JUNE 2018 • Vol. 4 • Issue 3
MONTHLY • Pages 60
₹ 200

RNI No.: DELENG/2015/67140; Published on: Every month; Posted at Lodi Road HPO, New Delhi on 9-10th of every month

THE AWARE CONSUMER

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Round Up

World's largest health protection scheme

Opinion

Will NHPS bridge the healthcare gap for India?

AYUSHMAN BHARAT

National Health Protection Scheme

PLUS REPORT • HORIZONS • THE LAST MILE

MAKE IN INDIA

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Certification Scheme

A roadmap to World-class manufacturing

HIGHLIGHTS

- A scheme by Ministry of MSME, Govt. of India
- Certification on the systems and processes of MSMEs
- Handholding MSMEs towards world class manufacturing
- Special emphasis on MSMEs supplying to Defence Sector
- Direct subsidy to participating MSMEs
- Creating a credible database of MSMEs for OEMS/CPSUs/Foreign Investors under "Make in India initiative"
- Quality Council of India (QCI) to function as the NMIU (National Monitoring and Implementing Unit) of the scheme

"Let's think about making our product which has 'Zero Defect'; so that it does not come back (get rejected) from the world market and 'Zero Effect' so that the manufacturing does not have an adverse effect on our environment"

SHRI NARENDRA MODI
Hon'ble Prime Minister

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VIEW  POINT

BEJON KUMAR MISRA | bejonmisra@consumerconexion.org

The National Health Protection Scheme is Promising but Sketchy

THE NATIONAL HEALTH Protection Scheme (NHPS) is being hailed as the biggest takeaway for the common man in this year's Budget. Given the noise that is being made around it, one is led into believing that the government has brought the nation into the next generation of health security. The government's NHPS envisions a massive coverage of 50 crore people. But previous experience shows us that merely constituting an insurance scheme will do little to enhance health care.

Any public health insurance scheme would logically enhance medi-care affordability for the masses, which will consequently enhance demand.But as Indian public health infrastructure is still in shambles, the supply would have to be met through expansion of private health infrastructure.

The NHPS is not a classic insurance programme, since the government pays most of the money on behalf of the poor, unlike private insurance where an individual or an employer pays the premium. However, the scheme operates around the insurance principle of 'risk pooling'. When a large number of people subscribe to an insurance scheme, only a small fraction of them will be hospitalised in any given year. In a tax funded system or a large insurance programme, there is a large risk pool wherein the healthy cross-subsidise the sick at any given time. The NHPS will be financially viable, despite a high coverage offered to the few who fall sick in any year, because the rest in the large pool do not need it that year.

Public insurance cashless schemes like Centre's 'Rashtriya Swasthya Bima Yojana' (RSBY), and Andhra Pradesh's Aarogyasri had been in operation, but they benfitited few and failed to reach the most vulnerable sections.Notably, outpatient care, which accounts for the most of the out-of-pocket spending, wasn't covered under the scheme. While both targeted people living below the poverty line, over-reliance on private hospitals and poor monitoring watered down their impact.

Considering the poor success of the previous schemes, some have even argued that mere demand oriented interventions by the government are futile. Unless the public health systems can compete with the private for funds from insurance scheme, quality healthcare will continue to elude the vulnerable. Also, it is important to develop monitoring systems to ensure that private hospitals registered under the scheme comply with the norms prescribed. Streamlining reimbursements to hospitals and efforts in the expansion of both private and public health facilities at newer geographies are needed.

While, the NHPS looks promising with it's massive coverage, it's sketchy at the same time and needs to comprehensively take the above mentioned factors into account to be successful.

Unless the public health systems can compete with the private for funds from insurance scheme, quality healthcare will continue to elude the vulnerable.

Message from the Editor-in-Chief

POOJA KHAITAN
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Only Time Can Tell

THERE IS NO doubt that on the issue of universal healthcare, India is playing catch up. Decades of low public investment have resulted in two health systems co-existing under one flag: World class care for those with money and connections to access it, and for the rest a stark choice between poor quality services or financial ruin, or very often both. Properly designed, funded and implemented, the NHPS represents a once-in-a-generation opportunity to improve the health and wealth of India's under-privileged.

Given that the backbone of NHPS is an insurance cover, a lot would depend on how insurance companies live up to this proposition though there is no obligation on them as yet.

Healthcare has always been tricky. Governments could fail if they do not deliver on its promise. Take the US for instance. One of the reasons for Donald Trump being elected as President of the US was his promise of disbanding Obamacare. When Obamacare was launched, millions lost their insurance cover as either employers or the insurance companies backed out.

While Modicare or NamoCare — as the current NHPS scheme is being named — is a tad different from Obamacare, all eyes are currently on the smooth implementation of systems for on-boarding, quality management and payment from the government.

It's just the early days for NHPS in India. When Obamacare was introduced, it disrupted the entire ecosystem around healthcare. The introduction of patent protection and Affordable Care Act linked the cover to tax and it meant increased tax outgo for people who did not opt for cover. The cost of healthcare went up, the prices of drugs went up and also, the pharma companies landed up with extra costs. In this context, the introduction of NHPS, looking at developing a new ecosystem that won't be abused, would be critical to long term success.

Worldwide such schemes are successful in countries where there is an enabling environment for private sector to participate in servicing the insured or where the government controls the provider side with adequate infrastructure. In the UK, for instance, the government is the provider and has government budget to support the services. From its position of strength, it is able to bring in quality protocols and cost containment both in services and consumption of medical products.

All in all, the question on people's mind currently is: Can NHPS transform itself into an election manifesto? Only time can tell, but steps are initiated to maintain a healthy India and empower India's poor and underprivileged. And lastly, as the saying goes, everything is achievable if we have our heart in the right place.

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THE AWARE CONSUMER

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JUNE 2018 • Vol. 4 • Issue 3

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The AWARE CONSUMER
is printed and published by
Bejon Kumar Misra
at F - 9, Second Floor, Kailash Colony,
New Delhi - 110048 and printed at
M/s. Spectrum Printing Press (P) Ltd.,
Shed No. 23, Computer Complex,
DSIDC Scheme I, Okhla Phase II,
New Delhi - 110020

Place of Publication: E - 45, Ground Floor,
Greater Kailash Enclave - I, New Delhi-110048

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Total number of pages - 60, Including Covers

SHRI ARUN JAITELY

THE UNION MINISTER FOR FINANCE AND CORPORATE AFFAIRS, GOVERNMENT OF INDIA

In order to further enhance accessibility of quality medical education and health care, 24 new Government Medical Colleges and Hospitals will be set up, by up-grading existing district hospitals in the country.

ROUNDUP

Modicare: World's Largest National Health Protection Scheme

A well run NHPS has the potential to become the cornerstone of India's healthcare needs for several future generations.

MODICARE ALSO CALLED "NaMoCare" is the World's largest health protection scheme.Modicare will cover more than 40% of India's population. In the words of the Finance Minister, "Modicare" would take public healthcare in the “world's largest democracy"to a new aspiration level.Only a "Swasth Bharat" (a healthy India) can be a "Samriddha Bharat" (a prosperous India). In all this we remember Canada, a country bordering the USA. This is a country which offers free healthcare to all its citizens. It's now being said, forget migrating to Canada, good healthcare is in India.”

This health protection scheme could be a game changer in India. The Ayushman Bharat Scheme is popularly called "Modicare".

DATA BRIEFING

National health protection Scheme to provide Hospitalisation cover to over 10 Crore poor and vulnerable families

Why Modicare?

Lakhs of families in India have to borrow or sell assets to receive medical treatment in hospitals. The Government is seriously concerned about health care and medical treatment of the poor and vulnerable families in India.

The aim of Swachh Bharat was to promote a clean India through sanitation programmes and construction of toilets. A clean India is a disease-free India. The obvious next step is a health protection system like Modicare, which covers all vulnerable families in India. The aim of Modicare is both, prevention of diseases and excellent health promotion.

Modicare will be completely cashless, and not a reimbursable scheme. To make this scheme completely cashless and paperless, state-level health agencies will be formed to implement the scheme.

While Modicare is good for insurers in India, the scheme will also solve a very big problem... Jobs. Lakhs of citizens and several thousand women can get jobs, because of Modicare.

Where is the money for Modicare coming from?

Modicare will cost the Government Rs 11,000 Crores a year. The Government estimates the cost of insuring each family at Rs 1,100 a year. The Government estimates that for Modicare, it will require Rs 11,000 Crores a year. The Central Government will contribute Rs 7,000 Crores, while the 29 States will provide the remaining amount.

The Government will most probably launch Modicare on Independence Day or the latest date would be Gandhi Jayanti.

Finances will never be a problem for National Health Protection Scheme: J P Nadda

Touted to be the world's largest government-funded health care programme, the scheme is aimed at benefiting 10 crore poor families by providing coverage of up to Rs 5 lakh per family per year.

HEALTH MINISTER J P Nadda assured that finances will never be a problem clearing concerns about the funding of the NHPS and said the Centre was working out the nitty-gritties of the programme.

He informed that the government is committed to roll out this programme and that they have made all arrangements for it. Every aspect of the scheme "has been calculated" and the details of the programme will only be shared when the government would be ready to roll it out.

The government will pay for the premium with state's share. For this Rs 2,000 crore has been kept for it as of now.

"History is witness that whatever we (the BJP-led government) have committed, we have completed. That is why finance is not the problem, has never been the problem and will never remain a problem," Nadda said.

Asked about an earlier scheme where the government had announced a Rs 1-lakh coverage, Nadda said that under that programme, there were only four crore beneficiaries, whose number has been enhanced now.

"States have to decide whether they want to subsume with this (scheme) or they want to run on their own," he said.

The health minister said there were a lot of operational problems in the earlier scheme which have been rectified in the present one. He said that all the diseases will be covered under the scheme.

"It is not only an insurance. There are many models which we are going to work out. That is why I am not saying now. We will come out with a full programme. We are going fast on it," he said, adding that the government is committed on it.

He said no specific date for the roll out has been fixed as yet, but it will be done "very soon".

Portability of Insurance between States

AYUSHMAN BHARAT: Benefits of the scheme are portable across the country, beneficiary covered under to be allowed to take cashless benefits from any public/private empanelled hospitals.

Government's flagship National Health Protection Schemehas got cabinet nod detailing the contours of the scheme. The mega health insurance scheme will be portable across all states and union territories in the country. The scheme will give cashless benefits in any public or private hospital across the country.

"The health insurance scheme will cover all pre-existing diseases," said a senior official of Niti Aayog. "Also, pre hospitalization of 3 days and post hospitalization for 15 days are covered under the scheme. Payments under the scheme will be done in package rates to control costs."

Any health insurance policy has waiting period of a couple of years before they cover pre-existing diseases, which is waived off in this scheme.

Portability of insurance for people migrating between states was a issue discussed with states and it has been decided to allow portability across all the states. States like Tamil Nadu, Rajasthan, Andhra Pradesh, Telangana, Madhya Pradesh and Chhattisgarh that have their own scheme to cover below poverty line will have the option to either integrate the existing scheme with NHPS and increase the existing limit to Rs 5 lakh as proposed by the government.

Portability will allow people insured under the scheme to transfer their existing health insurance policies to another state and get treatment in any private or public hospital.

Instead of each state floating a tender, group of states will come together and float a tender. However, there will be flexibility for states to either follow insurance model or state trusts model.

"The premium rate will be discovered by the market," said the official. "Pooling of risk will lead to lower premium rates."

Government to form council to roll out National Health Protection Scheme

The government is likely to form a council on the lines of the GST council and work with states to roll out the National Health Protection Scheme.

"THE PLAN IS to form a committee on the lines of the GST council to implement the Modicare scheme because a few states also have such a plan and a way needs to be found together to gel this scheme with states, where a similar scheme is already being offered," said a senior government source in the know, who did not want to be identified.

He added that the Gujarat government, for example, has a plan called Mukhyamantri Amrutum (MA) Yojana, which provides free insurance of up to Rs 2 lakh per year to the poor and needy.

"The committee with state representation would ensure that governments work together to ensure that one scheme does not clash with the other and rather gel with each other for effective implementation," he said.

The GST council, which is a key decision making body on GST, is headed by the union finance minister and has minister of state for finance in the Union government as well as ministers incharge of finance or taxation or any other minister nominated by each state government as its members.

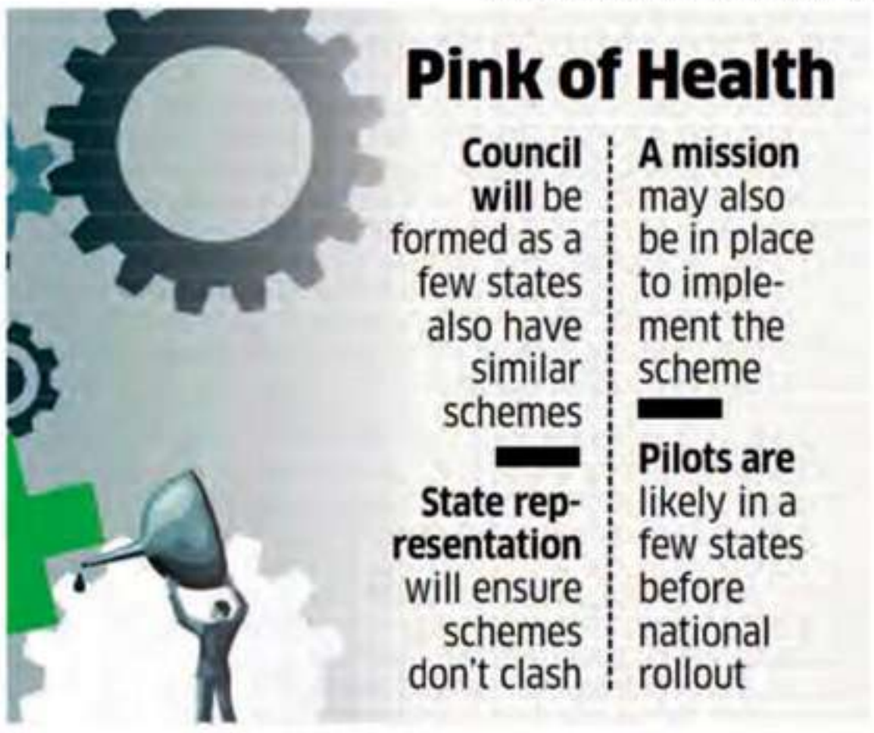
Another government source said a mission kind of arrangement would also be made to implement the scheme.

"That mission (or anything else that it may be called) would likely be headed by a senior bureaucrat or a technocrat to ensure successful and focused implementation of the project," said a government source.

The first source quoted above said it remains to be seen whether the government will be in a position to implement the scheme across the country before the 2019 elections.

"The implementation would start with a few states initially, where it will be implemented as a pilot. The national rollout could happen only after that," he said.

Finance secretary Hasmukh Adhia said that the government expects the mega healthcare scheme announced in the Budget to cost only aboutRs 10,000 crore annually and is expected to be rolled out in six to eight months. While the central government will contribute about half of the total cost, the rest will come from the states.



World Health Organization

Ghebreyesus said if a country as large and complex as India can achieve universal health coverage, any country can.

WHO Commends National Health Protection Scheme, Ayushman Bharat

WORLD HEALTH ORGANISATION (WHO) director-general Tedros Adhanom Ghebreyesus commended theNational Health Protection Scheme and Ayushman Bharat initiative, saying they have the potential of transforming the lives of hundreds of millions of Indians.

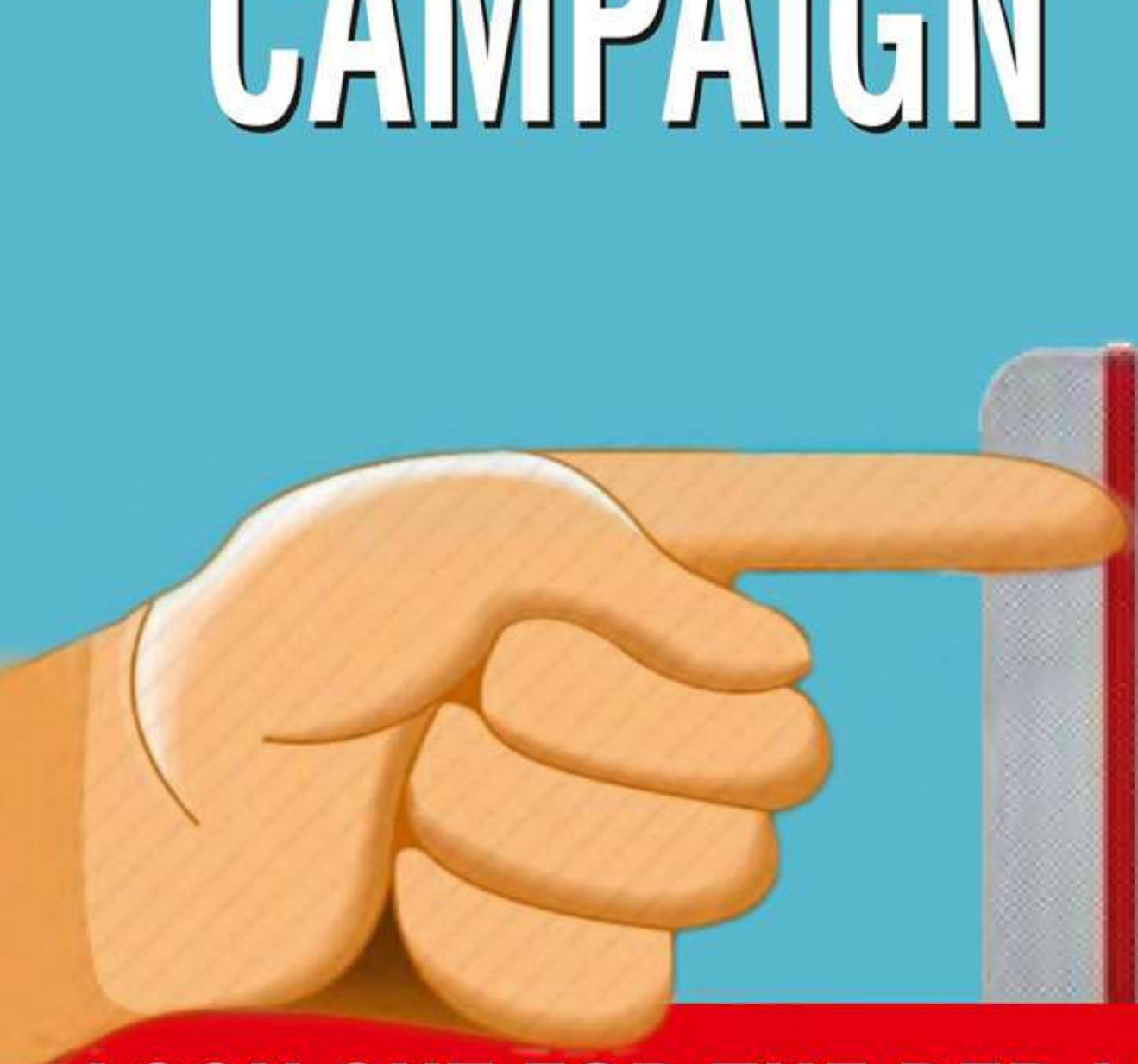
"The new National Health Protection Scheme has the potential not only to improve health, but to help lift people out of poverty," Ghebreyesus said at a gathering of health officials and experts at the NITI Aayog, the government's premier think-tank. "The reforms which India is embarking on are bold, and they must be." He, however, said the government should tread with caution, learning with international experience but using home-grown solutions.

