Deconstructing Ayushman Bharat and Infusing Institutional Reform

K. SUJATHA RAO

Prime Minister Narendra Modi and the Chief Minister of Jharkhand, Raghubar Das, wave to supporters at the launch of the Ayushman Bharat programme in Ranchi on September 23, 2018. Photo: Manob Chowdhary.

The Bharatiya Janata Party (BJP)-led National Democratic Alliance (NDA) government recently launched Ayushman Bharat (AB), promising it would revolutionise the health care sector in India. What remains unsaid, however, is that by 2017, 20 Indian States already had health insurance schemes in addition to the national Rashtriya Swasthya Bima Yojana (RSBY) started by the previous Congress-led United Progressive Alliance government.

Drawing from her expertise on policy issues, former Union Health Secretary, K. Sujatha Rao, argues that realising AB’s real potential requires a change in mindset. All existing government-sponsored health insurance schemes, including those for government employees, she says, will have to be brought under one umbrella; existing government health facilities will have to be strengthened and aligned with private establishments; provider regulations, laws to check existing corrupt practices and strong redressal systems
The former Chief Minister of united Andhra Pradesh, Dr. Y. Rajasekhar Reddy, was a doctor, a mining baron and an astute politician with that rare ability to connect with people. He found that a majority of the petitions received by the Chief Minister’s Relief Fund were for hospital expenses. As a doctor, he knew that hospitals needed volumes to make money and the people needed money to access the hospitals. As a politician, he sensed the opportunity for a political dividend from a legitimate action of bridging the divide between the doctor and the patient.

This was in 2006.

Two models were submitted to Reddy: the ICICI (Industrial Credit and Investment Corporation of India) one that had insured the entire BPL (Below Poverty Line) population of Assam for a sum paid by the state government to the insurance company, and the Karnataka model of Yeshaswani. Here too, the government paid the premium but to a government trust that then reimbursed the amounts to the hospitals. In Assam, the patients had to submit various documents to seek their reimbursements; in Karnataka, the patients got free service at the point of care. Reddy chose the latter because the model provided political control over an intensely important matter affecting every household. In 2007, he launched the Rajiv Arogyashri Scheme (RAS) that covered 85 per cent of the population and provided free and cashless surgical treatment in accredited hospitals at prices set up with help of the Hyderabad-based corporate hospitals. There was a trade-off: 25 per cent of the primary health care budget was diverted for the scheme. It was timed, undoubtedly, for the assembly and Parliament elections in 2009.
The RAS was a game changer: for the first time in India, an ordinary person was able to go to a corporate hospital for removal of an appendix without the stress of having to pay for it. The perception was that the RAS had a 5 per cent impact on the voting pattern in favour of the ruling party, resulting in a burst of similar government-sponsored health insurance schemes in nearly 20 States. By 2017, about 33 crores of persons were covered under government-sponsored health insurance schemes. Most States cover tertiary and secondary care, with some even covering diagnostics leading to hospital admissions and drugs for a year after discharge, all for an assured sum of about Rs 1-2 lakhs and an average payout of Rs 500 per capita of premium, that has steadily doubled in many States due to increased utilisation. For this reason, the Centre’s Rashtriya Swasthya Bima Yojana (RSBY) launched in 2009, for an assured sum of Rs 30,000 for secondary care did not attract much traction, not to mention the complexities of the technical design it entailed.

The Importance of Ayushman Bharat

It is in the context of these government-sponsored health insurance schemes that the ‘newness’ of Ayushman Bharat (AB), launched by the current Union government in 2018, needs to be assessed. If Dr Reddy’s RAS stepped into virgin territory, Ayushman Bharat can claim no such originality.

Nevertheless, it cannot be dismissed merely as an upgraded version of the RSBY. Its merit lies in attempting to craft an architecture to create a national health market. Such a vision is pregnant with possibilities that can bring about profound shifts in the fundamentals of health care service delivery in India.
The positives are that the vision has been built upon the existing structures, co-opting existing schemes, standardising prices and the list of services to be provided with the union government sharing 60 per cent of the amount incurred for the target population. The design also ensures that all those eligible to receive treatment anywhere in the country under the scheme require minimal documentation — just an Aadhar card or a ration card. To the extent the eligible population gets access to treatment, they will be protected from expenditure shocks and the compulsions to borrow money, sell assets or deny themselves treatment. In addition, the creation of an autonomous National Health Authority (NHA) to administer the programme (listing services, fixing prices, contracting hospitals, ensuring timely reimbursement, detecting fraud etc) has brought in institutional reform.

