

A Critical Analysis of National Health Policy 2017 with Specific Reference to Ayushman Bharat Pradhan Mantri Yojana and the Path to Universal Health Coverage

S. Manju Priya¹

Abstract

The key to human development is through the attainment of economic and social development. This can only be achieved by improving general health of the population. This has been aimed to be enforced through the 'Universal Health Care' vision in the recent decades. It is towards this aim that India's first National Health Policy 2017 (NHP) was formulated by the BJP-headed Modi government. Ayushman Bharat is a part of National Health Policy 2017 with an aim to meet the Universal Health Coverage (UHC) as well as to attain the Sustainable Development Goals (SDG). Through this paper, the researcher makes a critical analysis of the policy in general and the effect it has on its targeted audience in the last 3 years after its implementation. In this regard, the researcher finds various problems in the practical implementation of the policy wherein suggestions are provided for effective implementation to achieve the desire health outcomes.

Keywords: Universal Health Care, National Health Policy, Ayushman Bharat, Strategic Purchasing, Out-of-Pocket Expenditure

Introduction

According to WHO, more than 7.3 billion people do not have proper access to essential healthcare services, wherein approximately 800 million people be-

longing to vulnerable category spend a minimum of 10% of their already scanty incomes on costly pocket health care expenses, pushing them to destitution and extreme poverty². Thus, it can be understood that human development which is the key to attain economic and social development depends on the vital indicator, that is, health. The importance of such an indicator can be seen through the eyes of the framers of the Indian Constitution in the Directive Principles of State Policy. Further, it is a basic human right where the State has an obligation to fulfil it to the farthest extent possible under International Covenant on Economic, Social and Cultural Rights. While there is no explicit mention of the right to health, it is read by the Judiciary over the past through interpretative reading of Article 21 with Articles 38, 41, 43, and 47 of the Indian Constitution³. While the Preamble of the Constitution aims at development of the nation, it cannot be done away without ensuring the national well-being. Thus, when we look at the history of Indian government in healthcare setting, one could analyse that it has come to achieve the 3A's over time, that is, affordability, accessibility, and availability of healthcare for all. Now, in the recent two decades, one of the main priorities have been Universal Health Care Vision. However, this has remained a distant dream for the successive governments over the decades due to various factors such as workforce and infrastructure related substantial shortcomings combined with low expenditure of public healthcare when

1 LLM, School of Law, Christ University, Bangalore

2 Shalendra D. Sharma, *Health Care for India's 500 Million*, 18, JSTOR, 1, 2-14, 2018

3 INDIA CONST. art. 21, 38, 41, 43, 47

S. Manju Priya

compared to other countries of the world⁴. To bring this elusive aim into reality unlike the predecessor governments, the BJP headed Modi government in the budget session of 2018-19 brought forward the India's first National Health Policy 2017 (NHP-2017) which intent to achieve the concept of Universal Health Coverage. This program aims at 2 things: (i) centres for health and wellness and (ii) schemes for national health protection aiming to increase access and affordability to primary, secondary, and tertiary health care services. This Ayushman Bharat health scheme aims to provide from grassroot to approximately 10 crore vulnerable factions of the society to a proper health cover sponsorship up to Rs. 5 lakhs. The researcher through this paper critically analyses the policy in general and its effect in the past two years after its implementation. The paper will also analyse Ayushman Bharat Pradhan Mantri Jan Arogya Yojana which was enacted on recommendations under NHP, 2017 wherein its challenge in the current scenario is traced and suggestions for better effective implementation of the program to achieve the desired health outcomes in the future is provided.

Critical Analysis of National Health Policy, 2017

Background

Right to health is a basic human right recognized under international treaty named International Covenant on Economic, Social and Cultural Rights adopted in 1976. Here, India becoming a signatory in 1979 has an obligation to realize this right for all citizens of the country. This obligation and duty along with the political backdrop became one of the catalyst factors for the adoption of the National Health Policy, 2017. It is also called in Hindi as Ayushman Bharat Yojana (popularly called as 'Modi care') which came in place replacing the 2002 policy. Following the failure and loss of momentum in various countries of "Millennium Declaration" of 2000⁵ which aimed to accomplish accessible

