Ayushman Bharat

Healthcare in India

Issues and Challenges

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For the 94th FC

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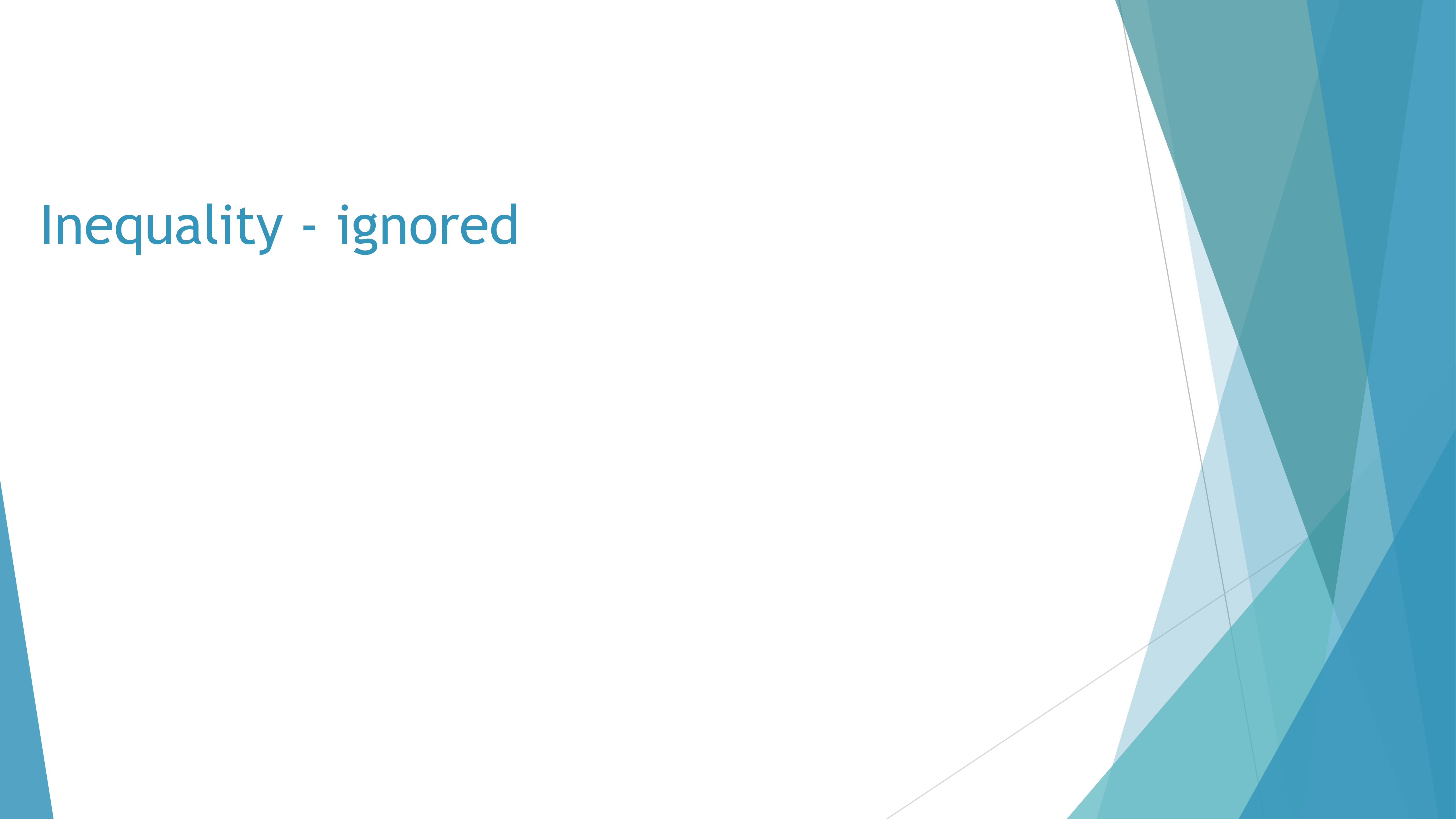
The Health challenge

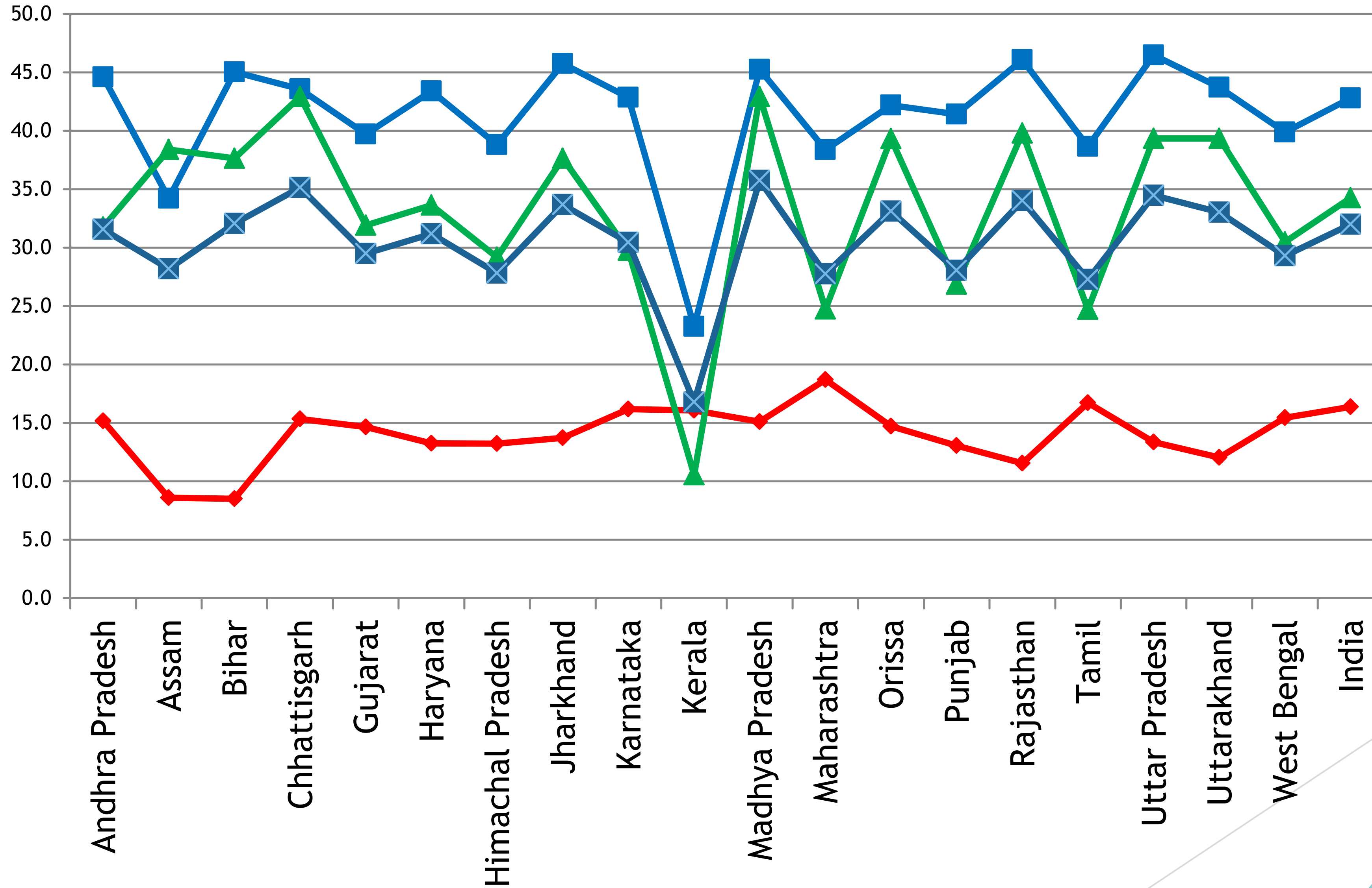
- Inequalities
- Population
- Sex ratios
- Life expectancies
- Healthcare today
- Healthcare expenditure
- Universal Healthcare
- Ayushman
- Challenges


