



MAY 2019



GLOBAL AND NATIONAL PERSPECTIVES ON AYUSHMAN BHARAT YOJANA HEALTHCARE SCHEME

SPRF RESEARCH TEAM

ISSUE BRIEF

Contents

| | |
|---|-----------|
| Executive Summary ... | 1 |
| Introduction ... | 1 |
| Historical Perspectives Leading to ABY ... | 2 |
| Challenges ... | 3 |
| Reaching the Ayushman Bharat Yojana ... | 4 |
| Salient Features of Ayushman Bharat Scheme (ABY) ... | 5 |
| Funding and Related Issues ... | 7 |
| Key Fundamentals of Health Financing and ABY ... | 7 |
| The Road Ahead ... | 9 |
| Conclusion ... | 11 |
| End Notes ... | 12 |
| Bibliography ... | 12 |

If you have any suggestions, or would like to contribute, please write to us at contact@sprf.in.

© Social and Political Research Foundation™

Executive Summary

Ayushman Bharat Yojana is the latest health insurance scheme funded by the Government of India. This scheme has been designed to be more comprehensive in terms of the beneficiaries covered and services delivered, especially compared with past schemes such as Rashtriya Swasthya Bima Yojana. In fact, Ayushman Bharat Yojana subsumed the already existing Rashtriya Swasthya Bima Yojana, apart from borrowing its basic design. However, no past healthcare financing scheme in India has succeeded in covering all eligible beneficiaries or reducing catastrophic financial expenditure for the people.

This report does not simply aim to inform the readers of the features of ABY that sets it apart from its predecessors. It also delves into the reasons behind why the poorest segment of our population has been unable to avail even the most basic health services. It further provides historical context to the origins of Universal Health Care, including the World Bank's structural adjustment reforms and India's efforts to focus on the health of its population. The concepts of Adverse Selection, Moral Hazard, Risk Pooling, Information Asymmetry and Agency Relationship, and Epidemiological Transition Theory would further lend a better grasp on the fundamental issues of health financing, in order to understand the relevance of this new scheme for the nation.

Introduction

"Of all forms of inequality, injustice in health care is the most shocking and inhumane."

Martin Luther King, Jr

This paper seeks to undertake an exploration into the Ayushman Bharat Yojana (ABY), which is the latest government funded health care financing scheme to provide comprehensive healthcare to the poorest segment of India's population. India's poor face major structural barriers that prevent them from accessing and utilising even the most basic health services, let alone any specialised health cover (Forbes India; Ensor and Cooper 2004: 70-73).

To provide readers with the necessary context required for a non-partisan discussion surrounding ABY, this report begins with an exploration of the historical perspective surrounding healthcare, along with certain fundamental concepts. This will lend insight into the rationale, design, and context behind the Ayushman Bharat Yojana (ABY), leading to a careful examination of its merits and demerits, as well as the likelihood of its success in the long run.

Beginning with an outline of what Universal Health Care entails, this paper will draw attention to the differing perspectives regarding free healthcare. This will include a brief summary of key global events, including Structural Adjustment Reforms by the IMF and World

Bank, which shaped the dominant system of public health and healthcare seen presently in India. This report will further look at the five fundamental concepts (Adverse Selection, Moral Hazard, Risk Pooling, Information Asymmetry and Agency Relationship) central to the functioning of any health financing/insurance scheme, which would contribute significantly towards the success or failure of ABY.

An adequate understanding of the historical context would further assist in better analysing the specific features of ABY that set it apart from other health financing solutions, so as to complement the unique health care scenario of present day India, keeping in mind that the country is currently undergoing a rapid epidemiological transition (1).

Historical Perspectives Leading to ABY

International Perspectives:

According to the World Health Organisation (WHO) constitution, which came into effect in 1948 (WHO 2019), the ‘highest attainable standard of health’ was included as one of the “fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (WHO 2019). During the same year, the United Nations adopted the Universal Declaration of Human Rights (UDHR) during the United Nations General Assembly held in Paris (UN 2019). This document was the first to declare that fundamental human rights are to be universally protected, and as part of Article 25 within UDHR, health was mentioned as one of these fundamental human rights (Ibid).

In 1978, the World Health Organisation (WHO) and UNICEF organised a Conference on Primary Health Care in Alma-Ata, now known as Almaty, Kazakhstan (HHR). During this conference, a declaration known as ‘Declaration of Alma Ata’ was signed (Ibid). This declaration provided a framework to the member states on how to make primary health care, for all people in the world, a reality by the year 2000 (Topp and Abimbola: 1).

Ironically, the above efforts to promote adequate healthcare as a human right encountered considerable opposition from the medical community at large. The ongoing cold war created uncertainty about the seriousness of WHO to lead a rights-based approach towards health equity, while maintaining the image of being an apolitical entity (HHR). The idea of Selective-Primary Health Care (as opposed to Primary Health Care), based on cost-effectiveness approach was, thereafter, conceived in 1979 during the Rockefeller Foundation Conference in Bellagio, Italy (Topp and Abimbola: 1). The next blow came during the 1980s, when policies known as Structural Adjustment Reforms were put in place by the World Bank and the International Monetary Fund (IMF) to bring about public sector restraint and promote market based solutions around the world (Ibid). As a result, countries cut national investments to their health systems (Ibid). For developing countries like India, the World Bank advocated the introduction of the ‘user charge financing mechanism’ (2) as an agenda reform since 1987 (Bir 2000: 72). This led to catastrophic health expenditures (Ghosh 2011: 63).

