AYUSHMAN BHARAT

Key to Universalization of Health Care

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Four key determinants of health

1.Population composition

- **Age and Gender, genetic characteristics, health beliefs, and cultural attitudes are the variables that influence health**
- *The diversity of urban populations ensures that there is no urban genotype,* ***genetic characteristics interact with environmental conditions to produce urban phenotypes with particular health resiliencies and vulnerabilities***

2.Physical environment :

RURAL AREAS:

Open air defecation, Lack of toilet facilities, waste disposal, Sewage drainage, animal desegregation & smokeless Chula's , Lack of safe water supply , hand washing practices are the causes of diseases

URBAN AREAS

i) Providing access to safe water, garbage removal, and sanitation, Hazardous waste landfill sites are often located in or near the slums in developing countries ii) Air pollution, Noise exposure due to number and kind of Industries, vehicles and iii) Road accidents are unique challenges for urban areas iv) Construction sites, ponds, lakes and air coolers act as mosquito breeding places cause of VBDs v) Poor transportation inhibits access to employment and health services vi) Poor work conditions lead to injuries vii)Crowded transport increase the risk of secondary smoking, transmissions of airborne diseases like TB, Influenza, viii) Improper planning of roads, street and lanes are hazards of Fire & impediments for fire control activities ix) Commuting Pain index is slowly posing a larger health challenge in Metropolitan cities

3.Social environment

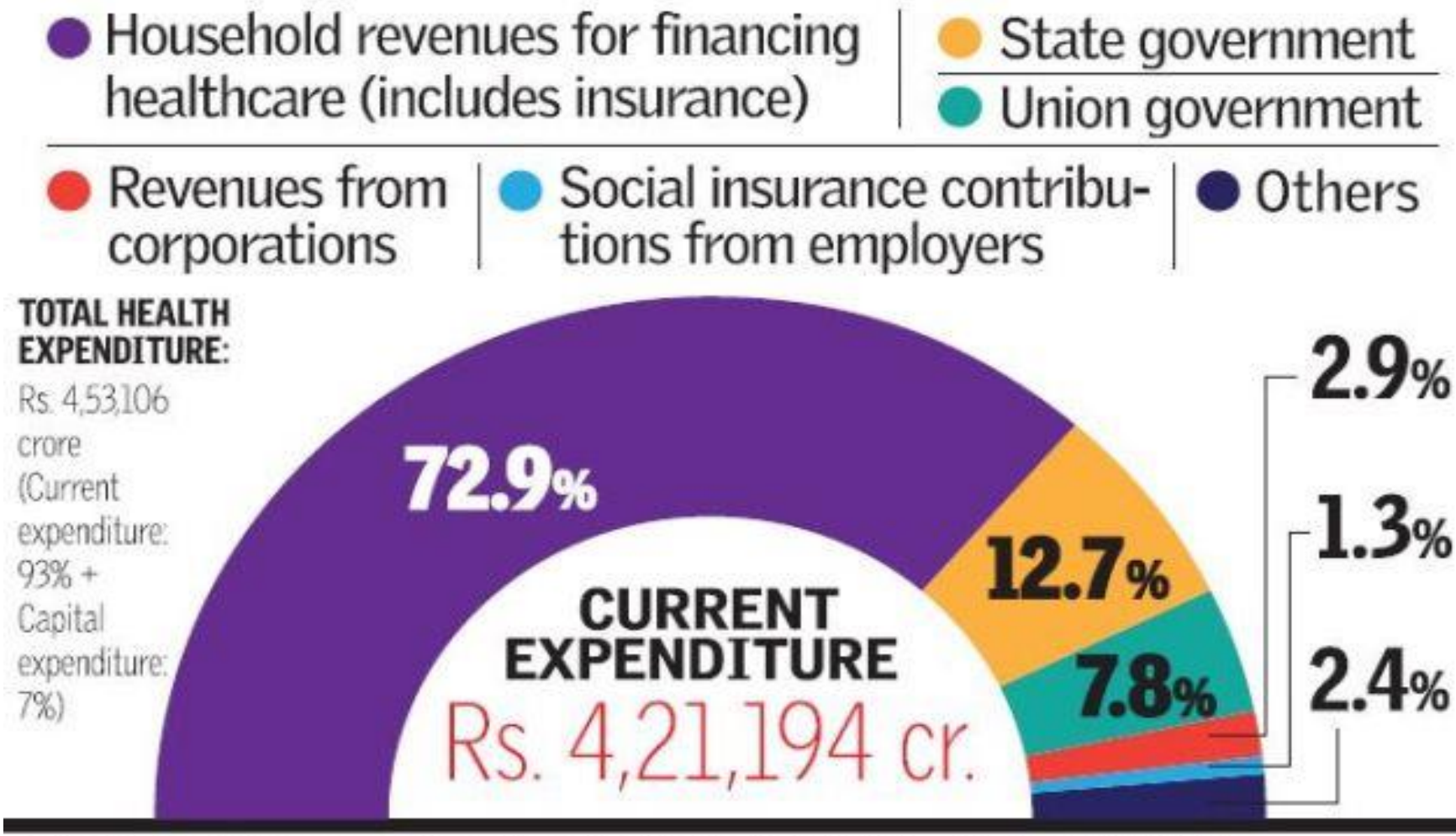
Problematic characteristics of the urban social environment may include social support for health damaging behaviour (drugs, gangs) and high levels of social stressors such as social isolation violence, and extreme poverty.

