

Review Article

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

Venkatesh U¹, Mogan KA², Mukesh Kumar³, Preety Doley⁴, Jugal Kishore⁵

⁵Director Professor & Head, ^{1,2,3,4}Department of Community Medicine, Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi.

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Corresponding Author:

Venkatesh U, Department of Community Medicine, Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi.

E-mail Id:

venkatesh2007mbbs@gmail.com

Orcid Id:

<https://orcid.org/0000-0001-8059-9364>

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A B S T R A C T

Ayushman Bharat approved by the Indian government in March 2018, is an ambitious reform to the Indian health system to provide Comprehensive Primary Health Care (CPHC) and to achieve Universal Health Coverage. The Ayushman Bharat with two components intends to provide a continuum of care services across the three-level of care, expanded service delivery through population enumeration and empanelment of Families at HWC and also expanded the range of preventive, promotive, curative, diagnostic, rehabilitative and palliative care services. There is sufficient evidence available that strengthening of primary healthcare is the most appropriate approach to achieve UHC. Investment on comprehensive primary healthcare system is a practical and affordable solution for India. The concept of Mid-Level Health Provider (MLHP) is newly introduced to improve Sub center and PHC resource utilization. Health and wellness centers with referral services provide preventive, promotive, curative, rehabilitative and palliative aspects with the inclusion of non-communicable disease and other important component will make the programme to deliver Comprehensive health care. With the availability of extensive potentially trainable human resources at comparatively low cost, the Health services of the programme are provided with the Human resource incentives. Ayushman Bharat National Health Protection Scheme will be implanted in conjunctions with the existing state insurance scheme, will provide a cashless benefit for identified secondary/ tertiary treatments, in public/ empaneled private facilities all over India without any cap on family size and age, beneficiaries being identified on the basis of Socio-Economic Caste Survey (SECC) 2011. The Utilization of manpower under Ayushman Bharat is proved by successful engagement and potential usage of nearly 1 million ASHA under the National Health Mission (NHM). The programme provides an innovative initiative of building a highly impactful health model with low cost with the utilization of skilled workforce. This review describes why Ayushman Bharat is a boon for the country.

Keywords: Ayushman Bharat, Universal Health Coverage, Health & Wellness Centre, Pradhan Mantri Jan Arogya Yojana, Comprehensive Health Care

Ayushman Bharat approved by the Indian government in March 2018, is an ambitious reform to the Indian health system to provide Comprehensive Primary Health Care (CPHC) and to achieve Universal Health Coverage.¹ It comprises of two interrelated components. The first component involves upgrading 1.5 lac Sub health centers (SHCs) and Primary health centers (PHCs) to Ayushman Bharat health and wellness centers. The second component comprises Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) which aims to provide financial protection of up to Rs. 5 lac per annum for secondary and tertiary care to about 40% of India's socially vulnerable and low-income households.^{2,3}

All the existing SHCs and PHCs both rural and urban are being upgraded to Health and Wellness Centers (HWCs) to ensure delivery of CPHC with the principle being "time to care" to be no more than 30 minutes. SHCs, which have been earlier upgraded to additional PHCs, will also be transformed to HWCs. The Ayushman Bharat with two components intends to provide a continuum of care services across the three-level of care, expanded service delivery through population enumeration and empanelment of Families at HWC and also expanded the range of preventive, promotive, curative, diagnostic, rehabilitative and palliative care services. A key addition to the PHC at the Sub health center HWCs would be the Mid-level Health Provider (MLHP) who would be a Community Health Officer (CHO).⁴ The CHO is broadly expected to provide 3 functions such as clinical functions to provide ambulatory outpatient care and management, public health functions for health promotion, prevention, and disease surveillance and lastly management functions for the efficient functioning of the HWCs. Robust Information and Communication Technology has been envisioned at the HWCs to support the HWC team in recording the services delivered, in enabling follow up of services users, in reporting to higher functionaries, and in population-based analytics.⁵