Outlining three crucial precautions the government must take, Ghebreyesus said, "To get best returns on investment, it is important to focus on quality of services, especially in primary health care, and to prioritise those who are most disadvantaged – enormous gains can be made relatively cheaply in these groups." "Second, it is important to equip and empower nurses and other mid-level health workers, who can carry much of the burden of providing care if they are given right training and permission. Since nurses are mostly women, investments need to be made in health as well as gender equality," he said.

Pointing out that the private sector plays an important role in India's healthcare system, where more than 70% people are seeking care at private facilities, he said "regulation is important to ensure profits do not come before people". "With the right safeguards, private providers will be crucial partners on the road to universal health coverage," Ghebreyesus said.

Extending WHO's support to the NHS, Ghebreyesus said if a country as large and complex as India can achieve universal health coverage, any country can. "Your success would mean that no country, at any income level, can say UHC is out of their reach," he said. ◗

SUPPORT THE CAMPAIGN



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CONSUMERS, BEWARE

Premium may be inadequate.
Apprehensions on how the plan may be rolled out.

EVEN AS DELIBERATIONS continue among key stakeholders on the government's National Health Protection Scheme (NHPS), it seems that general insurers are a little unsure and apprehensive about how the plan may be rolled out. In a letter written to the department of financial services, the general insurance council had besides offering suggestions, indicated that the premium amount of Rs 1,082 for a sum assured of Rs 5 lakh may be “inadequate”. The letter includes several suggestions on aspects like success metrics, premium payment terms and standardisationof treatments. Senior officials in the industry said that the ministry of finance had asked for suggestions on implementation of NHPS, and the council had shared its views in the letter. They added that at the indicated premium amount, insurance companies could incur losses and many may prefer not to join the scheme. Further, they suggested a cap on the number of individuals per family covered, and upfront payment of premiums by the government — as for all other policyholders.

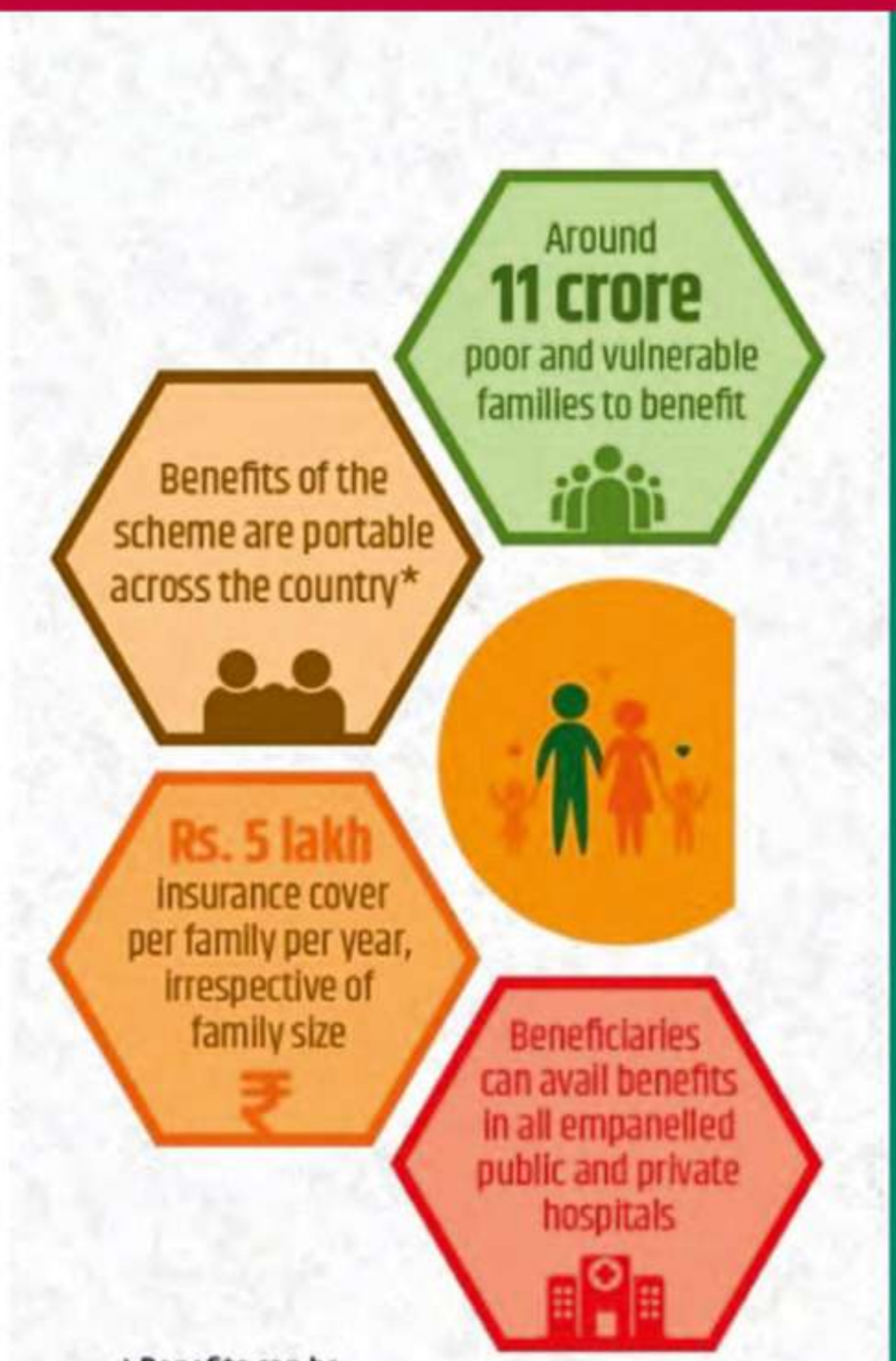
Officials of the health ministry held a meeting with non-life insurers in Delhi on the implementation of NHPS. The meeting included officials from NITI Aayog and General Insurance Corporation of India (GIC Re).

Senior officials in the insurance industry indicated that a decision on whether the scheme should be floated through a trust or insurance model, had also not been decided yet. In case of a trust model, the government will set up a trust and the trust will perform the role of an insurance company. States like Andhra Pradesh, Telangana and certain parts of Karnataka use the trust model. Under this model, the government fixes the price and there is no scope for price discovery.

On the other hand, under insurance model, the state governments will float tenders and the insurance companies shall be selected based through a bidding process. It is likely that for the initial period, the government might use Socio Economic and Caste Census (SECC) for enrolment of beneficiaries.

National Health Protection Scheme:

ALL YOU WANTED TO KNOW



Modi government approves world's largest and most comprehensive healthcare scheme

AYUSHMAN BHARAT

National Health Protection Mission

THE UNION CABINET chaired by the Prime Minister Shri Narendra Modi has approved the launch of a new Centrally Sponsored Ayushman Bharat -National Health Protection Mission (AB-NHPM) having central sector component under Ayushman Bharat Mission anchored in the MoHFW. The scheme has the benefit cover of Rs. 5 lakh per family per year. The target beneficiaries of the proposed scheme will be more than 10 crore families belonging to poor and vulnerable population based on SECC database. AB-NHPM will subsume the on-going centrally sponsored schemes -Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS),

Background

RSBY was launched in the year 2008 by the Ministry of Labour and Employment and provides cashless health insurance scheme with benefit coverage of Rs. 30.000/- per annum on a family floater basis [for 5 members], for Below Poverty Line (BPL) families, and 11 other defined categories of unorganised workers. To integrate RSBY into the health system and make it a part of the comprehensive health care vision of Government of India, RSBY was transferred to the Ministry of Health and Family Welfare (MoHFW) w.e.f 01.04.2015. During 2016-2017, 3.63 crore families were covered under RSBY in 278 districts of the country and they could avail medical treatment across the network of 8,697 empanelled hospitals. The NHPS comes in the backdrop of the fact that various Central Ministries and State/UT Governments have launched health insurance/ protection schemes for their own defined set of beneficiaries. There is a critical need to converge these schemes, so as to achieve improved efficiency, reach and coverage.

Salient Features of The National Health Protection Scheme

a. Institutional Structure — At the national level a National Health Agency (NHA) is expected to be put in place to manage NHPS. States/UTs would be advised to implement the scheme by 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 a new entity to implement the scheme.

An inter-ministerial group named as National Governing Council (NGC) is proposed to be set up under the leadership of Secretary (Health and Family Welfare) with representatives from line Ministries, NITI Aayog and State Governments.

b. Implementation Model — States/UTs can decide to implement the scheme through an insurance company or directly through the Trust/Society.

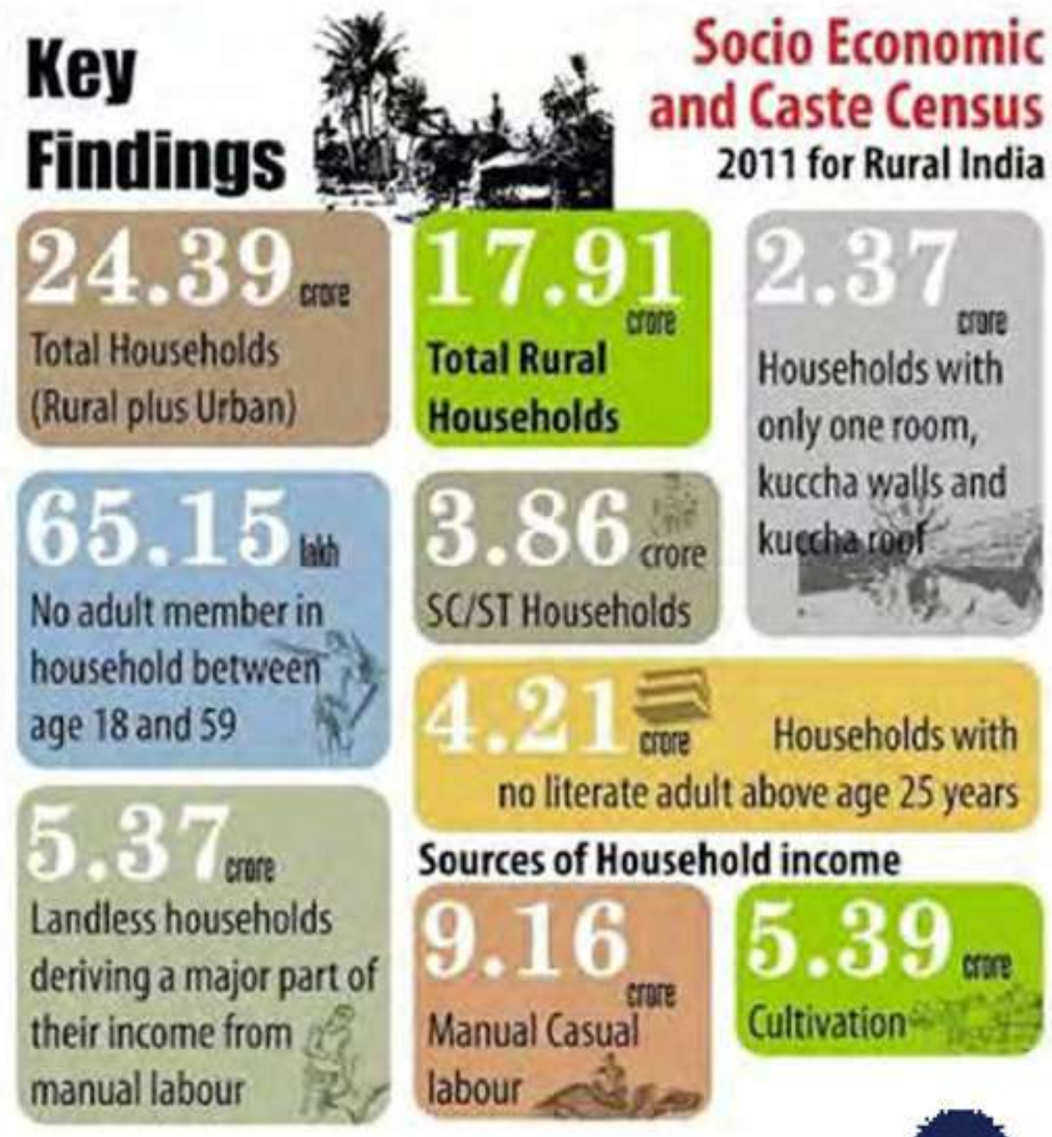
c. Benefit Package — The proposed scheme will have a benefit package of Rs.5 lakh per family per year. Various medical and surgical conditions upto this limit with minimal exclusions will be covered. Certain pre and post hospitalization are proposed to be covered. All pre-existing conditions shall be covered from day one. A defined transport allowance will also be provided to the beneficiaries at the time of discharge. Indicative rates of different procedures will be shared with the States.

d. Target Populations and Data — Socio Economic Caste Census (SECC) data (both rural and urban) will be the base data for NHPS as it is the most recent database which has data on deprivation criteria. It should be seeded with Aadhaar (as far as possible) in the rural area, beneficiaries belonging to any one of the Seven deprivation criteria and automatically included categories is proposed to be used while for urban areas, defined occupa-tional criteria would be used. Details of categories including number of beneficiaries are provided at Annexure 1.

e. Family size — There will be no family size and age limit in the proposed scheme and household in SECC Data will be treated as family.

f. Financing of the Scheme — The source of financing for NHPS is budgetary support. At present the ratio of contribution towards premium between Centre and State is 60:40 in all States except North Eastern States & 3 Himalayan States where the ratio is 90:10 with an upper limit for Centre. In Union Territory (without legislature) the Central contribution of premium is 100%, while in those with legislature, the contribution of Centre and States will be in ratio of 60:40.

The central share of premium will be paid based on market determined rate in such States/UTs where NHPS will be implemented through insurance companies. In States/UTs where they will implement the scheme in Trust/Society mode, the central share of funds will be provided based on actual expenditure. In both the cases, it will be subject to a ceiling rate decided by the Central Government from time to time.



g. Validation of Beneficiaries — All identified beneficiary families will be entitled to get benefits under NHPS. The Aadhaar number of each beneficiary will need to be linked with the family in SECC data. For persons without Aadhaar, an alternate mechanism would be developed till such time that they are enrolled under Aadhaar.

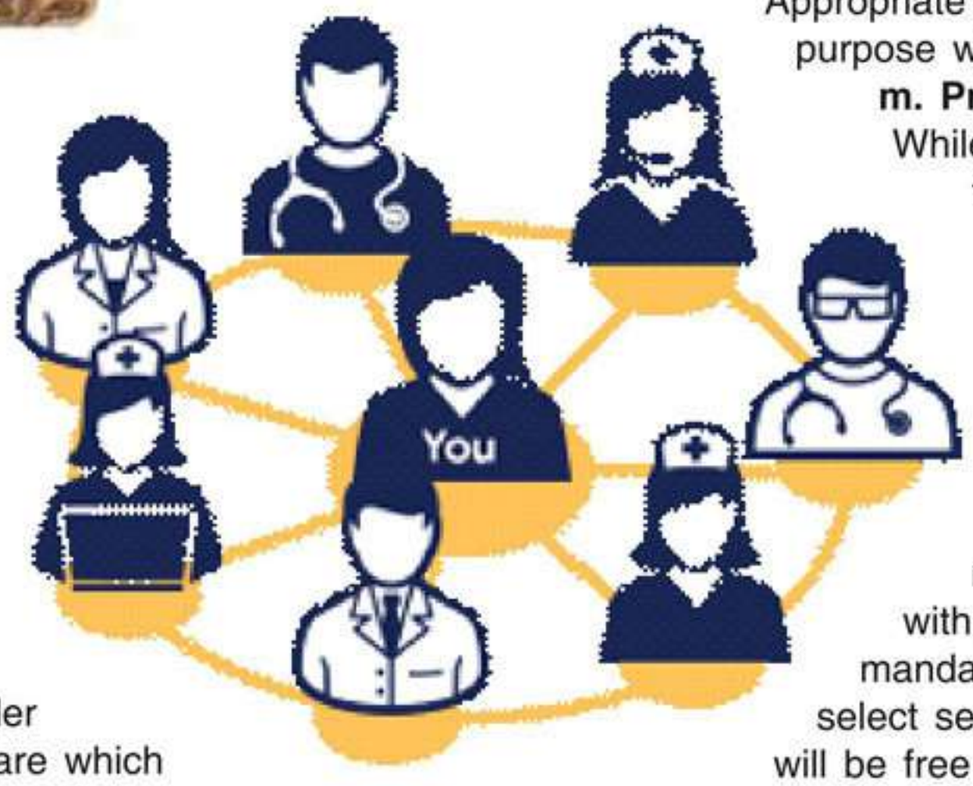
h. Continuum of Care — Under Comprehensive Primary Health Care which is the second pillar of Ayaushman Bharat. Family health folder will be maintained and beneficiary under NHPS will be linked to this record.

i. Health Care Providers — Both public and private health care facilities will be empanelled and be a part of the network for the scheme based on defined criteria (including specially specific criteria). The defined criteria will be shared with the States. Empanelment would be the responsibility of States/ UTs. Certain procedures will be reserved for public hospitals, however, State/UTs would be free to add additional procedures in this list based on field situation in terms of capacity of public system to provide the needed services in certain geographies. All Public hospitals at the level or above CHCs shall be deemed as empanelled.

j. Package Rate based Payment to Hospitals — For providing the treatment, hospitals will be paid, based on a fixed package rate. These packages and their rates will be fixed by the Government in advance and will include all costs associated with treatment. Hospitals will not be allowed to charge any additional money from beneficiaries for the treatment. States/UTs will have the flexibility to modify these rates based on ground level conditions. Hospitals with NABH/ NQAS or hospitals in rural areas can be provided incentives in package rates. States may decide to have differential rates for public and private hospitals to encourage use of public facilities.

k. Hospitalisation Services — On the basis of an Aadhaar based verification (as far as possible), a beneficiary will be able to get benefits at empanelled hospitals. For persons without Aadhaar, a mechanism to verify through other Government issued photo identity cards will be developed.

l. Strengthening of Public Health Care System — Public hospitals will get funds through claims received from insurance companies/ Trusts for treatment given to beneficiaries under NHPS. This fund may remain with them and can be used for infrastructure and human resources development. Part of this fund can be used for providing incentives to staff of public hospitals. Appropriate mechanism/ guidelines for this purpose will be developed.



