Gender and Economic Policy Discussion Forum

Unpacking the Gendered Implications of Ayushman Bharat

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HIGHLIGHTS / KEY POINTS

- Ayushman Bharat's commitment towards universal health coverage means having three components. One talks about the health care, second about the financial protection apart from improving the access by roping in the private facilities, third is fundamental restructuring in the manner that the beneficiaries can access health services at the primary, secondary and tertiary health care levels.
- Ayushman Bharat is an effort in the direction to tap the resources that are available in the private sector, so that the available resources could be tapped for utilisation of poor and vulnerable sections coming to the public sector, so as to empower the beneficiary.
- The government spending on free health care as a percentage of GDP is extremely negligible as compared to most countries worldwide. The country spends only 1.25% of its GDP on health care which makes health care as one of the most underperforming ecosystems overall. The government data suggest that about 63% of the people have to pay for their own health care and hospitalisation expenses and are not covered under any health protection scheme.
- Ayushman Bharat as any other scheme relies on heavy documentation to be able to prove oneself as the 'beneficiary'. When schemes that rely so heavily on the proof of being a deserving citizen, there is marginalization that happens for those a) who do not stay with families b) do not have fixed addresses, proper documentation c) do not have citizen identification and d) have always been stigmatized by the public health system because they are seen as the unclean vectors of infections for instance the HIV.

Ayushman Bharat has been called for as the largest health care scheme in the world and is supposed to be offering India's 50 crore population, Rs 5 lakh for in-patient hospitalisation. The idea of the scheme has apparently been to address the rising out of pocket expenditure. As per one report, there is staggering 50.6 million people who slipped below poverty line between 2004 and 2014, due to pocket expenditure on health care. Another report on the Global burden of disease study reveals that India ranks 145th out of a total of 195 countries in term of quality and access to health care even behind countries such as our neighbours like China, Bhutan Srilanka and Bangladesh. There has been another challenge that has been posed by emergence of new medical industries and biomedical markets. There has been no systematic framework for gender analysis of the biotechnologies in the level of areas of health related issues, practice and research such as clinical trials, commercialisation of fertility, vaccines, contraceptive technologies, surrogacy, uterus transplant, stem cell therapy, eggs donation etc. Gender is intrinsic in this enterprise as gendered bodies are source of biological material reproduction and also at the site of deployment of these biotechnologies.

In the light of this, the forum attempted to generate a discussion around a critical analysis of the National Health Protection Scheme- Ayushman Bharat, the arguments and debates of implementation and actual public health realities. At the same time the attempt has also been to understand and uncover the gendered implications of the scheme, especially keeping maternal and reproductive health as well as women's bodies in mind. How do exclusions happen? What kind of gendered marginalization does this hold- both for the vulnerable populations as well as in terms of the future of the scheme? The effort has been to open the debate to critical perspectives around the inter-linkages of public health, gendered marginalization and perhaps an understanding of health and care at a larger level- in thinking of

questions of implementation and the future of health in India.

The speakers at the forum were K. Madan Gopal (Senior Consultant, Niti Aayog), Jashodhara Dasgupta (National Foundation of India), Rama Shyam (SNEHA) and Shefali Malhotra (NIPFP). The discussion was chaired and moderated by Renu Khanna (SAHAJ). The chair brought the attention to the difference between universal health coverage and universal health care and the role of the government from being providers of health care and not strategic purchasers of "health care". She emphasized the importance of quality of service delivery in keeping the women's perspective and gendered implications in mind.

The narrative around Ayushman Bharat

A 2015 survey by the NSSO presented some alarming statistics on the extent to which medical emergencies batter the finances of poor families[1]. The survey showed that hospitalisation expenses for critical ailments had shot up by 300 per cent over a decade. With over 80 per cent of the households not covered by any health scheme, most of the cost was met out-of-pocket. An estimated 6 million families sink into poverty each year due to hospitalisation. Ayushman Bharat, by targeting the 40 per cent of India's households at the lower rungs of the socio-economic ladder, tries to pre-empt this battering to family finances from sudden healthcare costs, by attempting to project ensure cashless treatment.

Gopal[2] spoke about the efforts that the government has been making to address the low expenditure on health. He explained whether at all there is a capacity to be able to expend, if one talks about allocation. His contention remains that even though every year the amount of allocation is increasing, however it has not been managed to be spent. It is because according to Gopal[3] even if 6% of GDP gets allocated to health expenditure and the public system, that money hasn't been able to be absorbed and utilized.