National Perspectives:

The Constitution of India lays down health as a responsibility of the state governments (Arya 2012). Hence, while the central government sets the priorities related to healthcare, it is the responsibility of the state governments to actually deliver healthcare services (Arya 2012). Relatedly, under article 47 of the Constitution, states not only have to take appropriate steps to ensure that the right to healthcare is properly met, but that appropriate nutritional levels and living standards are ensured (Hazarika et al 2009: 199). Further, Part III and Part IV of the Constitution provide guarantees and policy directives for the right to health and healthcare (Ibid). The Supreme Court of India has reiterated in several judgments that the right to health is critically linked to the right to life under Article 21 (Ibid).

Along these lines, the Health Survey & Development Committee (also known as the Bhore Committee) was appointed in 1946 (NHP India). It laid emphasis on combining curative and preventive medicine at health facilities of all levels (NHP India). It also provided detailed recommendations for the 'remodelling' of health service delivery in India, including the development of Primary Health Centres (PHCs) in 2 stages (NHP India):

- Short-term measure – one primary health centre for a population of 40,000 people. Each PHC was to be manned by 2 doctors, 1 nurse, 4 public health nurses, 4 midwives, 4 trained dais, 2 sanitary inspectors, 2 health assistants, 1 pharmacist and 15 other class IV employees. A Secondary health centre was also envisaged to provide support to PHC, and to coordinate and supervise their functioning.
- A long-term programme (also called the 3 million plan) of setting up primary health units with 75 bedded hospitals for every 10,000 - 20,000 people, and secondary units with 650 bedded hospital, again regionalised around district hospitals with 2500 beds.

It is apparent from the above recommendations that an integrated approach with a variety of services and some form of 'task-shifting' (i.e. inclusion of skilled health workers such as assistants and midwives to suit resource-constrained settings) was put forward by the Committee. An equally important emphasis was put on preventive services.

Challenges

However, almost 70 years later, the above vision for providing comprehensive healthcare in India remains largely unfulfilled. As far as financing is concerned, India spends only 1.4% of its GDP on healthcare (Mondal 2013: 53). Similar figures are reported by other sources as well - according to the 2017 National Health Policy report released by the Ministry of Health and Family Welfare of the Government of India, the government spends 1.15% of its GDP on healthcare (Government of India 2017: 5). Consequently, according to the OECD, the government spent 1% of GDP on health in India in 2015 (OECD).

The public health system in India is organised into primary, secondary (district level) and tertiary (specialised high level care) levels (Chatterjee et al 2013: 1). Primary Health Centers

(PHC) constitute the backbone of the basic primary level care, with 23,458 primary health centers in India (Ibid). However, these underfunded public health facilities are often overcrowded and mismanaged. On the other hand, despite its massive expansion, private sector healthcare remains fragmented, unregulated and exorbitantly priced, leading to catastrophic health expenditure for those opting for these facilities (Kumar 2014). Furthermore, it has been reported that out of pocket payments for healthcare leading to catastrophic health expenditures pushed approximately 8% of Indians below the poverty line (Pandey et al 2018: 22).

Reaching the Ayushman Bharat Yojana

While in most developed countries, healthcare for the poor is subsidised, yet this group is integrated in the same pool as the non-poor, in low and middle-income countries like India, there are different pools for different segments of the population with unequal entitlements across various national level schemes (WHO 2019). Some examples of various national health schemes in India are ESIS (Sarwal 2015: 29), CGHS (ICRIER: 1), ECHS (ICRIER: 1) and RSBY (Dror et al 2012: 56). Once such separate schemes are established, it becomes very difficult to do away with them or to merge them (WHO 2019).

One of the most important erstwhile schemes, the Rashtriya Swasthya Bima Yojana (RSBY), was started by the United Progressive Alliance (UPA) government in 2008. This health insurance scheme was initially for below poverty line (BPL) families, but was later expanded to include informal sector workers like domestic helps, street vendors, and porters (Kalbag 2018). An annual insurance cover of Rs 30,000 per family was earmarked (Ibid). Though it was actually intended to cover 70 million families by the year 2017, it failed to achieve that target, and only 36.3 million families were enrolled by March 2017 (Ibid). The main reason cited for RSBY's failure of leaving 40% of its intended beneficiaries uncovered was the lack of good quality care (Mukherjee and Arora 2018: 387). This was further attributed to the absence of more stringent empanelment rules for hospitals so as to bring more facilities under the ambit of the scheme. However, the conditions for delivery of good quality care, especially in Northern India, remained unfavourable (Mukherjee and Arora 2018: 387). The failure resulting from a lack of information campaigns in order to raise awareness among beneficiaries, coupled with the inability to formulate regulatory mechanisms for private empanelled hospitals, adversely affected the functioning of RSBY (Mukherjee and Arora 2018: 387). Furthermore, only 1% of the total annual government spending on health was allocated towards the running of RSBY (Lahariya 2018: 501).

