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Review Article

'Ayushman Bharat is a Boon for the Country': Against the Motion

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A B S T R A C T

Background: Ayushman Bharat, came into existence in 2018, was based on recommendations of National Health Policy 2017 with an aim to provide Universal Health Coverage to citizens of India. Under this, two inter-connected components were envisaged namely, Health and Wellness Centres and National health protection scheme. But since its inception, there has been concerns with its implementation throughout the country.

Objectives: This article primarily identifies the lacunaes in framework and implementation of Ayushman Bharat across the nation. The secondary objective was to study the potential consequences of this scheme on health care infrastructure of country.

Result: There is a shortfall of about 20% Sub centres and an equal number of Primary health centres in India and almost 90% of existing ones do not meet Indian Public health standards. This coupled with shortage of manpower is a crucial barrier in concept of HWCs. Inadequate and incomplete coverage of health services with exclusion of outpatient services, ambiguity in beneficiary definitions and concerns related to reports of frauds might affect NHPS implementation. Insufficient financial allocation is a key obstacle for successful implementation of AB. This scheme might lead to compromise in other health related programmes.

Conclusion: Without addressing existing deficiencies in health care system, mere introduction of a new comprehensive scheme might fail to achieve its objectives. There is a need to address these gaps first to get the expected results and improve health outcomes in country.

Keywords: Ayushman Bharat, Health and Wellness Center, PMJAY, National Health Protection Scheme

Introduction

With the vision to achieve Universal Health Coverage, the Government of India launched its flagship program, Ayushman Bharat in 2018- to provide Comprehensive Primary Health Care (CPHC) through establishment of Health and Wellness Centers (HWC); as well as financial protection at the higher centers through the National Health Protection Scheme (NHPS). This paper highlights the potential gaps, flaws and detrimental consequences of this program, and discusses how Ayushman Bharat may not be the boon for the country, as envisaged.

Health and Wellness Centers

The first major component under the Ayushman Bharat scheme is the upgradation of 1.5 Lakh Primary Health Centers (PHCs) and Sub-Centers (SCs) to Health and Wellness Centers (HWCs). A majority of the Indian population, i.e., 700 million people, live in rural areas and to cater to their health needs, there are 1,58,417 SCs, 25,743 PHCs and 5,624 Community Health Centers in India as of 31st March 2018. However, there was a shortfall of 19% SCs and 22% PHCs in 2017. The situation is even worse in the Empowered Action Group states which have a shortfall of 30.8% SCs and 32.3% PHCs. This shortfall merely highlights the deficiencies in existence, implying that the existing health Centers are covering more population than the norms. As a result, the quality of services is likely to suffer. The Rural Health Statistics 2018 report indicates that barely 7% SC and 11.8% PHC meet the Indian Public health standards.[1,2] Thus the first issue with regard to the HWC under Ayushman Bharat is the very concept of "upgradation", when the basic recommended standards have not been met over the past decade.

There is an acute shortage of human resource in our peripheral health institutions. Five percent of the SCs are functioning without an Auxiliary Nurse Midwife (ANM) in position, and 48% without a Male Health Worker. There is an overall shortfall of 14.2% doctors and almost 6% of the PHCs are functioning without a doctor. Some surveys have found that more than 10 per cent PHCs in Jharkhand and over 20 per cent in Chhattisgarh function without doctors. Absenteeism among doctors is also as high as 43% in government healthcare facilities across Indian states.[2]

At the HWC, it is envisaged that a Primary Healthcare team will be made available to deliver an expanded range of services. This team will consist of 1 mid-level provider (MLHP), at-least two multipurpose workers- one male and one female along with a team of ASHAs. There is already an existing shortfall of about 1 lakh Multi-Purpose Workers (Male and Female) at the SCs, as described above- without addressing this shortfall, the team will only be a dream. The World Health Organization (WHO) has already released guidelines on self-care, in view of the impending increase in Health Care workers' shortage in the near future.[3] The addition of the new cadre of MLHP is not going to solve this problem, as there is no guarantee that they will not face the same fate of shortfall as other health care workers.

The MLHP would be a community health officer- a B.Sc. in Community Health or an Ayurveda practitioner, trained and certified through IGNOU/other state public health/ medical universities for a set of competencies in delivering public health services. It is envisaged that the MLHP shall also be treating few emergencies, in order to reduce the workload at the secondary and tertiary level. The list of essential drugs available at these Centers include all the Allopathic drugs, so it appears that the government is now not only promoting the prescription of allopathic drugs by the ayurvedic practitioners, but also equipping them with the power to manage critical and potentially life-threatening situations.

The credibility of the MLHP, a practitioner of the alternate system of medicine in providing routine and emergency allopathic care is certainly questionable. Does one really expect that after a short duration of training and certification, the understanding of pathological processes and pharmaceutical interactions by a MLHP would be equivalent to that of an MBBS doctor with 5 and a half years rigorous training? Is our country actually endorsing that doctors can be done away with at the peripheral level, or that one can get away by providing just any form of health care to the rural population?

