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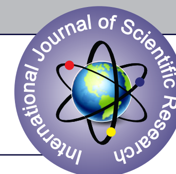

TRANSFORMING HEALTH CARE IN INDIA: AYUSHMAN BHARAT-NATIONAL HEALTH PROTECTION MISSION

Healthcare

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ABSTRACT

BACKGROUND: India with 1.34 billion population is facing unique health care delivery problems particularly regarding the poor spending on health, access, quality, safety, lack of accountability, corruption, etc. Inequalities and health-related expenses resulting in impoverishment further marginalises the poor, underprivileged and outreach. The government of India has come up with a highly ambitious initiative Ayushman Bharat – National Health Protection Mission (AB-NHPM) as a shift from traditional health planning approaches towards a comprehensive healthcare vision.

METHODS: Literature available, government publications, documents, press releases and other related material has been consulted to appraise the NHPM initiative.

RESULTS: AB-NHPS was officially announced by Prime Minister Narendra Modi on 15 August 2018, in his Independence Day speech. This flagship project was launched on September 25, 2018. The objective of ambitious AB-NHPSis to provide coverage of INR 500,00 per family annually, benefiting more than 10 crore poor families. The scheme will target poor, deprived rural families and identified occupational category of urban workers' families, 8.03 crore in rural and 2.33 crore in urban areas, as per the latest Socio-economic Caste Census (SECC) data. The eligibility criteria include: 10 crore families belonging to poor and vulnerable population based on SECC database, will take care of almost all secondary care and most of tertiary care procedures, the entitlement will be decided on the basis of deprivation criteria in the SECC database, automatically included families in rural areas having any one of the following: households without shelter, destitute, living on alms, manual scavenger families, primitive tribal groups, legally released bonded labour, will also come under this scheme. For urban areas, 11 defined occupational categories will be entitled under the scheme, the treatment in case of hospitalization will be free of cost for the family, all pre-existing conditions will be covered from day one of the policy. The benefit cover will include pre and post hospitalization and the beneficiary will be able to go to public or empanelled private hospitals across the country and get free treatment.

CONCLUSION: The NHPS enjoys a guaranteed potential to improve the lives of millions of Indians. The scheme is prominent against the backdrop that several Central Ministries and State/UT Governments have launched health insurance/ protection schemes for their own specific set of beneficiaries. To improve their efficiency, reach and coverage, a critical need has been recognized to converge these schemes, such as the Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS).

This article presents the critical analysis of policy initiative, philosophy, key features, implications, impact, concerns, constraints and paving the way for future healthcare solutions.

KEYWORDS

Ayushman Bharat, National Health Protection Mission, Universal Health Care, Health Insurance, Health Reform, National Health Stack

Human development is a grave concern for any country. As education, health, employment, food security, nutrition, and demographic transition are all crucial components, the government must necessarily accord to them the foremost priority. This entails strong political will, beyond mere economic growth minus appropriate interventions towards reducing poverty, and these issues must be at the top of the development agenda. The focus must be on knowledge revolution and the establishment of a knowledge-based society in India will require tapping into the huge untapped human potential. As the greatest challenge is employment generation this will probably be the most important factor to achieve reduction in poverty and ensuring easy access to food and other essentials for the citizens to maintain a healthy life. Today, nearly one-half of India's population suffers from chronic under-nutrition and malnutrition. Therefore, households need to be enabled to acquire the required purchasing power for assured economic access to food and livelihood security. India possesses good prospects of emerging as a developed economy by realizing the individual and collective potentials of its citizens. Broad lines of policy and strategy are essential to achieve this objective. In a couple of decades, India is predicted to have a healthier and more prosperous population than over the past few centuries. As education is the foundation for productivity growth, 100% literacy is an absolute need. Many factors together establish the health of the nation [determinants of health]. Although the Indian population has improved in health substantially over the past 70 years, many gray areas exist. Inequalities in health status are still present. A huge divide is evident between the urban and rural populations, rich and poor, among the different States, and even between the districts within the States, with regards to access to health care facilities, infant and maternal mortality rates, life expectancy and nutrition. The infant mortality rate among the poorest quintet of the population is 2.5 times higher than that among the richest. Nearly 100,000 women die each year from pregnancy-related complications.

India is facing the triple burden of disease, viz., communicable diseases, lifestyle diseases and injuries.

In order to support a more equitable and effective health care system and provide universal access, public spending must be increased four-fold from the present 1.3%. A geographically more dispersed and equitable development paradigm is crucial, to reduce the disparities between the rural and urban centers.

Good health is the foundation of any country's human capital. The health of a nation can be raised by establishing massive rural health infrastructure, with human resources. This requires over 500,000 trained doctors, over 700,000 nurses and other health care workers, 25,000 primary and community health centers, 1,600,000 sub-centers, complemented by 22,000 dispensaries, and 2,800 hospitals practicing the Indian system of medicine and homeopathy. This infrastructure, however, faces deficiencies like the lack of equipment, financial constraints etc. Other inadequacies include lack of access to essential drugs (only 35% have access, compared to the UMI reference level of above 82%); immunization below 12 years is 60% compared to the UMI level of over 90%.

A responsive and effective health system demands universal access and availability of good quality health care without financial burden, as well as the fair distribution of financial costs for the access and impartial distribution of the burden in rational care and capacity. Disease prevention and health promotion are pressing needs. Health insurance can definitely refine the health care system. The target must be the vulnerable groups (children and women), particularly the girl child. All levels and sections of the population from across the country should move together into a prosperous future.

An ideal health care system should include universal access, fair distribution of financial costs for the access, trained providers for competence and accountability and special attention paid to the vulnerable groups (children and women). When health policies and innovative schemes are formulated, one needs to go beyond the limits of the immediate past. India now faces the challenge of successfully implementing this innovative project. While both the knowledge and capacity to achieve Health for All are available, political will,

determination and honesty are needed to achieve it immediately. Knowledge is absolutely central to development and progress calls for resources to speed it up. The potential of knowledge-based resources (technology, organization, information, education, skills) must be fully exploited. Although the challenges are enormous, the opportunities are tremendous.

In light of the present issues it faces, India decided to transform its health system by introducing an innovative and pathbreaking scheme - the Ayushman Bharat-National Health Protection Mission [Modicare] - during its 2018-2019 budget, with Cabinet approval. This scheme, effective from August 15, 2018, (implemented on 25 September, 2018), offers free health insurance benefits cover for over 40% of the total population and is already making huge waves globally.

Towards the goal of Universal Health Coverage

The health system in India has steadily evolved over 70 years. Considering the prevailing demographic and epidemiological pressures, an effective and efficient health care delivery system is indispensable. The public health system today has drawbacks of low quality care, corruption, dissatisfaction with the system, lack of accountability, unethical care, overcrowded clinics, poor cooperation between the public and private spheres, barriers to access health services and medicines, ignorance regarding public health, and low affordability.[1,2]

Therefore, the wealthier Indians utilize the private health care system, which the low-income families cannot avail of, thus creating the inequality between the classes for medical treatment.[3]

Besides the rural-urban divide, another key factor driving India's health care is the high out of pocket expenditure (nearly 70%). Most Indian patients pay for their hospital visits and doctors' appointments straight up with cash after care, with no payment arrangements. The World Bank's and National Commission's reports on Macroeconomics show that only 5% of Indians are covered by health insurance policies. This low figure has produced a nascent health insurance market, solely available for the urban-, middle- and high-income populations. It is encouraging that the health insurance market has been steadily penetrating into the other areas, over time, and is ranked among the fastest-growing business segments, in India.