Inequality - ignored

The Key Challenge: Health and Access to Amenities

- Developed countries report a High Loss in Income index due to Inequality and moderate loss in Education
- Least in Health
- Low income countries record high Income inequality
- Inequality is high for heath and education
- India - inequality in health and education highest

Percentage loss in the three inequality adjusted indices



Population – pet peeve

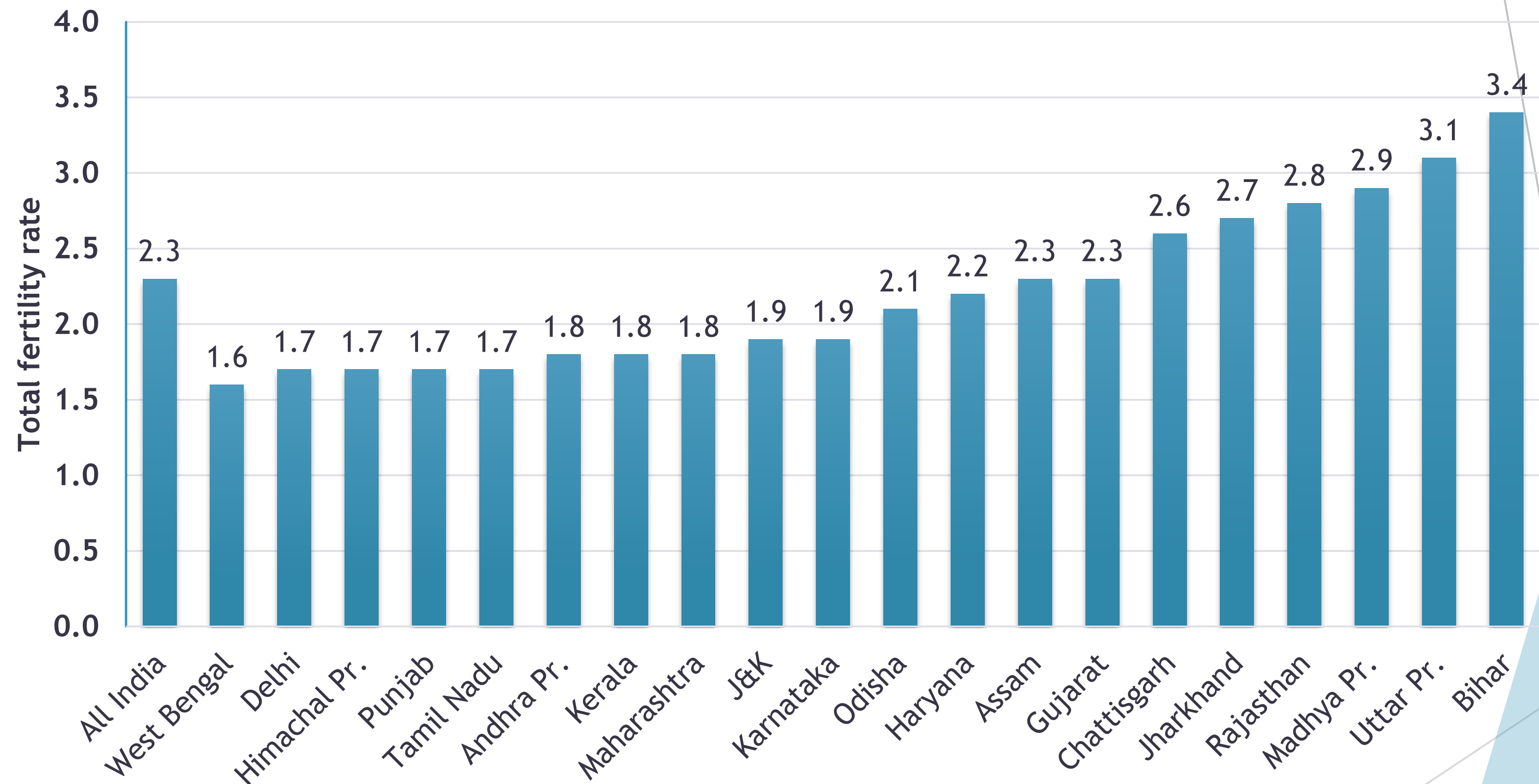
Highest and lowest TFRs 2010-15

Country	TFR
Niger	7.63
Somalia	6.61
Mali	6.35
Chad	6.31
Angola	6.20
DR Congo	6.15
Burundi	6.08
Uganda	5.91
Timor-Leste	5.91
Gambia	5.78

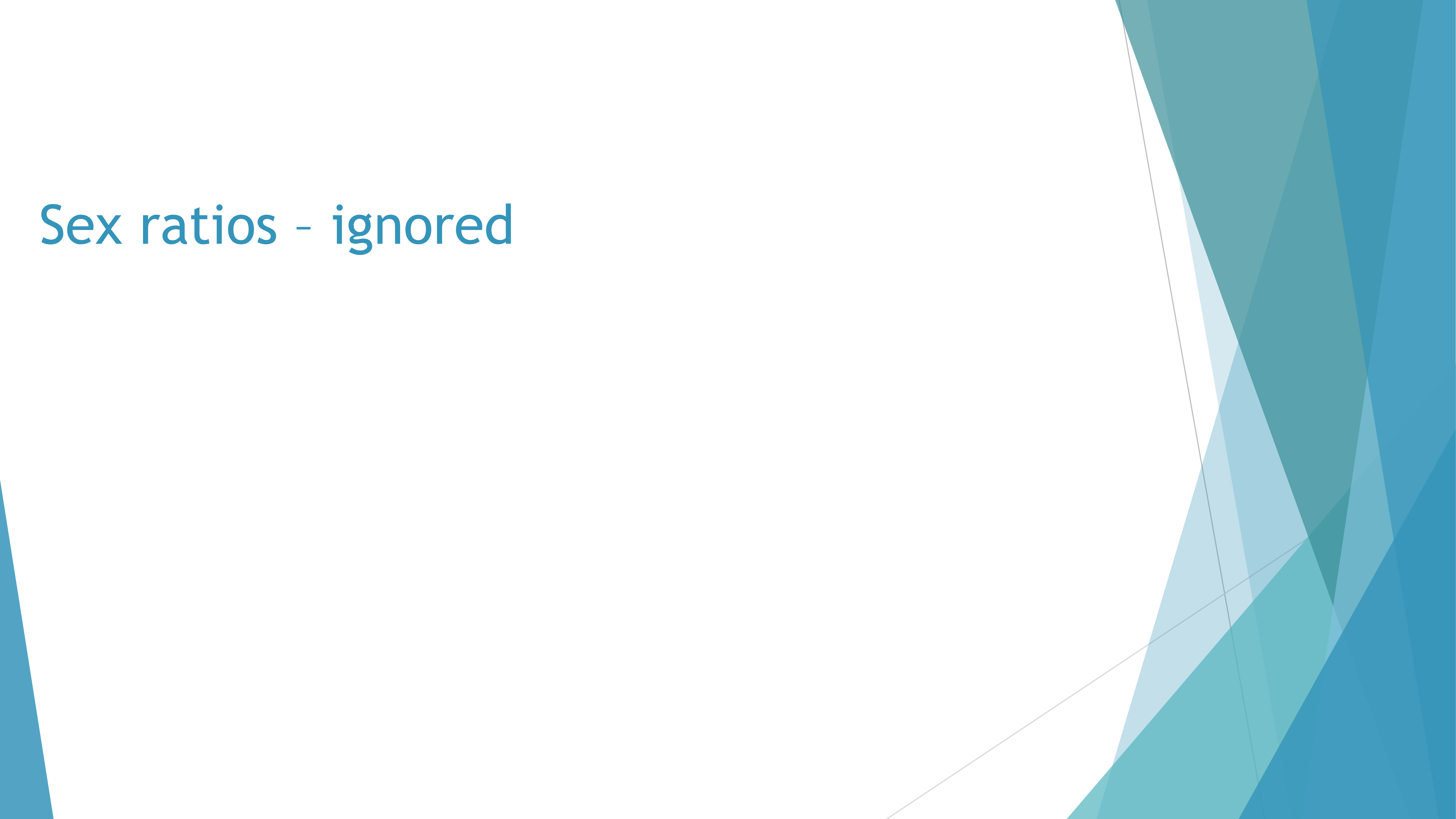
Country	TFR
Hong-Kong SAR	1.20
Singapore	1.23
South Korea	1.26
Moldova	1.27
Bosnia-Herzegovina	1.28
Portugal	1.28
Spain	1.32
Hungary	1.34
Greece	1.34