Talking about public (specifically rural) health structures, it has evolved in the last 50 years and has been able to create a maximum outreach through the support of the numerous ASHA workers throughout the country. At the same time the National Health Policy was made to further support the outreach system which emphasized the importance of women's health and need for gender mainstreaming with the following recommendations: enhanced provision for reproductive morbidities, health needs of the women, and women's access to health care needs. The focus has remained on Maternal and Reproductive child and healthcare when it came to women's health. However, Gopal[4] emphasized that the idea of the Ayushman Bharat (Pradhan Mantri Jan Suraksha Yojna) has been to focus on changing the health insurance landscape for the poor and vulnerable groups, including women. This can be evidenced by calculating the per capita expenditure on health and limited access available to the poor and vulnerable. Only the government hospitals are available which provide services free of cost or with nominal cost to the poor patients. And if a person goes to the private sector then one has to pay, whether poor or rich. At the same time there is an excessive burden on the government hospital, for instance beds aren't available for most of the time. Gopal's contention is that the resources available in the private hospital should be tapped, such as the beds in private hospitals are not being utilized. Gopal argues whether we can tap these un-utilized beds spared in the private sector and extend it to the poor. This is the kind of empowerment that is aimed for within the scheme, according to Gopal. However the question remains that whether these measures will improve women's access to health care, keeping in mind the various societal issues that still need to be addressed. The status of women, prevalence of gender-based violence, early marriages leading to early pregnancies are issues that need to addressed, before one can see changes in the patterns of women's health. This is because the general tendency still remains to invest and spend on health concerns of the male members of the family as opposed to women's health. The women and girls get the last chance to any kind of investment.

Gopal argued that despite legal framework and schemes for girls and women, there still exist gaps in implementations of these. Out of pocket payments for health care costs and pushes households towards poverty. And this stands true for even a middle class family, for instance if someone has an ischemic heart disease, the cardio vascular problem or cancer, the family is pushed back by 10 years in their economic realities. Our health is characterised by large inequalities, gaps in the public health providers and quality of health services. At the same time, the NSSO data shows that 80% of the population in the country do not have the health protection. Because there is no health protection, therefore there is dependence on others. The NSSO data tells us that more than 17% of Indian population spend its 10% budget on health services and catastrophic health care expenditure, which pushes the family to debt, 24% in rural areas and 18% in urban areas.

Gopal[5] explained then, that the scheme is a progression towards promotive, preventive, curative

palliative and rehabilitating mode through health awareness system, by targeting the sub health centre. The scheme will act as a provisioning for financial protection for secondary and curative care and also launch the access to health and wellness centres at the primary level. The system of providing preventive and curative care would stand as the base and the Pradhan Mantri Jan Arogya Yojna will take care of the secondary and tertiary health care system. Primary health care would essentially be comprehensive.

The core features remain that it will cover the Rs 500,000 per family per year, over 10 crore poor and vulnerable families, through cashless benefits throughout the country. Gopal described that as they are trying to rope in the private hospitals implying that the treatment will be cashless and paperless, that neither the patients have to sign any paper nor the hospitals have to maintain any paper for the scheme. There is no limit on the family size. What remains excluded from the scheme is out-patient care, individual diagnostics (for evaluation), drug rehabilitation programs, cosmetic and fertility related and transplants involving organs etc. At the same time, Gopal also mentioned that some of the packages like the hysterectomy, C-section, difficult procedures for women are reserved only for public sectors, so that the adverse selection in the private sector can be avoided.

In talking about the models of implementation, some states are going though the insurance, hiring of insurance agency covering the risks. The other is trust and assurance model that means if the patients are admitted based on the claims generated by the hospitals, claims will be paid. The third is a mixed model, that is part of the file is accessed through insurance model and rest to the assurance model. Under any mode, the central government share and the premium is the actual cost and the maximum ceiling is decided by the Government of India.

Will Ayushman Bharat cover the health care of women, is a question that remained. For the past six years, RSBY (Rashtriya Swastha Bima Yojana) data shows that the hospitalisation ratio was queued towards the females. Data shows that women are coming forward and getting themselves treated. Even Ayushman Bharat's data says that the utilisation by women is around 54% than male patients in surgery as well as the medical science. With awareness and making available the resources the scheme has the power to empower the beneficiary, remains Gopal's assertion.