Against this background, Ayushman Bharat Yojana (ABY) was launched by Prime Minister Narendra Modi in September 2018 (Dhaka et al 2018: 3152). The government envisages increasing public health expenditure to 2.5% of the GDP by 2025 in order to achieve the intended healthcare objectives (Bakshi et al 2018: 3).

Salient Features of Ayushman Bharat Scheme (ABY)

The Ayushman Bharat Scheme aims to tackle healthcare in a holistic manner by covering the primary, secondary and tertiary care systems. It has **two major initiatives**:

- The **first initiative** is to strengthen universal comprehensive primary healthcare by creating **Health and Wellness Centres**. These centres aim to provide for preventive as well as curative services, including those for non-communicable diseases and maternal and child health. Essential drugs and diagnostic services are to be provided free of charge at these centres (Bakshi et al 2018: 2). Almost 1.5 lakh Health and Wellness Centres are intended to be created across India (Chowdhary and Mukherjee 2019: 5).
- The **second initiative** is **Pradhan Mantri Jan Arogya Yojana (PM-JAY)**. This is a national health protection scheme to provide health insurance for secondary and tertiary care to at least 40% of India's poor and vulnerable population (Dhaka et al 2018: 3152). The Socio-Economic Caste Census (SECC) database is being used to identify and target the beneficiaries (Zodpey and Farooqui 2018: 328). The scheme provides cover for all secondary and many tertiary hospitals with a cover of Rs. 5 lakh for each family, with no restriction on family size and age (Bakshi et al 2018: 3). All pre-existing conditions are covered, and pre and post hospitalisation expenses including transport allowances are provided (Bakshi et al 2018: 2). The beneficiaries of this scheme can take cashless treatment from any public or private empanelled hospital anywhere in the country (Robert 2018). Payment for treatment can be made to the hospital on a package rate basis, which have been laid out in advance by the government (Robert 2018). In every empanelled hospital, there will be an 'Ayushman Mitra' who will be responsible for coordinating the treatment of the beneficiaries at the hospital (Goyal 2018). The Ayushman Mitras will be trained on every aspect of the Ayushman Bharat Portal and will provide key information to patients after verifying the identity of beneficiaries from the QR code given on the letters issued to each of them. They will also be tasked with keeping the state agency informed when a patient gets discharged from the hospital (Goyal 2018).

For the purpose of dissemination of information regarding the ABY scheme, in addition to recruitment Ayushman Mitras, a massive campaign has been started to involve gram sabhas in order to identify the beneficiaries, and to impart health education (Bakshi et al 2018: 2). In fact, April 30, 2019 will be observed as Ayushman Bharat Diwas, when all rural beneficiaries will be explained the details of the scheme, so as to ensure that no beneficiary misses out on the opportunity to be linked to a designated Health and Wellness Centre (Bakshi et al 2018: 2).

Digitisation of healthcare is also a unique aspect of ABY. Tim Kelsey, CEO, Australian Digital Health Agency, was given the 'Torchbearer of the Ayushman Bharat' Award at the ABY conclave held in New Delhi in February 2019 where he stated,

“Paper-based healthcare has failed – it is not efficient, cannot keep up to the large amount of data and track trends. It is unable to support precision medicine. We need to work much harder on creating a clinical culture to adopt technology to ensure safety, quality and equity in healthcare. We also need to empower people who now do not question the recommendations of the doctor. Digitizing healthcare will also help it make more accountable and transparent.” (BioSpectrum).

At the same conclave, Kamal Narayan, the principal founder of India Health and Wellness Summit Initiatives remarked,

“Health doesn’t discriminate between rich and poor. Ayushman Bharat is a crucial step that the government of India has taken for creating a happy and prosperous country; the possibilities are immense” (BioSpectrum).

However, not all share this enthusiasm. While ABY has been hailed as a landmark mission by the current government, and the Bharatiya Janata Party (BJP) has termed it as ‘Modicare’, there has been much reservation about this scheme from the other side of the political divide, as well as from state leaders for whom ABY remains a thorny issue (Ghosh 2018). Some of the misgivings have been a result of the perceived funding of the scheme.