Several other concerns regarding the development of the HWC, implementation of Ayushman Bharat, and its potential consequences are as follows:

1. The prime responsibility for ensuring the delivery of CPHC services through the PHCs, and the area served by the HWC, lies with the Medical Officer. As discussed, about 6% PHCs are functioning without a single doctor, and another 61% PHCs have only a single doctor. The existing manpower could feel overburdened with the additional responsibilities if the manpower is not proportionately and suitably placed.[2]
2. Multi-skilling of health workers has been mentioned in the document, and an additional major task of maintaining family health records of the population enumerated. This may also increase the existing workload and affect the functioning of the existing health programs.
3. Performance linked payments have been introduced for the team, yet no mechanism has been outlined to ensure the authenticity of data. Systems have to be developed to ensure that fraud is not committed to avail incentives.
4. Most of the "expanded range of services" that the HWC are expected to provide, have been laid out by the IPHS 2006 from a decade ago, and are already expected from the functioning SCs and PHCs.[4]
5. Digitization of all health records, population enumeration and telemedicine facilities seem to be challenging and ambitious tasks, as currently 7% PHCs are functioning without electricity, 35% without computers and 46% without telephone.[2] Only 35% of PHCs in-fact have a regular power supply.[6]
6. There is a shortfall of 30% Community Health Centers (CHCs) at an all-India level and 48% in EAG states. In the existing CHCs, there is a shortage of about 18,000

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(81%) specialists.[2] Ayushman Bharat has no provisions for strengthening this component of services, and this pitfall can prevent establishing the continuum of care, which is one of the principles of HWC.

7. One also needs to understand that if patients are not satisfied with the quality of services available at the HWC, they could be pushed towards the private sector, thereby defeating the objective of lowering Out Of Pocket Expenditure (OOPE). At the same time, they could choose to bypass the primary level, and unnecessarily burden the secondary or tertiary care services, once again defeating the intended 'gate-keeping' function of the HWC.[7]
8. The amount allocated for upgradation of 1.5 lakh HWCs is Rs. 1200 crores, which implies an average of Rs. 80,000 per HWC. The average amount estimated for upgradation is Rs. 9-15 lakhs depending on the type of facility to be upgraded.[7] Hence additional funds will be needed by the states for proper implementation. This could result in diversion of resources and budget cuts for other programs under the National Health Mission (NHM).
9. The timeline that has been set up for transforming 1.5 lacs HWCs is 2022. Till February 2019, i.e. almost one and a half year after implementation of the scheme, only 8030 HWCs have been reported to exist, out of which more than one-third are in Andhra Pradesh and Tamil Nadu. At the current pace, it could easily take another 10 years to reach the target of 1.5 lakh HWCs.[8]
10. Schoolteachers (one 1 male and one female) are the proposed Ayushman Ambassadors or the Health and Wellness Ambassadors. However, with a shortage of school teachers in public schools as high as 52% in some states and training and quality issues among the teachers, the functioning of these ambassadors can be an additional matter for concern.[9]
11. It is proposed that active empanelment and HWC database will improve the population coverage, however it does not guarantee improved utilization of public health services which is currently only 20-30%. The reasons cited for non-utilization of government health facilities in NFHS-3, District Level Health Survey (DLHS), and other studies were quality of care, timing, and absence of health care personnel, deficient infrastructure and manpower. These issues have not been addressed yet, so the whole concept of HWCs could fail if the utilization rates still stay so low.[6,10,11]

Without having first met the basic Indian Public Health Standards (IPHS) laid out in 2012, over a seven year period, expecting 1.5 lakh Centers to upgrade and transform into HWC by 2022 appears to be a very ambitious target. Continued focus on meeting the already established IPHS standards, creating basic infrastructure and ensuring that each PHC has at-least one doctor, appear to be more pressing needs than diverting funds and resources towards creating another workforce or upgrading the already well performing centers.

National Health Protection Scheme (NHPS)

The second component under Ayushman Bharat is the National Health Protection Scheme (NHPS) which has been publicized as "the largest health insurance scheme in the world" when fully implemented. It merges the existing Rastriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme.[12]

The World Health Organization defines "health" as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Thus, the name of the scheme- National HEALTH protection scheme, is itself a misnomer, as the scheme merely covers the medical and surgical aspects of a few diseases, focusing on secondary and tertiary level care, and does nothing to protect or promote "health" or complete wellbeing.[13]

To review the foundation of the NHPS, i.e., RSBY- the main objective to launch RSBY was to reduce poverty by reducing OOPE. It aimed to covered all the Below Poverty Line (BPL) families with a health insurance of Rs.30,000 per family per year and covered 5 members per family.[12]