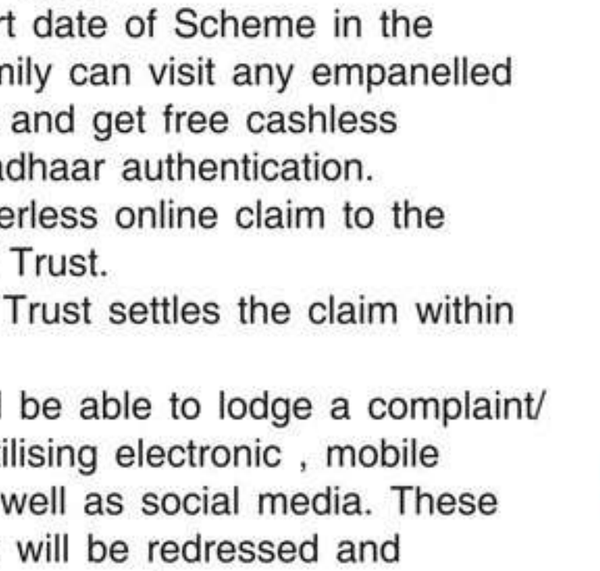
m. Prevention of Fraud/ Misuse — While ensuring user convenience and to prevent misuse by providers and users and minimize chances of frauds/ abuse, NHPS would create robust safeguards. Checks and balances will be designed in such a way that unnecessary hospitalization will be minimized. Pre-Authorisation within a defined time frame will be mandatory for all tertiary care and select secondary care packages. States will be free to introduce pre-authorisation to any additional procedure if they feel that it can be misused. Pre-authorisation will be provided through an online system. Medical audit, data analysis, flags and triggers; standard treatment guidelines, claim audit, electronic health records will be used.

n. Grievance Redressal — It is proposed to have a strong Grievance Redressal mechanism for quick and appropriate grievance disposal of complaints, false rejection by hospitals/ insurance company/ trust. It will be a multi-channel system actively utilizing electronic, mobile internet, call centre and social media through which complaint/ grievance will be registered, acknowledged, escalated for relevant action, resolved and monitored. It could be a tiered organically linked structure involving District Collectors, CEO/ Addl CEO and Secretary as in Rajasthan. Feedback of patients on their experience in different hospitals will also be captured through multiple channel.

o. Proposed Brief Process Flow in NHPS

i. Based on the numbers derived from SECC data by Government of India, each State Government will prepare database of targeted families using SECC data.
ii. State Government will carry out Aadhaar seeding of eligible beneficiaries.
iii. State Government will issue family health cards with NHPS ID based on proposed guidelines of Government of India in consultation with the States.
iv. The above activities will be preceded by intensive IEC campaign particularly among the targeted beneficiaries.
v. If the scheme is implemented through insurance mode then Insurance Company will be selected by the State Government through an open tender process. Model tender document will be shared with the states soon.
vi. State Government will take the decision to empanel the hospitals in each district based on defined criteria. In this endeavor, the State may take support of Insurance Company/ Trust.
vii. From the date of start date of Scheme in the State, beneficiary family can visit any empanelled hospital across India and get free cashless treatment through Aadhaar authentication.
viii. Hospital submits paperless online claim to the Insurance Company/ Trust.
ix. Insurance Company/ Trust settles the claim within a specified time.
x. Any stakeholder shall be able to lodge a complaint/ Grievance actively utilising electronic , mobile platform, internet as well as social media. These complaint/ Grievance will be redressed and monitored by the Government.
xi. It is proposed that all the tasks carried out by the insurance companies can also be done directly by a Trust/ Society in the State.

p. Use of Information & Communication Technology (ICT) — A robust, modular, scalable and interoperable IT plat connecting MoHFW/ NHA with SHAs and beneficiaries to the designated private and public health providers is proposed to be set-up. The IT Systems will allow horizontal/ vertical expansion as per States requirements. The following basic modules are required for implementation:

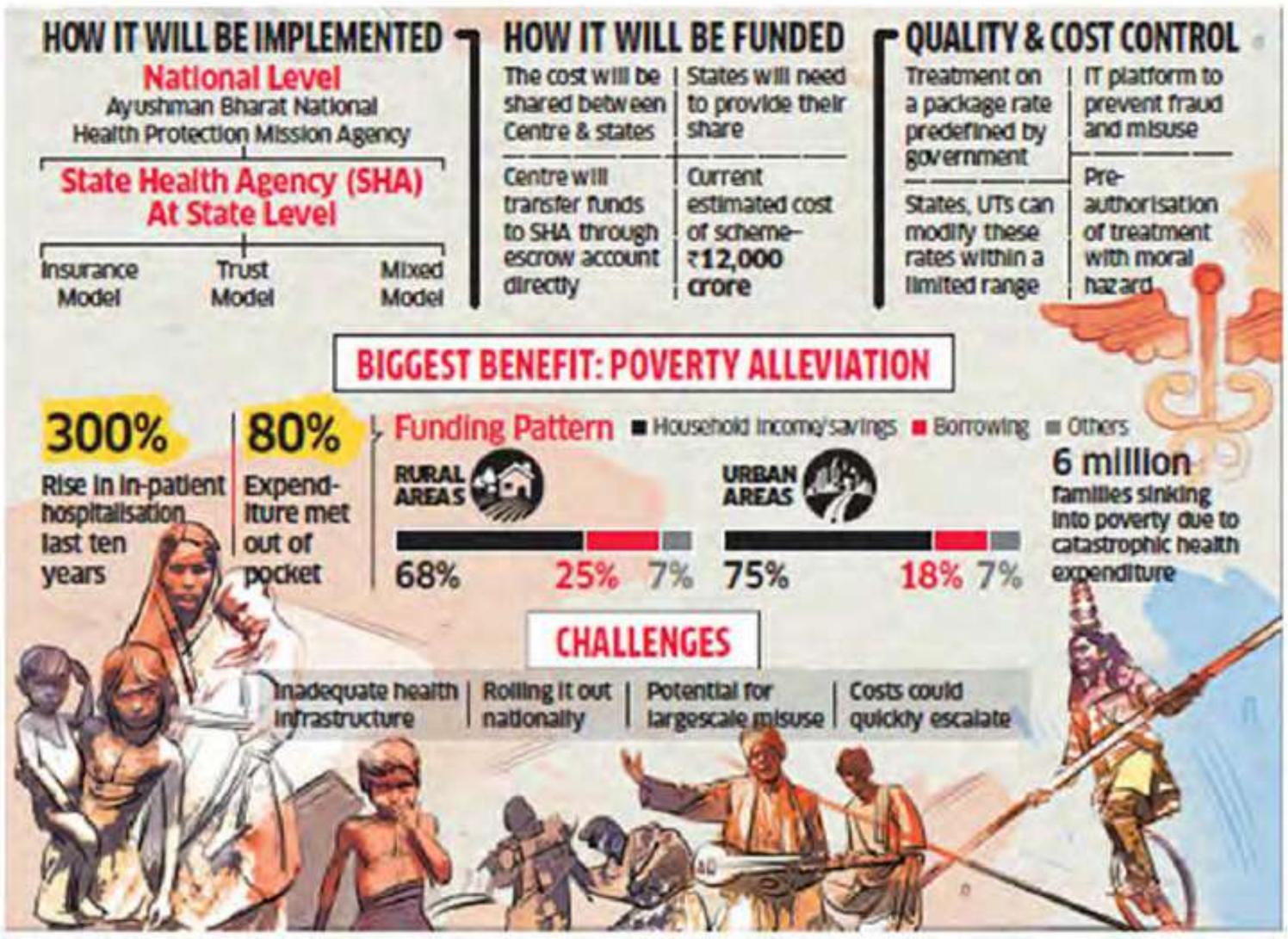


I. SECC data extraction module
II. Aadhaar seeding and card issuance module (can be done in the field or at the hospital)
III. Hospital empanelment module
IIII. Hospital treatment/ transaction module
V. Claims management module
VI. Monitoring and dashboard module
VII. Complaints and Grievance modules

Implementation Strategy

One of the core principles of AB-NHPM 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-NHPM 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.

For giving policy directions and fostering coordination between Centre and States, it is proposed to set up Ayushman Bharat National Health Protection Mission Council (AB-NHPMC) at apex level Chaired by Union Health and Family Welfare Minister. It is proposed to have an Ayushman Bharat National Health Protection Mission Governing Board (AB-NHPMGB) which will be jointly chaired by Secretary (HFW) and Member (Health), NITI Aayog with Financial Advisor, MoHFW, Additional Secretary & Mission



Director, Ayushman Bharat National Health Protection Mission, MoHFW (AB-NHPM) and Joint Secretary (AB-NHPM), MoHFW as members. CEO, Ayushman Bharat - National Health Protection Mission will be the Member Secretary, State Secretaries of Health Department may also be members as per the requirement. It is proposed to establish an Ayushman Bharat - National Health Protection Mission Agency (AB-NHPMA) to manage the AB-NHPM at the operational level in the form of a Society. AB-NHPMA will be headed by a full time CEO of the level of Secretary/ Additional Secretary to the Government of India.

States would need to have State Health Agency (SHA) to implement the scheme. States will have the option to use an existing Trust / Society / Not for Profit Company/ State Nodal Agency or set up a new Trust / Society / Not for Profit Company/ State Health Agency to implement the scheme and act as SHA. At the district level also, a structure for implementation of the scheme will need to be set up.

To ensure that the funds reach SHA on time, the transfer of funds from Central Government through AB-NHPMA to State Health Agencies may be done through an escrow account directly. The State has to contribute its matching share of grants within the defined time frame.

In partnership with NITI Aayog, a robust, modular, scalable and interoperable IT platform will be made operational which will entail a paperless, cashless transaction. This will also help in prevention / detection of any potential misuse / fraud / abuse cases. This will be backed by a well-defined Grievance Redressal Mechanism. In addition, pre-Authorisation of treatments with moral hazards (Potential of misuse) will be made mandatory.

In order to ensure that the scheme reaches the intended beneficiaries and other stakeholders, a comprehensive media and outreach strategy will be developed, which will, inter alia, include print media, electronic media, social media platforms, traditional media, IEC materials and outdoor activities.

Major Impact

In-patient hospitalization expenditure in India has increased nearly 300% during last ten years. (NSSO 2015). More than 80% of the expenditure are met by out of pocket (OOP). Rural households primarily depended on their 'household income / savings' (68%) and on 'borrowings' (25%), the urban households relied much more on their 'income / saving' (75%) for financing expenditure on hospitalizations, and on '(18%) borrowings. (NSSO 2015). Out of pocket (OOP) expenditure in India is over 60% which leads to nearly 6 million families getting into poverty due to catastrophic health expenditures.

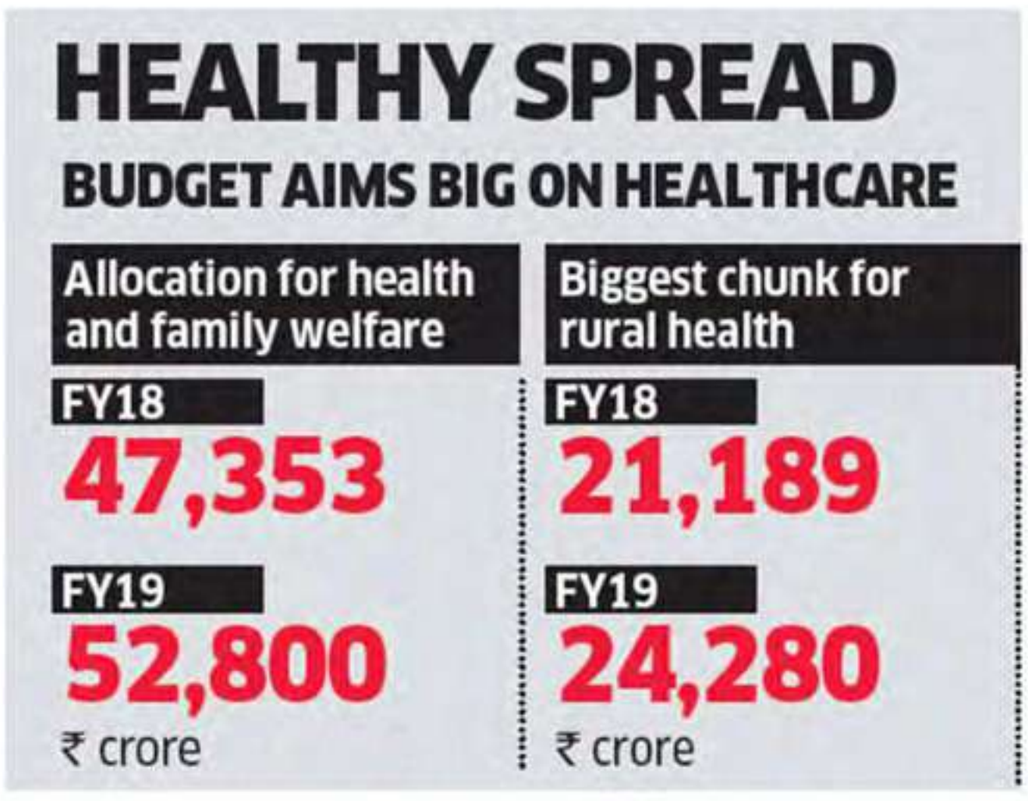
AB-NHPM will have major impact on reduction of Out Of Pocket (OOP) expenditure on ground of:

i) Increased benefit cover to nearly 40% of the population, (the poorest and the vulnerable)

ii) Covering almost all secondary and many tertiary hospitalizations. (except a negative list)

iii) 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,



Annexure 1: Estimation of Beneficiaries for NHPS based on SECC Data

I As per SECC there are total 24.49 crore households in the country

II. All India (Rural):

Total Households = 17.97 crore

A. Automatically included households (based on fulfilling any of the 5 parameters of inclusion):

a. Households without shelter
b. Destitute, living on aims
c. Manual scavenger families
d. Primitive tribal groups
e. Legally released bonded labour

= 15.95 lakhs

B. Deprived households:

Standard Deprivation Parameter	Household
Only one room with kucha wallas and kucha roof (D1)	2.38 crore
No adult member between age 16 to 59 (D2)	65.33 lakh
Female headed households with no adult male member between age 16 to 59 (D3)	69.43 lakh
Disabled member and no able bodied adult member (D4)7.20 lakhSC/ST households (D5)	3.87 crore
No literate adult above 25 years (D6)	4.22 crore
Landless households deriving major part of their income from manual casual labour (D7)	5.40 crore
Total deprived Households (with any one of the 7 deprivation).	8.73 crore

III. All India (Urban):

Total Households = 6.52 crore

Sub-classification of Households by main source of Income (Urban):

Sl.No.	Worker Category	Households
1	Rag picker	23.825
2	Beggar	47.371
3	Domestic worker	6,85,352
4	Street vendor/ Cobbler/ hawker/ Other service provider working on streets	8,64,659
5	Construction worker/ Plumber/ Mason/ Labor/ Painter/ Welder/ Security guard/ Coolie and other head-load worker	1,02,35,435
6	Sweeper/ Sanitation worker/ Mali	6,06,446
7	Home-based worker/ Artisan/ Handicrafts worker/ Tailor	27,58,194
8	Transport worker/ Driver/ Conductor/ Helper to drivers and conductors/ Cart puller/ Rickshaw puller	27,73,310
9	Shop worker/ Assistant/ Peon in small establishment/ Helper/ Delivery assistant/ Attendant/ Waiter	36,93,042
10	Electrician/ Mechanic/ Assembler/ Repair worker	11,99,262
11	Washer-man/ Chowkidar	4,60,433
12	Other work Non-work	2,68,68,018
13	Non-work (Pension/ Rent/ Interest, Etc.)	52,78,081
14	No Income From Any Source	95,65,262
	Targeted Households	**2,33,47,329**
		2.33 crore

IV.Categories as proposed for new scheme

Rural:

Total deprived Households with any one of the 7 deprivation = 8.73 crore

Automatically included (Households without shelter, destitute, living on aims, Manual scavenger families, Primitive tribal groups, legally released bonded labour) = 15.95 lakh = 8.89 crore

(+)

Urban:

Households by main source of Income (Rag picker, Beggar, Domestic worker, Street vendor / Cobbler/ hawker / Other service provider working on streets, Construction worker/ Plumber/ Mason / Labor / Painter / Welder / Security guard / Coolie and other head-load worker, Sweeper / Sanitation worker / Mali, Home-based worker / Artisan / Handicrafts worker / Tailor, Transport worker / Driver / Conductor / Helper to drivers and conductors / Cart puller / Rickshaw puller, Shop worker / Assistant / Peon in small establishment / Helper / Delivery assistant / Attendant / Waiter, Electrician / Mechanic / Assembler / Repair worker, Washer-man / Chowkidar)

= 2.33 crore

Total = 2.33 + 8.73 + 0.1595 = 11.22 crore

patient satisfaction, improvement in productivity and efficiency, job creation thus leading to improvement in quality of life.

Expenditure involved

The expenditure incurred in premium payment will be shared between Central and State Governments in specified ratio as per Ministry of Finance guidelines in vogue. The total expenditure will depend on actual market determined premium paid in States/ UTs where AB-NHPM 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.

Number of Beneficiaries

AB-NHPM will target about 10.74 crore poor, deprived rural families and identified occupational category of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data covering both rural and urban. The scheme is designed to be dynamic and aspirational and it would take into account any future changes in the exclusion/ inclusion/ deprivation/ occupational criteria in the SECC data.

Here's what could turn Modi's 'Ayushman Bharat' into a transformational scheme

– *Arvind Panagariya*

As officials design the Wellness Centres and NHPS, they must keep in mind the historical failure in the delivery of healthcare by public sector.

DURING THE BUDGET 2018-19, The Finance Minister Mr. Arun Jaitley mentioned a new programme called Ayushman Bharat Program. Under this Scheme, Two Major health Sector Initiatives have been announced, Which are – 1) Establishment of Health and Wellness Centers and 2) National Health Protection Scheme.

Other than the Swachh Bharat Mission, 'Ayushman Bharat' is potentially the most far-reaching social programme initiated by Prime Minister Narendra Modi. For the first time, the programme gives vulnerable families hope that they will be able to escape financial ruin when faced with illnesses requiring hospitalisation.

Though the media has focussed disproportionately on the National Health Protection Scheme (NHPS) aimed at covering 100 million households for secondary and tertiary care, Ayushman Bharat also includes a component that proposes to strengthen primary healthcare. This latter component would establish 1,50,000 Wellness Centres.