So far so good. But then these design features are not unknown or new, barring the portability factor that too, existed as a concept in a limited manner in infectious disease control programmes such as for HIV/AIDS. So what makes Ayushman Bharat a game changer are three factors that have the potential to make it one.

First, in bringing the many government-sponsored health insurance schemes under one umbrella the government acquires a certain advantage that it can leverage to influence prices, but only if it succeeds in bringing under its purview the CGHS (Central Government Health Scheme), the ESIS (Employment State Insurance Scheme), the ECHS (Ex-servicemen Contributory Health Scheme) and the RELHS (Retired Employees Liberalised Health Scheme), the last for Railway employees, as well. This then creates a big market presence with a good mix of beneficiary profile, at once impacting the premium rate as well as strengthening the government’s ability to negotiate prices with the providers. As an idea, this was first recommended in the Report of the National Commission on Macroeconomics.
and Health of 2005, based on the model followed in Chile, where a Social Health Insurance Agency was established as a Reinsurer. Thus, by broadening the umbrella of the NHA, the required velocity for building a financial risk protection cover can be achieved.

Second, if in ‘supply deficit’ geographies, financial instruments could be devised to help government-owned facilities (district and sub-district hospitals) alongside small and medium-sized private establishments, to build their capacities either as single entities or in partnerships, to provide a set of minimum services, prices can be controlled — for example, having the various All India Institute of Medical Sciences like Institutes established in tier 2 and 3 towns like Raipur, Rishikesh etc. - build referral chains with the publicly owned district and sub-district level hospitals. Likewise, the small nursing homes or mission hospitals, that dot the large two and three-tier towns providing limited services like emergencies or maternal care, can be encouraged to build partnerships with another small hospital that is providing paediatric or surgical procedures, so that together as a network, they can provide a set of four or five services – gynaecological, medical, surgeries, paediatric etc. and also be linked to the close by AIIMS for tertiary care. Such networks could then help create a more competitive environment that can help control price inflation. But then this would require implementing the Clinical Establishment Act and obtaining data for mapping access points on the supply side. Only when such resource allocation is deliberately implemented that inefficient and low quality entities will shut themselves down.

Similarly, affirmative policies are required to help existing district-level entities to gradually achieve minimum standards and, over time, qualify for a national standard like NABH (National Accreditation Board for Hospitals and Healthcare Providers) and help raise the overall quality of care in the country. In 2010, a
scheme was set in motion to link district hospital obstetricians and surgeons to top class public and private oncology centres/doctors to train them to undertake some surgeries and also provide chemotherapy by investing in building high-end laboratories. This was in response to requests from Mumbai’s Tata Memorial Cancer Hospital that was overwhelmed by cancer patients requiring surgeries that, with a bit of training, could well be performed in district hospitals.

A similar capacity building programme for doctors in small nursing homes could also be undertaken to raise the overall technical capabilities in the country and help expand access. But then this requires effort and a mindset to accept the important role being played by these actors that the poor and lower middle classes access.

Unfortunately, this potential is not being tapped. Instead what we find is Niti Ayog, stubbornly carrying on with the World Bank advise to formulate the suicidal policy of handing over on long lease, district hospitals to corporates to provide a few tertiary care services like oncology, cardiology etc. Policies to attract new investments with promises of subsidised land and electricity, even while existing hospitals pay commercial rates for power are another set that need to be implemented carefully to ensure that they do not “kill” existing ones. If mindlessly implemented, such policies have the potential to drag the health sector into a spiral of high costs that India cannot afford.

Another policy that is of concern and needs to be reviewed is the one related to standards, namely, incentivizing hospitals that meet NABH standards. Meeting NABH standards is expensive: that explains why only 550 hospitals in India are certified by it. Of these 550, 178 are in Maharashtra, 177 in Tamil Nadu and 139 in Delhi. Chasing such high standards is not the priority at this point of time and the current status of development of the health system. For example, Aravind Eye in Madurai does not have NABH certification. Yet it is recognised world over as a
top class hospital with outcomes that better the best in the world. What is important is laying down minimum standards and treatment protocols for the different segments of care – primary, secondary and tertiary that are non negotiable. By insisting on NABH, the small and medium hospitals may not only shut down but also make health care costly without any great benefit as NABH is currently very input oriented with a secondary focus on outcomes.

