Editorials

Is AB-NHPM Innovative and path-breaking?

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

As education, health, employment, food security, nutrition, and demographic transition are all crucial components, the government must necessarily accord to them the foremost priority. The focus must be on knowledge revolution and the establishment of a knowledge-based society in India will require tapping into the huge untapped human potential. As the greatest challenge is employment generation this will probably be the most important factor to achieve reduction in poverty and ensuring easy access to food and other essentials for the citizens to maintain a healthy life.

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

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

An ideal health care system should include universal access, fair distribution of financial costs for the access, trained providers for competence and accountability and special attention paid to the vulnerable groups (children and women). When health policies and innovative schemes are formulated, one needs to go beyond the limits of the immediate past.

AB-NHPM objectives include reducing out-of-pocket expenditure (OOPE) and increase in access to quality health and medications. The government is paying for the insurance premium of 50 crore people. The insurance is of approximately one lakh as the packages have been capped with the maximum cap being around one lakh for tertiary care procedures. For one lakh insurance, the premium calculation is correct. The government has divided the community into two segments the poor (under NHPS) and non-poor (personal insurance). Hospitals invariably will have two categories in their establishments (general ward for NHPS and private wards for others).

The aim of ambitious AB-NHPS is to provide coverage of INR 500,00 per family annually, benefiting more than 10 crore poor families. The scheme will target poor, deprived rural families and identified occupational category of urban workers' families, 8.03 crore in rural and 2.33 crore in urban areas, as per the latest Socio-economic Caste Census (SECC) data.

Sustainable healthcare encompasses the money, health infrastructure, valuing and managing human resource, professional management, economics, effectiveness, efficiency, and the environment. NHPM may exert a transformative impact if it is effectively implemented in a coordinated manner. India requires an integrated approach to reach out to the whole population and train the various service segments providing them. Managing performance and strengthening accountability for delivering quality health care will need continuous

monitoring for NHPM to succeed.

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

NHPS will have major impact on reduction of Out of Pocket (OOP) expenditure on ground of:

- Increased benefit cover to nearly 40% of the population, (the poorest & the vulnerable)
- Covering almost all secondary and many tertiary hospitalizations. (except a negative list)
- Coverage of 5 lakh for each family, (no restriction of family size)

This will lead to increased access to quality health and medication. In addition, 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, job creation thus leading to improvement in quality of life.

Current status

Public health expenditure in India (total of central and state governments) remained constant at approximately 1.3% of gross domestic product (GDP) between 2008 and 2015 and increased marginally to 1.4% in 2016-17. Including the private sector, total health expenditure as a percentage of GDP is estimated at 3.9%. In 2018-19, the Ministry of Health and Family Welfare received an allocation of Rs. 54,600 crore. The NHPM received the highest allocation at Rs.30,130 crore and constituted 55% of the total allocation. According to the National Family Health Survey 4 (2015-16) (Ministry of Health and Family Welfare 2017), only 29% of households in India have one member covered under any health insurance scheme, be it public or private (20% women and 23% men). The top five states according to coverage are Andhra Pradesh (75%), Chhattisgarh (69%), Telangana (66%), Tamil Nadu (64%) and Tripura (58%).

In-patient hospitalisation expenditure in India has increased nearly 300% during the last ten years (National Sample Survey Office 2015). Household health expenditures include out-of-pocket expenditures (OOPE) (95%) and insurance (5%). According to the National Health Accounts (2014-15), total OOPE is 3.02 lakh crore. The highest OOPE is made towards purchasing medicines—1.30 lakh crores. (43%), followed by private hospitals—86,189 crores (28%).

OOPE is typically financed by household revenues (71%). Rural households primarily depended on their ‹household income/savings› (68%) and on ‹borrowings› (25%) while urban households relied much more on their ‹income/saving› (75%) for financing expenditure on hospitalisations and on (18%) borrowings (National Sample Survey Office 2015). OOPE in India is over 60%, which leads to nearly 6 million families getting into poverty due to catastrophic health expenditures.

Institutional structure

The Government of India has set up three bodies in addition to State Health Agency:

- National Health Protection Mission Council
- Ayushman Bharat National Health Protection Mission Governing Board
- Ayushman Bharat - National Health Protection Mission Agency (AB-NHPMA) Health and wellness centres

Cost-effective health coverage must cover primary care. This is where the second feature of Ayushman Bharat Programme—the creation of 150,000 health and wellness centres across the country—is very significant. Sub-centres are the first line of contact of citizens to the public health system in India. Yet, even with the talk about strengthening health at the grassroots, overall allocation to the Department of Health and Family Welfare rose by a meagre Rs. 1,250 crore from the revised Budget estimate for 2017-2018, and allocations to the National Health Mission have fallen by more than Rs.600 crore. Our biggest constraint is also an acute shortage

of human resources.