To ensure success, it is important that enough thought goes into designing the two schemes. More than five decades worth of experience with the provision of primary, secondary and tertiary healthcare by the government have been deeply disappointing.

Those in charge of shaping the schemes must study the reasons for this failure and consult the best experts in health economics and management. This is a technical field in which the design of schemes is just as important as implementation. Failure to give technocrats sufficient voice risks reproducing the same failures we have witnessed over the last half century.

Consider first primary healthcare via our existing public healthcare system. Since at least the early 1960s, we have been investing in a massive network of sub centres (SCs), primary health centres (PHCs) and community health centres (CHCs) in rural India. SCs serve as the first point of contact between people and public health system. They provide public health services such as immunisation, curative care for minor aliments and maternal and child health and nutrition. They employ one male and one female worker with the latter being auxiliary nurse and midwife.

PHCs serve as referral units for six SCs and have a qualified doctor and four to six beds.

Primary Health Care Structure and their Population Norm

Centre	Population Norms	
	Plain Area	Hilly/ Tribal/ Difficult Area
Sub-Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

Source: Rural Health Statistics, MOHFW, GOI

CHCs serve as referral units for four PHCs. They have four doctors covering different specialties, 21 paramedical and other staff, 30 beds, an operation theatre and X-ray room.

Population norms per centre for the plains are 5,000 for SCs, 30,000 for PHCs and 1,20,000 for CHCs. With 1,56,000 SCs, 25,650 PHCs and 5,624 CHCs as per the Rural Health Statistics, 2017, we are currently within striking distance of these norms.

Admittedly, resource shortage has meant that SCs, PHCs and CHCs have had less than adequate infrastructure and personnel. But even making generous allowance for these deficiencies, service delivery has been disappointing. In 2014-15, a mere 28% of those needing outpatient care came to these facilities. A hefty 72% of patients went to private providers.

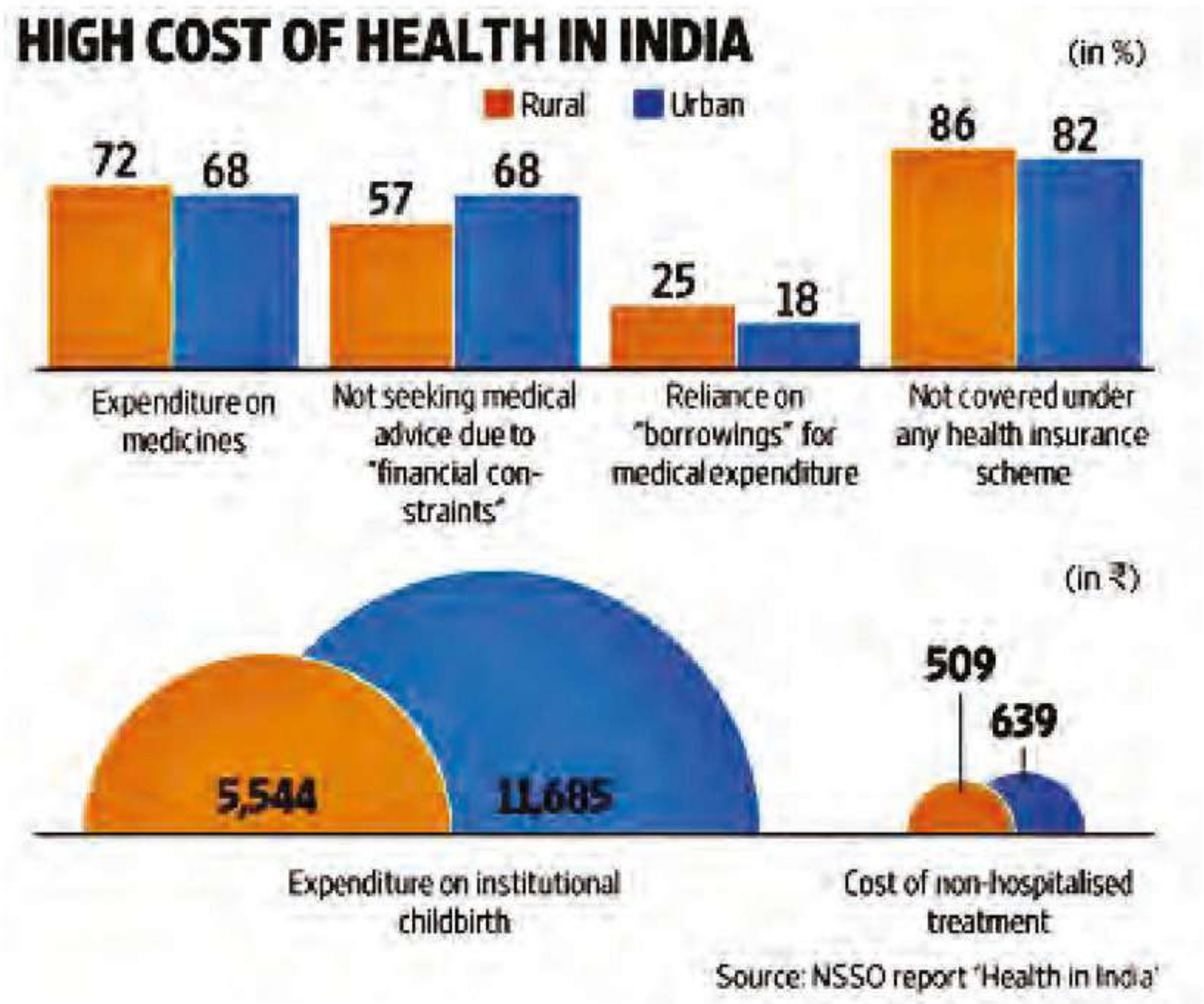
Considering that the private providers are predominantly unqualified individuals, often having no more than high school education and no formal medical education, such disproportionate reliance on them is indicative of a serious failure at SCs and PHCs. More than 50 years of investment have not resulted in rural households placing much trust in the SCs and PHCs.

Therefore, we need to be sure that the proposed Wellness Centres are designed to succeed where SCs and PHCs have largely not succeeded. Minor adjustments to SCs to turn them into Wellness Centres will not work.

Superior outcomes would require a fundamental change in governance whereby

Levels of health care

- **Primary Health care**
  - Provided at the community level
- **Secondary health care**
  - Provided at PHC, CHC, DH etc.
- **Tertiary health care**
  - Provided at hospitals

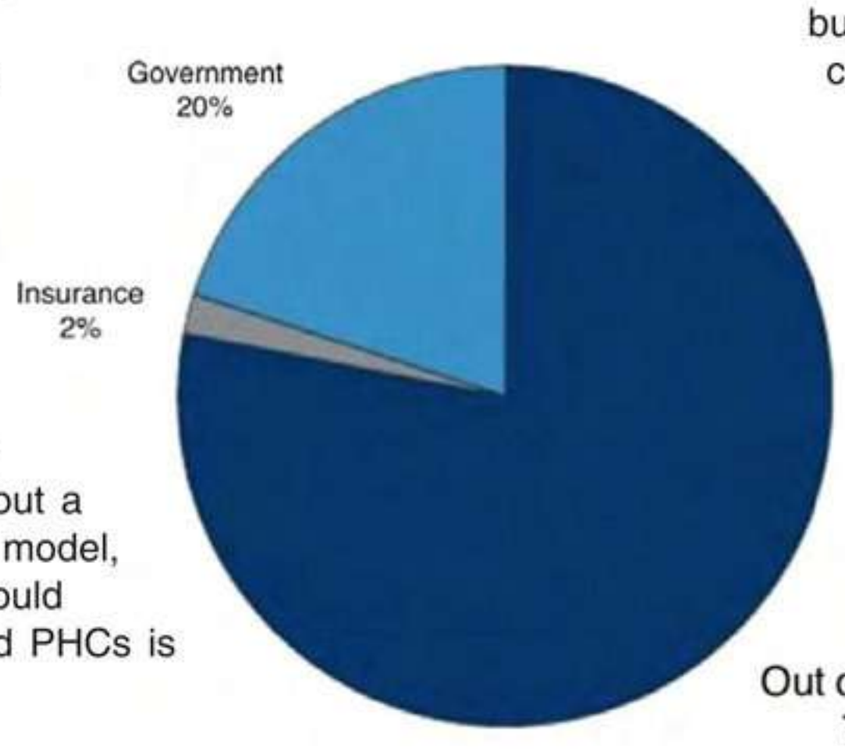


performers are rewarded and nonperformers are punished. The story on secondary and tertiary care is not especially different. In 2014-15, private hospitals treated 58% of in-patient cases in rural areas. Even among the poorest 20% rural households, 42.5% of the patients went to private hospitals for in-patient treatment.

For the poorest of the poor to seek private hospital care speaks volumes for their lack of confidence in the public healthcare system. Studies by experts do not give high marks to existing insurance schemes either. For instance, a 2017 study of the Rashtriya Swasthya Bima Yojana (RSBY), published in the journal Social Science and Medicine, concludes,

"Overall, the results suggest that RSBY has been ineffective in reducing the burden of out-of-pocket spending on poor households."

As officials design the Wellness Centres and NHPS, they must keep in mind this historical failure in the delivery of healthcare by public sector. Without a major change to the governance model, the risk that Wellness Centres would reproduce the failures of SCs and PHCs is high.



Design and implementation challenges facing NHPS are even greater. Hospitals will have an inherent interest in pushing patients towards more expensive procedures or towards procedures not even required. Any lack of clarity in delineating the included and excluded procedures will become a source of abuse.

The state nodal agencies will have to have sufficient resources and technical and administrative capability to monitor and check such abuse. Also, while the idea of 'One Nation, One Scheme' is enticing, we should not lose sight of the fact that we are a diverse nation. While the scheme can be one, it has to have sufficient flexibility built into it so that local administrations can adjust it as per local needs.

The current approach of National Health Mission – whereby states must pre-commit to expenditure allocations across 2,000 budget lines with no real flexibility to subsequently move expenditures between different line items – will render NHPS ineffective.

The writer is Professor of Economics at Columbia University

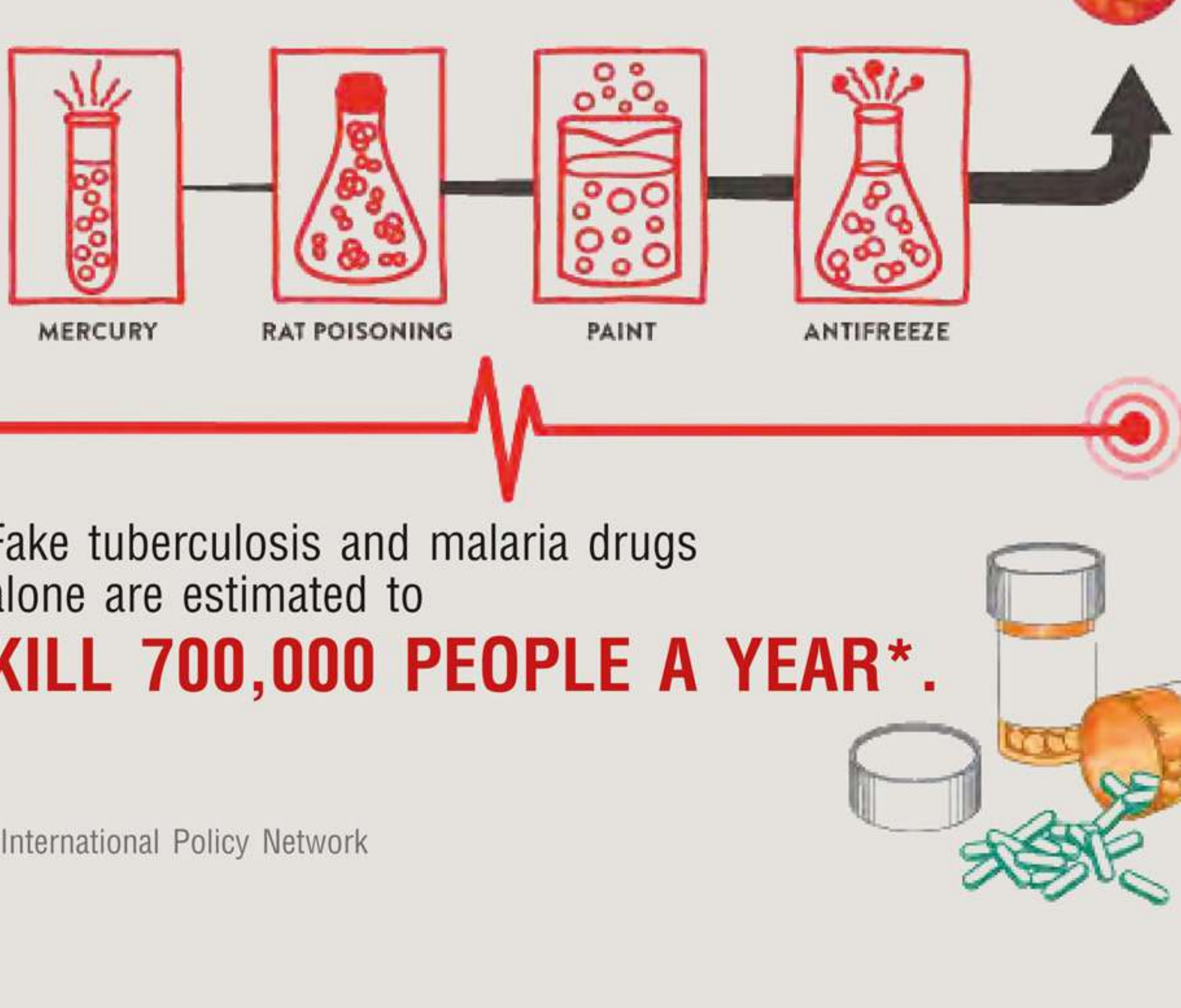
FIGHT THE FAKES

SPEAK UP ABOUT FAKE MEDICINES

VISIT FIGHTTHEFAKES.ORG

FAKE MEDICINES HARM – NOT HEAL

There are a lot of shady ingredients found in fake medicines that are directly responsible for serious disability and even death. This includes poisons such as mercury, rat poison, paint and antifreeze.



Fake tuberculosis and malaria drugs alone are estimated to

KILL 700,000 PEOPLE A YEAR*.

*International Policy Network

Is the National Health Protection Scheme a good public policy?

Photo: Indranil Bhoumik/Mint

While not all insurance programmes are successful, there is sufficient evidence that if implemented well, insurance can save lives and improve financial well-being.

Shamika Ravi | Neeraj Sood

INSURANCE THAT IS not easy to use will not be used. One way to make it easy is to minimize the number of forms people need to fill to enrol for insurance.

Since the announcement of the NHPS, there has been much debate about two issues. First, does this plan make sense? Second, if it is a good idea, what should the design of NHPS look like?

So, is the NHPS a good idea?

Definitely yes. There are several reasons.

First, India under-invests in the healthcare of its citizens and this is affecting the health and financial well-being of Indians. Out-of-pocket payments for healthcare services are very high in our country (about 70%, according to the National Sample Survey Office, 2014), which causes impoverishment to nearly 7% of our population. Health-financing policy directly affects the financial protection

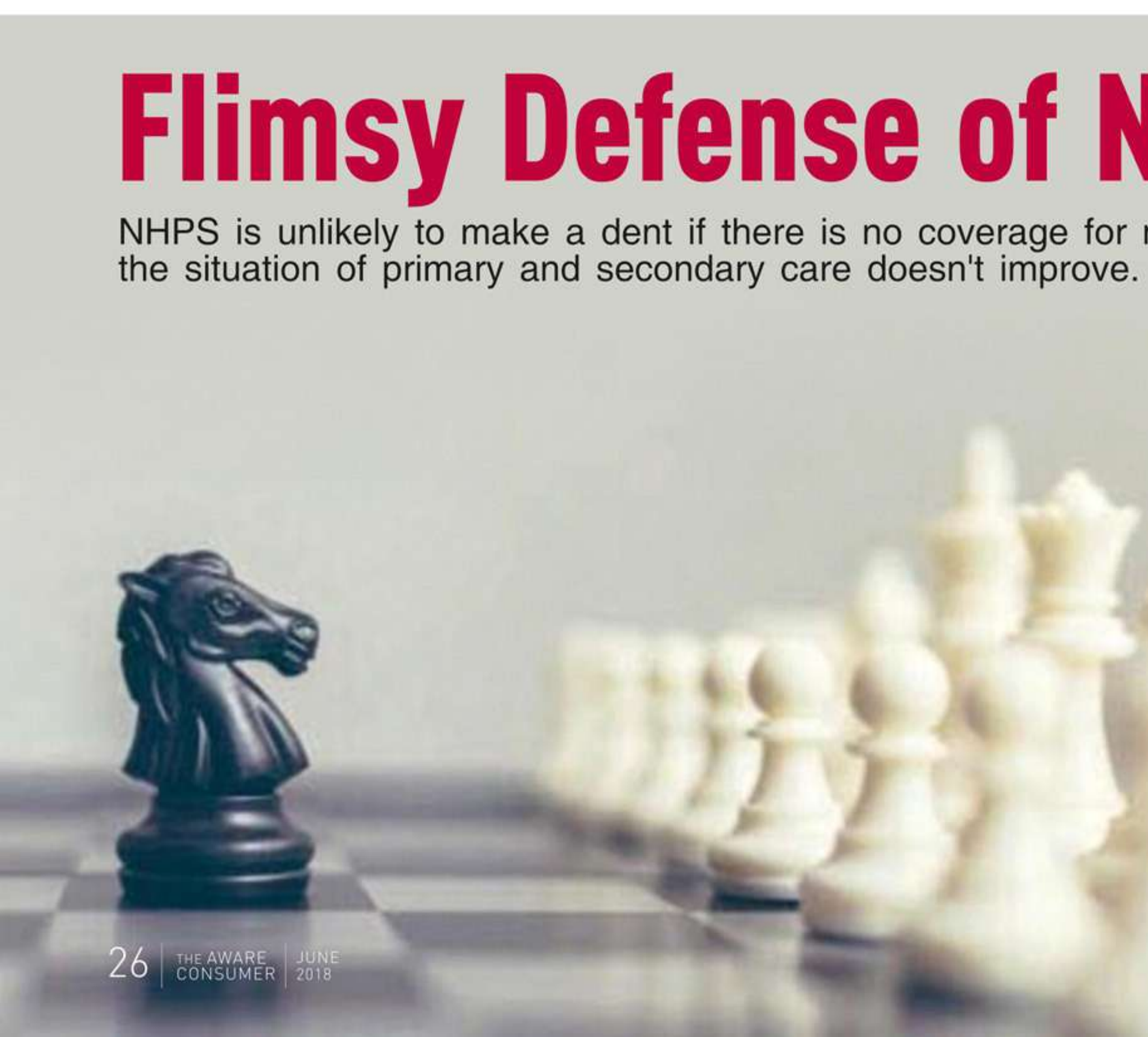
of people when direct payments that are made to obtain health services do not threaten their living standards. So the NHPS should be considered a significant move towards universal health coverage.