4.Health and Social Services

- We have a well organized Public Health infrastructure in Rural areas. Similarly WCD looks at social services
- Urban Health Services are many but generally caters to those who can pay & expose families to financial risk
- Some Urban poor (unorganized) may not have access to even emergency services
- Original urban Health services organized for poor are no more represent needy population.

WEALTH IN HEALTH

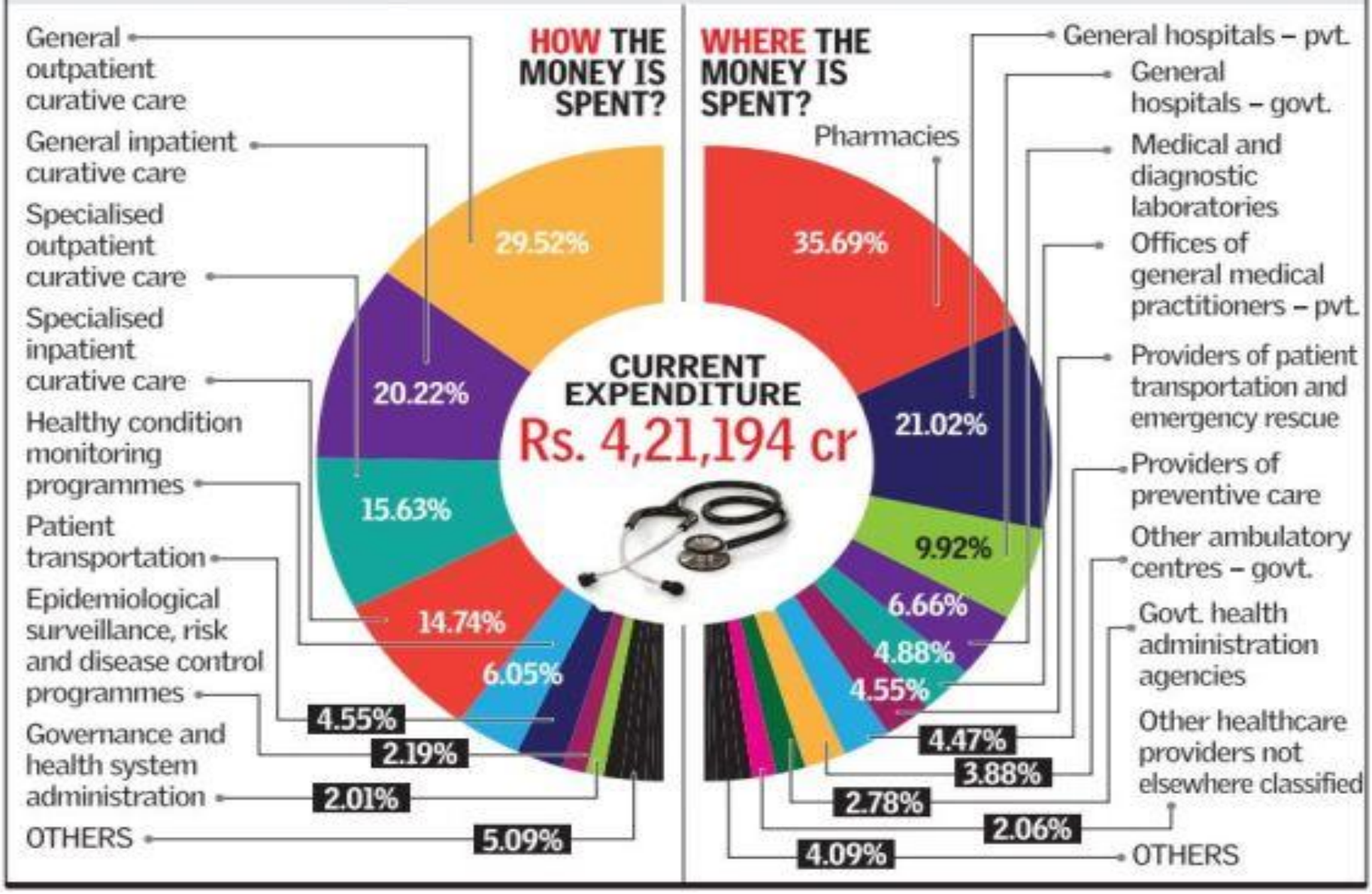
Indians spend much more on private hospitals than on govt. ones