Source: World Population Prospects: The 2015 Revision, UN Population Division

Population - TFRs of Indian states



Source: Sample Registration System, ORGI, 2014


Sex ratios – ignored

Highest and lowest sex ratios at birth, 2015

- Rwanda: 102
- Sierra Leone: 102
- Togo: 102
- Zimbabwe: 102
- Madagascar: 103
- Kenya: 103
- Malawi: 102
- Burundi: 103
- Mozambique: 103

- China: 116
- Azerbaijan: 116
- Armenia: 114
- Vietnam: 112
- India: 117
- Georgia: 111
- Maldives: 110
- Pakistan: 109
- Albania: 108
- Singapore: 107

- Sex Ratio - The number of male births per 100 female births
- Usually ranges from 103 – 107
- May be changed by sex selective abortions

World Population Prospects: The 2015 Revision, UN Population Division

Highest and lowest sex ratios at birth in India

- Haryana: 126
- Punjab: 126
- Gujarat: 118
- Uttar Pradesh: 117
- Delhi: 115
- Rajasthan: 114
- Himachal Pradesh:111
- **INDIA: 111**

- Assam: 102
- Chhattisgarh: 103
- Andhra Pradesh: 104
- Jharkhand: 104
- West Bengal: 105
- Karnataka: 106
- Tamil Nadu: 107
- Kerala: 105

Population Projections for India & States 2001 – 2026

Life expectancies – slow progress

Highest and lowest LE_{0}, 2010-15

- Swaziland: 49.2
- Lesotho: 49.5
- CAR: 49.54
- Sierra Leone: 50.2
- Chad: 51.1
- Angola: 51.7
- Nigeria: 52.3
- Mozambique: 54.6
- Zimbabwe: 54.8

- Hong Kong: 83.7
- Japan: 83.3
- Italy: 82.8
- Switzerland: 82.7
- Singapore: 82.6
- Iceland: 82.3
- Spain: 82.3
- Australia: 82.1
- Israel: 82.1
- Sweden: 81.9

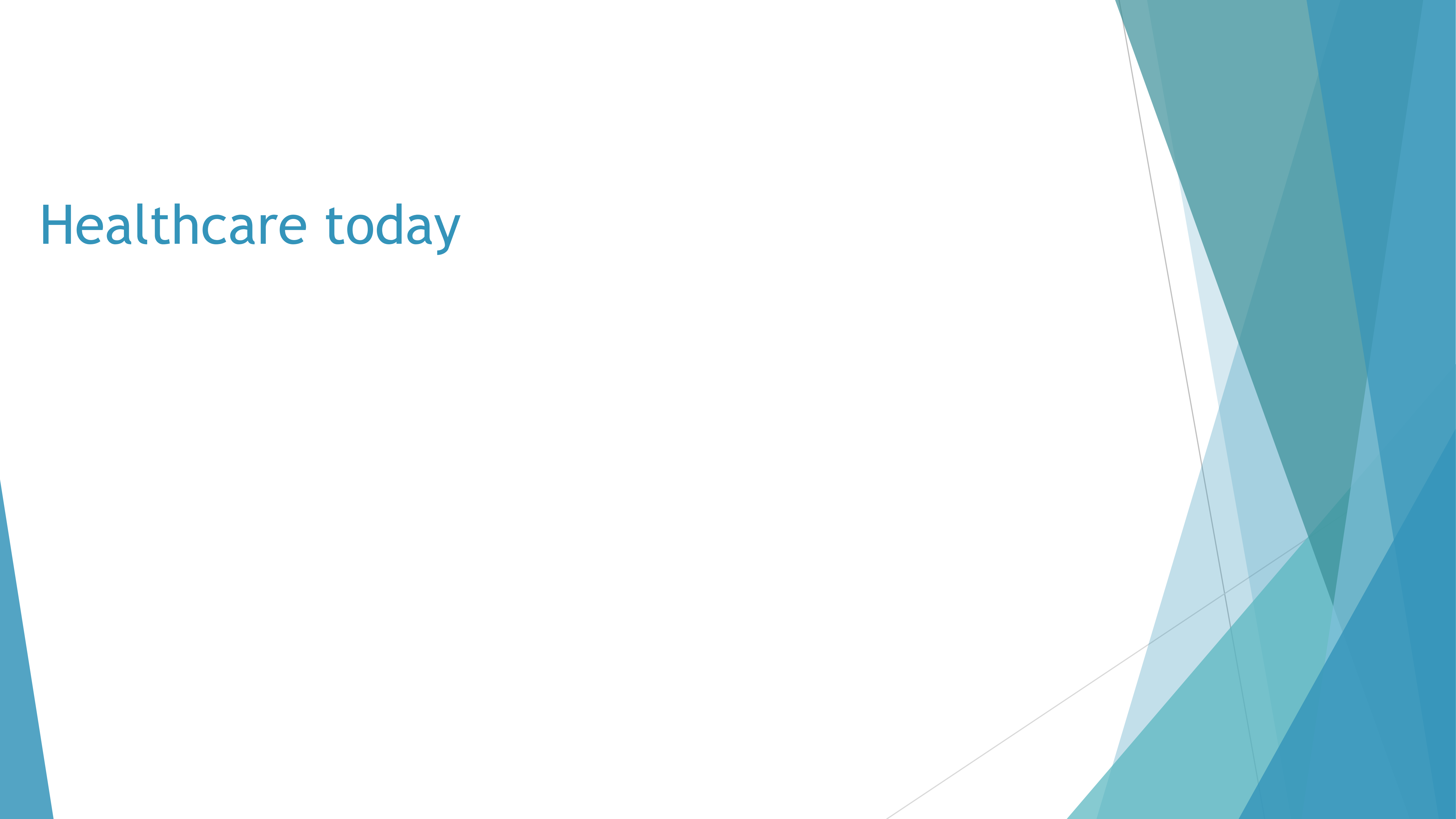
Life expectancy - The average number of years a person can expect to live given the current age-specific mortality rates

World Population Prospects: The 2015 Revision, UN Population Division

Highest and lowest LE_{0}, India

- Chhattisgarh: M-56.0; F-60.0
- Assam: M-57.6; F-58.8
- Madhya Pradesh: M-58.0; F-60.0
- Orissa: M-58.3; F-59.8
- U P: M-59.5; F- 59.4
- INDIA: M-61.8; F-64.1
- Andhra : M-61.4; F- 65.9
- Rajasthan: M-62.1; F-65.2
- Bihar: M-63.6; F-62.7
- West Bengal: M-64.7; F-67.4
- Maharashtra: M-64.4; F-68.1
- Punjab: M-66.2; F-68.9
- Himachal: M-67.3; F -70.9
- Kerala: M-69.3; F-75.2