Second, while not all insurance programmes are successful, there is sufficient evidence that if implemented well, insurance can save lives and improve financial well-being. For example, one study conducted a rigorous evaluation of the government health insurance scheme in Karnataka called Vajpayee Arogyashree Scheme (VAS). In February 2010, the state government offered VAS to below poverty line (BPL) residents only in the northern part of the state, the scheme was later implemented statewide. Researchers took advantage of the arbitrary boundary in early implementation of coverage to compare outcomes in neighboring villages on either side of the line.

In particular, they conducted surveys and compared outcomes in neighbouring villages on either side of the boundary drawn between the communities chosen for early versus late implementation. Since the eligibility boundary is arbitrary, early and late implementation villages located just above or below the eligibility threshold are likely to be similar and differences in outcomes across these villages are likely due to differential access to VAS. The study found that VAS

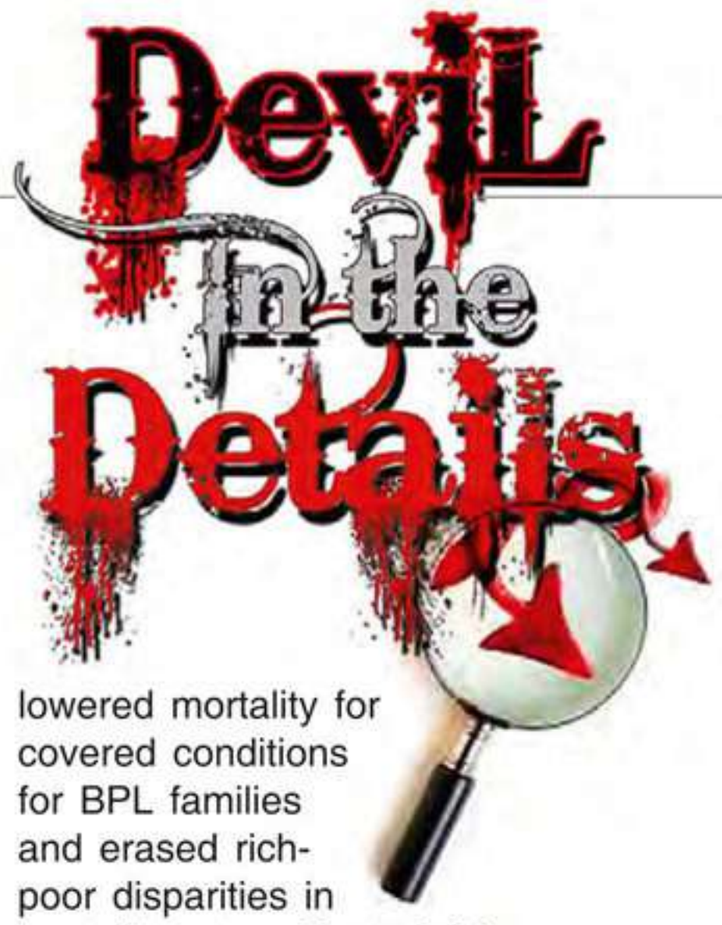
Flimsy Defense of NHPS

NHPS is unlikely to make a dent if there is no coverage for medicines and the situation of primary and secondary care doesn't improve.



The article on NHPS being a good public policy argues that NHPS is a good idea and suggests ways to ensure smooth implementation. It is a flimsy defense of NHPS.The article concludes that NHPS is a good idea based on the following three arguments.

1. *"Out-of-pocket payments for healthcare services are very high in our country (about 70%, according to the National Sample Survey Office, 2014), which causes*



Now that we have established that NHPS is likely a step in the right direction, how do we ensure that the programme is a success? The devil is in the detail: we need to pay attention to both the design of NHPS and its implementation. We offer some guiding principles.

lowered mortality for covered conditions for BPL families and erased rich-poor disparities in mortality rates. Most of this reduction was due to fewer deaths from cancer and cardiac conditions, which account for the bulk of VAS claims. They found that people covered by insurance were more likely to seek healthcare for their health issues and symptoms (such as chest pain), had better access to tertiary care hospitals, and had better post-operative outcomes likely due to seeking care at higher quality hospitals. They also found that insurance lowered out-of-pocket medical costs and lowered the chances of having catastrophic expenditures that are likely to push people into poverty.

Third, existing evidence shows that providing insurance to the poor not only saves lives but is also "cost-effective". That is, it provides good value for money as the benefits of insurance far outweigh the costs.

However, cost-effective health coverage must cover primary care.

This is where the second feature of Ayushman Bharat Programme — creation of 150,000 wellness centres across the country—is a very significant and welcome announcement. Sub-centres (and primary health centres) are the first line of contact of citizens to the public health system in India. Strong primary care is fundamental to keeping overall access to healthcare equitable and affordable in the country. Our biggest constraint to making this happen is not shortage of capital or infrastructure, but an acute shortage of human resources. Most public healthcare facilities (primary, secondary and tertiary) have

impoverishment to nearly 7% of our population."

2. Evidence from Karnataka's Vajpayee Aarogyashree programme lowered mortality for covered diseases and erased rich-poor disparities in concerned mortality rates. It also lowered out of pocket expenditure.
3. "Existing evidence shows that providing insurance to the poor not only saves lives but is also "cost-effective.

The above three points are either inappropriate or incomplete arguments in defence of NHPS, far from terming it as a step in the right direction.

1. There is no debate on the fact that the out-of-pocket expenditure on health care is huge in India. But, National Health Accounts data points out that **42% of the total out-of-pocket spending (OOP) is used towards buying medicines.**

   Given this scenario, a simple and significant step to reduce OOP would be to make all medicines free. Expenditure on NHPS with no coverage for medicines, while still requiring people to buy medicines for other conditions too, may not be of much use.

   "People who had health insurance coverage did not see any significant difference in their total real OOP health expenditures, relative to people without any health insurance"
2. While some agree that not every insurance programme has been successful, the cited programme VAS is not a representative example. A host of other programmes have failed but one can give a benefit of the doubt regarding the implementation quality. It thus brings us to the next aspect—the range of conditions and cost-effectiveness.
3. Surprisingly, the article claims the existence of evidence which shows that insurance programmes are cost-effective. The evidence on the same is to the contrary. Insurance programmes are anything but cost-effective. Starting from the US where they spend 18% of GDP but still don't get timely and quality care to the Indian data, insurance programmes are known for NOT being cost-effective.
4. The argument for primary and secondary healthcare as a prerequisite for good public health system is well taken but the budget allocation to the same is not proportional to its importance. The right question to ask is—assuming that there is an increased spending on health care, where should the increased funding go? Of course, if it ends up being the case that the overall expenditure on health care is NOT increased but money is rearranged towards NHPS, its a lost battle.

Overall, with no increased funding for primary and secondary care, with no coverage for medicines (42% of OOP), and with our existing weak state capacity, the defence for NHPS is flimsy.

The way out is to retain private insurance coverage for terminal illnesses with expensive treatments like cancer, but increase the spending significantly and use a bulk of it towards primary and secondary health care.

significant shortage of doctors, nurses and other health workers, often higher than 50%.

Make insurance easy to use

Insurance that is difficult to use will not be used. Therefore, we need to streamline both the enrollment process and access to care once enrolled. The number of forms people face to enrol in NHPS must be minimized. Aadhaar makes it easy to verify eligibility and enrol. Maybe all you need is Aadhaar and no other forms or hassles to enrol. For this, Aadhaar should be made readily available to demographics where it does not exist. This would require continuous and active collaboration between ministry of health and family welfare and Unique Identification Authority of India (UIDAI). In the case of children, the UIDAI authorities should take a more proactive approach and increase their coverage—as of today, data shows that of all the Aadhaar numbers issued so far, less than 5% are for those under five years of age, which is a gross undercounting of children.

Once enrolled, access to care should be provided where people live. This is a challenge in rural India but can be addressed with innovative models. For example, In Karnataka, health camps organized by super specialty hospitals were successful in improving access to care. Hospitals in Bengaluru would send cardiologists and other specialist to camps in villages. Patients identified as needing additional care were offered free transportation for patient and companion in Bengaluru. Other models are also being piloted, such as telemedicine in Uttar Pradesh where patients at primary health centre are connected to specialist doctors in Andhra Pradesh for virtual OPD care.

Target low-income populations

A programme financed by public money needs to conserve resources. Therefore, we should provide government sponsored insurance only to those who cannot afford insurance on their own. Existing coverage data shows that while private health insurance is largely concentrated among the urban richest quintile in India, public health insurance is more equitable, covering bottom quintiles of urban and rural population of the country. “Mission creep” or mis-targeting, however, is a significant threat as we witnessed in the case of Aarogyasri, where nearly 80% of Andhra Pradesh's population reported having coverage while the scheme was exclusively aimed at population below poverty line. This is why the Aadhaar platform becomes fundamental to enrolment to the NHPS. Also evidence from prior studies suggests that insurance has much larger effects on health and financial well-being for the poor compared to the rich. In addition to targeting the poor, insurance should target health conditions where disease burden is high and effective interventions are available but underused.

Contract with private hospitals and clinics

Nearly 75% of out-patient department care and 55% of in-patient department care in India is exclusively from the private sector. Therefore, private hospitals and clinics provide care to a large fraction of the population and they need to be part of NHPS. Yes, private hospitals will try to exploit NHPS. But the solution is not to exclude them but to monitor them and create the right incentives for them.

Private hospitals and clinics provide care to a large fraction of the population and they need to be part of NHPS

There are several options. First, not all hospitals should be eligible for NHPS. Only hospitals that meet certain quality standards should be allowed to serve NHPS beneficiaries. Quality should be measured not only by the infrastructure available at the hospital but also by actual patient outcomes achieved. Second, NHPS should institute prior authorization for expensive medical procedures and surgeries. NHPS doctors should review the medical records of NHPS beneficiaries to make sure that the surgery is medically warranted and meets evidence-based guidelines. Third, NHPS should reimburse hospitals using "bundled payment" so that the hospital receives a fixed amount per episode of care that covers all services provided by the hospital. This lowers incentives for the hospital to provide care just to make more money. The bundled payment can also be tied to quality metrics, creating further incentives to improve quality of care.

Use data to learn and evolve

The NHPS will have access to health information of 500 million people. This is an unprecedented amount of data and if curated well, it can have far-reaching applications. It can be used for comparative effectiveness research or understanding which treatments work in the real world rather than just in clinical trials.

Treatments and interventions can be highly contextualized to local conditions. It can be used to advance personalized or precision medicine. That is, tailoring treatment based on individual genetic or other characteristics. It can be used to improve the health system and understand how different delivery and financing designs affect care outcomes and costs. It can be used to improve transparency by providing information on quality of care provided by different hospitals or clinics in India.

Tracking the NHPS will be extremely important to set priorities and shape future health policies in India. In a large and diversified country, health needs differ from state to state, and, within a state, can vary greatly from one district to another. Good disaggregated measures of health outcomes will become the basis of framing and assessing future health policy. In spite of the best efforts of previous governments, there is little or no evidence on whether past health policies have had the intended effects. There is little political pressure on elected representatives to address health issues, largely abetted by lack of good local health data. Of course, this disproportionately affects the weaker and vulnerable sections of society – women and children – far more. A well run NHPS has the potential to become the cornerstone of India's healthcare needs for several future generations. ▸

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Priorities of CEO of 'Ayushman Bharat' mission while planning it's feasibility and potential impact

Indu Bhushan has been appointed as the Chief Executive Officer (CEO) of the Centre's ambitious Ayushman Bharat National Health Protection Mission (ABNHPM).

INDU BHUSHAN, the Director General of East Asia Department, Asian Development Bank (ADB) in Manila, Philippines, has been appointed to the post for a period of two years.

Prior to his appointment to EARD, Bhushan was Director General of the Strategy and Policy Department, which leads the preparation and coordination of ADB's corporate strategy and policies, resource mobilization and allocation, and results management.

He has been with the ADB since 1997. Bhushan holds a PhD in Economics and Master of Health Sciences from Johns Hopkins University in Baltimore.

Tasked with making the NHPS program a reality is Indu Bhushan. In an exclusive interview, Bhushan, PhD, MHS, discusses what his priorities will be as CEO of the Ayushman Bharat National Health Protection Mission, as well as the plan's feasibility and its potential impact.

Q Modicare will provide health insurance to 500 million people. That's a massive challenge. Where will you start?

I feel honored and privileged that Prime Minister Modi has chosen me to lead this ambitious and potentially game-changing initiative. The first step will be to agree on the approach to be followed and develop clear guidelines. The government has established 6 working groups to work on processes to follow in selecting beneficiaries, accrediting providers, making payments to providers, creating the demand for the use of services, how to ensure the continuum of care, etc.

Working with these groups to prepare a blueprint for the scheme and launching it in the next few months is the first major step. Then comes the big challenge—the implementation.

Q Could you sketch out the highlights of the plan for us?

Ayushman Bharat has 2 pillars. First, strengthening primary health care through establishing 150,000 health and wellness centers, which will provide the usual public health and reproductive and maternal and child health services as well as screening for noncommunicable diseases. Second, covering 500 million of the poorest people in the country for the expenditure they incur in seeking secondary and tertiary health care.

Q Is a plan this big economically feasible?

The plan is both technically and financially feasible. It is an economically sound initiative. Several other developing countries, including China, Thailand and Vietnam, have implemented similar schemes with considerable success. Prime Minister Modi is very committed to this scheme—strong political commitment, of course, is an essential prerequisite for the success of an initiative like this.

Q How long will it be before it is up and running?

Difficult to say. Every long journey starts with a series of small steps. We hope to put the plan in place fairly soon. The Prime Minister is keen to expand the coverage to 500 million people as soon as possible.

Q How would you like to see Modicare transform the country's health and its economy?

If implemented well, the ambitious mission will significantly increase access to health care services—especially for the poor, improve the quality of government health services, and expand the coverage of health services—both public and private—in underserved areas. This should considerably reduce the out-of-pocket share of expenditure for health care, which stands at an unacceptably high level of about 70%. Expenditure on health has been a major cause of impoverishment. The mission will help reduce poverty and harness the productive potential of the country by reducing morbidity, improving health and rationalizing health care expenditures.

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INTERVIEW

'Insurance Should Not Be The Only Financing Model For Public Healthcare In India'

Shamika Ravi, member of the PM's Economic Advisory Council, on the scope and limitations of the National Health Protection Scheme.

'INSURANCE SHOULD NOT BE THE ONLY FINANCING MODEL FOR PUBLIC HEALTHCARE IN INDIA' //

THE MOST-DEBATED QUESTION about the National Health Protection Scheme that Finance Minister Arun Jaitley announced in the Budget has been about how the government intends to finance the ambitious programme. The government plans to provide health cover of Rs 5 lakh per family to 10 crore families in India, which is about 50 million people or 40% of the population.

Many observers believe that the allocations made in the budget are far from adequate. However, Shamika Ravi, member of the Prime Minister's Economic Advisory Council and director of research at Brookings India, argues that the allocation is enough with the view that insurance should not be the only method of health financing but that India needs to find new innovative ways of providing adequate accessible healthcare to all.

While the broad outlines of the scheme are known, the details are being worked out in discussions with state health secretaries, which will involve questions about how the centre and states will split financing the scheme in a 60:40 ratio, how states will be implementing agencies in the scheme and how the national insurance scheme will fit in with the existing Rashtriya Swasthya Bima Yojana or RSBY and state level schemes in states like Kerala, Karnataka and Andhra Pradesh.

The National Health Protection Scheme is one of two features of the Ayushman Bharat programme. The other is the establishment of health and wellness centres that will essentially be upgraded primary health centres and sub-centres. for which the government has allocated Rs 1,200 crores for the coming financial year. 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 has fallen by more than Rs 600 crore.

Ravi spoke on health financing and the bigger question of investing in making healthcare accessible across India. Here are edited excerpts of the interview.

Q What is the thinking behind this model of health financing?

Many states have some form of public health insurance. The southern states – Andhra, Tamil Nadu, Karnataka – have their own schemes, which have now been running for over 10 years. They have experimented with what the cover is going to be, criteria for hospital empanelment, IT solutions to detect fraud, what the premium is and so on.

From 2008, we rolled out the national health insurance scheme – the RSBY – that was adopted by most states that did not have their own health insurance schemes. In places like Karnataka, it evolved into some kind of combination of the state scheme and RSBY, which is good because it is in the spirit of fiscal federalism.

Given this background, the announcement of the National Health Protection Scheme was fairly significant because the coverage and beneficiaries base has been expanded. It provides cover to 50 crore people that is 40% of the population. Given that the poverty level is at about 25%, this scheme will also cover people above the poverty line but still in the second income quintile. The reason this is important is because India has 7% impoverishment exclusively due to healthcare expenses. This has not improved in the last 10 years despite growth and whatever else we have done in health policy.

But we also need to look at the utilisation of health insurance in this market segment. The claim-to-coverage ratio is much lower in the poorest two income quintiles compared to the average health insurance market. So you also need education and financial literacy and whatever else is required for people to start using health insurance.

When the government is paying the premium, the claims-to-coverage will be taken into account while negotiating the premium with insurance agencies. To make it actuarially fair, you have to factor in that claims to coverage are low while setting the premium. If the claims to coverage increases – which it should ideally because people do fall sick, especially among the poor – then the government can adjust the premium with increased utilisation.

People criticised the announcement saying that the amount of money pledged to the scheme wasn't much, but I think it is a reasonable outlay right now. The capacity to use capital within states is not there right now within the health sector.

Q Is this the right way to go about financing healthcare?

No, health insurance should not be the only financing model for public healthcare in India, which is why I am glad that we have not done this blockbuster announcement and pledged all the funds. We need to evolve these schemes into something else, like perhaps a medical saving health scheme or public provisioning of services, because there is a large public health sector

\\ 'INSURANCE SHOULD NOT BE THE ONLY FINANCING MODEL FOR PUBLIC HEALTHCARE IN INDIA'

also that we need to revive. If you put all your money into health insurance, it will be very difficult to put money into these other things. Funds for health itself are competing with whatever other demands there are on the government.

Within the health budget, I would rather that only that much money is given to the NHPS as the states have the capacity to absorb right now. Secondly, it should not be so large that we cannot evolve and adapt new financing methods. We need to experiment with financing models.

The NHPS is good in that it is one mode of financing and frankly insurance is probably the easiest to fund. I think we have to think of a Singapore-type model where people actually put aside savings for health and the equity aspect is there in that the government pays for health needs of people below a certain income level. It is a better way of financing health because, in insurance, there are huge asymmetries in information that neither the healthcare providers nor the patient has any incentive to lower cost or lower utilisation. If you are insured, you will be given all diagnostic tests and probably overdiagnosed. The US, which has an insurance funded health system, spends 18% of its GDP on healthcare, while Singapore spends 4% and they have very similar comparable health outcomes.