SOURCE: NHA ESTIMATES FOR INDIA 2013-14, MINISTRY OF HEALTH AND FAMILY WELFARE

COST OF CURE

Public spending in India is abysmally low, constituting around 29 per cent of the total health expenditure



Current Health Care & Way Forwards

- limited to RCH and Communicable Diseases- addresses about 20% of health care needs.
- NSSO data (71st Round-25, January - June 2014) Only 28% in rural areas and 21% in urban areas sought care in the public sector; of which only 11% and 3% respectively sought any form of care at a level below the CHC (other than child birth related services).
- Health care is fragmented –disrupts continuity of care and impacts on clinical outcomes and leads to high OOPs.
- High Costs are incurred because of lack of gate keeping function – raises the load on secondary and tertiary facilities and compromises quality.
- Some of the interventions get higher priority at cost of comprehensive care that population expects. In the last decade Immunization and polio eradication activities have had opportunity cost for other interventions.
- To this ass Epidemiologic Transition Death from the four major NCDs –Cancer, CVD, Diabetes, and Respiratory Diseases accounts for nearly 62% of all mortality among men and 52% among women –of which 56% is premature that need to be addressed.
- Through Ayushman Bharat, the government is targeting to increase healthcare accessibility while reducing out-of-pocket expenditure on health. While out-of-pocket payments constitute over 60% of health financing in India, many are still deprived of tertiary care because of its high cost.

National Health Policy 2017- Current Programming

- The fact is that all the disease conditions for which national programmes provide universal coverage account for **less than 10% of all mortalities** and only for about 15% of all morbidities.
- Over 75% of communicable diseases are not part of existing national programmes.
- Overall, Non-communicable diseases contribute to (39.1%), communicable diseases to 24. 4% maternal and neonatal ailments contribute to 13.8%, and injuries (11.8%) now constitute the bulk of the country's disease burden.
- National Health Programmes for non-communicable diseases though started in 2008 are very limited in coverage and scope, except perhaps in the case of the Blindness control programme.

Organization of Health Care Services-
The 7 Key Policy Shifts in Draft NHP 2017:

1. In Primary Care: From a Selective Care that is fragmented from secondary / tertiary care to Assured Comprehensive care that has continuity with higher levels
2. In Secondary and Tertiary Care: From an input oriented, budget line financing to an output based strategic purchasing.

3. In Public Health Facilities: From User Fees & Cost Recovery Based Public Hospitals to Assured free drugs, Diagnostic and Emergency Services to all.
4. In Infrastructure and Human Resource Development: From normative approaches in their development to targeted approaches to reach under-serviced areas.

5. In Urban Health: From token under-financed interventions to on-scale assured interventions that reach the Urban Poor and establish linkages with national programmes- Scaling up of the interventions with focus on the urban poor and achieving convergence among the wider determinants of health.

6. In National Health Programmes- Integration with health systems for effectiveness, and contributing to strengthening health systems for efficiency.