Several states are now moving forward with the implementation of HWCs. Expanding of human resources and multiskilling of frontline workers such as Accredited Social Health Activist (ASHA), male and female Multipurpose workers and upgrading of infrastructure for HWCs to achieve an equitable distribution of health care with efficient utilization of resources are adopted.⁶ Ayushman Bharat National Health Protection Scheme will be implanted in conjunctions with the existing state insurance scheme, will provide a cashless benefit for identified secondary/tertiary treatments, in public/ empaneled private facilities all over India without any cap on family size and age, beneficiaries being identified on the basis of Socio-Economic Caste Survey (SECC) 2011. Along with transport allowance, the scheme will also include pre- and post-hospitalization expenses. Unlike private insurance schemes, PMJAY does not exclude

a person on account of pre-existing illness. One of the unique features of PMJAY is its national portability once fully operational.^{6,7}

In India, some of the best healthcare in the world are provided through the private sector. Nine out of ten doctors in India work in the private sector. However, the reality remains that for virtually 600 million poor population living in rural and urban areas, quality & affordable healthcare is beyond their reach. Despite being the fourth largest economy in the world, India is furthest behind in the U.N. Human Development Index and inequities in healthcare contribute greatly to India's low standing. A recent report by the WHO highlighted the fact that almost 70 percent of India's population spends most of their obtainable income on healthcare. Each year about 40 million Indians are thrown into poverty because of out of pocket health spending. Many countries such as Chile, Costa Rica and Thailand have succeeded through their own context-specific model for primary healthcare at low cost and achieved comparable health outcomes as to high-income countries.⁸ Therefore, we need to develop our own context specific model, which address the health inequalities, our morbidity patterns and a program, which give so much flexibility. Therefore, India do not need Cuba model or Thailand model, India need Indian model. The primary focus of the programme is on restructuring the flow of health care access of the beneficiaries at different levels of health care system. Thus, the programme articulates the segmental, fragmented model towards comprehensive, holistic, integrated and need-based healthcare system.⁸

There is sufficient evidence available that strengthening of primary healthcare is the most appropriate approach to achieve UHC. Investment on comprehensive primary healthcare system is a practical and affordable solution for India. With the availability of extensive potentially trainable human resources at comparatively low cost, the Health services of the programme are provided with the Human resource incentives. The Utilization of manpower under Ayushman Bharat is proved by successful engagement and potential usage of nearly 1 million ASHA under the National Health Mission (NHM). The programme provides an innovative initiative of building a highly impactful health model with low cost with the utilization of skilled workforce.¹⁰

In last few decades our country has witnessed major changes in the disease burden. We all know India has made good progress in reducing maternal and child mortality under the national health mission. Ten to fifteen years ago communicable disease along with maternal and nutritional disorder contributed to the major disease burden. India is also witnessing an epidemiological and demographic transition, where non-communicable diseases such as

cardiovascular diseases, diabetes, cancer, respiratory, and other chronic diseases, account for over 60% of total mortality. Despite the changing pattern, the public health delivery system focused only on provision of care related to reproductive, maternal, new borne and child health and few communicable diseases under the disease control programs. These conditions together represent merely 15% of all morbidities. Further, majority health care is sought at district hospitals as primary health centers and subcenters are not providing a wider range of services. For the rest of the services people are availing care from the private sector that leads to high out of pocket expenditure on health care.^{7,12}

Studies show that 11.5% households in rural areas and about only 4% in urban areas, reported seeking any form of OPD care - at or below the CHC level (except for childbirth) primary care facilities, signifying low utilization of the public health systems for other common ailments. National Sample Survey evaluations in the period 2004 to 2014 showed 10% increase in households facing cataclysmic healthcare expenditures. This could be ascribed to the fact that private sector remains the major health service provider in the country and caters to over 75% and 62% of outpatient and in-patient care respectively. Therefore, by establishing HWC our vision is to improve access to health care, Reduce OOPE, Increase the utilization of primary health care services, reduce fragmentation of care, Reduce workload of secondary and tertiary care facilities. Aim of national health protection mission is to provide health protection cover to poor and vulnerable families against financial risk arising out of catastrophic health episodes.¹³