Population Projections for India & States 2001 – 2026: Table 1: Page No.13


Healthcare today

Healthcare in India: A Snapshot

Infectious diseases and antimicrobial resistance remain a threat as India confronts the problem of chronic non-communicable diseases, which are now the leading cause of mortality

With **17.5%** of the world's population, Indians account for **20%** of the global burden of disease

Private sector caters to **75%** of outpatient care and **60%** of inpatient care

2.07 million doctors required by 2030 to achieve a doctor-to-population ratio of 1:1,000

Govt healthcare providers account for only **23%** of the current health expenditure

1 govt doctor caters to **11,082 people; 1 govt hospital bed** to **1,908 people**

80% of population does not have significant health coverage

1. https://www.pwc.in/assets/pdfs/publications/2018/ayushman-bharat-national-health-protection-mission.pdf
2. https://www.financialexpress.com/opinion/preventive-healthcare-going-beyond-an-apple-a-day/1273032/lite/?__twitter_impression=true
3. https://www.livemint.com/Politics/4CiUr7PYL0EyUyyHZQRZ7N/Government-may-take-PPP-route-to-increase-hospital-beds-unde.html
4. https://www.news18.com/news/india/only-1-govt-doctor-per-11000-people-is-ayushman-bharat-the-answer-1858705.html

“Poor health at high cost”

	US	UK	Canada
Life expectancy (years)	78	81	81
Infant mortality rate (per 1,000)	6.9	4.8	4.5
Physicians per 1,000 people	2.4	2.5	2.2
Per-cap exp on health (US$)	7,290	2,992	3,895
Health exp as % of GDP	16	8	10
% of health costs paid by govt	45	82	70

Healthcare expenditure

Healthcare Expenditure in India

1.2% of GDP spent by India on healthcare

6% Indians do not seek healthcare due to financial reasons

55-60 million Indians are pushed into poverty every year because they shell out half of their annual household expenditure for medical needs

2/3rd of all expenditure on healthcare is out of pocket (OOPE)

9.6% of overall healthcare expenditure goes towards preventive healthcare

90% (INR 3.6 lakh crore of 40 billion USD) of overall healthcare expenditure goes into treating diseases and their complications

50% of all expenses go towards inpatient beds for lifestyle diseases

1. https://www.pwc.in/assets/pdfs/publications/2018/ayushman-bharat-national-health-protection-mission.pdf
2. https://www.financialexpress.com/opinion/preventive-healthcare-going-beyond-an-apple-a-day/1273032/lite/?__twitter_impression=true

(Kenneth Arrow, 1963, “Uncertainty and the Welfare Economics of Medical Care”)

“It is the general social consensus, clearly, that the laissez-faire solution for medicine is intolerable.”

PROFIT

“From these special relations [of trust etc.] come… various forms of ethical behavior… and… also… the relative unimportance of profit-making in hospitals. *The very word, ‘profit’, is a signal that denies the trust relations.*”

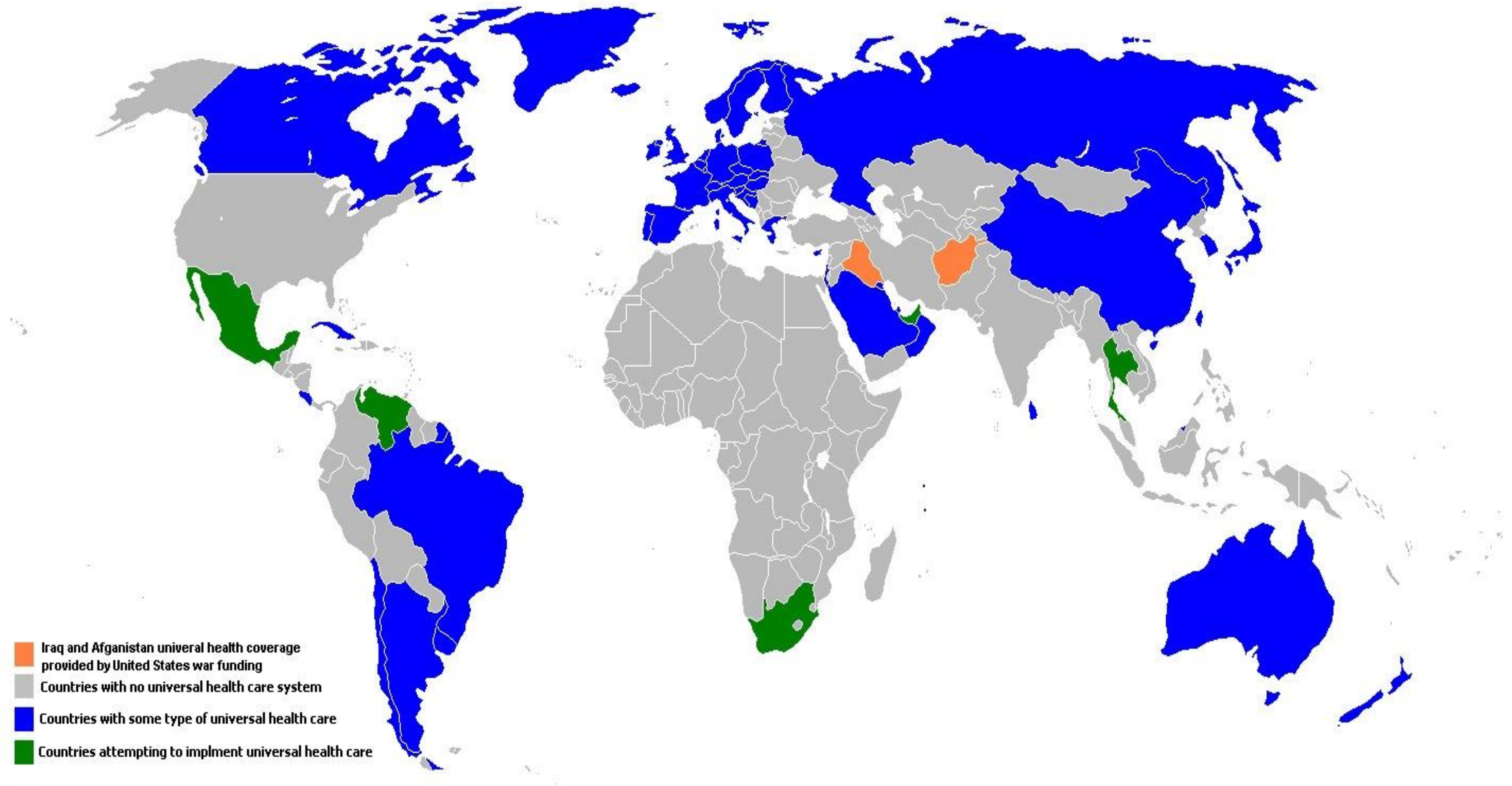
Equity and the right to health

Even in “ideal” conditions, market allocation may leave poor people deprived of health care.

“No-one should be deprived of health care because of her inability to pay.”