affordable health care for all, came the unanimously adopted resolution of 'Universal Health Coverage' by the United Nations General Assembly in December 2012 where it was aimed to make it an essential element of international development. This resolution urged all international governments at national level to implement policies to achieve this UHC by 2030 if not earlier, by realizing all rights of citizens to affordable quality health care services. Despite these measures, there is still 62.4% of the population as of 2014 who spend out of pocket payments⁶ leading to further hardship and poverty. To address this persistent issue, came several committee recommendations, one of which is the 2002 "National Health Policy" under the Congress-led United Progressive Alliance (UPA) which aimed for more inclusivity of the private sector in health care provision. It also focused on the decentralization of powers at the local level district for "accessible, equitable and affordable" health care for all. This was followed by schemes such as the 2005 National Rural Health Mission (NRHM) which was eventually subsumed under the 2013 National Health Mission (NHM). Further, following the recommendations of 2012 "Universal Health Coverage" report by the High-Level Expert Group (HLEG) came the establishment of National Health Policy (NHP), 2017 under the Narendra Modi Government.

It can be seen through the policy that NHP, 2017 intends to realize the commitment India made towards Universal Health Coverage (UHC). This can be observed through its key principles and objectives enumerated in the document⁷. It aims to cover 100 million "poor" and "vulnerable" families, that is, roughly around 500 million individuals for coverage of health insurance through reimbursements. Some of the key contrast from the 2002 policy can be seen through the shifts in 1st and 3rd policy out of the 7 key mandatory policy shifts that is seen necessary under NHP. The 1st policy shift focuses on assured comprehensive care when it comes to primary care which is achieved through linkages to

4 The Wire, Soumitra Ghosh, *Its time to have Universal Healthcare as a Public Service- and a Right*, <https://thewire.in/health/universal-healthcare-congress-bjp> (last visited on Aug. 14, 2022).

5 The Guardian, John McArthur and Krista Rasmussen, *How successful were the millennium development goals?* <https://www.theguardian.com/global-development-professionals-network/2017/mar/30/how-successful-were-the-millennium-development-goals> (last visited on Aug. 14, 2022).

6 The Hindu Business, <https://www.thehindu.com/business/out-of-pocket-spend-makes-up-62-of-health-care-costs/article21860682.ece> (last visited on Aug14, 2022).

7 Niti Aayog, <https://www.niti.gov.in/long-road-universal-health-coverage> (last visited on Dec 18, 2021).

referral hospitals as opposed to the then health sectoral reforms of 1990 which focused on selective primary healthcare⁸. The 3rd policy shift focuses on assured free drugs on diagnostic services in public hospitals as opposed to the user fee's structure of 1990's reforms.

Challenges Under the National Health Policy, 2017

It cannot be denied that there are glaring inadequacies in sector of public health in India over the past 3-4 decades which has forced the then government in the 1990's to liberalize the same to private entities at exponential rate. Even the 2017 Policy has rather made it clear that private sector players would play a major role in realizing the 'Universal Health Coverage' and thus their role does not end with just engagement of providing care to the government. While the government has stated so, however the ground reality of regulatory regime to monitor and oversee such private players is weak. This is because the private players see this as a mere profit motive treating patients like cash cows to extract money through unrequired costly tests and surgical procedures⁹. Further the out-of-pocket expenditure according to government reports account as high as 70 percent of the total expenditure of the country. This scenario in many cases lead to disincentive actions such as families not choosing to seek health treatments, thereby foregoing severe diseases which in extreme cases leading to death of the individual. It is a known fact that the control of out-of-pocket (OOP) expenditure that is pro-poor will result in large raise of overall health outcomes where such practices not only help the poor out of negative financial exposure and poverty, but also result in increased household consumption, thereby increasing in economic growth. While this is a step in the right direction, the NHPS focuses only on secondary and tertiary care and not primary care which is the main cause behind the largest percentage of OOP expenditure as outpatient treatment inclusive of basic

diagnostics and medicines account for more credit in a practical setting¹⁰. In addition to this, the Act is silent on matters involving procedure of 'strategic purchasing' from public and private providers which claims to do to cover the costs of hospitalization. Such absence of provisions can make the private players very competitive in nature to attract possible patients, thereby achieving the objective of 'Universal Health Care' a business than an obligation on the part of the State. This also paves way for fraudulent transaction as there is no enumerated and exhaustive list providing for what medical conditions or treatment or tests are covered under the NHP, 2017. This scenario is coupled with no proper provisions or authority to monitor the quality of such treatment given. Such inadequacy in providing an exhaustive list can lead to medical malpractices such as exorbitant charging for basic tests and treatment on the part of public and private players in the healthcare industry. Finally, the scheme do not provide for a preventive approach to address the root causes of such health concerns in urban and rural areas such as malnutrition, environmental pollution, inadequate access to clean drinking water and poor sanitation facilities where such conditions have the capacity to directly affect the overall health outcomes.