7. In AYUSH services: From stand-alone AYUSH to a three dimensional mainstreaming.

Key Features of Ayushman Bharat

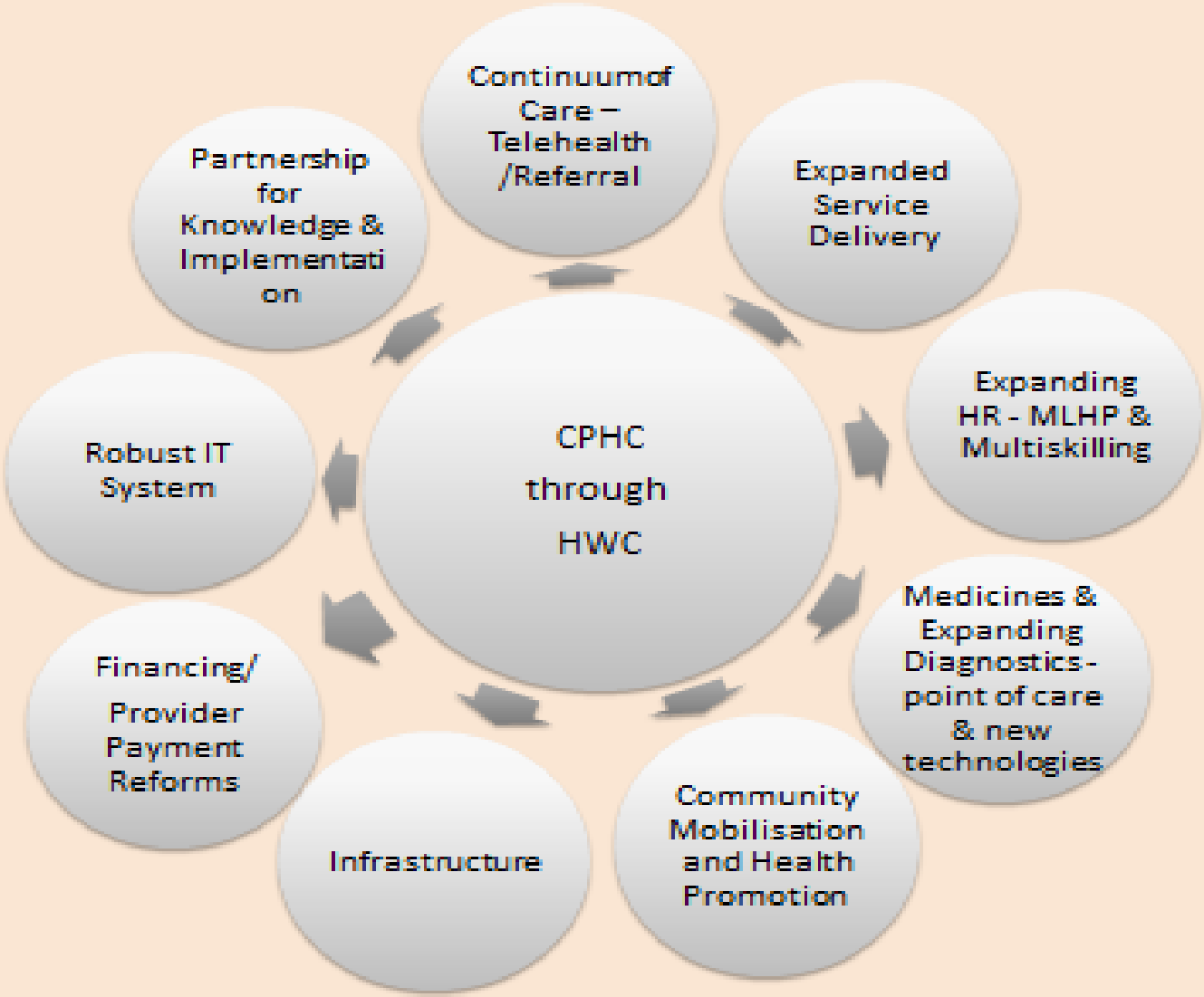
- **Ayushman Bharat - Pradhan Mantri Jan Arogya Abhiyan (AB-PMJAY) is a new Centrally Sponsored Scheme having central sector component under Ayushman Bharat Mission anchored in the Ministry of Health and Family Welfare (MoHFW).**
- **The financial support has been increased to INR 5 Lakh from what was 30,000 (BPL families) in yester years**
- It is an umbrella of two major health initiatives:
  - Health and wellness Centres and
  - National Health Protection Scheme.
- The H&W centres idea is appreciated for improving the health care access.
- One would like to see explicit policies and resources to improve the quality of care in Public sector facilities (from PHCs to MCHs)
- **Then one can put Quality of healthcare as critical parameter and not the Financial upper limit .**

Health and Wellness Centres

- **Under this 1.5 lakh existing sub centres will bring health care system closer to the homes of people in the form of Health and wellness centres.**
- These centres are expected to provide comprehensive health care, including for non-communicable diseases and maternal and child health services but capacity building for that takes time
- Most of our primary care and secondary health care institutes lack basic hygiene & cleanliness that deters people seeking care.
- Though there has been some improvement in services available, as I have seen for last 50 + years, there is still a long way to go to match private sector
- Apart from difficulty in attracting and retaining various medical specialists (doctors & technicians) system needs to develop a team approach in health care management and delegating some tasks to non-medical staff and building robust referral mechanism
- Universal Health Care appears to be a distant dream with vertical programs focus.