Critical Gaps and exclusions: Lessons from the past

The key objective of any health insurance programme[6] is to protect individuals from income shocks that entail an unexpected event like an illness requiring lumpy expenditures to be incurred without prior notice. Due to the abysmal public spending of about 1.15% of GDP on health, it is individual households that bear the brunt of the expenditures accounting for almost 67% of the total health spend. Given that 93% of our workers are in the non-formal sector with no certainty or reliability of income flows, the government has been taking the responsibility of paying the premium on behalf of the poor and vulnerable. While in 20 states, such financial arrangements are made through the intermediation of commercial insurance companies, about three states have established government-owned trusts and five have a combination of both. In 2008, the Rashtriya Swasthya Bima Yojana (RSBY) was launched providing annual insurance cover for Rs 30,000 for a BPL family. Evaluation studies of RSBY show that despite the lapse of a decade, only 3.6 out of the 5.9 crore families have so far been covered. With the average claim ratio at about 33%, the scheme is reported to not have had any impact on reducing out-of-pocket expenses. The reason for such poor outcomes is access to good quality care[7].

Dasgupta[8] talked about her perspective, from her prior experience within the Planning Commission's level expert group on universal health coverage, platforms like medico- friend circle and the Jan Swasthya Abhiyan. She spoke about the high level expert group on universal health coverage, set up by the Planning Commission in late 2010 and it was meant to provide the report by 2011. The mandate required mapping of human resource requirements, norms for ensuring access to quality services, defining the roles of public and private sector and recommendations on necessary reforms for improving efficiency and accountability of the health system, in order to obtain universal health coverage. The expert group was also meant to give the outlines as to how communities, panchayati raj and local bodies, NGOs and the profit sector could participate in this entire endeavour and also suggest reforms in policies about drugs vaccines and other essential equipments. And finally there was the big question which was what would be the role of health insurance sector for the universal access to the services and how could subsidiary be given to the poor and ensure that how the entire out of pocket catastrophic expenditures could be avoided. The expert group came out with the following recommendations and

definitions; that universal health coverage meant three things: it meant health care, health coverage and health protection. Care was meant to provide treatment at services, coverage was about making it affordable and totally avoiding catastrophic expenditure and protection was actually taking a larger view of social and political determinants of health which is not limited to hospital care and sickness and disease but includes all the other policies that are made by state agencies which either enhance people's health or actually cause adverse outcomes.

The expert level group talked about equitable access regardless of income, social status, gender and caste relations and doesn't aim to disqualify people. The recommendations were focussed on providing quality and how the current health sector could be reformed and improved in order to ensure that there are all kinds of care including promotive and preventive but of course curative and rehabilitative as well. The group put a lot of emphasis on the wider determinants of health, to flag the question of protection that there are actually other factors which operate outside of the health system not controlled by the Ministry of health or the health department but which do have very strong and an immediate impacts on the health of population. Finally, the committee felt that the government has to be the guarantor and the enabler if not the only provider of health and related services.

Expanding on the kind of public health system in India, Dasgupta[9] spoke about the challenges of such a system. There is the Central Government Health Services, then an entirely separate stand alone set of services for the armed purposes, another set of services for the employers which is within the ESIC system, then a vast and undulated private health system and finally there is the "Public Health System". The per capita investment in each of these is widely different. For instance, in the CGHS per capita investment by the government ranges to 10,000 per year by old estimates, whereas the per capita investment in the public sector is Rs 300 per year per head. So in light of this diversity and about single tax based universal health coverage system, the expert committee recommended that there should be a mandatory deduction from all tax bearers of all employed people and it should be pooled and of the total quantity of money thus received, 70% must be ring fenced for strengthening comprehensive primary health care.

The expert group unequivocally emphasised avoiding insurance as the root. It stressed that there must be a consolidated and strengthened public health provisioning which would mean that army hospitals, CGHS clinics, ESIC hospitals would become open and available and accessible for all the citizens of this country. As of now, entry is restricted at the other health systems which are exclusively meant for the specific categories of citizens and creates inequitable health access and health outcomes.

