AYUSHMAN BHARAT: INDIA'S ROAD TO UNIVERSAL HEALTH COVERAGE

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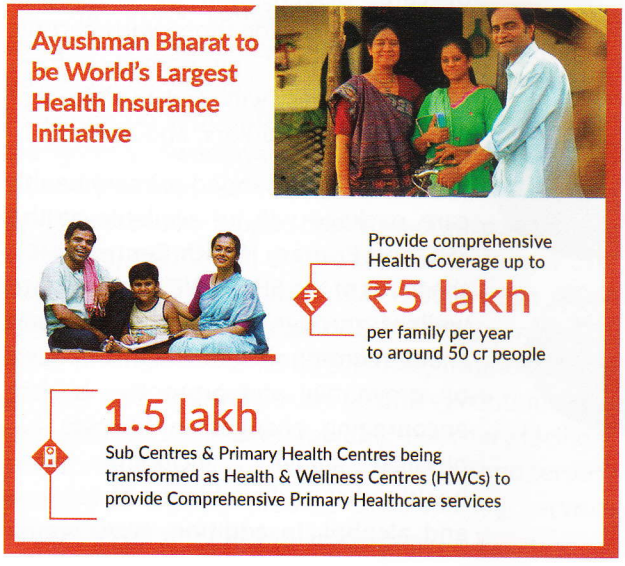
No central scheme, no matter how consultative and participatory the process of design, can hope to address the challenges in implementation. Differences between existing health systems in states, funds availability, political, geographical and governance contexts elucidates that there cannot be a one-size-fits-all approach. Nevertheless, there are common strategies that can help all states expand and improve access to CPHC. The ability to convert vision into practice, learning from multi contextual experiences and evidence and converting them into intervention strategies, will be the true test of Ayushman Bharat.

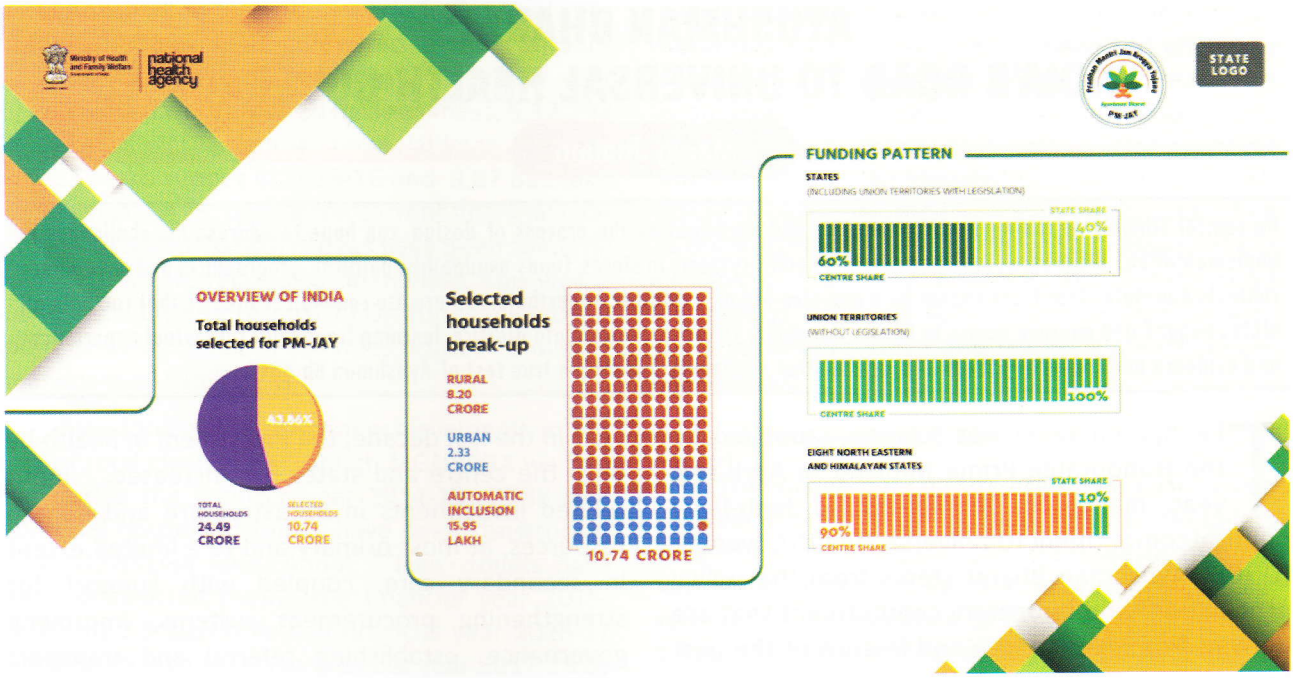
The Ayushman Bharat scheme, launched by the Honourable Prime Minister in April this year, marks an unprecedented high-level political commitment to Universal Health Coverage (UHC). Ayushman Bharat stems from the policy articulation[1] and budgetary commitment that are derived from experiences and lessons of the past few decades.