Comprehensive Primary Health Care (CPHC)

Key Elements to Roll out CPHC



Essential Package in CPHC under Ayushman Bharat

1. **MCH:** Care in Pregnancy and Child-birth, Neonatal and Infant Health Care Services, Childhood and Adolescent Health Care Services.
2. **Family Planning**: Family Planning, Contraceptive Services and other Reproductive Health Care Services (RTI, STD control etc)
3. **Communicable Disease Control**: Management of Communicable Diseases through National Health Programmes, NVBDCP, HIV/AIDS CP, RNTCP
4. **General Out-patient Care** for Acute Simple Illnesses and Minor Ailments

5. **Screening, Prevention, Control & Management of Non-communicable Diseases**

6. **Care for Common Ophthalmic and ENT Problems**
7. **Basic Oral & Dental Health Care**

8. **Elderly and Palliative Health Care Services**
9. **Emergency Medical Services including Burns and Trauma**

10 **Screening and Basic Management of Mental Health Ailments**

Managing Healthcare

Influence – Basics Right

Ensure Quality Outcomes & Result Oriented Effective Care.

Influence – Implementation Excellence

Judiciously managing the healthcare institutions while delivering consistently effective and efficient care.

Managing Healthcare – Basics Right

BEFORE ADMINISTRATOR JOINS

1. **PLACE – LOCATION VISIBILITY & REACH**
2. **PRODUCT – INFRASTRUCTURE, SPECIALITY MIX, AMBIANCE & SPACE**

Ensure Quality Outcomes
Result Oriented Effective Care

Managing Healthcare – Basics Right

ADMINISTRATOR CAN IN... NCE

1. DOCTORS TEAM
2. FACILITY MIX
3. INSTRUMENTATION
4. PRICING & PAYOUT MATRIX
5. HIS
6. LOOK & FEEL
7. PATIENT CARE PROCESSES & KEY SOPS

SUFFICIENT TO GIVE COMPLETE QUALITY COVER FOR OPD / IPD / OT / EMERGENCY

Managing Healthcare – Basics Right

1. DOCTORS TEAM – COMPLETE & INVOLVED

1) **FULL TIME -** SALARY OR RETAINERSHIP, PRIME TIME OPD SLOT, WALKIN PATIENTS, TPA & CORPORATE PATIENTS, PRIME PROMOTION
2) **PART TIME (WITH OPD / WITHOUT OPD) -** HIS OWN CLINIC + CORPORATE HOSPITAL, WITH 1 OR 2 DAYS OPD & EMERGENCY ON ROTA, SELECTIVE PROMOTION
3) **VISITING (WITH OPD / WITHOUT OPD) -** HIS OWN CLINIC + 3-4 CORPORATE HOSPITALS. RIGHT TO ADMIT THEIR CASES

VERY IMPORTANT 24 X 7 SUPPORT DOCTOR TEAM IN OPD / IPD / EMERGENCY / OT / ICU ...STAYING NEARBY

Managing Healthcare – Basics Right

2. FACILITY MIX – COMPLETE & WELL SUPPORTED

EXAMPLE MOTHER & CHILD

1) EMERGENCY
2) OPD & DIAGNOSTICS
3) IPD / ICU
4) NICU
5) PHARMACY
6) PATHOLOGY
7) OT / LABOUR ROOM
8) ANC CLASES
9) BLOOD STORAGE

WITH 24 X 7 SUPPORT OF CRO, NURSING, CLINICAL ASSOCIATES, PEADIATRICIAN, ANESTHETIST, DIAGNOSTICS

Managing Healthcare – Basics Right

3. INSTRUMENTATION – COMPLETE FOR THE GIVEN PRODUCT MIX

SUFFICIENT TO GIVE COMPLETE QUALITY COVER FOR OPD / IPD / OT / EMERGENCY

1. **SURGICAL**
2. **OPD**
3. **MONITORING**
4. **IPD**
5. **EMERGENCY**

IN CASE CAPEX APPROVAL IS AN ISSUE ...
TIE UP WITH OWN DOCTORS OR
WITH RENTAL AGENCIES

National Health Protection Mission (AB-PMJAY)