Universal Healthcare

UHC in the World Today



UHC: Two Basic Approaches

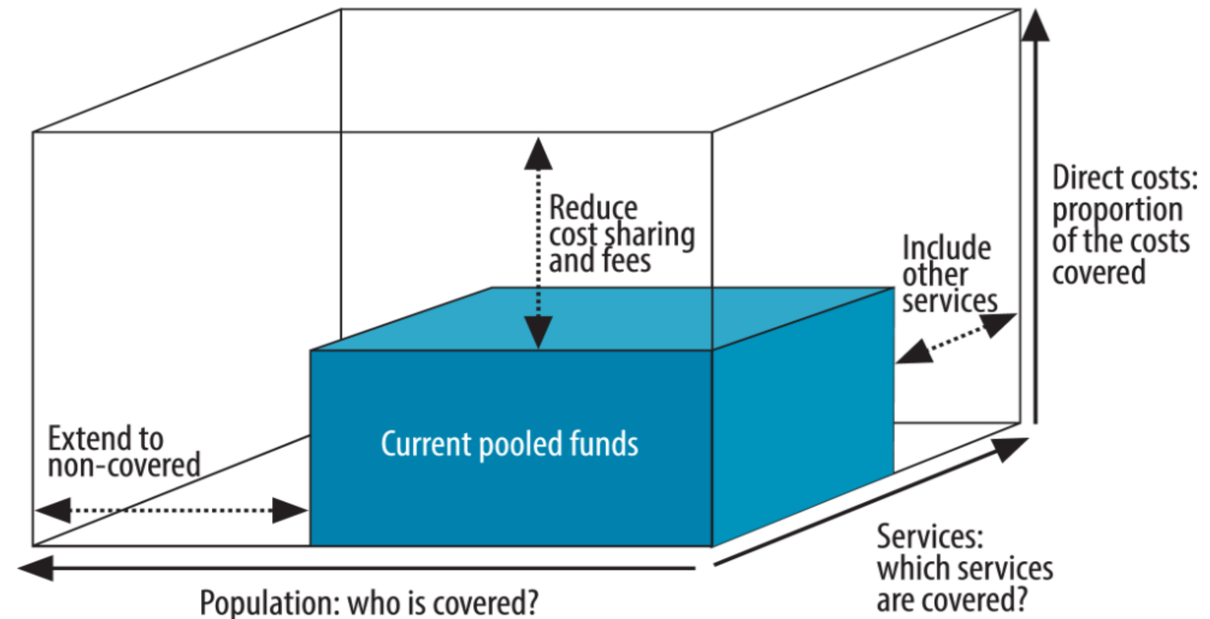
A. *Public service* (e.g. UK, Scandinavia, Italy, Spain, Sri Lanka, Cuba)
B. *Social insurance*:

2a) National insurance (e.g. Canada, Thailand)

2b) Multiple *non-profit* insurance funds (e.g. Germany, France, Japan)

UHC: Global Picture

- WHO has identified four key financing strategies to achieve UHC - increasing taxation efficiency, increasing government budgets for health, innovation in financing for health and increasing development assistance for health
- The levels of service coverage vary widely between countries. As measured by the UHC service coverage index, it is highest in East Asia and Northern America and Europe. Sub-Saharan Africa has the lowest index value, followed by Southern Asia
- An analysis of South Asian countries reported that access to basic care varied substantially within and across each country. The study also raised equity concerns, highlighting that **access to care for maternal and child health** was higher among rich as compared to poor mothers



Source: World Health Organization. *Health systems financing: The path to universal coverage*. Geneva: WHO; 2010 ,
https://www.sciencedirect.com/science/article/pii/S1098301512041526
https://journals.plos.org/plosmedicine/article/figure?id=10.1371/journal.pmed.1001731.g001

Universal Health Coverage: Global Picture

Out of the 33 developed countries, 32 have UHC. They adopt one of the following three models:

1. In a single-payer system, govt taxes its citizens to pay for healthcare. E.g. UK
2. Other countries use a combination of government and private service providers. It requires everyone to buy insurance, either through their employer or the government. Germany is the best example of this system
3. A two-tier approach where the government taxes its citizens to pay for basic government health services. Citizens can also opt for better services with supplemental private insurance. France is the best example

Source: World Health Organization. *Health systems financing: The path to universal coverage*. Geneva: WHO; 2010 , https://www.sciencedirect.com/science/article/pii/S1098301512041526

Some useful lessons

- UHC is not a fanciful idea
- There are several routes to UHC
- Commercial insurance has not been one
- A core of public health facilities is essential
- Public-private dichotomy not always useful
- Building a UHC system takes many years
- Big political challenge!

India's major health reform/health financing platforms

- Universal Health Coverage – "Provide accessible and affordable health coverage to all Indians through 1) financial protection, 2) improvement of delivery via adequate infrastructure, HR, and access to drugs and technologies, and 3) development of efficient management systems"
  - Expert Group Financing recommendations: increase public health expenditures to 3% ● eliminate user fees for services and essential drugs ● general and payroll taxes for financing ● central government as single purchaser ● primary care and health promotion accounts for 70% of expenditures

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- RSBY– "Provide financial protection from health care expenses of hospitalization, improve access to quality health care and, provide a scheme which the illiterate can use"
  - Covers inpatient care for 160M BPL since 2008
  - No user fees beyond small enrollment fee; services 100% subsidized by central and state governments
- JSY– "Promote universal access to institutional deliveries by providing a financial package to pregnant woman and reduce MMT to 100/100,000"
  - Covers ANC visits and institutional deliveries for 10M women since 2006
  - Pays women a cash transfer for institutional delivery and pays ASHAs for promoting it
- Aarogyasri– "Provide social protection, addressing healthcare problems that cause indebtedness and bring people into devastating financial and physical distress"
  - Covers inpatient care for 65M BLP in Andhra Pradesh since 2007
  - No user fees; 100% subsidized by state government

Discussion: some critical health financing questions in India

Politics & political economy of health reform in India (and everywhere)	• Highly charged debate about how best to spend the promised 2% of GDP on health • Complex stakeholder environment with many vested (and competing) interests • Ongoing epidemiological and economic transition – high levels of income inequality and health inequality
Universal access vs. targeted programs for the poor	• High Level Expert Group recommends a government-run, government-financed system for all Indians • Current programs focus on specific populations (i.e. RSBY for poor workers, JSY for poor mothers, etc.) • Long-standing philosophy for building entitlement programs, but what about sustainability?
Private vs. public provision	• Highly heterogeneous delivery system; huge variety in availability, type and quality of providers • The poor use the private sector just as much as the rich (IDHS 2010) • Public services not necessarily 'cheaper' or 'better' than private
Health insurance vs. national health service	• Health insurance a growing sector in India, but mostly focuses on hospital-based cover • Insurance regulation pretty weak, lots of 'opportunity' for cream-skimming and predatory practices • National health service model (e.g. UK) does not really 'fit' the Indian context

Ayushman Bharat

Concept and Challenges

Ayushman Bharat

While presenting the General Budget 2018-19, the FM announced two major initiatives in the health sector, as part of Ayushman Bharat programme:

- **Health and Wellness Centres (HWCs)**: 150000 centres will bring comprehensive healthcare services; including for non-communicable diseases and maternal and child health services; closer to the homes of people
- **Pradhan Mantri Jan Arogya Yojana (PMJAY)**: To cover 107.4 million poor and vulnerable families (500 million crore beneficiaries in the near future) by providing them with health coverage up to INR 0.5 million per family per year for secondary and tertiary care hospitalisation. It will also cover drug and diagnostic expenses for three days before and 15 days post hospitalisation

Source: https://www.india.gov.in/spotlight/ayushman-bharat-national-health-protection-mission

Salient Features, Key Players of AB-PMJAY

- Ayushman Bharat National Health Protection Mission Agency to be put in place to manage programme at national level
- States/UTs advised to implement the scheme through a dedicated entity called state health agency (SHA).
- They can either use an existing trust/society/not-for-profit company/state nodal agency (SNA) or set up an entity
- States/UTs can implement the scheme through an insurance company or directly through the trust/society or use an integrated model
- Benefits of the scheme are portable across the country and beneficiaries will be allowed to take cashless benefits from any public/private empanelled hospitals across the country
- Entitlement is decided on the basis of deprivation criteria in the Socio-Economic Caste Census (SECC) database

Source: 1) https://www.india.gov.in/spotlight/ayushman-bharat-national-health-protection-mission
2) https://timesofindia.indiatimes.com/business/india-business/ayushman-bharat-healthcare-scheme-key-things-to-know/articleshow/65423120.cms
3) https://www.business-standard.com/article/economy-policy/10-key-things-you-must-know-about-modi-s-ambitious-ayushman-bharat-scheme-118081000346_1.html

Challenge - Costs

- Insurance and the provider private sector
- Insurance wanted it to be a continuation of RSBY
- They will be paid
- The package is too comprehensive, includes everything
- All secondary and tertiary care
- The cost will be too high
- 40 per cent of total population gets all healthcare costs covered
- The actual costing according to the insurance companies is too little
- 1100 per family is too little indeed

Challenge - Providers

- Procedure prices are being set at marginal cost
- Assumes unutilised capacity
- Large hospitals are already running at full capacity
- In the tier 2 and 3 cities, there are some like that
- Huge regulatory uncertainty – stent prices
- Investors worried about the brownfield investment already on account of this price controls
- See government as intervening greatly in price regulation
- RSBY and late payments

Challenge - States?