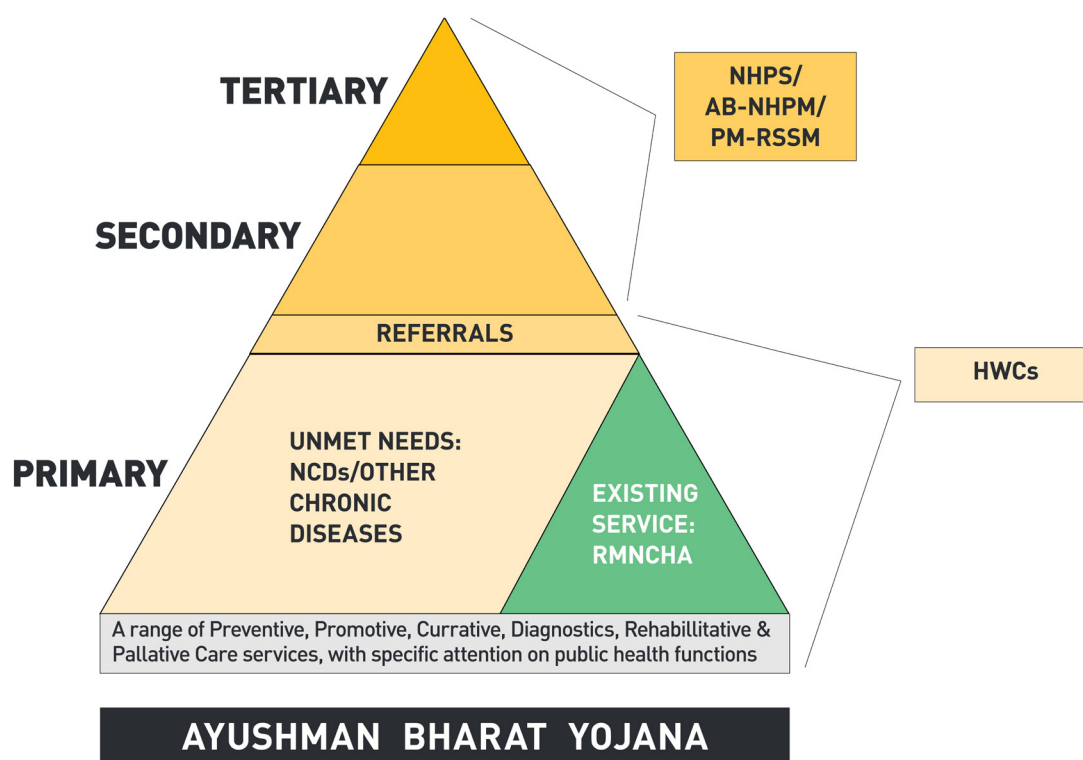


Figure 1: A recent depiction of the structure of ABY scheme (Lahariya 2018: 497)

(Key: In the above figure, RMNCHA = reproductive, maternal, neonatal, child health and adolescent; NCD = Non Communicable Diseases; HWCs = Health and Wellness Centres; PMRSSM = Pradhan Mantri- Rashtriya Swasthya Suraksha Mission; AB-NHPM = Ayushman Bharat- National Health Protection Mission; NHPS = National Health Protection Scheme)

Funding and Related Issues

The funding for the scheme is to be shared by the Centre and State in the ratio 60:40 in all states and Union Territories with their own legislature, and 90:10 in North Eastern states and the three Himalayan states of Jammu and Kashmir, Himachal Pradesh and Uttarakhand. Union territories without a legislature will be entirely funded by the Centre. Some states, however, have reached a consensus, allowing AB-NHPM to enter in 'alliance' with certain state programmes and health schemes. In Telangana, for instance, Ayushman Bharat will be in alliance with Aarogyashri; in Tamil Nadu, it will be in alliance with the Chief Minister's Comprehensive Health Insurance Scheme; and in Maharashtra it will be in alliance with the Mahatma Jyotiba Phule Jan Arogya Yojana (Ghosh 2018).

Some states have also refused the implementation of ABY. The Mamata Banerjee led West Bengal government is said to have been pulling out of the Ayushman Bharat Scheme after blaming the central government for taking the entire credit for the scheme, despite it being a 60-40 partnership between the centre and state government. They have raised complaints regarding the letters being sent out to targeted families by the central government bearing the photograph of Prime Minister Narendra Modi and the BJP election symbol, while making no mention of the state leader or the Trinamool Congress (Chanda 2019).

The Centre insists that pulling out at this stage may affect 60 lakh families in West Bengal, since the state's Swasthya Sathi Scheme covers only 50 lakh families while ABY covers about 1.11 crore families (Sharma 2019). Indu Bhushan, CEO of the National Health Agency (NHA), has written to the state government on January 11, 2019 regarding the distribution of letters to the beneficiaries being done as per the NHA guidelines, as well as the stipulated memorandum of understanding (MoU) which was signed between the Centre and the West Bengal Government (Sharma 2019).

Furthermore, the decision to include public-private partnership in order to empanel private healthcare providers and insurance companies has received considerable criticism from the opposition, and it remains a point of dispute. (Mazumdar 2018). However, owing to ABY's extremely large target population, the government has defended its move to support private sector involvement for the provision of services (Mazumdar 2018).

Key Fundamentals of Health Financing and ABY

The most important concern for financing healthcare based on insurance or a third-party payer is the risk of **moral hazard**. Moral hazard arises when consumers who pay only a small part, or none of the marginal cost of services, knowingly take more health risks or avoid taking preventive measures and present themselves to the health system with more health problems and of possibly higher severity (Shmanske 1995: 194-95). For example, smokers who are almost indifferent about quitting are more likely to not quit if they expect the costs of future smoking-related illnesses to be paid by someone else (Ibid). Apart from not

undertaking preventive measures, patients under moral hazard also consume more health-care than required, such as additional doctor visits and more days spent in hospitals (Ibid). During stakeholder consultations for the implantation of ABY, there have been many concerns that unnecessary expenditure due to moral hazard may not enhance the health of the individual, but would financially bleed the insurer i.e. the government (Ghosh 2018). It has been suggested that more emphasis has to be on preventive health component which is given by the Health and Wellness centres to reduce the challenges of moral hazard at tertiary care level -- the focus being the de-linking of primary and tertiary care (Ghosh 2018). Whether this de-linking actually results in an increased risk of moral hazard and to what degree remains to be seen.