In multi-player systems and, that too, those with weak regulations, competition is one means of hold prices. But such a competitive environment in health markets that has severe market imperfections, can be created only where government has at least 50 per cent of the market share in terms of demand as well as supply and has the capacity to provide competition in terms of both quality and price. Similarly, strengthening small hospitals and nursing home chains can further help increase competition as well as access. In other words, such competition cannot be induced by creating corporate monopolies. Small hospitals have the ability to provide reasonably good quality care at affordable rates. For example, a 20-bed mission hospital in Uttar Pradesh provides excellent quality of a normal delivery for Rs 600 to Rs 1000. In other words what is urgently required is for government to formulate affirmative policies to extend financial and technical incentives to public hospitals and small hospitals, charitable and not for profit hospitals etc. In the absence of such a policy framework, most are shutting down as is now unfolding in Kerala. That will be a tragedy.

Third, policymakers assume that by creating an effective market, they can push private investment into the sector to bridge the infrastructure gaps in terms of hospitals and beds. But this is simplifying complex realities and, of course, ignoring the evidence. It is not a lack of money that is holding up expansion as much as the severe shortage of human resources.
expansion as much as the severe shortage of human resources. Addressing human resources requires bold reforms in the MCI and the mindset that currently governs.

Commercialisation of medical and nursing education clearly works against having adequate number to work for public health or in small towns. So when big investment is lured into tier two and three towns, human resources will either be drawn away from the public hospitals or from the small nursing homes. This will lead to distortions that the government will not be able to control. Besides, these investments will not go to Hazaribagh or Bundelkhand, but to Madurai or Mysore where the public system is functioning well and where a competitive environment not only exists but can be further boosted. In other words, by promoting corporate and commercially driven hospitals to gain access to secondary and primary care markets, the government is clearly destroying both competition and sustainability. In other words, a much more nuanced approach is required to handle the three segments of the health system.

The random responses emerging from government seem to suggest that it is quite unclear about the complexities of the functioning of health markets and what and how to go about the implementation design. In the absence of provider regulations and no laws to check the existing corrupt practices or strong redressal systems, there is legitimate worry that the scheme may end up becoming fiscally a nightmare for the government and the patient - manifold worse than what currently exists in the United States – the model that policymakers seem so keen to replicate.
Health & Wellness Clinics: a potential game changer

This then brings into focus the second pillar of Ayushman Bharat, the Health and Wellness Clinics. This is a very critical intervention as it is aimed at strengthening health facilities that are within easy reach of the people for addressing their daily health needs. The success of the mohalla clinics in Delhi are a pointer to the immediate response of the people to such an intervention.

The scheme consists of strengthening the capacity of the existing 1.5 lakh subcentres (not establishing new ones as often reported in the media) to provide the 5,000 people under each centre, to 12 services ranging from ante-natal care and child immunisation to mental health and palliative care for chronic diseases. If implemented well, this can be a game changer as primary health care, when implemented in tandem with universal access to safe water, sanitation and nutrition, can reduce hospitalisation by one third, reduce out-of-pocket expenditures by half and address 90 per cent of the health needs of the population. Besides its enormous importance, it is the most difficult and challenging to implement, far tougher than handing over vouchers and public hospitals to private corporates. The concept needs an array of skills and competencies – counsellors, nurse practitioners, mid-level providers, physician-assistants, family health physicians, epidemiologists, statisticians, home and community health nurses, health communicators, pharmacists, physiotherapists, facility managers, laboratory technicians, computer professionals and so on. This is a far cry from the single Auxiliary Nurse Midwife-manned subcentres and a doctor-manned PHC with few resources.

This is a far cry from the single ANM (Auxiliary Nurse Midwife)-manned subcentres and a doctor-manned PHC with few resources, poor buildings and obsolescent equipment and a capacity to deliver a small set of services related to reproductive and child health and infectious diseases.
The strengthening and creating of wellness clinics then implies not just adding another room but creating a public health ecosystem that does not exist. Creating teams and personnel appropriate to the local epidemiology and peoples’ needs then requires huge investments in establishing training schools, improving the quality of training, building systems for concurrent site training and supervision, mobilising community support to make the system more accountable to them, data tracking systems and providing the financial resources along with public health laws. The central government has indicated no appetite for incentivising institutions undertake the implementation of this vision that would help it understand the fiscal requirements and the implementation constraints for designing the appropriate policy.