Unfortunately, the 12th five year plan uncritically endorsed the RSBY model with a plan to expand it and even though the NSSO data clearly indicated that out of pocket expenditure was overwhelmingly for out patients cost, drugs, tests and procedures, the emphasis continued to be on hospitalisation. With the evidence being ignored, there was an unregulated largely unethical and sometimes corrupt private sector that continued to profit from the RSBY insurance claims. Because of this exclusion, the poor got excluded. Also the socio political realities of groups were not understood in the design and implementation and also in another state scheme it was found that the poor actually have less than 1% utilisation[10]. So, basically then it shows how a public funded health insurance scheme, within which hundreds of crores of tax payers money would be given for insurance staff. They would actually have the mandate to ensure that there are low settlement rates because that is what insurance companies makes their profits out of; by denying and disqualifying people for the treatment coverage. Dasgupta also cites a study done in Andhra Pradesh which says that 25% of health budget was covering only 2% of the disease burden and 75% of the resources were going into private hospitals. Hence, public hospitals are being systematically under-resourced.

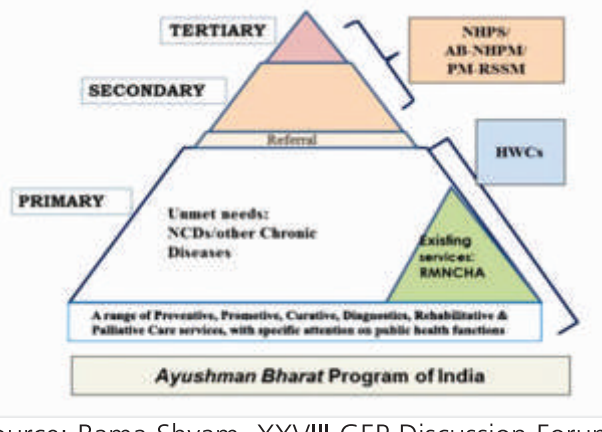
Talking about the exclusions under Ayushmann Bharat, Dasgupta talks about the arbitrary nature of the letter that will come from the Prime Minister's Office stating how a family may or may not be selected[11] and the person has no way of actually accessing that letter. Also there is a very key element of identity document and this actually means that people like women, migrants, people who have been through catastrophes like floods, fire, which keep happening to the poor, would not have their identity papers and would not be able to prove as eligible people or verify their family relationships (blood relations), because of the requirement of these documents. At the same time, it can be seen that the investment in the public hospitals retains the same low. This can be seen by how C-sections are not going to be included and thus remain left to these under-served, under-resourced, under-staffed public hospitals. There has been systematic disinvestment in PHC and sub-centre services over

the last several years and Dasgupta mentions about her work in Uttar Pradesh which shows that there has been under equipping, understaffing of these centres and now the budget actually means just Rs 200 per sub-centre. The question then remains, how and what kind of care, will the health and wellness centres (under the Ayushman Bharat scheme) provide?

The significance of the Referral System

Experts suggest that the success of the scheme will depend upon focusing on 'health' and not merely sickness. Reducing disease burden through robust primary care, focus on allied determinants of health, quality outdoor and indoor services in public hospitals and incorporation of indigenous school of medicine and technology will all help in checking farcical and wasteful expenditure. If some of these funds are allocated to revive/strengthen the system, patients will avail comprehensive health care nearer to their homes rather than being referred to far away urban private operators for on-demand secondary/tertiary care with added cost of transport, stay/loss of wages of attendant(s) etc.

Shyam[12] elaborated on SNEHA's (acronym for Society for Nutrition, Education and Health Action) work, which is a 20 year old implementing organisation in Bombay working very closely with women, children and the public health care system. All the founding members of SNEHA were women doctors who emerged from the public health care systems and decided to form the organisation to be able to take their experiences back to strengthen the public health care system. SNEHA has attempted to address and strengthen the referral mechanism and how unfortunately referral is still not being addressed within the purview of the given definition of protection, coming in the form of universal insurance.



Source: Rama Shyam, XXVIII GEP Discussion Forum, Nov 2018

Shyam argued for the importance of beginning with adolescent health because SNEHA as an organisation has looked at the continuum of care approach starting with adolescent health milestone thereof and then going on talking about maternal health, child born health, abortion etc. They look at adolescent health through the state document called Rashtriya Kishore Swasthya Karyakram (RKSK), which has had provisions and a vision towards adolescent health care. There has been sub-zero implementation of the RKSK operation framework, especially in the urban areas.