Q Right now, are we thinking of any other innovative ways of financing health?

We are. There are several discussions on but they are at a stage when it is too early to announce these things.

Q Is this kind of large insurance coverage for 10 crore families sustainable? We have seen from the Aarogyasri scheme in Andhra Pradesh that public health insurance has placed a huge burden on the state exchequer – so much so that the state has asked the centre to provide financial support.

There are several lessons to be learnt from Aarogyasri. It was meant for the poor but in around 2009, the government said that 80% of people in Andhra Pradesh had Aarogyasri cards. They don't have a poverty line of 80%, which meant that it was fraudulent in terms of the number of people who were availing of Aarogyasri. Now, with all the digitisation and linking with Aadhaar, it becomes easier to stick to that number of 50 crore people that we want to target. There are tools with the government to make implementation more efficient that will keep the costs down.

Andhra has learnt through its mistakes and I don't think that at an all-India level we will necessarily be repeating those. Under NHPS, we cannot go from covering 40% of the population, which is the target, to something like 80%, like under Aarogyasri. Empanelled hospitals will have to be monitored and audited regularly.

Q Are we then still talking about NHPS as a step towards universal health coverage? It seems, from what you are saying, that this model might work for the 40% that covers below poverty line families and the segment above but not for universal health coverage.

I don't think a country like India can move to universal health coverage overnight. If we did have universal health coverage then we would be able to afford a very minimal amount of service. We are now going about it in a way where we can offer significant coverage to 40% of the population.

Universal health coverage is not just about financing but also about access to quality care, which is where the second part of Ayushman Bharat comes in with the Health and Wellness Centres – which, frankly, I think, is the bigger announcement and not getting adequate coverage. Eventually, it is well-run wellness centres that are going to bring down costs of healthcare across the country because they will perform the function of gatekeeping. People are not going to go to super speciality hospitals

for colds and coughs. These are things that a nurse or ANM should be able to attend to within three km of where people live.

Right now, we do have these facilities in primary health centres and the idea is to see whether we can put down additional resources to make them good quality centres. This is the problem of the first order for access to quality care.

Q We have had a problem with human resources at primary health centres and sub-centres. Is there a plan to fix this with the revamped health and wellness centres? Is there an idea of what portion of what has been allocated to health and wellness centres will go towards human resources and what will go to infrastructure, IT etc?

Those details are being worked out right now. There was a pledge last year to double the health budget and the roadmap towards that has to be on an annual basis. You cannot have a doubling all at when when the targeted time of four or five years are up. The roadmap leading to the doubling the budget involves exactly these kind of exercises, like what kind of funding will go to what aspect of the wellness centre. We are doing a lot of investment gap analysis, for instance. I think for healthcare in India, human resources is a much more binding constraint than capital. This is not just for the public sector but also for the private sector. The WHO has certain benchmarks by which standards we have half the number of doctors and nurses required overall. Solving that is not a financial or capital issue. Then you go back to the National Medical College bill, which has to be cleared fast so that we can clean up medical colleges and regulate them in such a way that we can have more well-trained doctors and nurses.

Q How is the 60:40 model going to be worked out? Is the 60:40 distribution for the contribution towards premium or also for administrative and other costs under the NHPS?

Those details are being worked out in deliberations with state health secretaries. Different states have different health insurance schemes and some don't and they only rely on RSBY. For the states that already have schemes, the NHPS becomes the minimum guaranteed financial service available for everybody in that 40% bracket and then the state scheme will top up. If they have the capacity to absorb funds and raise coverage, so be it.

Q Will the NHPS help significantly with health insurance portability, where people from one state can get insurance in another, considering we have so many people across India moving across states to find work and jobs?

Absolutely. The thing about healthcare is that 75% of all health infrastructure is urban. So people migrate a great deal for health needs. When that happens, portability has to be a natural feature of national policy.

Q When we are trying to cover below poverty line families and the segment above, we might encounter a data problem, given that there have been several questions raised as to the quality of Socio-Economic and Caste Census data. How do we decide who is going to be eligible under the scheme?

The caste census has a fairly rich data set and the idea is that it will be used for targeting. Obviously, Aadhaar will have a fundamental role to play in this as with all government schemes because the state really does want to minimise distortions and inefficiencies.

I have a feeling they will have to use the census data along with the RSBY data, because the RSBY has been around for 10 years. The census happens every 10 years. So while we may begin with this we will need something that is more frequent and recurring to really make the basis for targeting.

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AFTERWORD

Digital Technology Kicking In

Pyush Misra
Director, Consumer Online Foundation

GOVERNMENT OF INDIA (GOI)'s big and bold vision for India's healthcare needs is set to be realised through the ambitious Ayushman Bharat Programme. It seems that GoI is now moving from 'ease of doing business' to the 'ease of living' for the poor and middle classes. The three major challenges to overcome so that the scheme is meaningfully successful would be access to healthcare, funding and providing quality healthcare.

The first step for the National Health Protection Scheme (NHPS) would be to strengthen infrastructure in government hospitals before allowing, or even considering, strategic participation from private players.

Only caution and discipline need to be put into the thought and action respectively while planning to roll out the scheme. Because the challenge will be in scheme implementation and, most importantly, its governance.

Now that access to healthcare and finances seems to be all sorted at least in theory, the provision for delivering quality healthcare is an issue on everyone's mind.

Since the scheme covers hospitalisation and services in the secondary-tertiary space of healthcare delivery, the doctors and nurses, technicians and medical staff in health centres are required to be trained for a higher level of delivery, so that the screening of patients for the higher referral centres is done intelligently.

The development of digital technologies represents a huge opportunity to transform the healthcare sector in a way that raises efficiency as well as quality. The west had been at the forefront of the adoption of such advancements. As per Moore's Law, the power of computing is doubling every year. Hence, to scale up the skill levels of a doctor may take some time. But to scale up technologies would not take much time.

Today, the medical technologies are working as a second pair of dependable eyes, analysing mass data while trying to find the patterns in the signs and symptoms of the diseases. We see the larger part of the equation building up on the sly via data-driven technologies in trying to recognise patterns that would warn of early signs of the diseases. Healthcare and technology go hand in hand, and will always do so.

India is considered by many as a future startup destination in a whole lot of industries. The Indian Institutes of Technology, like our defence

laboratories, can produce some amazing patented products at an unbelievably low price to address the technological needs, ensuring success to this health scheme.

The multiplier effect of digital technology integration

Digital technologies provide the opportunity to ensure an agile, scalable, and future-proof implementation of NHPS. Here is how:

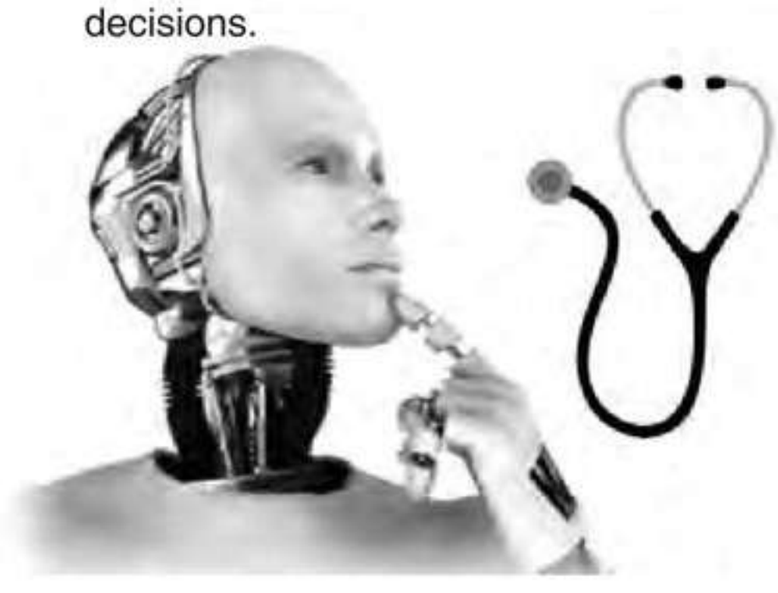
- **Cloud:** A NHPS digital platform deployed on a highly secure government-certified cloud can provision all core NHPS services digitally for beneficiaries and other NHPS stakeholders, using an 'as-a-Service' model. Digital workflows provide a transparent, 'straight-through-processing' environment to minimize manual intervention. The

platform can be designed to interact with the external systems of government agencies including UIDAI, regulatory bodies, healthcare agencies, financial institutions, and banks through open standards-based digital interfaces. Using virtualization technologies, all states and union territories can configure the NHPS platform based on individual requirements while ensuring that the NHPS platform has only one physical instance. This means each state can access only beneficiary and transaction data specific to it. A digital NHPS platform will ensure a 'single source of truth' as beneficiary and transaction data is maintained in a common repository in a standardized format.

- **Mobility:** Ubiquity of smartphones and pervasive connectivity make mobile the de facto channel for accessing NHPS services. All beneficiary services can be provisioned through

mobile apps for easier user-friendly access and wider reach.

- **Big Data analytics:** NHPS will over time collect huge volumes of data. By converting this data into actionable insights using analytics, healthcare organizations can drive empirical policy decisions and also design demographic and location-specific healthcare interventions – instead of the less effective 'one-size-fits-all' approach. Predictive analytics helps forecast healthcare trends to enable preventive healthcare efforts.
- **Artificial intelligence:** The overall shortage of doctors and their urban concentration – especially specialists – is expected to persist for a while, leaving rural India deprived of access to specialist care. AI-enabled machine learning based healthcare applications empower general practitioners to conduct 'specialist' patient diagnosis in rural and semi-urban settings, driving more informed treatment decisions.



- **Biometrics:** To mitigate beneficiary fraud either through identity theft or ghost beneficiaries, biometrics-enabled identity assurance should be implemented for enabling beneficiary enrolment and accessing beneficiary services. The wide spread adoption of Aadhaar in India makes biometric identity assurance easily implementable in NHPS.
- **Augmented reality:** Reskilling of Accredited Social Healthcare Activist (ASHA) workers in primary healthcare centers as well as doctors in Ayurveda, Yoga, Naturopathy, Unani, Sidda, and Homeopathy (AYUSH) is a key priority to augment healthcare capacity, particularly in non-urban locations.

Augmented reality-based skill development courses provisioned through cloud-based eSkilling platforms and accessed through mobile devices enable convenience and help overcome challenges related to shortage of in-person trainers.

NHPS is poised to be the world's largest healthcare assurance intervention. Instead of deploying traditional implementation models, an integrated play of digital technologies can lead to a far more agile, scalable, secure and future-proof NHPS implementation, in a reduced time-frame. The result: enhanced quality of life for Indian citizens.

Difference Between 'Coverage' and 'Care'

The idea behind Universal Health Coverage (UHC) or any state-funded health insurance scheme is to provide financial protection to the people — so that families do not become impoverished while trying to access health services because of the catastrophic rise in out-of-pocket expenditure. Between 2004 and 2014, 50.6 million people were pushed below the poverty line due to out-of-pocket spending on healthcare.

THE MUCH-VAUNTED National Health Protection Scheme (NHPS) is not "the world's largest government funded health care programme", as proclaimed by finance minister Arun Jaitley. Because the NHPS is not a "health care" programme at all.

It is an insurance scheme aimed at providing financial "coverage" — up to Rs 5 lakh per family per year for 10 crore families for secondary and tertiary care hospitalisation — not "care".

Jaitley said the government is "steadily but surely progressing towards the goal of Universal Health Coverage". Never mind that the NHPS is far from even being "universal" in scope, but what does this "goal" of Universal Health Coverage (UHC) entail, and where did it come from?

Difference between Coverage & Care

The idea behind UHC or any state-funded health insurance scheme is to provide financial protection to the people — so that families do not become impoverished while trying to access health services because of the catastrophic rise in out-of-pocket expenditure. Between 2004 and 2014, 50.6 million people were pushed below the poverty line due to out-of-pocket spending on healthcare.

The goal of UHC was first propagated by the international financial institutions like the World Bank — which are directly responsible for the dismantling of public services in the developing world.

"Global health agencies such as the World Health Organization, and international financial institutions such as the World Bank, are promoting this approach in response to the rise in catastrophic out-of-pocket expenditure for health services, and in the face of crumbling public health systems in the global South (both of which were precipitated by the fiscal austerity imposed by these same international financial institutions in the 1980s and early 1990s)," writes Dr Amit Sengupta of the Jan Swasthya Abhiyaan (JSA), in the Municipal Services Project.

However, UHC has nothing to do with providing care to the people. Government funded or public provision of healthcare means ensuring that everybody — irrespective of their economic status — can access quality healthcare for free at any point, and includes building an adequate network of primary healthcare centres, affordable and good-quality public hospitals and dispensaries.

Health coverage is merely about financing — the government paying the premium for the insurance cover provided to the people by private insurance companies (whose entry the coverage scheme facilitates) for people to access health services in mostly private hospitals, since public hospitals are not enough in number and are largely in a state of neglect.

As K Sujatha Rao, former *Union secretary in the Ministry of Health and Family Welfare,* writes in The Indian Express, the NHPS seeks to create "an effective demand to trigger private investments in supply deficit areas".

It "redefines the role of the state — a service provider to the financier," Rao says.

"Coverage" is not concerned with the actual delivery of health services to the people, the quality of the service, the equity in access and the nature of health systems.

"The use of the term 'coverage' rather than 'care' symbolizes the move away from concerns of health systems design toward financing," says Dr Sengupta.

This is the most important, but not the only, reason why insurance schemes are not the answer to 'Indias ailing health system.

The NHPS will provide coverage for "secondary and

Coverage Excludes Out-Patients and Primary Care

tertiary care hospitalisation", or only inpatient treatment, in other words.

As health economist Indranil Mukherjee states, "The major cause of out-of-pocket expenditure is on preventive care and outpatient care. Out of Rs 100 spent from people's pockets on healthcare services, say, 60 is on outpatient and preventive care, while only around 40% is on inpatient care or hospitalisation."

"So basically you're not covering the major proportion of the expenditure by this focus on insurance."

Indeed, a study of the Rashtriya Swasthya Bima Yojana (RSBY) found that despite high-enrollment in RSBY, out-of-pocket expenses had only increased and that the government-financed health insurance scheme had no impact on medical impoverishment in India.

The study also said one of the reasons for this was "the narrow focus on secondary and tertiary care hospitalisation. Essentially, these models are designed to address low-volume, high-value financial transactions that could result in catastrophic expenditure and impoverishment of households. However, evidence points in the opposite direction."

Mukherjee also pointed to the patients' experience of access to healthcare in the private sector, when they are armed with such schemes.

"All these tax-financed insurance programmes are essentially targeted towards the poor working classes, say, unorganised sector workers, who are supposed to benefit from schemes for free care/free hospitalisation," he said.

"But if you look at the NSSO data, out of hundred people who have insurance and have gone to hospital, only three get free care."

Why? There are several reasons, says Mukherjee.

Malpractices

"Often private hospitals mislead patients by saying this or that treatment is not part of your coverage, because there is a massive lack of information among the poor sections that manifests in different ways. Even though medicines are covered in many schemes, for example, patients are often asked to pay from their pockets."

Another highly prevalent malpractice that private hospitals indulge in — especially when they know that the patient has an insurance scheme — is to provide "unnecessary care". They prescribe unnecessary tests and procedures, and hospitalisation when it is not required. "Patients are pushed towards hospitalisation, even when they don't need it. They are pushed towards surgery when they don't need it. There have been lots of cases where women are being sterilised. For example, poor women in Bihar who were forced into hysterectomy," he said.

"So the patients' experience tells us that this thing about free care is false."

Most importantly, given the oligopoly in the healthcare sector — especially in the hospital care market, which is dominated by a handful of large, apathetic and profiteering corporate hospital chains — the costs of healthcare as well as the insurance premium will only keep rising.

"As oligopolisation increases, the cost of care also steeply increases. This has also been the experience in many developed countries like the US, Singapore, etc. Even OECD countries are not being able to deal with these kinds of costs," said Mukherjee.

"Look at states in India where insurance is popular, like Kerala, where the premium is increasing. The state has to keep giving more money to the insurance companies over time as it only becomes costlier. Because the cost of care increases and the premium increases."

Again, it is vital to remember that an insurance premium is a one-time payment, and not a guarantee of the services one gets in return.

"But if you invest in public systems, it's an investment which gives continuous returns. If you recruit a doctor, it's a human resource you're creating. You build a system in the hospital to deliver medicines, it's a systemic thing, which has a long-term gains, which insurance does not provide," Mukherjee said.

"So every time you're paying the premium, this money is given up in some sense. Whether in return you get some care is a derivation, not a natural outcome."

India is already among the countries with the lowest expenditure on health as a percentage of GDP — the Centre spends around 1.3% of the GDP on health. This is also the lowest expenditure on public health among the BRICS countries. Even the National Health Policy 2017 approved by the BJP-led NDA had recommended increasing the central government spending to at least 2.5% of the GDP by 2025.

Investing in public health is not only good for the economy, with long-term impacts on the well-being and productivity of the people, but is also "is the best regulation a country can have over the private sector", as Mukherjee said.

"If all the care is provided by the private sector and then you want to regulate prices in the private sector, it will not work, because they have a virtual monopoly over the care. You need to have an economic instrument to exercise control, and a viable public sector is the most effective instrument to check and negotiate costs."

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Other Existing Health Schemes

Rashtriya Swasthya Bima Yojana (RSBY)

Rashtriya Swasthya Bima Yojana (RSBY) is a government-run health insurance scheme for the poor sections of the society. It was launched in the year 2008, aimed to provide coverage to Below Poverty Line (BPL) households against financial expenses arising out of hospitalization. Beneficiaries can avail health coverage of up to Rs 30,000 annually. The beneficiary will enjoy cashless hospitalization in any of the empanelled hospitals. People who get enrolled under this health program, need to pay only Rs 30 as registration fee and the premium is payable by the central and state government.

Employees' State Insurance Scheme (ESIC)

ESIC provides complete medical cover for self and dependants from day one of employment. The insured person is also entitled to receive cash benefits in case of physical illness, disablement, etc. resulting in loss of earning capacity. On employment injury or on death of the insured person in the industrial accident, his/her dependants are entitled to a monthly pension. This scheme also covers domiciliary treatment and specialist consultation expenses. Medical care to retired and permanently disabled insured persons and their spouses is also provided.

Central Government Health Scheme (CGHS)

CGHS was launched in the year 1954 under the Ministry of Health and Family Welfare with an aim to ensure comprehensive medical care to central government employees and pensioners enrolled under the scheme. CGHS provides health care to beneficiaries through Allopathic, Homoeopathic & AYUSH systems of medicine.