The government of India runs several safety net health insurance programs for the high-risk population and actively regulates the private insurance markets. Currently, the programs available include, Community Health Insurance for those below the poverty line and Life Insurance Company (LIC) policies for senior citizens. These plans which are monitored and controlled by the government-run General Insurance Corporation, are designed to enable individuals to pay cash up-front, and then get reimbursed by filing their claims. Additional plans are being offered to government employees, and a few private companies are also selling private health insurance policies to the public.[1]

Currently, the private sector provides nearly 80% of outpatient and 60% of inpatient care.[3] However, due to their urban aggregation and nonengagement with primary health care providers, these facilities fail to provide basic health care both to large segments of the rural population and the urban poor. Although modest by international standards, the private-sector health care remains unaffordable for most Indians. As the prevailing weak regulatory systems have neither set nor enforced standards of quality and cost, many patients receive inadequate, inappropriate, or even unethical care. Only very few can afford privately purchased or employer-provided health insurance because 93% of the workforce are self-employed or contracted workers, and poverty levels are high. Therefore, 70% of the health care expenditures involve out of pocket spending, impoverishing many.[3,4]

The burgeoning discontent with the access, affordability, and quality of care has catalyzed reforms over the past decade. Policymakers have recognized that health is essential to economic development, and that India's healthy young population offers a demographic window of opportunity for accelerated economic growth. Simultaneously, the Indian civil society organizations were advocating legislated “right to health.” The policy discourse on universal health coverage picked up momentum from the convergence of these arguments.[3,4]

The recent global cry is for universal health coverage that will ensure that anyone requiring health services can get them, without undue financial hardship. This has triggered a strong demand for greater expertise, evidence, and measures of progress towards UHC, and an impetus for the UHC as one of the possible goals of the post-2015 development agenda.

India is commencing an ambitious trajectory of achieving Universal Health Coverage for all during 12th Five Year Plan, where every citizen will be entitled to comprehensive health security. Every State will be obligated to provide adequate food, appropriate medical care, safe drinking water, proper sanitation, education and health-related information for good health. The State will be responsible for ensuring and guaranteeing its citizens UHC. Delivery of the UHC includes the availability of adequate health care infrastructure, skilled health workforce and access to affordable drugs and technologies to guarantee the entitled level and quality of care given to every citizen. Further, the design and delivery of the health programs and services require efficient management systems, besides the active participation of the communities thus empowered.

UHC is pivotal to improved health security and transformation of individual wellbeing. Ayushman Bharat – National Health Protection Mission (AB-NHPM) will warrant health for all, specifically the poorest and most vulnerable, utilizing core technology as its backbone to leverage cutting-edge digital solutions. NITI Aayog proposes the imperative need to completely redesign the flow of people, money, and information, as well as introduce a layered approach to provide comprehensive foundational health functions for all the States and programs, grounded strongly in an inclusive and interoperable technology strategy.

Universal health coverage aims at providing all individuals with access to their required health services (including the prevention, promotion, treatment and rehabilitation), effective in quality and ensure that these services do not put the user under financial stress. This necessitates a strong, efficient, and well-run health system; a system for financing health services; access to essential medicines and technologies an adequate number of well-trained, motivated health workers. The UHC thus directly impacts the health and welfare of a population. Access to health services raises the productivity of individuals making them active contributors to both their families and communities. It also guarantees that children can attend school and acquire education. At the same time, this financial risk protection keeps people from falling into poverty, which occurs when health services have to be paid out of pocket.

Continued progress and a large public-sector role in health systems reform are crucial and urgent needs. From now onwards the focus must be on the ways to cope with the transition.

A good health system delivers quality services to all individuals, when and where they require them and involves the following: a robust financing mechanism; well-trained and adequately paid workforce; reliable data on which to base decisions and policies; well-maintained facilities and logistics to deliver high quality medicines and technologies.

The government should ensure equitable access for all Indian citizens, resident anywhere in the country, irrespective of their income levels, social status, gender, caste or religion, to affordable, accountable and appropriate health services of assured quality (promotive, preventive, curative and rehabilitative), as well as public health services which address the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the sole provider of health and related services.

The UHC essentially entails a strong, efficient and well-run health system, with a system to finance it, access to essential medicines and technologies and adequate numbers of well-trained and motivated health workers.

The Indian government has already initiated several schemes to provide quality health services to its citizens. The National Rural Health Mission (NRHM) launched in 2005 seeks to provide accessible, affordable and quality health care to the rural population, especially the most vulnerable segments. It also desires to reduce the Maternal Mortality Ratio in the country from 407 to 100 per 100,000 live births. Infant Mortality Ratio decreased from 60 to 30 per 1000 live births and the Total Fertility Rate declined from 3.0 to 2.1 within

the 7-year period of this Mission.

Today, the NRHM along with the recently launched National Urban Health Mission (NUHM) is under the National Health Mission (NHM). Despite significant progress, India has faced enormous challenges in terms of the *availability* of health care services which are inadequate, *quality* of health care services which varies considerably, as the regulatory standards for public and private hospitals are poorly enforced, and *affordability* of health care which remains a humongous problem for the vast majority of the population, especially at the tertiary level.

The lack of extensive and adequately funded public health services has caused a substantial proportion of the population to incur heavy out of pocket (OOP) expenditure to avail of the private sector services. The OOP expenses in India as a proportion of total health expenditure is at a high of 61.7%, contrary to the global average of 20.5%.

The total expenditure on health care, including public and private expenditures is broadly comparable to that of the other developing countries possessing similar per capita income levels. The total expenditure on health care (both public and private) is 3.7% of the GDP. However, according to the World Health Statistics 2013, public expenditure on health is very low, constituting 28.2% of the total health expenditure. According to the Government of India's 12th Five Year Plan, public health expenditure in India was only 1.04% of the GDP in 2011–12 compared to the global average of 5.4%.

Only a few people have health insurance in India. In fact, only 21.62 crore people, or 17% of the total population, had health insurance, by March 2014. The estimate, prepared by the Insurance Regulatory and Development Authority (IRDA), is sharply below that of the World Bank. The October 2012 report stated, “Government-Sponsored Health Insurance in India: Are You Covered?” The World Bank estimated that over 30 crore people, or above 25% of the population, had acquired at least some form of health insurance by 2010, an increase from 5.5 crore during 2003-04. It stated more than 18 crore individuals of this group included people below the poverty line,.[5]

Observing that health expenditure ranked among the significant causes of poverty in India, it was reported that from 2007 to 2012, government-sponsored schemes enabled a significant increase in the population covered by health insurance, at a pace almost unmatched elsewhere globally. Based on these trends, the report projected that above 63 crore people, or about 50% of the population, could get health insurance cover by 2015. By then, spending through health insurance was also predicted to reach 8.4% of the total health expenditure, an improvement from 6.4% during 2009-10.[5]

India's public financing for health care, according to the World Bank estimate is less than 1% of the world's total health expenditure, although it supports over 17% of the global population. Families meet almost 70% of their health expenses out of pocket, a heavy burden on poor households, often forcing them deeper into poverty.[5]

Demographic Transition

India, with a total of 1,349,985,632 (1.34 billion) individuals is the second most populous country in the world, while China is the foremost with over 1,415,489,506 (1.41 billion) people. India represents almost 17.85% of the global population, implying one out of six people on this planet is of Indian origin. With the population growth rate at 1.2%, India is predicted to cross 1.53 billion in population by the end of 2030.[6]

More than 50% of India's population at present is below 25 years, while over 65% are under 35 years of age. About 72.2% of the population occupy around 638,000 villages while the remaining 27.8% reside in about 5,480 towns and urban agglomerations. The birth rate (childbirths per 1,000 people per year) is 22.22 births/1,000 population (2009 estimated), while the death rate (deaths per 1000 individuals per year) is 6.4 deaths/1,000 population. The fertility rate is 2.72 children born per woman (NFHS-3, in 2008) and the infant mortality rate is 30.15 deaths/1,000 live births (2009 estimated). India also has dubious distinction of having the largest illiterate population in the world. According to the Population Census of 2011, the India has a literacy rate of 74.04%, with the rates of male and female literacy of 82.14% and 65.46%, respectively. State wise, Kerala with 93.9% boasts the highest literacy rate, Lakshadweep, with 92.3% is next and Mizoram with 91.6% is third.[7,8,9]

India's rapidly growing population is caused by significant factors like poverty, illiteracy, high fertility rate, rapid decline in the death or mortality rates and immigration from Bangladesh and Nepal.