Ayushmaan Bharat comprises two pillars - the first is provision of universal and Comprehensive Primary Health Care (CPHC) delivered in formulation of Health and Wellness Centres (HWCs); which are the transformed first two tiers of the public health system i.e. the Sub Health Centres (SHC) and the Primary Health Centres (PHC). The second component is the Pradhan Mantri Jan Arogya Abhiyaan (PMJAY), for provision of health coverage of upto Rs. 5,00,000/family for nearly 10.34 crore households to obtain secondary and tertiary in-patient care. The implementation of Ayushman Bharat rests on the health systems strengthening achieved through the National Health Mission (NHM).



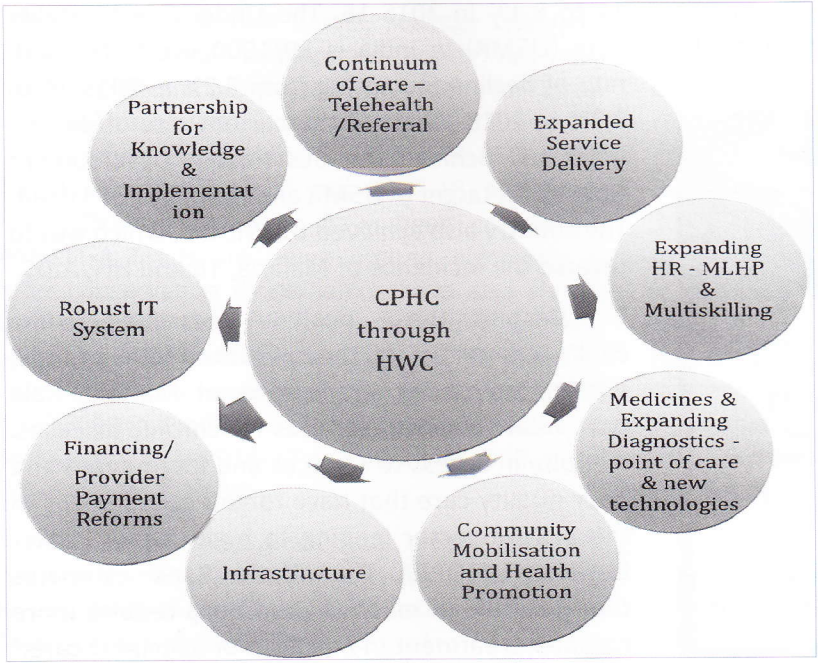
In the last decade, the investment in health by both the centre and states has increased. Input related investments in infrastructure and human resources, at most primary and to a limited extent in secondary care, coupled with support for strengthening procurement systems, improving governance, establishing referral and transport systems, incentives for performance have yielded accelerated positive outcomes for mothers and children, and to an extent ,in communicable diseases as well. As per the latest report of the Registrar General of India, Sample Registration System (RGI-SRS), MMR of India has shown a decline from 167 per 100,000 live births in the period 2011-13 to 130 per 100,000 live births in the period 2014-16. India has thus, achieved the Millennium Development Goal (MDG) for Maternal Mortality Ratio (MMR). Infant Mortality Rate (IMR) is 34/1000 live births with rate of decline increasing from 2.5% in 2013-14 to 8.1% in 2015-16. The Under-Five Mortality Rate (U5MR) in India is 39/1000 live births with rate of decline increasing from 8.2% in 2013-14 to 9.3% in 2015-16. At at the current rate of decline India will achieve the Sustainable Development Goal (SDG) target of U5MR and MMR by 2023 itself. The country also achieved the MDG 6, which was to reverse the incidence of Malaria, TB and HIV/AIDS.