However, in 2016-17, more than 65 million Indians were pushed into poverty because of rising expenditure on healthcare, which in 2011 was 55 million. OOPE, which was 71% in 2006 reduced to 67% in 2014 according to the National Health Accounts estimates. A meagre reduction of 4% over almost a decade of implementation of the RSBY, points to its inability to decrease poverty by reducing OOPE.[14]

One of the reasons for the inadequate performance of RSBY could be that most of the states used the 2002 census data for enrolling its beneficiaries. They had a six-year gap between the year of the economic census and launch of the RSBY, therefore many poor households were left out and many non-poor households were on the list. A similar error is being committed by the NHPS, as it is based on the 2011 Socio-economic Caste Census (SECC) data - which is outdated by at least 7 years.[13]

Another probable reason for the failure of RSBY to reduce OOPE substantially could be that the RSBY did not provide coverage for outpatient care. Out-of-pocket payments on outpatient care constitutes almost two-third of the total healthcare expenditure by a household.[15] This includes OPD fee, medicines, other pharmaceutical goods. The NHPS also overlooks this major contributor of OOPE and therefore, is likely to have a similar outcome like its predecessor RSBY.

There are other loopholes in the eligibility criteria of the

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beneficiaries as well. According to the D1 criterion an eligible citizen is one who possesses a home with only one room with *kuccha* walls; the D3 criterion states that female households with no male adults are eligible; and as per the D5 criterion all SC/ ST Households are eligible to be beneficiaries. This implies that an upper socio-economic class working female (with no males in the household), or the son of SC/ ST category lawyer/ doctor/ businessman is eligible for the scheme. On the other hand, a class-IV worker belonging to the general category, living in one *pukka* room with his 5 membered family is not eligible to avail the benefits under NHPS.[16]

The NHPS attempts to increase the outreach and service delivery by empaneling private hospitals to provide the pre-determined package of services. These packages of medical and surgical procedures have fixed rates which are insufficient for private hospitals to function with, resulting in reluctance and low empanelment from the private sector. Also, in order to ensure the quality of services by the private sector, there are stringent criteria for the empanelment of private hospitals under the NHPS. One of the essential criteria includes the provision of general wards with minimum 10 beds and an area of 80 square feet per bed with basic amenities. Another criterion is that all hospitals should have adequate and qualified, medical and nursing staff. Ironically, overcrowding, lack of resources and staff shortage are major challenges that government hospitals are themselves struggling with, and are known factors influencing the quality of service provision.[11,17-19]

A few possible secondary effects of NHPS could be the overburdening of tertiary centers, which could result in further deterioration of the quality of services, unless the manpower and other resources are proportionately increased.

Leading newspapers have published many reports from some states like Uttarakhand and Chhattisgarh, where incidents of fraud patients and fraud claims by the private hospitals have been made. Every day, several fraudulent websites and mobile apps are launched that fleece money in the name of enrolling beneficiaries. While efforts to curb fraud by the NHA are ongoing, and have resulted in closure of more than 125 fake websites, and more than 195 fake android applications; many more are still functional.[20-23] Without quality checks in the private sector, unnecessary and excess inpatient admissions, unnecessary procedures, or inferior quality of services can be foreseen.

The funding for the scheme also appears to be underestimated. The sanctioned amount of Rs. 3,200 crores would be grossly insufficient to cater to claims from even a small subset of the estimated 10 crore beneficiaries. As the popularity of scheme increases, and if 10% of the beneficiaries claim 10% of the maximum cover, the claims would amount to Rs. 50,000 crore each year. Even with the state and centre sharing costs, it is likely that in the absence of robust financial mechanisms to support it, the scheme could collapse.

The Ministry of Health and Family Welfare received a 16.3% increase in budget in FY 2019-20 as compared to the previous year, with a rise in allocation from Rs. 52,800 crores to Rs. 61,398 crores. The highest increase in budget allocation has been to Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (PMJAY), which was more than doubled, from Rs. 2400 crores to Rs. 6400 crores.[24]

This increase in allocation for the NHPS has been accompanied by a decrease in allocation under the head of flexi-pool for non-communicable diseases (NCDs), injury and trauma which are the largest cause of death in the country. Together with a reduction in the flexi-pool for routine immunization program and pulse polio immunization program, there has been a curtailment of almost 1000 crore in 2019-20. It appears that tertiary care is being prioritized over primary health care, which is the basic premises of achieving universal health coverage.

In conclusion, undoubtedly Ayushman Bharat is a well-intentioned scheme moving in the direction of achieving Universal Health Coverage, however, the existing scenario of public health infrastructure and resources do not appear to be conducive for its implementation. The scheme may be more detrimental to India's public health on a larger scale, than what a few success stories may depict.

Conflicts of Interest: None

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