NHPS is different from RSBY in one fundamental way: RSBY was based on enrolment whereas NHPS is an entitlement-based scheme, ie all the identified population sub-groups under NHPS will automatically get covered once the scheme becomes operational. The functions of risk and resource pooling, which is the central role of any insurance company, are almost non-existent in NHPS as the scheme is fully subsidised by the Central and State Government through their budgetary support. The key functions that remain central in NHPS are hospital empanelment and claims settlement.

RSBY provided limited coverage of only Rs. 30,000, usually for secondary care. Though it improved access to healthcare, it did not significantly reduce OOPE as proved in many studies. The NHPS tries to address those concerns by sharply raising the coverage cap, but shares with the RSBY the weakness of not covering outpatient care. which accounts for the largest proportion of OOPE.

Challenges in effective implementation of NHPS

Major challenges facing the Indian public healthcare system are the sheer complexity of financing and managing preventive, promotive, curative and rehabilitative care; of proactively addressing the social determinants of health; of assuring quality in the public sector; of harnessing the initiative and resources of the private sector while ensuring effective regulatory systems; and of ensuring equity of access to services across social and economic divides.

Selecting the insurance provider is an extremely complex process. Each step, such as the design of the tender documents, contract and legal agreements, payment terms, penalties for non-compliance, pre-qualification of bidders, transparent and secured e-tendering process, which tenders would be called state-wise or nationally—must be considered carefully.

Key advantages of implementing the scheme through a trust model are: its not-for-profit orientation and conducting awareness and sensitisation functions using government administrative machinery, especially at district/sub-district level.

Risks of this model is it weak in-house capacity to perform critical functions that depend on the quality of hired personnel. Andhra Pradesh, Telangana, Karnataka and Gujarat are using the trust model.

Some of the main advantages of implementing the scheme through an insurance company are: its experience of working with third-party administrators (TPAs), and possible scale-up of scheme to cover the non-poor population, which would involve marketing of the scheme and premium collection

The effective implementation of AB-NHPM will largely depend on ensuring that the package of services prioritised under NHPS is based on community needs, evidence-based, well governed and inclusive.

Project to Map Every Health Facility in India

The National Health Resource Repository [NHRR] project is a map indicating the locations of approximately 2,000,000 to 2,500,000 health care facilities (both private and government run) in the country, as well as details on their functioning, the number of patients they serve and performance of the doctors. The NHRR will also be a significant tool for the AB-NHPM. The NHPM will depend on this mapping exercise for both implementation and monitoring. The two pillars of the Ayushman Bharat — the NHPM and comprehensive primary care — will definitely require this map. Some amount of data in terms of government health facilities has already been collected. The data intends to geo-tag the sites of the health facilities and construct the layers. For example, it can indicate a health center offering cardiac care or one well equipped for maternal care.

National Health Stack

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

actions that will propel the nation's progress towards becoming a global digital powerhouse, NITI Aayog proposed the National Health Stack (NHS). The NHS will facilitate the collection of comprehensive health care data from across the entire country. It will also provide a mechanism via which every participant user in the system can be uniquely identified. Each registrant may create a virtual health ID to preserve his/her privacy when interacting with the other users or stakeholders in the system. The stack will embrace the health management systems of the public health programs and socio-demographic data systems.

Is NHPS Innovative and path-breaking?

NHPS is an effort by the government to shift from sectoral and fractional delivery of health care services to all-inclusive healthcare services. It is NHPS that will provide health insurance coverage worth Rs. 5 lakh to each of the selected 10 crore poor families every year for secondary and tertiary care hospitalization. There are about 1,354 medical packages included in the scheme by the health ministry. These packages include surgical procedures and medical treatments involving expenses relating to medicines, transport, and diagnostics. The scheme is an amalgamation of the two central government schemes – Senior Citizen Health Insurance Scheme (SCHIS) and Rashtriya Swasthya Bima Yojana (RSBY).