For example, a Health Secretary of an important State finds this vision highly ambitious and unachievable. Such perceptions arise when implementation science and knowledge accretion is ignored and policies are made in ideal and not real world situations. For instance, today, no one knows what primary health care providing these 12 services would cost. By any yardstick adopted, the vision as articulated by the government would require an additional 1 per cent of GDP to be spent on primary care alone.

To achieve the above vision also implies having the political courage to bring in institutional reform and review the incentive structures to optimise outcomes. Establishing public health cadres, a prerequisite for an effective primary health care system, has been discussed for decades as the single most important institutional reform for helping India reduce the load of communicable and avert non-communicable diseases. Yet it has been ignored. Unless the Centre and every State government establishes a public health department to give the
issue the necessary momentum and stimulus, the dying public health cadres cannot be revived.

Rather than looking at the broader architecture required for building public health, discussions often boil down to MPH (Master of Public Health) degrees or duration of public health training to be provided to medical doctors as a prerequisite for occupying public health posts. Similarly, management of public health hospitals and public health programmes is confused with public health expertise that requires a strong knowledge and understanding of biostatistics, epidemiology, environmental and occupational health and so on. In the absence of any information or of any road map reflecting such an understanding, there is widespread scepticism of the government’s ability and seriousness to energise the primary health care system in the country.

Institutional reform is critical for addressing the growing complexity of the sector. Creating special platforms becomes important to provide the needed energy. For example, the HIV AIDS control programme succeeded whereas the one for tuberculosis did not, because in the former, the financial, institutional, and political efforts were aligned. The same logic applies for the creation of the NHA or proposing the National Medical Commission to replace the Medical Council of India (MCI) or to understand why our drug regulation is so weak.

**Conclusion**

It is no one’s case that reform will be easy in a diverse, highly disaggregated, corrupt and chaotic health system where the country simultaneously combines conditions of developed economies alongside those of sub-Saharan Africa. Attempting to tackle both building primary care as well expanding access to
hospital treatment, as was done in Turkey, with 1 per cent of GDP public spending is unrealistic. Turkey not only has 80 per cent of its health system in the public sector but has also provided the required resources that enabled it to bring in bold reforms, such as banning private practice among its doctors and paying them market rates instead. Can India? Besides, given India's macroeconomic fundamentals and the reality of restricted resources, incrementalism is inevitable.

Taking every expression of concern as criticism is an unhealthy practice. What is expected is that when ambition is huge and the challenge thrown by the political system is extraordinary, formulating strategy must be an exercise that must be carried out carefully. It must be based on evidence, adopting a ‘stepping on the stones to test the waters’ approach in a consultative environment peopled by communities, academic institutions and researchers, policymakers, practitioners, civil society organisations, and persons engaged in the health sector. And it must be done in humility born out of a demonstration of keenness to address the concerns.

Unfortunately, policies continue to be made within four walls with strictly limited entry for chosen consultants, consultancy firms and development agencies. Such centralisation is unhelpful and if not corrected, India’s health sector will continue to haemorrhage, once again losing an opportunity to bring in the change that it so desperately needs.
[K. Sujatha Rao is a former Union Secretary of the Ministry of Health and Family Welfare, Government of India. Of her 36 years service as a civil servant, she spent 20 years in the health sector in different capacities at the State and federal levels. Rao was chairperson of the Portfolio Committee of the Global Fund for HIV/AIDS, TB and Malaria (GFATM) 2007-09; Member of the Global Advisory Panel of the Bill & Melinda Gates Foundation; Founding member of the Public Health Foundation of India; Member of the Advisory Board of the Ministerial Leadership Program of the Harvard School of Public Health and member of the High Level Panel on Global Risk Framework of the National Academy of Sciences, U.S.

A MPA from Harvard University, USA 1991-92, she was a Takemi Fellow at the Harvard School of Public Health 2001-2002 and Gro Harlem Brundtland Senior Leadership Fellow at HSPH in 2012. She is author of the book entitled *Do We Care? India's Health System*, published by Oxford University Press.

She can be contacted at ksujatharao@outlook.com]