. The choice of the intermediary will be left to the state governments. The trust, established by the government, has greater accountability and less overheads. An insurance company comes with prior expertise in strategic purchasing and payments but has more expensive overheads and is likely to demand higher premiums as the utilisation rates go up. In either case, it is the government that pays the premiums. While this differs from an individually purchased insurance scheme, the principle of 'risk pooling' is common. In a large risk pool, the healthy cross-subsidise the sick in any given year, keeping the premiums down. Though NHPS is a targeted programme for the poor and vulnerable families, financed from tax revenues of the government, there is an opportunity for the non-

poor also to buy in to this scheme by paying the premiums set for NHPS.

The need for producing more basic doctors and specialists has been recognised, as is the necessity of strengthening district hospitals. The budget proposes to start 24 new medical colleges, attached to upgraded district hospitals. A medical college for every three parliamentary constituencies has been envisaged. This too calls for higher levels of public financing, as private sector investment has mostly been limited to a few states. The overall increase in the health budget, however, is only 2.8 per cent over the revised estimates for the previous year's allocation. Allocation for establishment of new medical colleges has been reduced by 12.5 per cent. Unless the budgets from now on show a substantial year on year increase, the NHP target for public financing, of 2.5 per cent of GDP by 2025, is unlikely to be attained.

The budget addresses some of the social and environmental determinants of health. ₹600 crores has been allocated to provide financial support to patients of tuberculosis to improve their nutrition, through a monthly stipend of ₹500. This will help to boost their immunity and improve treatment results. Sanitation component of Swachh Bharat mission will be scaled up through construction of more toilets, to reduce the health hazards of open defecation. Air pollution, the second most important cause of ill health in India according to a recent estimate, will be addressed through interventions aimed at both ambient and indoor air pollution. Delhi's neighbouring states would be provided financial support for promoting in-situ disposal of crop waste by non- burning methods. The Ujjwala scheme will be expanded to provide cooking gas connections to more poor women, to help them and their young children escape the kitchen's curse of air pollution from combustion of solid biomass fuels. Risks of respiratory diseases, cardiovascular disorders, cancers, childhood asthma and respiratory infections and even diabetes will be reduced through control of air pollution.

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