In talking further about the line of thinking of SNEHA, Shyam[13] talks about the significance of frontline health workers, who are by and large women themselves. At the same time, there is no indicator in India heath profile that talks about percentage of referral processes institutionalised within the system. She asks, what happens to the movement from the primary health care system to the secondary and to the tertiary? What are the regulatory mechanism in place to understand that overloading and burdening is not happening at the tertiary level and what are the mechanisms to understand that there are cases that are optimally been taken care of at the primary and secondary level?

Shyam[14] points out to the grim indicators of violence against women and how for SNEHA one of the approach is 75% in public health system staff addressing and responding the cases of gender based violence. So if a woman comes to the hospital with a broken arm, it is also important to understand why the arm has broken? And therefore what are the services due to her, not just first aid in terms of fixing a fracture. Some of the results that SNEHA has arrived at shows how universal health coverage needs to focus on the levels of anaemia especially among young girls, which is no way covered under universal health coverage or insurance. As this actually gets counted largely as out of pocket expenditure, for instance in severe cases of anaemia one injection costs Rs. 2500 and three shots would mean Rs. 7500. And this for instance can be understood from the case of a family living in the eastern suburbs of Bombay with an average monthly income of Rs. 8000, with very high levels of severe anaemic conditions among young girls and pregnant women.

Shyam explained the positive outcomes of working on the referral system and spoke about the SNEHA model. It is called the MCGM (Municipal Corporation of Greater Mumbai) and the SNEHA referral model. It is a successful model that has run across 7 municipal corporations including the one in Bombay and other peripheral also including the Thane Municipal

corporation wherein it has been observed that enhancing clinical and behavioural trainings, skills of health care providers and trainings to the link workers to enable them to incorporate maternal and new born has really worked. So making it a simultaneous emphasis on building awareness of health seeking behaviour in the community, while at the same time working assiduously with the public health care system and to work towards convergence, strengthens the system. The convergence that is foreseen in the referral model is to stimulate communication across the structure. Because usually the primary health care professionals as well as the secondary system aren't aware of where to refer people, which often has lead to the overburdening of the tertiary sector on a daily basis, with people running to a tertiary hospital without knowing what exists at the secondary facility. Thus Shyam[15] critically examined the dearth of machinery in the public health care systems and argued that the machinery be oiled consistently and made to work, instead of thinking of investment in the private facilities.

Measures towards regulation and quality health care

The Ayushman Bharat scheme consists of two separate parts. One is the creation of 150000 "Health and Wellness Centres" which are primarily the old primary health centres, and for each of which the 2018-19 Union budget allocates only Rs.80000. The other part is the Pradhan Mantri Jan Arogya Yojana (PMJAY), which is the old Rashtriya Swasthya Bima Yojana (RSBY) in a new avatar. This new scheme is supposed to cover 10 crore families (or 50 crore persons) and provide insurance cover up to Rs.5 lakh per family per annum. It is being touted as the largest health insurance scheme in the world. And yet the amount earmarked for the scheme in the 2018-19 budget is just Rs.2000 crores, which comes to Rs. 40 per person per year. Even if the states share is additionally taken into account, the per capita provision comes to a mere Rs.67 (Patnaik, 2018)[16].

Malhotra[17] talked about the quality of health care that is being mostly denied and dismissed when it could have been easily provided for. It is important to understand this in the context of Ayushman Bharat scheme, being argued as the largest health care scheme and which is purchasing health care. It has greater power to regulate quality of care. She explains that one of the key priorities of PMJAY is women and children, which has two aspects to this; one is providing access and the other is providing access to quality care.

Malhotra[18] shares that PMJAY addresses the problem of access to some extent by making it easier for women to reach hospitals by removing any cap on family size. However, this comes with its own set of problems even though it has attempted to address at least that the women reach the hospital in the first place. But the second aspect of providing quality care is not very focussed in PMJAY. It needs focus and there are many lessons from existing schemes which focussed on maternal and child health. As an example in 2017, the Comptroller and Auditor General of India published a report of performance audit of reproductive and child health under the National Health Mission. They found many deficiencies in the infrastructure such as availability of basic facilities such as water, electricity, hygiene of the reproductive and child health centres, low availability of technicians. So although there are machines available but there are no operators to operate those machines and those machines lay idle. Then there is non-availability of essential drugs, prescriptions happens without any checks, medicines dispensed without checking whether they have crossed their expiry or not and without checking their quality. The report also found out that many hospitals do not have any internal quality assessment systems, do not report on key indicators; such as the number of still births, the number of complicated surgeries etc. There are a host of indicators which the hospitals do not report and the thrust of PMJAY should be on strengthening and reforming administration in order to provide quality care. She argues for the regulation of the private health sector which is also going to be playing an important role in this scheme and a control on the malpractices such as the large and unnecessary number of C-sections even when not needed. Many of private hospitals feel that they are getting way below the market price under the scheme and because of which there could be practices where they just prescribe unnecessary tests in order to plate the bills.