Aam Aadmi Bima Yojana (AABY)

Aam admi bima yojana launched in the year 2007, is a social security scheme wherein the member should be the sole earning member or usually the head of a BPL family or marginally above the poverty line. The rural landless households within the age of 18 to 59 years are only eligible to join this scheme. The premium amount is shared equally by the central and state government. Upon natural death, sum assured of Rs 30,000 is payable. In the event of accidental death or disability within the period of insurance cover, Rs 75,000 is payable. Scholarship benefits of Rs 100 per month are also payable to a maximum of two children of the beneficiary studying between 9th to 12th standard.

Universal Health Insurance Scheme (UHIS)

UHIS is offered by the govt. to both the segments of society i.e 'Below Poverty Line' &'Above Poverty Line' families. The 4 public sector general insurance companies (New India Assurance, United India Insurance, Oriental Insurance & National Insurance) have implemented Universal Health Insurance Scheme with an aim to enhance access of health care, especially to poor families.

The scheme provides medical expense reimbursement of up to Rs 30,000 towards hospitalization for the entire family, accidental death cover of Rs 25,000 for a sole earning member of the family, compensation for the loss of the earning member as Rs 50 per day for up to 15 days.

What's in a health insurance: 5 important features a health insurances needs to have

Buying a health insurance has become a necessity. In spite of rising costs of medical treatments and increasing awareness about buying health insurance, people are still unaware of what makes a health insurance policy a winner. While we enjoy the tax benefit that comes with buying a health insurance policy, how much do we actually know about the policy and how to choose the best health insurance scheme based on your needs? We aim to address these long-standing questions and also highlight five important areas that need to be checked before opting for a health insurance policy.

1. Is your health insurance policy same as the others?

There have been many cases where the insurance plan being sold to people differ based on their location. This has been a code of sorts where health insurance companies offer lower cover for health insurances bought from a tier II or tier III cities compared to a tier 1 city. This is one of the first factors that needs to be analysed. Whether you are buying any health insurance form Mumbai or Jaipur, the benefits need to be uniform.

2. The OPD Charges

While all our health insurance covers the cost of being admitted in a hospital, people still have to shell out the cost of a doctor's visit as well as normal medications. Several health insurances shy away from providing the cover for your out patent visits and medicines that is otherwise spent from our own pockets. It is essential to check if your health insurance covers the cost of the OPD expenses or at least has a top up cover to avail such benefits by paying a nominal charge.

3. Alternate treatment coverage

Your health insurance usually covers your medical treatments in hospitals; however, there are many diseases where alternate treatment options like ayurveda, homeopathy, etc may seem more relevant. It is important to check if your health insurance provides coverage for such treatments. Some policies, in their in-patient AYUSH treatment covers expenses for Ayurveda, Yoga and Naturapthy, Unani, Siddha and Homeopathy (AYUSH) treatment undergone in a government hospital or in any institute recognised by the government. This addition allows you to explore your treatment options without worrying about the expenses incurred.

4. Additional Benefits

Your health insurance plan is aimed at keeping you covered and protected during a medical emergency, but what about the times when you have a claim free year? A good health insurance plan recognises and appreciates a claim free year with additional benefits. Health insurance plans should come with special benefits like bonus sum insured for a claim free year.

5. Promote Healthy Living

Living a healthy life is a difficult path when we have so much junk and such a busy life. The desire to live a healthier life increases when we are offered special benefits for staying fit. This is something that the health insurance companies need to remember. There are specially designed wellness plans which rewards and appreciates you staying fit.

These are just a few of the basic pointers to check your health insurance on and if your insurance does not stand tall in these simple plans, it is time to make a smart switch

STATES' TAKE

Health Welfare Schemes of States and their decision on NHPS

THE WORK ON National Health Protection Scheme (NHPS) is in full swing with Niti Aayog officials going through health welfare schemes of 6 states— Rajasthan, Uttar Pradesh, Maharashtra, Karnataka, Tamil Nadu and Telangana.

The schemes in relatively large states are being studied. Concept, design, medical records, data and implementation is being looked at, adding that best global practices are also being looked at for the programme. Technology will be the strongest point of the programme.

Confirming their presentations to the Centre, Rajasthan government officials said the Bhamashah Swasthya Bima Yojana (BSBY), introduced by CM Vasundhara Raje in 2006, gives a cover of Rs 30,000 for general illnesses and Rs 3 lakh for critical illnesses and covers around 1,715 diseases.

The Chief Minister's Comprehensive Health Insurance Scheme in TN gives general coverage of up to Rs 1 lakh, and critical illness cover of Rs 2 lakh. Launched by the DMK in 2009 and repackaged by AIADMK, the scheme covers over 1,000 procedures.

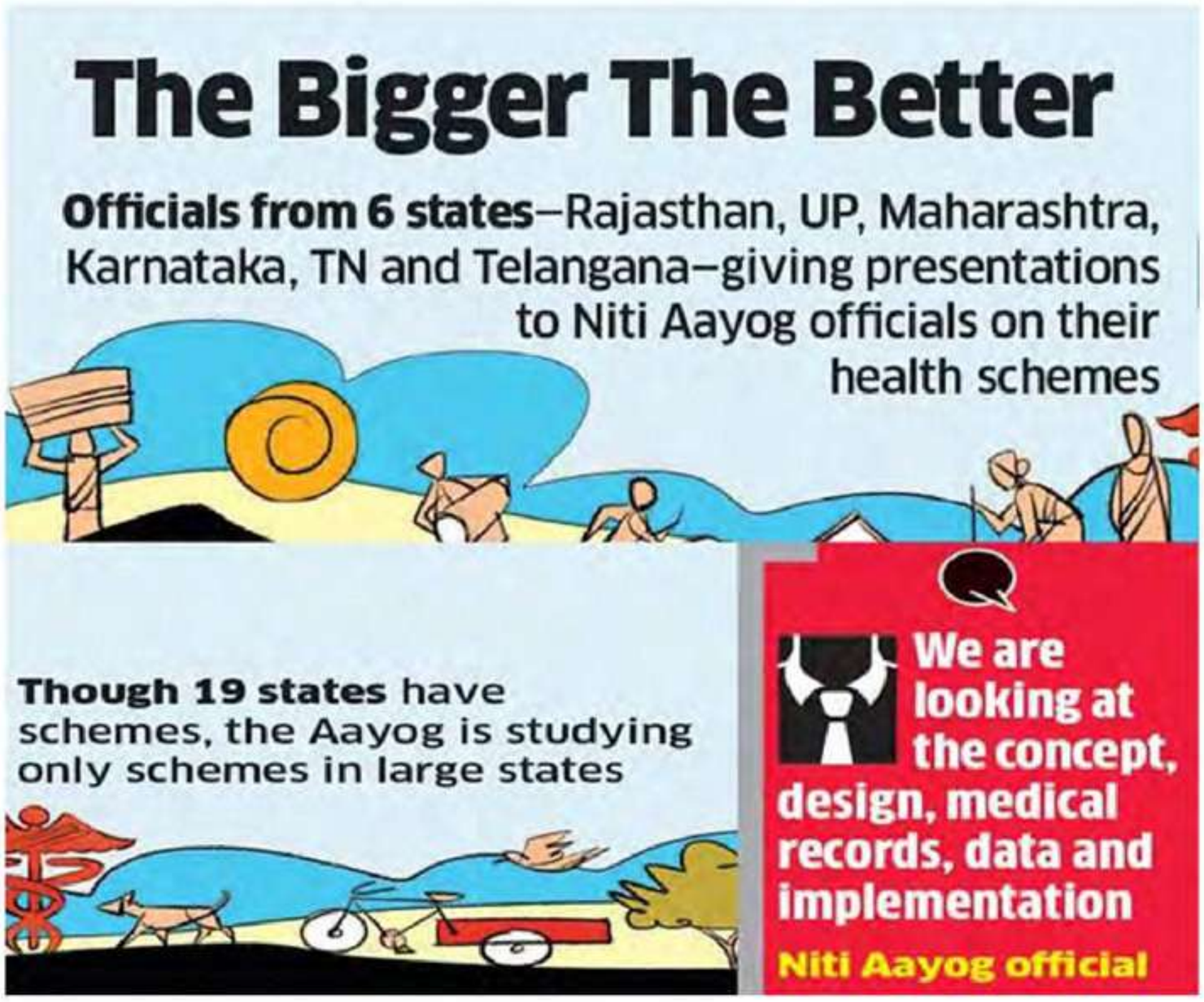
"For past one year UP health minister Siddharth Nath Singh said the state was focussing on getting the resources and infrastructure ready for the Rashtriya Swasthya Bima Yojana that the Samajwadi Party government had abandoned."

"We already have a blue print for rolling out the scheme which provides a cover of Rs 30,000 and are working on a Rs 2.5 lakh top-up for RSBY covering 1.5 crore families. We should be the among the states best prepared for the roll out of NHPS," the minister said.

Among the other schemes being looked at is that of Maharashtra which provides benefits to 85%of its population from fourteen districts. Started as Rajiv Gandhi Jeevandayee Arogya Yojana, launched in July 2012, it was changed to Mahatma Jyotiba Phule Jan Arogya Yojana in 2017 and covers 22.3 m ration card holders.

Election-bound Karnataka will roll out Universal Health Coverage (UHC) from November 1, bringing all government health schemes under one umbrella, under which all the 1.4 crore households will be eligible for cashless treatment for up to Rs 1.5 lakh in government and private hospitals.

In Telangana, CM K Chandrasekhar Rao had announced the cashless health insurance scheme for government employees and runs wellness centres too for multi-speciality treatment, apart from a health-cum-life insurance scheme of Rs 5 lakh for the farmers in the state.



West Bengal becomes first state to opt out of National Health Protection Scheme


Mamata Banerjee

West Bengal became the first state to opt out of Centre's National Health Protection Scheme (NHPS). According to State Government, it has already made hospitalisation and medical treatment free for its citizens and has already enrolled 50 lakh people under its Swasthya Sathi programme. Chief Minister West Bengal, Mamata Banerjee announced her decision to opt out of the scheme on the above grounds that her state already has its own medicare programme.

Karnataka opts out of centre's health scheme

Karnataka has declined to join the Centre's health insurance scheme —the world's largest government-funded healthcare programme.

The Centre's National Health Protection Scheme, which the Centre hopes to implement by the end of this year, promises an annual cover of up to5 lakh per family for secondary and tertiary care hospitalisation.

The Congress-ruled state is set to face Assembly polls in less than three months, and does not seem to be embracing a social sector programme tailored by the BJP.

"We are already a step ahead of (Prime Minister) Modi," state's health & family welfare minister Ramesh Kumar said a day ahead of Karnataka's election year budget. The state government, he said, already has a universal health scheme. While calling the NDA regime's programme as just a "pretension", the health minister said his government's programme was a well thought-out programme, and his department has worked for one year to device the scheme. The health minister suggested that the Centre, if it wished, could copy Karnataka's scheme, but the state does not have to take anything from the Centre's scheme.

Asked if Karnataka would also provide a medical cover of up to 5 lakh for a family as announced in the Union Budget, Ramesh Kumar said the question never arose, as the state never intended to have a cap. Karnataka will have no insurance. "Insurance is Modi's business. Ours is assurance," he said.

Chief minister Siddaramaiah, in his Budget speech last year, announced bringing various health insurance schemes together and including all the families under university health coverage. "Yashaswini Arogya Suraksha Scheme will be continued as per the existing rules. But, this scheme will be brought under the control of health and family welfare department," the CM had said in his speech on March 15, last year.

Undecided Kerela

It is unclear where the CPM-ruled Kerala stands as finance minister Thomas Isaac has hailed the Centre's insurance scheme, though he seems to advocate a different yardstick for finalising beneficiaries. In its own pre-Budget memorandum to the Centre, Kerala had asked for raising benefits under the Rashtriya Swasthya Bima Yojana (RSBY).

Will Modicare or NHPS Bridge the Healthcare Gap for India?

WITH THE ANNOUNCEMENT to cover 500 million people under the National Health Protection Scheme (NHPS) or 'Modicare', the Indian healthcare is finally acknowledging and moving forward on the path of providing Universal Healthcare Coverage. The political awareness, the directional approach and the realization of considering the importance of healthcare an aspect of national importance is commendable. India is definitely rising, shining and coming through to highlight 'Healthcare Matters'.

However, just as the Niti Ayog announces that it shall be preparing and presenting an operational plan soon and unconfirmed sources of the government give a scoop to the media, three people are left puzzled – the healthcare provider, the insurance providers and last the taxpaying citizen of the country.

As I, a private healthcare provider, actively pursuing the nation's vision of bridging the gap and providing accessible, affordable, quality care to the common man, ponders over the mammoth task of rolling out a project that could change the paradigms of healthcare for the poor, the odds at this point of time seem confusing. I am not too convinced, at the moment, but I am optimistic that even after a few glitches, good initiatives will prevail. The issues that the Ayog and the on ground implementation of the scheme could face can be divided into three parameters – Operational, Ideological and Financial.

For a country that spends less than 1% on public health, the announcement of introducing the world's largest government funded healthcare program of Rs 1200 crore, makes Indians optimistic about making the right to specialized quality healthcare a reality for all?

Let's talk about the questions surrounding the functioning of 'Modicare': Operational

- How will the process be simple for the poor, uneducated and needy patients?

The most challenging task for the Niti Aayog would be to formulate a simple flow that is acceptable and functional for the poor. It is also

important to understand that the poor may also be illiterate and may feel lost if asked to read through documents or run from pillar to post for approvals. These are the challenging reasons that make running projects for the poor difficult as implementation, continuity and sustainability are crucial. The same needs to also cover the aspect that this population is transient and travelling to different states for work and livelihood. How will each family be mapped and how will they get the care they have been promised without any delay caused due to bureaucratic paper work?

- Criteria of enrollment of beneficiaries and healthcare providers?

Modicare is yet to introduce the mechanism through which it will be linking the poor population with the healthcare scheme. Moreover with public hospitals being over burdened and private hospitals providing more than 70% of health facilities in India, Modicare is yet to come up with an enrollment and eligibility criteria for hospitals to empanel.

Will the midsized hospitals without quality accreditations be empanelled or the corporate hospitals, recognized as leaders in tertiary care, be part of the same, is yet to be decided and made clear.

- The referral or third party administrator path to treatment?

Detecting a poor Indian with an ailment that needs hospitalization would be his onus but what will be the path through which we would get admitted for cashless treatment in a medical facility is as of now an ambiguity. Will the system function with a third party administrator or a referral system will ensure that the poor patient gets the treatment? Who will coordinate the path of the patient and will the process be transparent and include a digital footprint that includes the patient knowing about his treatment approvals?

- How will Modicare include the areas that have no access to specialized care?

Providing cashless treatment to the poor is one aspect and ensuring the accessibility of the same is another. How will the program ensure that the best tertiary care services reach all? The rural to urban healthcare paradox and the absence of tertiary care facility or any healthcare facility in Tier 2 and Tier 3 city is a challenge. Will this include introduction of more medical colleges? The hard reality that money cannot buy health would be staring the planners at Niti Aayog starkly.

Let's now talk about the speculation on the ideology behind Modicare:

- Is this scheme against the whole concept of the term – Universal Health Coverage?

When you discuss an aspect – Universal Health Coverage, the same highlights the access of affordable, accessible, quality healthcare to the common man, irrespective of socio-economic status. However, the current initiative puts the poor at the forefront and the middle class or even the

citizens in the non-taxable slab at a back hand. Wouldn't a system that decides the cess as per the salary, be a better solution? Why wouldn't the citizens of the country be ready to pay higher cess to ensure that their interests are protected and that their out of pocket expenses are covered under the insurance. For contributions, there could be a limit set – like those earning below minimum wages should be exempt from contributions and their contributions could be paid by the state.

- Isn't it important to strengthen the primary care?

As per a Lancet report 65% of the cancers detected in India are in the later stages, putting the patient at a higher risk and reducing the chances of survival. Other than cancer, heart disease, kidney failure and liver disease have high mortality rates due to non existence of robust screening, awareness and prevention oriented programs. With the doctor-patient ratio and bed-to-patient ratios standing at dismal 1:30000 and 0.9/1000 respectively, a good primary healthcare system could help sensitize the population, decrease the tertiary healthcare burden and improve the quality of life of Indians. However Modicare only stresses on hospitalizations.

- Modicare misses out on the OPD care!

Citing the National Economic Survey, Honorable Finance Minister, Shri Arun Jaitley, had stated that on an average a family has to spend Rs 26,000 per hospitalization case in private hospitals and these statistics highlighted the struggle that millions of Indians have to endure. However, with the insurance industry growing at a rate of 25% per annum, along with organizations providing ESI, corporate insurances to the employees, we see a numerous middle class and salaried Indians opting for insurance to save out of pocket

IPD expenses. The tax rebates on health insurance also motivates the business class to opt for cover. However, the crux of Modicare providing Rs 5 lakh coverage to the poor misses the OPD expenses. With MRI's and CT Scans costing thousands and even generic medicines seeming out of reach for the poor, will Modicare just promote admissions. Are we looking at another nexus similar to the Rasthriya Swasthya Bima Yojana (RSBY)?

- Why didn't the government support the already existing ESI Scheme?

The Employee State Insurance Scheme is a robust plan that is backed by pre exitsing laws, infrastructure and support. Second, it is a robust framework that has been neglected and needs to be strengthened – and what better way than to make it universal to make it robust again? Strengthening the ESI would have ensured access to specialized care to a strong salaried class that thrives on a gross salary of or less than Rs 252,000 per annum. Moreover the hospital chain of ESI also ensures that the patients don't bear the OPD expenses. Why the system was overlooked is still a mystery.

The number game: Financial Implications and Questions

- Is the insurance industry ready?

The IRDA data of 2016-17 stated that there were 8,79,493 number of policies, out of which 8,59,593 claims were paid, highlighting that 2.2% of the insurers did not file any claim. This shows every 1 in 45 people did not file for a claim. With a claim clearance rate of average 91.60% and claim refusal rate of average 6.6%, there are certain insurance companies lagging behind in claim pending statistics. However, with NHPS or Modicare, we are looking at providing care to 100 million and enroll 500 million. Do we have the systems to accommodate such a massive task? Moreover will it be a single private, PPP project or a consortium of various insurance companies paving the way for Modicare?

- Why was the announcement not a part of the National Health Budget?

I can only ponder and speculate and the politically minded can reason the same.