Despite these positive outcomes, some challenges persist viz. the unfinished MDG agenda, elimination of TB, eradication of Malaria, Kala Azar, relative lack of services for chronic diseases, inequity in access to services and fragmented and poor quality care that have forced care seeking in the private sector leading to high Out of Pocket Expenses (OOPE). The World Bank estimates that just 10% of medical conditions require more complex treatment in hospitals or specialist care.[2]



The delivery of CPHC through HWCs therefore becomes a necessity. Without effective primary health care, India is likely to be unable to meet either the goals of the NHP-2017 or its commitments to the SDGs. However, the transformation of HWC requires action on many fronts and coordination of multiple work streams, as demonstrated in Box 1.

The impetus on Ayushman Bharat – HWCs is aimed at a paradigm shift in provisioning CPHC to the people:



i) HWC will enable the expansion of package of services that go beyond Maternal & Child Health (MCH), to include care for non-communicable diseases, palliative and rehabilitative care, oral, eye and Ear-Nose-Throat (ENT) care, mental health and first level care for emergencies and trauma.

ii) In order to provide these services at the Sub Health Centre (SHC)- HWC, a new cadre of worker – the Mid-Level Health Provider (MLHP)- who is either a nurse or an Ayurveda practitioner, trained in competencies of public health and primary health care, clinical management, continuum of care, dispensation of drugs and close follow up for those with chronic illness/patients discharged from health facilities, will lead the team of Multipurpose Workers, and ASHAs.

iii) While the expanded primary health care package will be available at the SHC and Primary Health Centre (PHC), the focus of the SHC-HWC is to promote wellness through social and behavioural change communication for an emphasis on preventive and promotive health, encouraging changes in lifestyle i.e. physical activity, including yoga, healthy diet and avoidance of tobacco and alcohol. In addition, HWC would

provide preventive care for MCH and undertake screening and early detection, dispense drugs and conduct regular follow up for chronic care, including post operative, rehabilitative care.

iv) The HWC would follow a well-defined referral chain to ensure continuum of care. PHC-HWC are linked to their SHC- HWC, with the PHC Medical Officer (MO) serving as the team leader for the HWC cluster. Care for all packages is also available at the PHC level, but of a higher order of complexity. For chronic diseases such as hypertension and diabetes, the PHC MO could initiate the treatment plan. In addition, the MLHP and PHC MO would access specialist care through telemedicine hubs located at the district/ medical college levels.

v) There would be a progressive inclusion of diagnostic tests and medicines available at the HWCs so that more conditions could be managed at those levels and less referral happens to higher facilities.

Besides the above mentioned services, other important elements of the HWCs include: (i) a robust IT system for population enumeration (such that every individual and family is mapped to a particular SHC-HWC and uses it as the first port of call), (ii) use of digital apps for frontline workers for enumeration, recording of services, reporting and payment of team based incentives, serve as clinical decision support system and (iii) regular up-gradation of skills of all providers through distance learning and the use of platforms such as ECHO for clinical support, supervision and mentoring.

The other component of Ayushman Bharat which makes it a programme for ensuring UHC is the Pradhan Mantri Jan Arogya Yojana (PMJAY). Launched on September 23, 2018, it has subsumed the Rashtriya Swasthya Bima Yojana (RSBY) and Senior Citizen Health Insurance Scheme (SCHIS). Poised to be the largest public-funded health insurance scheme in the world, PMJAY will ensure the continuum of care from AB-HWCs and substantial reduction in OOPE on catastrophic healthcare. AB-PMJAY leverages on CPHC through HWCs for preventive, promotive and curative care and will ensure seamless continuum of care. This will avoid overcrowding in tertiary facilities and improve quality of care at secondary and tertiary facilities as well as provide UHC, making services equitable, affordable and accessible.