NHPM in a Nutshell

- The scheme will provide a health insurance cover of Rs. 5 lakh to each family every year.
- The medical benefits to be given under this scheme will be based on the deprivation norms in the SECC database.
- The scheme is applicable all over the country and its beneficiaries can have cashless health benefits from any public or private empanelled hospitals in India.
- The central principle of AB-NHPM is to promote co-operative federalism and adaptability to the states.
- The funds for the implementation of the scheme will be directly transferred by the Central Government to the State Health Agencies by way of an escrow account on a timely basis.
- No restriction on the size of the family, the age of the beneficiaries, or their gender.
- Priority is given to girl child, women, and senior citizens.
- All the members of the eligible families present in the database of SECC are necessarily covered.
- The medical treatment given to the eligible families is free of cost.
- Paperless and cashless availability of health care services to the beneficiaries.
- Good number of medical packages available to the beneficiaries which include surgery, medicine and diagnostics cost, and other treatments.
- The scheme ensures the availability of good quality secondary and tertiary care services through empanelled private and public hospitals to the members of the poor and vulnerable families free of cost.
- Aligns the development of the private sector with the public sector health goals.
- Helps in the setting up of fresh health framework in the rural and remote areas.

Implementation strategy

At the state level: State Health Agency (SHA) in every state has to implement the scheme in the states and union territories. The SHA can either be a Society/State Nodal Agency (SNA)/ Trust/Non-profit company or a new entity. The states or union territories can implement this Ayushman Bharat scheme through insurance companies, society, or trust. The funds to be used in this scheme will be transferred by the government through an escrow account.

All the expenses relating to payment of premium will be borne by the government. It will be shared by the Central and the State governments in a specified ratio prescribed by the Ministry of Finance.

In a country where around 63 million people are pushed into poverty due to health-care expenses, Looking Ahead, NHPS could be an effective approach to ensure universal health coverage. Some of the problems envisaged in the implementation of this program are predominantly the funding, acceptance by the states, exclusion of primary health care and

outpatient expenditure from the scheme, problems regarding awareness of the scheme among its beneficiaries who are automatically included under the ambit of scheme, and the best model to provide health-care insurance to be used in the implementation of the program. AB-NHPS is the largest government-sponsored healthcare scheme in the world aimed to provide healthcare facilities to over 10 crore families (8.03 crore families in rural and 2.33 crore in urban areas will be entitle), covering urban and rural poor families as per the socio-economic census of 2011. It will also benefit the lower middle-class, middle-class and upper-middle class by job opportunities in the medical sector as new hospitals will open in Tier-2 and Tier-3 cities. This scheme is targeted at poor, deprived rural families and identified occupational categories of urban workers' families. To ensure that nobody is left out (especially women, children and the elderly), there will be no cap on the family size and age under the AB-NHPS. The scheme will be cashless and paperless at public hospitals and empanelled private hospitals. At a time when cost of private health care is shooting up, a universal health insurance scheme is expected to be lapped up by the poor. The scheme can be a step in the right direction to reach out to the poorest of the poor just before the next elections. The future healthcare is seen as a high-volume, low-margin venture, inching towards universal healthcare with an active role played by the government. Healthcare industry will now be a highly regulated accountable system. It will witness the next waves of disruptive metamorphosis. Organizations that do not adapt to this new philosophy will face closure. Focus is shifting from curative medicine to disease prevention, health promotion and wellness, and compounding growth of newer areas like digital health. Skill development and newer training modules with be required for providing quality care. Operational excellence will emerge as the buzz-word.
Will NHPS ensure healthcare for all and wellness for all is a matter of time to see.

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Is Stethoscope an Obsolete Instrument?

Ever since the development of a stethoscope by Laennec in France in 1816 it has been constantly modified by several persons who includeArthur Leared in 1851 and George Philip Cammann in 1852 to give its present look of a bin aural instrument. A medical doctor looks incomplete without a stethoscope hanging and drooping from his shoulders. Even patients who come with complete work up done including most investigations done for example a symptomatic patient with dilated cardiomyopathy, left bundle branch block and echocardiogram showing LVEF 28% with mild mitral regurgitation seeking another opinion for the need of a CRTd implantation would expect a full clinical examination including auscultation of the heart.
In fact I have several instances when a patient referred for coronary angiography after a complete work up including a stress echocardiogram or a nuclear scan, and having taken an appointment for admission gets very disappointed if he is not examined clinically included auscultation of heart using a stethoscope. I remember a fewwhen patient refuses to get admitted because of this inadequacy.
As a part of medical education in medical schools, students after their basic training in anatomy physiology and biochemistry are coached in the art of medicine which involves emphasis on