Overview of AB-PMJAY: Challenges and the Way Forward

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, a State funded insurance scheme was launched in continuation of the recommendations of National Health Policy, 2017 in 2018. This scheme aimed to work as an insurance-based model to cover expenditure of the poor for hospitalization to achieve the vision of universal health coverage. The prior scenario before the launch of AB-PMJAY in accordance with national Statistical office data reveals that only about 10% of the poorest Indians have has any type of insurance be it, private or government¹¹. It remains till date as the world's larg-

8 Rumki Basu, *Universal Health Coverage and the National Health Policy 2017: Some Observations*, 66 Indian Journal of Public Administration 127, 127-132 (2020).

9 K.Sujatha Rao, *India's New National Health Policy is Ambitious on Paper but lacks Clarity*, The Wire (Aug 14, 2022), <https://thewire.in/health/indias-new-national-health-policy-is-ambitious-on-paper-but-lacks-clarity>

10 The Hindu Business Line, <https://www.thehindubusinessline.com/news/national/5-reasons-why-indias-healthcare-system-is-struggling/article34665535.ece> (last visited on Aug. 14, 2022).

11 Ministry of Statistics and Programme Implementation, Government of India, http://mospi.nic.in/sites/default/files/publication_reports/KI_Health_75th_Final.pdf (last visited on Aug 13, 2022).

S. Manju Priya

est health insurance scheme intending to cover all the below poverty line families as the beneficiaries who are picked and based on the 2011 socio-economic case census. It covers insurance without cash for Rs. 5,00,000 for each family per year for hospitalization which includes secondary and tertiary care. Apart from schemes such as insurance, Ayushman Bharat intends to create health and wellness centers to address comprehensive primary care that is inclusive of maternal care, health services for children, services for non-communicable diseases which includes diagnostic services as well. The performance so far according to the scheme's dashboard is that there are about 76,600 health and wellness centre operational as on 2020 January with the earlier target of about 40,000 centres all around the country to be made operational¹². It is also interesting to note that high income States have the highest centres set up as of 2020 such as Tamil Nadu, Gujarat, Andhra Pradesh and Maharashtra¹³. The scheme of PM-JAY is managed by the National Health Authority (NHA) created in this behalf with the Union minister chairing the proceedings of the Board where the functions of such Board is not just implementation of policies but also in formulating one with operational guidelines depending on adequacy if so ever needed. Likewise, State Health Authority which is headed by the State Government take over on behalf of the States to effectively rollout and implement PM-JAY. However, unlike central level, the States have the discretion to choose either models in trust, insurance, or mixed/hybrid model. Further under the scheme to track fraudulent transactions in Central and State level respectively, 2 bodies called National Anti-Fraud Unit (NAFU) and State Anti-Fraud Unit (SAFU) has been formulated.

Challenges Under PM-JAY

Lack of coordination between public and private sector players: It is a well-known fact that the National Health Authority considers PM-JAY Scheme as a partnership in its truest sense between public and private sector health systems. However, this goal has seen a considerable absence on the part of private players after a year of enactment of the scheme in place¹⁴. It is also interesting to note that while there is very less participation of private hospitals in cities like Mumbai and Bangalore, there have still been some major hospitals which as on January 2020 are yet to join the PM-JAY scheme such as Apollo hospitals and Max Healthcare¹⁵. This could be because the private players often contend that PM-JAY is not viable for them to meet the expenditure costs where it is cited that it does not cover more than 40-80% of the total costs for them which is incurred in the process of allocating beds to patients of PM-JAY scheme. Further, there has been a few instances under Central Government Health Scheme (CGHS) and Ex-Servicemen Contributory Health Scheme (ECHS) wherein it has been contended that cashless treatments made by the private players have been delayed in settling bills leading to huge loss of revenue¹⁶. One such incident happened in December 2019 when a group of private players such as Fortis, Max and Medanta contended that they will discontinue such services of cashless treatment under CGHS and ECHS as there has been Rs 1,700 crores delay in non-payment of dues¹⁷. On the other hand, such insurance model has been severely criticized by government players stating that Universal Health Coverage should replace such

12 Ministry of Health and Family Welfare, Government of India, <https://ab-hwc.nhp.gov.in/> (last visited on Aug 14, 2022).