Health and Human Development Indicators

The per capita expenditure in India on health care is among lowest in the world, with the spending as low as INR 3 per day, per citizen.[7,8]

The public health per capita per year costs the government INR 1,112, which is sadly less than the cost of a single consultation at the country's top private hospitals or approximately the cost of a single pizza! This is equal to INR 93 per month or INR 3 per day.[6]

At 1.02% of its gross domestic product (GDP) – a figure which has remained almost unaltered in nine years, since 2009 – India's public health expenditure ranks amongst the lowest in the world. even below that of most low-income countries, which according to the National Health Profile, 2018, spend 1.4% of their GDP on health care.

The National Health Policy 2017 reiterated that public health spending must be raised to 2.5% of the GDP by 2025, but India has not yet fulfilled even the 2010 target of spending 2%! This has been a major reason for patients seek health care from the private sector. Indians rank sixth in the low-middle income group of 50 nations, for out of pocket (OOP) health spending. These costs drive between 32 to 39 million Indians below the poverty line every year, according to several studies.[9]

Without substantially raising in its health care budget, India will find it hard to achieve its health targets namely, a reduction in the infant mortality rate from 41 deaths per 1,000 live births in 2015-16 to 28 by 2019 and a decrease in the maternal mortality ratio from 167 deaths per 100,000 births in 2013-14 to 100 by 2018-2020 and complete eradication of tuberculosis by 2025.

India's $16 (INR 1,112) per capita expenditure on health is the fourth lowest in South East Asia.[7,8,9,10]

In terms of human development, population health is crucial for the economic growth and stability of any country. Good health involves disease control, balanced nutrition, and an efficient medical care system.[11]

According to WHO, the per capita expenditure per year on health in India is a mere USD 63.[12] This report also states that the life expectancy in India is only 59.3 years, which is very low compared to that of several other developing countries. The per capita expenditure by India on health is a miserable $63, even less than that of its neighbors, Bhutan and Sri Lanka, as mentioned in the World Health Statistics report, 2018. The per capita health expenditure per person in India is among the lowest for developing countries, with China reporting a per capita spending of $426, Thailand $217, Malaysia $386, Philippines $127, Sri Lanka $118 and Indonesia $112.

Among the SAARC countries, Pakistan registers a per person health expenditure below that of India at $38, while Bhutan has a higher expenditure of $91.

The developed countries, however, record a much higher health expenditure, with the USA reporting $9,536, UK $4,356 and Germany spending $4,592 per capita per year.

The report also highlights the fact that India's health expenditure is a meager 3.9% of the GDP. Out of this, public spending is a pitiful 1.15%, which the government intends to raise to 2.5% by 2025.

India currently faces criticism for its poor spending on health. The government aims at investing only 2·5% of its GDP in health care by 2025, when the global average for countries is around 6%. The National Health Policy [NHP] 2017 discussed the allocation of two-thirds of its budgetary resources for primary health, to convert primary health centers into “Wellness Centers” focusing on disease prevention and health promotion, and to deploy more numbers of doctors and paramedics in the public hospitals currently facing shortages.

The policy had also set several quantitative goals, including raising the

life expectancy in India at birth from 67.9 (2014) to 70 years by 2025 and lowering premature mortality from cancer, cardiovascular diseases, chronic respiratory diseases and diabetes by 25% by 2025.

India has 59.3 years of healthy out of pocket life expectancy at birth, USD 63 per capita health expenditure, 0.8 density of physicians per 1,000 population, 201 nursing and midwifery personnel per 1,000 population, 174 MMR per 100,000 live births, 43 under-5 mortality rate per 1,000 live births and 56 universal health coverage index ranking.

Catastrophic expenditure

A large percentage of Indians purchase health care from the private sector, which causes the high proportion of health care-related expenditure. To reduce this burden, the government must strive to improve the availability and affordability of generic and essential medicines in the market. This is possible because India possesses a huge pharmaceutical industry which is a major source of generic medicines globally.

According to a Public Health Foundation of India estimate, around 55 million Indians were driven to poverty in a single year because of having to pay for their own health care and 38 million of them dropped below the poverty line due to expenditure incurred for medicines alone. According to this study, published in the British Medical Journal, noncommunicable diseases like cancer, heart diseases and diabetes are responsible for the biggest slab of spending on health by the households called “catastrophic expenditure”.[13]

Health expenditure is termed catastrophic if it consumes 10% or more of the overall household expenditure. When road traffic and non-road traffic injuries were considered, catastrophic expenditure was found to be higher among the poorest, for more than seven days of hospital-stay on average.

Despite the several health government-launched insurance schemes, a majority of the population continued to incur significant expenditure for medicines. The study stated that this was because hospitalization-based treatment, which is what most insurance schemes cover, was responsible for only one-third of India's morbidity burden.

With the shrinking availability of free drugs dispensed in the government health system for outpatients and a sharper decline in their availability for inpatients, patients have very little incentive to pursue public health care. The study further noted that medicine-related expenditure for households continued to remain high, as most patients sought outpatient care in the more expensive private sector.

With respect to the government's promise to provide cheap medicines through the Jan Aushadhi stores, despite meeting the target of opening over 3,000 stores, the frequent stockouts and quality issues have been huge obstacles to their success. Most Jan Aushadhi stores stock barely 100-150 formulations, contrary to the promised 600-plus medicines and they are fewer in number when compared to the 5.5 lakhs and more pharmacies in India.[14]

A formidable 70% of health care expenses in India are met out of pocket by the individual, causing nearly 7% of the population to fall below the poverty threshold, every year.

The National Health Protection Mission, announced during the Budget of 2018-19 aims at providing a cover of INR 5,00,000 per family, per year, to about 10.7 crore families from poor and vulnerable populations. The insurance coverage is targeted for hospitalization at the secondary and tertiary health care levels.

The public health expenditure in India (sum total of the Central and State governments) has remained stagnant, at roughly 1.3% of the GDP from 2008 to 2015, with a marginal increase to 1.4% in 2016-17. This is far below the global average of 6%. However, the goal of the NHP, 2017 is to increase this to 2.5% of the GDP by 2025.

The total health expenditure, including the private sector, as a percentage of GDP, is estimated at 3.9%. Out of the total expenditure, the public sector effectively contributes about one-third (30%). This contribution is low, in comparison to other countries, for instance, Brazil (46%), China (56%), Indonesia (39%), the USA (48%), and UK (83%).

If the public sector cumulatively incurs 30% of the total health expenditure, the consumers bear the remaining health expenditure (70%). Household health expenditures include out of pocket expenditures (95%), which refer to the payments the individuals make directly at the point of services and not covered under any financial protection scheme, and insurance (5%). The highest percentage of out of pocket health expenditure (52%) is for the purchase of medicines, followed by payment for services at private hospitals (22%) and diagnostic centers (10%), as well as for patient transportation and emergency rescue (6%). Out of pocket expenditure (71%) is typically financed by household revenues.