- Working capital and pressure on the P and L
- What about those who don’t have spare capacity
- Here it will be actual cost
- Will NHPM create new capacity?
- Will the big states be ready on time?
- States ahead on the curve –
- Tamil Nadu and Karnataka and AP are participating
- Maharashtra refusing
- West Bengal is participating

Challenge - Fiscal pressure

- Maharashtra already has a state scheme
- This provides for 30 to 40 for a comprehensive package
- Much greater coverage than the existing
- State will have to dish out far more
- Fiscal pressure on the state
- Already under pressure from farm loan waivers/corporate tax cuts
- Finance ministry

Challenge - Identifying Beneficiaries

- Entitlement is decided on the basis of deprivation criteria in SECC data
- For urban areas, 11 defined occupational categories are entitled
- Different categories in rural area include:
  1. Families having only one room with *kuccha* walls and *kuccha* roof
  2. Families having no adult member between age 16 to 59
  3. Female-headed households with no adult male member between age 16 to 59
  4. Disabled member and no able-bodied adult member in the family
  5. SC/ST households (About 400 million deprived households)
  6. Landless households deriving their income largely from manual casual labour
  7. Automatically included families in rural areas having any one of the following: households without shelter, destitute, living on alms, manual scavenger families, tribal groups, released bonded labour

Source: http://pib.nic.in/newsite/PrintRelease.aspx?relid=177816

RSBY and Lessons Learnt

- Several developing countries have introduced tax-financed health insurance coverage to their poor populations
- India launched *Rashtriya Swasthya Bima Yojana* (RSBY) in 2008.
- Poor families get an annual coverage of ₹30,000. Several states implemented or supplemented health protection schemes that provided varying coverage
- Till March 25, 2013, RSBY had 34,285,737 smart cards and 5,097,128 hospitalisation cases. By September 2016, more than 41 million families out of a targeted 65 million families, were enrolled in RSBY
- Currently, 13.5 lakh hospital beds exist for 18 crore individuals covered under the scheme
- However, results of a 2017 study on the impact of RSBY suggest that scheme has been ineffective in reducing OOPE
- Private hospitals chose high-paying surgeries, leaving the 'low profit' patients for the public hospitals
- As the insurance agency was doing enrolment, they were keen to enrol people to get more premium but were not promoting use of services

Source: https://www.thehindu.com/business/budget/ayushman-bharat-the-big-budget-scheme/article22624257.ece
https://www.epw.in/journal/2018/23/commentary/publicly-financed-health-insurance-schemes.html
https://www.thehindubusinessline.com/news/ayushman-bharat-will-bring-private-hospitals-to-poor-areas/article24194487.ece
https://swarajyamag.com/insta/ayushman-bharat-government-looks-to-ppp-model-to-raise-160000-additional-beds

Salient Features, Key Players of AB-PMJAY

- Benefits can be availed in public and empanelled private facilities
- To control costs, the payments for treatment will be done on package rate (to be defined by the government in advance) basis
- Expenditure for premium payment will be shared between centre and states in specified ratio as per finance ministry's guidelines in vogue
- In partnership with NITI Aayog, an IT platform will be made operational that will entail a paperless, cashless transaction
- All beneficiaries will be given QR codes that will be scanned for identity authentication and to verify their eligibility for the scheme
- Each empanelled hospital will have an Ayushman Mitra to assist patients and coordinate between beneficiaries and the hospital
- WHO, University of Chicago, PWC, KPMG, World Bank and GiZ to provide operational and technical support

Source: 1) https://www.india.gov.in/spotlight/ayushman-bharat-national-health-protection-mission
2) https://timesofindia.indiatimes.com/business/india-business/ayushman-bharat-healthcare-scheme-key-things-to-know/articleshow/65423120.cms
3) https://www.business-standard.com/article/economy-policy/10-key-things-you-must-know-about-modi-s-ambitious-ayushman-bharat-scheme-118081000346_1.html

Tracking Beneficiaries

- The scheme is designed to be dynamic and it would take into account any future changes in the exclusion/ inclusion/ deprivation/ occupational criteria in the SECC data
- While in rural areas 85% beneficiaries have been tracked, in urban areas not more than 50-60% have been identified.
- In villages, it is not much of a problem because people know where others live.
- In urban areas however, there are street numbers to be tracked. Occupation in urban areas is also a volatile concept, so tracking people is difficult

AB-PMJAY: Progress Report

- **80.3 million** families to be covered in rural and **23.3 million** in urban areas, as per latest SECC data
- **8,000 hospitals** have been empanelled
- **1,354 treatment packages** listed in the scheme; including treatment for coronary bypass, knee replacements and stenting
- **29 states/UTs** have signed up to be part of AB-NHPS; some of them already offer health schemes at the state level
- **16 states/UTs** are implementing the pilot project
- **15 states/UTs** are implementing training of Arogya Mitras training in collaboration with National Skill Development Corporation and Ministry of Skill Development
- Some private players are threatening to stay away, citing unviability of rates of medical procedures under the scheme

Source:1) https://www.business-standard.com/article/economy-policy/stage-set-for-ayushman-bharat-s-launch-on-i-day-six-states-on-board-118081301354_1.html
2) https://www.financialexpress.com/opinion/financing-ayushman-bharat-are-states-ready/1255666/
3) http://pib.nic.in/newsite/PrintRelease.aspx?relid=183088
4) https://www.bloombergquint.com/law-and-policy/2018/08/15/beds-in-rural-areas-pricing-biggest-challenges-to-ayushman-bharat-scheme#gs.dm51BBI

AB-PMJAY: Progress Report

- Software for the scheme's roll-out, based on Telangana's Arogyashree scheme, has been designed by TCS and is in field testing; the portal that will allow national portability is ready
- Financially, most states are choosing to create trusts which will be managed by SHAs. Escrow accounts have been set up, but no state has asked for money so far
- Primary health centres are expected to participate for follow-ups and management of diseases
- Scheme has been officially christened the **Pradhan Mantri Jan Arogya Yojana (PMJAY)**; all other national health schemes and centrally supported insurance programmes, including RSBY, are to merge into PMJAY
- National Health Agency has put in place 100 controls; including authorisation, authentication, passwords, firewalls and data encryption; to protect the data of the 50 crore beneficiaries

Source: 1) https://www.business-standard.com/article/economy-policy/10-key-things-you-must-know-about-modi-s-ambitious-ayushman-bharat-scheme-118081000346_1.html
2) https://timesofindia.indiatimes.com/business/india-business/ayushman-bharat-healthcare-scheme-key-things-to-know/articleshow/65423120.cms
3) https://www.financialexpress.com/economy/modicares-another-first-pradhan-mantri-jan-arogya-yojana-becomes-1st-healthcare-scheme-with-privacy-policy/1295813/