13 Chandrakant Lahariya, *Health & wellness Centers to strengthen Primary Health Care in India: Concept, Progress and Ways Forward*, 87, *The Indian Journal of Pediatrics*, 916, 916-929 (2020).

14 Dr.Indu Bhusan, *One year of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana: 50 lakh hospital treatments with an eye towards universal health coverage*, Abpmjay, Government Of India (Aug `14,2022, 10:12AM), <https://pmjay.gov.in/One%20year%20of%20Ayushman%20Bharat>

15 Poonam Aggarwal, *Govt to Revise Ayushman Bharat Rates as Several Hospitals Back Off*, *The Quint* (Aug 14,2022, 2:54 PM), <https://www.thequint.com/news/india/ayushmanbharat-pmjay-rates-to-be-hiked-to-get-big-hospitals-on-board>

16 Ministry of Health and Family Welfare, Govt of India, https://www.pmjay.gov.in/sites/default/files/201910/3_Press%20release%201%20year%20completion%20of%20Ayushman%20Bharat%20PMJAY%20%2822nd%20Sep%29.pdf (last visited on Aug 13, 2022).

17 Himani Chandna, *Fortis, Max, Medanta Want to Scrap Cashless CGHS Treatment as Govt Dues Touch Rs 1,700 Cr*, *The Print* (Aug 14,2022, 9:33 AM), <https://theprint.in/health/fortis-max-apollo-want-to-scrap-cashless-cghs-treatment-as-govt-dues-touch-rs-1700-crore/330968/>

model where the government can directly fund them leaving the private players out the scheme of PM-JAY¹⁸.

Exclusions within PM-JAY and the lack of Grievance Redressal Mechanism: The criteria for determining beneficiaries under the PM-JAY scheme through social economic caste census (SESC) to target and cover 100 million households has been severely criticized by various scholars as it is contended that as high as 20 million household who come under poor household and are eligible under the act have been left out to avail such benefits¹⁹. Even to report this and avail the benefits on meeting the 6 & 11 marked criteria for rural and urban area households respectively cannot be done as there is no grievance redressal mechanism under the scheme to solve such exclusion errors. Further even after a suggestion for such constitution of grievances redressal mechanism by the Ministry of Rural Development, no action has been taken so far under the Act to address this issue.

Lack of Awareness among the beneficiaries: Despite Bihar being a State declared as experiencing Acute Encephalitis Syndrome epidemic by the government in June of 2019, the scheme has managed to cover only 36 patients so far hinting towards a total obliviousness and lack of awareness regarding the scheme in the minds of the beneficiaries who are included under the scheme²⁰. Various survey conducted after the announcement of the scheme through the process of sending letter to a 100 million poor households along with health card, it was concluded that there was as low as 20% awareness regarding functionality of the scheme in the minds of the public in Bihar and Haryana²¹.

Exclusion of certain diseases from PM-JAY Scheme: Another main drawback that has been time and again challenged is that the scheme does not cover any medical treatment longer than coverage of 15 days after such hospitalization, thereby leaving out diseases which require long term treatment such as cancer, HIV etc. Further, it also leaves out diseases such as last stage kidney failures and chronic liver diseases where now it cannot be even claimed under other benefit scheme of Rashtriya Arogya Nidhi (RAN) which often rejects the application on the basis that they are already covered under PM-JAY²². The scheme of RAN was aimed to aid people below the poverty line to a maximum amount of Rs15,00,000. Further to rectify this anomaly, there was a proposal on the part of Union Health Ministry to rectify the same which was eventually rejected²³.

Exclusion under PM-JAY Scheme on the basis on geographical location: While the scheme is in place treating the citizens of the country as one homogenous group, this is not often the case in practical setting. The citizens in each State are situated at a different standpoint where different set of attention is required for better implementation of PM-JAY scheme. This could be understood when we look at how the scheme has been implemented in various States after its inauguration. It is commonly observed that the States with higher capita income has been able to reach a large set of beneficiaries under the scheme while the States with low per capita income are able to reach very less percentage of the total beneficiaries who can claim under the scheme. This is because lower per capital income in these States

18 The Hindu Business Line, <https://www.thehindubusinessline.com/economy/policy/restrict-ayushman-bharat-to-the-private-sector-ima/article29550117.ece> (last visited Aug 14,2022).