Nearly 86% of the rural and 82% of the urban populations are not covered under any scheme of health expenditure support. Therefore, this huge out of pocket health care expenditure forces nearly 7% of the population below the poverty threshold every year.

From among the total number of persons covered under health insurance in India, three-fourths are covered by the government-sponsored health schemes, while the remaining one-fourth are covered by private insurers. Regarding the government-sponsored health insurance, more claims have been made than the premiums collected, i.e., the returns to the government have been negative.

Therefore, the newly proposed National Health Protection Mission will be implemented. The scheme aims at first providing coverage for hospitalization at the secondary and tertiary health care levels. Second, the Mission appears to focus on hospitalization (including pre- and post-hospitalization charges). However, most of the out of the pocket expenditure borne by the consumers goes towards the purchase of medicines (52%) as mentioned earlier. Most often, these purchases are incurred for patients not requiring hospitalization.[15]

It is heartening that the health indicators have revealed substantial improvements across the country. **Life expectancy has increased by 5 years in the past decade. The** male and female l**ife expectancies which earlier stood at** 62.3 years and at 63.9 years respectively in 2001-2005 was at 67.3 years for males and 69.6 years for females in the period of 2011-2015.

The Infant Mortality Rate dropped to 42 in 2012, from 58 per 1000 live births in the year 2005. The **Maternal Mortality Ratio** also decreased from 301 per 100,000 live births in 2001-03 to 212 in 2007-09.

Such appreciable developments are due to the health infrastructure being strengthened, and the Ministry of Health and Family Welfare being more focused. Further, the National Health Mission (NHM) includes two subcomponents, viz., the National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM), both of which aim at providing accessible, affordable and quality health care to the rural and urban populations.

Under the NHPS, four in ten Indians will be able to avail of secondary and tertiary care in government and private hospitals, within the insurance cap allotted per family.

Secondary health care includes those services offered by skilled medical practitioners, as outpatient treatment, or a brief hospitalization stay for serious illnesses. Tertiary care is made available to patients who are hospitalized for longer bouts of illness and require specialist doctor services. Tertiary care is extended to patients suffering from acute pain or terminal illness.

The NHPS will require an expenditure outlay of over $1,000 billion. The Rashtriya Swasthya Bima Yojana (RSBY), the affordable-health care scheme available at present, provides an insurance cover of INR 30,000 for a family of a maximum of five members. Out of the corpus reserved for the scheme in the budget, the Central government pays 75% of the expense, while the States bear the rest. The RSBY, which is the precursor to Modicare, targets families at the Below Poverty Line (BPL) level and has been implemented in 15 States.

Besides the NHPS, the government plans to set up 1.5 lakh Health and Wellness Centers under the Ayushman Bharat program, to provide treatment for noncommunicable diseases and disburse primary care to young mothers and children. Free supply of essential medication and diagnostics is also in the pipeline.

To satisfy the growing demand for accessibility to health care, more Government Medical Colleges and Hospitals are being planned to fulfill the goal of having at least one medical college for every three parliamentary constituencies. At present, 479 medical colleges are affiliated to the Medical Council of India (MCI) as against 543 parliamentary constituencies. However, an uneven spatial distribution is evident, with more colleges clustered around the urban centers.

The number of doctors per 100,000 population is also below the ideal. According to a World Health Organization (WHO) report, *The Health Workforce in India,* the country has only 79.7 doctors on average, per 100,000 people.

According to the data compiled by the World Bank, India's health expenditure per capita was $267 in 2014, very much lower than the world average of $1,271. The per capita spending on health care in India is also less than that of the other developing countries like Indonesia, and the African countries of Djibouti and Gabon, where the average citizen spends $338 and $599, respectively, on health care.

The perspective of the developed countries which invest in the health of their citizens, is that the expenditure incurred is a means of achieving a more economically equitable society. The Heritage Index of Economic Freedom 2018, which grades the pecuniary freedom of the citizens, highlighted the fact that the top ten nations in the list possessed universal health care schemes. Hong Kong, Singapore, Australia, New Zealand, Canada, Switzerland, and Denmark are among the countries occupying the top ten positions. The United States, ranked 12, has been surpassed by Estonia and Chile, both providing universal health coverage. Out of the 180 countries included in the study, India is ranked at 130.

The NHPS will cover nearly 1354 packages that have been finalized by the Health Ministry. Around 23 specialties from Cardiology to Oncology to Ophthalmology, Orthopedics and Urology, are cited for inclusion in this package. Some even include special treatment for complex diseases akin to cancer.

The outcome of the move

The Union Budget for the fiscal year 2018-19 set the foundation for the inception of the ABY program, designed to address health issues holistically, by installing 1,500,000 Wellness Centers for comprehensive Primary Health Care, making preventive and promotive health care accessible to all. The Pradhan Mantri Rashtriya Swasthya Suraksha Mission (PM-RSSM) was also initiated, offering coverage to more than ten crore poor and vulnerable families and providing up to 500,000 INR coverage per family per year for secondary and tertiary care hospitalization. The goal of the PM-RSSM is to converge multiple health protection schemes across the States into a single universal health protection scheme over time. This is a vital step towards attaining UHC and Portability – transforming into an environment where All individuals can avail of health services anywhere in the country without experiencing financial hardship. AB [Ayushman Bharat] is a promise by the government to escalate its financial commitment towards the health care of the people.

Costs and Consequences

Certain treatments can produce an outcome which requires nearly INR 50,000. A total knee replacement surgery for example will cost INR 80,000 while a C-section will cost INR 9,000. Furthermore, the cost of a vertebral angioplasty with a single stent will cost INR 50,000 and the one involving a double stent will cost INR 65,000. The list includes even mental disorders and pediatric surgeries.

For a better picture of the costs, some prices that private hospitals may levy, is as follows: INR 1.5 lakh for a C-section, INR 1,500,000-200,000 for angioplasty, and INR 3,500,000 for a total knee replacement surgery.

The beneficiaries can opt for a greater number of procedures under the scheme – an advantage which is made possible by the lower prices.

Not only will new pricing standards be applied, this act will also help towards decreasing the health expenses. In turn, this will compel health care providers to reduce the charges they would otherwise levy on the general public.

The cover extends to expenses which include registration, general ward boarding, and nursing. A few other aspects included under the cover include, consultation fees, diagnostic tests, procedural expenses, surgical equipment, medicines, and food for the patients. Apart from these, even the expenses for patient care during follow up and both pre- and post-hospitalization will also be covered.

In the case of an individual requiring several surgeries, the highest cost of the first treatment will be covered, after which the costs for the second and third treatments will be supported by only up to 50% and 25%, respectively. The remaining expenses are the individual's responsibility.

The beneficiaries of this scheme can avail of cashless benefits from any “in network” private/public hospital, anywhere in the country. Public hospitals will be assumed to be “in network” all the time.

Private hospitals too will benefit. Those certified at an entry level by the National Accreditation Board for Hospitals & Health care Providers (NABH) will acquire 10% more, while those certified at an advanced level will receive an extra 15% as an incentive. Hospitals in the underdeveloped regions too will gain an extra 10%.[16]

Once this scheme is implemented, the health care rates could drop by 20% compared to the CGHS under AB-NHPM.

What will change?

The National Health Protection Scheme enjoys a guaranteed potential to improve the lives of millions of Indians. The scheme is prominent against the backdrop that several Central Ministries and State/UT Governments have launched health insurance/ protection schemes for their own specific set of beneficiaries. To improve their efficiency, reach and coverage, a critical need has been recognized to converge these schemes, such as the Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS).