Malhotra asserts that the scheme ought to move towards promotive and preventive health care, in building primary health and wellness centres. Another aspect she mentions is about dealing with pure public goods in health and in the economic sense. To be able to control pollution, tackle drainage system, a big role can be played by the municipalities and the scheme needs to involve these to deal with the promotive and preventive aspect. Talking about her experience in Kerala, she says that the benefit packages which are being made, follows a very top down approach. There is no consultation either with patients or with hospitals. It is very arbitrary and the amount gets just sent. Many times these amounts are very low. Even small private clinics find it difficult

to be able to manage themselves within such low amount. Another big problem is there is a lot of delay in claim settlements, sometimes it takes up to three years to get their claim. Now for a Govt. hospital it can be easy to absorb that, but for a small private or even an NGO, they cannot sustain themselves if the wait is too long. Secondly the way the benefit packages are made, are a bit irrational. Continuing with the example of Kerala, she elaborated that, for instance if one wanted to get a knee replacement done so they will cover the surgery but they will not cover the implants. Then it is not free in the true sense. Also there are very rigid requirements, in order to be able to get the claim the amount. So there are a lot of road blocks for the smaller player or NGOs to actually come into the system.

Conclusion and Recommendations

The chair pointed that Ayushman Bharat and its scheme of things seems to have completely lost touch from the reality. The aim of Ayushman Bharat was to reduce out of pocket expenditure and therein lies the biggest flaw of this scheme for what is being covered is only secondary and tertiary hospitalization. At the same time when it is a known fact that the 67% of out of pocket cost is on patient treatment that is not being covered and out of which about 75% goes on medicines. So unless access to free medicines is geared up and medicines too have to expand its definition to include devices and essential goods like blood supplements in them, out of pocket expenditure is not going to reduce. The whole issue of JSSK (Janani Shishu Suraksha Karyakram) was actually a stepping stone to universalising maternal health. All deliveries and child care up to one year in public facilities was supposed to be cashless. And several studies have been done that are showing that they are not cashless. People are incurring out of pocket expenditure, even in JSSK public sector facilities, for instance women going to the public sector but being denied services and asked to go to the private sector.

- There has to be an increase in the health budget and that all publicly funded health insurance and coverage schemes must be merged.
- What is extremely important is building a gender perspective at the beginning, at the design itself and think about structural inequalities. What can be done to make designs gender sensitive, despite being aware of the structural inequalities across the country?
- PMJAY needs to think about regulatory mechanisms and focus on addressing the severe under-utilization of funds. Even in increasing expenditure, thought needs to be given to optimal utilization of funds.
- Finally, one needs to move beyond of having to equate the word gender with the word women and girls. Gender is not a binary, gender is a spectrum, it is a performative. So attention needs to be given to a range of genders and conversation and dialogue within it needs to be generated.

Endnotes

[1] https://www.thehindubusinessline.com/opinion/columns/slate/all-you-wanted-to-know-about/article25030717.ece
[2] Madan Gopal, XXVIII GEP Discussion Forum November 2018
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] K. Sujatha Rao (https://thewire.in/health/the-governments-previous-health-insurance-schemes-have-failed-why-should-the-new-one-work).
[7] Ibid.
[8] Jashodhara Dasgupta, XXVIII GEP Discussion Forum November 2018
[9] Ibid.
[10] Ghosh, S. 2018. Publicly Financed Health Insurance Schemes. Economic and Political Weekly. 53(23).
[11] She also reminds us that the socio economic caste census was done in 2011, for which there have been no public sharing or even validation of the findings.
[12] Rama Shyam, XXVIII GEP Discussion Forum November 2018
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Prabhat Patnaik (http://www.networkideas.org/featured-articles/2018/10/ayushman-bharat/)
[17] Shefali Malhotra, XXVIII GEP Discussion Forum November 2018
[18] Ibid.

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Prabhat Patnaik (http://www.networkideas.org/featured-articles/2018/10/ayushman-bharat/)

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Rama Shyam (SNEHA)

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Chairperson

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