- AB-PMJAY will have a defined benefit cover of Rs. 5 lakh per family per year. This cover will take care of almost all secondary care and most of tertiary care procedures. To ensure that nobody is left out (especially women, children and elderly) there will be no cap on family size and age in the scheme. The benefit cover will also include pre and post-hospitalisation expenses. All pre-existing conditions will be covered from day one of the policy. A defined transport allowance per hospitalization will also be paid to the beneficiary.
- Benefits of the scheme are portable across the country and a beneficiary covered under the scheme will be allowed to take cashless benefits from any public/private empanelled hospitals across the country.
- AB-PMJAY will be an entitlement based scheme with entitlement decided on the basis of deprivation criteria in the SECC database, The different categories in rural area include families having only one room with kucha walls and kucha roof; families having no adult member between age 16 to 59; female headed households with no adult male member between age 16 to 59; disabled member and no able bodied adult member in the family; SC/ST households; and landless households deriving major part of their income from manual casual labour, Also, automatically included families in rural areas having any one of the following: households without shelter, destitute, living on alms, manual scavenger families, primitive tribal groups, legally released bonded labour. For urban areas, 11 defined occupational categories are entitled under the scheme.
- The beneficiaries can avail benefits in both public and empanelled private facilities. All public hospitals in the States implementing AB-PMJAY, will be deemed empanelled for the Scheme. Hospitals belonging to Employee State Insurance Corporation (ESIC) may also be empanelled based on the bed occupancy ratio parameter. As for private hospitals, they will be empanelled online based on defined criteria.
- To control costs, the payments for treatment will be done on package rate (to be defined by the Government in advance) basis. The package rates will include all the costs associated with treatment. For beneficiaries, it will be a cashless, paper less transaction. Keeping in view the State specific requirements, States/ UTs will have the flexibility to modify these rates within a limited bandwidth.
- One of the core principles of AB-PMJAY is to co-operative federalism and flexibility to states. There is provision to partner the States through co-alliance. This will ensure appropriate integration with the existing health insurance/ protection schemes of various Central Ministries/Departments and State Governments (at their own cost), State Governments will be allowed to expand AB-PMJAY both horizontally and vertically. States will be free to choose the modalities for implementation. They can implement through insurance company or directly through Trust/ Society or a mixed model.

68% of Patients get treatment in private hospitals

Source: Times of India-Bengaluru edition 18th November 2018 (according to data compiled by the National Health Agency-NHA)

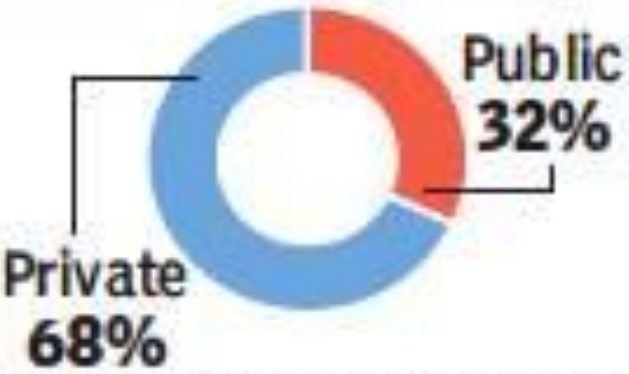
- Pradhan Mantri Jan Aarogya Yojana — the secondary and tertiary care arm of the government-funded health insurance scheme was launched on 23 September 2018
- In encouraging news for the Ayushman Bharat programme, around 68% of the some 2.3 lakh beneficiaries to be admitted to hospitals under the scheme received treatment in private hospitals with Gujarat, TN, Maharashtra and West Bengal, topping the list.
- 2,32,592 beneficiaries received hospitalisation under in less than two months of its rollout .The data show that oral and maxillofacial surgery, general surgery, ophthalmology and gynaecology as the most sought-after treatments.
- These statistics assume significance as initially private hospitals had expressed concerns about the low pricing of packages fixed by NHA. This had also led to speculation about the take-off and spread of the scheme, which requires a network of empanelled hospitals for patients to seek care across the country.
- NHA has so far received 55,482 applications for hospital empanelment. Out of this, nearly 15,000 hospitals have either been empanelled or are in the pipeline following approvals. Around 8,000 empanelled hospitals are from the private sector. The response in tier 2 and 3 cities in states like Haryana, UP, Jharkhand and Chhattisgarh is tremendous,
- “Costing issues are primarily in Delhi and in other metro cities where the cost of services and human resources is high.
- PMJAY target is to increase accessibility of tertiary care by 6,000 to 7,000 patients / day
- PMJAY, aims to cover nearly 50 crore beneficiaries from 10.74 crore deprived families with an annual cashless health cover of Rs 5 lakh per family.