Ayushman Bharat – National Health Protection Mission (AB-NHPM) is fully ready to provide comprehensive health care coverage to ten crore poor and vulnerable families in India.

Partnering with NITI Aayog, a robust, modular, scalable and interoperable IT platform will start to become effective, ensuring a paperless, cashless transaction. This will also enable the prevention/detection of any potential cases of misuse/fraud/abuse, and will be supported by a well-defined Grievance Redressal Mechanism. Besides, pre-authorization of treatments with moral hazards (with the potential of misuse) will be compulsory.

To warrant that the scheme reaches the beneficiaries intended and other stakeholders, a comprehensive media and outreach strategy will be drawn up, which will, inter alia, be inclusive of the print media, electronic media, social media platforms, traditional media, IEC materials and outdoor activities.

The government will ensure that the treatment costs be paid on a package rate basis, also predefined by the government, for cost control. This will include all the treatment-related expenses. However, beneficiaries at all times will experience it as a cashless transaction.

The various classes in the rural regions include families living in only a single room with “kucha” walls and “kucha” roof, and families lacking any adult members, among others. It also automatically includes those rural families experiencing any one of the following situations: households lacking shelter, destitute, living on alms, manual scavenger families, primitive tribal groups, and legally released bonded labor. Specifically, 11 defined occupational categories are available for the urban families who qualify under this scheme.

The government will set up the Ayushman Bharat National Health Protection Mission Council (AB-NHPMC) and Ayushman Bharat National Health Protection Mission Governing Board (AB-NHPMGB) to explain and offer policy directions and thus promote good coordination between the Center and States.

The AB-NHPM is expected immensely assist the common man. Currently, an estimated 80% of inpatient hospitalization is borne out of pocket. In fact, nearly 68% in total, depend upon their personal savings, while around 25% people rely on borrowing to cope with such expenses. The Ayushman Bharat scheme anticipates lowering this

number, because it will cover approximately 40% of the total population.

The poorest and the most vulnerable sections of the country will enjoy the benefit of increased coverage which actually extends to almost 40% of the population.

Almost all the secondary and several tertiary hospitalizations (barring a negative list) will be covered as part of the scheme.

This scheme also includes many hidden benefits for the beneficiaries, including greater access to quality health and medication for their health requirements, which had often been overlooked in the past because of the paucity of financial resources, but which can be availed of with the additional resources offered by the scheme.

Once the scheme is implemented, the patients can avail of timely treatments for their ailments. This will result in improved health, satisfied patients, creation of jobs and productivity and improvement of efficiency. Hence, the overall improvement in the quality of life will be guaranteed.

Expenditure

The Central and State Governments will share the total expenses accrued in the premium payment, according to the ratio specified by the trending guidelines of the Ministry of Finance

The total expenditure is dependent upon the actual market-determined premium paid in the States/UTs where the AB-NHPM will be implemented through the insurance companies.

In the States/UTs where the scheme will be implemented in the Trust/Society mode, the share of the funds from the Center will be provided, based on the actual expenditure or premium ceiling (whichever is lower) in the pre-fixed ratio.[17]

Beneficiaries can avail of cashless benefits from any of the Public/Private empaneled hospitals. The Central government will supply the beneficiaries payment on a Package Rate basis, which will include all the treatment-related costs as a cashless, paperless transaction. Refer to the List of Services at Health and Wellness Centers and fill in the Online Application for Ayushman Bharat Yojana 2018.

One of the core principles of the AB-NHPM is the Co-operative Federalism and Flexibility to the States. Provision is made to partner with the States through co-alliance.

Under the AB-NHPM, the States are free to select the modalities for implementation, either through an Insurance Company or directly through the Trust / Society or a Mixed Model.

A cabinet committee was proposed to give policy directions and promote coordination between the Center and States to set up the Ayushman Bharat National Health Protection Mission Council (AB-NHPMC) at the apex level, under the chairmanship of the Union Health and Family Welfare Minister.

The State will require a State Health Agency (SHA) to implement the scheme.

Partnering with the NITI Aayog, a robust, modular, scalable and inter-operable IT Platform, which will involve a paperless and cashless transaction, will become operational.[18]

The AB-NHPM will be an entitlement-based scheme with the entitlement pre-fixed and based on the deprivation criteria listed in the SECC database.

The different categories for the rural area include families living in a single room with non-concrete walls and roof, families without an adult member between ages 16 and 59, female-headed households with no adult male member from 16 to 59 years of age, disabled family member and no able-bodied adult member in the family, besides those households from the Schedule Castes/Schedule Tribes, and landless households who earn most of their income by engaging in manual casual labor.

Families in the rural areas satisfying any one of the following criteria, such as households without shelter, destitute, living on alms, manual scavenger families, primitive tribal groups, legally released bonded labor, are also included in this scheme. For the urban areas, this scheme is extended to 11 defined occupational categories.

The Central and State Governments will share the expenditure incurred in the premium payment in the ratio fixed by the trending Ministry of Finance guidelines.

The total expenditure will be based on the actual market determined premium paid in the States/UTs where the AB-NHPM will be implemented through insurance companies.

In the States/UTs where the scheme will be implemented in a Trust/Society mode, the central share of funds will be supplied based on the actual expenditure or premium ceiling (whichever is lower) in the pre-fixed ratio.[19]

Implementation will be done depending upon the readiness of the states, as several preparatory actions must be in place. The states need to announce their readiness to implement the scheme.

The government will meet the costs involved for the scheme, with no issue. The NHPM will pay the hospitals on pre-fixed package rates. Clinical protocols and audit mechanisms will be included to control malpractice among the providers. Thus, over the long term, the costs can be efficiently monitored.

All the public hospitals will be deemed empaneled under the scheme, while the private hospitals will be empaneled based on specific criteria. The Ministry of Health has set up a committee under the chairmanship of the Director General of Health Services which is in the process of finalizing the empanelment criteria for private hospitals.[20]

Project to Map Every Health Facility in India

The Health Ministry has requested the use of the technology and guidance of the Indian Space Research Organization (ISRO) for the Central Bureau of Health Intelligence (CBHI), the ministry body responsible for this project. It has partnered with the WHO and the Bill and Melinda Gates Foundation.

Recently, a massive project was launched to map all the health facilities available in the country. The National Health Resource Repository [NHRR] project is a map indicating the locations of approximately 2,000,000 to 2,500,000 health care facilities (both private and government run) in the country, as well as details on their functioning, the number of patients they serve and performance of the doctors.

The NHRR will also be a significant tool for the Ayushman Bharat National Health Protection Mission (AB-NHPM). The NHPM will depend on this mapping exercise for both implementation and monitoring. The two pillars of the Ayushman Bharat — the NHPM and comprehensive primary care — will definitely require this map. Some amount of data in terms of government health facilities has already been collected. Commenced approximately four years ago, this data collection was performed as an exercise under the National Health Mission, for a clearer picture of the strengths and gaps in the health system. Its existence is the reason for the first phase of the NHRR to focus on private facilities.[21]

The data intends to geo-tag the sites of the health facilities and construct the layers. For example, it can indicate a health center offering cardiac care or one well equipped for maternal care. The current government data failed to adequately satisfy these requirements. As it is limited to only 10 variables, it merely provides the coordinates, with no details about which centers were running and which were not, which were not functioning to capacity, and which provided the requisite tests and diagnosis, etc.

National Health Stack

A strong, accurate and timely digital backbone is the crucial need for an effective health system. National Health Policy 2017 emphasized the creation of a digital health technology ecosystem focused on developing an integral health information system to satisfy the stakeholders requirements. To bring the Center and the States together and formulate strategic policy actions that will propel the nation's

progress towards becoming a global digital powerhouse, NITI Aayog proposed the National Health Stack (NHS).