Financing the Scheme

- **INR 3,200 crore (500 million USD)**allocated to Ayushman Bharat in budget 2018-19
- **INR 5,000 crore (800 million USD)** expected allocation from states and centre combined
- **40%** of the cost of Ayushman Bharat (10% in case of special category states) to borne by state — up from 25% that states contributed in the central health programmes previously
- Total expenditure will depend on actual market determined premium paid in states/UTs where AB-NHPS will be implemented through insurance companies
- In states/UTs where the scheme will be implemented in trust/society mode, the central share of funds will be provided based on actual expenditure or premium ceiling (whichever is lower) in the pre-determined ratio

Source: 1) https://www.business-standard.com/article/economy-policy/10-key-things-you-must-know-about-modi-s-ambitious-ayushman-bharat-scheme-118081000346_1.html
2) https://www.financialexpress.com/opinion/financing-ayushman-bharat-are-states-ready/1255666/

Trust Model and Exclusion of General Insurers

- States were given the option to implement the scheme through one or more companies bidding out the rights, or operate directly using a trust model. They could also choose a hybrid model
- Of the 29 state governments that have agreed to join AB-NHPS, most have decided to opt for the trust model and keep insurance companies out of the loop
- Under the trust model, the premium will not be paid to an insurance company, but will be pooled into a trust. It is this trust that will manage and administer the health scheme and also pay the claims
- Under the insurance model, the state will pay premiums to an insurance company. The onus will be on the insurer to administer and pay the claims
- In Gujarat, one of the three states to opt for a hybrid model, treatment up to INR 50,000 per family will be covered by an insurance company, while INR 4,50,000 worth of cover will be assured by the government

Source: https://www.livemint.com/Money/IMcFw14AYG8fpxoku7xiYJ/Ayushman-Bharat-and-concepts-of-insurance.html
https://www.business-standard.com/article/economy-policy/exclusion-from-ayushman-bharat-could-deal-a-body-blow-to-general-insurers-118081400542_1.html

Trust Model vs Insurance Model

Health Insurance Market: Some observations

- Dominated by hospitalisation indemnity products and package policies
- Only 45% of all claims have valid diagnosis codes, indicating that treatment centres are misreporting the rest
- 99% of total claims are for amounts below INR 3,00,000. Most claims are in the INR 10,000-25,000 range

States' Arguments for Excluding General Insurers

- Keep the scheme simple, cheap and serviceable
- No value-addition coming from general insurers, so commissions are a deadweight loss
- The more people the states brought in as insured under earlier schemes, the higher was the bill for subsidising their premiums. This made the states run into arrears, which by April 2017 had stretched to over INR 50 billion in the INR 200-billion estimated market for the older scheme

Source: https://www.livemint.com/Money/IMcFw14AYG8fpxoku7xiYJ/Ayushman-Bharat-and-concepts-of-insurance.html
https://www.business-standard.com/article/economy-policy/exclusion-from-ayushman-bharat-could-deal-a-body-blow-to-general-insurers-118081400542_1.html

Trust Model vs Insurance Model

General Insurers' Response

- Smaller states don't have technical bandwidth to run such a scheme
- Trust model adopted by some states could be misused down the road
- Want a govt-funded finance company as a buffer between themselves and the states to keep AB-NHPM running smoothly
- The insurance model will have an edge over the trust model because government funds are safer in a licensed insurance company with strict regulatory oversight, especially investments of short-term surplus money
- If the risk management and service delivery are found to be better under insurance and mixed model, it will force other state governments that have opted for a trust model to go for a more efficient route
- Increased awareness, standardisation of healthcare provider practices, standard medical protocols and package prices, IT platform for standard codified data, paperless transaction and electronic health records and fraud control are key benefits of the scheme to the insurance industry

Source: https://www.livemint.com/Money/IMcFw14AYG8fpxoku7xiYJ/Ayushman-Bharat-and-concepts-of-insurance.html
https://www.business-standard.com/article/economy-policy/exclusion-from-ayushman-bharat-could-deal-a-body-blow-to-general-insurers-118081400542_1.html
https://www.livemint.com/Money/CJNZosyTATRukPga9LrWGI/Is-trust-model-under-Ayushman-Bharat-a-lost-chance-for-insur.html

Modes of Implementation

Insurance Mode (7)	Trust Mode (18)		Mixed Mode (9)
Meghalaya	Andhra Pradesh	Tripura	Chhattisgarh
Mizoram	Arunachal Pradesh	Uttar Pradesh	Gujarat
Nagaland	Assam	Uttarakhand	West Bengal
Dadra & Nagar Haveli	Bihar	Lakshadweep	Rajasthan
Daman & Diu	Goa	Andaman & Nicobar	Jharkhand
Jammu & Kashmir	Madhya Pradesh	Chandigarh	Delhi (likely)
Punjab (likely)	Manipur	Puducherry (likely)	Kerala (likely)
No Info (2)	Sikkim	Karnataka (likely)	Maharashtra
Telangana	Himachal Pradesh	Haryana	Tamil Nadu (likely)
Odisha			