PMJAY is an entitlement based scheme. This scheme covers poor and vulnerable families based on deprivation and occupational criteria as per Socio-Economic and Caste Census (SECC) data. It will cover over 10 crore poor and vulnerable families (approx. 50 crore beneficiaries) providing coverage upto Rs. 5 lakh per family per year for secondary and tertiary hospitalization. There is no limit on the family size to ensure that all members of designated families specifically girl child & senior citizens, get coverage. Services are cashless & paperless, at the point of service, in both the public and empanelled private facilities. These will also be portable anywhere in the country.

The AB-PMJAY is being managed by National Health Agency (NHA). The current status of implementation of this schemes is that 33 States/ UTs have signed MoUs or agreed to sign MoU with the Centre (remaining being Odisha, Telangana and Delhi) and out of these, 26 States have started the implementation. There are three modes of implementing the scheme i.e. Insurance Mode,

Trust Mode and Mixed Mode. The NHA has created robust safeguards to prevent misuse/ fraud/ abuse by providers and users, including pre-authorisation being made mandatory for procedures with moral hazard. As on date, one lakh beneficiaries have availed of services under PMJAY, in a period of just about a month.

In conclusion, we must be cognizant that policy articulation alone will not suffice. In India's federal structure, the power for effective implementation vests with the states. No central scheme, no matter how consultative and participatory the process of design, can hope to address the challenges in implementation. Differences between existing health systems in states, funds availability, political, geographical and governance contexts elucidates that there cannot be a one-size-fits-all approach. Nevertheless, there are common strategies that can help all states expand and improve access to CPHC. The ability to convert vision into practice, learning from multi contextual experiences and evidence and converting them into intervention strategies, will be the true test of Ayushman Bharat. This programme will succeed or fail depending on our efforts and collective energy focussed on its implementation, advocating with all stakeholders, operationalizing multi-sectoral action, making sufficient financial investment and above all, holding ourselves accountable to people to deliver high quality CPHC as we move towards the aspiration of Universal Health Care.

Footnote

1. National Health Policy, 2017, Ministry of Health and Family Welfare, Government of India.
2. Doherty G and Govender R, 'The cost effectiveness of primary care services in developing countries: A review of international literature', Working Paper No. 37, Disease Control Priorities Project, World Bank, WHO and Fogarty International Centre of the US National institutes of Health, 2004, https://www.researchgate.net/publication/242783643_The_Cost-Effectiveness_of_Primary_Care_Services_in_Developing_Countries_A_Review_of_the_International_Literature

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National Health Agency (NHA)

For focused approach and effective implementation of PM-JAY, an autonomous entity, the National Health Agency (NHA) was constituted. Established as a Society on 11th May 2018, the National Health Agency is registered under the Society Registration Act, 1860. The State Governments are expected to similarly set up State Health Agencies (SHA) to implement PM-JAY.

The National Health Agency (NHA) will provide overall vision and stewardship for design, roll-out, implementation and management of Pradhan Mantri Jan Arogya Yojana (PM-JAY) in alliance with state governments. Inter-alia, this will include, formulation of PM-JAY policies, development of operational guidelines, implementation mechanisms, co-ordination with state governments, monitoring and oversight of PM-JAY amongst other.

The National Health Agency will play a critical role in fostering linkages as well as convergence of PM-JAY with health and related programs of the Central and State Governments, including but not limited to Ayushman Bharat - Comprehensive Primary Health Care, the National Health Mission, RSBY to name a few.The NHA will lead the development of strategic partnerships and collaborations with Central and State Governments, civil society, financial and insurance agencies, academia, think tanks, national and international organizations and other stakeholders to further the objectives of PM-JAY.

The National Health Agency will provide technical advice and operational inputs, as relevant, to states, districts and sub-districts for PM-JAY including formulating standards/ SOPs/guidelines/manuals to guide implementation, identification of capacity gaps and related trainings, development of health information and IT systems, facilitating cross-learnings, documentation of best practices, research and evaluation and undertake associated administrative and regulatory functions as a Society.

(Source : Ayushman Bharat Website (www.abnhpm.gov.in)