Unlike moral hazard, **adverse selection** is pre-contractual information asymmetry. In simpler words, it refers to a situation where individuals have more information about their health and their health risk status as compared to their insurer (Shmanske 1995: 192-93). This information asymmetry i.e. one party knowing things that the other party does not, can lead to a greater number of riskier individuals acquiring insurance (Ibid). This leads to higher cost burden for the insurance scheme to cover the claims of the riskier individuals and the insurance premiums have to be raised to keep the scheme alive (Ibid). Individuals with lower risks would show greater reluctance to pay the increased premiums (as the insurer price their premiums according to average costs) and they would consequently be left out by either leaving the insurance scheme or not joining in the first place (Ibid). ABY, however, aims to cover all eligible individuals irrespective of age and pre-existing conditions, thereby avoiding the problem of adverse selection.

The **agency relationship** between a hospital and a patient can be described within a typical principal agent framework. The patient has to rely on the specialised knowledge of the doctor and there is an asymmetry in information about the treatment of the health problem. It is difficult for the patient to measure the performance of the hospital (Ludwig et al 2010: 292).

Information asymmetry also exists between the patient and the hospitals. ABY has tried to address this problem through the recruitment of Ayushman Mitras. As mentioned above, on Ayushman Diwas, every entitled person will be explained about the policy and linked to a Health and Wellness Centre. Also, referring back to Tim Kelsey's statement on digitisation under ABY, the issue of information asymmetry and agency relationship with implications on performance and quality have a greater likelihood to be better monitored and addressed.

The final fundamental issue is the concept of **Epidemiological Transition Theory**. As per this theory, a long-term shift occurs in mortality and disease patterns whereby, in a country, the era of pandemics of infection gradually recedes as the country becomes more developed, in terms of public health and medicine as well as food security, and the era of infectious diseases is replaced by an era of degenerative and man-made diseases that become the main cause of morbidity and the primary cause of death (Omran 2005: 736-737). In a 2018 article published in The Lancet, it was reported that, as of November 2017, the burden of disease

due to non-communicable diseases and injuries was greater as compared to communicable diseases in every state of India (Bhargava et al 2018: 1). This was based on the first assessment of the 'State-Level Disease Burden Initiative' that used the framework of the 'Global Burden of Disease Study' to assess the trends in major diseases/risk factors for every state of India between the years 1990 and 2016 (Bhargava et al 2018: 1). To address the feasibility of treatment for these widely prevalent non-communicable diseases, the government has negotiated treatment packages for ABY, which will be 15-20% lower in price as compared to prices under CGHS (MyLoanCare).

The Road Ahead

As per the National Health Authority Portal 2,89,63,698 cards have been issued; 15291 hospitals have been empanelled for secondary and tertiary care and 1835227 beneficiaries have been admitted to them (NHP). Indu Bhushan, ABY CEO, says,

“Every year, 6 crore people fall below the poverty line due to catastrophic health expenditure. Besides, 40% of poor people do not have access to private healthcare that provides 70% of the services. 33 states on board for rolling out the program and Punjab and Kerala are going to start soon. We are yet to have an official word from West Bengal on withdrawing from the program. The states also have the option to expand the beneficiary base it wants to cover – in that way, Ayushman Bharat has the possibility of covering as many as 14 crore families, more than the targeted number.” (BioSpectrum).

However, some critics have pointed out that the amount of funding that has been planned for ABY (Rs. 2,000 crore for 2018-2019) is not enough to make this scheme function for 40% of India's population, and that the amount of funding actually required would be over Rs. 18,000 crore (Knowledge @Wharton). Indu Bhushan has stated that the current amount of ABY funding remains only notional, as it is a usual practice for a placeholder figure to be released whenever a new scheme is launched (Ibid). He further said that “There is no cap on funding for this project, and we will go back to the ministry for more resources as and when required” (Ibid). In fact, it is claimed that his department has already asked for an additional Rs. 4,000 crore for ABY this year (Ibid).

In addition, to address the concern of healthcare providers regarding the rates of many medical and surgical procedures being too low to be viable, he says that “based on data and evidence, if we find that the prices fixed by us are indeed low, we are open to reviewing them” (Ibid).

Finally, we need to ask why healthcare is so expensive in the first place. Are the prices charged by providers (mostly private in India) for healthcare services actually worth the costs? Thinking about these questions is important because a new health financing scheme

such as ABY should not just feed into the current pattern, especially if it is plagued by inefficiency and unreasonable levels of supplier-induced demand, for the scheme to be sustainable and offer a course correction in the healthcare landscape of India. Indu Bhushan has mentioned that “We are looking at prices which will not only cover 40% of the population, but will also be a benchmark for the remaining 60%” (Knowledge@Wharton). This is important because it points to efforts to prevent cost escalation by trying to establish a ‘yardstick’ for prices, which could be beneficial to people not just covered by ABY, but also those in higher income brackets who may face unexpected catastrophic healthcare expenditure during their lives.