- Contradicting NSSO Data highlighting that the premium of Rs 1200 per family might be too low

The National Sample Survey Office (NSSO) under the Ministry of Statistics and Program Implementation, Government of India, highlights that out of 1000 people, 40 need hospitalization. It also shows that an average expenditure of about Rs 12500 per hospitalization case for the poorest 40%, adding the same annually to Rs 5 lakhs. Hence taking an approximation that 1000 people would comprise of 250 families, the premium of Rs 1200 is insufficient and the same should stand at Rs 2500 minimum. Moreover the data states that the private hospitalization is about 4 times more expensive as in government hospitals. Do these statistics make the private set ups inaccessible to the poor? What will be the final premium cost that the central and the state governments be incurring?

In the end we are all 'Optimistic Indians' that wish for order & a framework

The questions are many and as the Niti Ayog works to piece together the jigsaw of healthcare in India, we are optimistic. We definitely want Modicare or NHPS to work. It can be viewed as an initiative that can empower the poor with access to specialized tertiary care which in the future can definitely be amplified to include the middle class.

However we can recommend a few aspects too that the Aayog can think worthwhile to include.

1. Need of medical infrastructure and manpower –

The low doctor to population ratio, currently standing at 1:30000 against the WHO recommended ration of 1:1000 and the nurses to patient ratio 1:40 against the worldwide recommendation of 1:4, highlight the shortfall in the manpower. The scenario is grimmer in the tier 2 and tier 3 cities. The medical infrastructure stands no better, with less than 1 bed (0.9) per 1000 in India. The focus should be both, to provide Universal Health Coverage and also ensure its delivery and access. Development of medical colleges and the incorporation of more seats under the DNB programs under the private hospitals will be key.

2. Make the private hospitals venturing in Tier 2 and Tier 3 cities NHPS champions

The players daring to take up the challenging task of providing affordable, accessible, quality specialized care in underserved areas should be considered partners of NHPS. The government should incentivize their operations motivating others also to be vehicles bridging the healthcare gap.

3. Give priority to empanelment of private hospitals in Tier 2 and Tier 3 cities

To ensure access, the NHPS team needs to ensure that the entire focus should be on the tier 2 and tier 3 cities. The empowerment of the poor with access to private hospitals providing specialized care could transform our country.

In the end as the stage is set, let's begin with a few million and be working spokes that can move the wheel of progression further. Let's be optimistic that this is a positive step towards achieving a Swasth Bharat. As Robert Frost's famous poem Stopping By the Woods On A Snowy Evening quotes: 'The woods are lovely, dark and deep, but I have promises to keep, and miles to go before I sleep,' our Niti Aayog also has a herculean task of conceiving, implementing and achieving success for the poor Indian.

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THE LAST MILE

Is it all a jugglery of figures, and no health benefits for the common citizen?

Finance Minister Arun Jaitely said a sum of Rs. 30,000 crores have been allocated. But Revenue Secretary Hasmukh Adhia, Jaitely's de facto boss, has just confirmed that only Rs. 2,000 crores have been actually allocated.

THE BUDGETARY PROVISION for the National Health Protection scheme is actually Rs.2000 crores this year.

The manner in which it has been announced gives the impression that the scheme starts as of now. No, far from it. The scheme does not even have back of the envelope workings. The government is still to work them out.

Jaitely said a sum of Rs.30,000 crores have been allocated. But Revenue Secretary Hasmukh Adhia, Jaitely's de facto boss, has just confirmed that only Rs.2000 crores have been actually allocated.

As usual they are just distracting us with promises and hoping to stave off the inevitable - popular discontent. Take for instance the much-hyped National Health Protection scheme to cover 500 million people or 100 million families with medical cover of up to Rs.5 lakhs.

But what is the proposed outlay for this? It is a measly Rs.30, 000 crores translating into a premium of about Rs.3000 per beneficiary family, whereas the prevailing premiums are at about Rs.4400 a year.

Even here the government is being disingenuous. If this were in addition to what is allocated to the Rs.1.38 lakh crores to health, which was Rs.1.22 lakh crores in the previous year, there would be some little cause to cheer. No, instead it comes from the health budget, which in effect means that this year less money is being spent on public healthcare

So if government hospitals and clinics continue to have fewer doctors and lesser medicines be happy with your health insurance and go to a private nursing home or corporate hospital and see how soon the cover evaporates. In effect this is a direct benefit to private healthcare providers, and insurance companies who will get an Rs.30, 000 crores windfall.

The Citizen Bureau adds: Dr Arun Mitra, Senior Vice President Indian Doctors for Peace and Development (IDPD), has also issued a statement saying that the government is completely shying away from its commitment to universal health care.

The statement reads, “These provisions in the budget are total jugglery as it offers no real health benefit to the people of the country. Instead of direct state expenditure on health, the proposal is to cover insurance to 10 crore families.

This insurance already exists under Rashtriya Swasthya Bima Yojna (RSBY). This scheme is to pass the benefit to the insurance companies and private hospitals through public private partnership.

Only 24 medical colleges in the state sector will be upgraded. This reflects the tendency to open up medical education to the private sector and make it more expensive which will make healthcare expensive.

That the government will give nutrition to the persons suffering from Tuberculosis is a hoax. What is needed is food security to poor people with increased wages so that the nutritional status of the society as a whole improves and disease rate comes down. Just giving some food to the sick people means nothing.

There is no talk of streamlining the drug prices. The spending on drugs forms the 70% of out of pocket expenditure on health. That free dialysis will be free for poor people, does not explain the definition of poor as a result lot of people will be left out. Increase in health cess from 3% to 4% will be a burden on the people.

Gaps not addressed

While health is getting a mention in the Budget in terms of the 3000 Jan Aushadi centres that sell less expensive medicines or the Government's initiatives to bring down the price of cardiac stents, there is little in it to address several other gaps affecting public health.

Shailaja Chandra, former secretary at the Health Ministry, is happy at the priority mention that healthcare is getting in the Budget in terms of an expanded health insurance or financial support of Rs 500 per month toward the nutritional of a person undergoing treatment for tuberculosis.

However, she adds, many of the initiatives don't seem to be thought through. For instance, the gaps in public healthcare delivery in terms of staffing or the regulatory coverage of the healthcare prevention scheme. There needs to be greater focus on a preventive set up or a strengthening of the existing framework to tackle communicable diseases and to prevent more Gorakhpur's from happening, she says, referring to the deaths of several infants at a Government hospital in Uttar Pradesh.

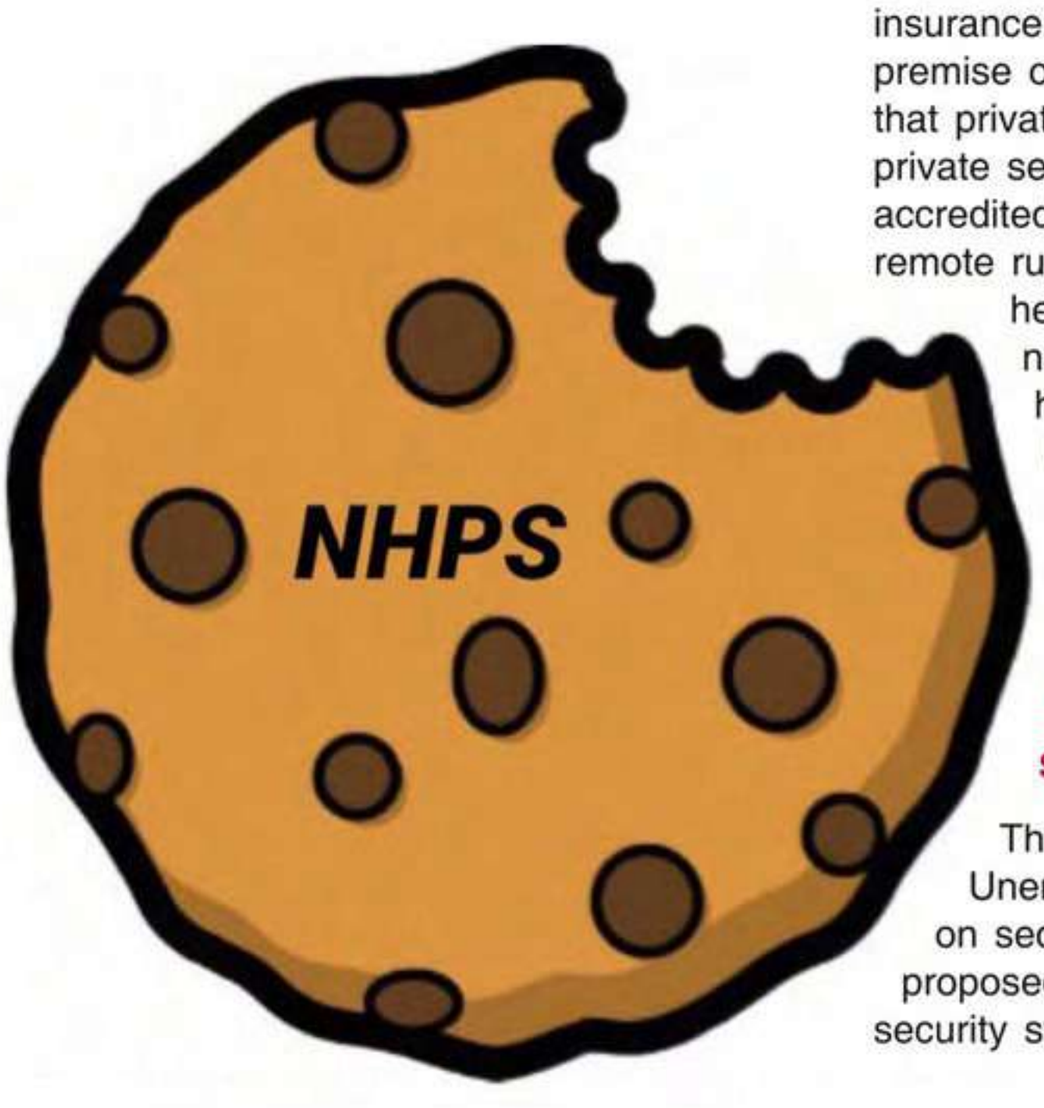
Insurance companies could end up reaping the benefits of the health coverage scheme, she says, calling

for a regulatory mechanism to make sure they pay patient bills without delays.

With the Budget being high on making promises, the critical element now is how the Centre rolls out these initiatives, some of which have already stumbled in the past over inadequate funds.

Has the government bitten off more than it can chew?

After the announcement of the National Health Protection Scheme (NHPS), the labour ministry has now proposed a comprehensive social security system which is expected to cover over 50 crore workers. Both the schemes are a result of the government's plan to increase social welfare of the marginalised groups of the country.



A significant component will be to strengthen the IT structure of the scheme to detect any malpractice and fraud. It is expected that 50 percent of the vulnerable families will be benefitted within the first year of its implementation.

While on one hand, Dr Tedros Adhanom Ghebreyesus, General Director of World Health Organisation called the scheme a significant step, Dipa Sinha, Public Health expert had a different opinion. She said, "This insurance scheme is based on the premise of in-patient care and hopes that private sector will deliver. The private sector and most of the accredited hospitals do not exist in remote rural areas. The issue of healthcare access remains. We need to strengthen primary healthcare systems and the budget does not focus on that."

Another comprehensive social security scheme

The Ministry of Labour and Unemployment also announced on second March 2018 that it has proposed a comprehensive social security system that aims to provide retirement, health, old-age, disability, unemployment, and maternity benefits to over 50 crore workers of the country comprising of workers in the unorganised sector, destitute and people below the poverty line. This scheme was thought of because a significant portion of the total workforce of India works in the unorganised sector and lacks any security cover. The project will be implemented in three stages over a span of ten years. The first phase will aim at providing health security and retirement benefits to all workers. This stage will incur a cost of ₹18,500 crores. Next, the second stage will add unemployment benefits to the scheme. Finally, in the third phase, other welfare measures will be added.

The scheme will be implemented in four tiers. The first tier will constitute of the destitute and people below the poverty line. Since such people cannot contribute much to their own security, the entire cost will be financed by the government. Secondly, the second tier will comprise of workers in the unorganised sector who may have some contributory power but are not self-sufficient to do so. Next, the third tier will include people who can make an adequate contribution to the schemes either by themselves or jointly with their employers. Lastly, the fourth tier will be made up of affluent and prosperous people who can take care of contingencies as and when they arise.

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The government has taken a huge stepin making healthcare affordable by launching the scheme. It is indeed heartening that 40 percent of India's population will be covered under an insurance scheme. If the National Health Protection Scheme is properly implemented and monitored we would have taken an important step in creating a Swasth Bharat. Effectively this initiative which amounts to $800 billion dollars tops even the US' Medicaid programme which amounts to $550 billion.

- **Suneeta Reddy,** MD, Apollo Hospitals

This is the world's largest government funded healthcare programme and would lead to a clear increase in demand for quality healthcare facilities and services and to match this rise in demand, several measures have also been announced to improve supply of quality health services in the country.

However, given the performance on the disinvestment front this year, there were hopes that the government would be more ambitious in terms of setting the target for the next year - the Rs 80,000 crore target for disinvestment receipts in FY19 is a bit conservative in FICCI's view.

- **Mr. Rashesh Shah,** President, Federation of Indian Chambers of Commerce and Industry (FICCI)

There are two announcements which will impact the healthcare delivery industry. The Suraksha Bima Yojana enhanced limit of 5 lakh rupees per family is yet to be launched, so the details and capital allocation will only be known when it is launched. However, the intent is quite positive, as almost 40% of underprivileged population would be able to access the secondary and tertiary care healthcare, and this would increase the market size for healthcare providers radically. The second scheme is for 1.5 lakh healthcare centres, where the budgetary provisions are only 1200 crores. However, it may be a good beginning for creating healthcare accessibility to the rural poor.

The investment in hospitals is a subject matter of viability, so it is yet a bit premature to assess the investment potential of the schemes announced. However, if the prepositions are commercially viable, these would be opening a vast market for the investments to flow in."

- **Ms. Zahabiya Khorakiwala,** MD, Wockhardt Hospitals group

Such ambitious out of the box thinking was a burning need of the hour and the government has not disappointed.

- **Dr. Prathap Reddy,** Chairman, Apollo Hospitals

The announcement of the Aayushman Bharat program will give an impetus to healthcare benefits for people in the most deserving sections of society.

- **Satish Reddy,** Chairman, Dr. Reddy's Laboratories

It is a very welcome step by the government of India to provide subsidized healthcare for the poor in the country. It is a splendid step towards building a new India. The only challenge here from an infrastructure perspective is to build the essential point of care network to deliver these benefits to the patients. It is a grand move by the government towards strengthening Aarogya Bharat.

- **Dr. Sujit Chatterjee,** CEO,
Dr L H Hiranandani Hospital

The NHPS will help bring healthcare closer to homes of the people, and will enable them to receive medical help within the golden hour hence improving the chances of survival.

- **Mr. Naresh Jain,** CEO, Ziqitza Healthcare Ltd

The government has reiterated its commitment to 'Universal Healthcare' and has announced flagship schemes to provide better healthcare to people at bottom of the pyramid.

- **Mr. Pavan Choudary,** Chairman & DG,
Medical Technology Association of India (MTaI)

It is really encouraging to see that the government has laid strong emphasis on Healthcare by announcing the World's Largest Health Protection Plan. We are confident that progressively, similar importance will be given to Home Healthcare which is fast becoming an important element in the health Management value chain

- **Mr. Rajiv Mathur,** Founder, Critical care Unified (CCU)

For the first time, Universal Health Care has got the impetus it needs. The 1.5 lakh centres which will provide free essential drugs and diagnosis is a welcome move and a step towards boosting the Government's National Health Policy. The flagship national healthcare protection scheme which will cover 10 crore, underprivileged families, is a highly commendable initiative."

- **Ms. Ameera Shah,** Promoter and Managing Director,
Metropolis Healthcare Ltd.

The proposed National Health Protection Scheme (NHPS), the world's largest government-funded, universal healthcare programme is a tremendous revolution which will drive greater investment in hospital infrastructure in tier-2 and tier-3 cities and also lead to evolution of existing business models to address health needs of people covered under this scheme. Higher healthcare consumption will be positive for life sciences industry and is likely to boost demand; this may however require companies to invest in increasing the depth of their distribution networks. The abolition of Education cess of 3% along with introduction of Social Welfare Surcharge @10% on custom duties would have a negative impact on this industry.

The private sector has been asked to partner the Government by adopting centres under the Rashtriya Swastha Bima Yojna and also contribute in the NHPS by offering free essential drugs and services.

- **Santosh Dalvi,** Partner and
Head-Indirect Tax - West India, KPMG in India

The Ayushman Bharat initiativeis a welcome move for the country's healthcare development as they intend to significantly reduce the cost of healthcare borne by the households on medicines, diagnostics and hospitalisation. While these schemes are conceptualised with good intentions, the government has to match up with a strong regulatory framework and clear financial outlays and implementation plans.

While universal access to health care services remains a distant dream with the current allocation strategies of the government, resource prioritisation is the key to effectively utilise the available budgets for primary health care. To quote an example, prioritising critical elements of reproductive health care for instance can reduce large expenses incurred on incentives and compensation. Rather, these amounts can be used more productively to improve the quality of care and strengthen health service delivery".

- **Poonam Muttreja,** Executive Director,
Population Foundation of India

The announcement in the healthcare space is clearly path breaking considering the sheer size and the impact it will have on the committed amount per family. With 1 Lac gram panchayats connected via optic fibre and an additional 5 crore rural population to be connected with 5 lacs wi-fi spots will usher India firmly in the next generation of healthcare regime . We welcome the move by the Finance minister as it will give further impetus to companies such as ours to penetrate in the areas where the poor is deprived of medical facilities.

- **Mr. Amit Munjal,** CEO and Founder of Doctor Insta

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50,00,000
NEFT transactions
processed to Amway Direct Sellers in a year

Partnership with ITZ prepaid cards
Forged a partnership with ITZ prepaid cards six years ago to digitise cash transactions

ATM enabled purchases
Bank ATMs enrolled for Amway product purchases

95% collections went digital
in November, including 3,00,000 active orders processed via debit, credit, ITZ pre-paid cards & Net Banking

NACH enabled product purchases
in the North-East

Mandatory KYC
Bank account and Aadhaar KYC made mandatory for appointment as an Amway Direct Seller

100% digital payments
100% of vendor and employee payments happen digitally

Amway India's state-of-the-art manufacturing facility in Nilakottai, Tamil Nadu.

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Posted at Lodi Road HPO, New Delhi on 9-10th of every month
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RNI No. DELENG/2015/67140
REG. NO. DL (S)–17/3523/2017-19

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Printed, published & owned by Bejon Kumar Misra, Printed at M/s. Spectrum Printing Press (P) Ltd., Shed No. 23, Computer Complex, DSIDC Scheme I, Okhla Phase II, New Delhi - 110020 and Published at E - 45, Ground Floor, Greater Kailash Enclave - I, New Delhi-110048, Editor: Bejon Kumar Misra