19 NC Saxena, *Socio Economic Caste Census: Has It Ignored Too Many Poor Households*, 50, JSTOR, 14, 14-17, 2015.

20 Nidhi Sharma, *Acute Encephalitis Syndrome: Only 36 make use of Ayushman Bharat*, The Economic Times (Aug 13,2022, 7PM), <https://economictimes.indiatimes.com/news/politics-and-nation/acute-encephalitis-syndrome-only-36-make-use-of-ayushman-bharat/articleshow/69951606.cms?from=mdr>

21 Nidesh Sharma, *Ayushman Bharat Awareness 80% in TN, barely 20% in Bihar and Haryana*, The Economic Times (Aug 13, 2021, 7:49 AM), <https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/ayushman-bharat-awareness-80-in-tn-barely-20-in-bihar-and-haryana/articleshow/70953467.cms?from=mdr>

22 The New Indian Express, <https://www.newindianexpress.com/nation/2019/dec/27/clash-of-medical-benefits-nhrc-seeks-report-from-health-ministry-2081366.html> (last visited on Aug 13, 2022)

23 The Economic Times, PTI, *NHRC Seeks Report Over Ayushman Bharat Beneficiaries not able to avail High-cost Treatment under RAN*, <https://economictimes.indiatimes.com/news/politics-and-nation/nhrc-seeks-report-over-ayushman-bharat-beneficiaries-not-able-to-avail-high-cost-treatment-under-ran/articleshow/72979534.cms>, (last visited on Aug. 13, 2022).

S. Manju Priya

has resulted in lower establishment of private hospitals by the insurance companies²⁴.

Conclusion and Suggestions

The bold move through NHP, 2017 taken by the Modi administration is indeed a step in the right direction; however, there is a need to achieve a recommended amount of 5% in GDP for health care so that there is “equity in access” which in turn helps in realizing universal health coverage in actual practical setting. As discussed earlier, there is an urgent need as stressed by the Prime Minister on several occasions to take steps in curbing air pollution and to provide for basic sanitation facilities which can work as a precursor to good health practices. Further while the scheme of Ayushman Bharat now into 3 years after its implementation is fairly doing well in providing millions, the very needed insurance on their expenditure for health concerns and treatment, this burden has not been lifted but rather shifted to the shoulders of government. Thus, there is a need to have proper channel and procedure to regulate the steps of ‘strategic purchasing’ on the part of private players so that there is no malpractice due to non-enumeration of list providing for what medical conditions or treatment or tests are covered under the NHP, 2017.

Though India has been ranked so low in the list of countries to spend on healthcare, there is much hope in recent times as over the last couple of decades that there have been various ambitious schemes such as Ayushman Bharat and PM-JAY to improve the government’s

capacity to meet the hospital expenditures of the below poverty line population. While PM-JAY scheme which is based on an insurance model has been moderately successful, however, the main problem that still remains to be tackled is the issue of out-patient expenses inclusion into the scheme. Thus, the whole idea to reduce such medical expenditure without addressing this issue won’t bear any fruit in the long run of the scheme as it will continue to remain as fundamental absurdity with most of the population relying on private healthcare for their treatment. This is because in India there has been more death due to poor health care quality than by the lack of access to such healthcare; thereby confirming the assertion as to why there is a common wave of very low faith in the public health care system in the country. Further the current trend in PM-JAY in determining the beneficiaries using the SECC 2011 database is flawed in itself and thus won’t succeed in the aimed wholesome health coverage to the most vulnerable. Thus, it needs an urgent amendment. Also, even if this anomaly is rectified there is an urgent need to sensitize and create awareness among the public of beneficiaries who have received the card under PM-JAY to make them avail the scheme through the proper channel. Only such awareness will result in the better implementation of the Scheme. However, despite all the shortcomings, it is currently the most ambitious plans with the highest financing so far and thus it is expected to grow with the NHA being transparent about their findings on the functioning of the Scheme.

²⁴ Mitra Chaudhary and Pritam Datta, *Private Hospitals in Health Insurance Network in India: A Reflection for Implementation of Ayushman Bharat*, National Institute Of Public Finance And Policy (2019), <https://ideas.repec.org/p/npf/wpaper/19-254.html>