The NHS is proposed to be the country's first futuristic nationally shared digital health care infrastructure, functional by both the Center and States across the public and private sectors. According to a consultation paper titled 'National Health Stack Strategy and Approach', the NHSwill facilitate the collection of comprehensive health care datafrom across the entire country. It will also provide a mechanism via which every participant user in the system can be uniquely identified. Each registrant may create a virtual health ID to preserve his/her privacy when interacting with the other users or stakeholders in the system. The stack will embrace the health management systemsof the public health programs and socio-demographic data systems.

The vision of the NHS is to establish a centralized health record for all the citizens in India, and streamline the information on their health and facilitate effective management of the same.

The proposed NHS is a means of addressing this challenge. It desires to employ the latest technology including Big Data Analytics and Machine Learning Artificial Intelligence, a state-of-the-art Policy Markup Language and create a unified health identity of the citizens, as they navigate across the services and across the levels of care.

This program is designed to develop a wellness-focused strategy, ensuring cost effective health care for every citizen, and involves a two-pronged approach:

It will facilitate the collection of comprehensive data on health care across the country. This health care database, with its secured aggregated data, will possibly propel India to the forefront of medical research in the world.

The key constituents of the NHS include the National Health Electronic Registers, A Coverage and Claims platform, a Federated Personal Health Records Framework, a National Health Analytics Platform and other Horizontal Components like Unique Digital Health ID, supply chain management for drugs, etc. The NHS is also likely to achieve a continuum of care, shift the focus from illness to wellness, offer cashless care and timely payment on scientific package rates, as well as robust fraud detections, improved policy making, and enhanced trust and accountability. The innovativeness of the NHS design proposed lies in its ability to leverage a shared public good by supporting a multitude of health verticals and their disparate branches – a visionary digital framework across the public and private sectors.[22]
The creativeness of the proposed National Health Stack design is its ability to leverage a shared public good – a strong digital backbone constructed with profound understanding of the incentive structures of the system. Once implemented, the NHS is expected to significantly lower the health protection costs, converge the disparate systems to ensure a cashless and seamlessly integrated experience for the financially poor beneficiaries, and promote wellness across the various populations.

Employment generation
Today, India is ranked the second most populous country in the world, with a population of around 1.33 billion, supporting one-sixth of the total number of human beings. In India, the population is continually expanding. Standards of living are steadily rising. Therefore, food security (both availability and access to it) continues to pose an enormous challenge. All citizens must be endowed with the required purchasing power to obtain the food necessary for a healthy life. India needs to generate sufficient employment opportunities to ensure that its workforce productivity can match international levels.

The expansion of operations in the private sector will produce the 'largest chunk' of jobs focused on providing implementation support at the Central and State levels.

The AB-NHPM is expected to generate more than 100,000 'long-term' skilled and semiskilled employment opportunities in the next four years, most of which will come from the anticipated expansion of private hospitals. It is hoped that individuals will be engaged in fields ranging from 'implementation support' at the Central and State levels to 'claim management support' from the trust and insurance agencies in the States implementing the scheme. The expansion of operations in the private sector will provide the 'largest chunk'. Nearly 25,000 hospitals will be empaneled in the scheme to satisfy the health care service demands. The AB-NHPM is also expected to create over 900 jobs for the government agencies managing the scheme, 1500 jobs for the insurance companies, 60,000 skilled workforce jobs in the new hospitals that have adopted the scheme, and 12,500 'Ayushman Mitra' jobs to guide the patients. Moreover, 80,00000 'short-term' jobs will likely be created during the roll-out of the mission, for the construction of new hospitals and expansion of the existing ones.

In order to inform the beneficiaries about AB-NHPM, the government will probably hire approximately 200,000 people on ground, for a short term.

It is argued that the scheme may include a few limitations as it may not necessarily drive the creation of more numbers of private sector hospitals because of the low reimbursement pre-fixed rates for the treatment packages. It is felt that in its present form, this scheme will not be financially viable for the private hospitals to expand to the under-served areas, because the rates of the treatment packages have clearly not been scientifically set. From a recent study conducted by the government of Karnataka, the Ayushman Bharat scheme would underwrite up to 30-40% of the actual costs of the hospital operations. Therefore, for this scheme to be successful, a large number of medical specialists and support staff are required.

One of the major concerns is from where to get the specialist doctors, as India is already facing a shortage of such doctors. Insufficient numbers of specialists are being trained in the country. Over the last few years, although the government has increased the number of medical seats in medical colleges in India by 10-20%, more seats will be necessary to produce sufficient numbers of specialists.

By 2030, India will need 2.07 million doctors to reach a doctor-population ratio of 1:1,000. This implies a growth of 151% registered doctors in the country between 2010 and 2030, according to the study estimates. In fact, the 'current ratio of practicing doctors to population is a mere 4.8 per 10,000. The total number of Allopathic Doctors registered (up to 2016) were 1,005,281. There is an increasing trend in the availability of Allopathic Medical Practitioners, Dental Surgeons and Nurses per 100,000 population over the years. The number of Dental Surgeons registered with Central/State Dental Councils of India up to 31.12.2016 was 1,97,734. while that of registered AYUSH Doctors in India as on 01.01.2016 was 7,71,468. There are 3123 Institutions for General Nurse Midwives with admission capacity of 125,762 and 777 colleges for Pharmacy (Diploma) with an intake capacity of 46,795 as on 31st March, 2016. There are 14,379 government hospitals with 6,34,879 beds in the country. Rural areas have11,054 hospitals with 209,010 beds and the urban areas have 3,325 hospitals with 4,25,869 beds. As 70% of India's population lives in rural areas, to cater to their needs, there are 1,55,069 subcenters, 25,354 Primary Health Centers and 5,510 Community Health Centers in India as on March 2016.[23]

To achieve the target of doctor-population ratio of 1:1000 an impeccable growth rate of the registered stock of doctors by 151% is essential, in the 20-year period from 2010. Moreover, it may be noted that even 1 doctor per 1000 people in the aggregate may not necessarily ensure adequate access of doctors in the rural areas. A genuine commitment to provide adequate, equitable, and sustainable health care to the rural population is to innovate and mandatorily introduce a special cadre of practitioners for rural areas on a pan-India basis. Given the rather insufficient growth rate of 14.41% achieved in the stock over a 5-year period between 2010 and 2014, the projected 151% appears to be an almost impossible target to achieve within the remaining 15-year period.[24]

Is NHPS Innovative and path-breaking?
The NHPS may exert a transformative impact if it is effectively implemented in a coordinated manner. It is rather doubtful if the NHPS scheme, which primarily offers support to the clinical services like hospitalization, can help to fix the broken public health system prevalent in the country. Most Primary Health Care centers constantly experience a paucity of doctors and even district hospitals function without specialists.

Health care in India is presently in a state of transition. Infectious diseases continue to remain a threat to health and economic security. At

the same time, the country needs to confront the emerging challenge of chronic lifestyle (noncommunicable) diseases such as cardiovascular diseases, diabetes, and cancer, which are now the leading causes for mortality. Moreover, rapid industrialization and urbanization have further accelerated the rate of morbidity and mortality due to injury, particularly in terms of motor-vehicle accidents. Therefore, India today, is living under the shadow of a triple burden of disease.

This epidemiological transition is being powered by social and economic determinants of health, as well as by demographic variations such as an ageing population, by environmental factors such as climate change, and by factors like globalization, urbanization and changing lifestyles. Consequently, the health infrastructure is already buckling under severe strain. The high cost of health care and out of pocket expenditure force families to even sell their assets, pushing nearly 60 million people every year into poverty.