This brings us to the question of how much and how long the current momentum regarding ABY is likely to be maintained. If we go back in history, we see that the RSBY, which was launched by the UPA government in 2008, lost its momentum after the UPA lost the subsequent election (Kalbag 2018). In this context, it is pertinent to note that, in its election manifesto of April 2019, the Congress Party criticised the ABY scheme, and has clearly stated that “We are of the firm belief that the insurance based model cannot be a preferred model to provide universal healthcare in our country” (The Wire Staff 2019). The party has promised to “vigorously promote and implement the free public hospitals-model to provide universal healthcare” (The Wire Staff 2019). In essence, the Congress is promising a total reversal of the Ayushman Bharat Scheme if it comes to power (The Wire Staff 2019). It is imperative to

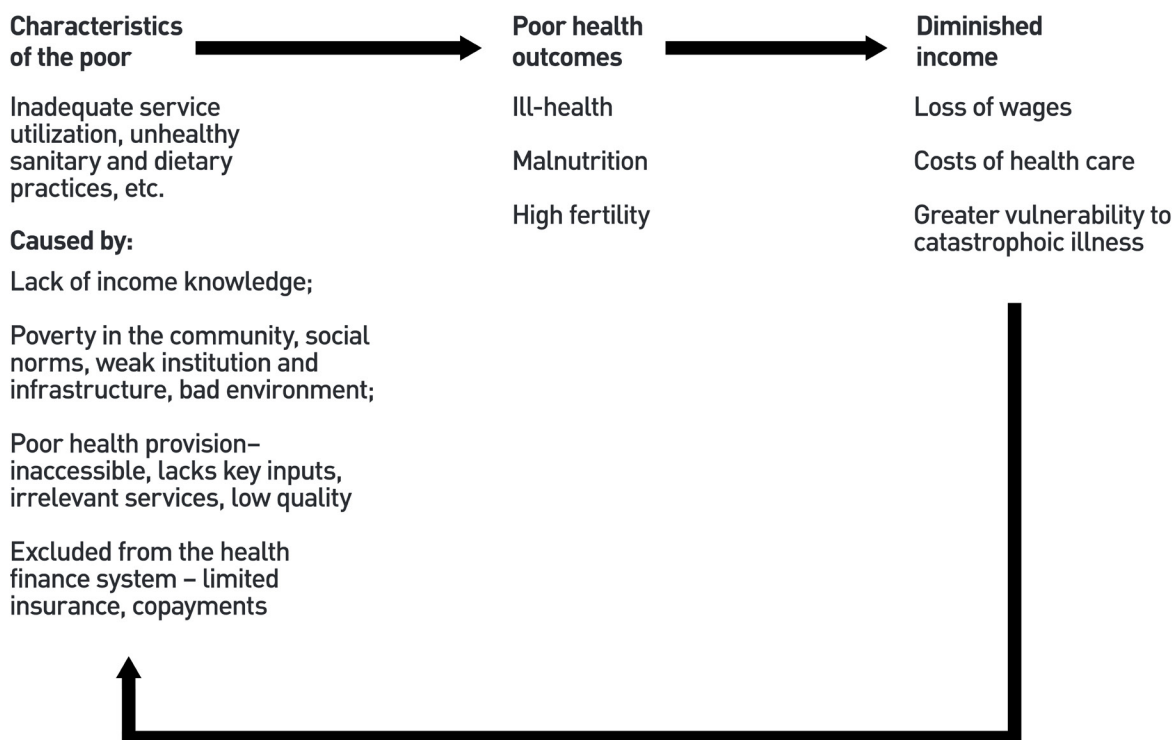


Figure 2: An illustration of the link between poverty and health of populations (Wagstaff 2002: 98)

note that no healthcare scheme can become a success by functioning in isolation. It has to be harmonised with other social welfare projects (Lakshminarayanan 2011: 28).

Many factors, other than patterns of health financing (such as social determinants and investments in non-health sectors), impact the effectiveness and outcome of health expenditure (Kumar 2011: 5). Lack of safe drinking water, poor sanitation and poor housing conditions continue to lower the health status of the population, and merely providing insurance cover is not sufficient (Lakshminarayanan 2011: 28).

There have been concerns, especially from healthcare providers, regarding the rates of many medical and surgical procedures listed in PM-JAY being very low, and some may prove to be completely unviable.

Finally, to correctly assess the impact of ABY, strong emphasis needs to be placed on the importance of good quality data. When RSBY was being assessed, almost all studies relied on household data (Chowdhary and Mukherjee 2019: 10). It was highlighted that there should have been an assessment of the scheme from a different perspective, by using the claim and facility level data (Ibid). This utilisation and claim data would have allowed better insights into the scheme. Moreover, when this data was available, it unfortunately suffered from quality issues (Ibid).

Conclusion

ABY is designed to be the world's largest insurance scheme to achieve the goal of providing Universal Healthcare in the country. The demand for healthcare, meanwhile, continues to increase, and the healthcare sector is rapidly growing to cope with it. Whether Ayushman Bharat proves to be a game changer would depend on adequate financing of the scheme, robust and good quality delivery of services and the commitment of all stakeholders. Success of other national programmes, for example Swachh Bharat, Ujjwala Yojana i.e. free LPG connections to poor families to reduce smoke related respiratory diseases, and the National Food Security Act (NFSA), in tandem with a robust healthcare policy, would go a long way in uplifting and maintaining the overall health status of the population. Finally, in order to judge the impact of ABY, good qualitative and quantitative studies would have to be designed around high quality data.