Any program's inefficiency in accomplishing its goal can be accredited to one or more of the three factors: Technical insufficiency, Administrative inanity and Operational ineffectiveness. Even a single distraction of any of these determining factors can be sufficient deterrent causing program failure. If we look at the working pattern of some of our front-line workers, technical deficiency can be understood. The AWW is expected to maintain 24 registers, which is a hardly possible task. The ANM also devotes 45% of her time in data keeping and about 25% time in travel when all activities of the health sector are supposed to be executed only by her, which again is a realistically impossible feat. Meanwhile, we have completely forgotten that the trained staff in the form of multipurpose health worker (male) remains underutilized. The NRHM was launched for a period of seven years (2005-2012) while the recruitment of ASHAs sustained up to 2010. Hence, the ASHAs who were hired in the system later did not get proper training in handling the drugs and equipment's.

Incentive issues and lack of teamwork incentive, lack of monitoring supervision, job-overloading, and no career

enhancement opportunity, etc. are a few to account. All these things were taken care under Ayushman Bharat program and it appears to be a balanced approach, which combines provision of comprehensive primary healthcare (through HWCs) and secondary and tertiary care hospitalization (through PM-RSSM).¹⁴ Ayushman Bharat keeps the first step towards Universal Health coverage, in fact it covers 40% of whole Indian population as it is improbable to reach Universal health coverage in a single step. Thus, the scheme tries to prioritize the vulnerable population who are pushed into poverty during catastrophic situations.^{1,7} Further in long-term, quality of the care in public sector will improve. Although initially people access private sector during catastrophic, thus decreasing the load in public sector. Additionally electronic sharing of data by private hospitals helps in transparency.^{15,16} The benefit of the programme is on the migrated population, that they can avail the quality services from any part of the country, thus protecting the right of the patient.⁸ AB-PMJAY will significantly control the prices of health services by moving towards a high volume low margin model. Further, due to competition the insurance companies will quote competitive premium.¹⁵ The programme meets the demand with supply since demand create its own supply. Further, the upcoming demands will be met through effective utilization of work force and quality utilization of Private sectors.¹⁶ An ideal health personnel are multilayered and multi-skilled, with harmonizing roles delivering competent, comprehensive, continuous and compassionate care. Doctors and nurses are most distinguishable, but a variety of similar health professionals and community health workers are also vital.

Mid-level health workers are a category of care providers who are more skilled and qualified than CHWs. It is the beauty of the programme to utilize the uneven distribution of the human resources and provide quality health care with empaneled hospitals under NABH health standards.⁸ The transparency is maintained by the digitalization of health records by creating family folders and regular audits. The Non communicable disease component is added with other inclusions to provide comprehensive health which further differs from care provided under National Health Mission.¹⁷ The concept of Mid-Level Health Provider (MLHP) is newly introduced to improve Sub center and PHC resource utilization. The capacity building is performed to improve the manpower by training the National level Public Health specialists to train the community Health workers.¹¹ Health and wellness centers with referral services provide preventive, promotive, curative, rehabilitative and palliative aspects with the inclusion of non-communicable disease and other important component will make the programme to deliver Comprehensive health care.^{1,7} The government is committed to increase the budget to 2.5% of GDP by 2025. AB-PMJAY currently uses 0.1% of GDP and

will not cost more than 0.2% of GDP even over few years.

Further India needs mid-level healthcare providers in several forms like nurse practitioners, physician assistants and community health providers to fill the vast gaps of access and quality in our health services. They are especially required for primary care. Thus, the goal of Ayushman Bharat is to endeavor path-breaking interventions to holistically address comprehensive health care at primary, secondary and tertiary health level.¹⁸

Conflicts of Interest: None

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