To cope effectively with these challenges, the government of India approved the largest government-funded health program, the NHPS. This scheme aims at providing secondary and tertiary health care, mainly for hospital care. This scheme will likely benefit above 37% of the population, implying coverage will be extended to nearly all the poor and vulnerable families. The implementation will cost the government INR 12,000 crore, with the Central and State governments sharing it on a 60:40 basis, respectively.

Further, the government has announced the setting up of or conversion of 150,000 subcenters in the country into so-called “Health & Wellness” centers which will offer a set of services including maternal and child health services, mental health services, vaccinations against selected communicable diseases, and screening for hypertension, diabetes, and some types of cancer. The subcenters which at present serve about 5000 each, are manned by only two paramedical staff.

The NHPS is driven by two main aims, viz., to strengthen the availability of primary health care which has been lacking in the country and to offer financial protection from catastrophic expenditure, often encountered when a family member falls ill and requires long-term health care.

One of the core principles of the AB-NHPM is the Co-operative Federalism and Flexibility to the States. Provision has been made to partner with the States through co-alliance. Under the AB-NHPM, the States can freely choose the modalities for program implementation, and do it either through the Insurance Company or directly through the Trust/Society or a Mixed Model.

The State must necessarily have a State Health Agency (SHA) to implement the scheme. In partnership with NITI Aayog, a robust, modular, scalable and inter-operable IT Platform will become operational, promoting paperless and cashless transactions.

It is critical to converge these schemes to improve the efficiency, reach and coverage. Insurers in the NHPM will be required to return a share of the premium collected from the government for failing to satisfy a healthy claim ratio. The insurers will be obligated to return part of the premium collected if they fall below the 85% claim ratio. For any claim ratio less than 85%, the insurers can hold back up to a maximum of 15% of the unclaimed premium and return the remainder to the government.

If only 50% of the total annual premium paid to an insurance company is utilized for medical claims, the insurer cannot take the entire remaining sum of the money. It will need to return 35% of the premium amount to the government at the end of the year and take only the remaining 15% of the unclaimed premium and return the rest to the government.

For a claim ratio of up to 85%, the insurance companies can retain the balance. For any amount below that, they will need to return the money to the government. This will prevent any windfall gains for the insurance companies. The beneficiaries should enjoy the maximum benefit. Insurers will need to return a share of the premium collected from the government for failing to meet a healthy claim ratio. Claim ratio is calculated as the total value of all the claims paid by the company divided by the total amount of premium collected in a financial year. A claim ratio of 75-90 is usually accepted as an indicator of a robust claim settlement system by an insurer.[25]

NHPM will facilitate health research. Huge volumes of data from the hospitals will help medical scientists understand the dynamics of diseases. The scheme will also create federal personal health records framework to solve challenges of access to healthcare data by patients and availability of health data for scientific research.

Implementation is Key

Health Services must be made available in the vicinity of the people's residences. The National Health Policy of India 2017 had prioritized primary health care as a principal element in strengthening the health system.

The NHPS, if correctly implemented, could be transformative and innovative by enhancing the accessibility to health care, which will include early detection and treatment services for a large section of society who would otherwise be unable to afford them. The beneficiaries can be identified by linking with their Aadhar [a 12-digit unique identity number that can be obtained by the residents of India] and similarly following up for services received and health outcomes achieved, thus assisting in monitoring and evaluating the impact of the program.

This initiative could help the country advance towards universal health coverage and equitable access to health care. As health is a State subject, ownership and commitment by the State will be critical for the success of the program.

The NHPS is not likely to be able to fix the broken public health system in the country. The most critical issue continues to be the limited and unequal distribution of human resources at various levels of health services. Most Primary Health Care centers experience a perennial shortage of health professionals and even district hospitals are functioning without specialists.

Unless the human resource situation is addressed, public sector health care will remain low in quality and largely unacceptable, forcing patients to seek help from the private sector. It is felt that the NHPS is likely to benefit the private parties more than the government health services. This will ultimately be unsustainable and even detrimental for the poor, for whom the scheme is primarily envisioned.

The services that the government health facilities will provide must be clearly stated, as well as the conditions for which the patients will need to seek the help of private parties and the mechanisms being considered. A uniform pricing system for the various health interventions, including diagnostics and medicines is urgently required, making it transparent by displaying the list in the hospital premises.

A continuum of the care system must also be established by linking the institutions or hospitals, with the health centers and community. Community engagement is thus crucial in the planning and implementation of the program and in ensuring that the Health and Wellness Centers and the Primary Health Centers are meeting the community needs.

For the program to be successful, effective implementation is the key. To accomplish this an independent body or agency may be established within the Ministry of Health & Family Welfare to plan, coordinate, and supply technical backstopping to the States, including capacity building and development of the standards and guidelines needed for this program. Such a unit will ensure a uniform and systematic approach to implement this program across the country.[26]

Massive galvanizing of the healthcare system including careful coordination with healthcare providers is the key to success. The opportunities for graft have to be addressed.

Concerns and Constraints

The Indian Medical Association (IMA) in its Press Note of July 3, 2018 expressed its concerns and demanded that the "Government of India should re-negotiate reasonable and fair package rates for its flagship program NHPS of Ayushman Bharat". After the IMA was invited by NITI Ayog for parleys on 22nd June, 2018, it expressed its willingness to work with the Government for the success of the program.

The NHPS pinpoints the economically weaker sections, particularly those in the tier III and IV towns.

In fact, 60% of OAE (Own Account Enterprises) and Establishments are run by modern medicine doctors. The IMA thus essentially holds the last mile connectivity as being crucial for the success of the scheme. Two of the three major demands of the IMA, Empanelment Criteria & Payment modalities have been partially addressed. Empanelment, Package Rates, and Claim Settlement, as well the Grievance Redressal are the major spheres of concern. The Government has agreed to allow empanelment of all the registered hospitals having 10-bed capacity and above. The government has also promised a robust claim settlement mechanism and settlements within 15 days.

As the Government-fixed package rates are very low, it becomes impractical to provide quality services at such rates. Curiously, the Government has fixed these costs arbitrarily without resorting to any scientific costing.

The Government also talks about volumes. It is only the insurance companies and corporate hospitals that will benefit from volumes. Small and medium sized hospitals do not have the capacity to absorb volumes.

The IMA has genuine apprehensions that this well-intentioned initiative of the Government will actually culminate in eliminating the small and medium hospitals. The IMA has been working on the costs of commonly performed procedures, which is certainly an eye-opener. The Government cannot wish away the realities.

It will be unfair to expect the hospitals to provide services below their survival costs. The IMA remains hopeful that the Prime Minister himself will address the situation.

The NITI [National Institution for Transforming India] Aayog has agreed to set up a sub-group to explore the concerns of the Indian Medical Association (IMA) and complaints of the private hospitals regarding the government-proposed treatment pricing for the principal ailments.

Meanwhile, the Indian government has drawn up a draft model tender document. It has proposed prices for knee and hip replacements at INR 9,000 each, stenting at INR 40,000, coronary artery bypass grafting (CABG) at INR 110000, cesarean delivery at INR 9,000, vertebral angioplasty with single stent at INR 50,000 and hysterectomy for cancer at INR 50,000.

The IMA had argued that these package rates were too low and unacceptable. It stated that the hospitals would essentially need to compromise on quality, and consequently expose their patients to risks.

Therefore, to resolve the impasse between the government and IMA, the NITI Aayog has decided to set up a sub-group of experts to investigate treatment pricing under Ayushman Bharat.