BENEFICIARIES: GUJ TOPS LIST

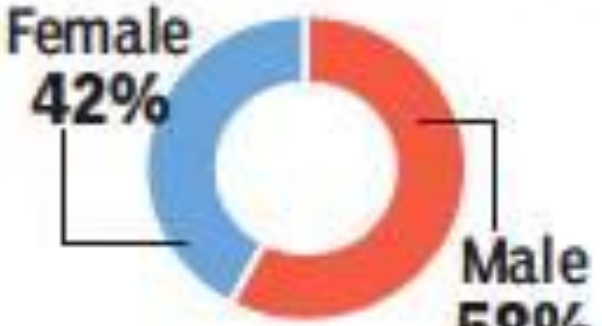
Beneficiaries admitted to hospitals

2,32,592

Hospital admissions



Gender Distribution



Top 5 specialities by claim

- Oral and Maxillofacial surgery
- General surgery
- General medicine
- Ophthalmology
- Obstetrics & gynaecology

Top five states by beneficiaries admitted

- Gujarat
- Tamil Nadu
- Maharashtra
- Chhattisgarh
- West Bengal

*PMJAY progress update till Nov 17

Challenges for Ayushman Bharat

- Infrastructure and Location of HWCs: Roadmap for various contexts
- While health infrastructure in rural areas is well established, there is a need to improve the round clock availability of services, quality of services and emergency obstetric and paediatric services.
- In Urban area these infrastructures are yet to be built ,as since 2013 roll out of Urban Health Mission has been very slow.
- Human Resources: The capacity development of human resource recruited especially the skill development will be going to be tough. Training of this staff and retaining them especially in urban areas is not going to be easy.
- Role of Information Technology in Primary Health care: There are many recent developments in information and digital diagnostic technologies, adapting them to CPHC is the need of the hour but not going to be easy,
  - For example in Bengaluru a Digital start-up has developed a diagnostic tool for breast cancer screening. It has great potential and minimises the cost from 5000-10000 for mammography to 1500-2000 and also does need to be interpreted by a doctor or a trained technician.
  - Diabetes diagnosis and management
  - Digital diagnosis of Heart strokes giving enough time to save lives

Challenges for Ayushman Bharat (contd.)

- Essential Medicines and Diagnostics: Though in principle generic drugs are accepted and many diagnostics are there for making them available, their use and treatment need to be closely monitored.
- Health &Wellness Centres in urban areas: A new venture, though some cities have started providing parks, open Gyms, their maintenance & replacements needs attention
- Review of HWC costing and Payment of Performance:
- Monitoring the performance especially the quality need to be addressed in a comprehensive manner
- Organizing Referrals and Ensuring Continuum of Care: Maintaining continuum of the care especially between public sector and private sector will be big challenge. Even within public health system the referral mechanism is not yet established and going to pose a challenge.

Building Trust in Public Sector Facilities

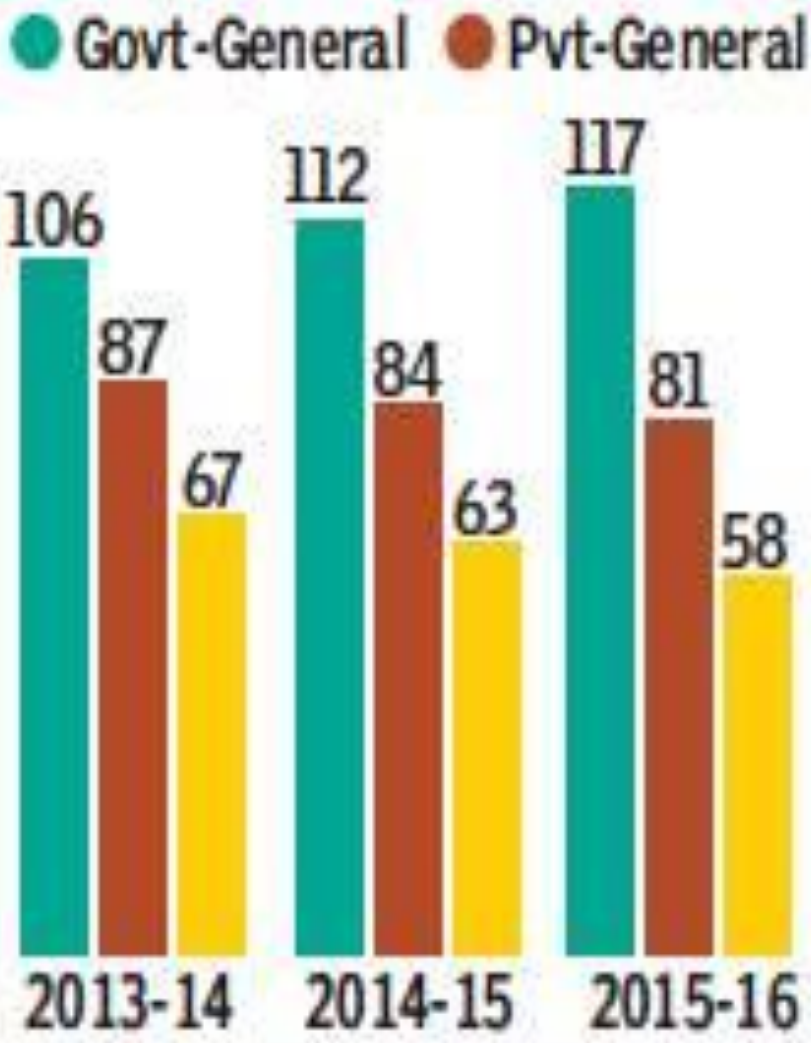
- Building work flow for all hospitals in Public sector involving Health & Hospital care managers will be one option to be considered seriously
- Financing in time under the assurance scheme in general will be critical, , more importantly if the costs of interventions goes beyond the limit
- Negotiating with private sector particularly for tertiary super-speciality care
- Working with other factors influencing health (environment- safe water, excreta and waste disposal) traffic, Air and Noise pollution, demands highest level commitment, as we see at present poor coordination among various departments
- Highest attention to UNICERSAL HEALTH CARE at all levels of facilities is the need of the time
- Encouraging health system for comprehensive planning with district specific models (including urban, tribal and rural India) , aggressive implementation and community monitoring of UHC only will yield results to match SDGs