Source: https://sarkariyojna.co.in/pradhan-mantri-jan-arogya-yojana-pmjay/

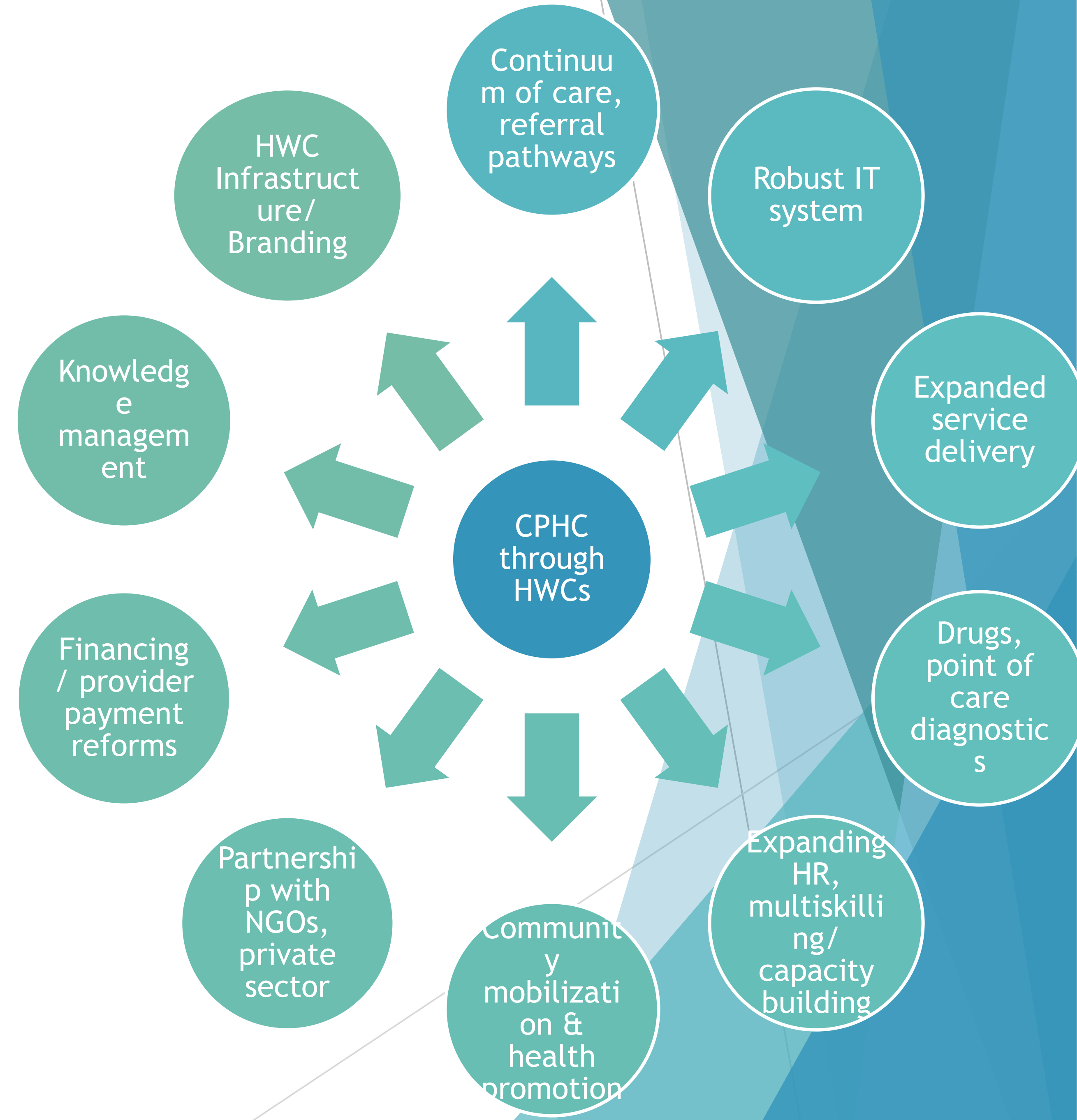
Impact of Scheme

Ayushman Bharat could spawn the growth of a domestic revenue cycle management industry in India

AB-HWCs: Key Features

- **Human Resource (outreach team):**
  - At least 1 mid-level healthcare provider (nurse practitioner/*Ayurveda* physician/community health officer)
  - 2 Auxilliary Nurse Midwives
  - 5 Accredited Social Health Activists

- **Essential Package of Services (incremental phasing):**
  - Maternal and Child Health, Family Planning, Common Communicable Diseases, Non Communicable Diseases, Mental Health, Common Ophthalmic and ENT Problem, Elderly care, Palliative Health Care Services, Emergency Medical Services



AB – HWCs: Progress

- First HWC inaugurated by PM on April 14, 2018 in district Bijapur, Chhattisgarh
- More than 4000 HWCs set up/ operationalized till date
- ECHO or Extension for Community Healthcare Outcomes model being used to train ASHAs
- A 'National Health Stack'- digital framework to serve as centralized health record for all citizens of the country, to be developed; it aims to accomplish digital health records for all citizens by the year 2022
- Operational Guidelines/Training Manuals for Primary Health Care Team being developed
- Current implementing partners across states/ UTs- Jhpiego, USAID, TATA Trust, Piramal Foundation, ECHO, WISH Foundation, etc.
- All non- government/ private sector support being provided in non- profit mode

Impact of Scheme

Adoption of standard treatment guidelines and defined package rates for surgical procedures. This will have a major impact on reduction of Out of Pocket (OOP) expenditure

Widespread use of IT and data analytics to monitor scheme implementation and manage fraudulent claims. This will also help in generating large volumes of data which may be used later for designing better and targeted health programmes

The scheme will also help in enriching the database of hospitals registered with the Registry of Hospitals in Network of Insurance (ROHINI) System and the human capital captured under the National Health Resource Repository project; these can be used for improvement of access to and quality of healthcare services

Source: 1) https://www.pwc.in/assets/pdfs/publications/2018/ayushman-bharat-national-health-protection-mission.pdf
2) https://www.india.gov.in/spotlight/ayushman-bharat-national-health-protection-mission

Impact of Scheme

The unmet needs of the population which remained hidden due to lack of financial resources will be catered to. This will lead to timely treatments, improvements in health outcomes, patient satisfaction, improvement in productivity and efficiency

The scheme will have a multiplier effect on the Indian economy through employment generation and promoting the healthcare industry in tier 3 and 4 cities. AB-NHPM is likely to create more than 1,00,000 long-term skilled and semi-skilled jobs in the next three to four years, particularly for women

The scheme will have a multiplier impact on the healthcare and allied sectors like pharmaceutical, diagnostics and medical devices, leading to access to quality health and medication

Source: 1) https://www.pwc.in/assets/pdfs/publications/2018/ayushman-bharat-national-health-protection-mission.pdf
2) https://www.india.gov.in/spotlight/ayushman-bharat-national-health-protection-mission
3) https://www.livemint.com/Politics/aU82oNLkFexUK0oFv4TMLM/How-Ayushman-Bharat-can-change-healthcare-system.html
4) //economictimes.indiatimes.com/articleshow/64657167.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

Challenges and Way Forward

1,60,000 additional beds would be required to meet the demands under Ayushman Bharat. The scheme cannot work without effort to widen the supply of hospital beds, medical specialists, etc

Govt should come up with a pharma policy that will unify and synergise its various components such as Drug Price Control Order, manufacturing, R&D, financing, quality control, drug control and price control

Assessment of the IP system needs to be made and legal flexibilities used judiciously, for humanitarian non-commercial use in treating diseases that are epidemic or communicable, with compulsory licensing being invoked rarely

Source: https://www.nhp.gov.in/state-health-insurance-programmes_pg
https://www.thehindu.com/opinion/op-ed/a-health-scheme-that-should-not-fail/article24007836.ece
https://www.business-standard.com/article/opinion/first-prepare-118081401611_1.html
https://www.hindustantimes.com/analysis/the-government-must-establish-a-department-of-public-health-soon/story-p4jm3Uk9A9vXDhG0zE6J2O.html
http://www.rediff.com/business/column/ayushman-bharat-may-help-patients-access-life-saving-drugs/20180516.htm

Challenges and Way Forward

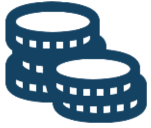
Shift in focus towards preventive healthcare would mean investing in R&D, especially technology. Artificial intelligence can use algorithms to ‘learn’ patterns from healthcare data, and use obtained insights to assist reporting of diagnostic tests for use in clinical practice

Reducing disease burden through robust primary care, focus on allied determinants of health, quality outdoor and indoor services in public hospitals and incorporation of indigenous school of medicine and technology will all help in checking farcical and wasteful expenditure

Greater accountability, shorter turnaround times through automation, next-generation logistics networks, value-added services like mobile application with real-time information, and a greater customer-centric approach starting with the basic establishment of a connection with customers are just a few changes that will make the biggest differences

Source: https://www.nhp.gov.in/state-health-insurance-programmes_pg
https://www.thehindu.com/opinion/op-ed/a-health-scheme-that-should-not-fail/article24007836.ece
https://www.business-standard.com/article/opinion/first-prepare-118081401611_1.html
https://www.hindustantimes.com/analysis/the-government-must-establish-a-department-of-public-health-soon/story-p4jm3Uk9A9vXDhG0zE6J2O.html

Challenges and Way Forward



Retain focus on increasing government investment on health as universal implementation of scheme's twin components would require INR 70-100 thousand crore per annum

Going by experience from RSBY, NHPS is likely to result in over-treatment or unnecessary surgeries. Well-designed standardised protocols and guidelines for admission, testing, treatment, referral, recording, and quality check will be essential

If some of the funds are allocated to revive/strengthen the system, patients will avail comprehensive healthcare closer home rather than being referred to far away urban private operators with added cost of transport/stay/loss of wages of attendant(s), etc

Not all states are similarly placed in stepping up health investments. Improved understanding of their current health spending is necessary to devise strategies that states need to meet funding commitments

Source: https://www.nhp.gov.in/state-health-insurance-programmes_pg
https://www.thehindu.com/opinion/op-ed/a-health-scheme-that-should-not-fail/article24007836.ece
https://www.business-standard.com/article/opinion/first-prepare-118081401611_1.html
https://www.hindustantimes.com/analysis/the-government-must-establish-a-department-of-public-health-soon/story-p4jm3Uk9A9vXDhG0zE6J2O.html