NITI Ayog advocates the need for comprehensive cost-based data for the health care procedures for which NITI Aayog is in partnership with the Department of Health and Family Welfare and Indian Council of Medical Research (ICMR). NITI Ayog will form a sub-group which will conduct a comprehensive study with the public and private sector representatives. The sub-group will begin a systematic study of treatment costing and the suggestions will be considered, while the prices are revised in the future.

At present, the government will go ahead with the treatment pricing for the ailments under the Ayushman Bharat Scheme, based on the draft model tender document.[27]

Health care at its essential core is a public good. Its demand and supply should not be allowed to be regulated solely by the market. Health policy must consider the progress made in mitigating poverty and providing health care to the poor, addressing the inequalities, generating employment, promoting preventive selfcare and reducing the risks and coping with lifestyle changes.

Although it is undeniable that some progress has been made in improving the quality, the broader economic and social costs of poor quality of care are projected to cost a huge amount. India will need to focus on the UHC and ensure that those services are of high quality. Quality care is an absolute requirement for universal health coverage.

A good health care system needs more money as well as properly trained health professionals and good hospitals and clinics. Establishing more primary health facilities, distributed evenly throughout the country and within the reach of low-income families, is vital. Focus on health services research is critical. Health education must reach the out-of-reach, ordinary people living in rural and remote regions. Medical education needs to be revamped to produce the doctors of the twenty-first century. More general practitioners are required to serve the population.

Health is a significant issue in justice. Politics must actively engage in health care. Zero tolerance for corruption must be ensured. Poverty should be eradicated. The management of the health care delivery system should be professionalized and strengthened. The private sector should be regulated and its role clearly defined. Special attention must be focused on a sound and dependable referral system. The government must become more aware of the health of the poor and reduce the prevailing health inequalities through a much higher level of transfer of public resources for provision and financing. Variations in drug pricing, medical care costs (diagnostic and therapeutic), hospital fees, etc., need to be addressed. Accountability and transparency, community participation, and placing health in the people's hands are some vital pre-requisites necessary for the success of this program.

CONCLUSION

If effectively implemented, the NHPS is expected to make a substantial difference in the Indian health care system over the next decade. Being the largest health insurance plan, from a global perspective, its vision is to cover 50 crore beneficiaries (poor and vulnerable).

Among some of the important issues discussed, the published procedure pricing may pose a hindrance in efficiently executing the scheme. Several key procedures have been priced at nearly 20% discount when compared with the other existing schemes. Many private hospitals may opt to stay out of the NHPS. The diversity of patients in the private hospitals will experience a significant change (the NHPS may also alter the demand profile). The success will depend on the ability of the providers to review their cost of delivery. Cost-effective players will play a crucial role. The providers will need to overcome the challenge to define and control the use of drugs, consumables, diagnostics and implants, as part of the standardized kits. Management of the revenue cycle will be another test of their ability. The primary and preventive care framework requires strengthening and redesigning, without which the BHPS costs will probably spiral out of control. The pricing mechanism must be reviewed to be reasonable for all the parties concerned, a vital necessity for providing quality care and better coverage.

The implications involved in the Indian health care sector need to be understood in terms of its potential impacts on the patients, providers and payers, i.e. the government. The scheme covering 100 million families, is expected to generate greater patient demand for the health care system, induced by the increased population coverage and enhanced cover amount per family, as well as procedural ease. The scheme is likely to close the gaps between the north and south of the country, between the urban and rural divide, so far as the demand and supply are concerned. Thus, health inequalities will be addressed to a large degree.

India requires an integrated approach to reach out to the whole population and train the various service segments providing them. The health technology ecosystem must combine its efforts and map the health facilities and sensitize them in partnership, at various levels across the country.

In an environment of mass inclusion, where 100% of the population has health insurance cover, India needs to focus on the UHC. Affordable health care must reach the unreached and the NHPS is a commendable step in that direction.

REFERENCES

1. Twelfth Five Year Plan (2012-17) (PDF) (Vol-III, ed.). Planning Commission, Government of India, New Delhi
2. Hammer, Jeffrey; Aiyar, Yamini; Samji, Salimah (6 October 2017). "Understanding Government Failure in Public Health Services". Economic and Political Weekly. 42 (40): 4049–4057. Retrieved 27 July 2018
3. K. Srinath Reddy. India's Aspirations for Universal Health Coverage. N Engl J Med 2015; 373:1-5
4. Reddy KS, Patel V, Jha P, Paul VK, Kumar AKS, Dandona L. Towards achievement of

universal healthcare in India by 2020: a call to action. Lancet 2011; 377:760-768[Erratum, Lancet 2011;377:1154.]
5. http://www.worldbank.org/en/news/feature/2012/10/11/government-sponsored-health-insurance-in-india-are-you-covered
6. http://www.indiaonlinepages.com/population/india-current-population.html
7. https://www.firstpost.com/india/indias-per -capita-expenditure-on-healthcare-among-lowest-in-the-world-govt-spends-as-little-as-rs-3-per-day-on-each-citizen-4559761.html
8. World Health Organisation. The world medicines situation [Internet]. Geneva: WHO;2004[cited 2013 Mar 25]. Chapter 7, Access to essential medicines; p.63. Available from: http://apps.who.int/medicinedocs/pdf/s6160e/s6160e.pdf
9. Anurag Bhargava, SP Kalantri. The crisis in access to essential medicines in India: key issues which call for action. IJME. 2013:10(2)
10. Public Expenditure on Health, South East Asia. Source: National Health Profile, 2018
11. http://www.yourarticlelibrary.com/essay/geography-essay/health-and-human-development-indicators-in-india/42386
12. http://www.who.int/health-accounts/atlas2014.pdf and http://www.newindianexpress.com/ nation/ 2018/may/18/india-spends-just-us
13. https://economictimes.indiatimes.com/news/politics-and-nation/health-spending-pushed-55-million-into-poverty-in-a-year-study/articleshow/64568199.cms
14. https://timesofindia.indiatimes.com/india/health-spending-pushed-55-million-indians-into-poverty-in-a-year-study/articleshow/64564548.cms
15. https://thewire.in/health/who-is-paying-for-indias-healthcare
16. https://economictimes.indiatimes.comhttps://economictimes.indiatimes.com/tdmc/your-money/healthcare-rates-could-be-20-lower-than-cghs-under-modicare/tomorrowmakersshow/64649735.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst
17. http://ayushmanbharat.net/framework-for-ayushman-bharat-national-health-protection- mission/
18. https://www.sarkariyojna.co.in/ayushman-bharat-national-health-protection-mission-ab-nhpm/
19. https://www.studydhaba.com/ayushman-bharat-national-health-protection-mission-ab-nhpm-pdf/
20. https://www.livemint.com/Politics/YHWz7EjkrDKVE6j3wkUxUM/Govt-is-committed-to-take-public-expenditure-on-healthcare.html
21. https://in.news.yahoo.com/govt-starts-ambitious-project-map-025950427.html
22. Niti Aayog [National Institute for Transforming India], Government of India. National Health Stack: Strategy and Approach. Consultation paper.
23. Government of India, Central Bureau of Health Intelligence, Directorate General of Health Services, Ministry of Health and Family Welfare, New Delhi. National Health Profile 2017
24. Potnuru B. Aggregate availability of Doctors in India: 2014-2030. Indian J of Public Health -7
25. http://pmjandhanyojana.co.in/national-health-protection-scheme-2018-rashtriya-swasthya-sanrakshan-5-lakhs/
26. https://indianexpress.com/article/opinion/is-ayushman-bharat-a-game-changer-national-health-insurance-scheme-5054394/
27. http://www.btvi.in/article/read/news/82374/niti-aayog-to-set-up-sub-group-to-study-treatment-pricing-under-ayushman-bharat