Hospital Transaction Management Workflow

Are Indian Better Off without Health Insurance?

- Individual buyers of health insurance are worst off in India, especially if they have bought it from private stand-alone health insurance companies. They have difficulty in getting the companies to pay up when they need the cover.
- National Institute of Public Finance and Policy (NIPFP) study-Fair Play in Indian Health Insurance, the claims ratio as a percentage of the total premiums collected had fallen from 67% to 58% between 2013 and 2016 for private standalone health insurers, raising consumer protection concerns.
- In contrast, the claims ratio of government-backed general insurance firms had gone up from 106% in 2013-14 to 117% in 2015-16.
- Private insurers use a higher percentage (up from 10% in 2013-14 to over 12% in 2015-16) of the premium paid by consumers to pay agent commissions, while public sector insurers used just 6.8% in 2013 and now over 7% .
- Insurance firms often rejected legitimate claims only to lose in dispute resolution mechanisms, like the ombudsman and consumer fora. There are no penalties in the existing regulations for rejecting valid claims even when the rejections are in violation of the regulations.
- **In India there is no provision to refund consumers if the claims ratio is below a minimum level, unlike in USA**

SHARE OF PAYOUTS VS PREMIUMS COLLECTED LOWEST FOR PVT HEALTH INSURANCE COS



India Had Highest Rate Of Complaints* Related To Claims

*Per 10 lakh people insured, 2013-14

Quality of healthcare should be the critical parameter and not financial upper limits

- The supremacy of private healthcare is spoken by all but no party wants to be like a gawker at a traffic wreck when it comes to health.
- In the 1950s, private health costs were between 5% to 10% of the total health bill of the country, today the number of private hospitals between 1980 and now.
- National Sample Survey records, as many as 24% of rural households and 18% of urban households fall into the debt trap on account of medical expenses. Two out of five cancer patients lack the finance required for their treatment
- UPA's Rashtriya Swasthya Bima Yojana only promised Rs 30,000 per year for five members of every BPL household where as PMJAY promises 5 Lakhs.
- Illnesses, don't abide by financial discipline or threshold. A cardiac ailment, or cancer, can wipe out even relatively prosperous families
- Unfortunately, just 700 or so out of nearly 80,000 Hospitals (Govt. & Private) meet the standards of the National Accreditation Board for Hospitals and Healthcare Providers (NABH).
- Without quality control, most hospitals will fail to arouse trust in people
- With drugs and pathological tests as well, patients seek quality. Estimates from different sources suggest that about 80% of out of pocket expenses are for privately purchasing medicines and pathological tests, most of it for outpatient care.
- Yet, all our state health policies have leaned heavily all along towards inpatient cost reimbursement, once again, mostly private.
- **There is no political pressure to upgrade our public hospitals to effectively compete against private ones. When this happens we will know what really works, and what doesn't, in the Indian setting. Can public hospitals match up, or not?**