Endnotes

(1) The theory of epidemiologic transition centers on the shift in patterns of health and disease along with its interaction with complex demographic, sociological and economic determinants. India's current stage of epidemiological transition is said to be characterized by low mortality, high morbidity, and by the dual burden of communicable diseases and non-communicable diseases (NCDs). It is suggested that India presents a significant contrast in the process of epidemiological transition when compared to conclusions derived from studies of developed nations.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4028906/>

(2) User charge in health services has been advocated to meet the cost of good quality healthcare. Ghosh has pointed out that following the World Bank-sponsored health reforms in India, although user fees for those below the poverty line was waived, the definition of poor remained arbitrary. This did not lead to much relief and instead generated an increase in user fees in government hospitals.

Bibliography

Arya, Suhasini B, (2012), 'A comparative study of public and private health services in Mumbai region – Availability and utilization pattern', Department of Economics, SNDT University.

Bakshi, Harsh, Sharma, Rashmi, & Kumar, Pradeep, (2018), "Ayushman bharat initiative (2018): What we stand to gain or lose!", *Indian journal of community medicine: official publication of Indian Association of Preventive & Social Medicine* 43(2): 63-66.

Bhargava, Balram, & Paul, Vinod K, (2018), "Informing NCD control efforts in India on the eve of Ayushman Bharat.", *The Lancet*.

NHP, (2019), "Bhore Committee". Last Accessed April 13, 2019.

https://www.nhp.gov.in/bhore-committee-1946_pg

Biospectrum, (2019), "Delhi conducts 1st Edition of Ayushman Bharat Conclave.", Biospectrum, March 1, 2019.

<https://www.biospectrumindia.com/news/79/12958/delhi-conducts-1st-edition-of-ayushman-bharat-conclave.html>

Bir, T, (2000), "User charge: A Policy Option for Health Service Development in Developing Countries like India.", *Health and Population: Perspectives and Issues* 23(2): 71-84.

Chanda, Aishik, (2019), "Here is the real reason behind West Bengal pulling out of Ayushman Bharat", *The New Indian Express*, January 16, 2019.

<http://www.newindianexpress.com/nation/2019/jan/16/here-is-the-real-reason-behind-west-bengal-pulling-out-of-ayushman-bharat-1925524.html>

Chatterjee, Susmita, Levin, Carol and Laxminarayan, Ramanan, (2013), "Unit cost of medical services at different hospitals in India." *PLOS One*, 8 (7): 1-10.

Chowdhury, Subhanil, & Mukherjee, Subrata, (2019), "Can Ayushman Bharat National Health Protection Mission protect health of India's Poor?", *Institute of Development Studies Kolkata*.

Dhaka, Rohit, Verma, Ramesh, Agrawal, Ginni, & Kumar, Gopal, (2018), "Ayushman Bharat Yojana: a memorable health initiative for Indians.", *International Journal Of Community Medicine And Public Health* 5(8): 3152-3153.

Dror, David M, & Vellakkal, Sukumar, (2012), "Is RSBY India's platform to implementing universal hospital insurance?", *The Indian Journal Of Medical Research* 135(1): 56-63.

Ensor, Tim, and Cooper, Stephanie, (2004), "Overcoming barriers to health service access: influencing the demand side.", *Health policy and planning* 19 (2): 69-79.

Forbes. (India). "5 Things to know about India's Healthcare System". Accessed April 23, 2019. <http://www.forbesindia.com/blog/health/5-things-to-know-about-the-indias-healthcare-system/>

Ghosh, Abantika, (2018), "Health cover scheme: Who, how", *The Indian Express*, June 14, 2018.

<https://indianexpress.com/article/explained/national-health-mission-ayushman-bharat-health-mission-jp-nada-health-budget-5216382/>

Ghosh, Soumitra, (2011), "Catastrophic payments and impoverishment due to out-of-pocket health spending.", *Economic and Political Weekly* 46 (47): 63-70.

Government of India, (2017), *National Health Policy 2017*, Ministry of Health and Family Welfare, Government of India.

Hazarika, Sukanya, Yadav, A., Reddy, K. Srinath., Prabhakaran, Dorairaj, Jafar, T. H., & Narayan, K. V., (2009), "Public health law in India: A framework for its application as a tool for social change.", *Natl Med J India* 22: 199-3.

Health and Human Rights Journal, (2018), *ALMA-ATA at 40: A Milestone in the Evolution of the Right to Health and an Enduring Legacy for Human Rights in Global Health*, Boston, USA: Health and Human Rights Journal.

Indian Council For Research on International Economic Relations (ICRIER) (2010), *Healthcare Delivery and Stakeholder's Satisfaction under Social Health Insurance Schemes in India: An Evaluation of Central Government Health Scheme (CGHS) and Ex-servicemen Contributory Health Scheme (ECHS)*, India: ICRIER.

Kalbag, Chaitanya, (2018), "Will Ayushman Bharat do better than its predecessor schemes?", *The Economic Times*, August 9, 2018.

<https://economictimes.indiatimes.com/news/politics-and-nation/will-ayushman-bharat-do-better-than-its-predecessor-schemes/articleshow/65139383.cms>

Kumar, A.K. Shiva, (2014), "Fixing India's healthcare system", *live mint E-paper*, May 13, 2014
<http://www.livemint.com/Opinion/pl58bANi9zaF0AR2MkUYuN/Fixing-Indias-health-care-system.html>

Kumar, A.K. Shiva., Chen, Lincoln C., Choudhury, Mita, Ganju, Shibani, Mahajan, Vijay, Sinha, Amarjeet, & Sen, Abhijit, (2011), "Financing health care for all: challenges and opportunities.", *The Lancet* 377(9766): 668-679.

Lahariya, Chandrakant, (2018), "Ayushman Bharat Program and Universal Health Coverage in India.", *Indian Pediatrics* 55(6): 495-506.

Lakshminarayanan, Subhita, (2011), "Role of government in public health: Current scenario in India and future scope.", *Journal of Family and Community Medicine* 18(1): 26.

Ludwig, Martijn, Van Merode, Frits, & Groot, Wim, (2010), "Principal agent relationships and the efficiency of hospitals.", *The European Journal of Health Economics* 11(3): 291-304.

Mondal, Swadhin, (2013), "Healthcare services in India: A few questions on equity.", *Scientific Research* 5 (1): 53-61.

Mukherjee, Reema and Arora, Manisha, (2018), "India's national health protection scheme: A preview.", *Medical Journal of Dr. DY Patil Vidyapeeth* 11(5): 385-388.

MyLoanCare (India), "Ayushman Bharat Scheme 2018", Last Accessed April 13, 2019.
<https://www.myloancare.in/info-bank/ayushman-bharat-scheme>

OECD. "Health Spending." Accessed April 25, 2019.
<https://data.oecd.org/healthres/health-spending.htm#indicator-chart>

Omran, Abdel R, (2005), "The epidemiologic transition: a theory of the epidemiology of population change.", *The Milbank Quarterly* 83(4): 731-757.

Pandey, Anamika, Ploubidis, George B, Clarke, Lynda, & Dandona, Lalit, (2018), "Trends in catastrophic health expenditure in India: 1993 to 2014.", *Bull World Health Organ* 96, 18-28.

Rao, K. Sujata, (2018), "The Government's Previous Health Insurance Schemes Failed. Why Should the New One Work?", *The Wire*, February 5, 2019.

<https://thewire.in/health/the-governments-previous-health-insurance-schemes-have-failed-why-should-the-new-one-work>

Robert, Olga, 2018, "What is Ayushman Bharat? Salient Features of the National Health Scheme", *goodReturns*, Accessed September 12, 2018.

<https://www.goodreturns.in/classroom/2018/08/what-is-ayushman-bharat-salient-features-the-national-health-745928.html>

Sarwal, Rakesh, (2015), "Reforming central government health scheme into a universal health coverage model.", *National Medical Journal of India* 28(1): 29-37.

Sharma, Aman, (2019), "Centre writes to Bengal after it pulls out of Ayushman Bharat", *The Economic Times*, January 18, 2019.

<https://economictimes.indiatimes.com/news/politics-and-nation/centre-writes-to-bengal-after-it-pulls-out-of-ayushman-bharat/articleshow/67581769.cms>

Shmanske, Stephen, (1996), "Information asymmetries in health services.", *Independent Review* 1(2): 1086-165.

The Wire Staff, (2019), "Congress Manifesto Downgrades BJP's Ayushman Bharat Health Insurance," *The Wire*, April 2, 2019.

<https://thewire.in/health/congress-manifesto-healthcare>

Topp, Stephanie M, & Abimbola, Seye, (2018), "Call for papers—the Alma Ata Declaration at 40: reflections on primary healthcare in a new era.", *BMJ Global Health* 3 (2): 1-2.

United Nations (UN) (Geneva, Switzerland). "The Universal Declaration of Human Rights". Accessed April 13, 2019.

<https://www.un.org/en/universal-declaration-human-rights/>

De Vogli, Roberto, (2011), "Neoliberal globalisation and health in a time of economic crisis.", *Social Theory & Health* 9(4): 311-325.

Knowledge@Wharton (University of Pennsylvania, USA), "Will 'Modicare' Be a Game Changer for India?", Accessed April 13, 2019.

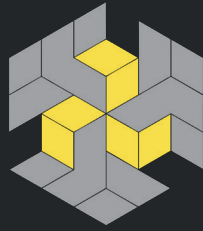
<http://knowledge.wharton.upenn.edu/article/will-modicare-game-changer-india/>

Wagstaff, Adam, (2002), "Poverty and health sector inequalities", *Bulletin of the World Health Organization* 80 (2): 97-105.

World Health Organisation (WHO) (Geneva, Switzerland). "Risk Pooling for Universal Health Coverage (UHC)". Accessed April 13, 2019.
https://www.who.int/health_financing/topics/pooling/risk-pooling/en/

World Health Organisation (WHO) (Geneva, Switzerland). "Origin and development of health cooperation". Accessed April 13, 2019.
https://www.who.int/global_health_histories/background/en/

Zodpey, Sanjay, & Farooqui, Habib H, (2018), "Universal health coverage in India: Progress achieved & the way forward.", *The Indian Journal Of Medical Research* 147(4): 327-329.



**SOCIAL & POLITICAL
RESEARCH FOUNDATION
NEW DELHI, INDIA**

+91 11 26145067 | contact@sprf.in | sprf.in