Editorial

Universal health coverage – Time to dismantle vertical public health programs in India

Abstract

Primary care has traditionally meant different concepts for developed and developing economies/countries. Immediately after independence, India pushed aside the recommendations of the Bhore committee, which was for implantation of comprehensive primary healthcare. Instead, we opted for the path of selective primary care modeled on vertical disease-based programs under the guidance of international development agencies. After several decades of implementing selective primary healthcare, India has now embarked upon ambitious journey of universal health coverage (UHC) with announcement of Ayushman Bharat – National Health Protection Mission. How much we resolve and how much we refer (90% vs 10% and 10% vs 90%) within primary care will determine the overall cost of the health system, be it out of pocket or publicly funded. Implementation of comprehensive primary healthcare and UHC along with existing disease focused vertical public health programs is a unique situation to India. Will the Indian economy be able to sustain the double burden of UHC and the vertical programs? Or is it indeed the time to dismantle the vertical programs and implement comprehensive primary care towards containing over all cost of the health system to the country. Continuing both may be a good bankruptcy plan.

Keywords: Ayushman Bharat, National Health Programme, PMJAY, Universal Health Coverage

Ayushman Bharat: PMJAY – Prime Minister's Jan Ayogya Yojana

After several decades of implementing selective primary healthcare, India has embarked upon ambitions journey of universal health coverage (UHC) with announcement of Ayushman Bharat – National Health Protection Mission.[1] Dubbed as the largest public health program Ayushman Bharat – National Health Protection Scheme will have a defined benefit cover of Rs. 5 lakh per family (on a family floater basis) per year for secondary and tertiary care hospitalization. It will subsume the existing publicly funded health insurance namely Rashtriya Swasthya Bima Yojana (RSBY), launched in 2008. Benefits of the scheme are portable across the country and a beneficiary covered under the scheme will be allowed to take cashless benefits from any public/private empanelled hospitals across the country. Ayushman Bharat – National Health Protection Mission will be an entitlement–based scheme with entitlement decided on the basis of deprivation criteria. The beneficiaries can avail benefits in both public and empanelled private facilities.

Gate Keeping, Governance, Referral, and Cost of UHC

In any model for UHC, one of the key considerations is the gatekeeping role of the primary healthcare to expensive hospital/tertiary care. Ayushman Bharat will not cover community-based outpatient coverage [general practitioner (GP) services] unlike NHS in the United Kingdom. Instead, wellness centers will be established to provide primary care. Rupees 1200 crores ($170 million) have been allocated for 1.5 lakh (150,000) health and wellness centers. These centers will be set up to provide comprehensive healthcare, including for noncommunicable diseases and maternal and child health services, apart from free essential drugs and diagnostic services. The government will upgrade the existing public health centers to wellness centers. Mid level provider or nurse practitioner a totally new skill basket for Indian health system, shall play a key role as human resource for health at these centers. Human resource personnel is a contentious issue from the point of view of gatekeeping, clinical governance, and referral system. When we talk of human resource for health, we often become selective and biased from where the experts stand. No one denies the role of health workers, nurses, paramedics, and health educators in primary care. It is a teamwork. But when we talk about role shifting (for a purpose – or agenda), it has a direct bearing on the "gatekeeping role of primary care." How much we resolve and how much we refer (90% vs 10% and 10% vs 90%) determine the overall cost of the health system; be it out of pocket or publicly funded. Without any efficient gatekeeping and clinical governance, universal coverage amounts to nothing but a direct subsidy transfer to industry. It is also unfortunate that India is a country which is implementing UHC in the "program model" instead of under an constitutionally competent authority defined through an act of parliament like NHS act of the United Kingdom. There is an issue of accountability within constitutional framework.

Ongoing National Vertical Programs

Immediately after independence, India pushed aside the recommendations of the Bhore committee for implantation of comprehensive primary healthcare. Instead, we opted for the

path of selective primary care modeled on vertical disease–based programs.[2] Currently, 36 programs are listed in the website of the Ministry of Health and Family Welfare, Government of India. These include National Dialysis Programme, National Mental Health Program, National Program for Prevention and Control of Cancers, Diabetes, Cardiovascular Diseases and Stroke, and so on. While these have been ambitious programs addressed to resolve the pressing public health and medical need, the ground situation continues to project a discomforting picture.

We need to be little more ambitious for our rural and remote population – citizens. We can learn from our neighboring countries like Nepal. Kathmandu is connected to almost all the districts of Nepal through local flights. We can compare Nepal to Bihar, Jharkhand, and Chattisgarh states in India. There are helicopter ambulances effectively run by GPs and emergency physicians. Compare this to what happened in Bihar during mid-day meal tragedy where 40 children died on the way (80 km and 5 hours) from a district to Patna Medical College. How can we allow this to happen when National Health Mission had been funding more than INR 100 crores to each district every year.

Way Forward

Superspecialty care, fragmented public health programs, and quackery have become three pillars of the Indian health system. How can there be comprehensive primary care/UHC without dismantling the vertical program based approach to disease control? There cannot be two parallel systems. An UHC design without adequate gate keeping and cost consciousness; simultaneously vertical disease control programs continuing to suck into major funding chunk. It will bleed our country more. Public health experts are often happy to sing to the tune of the chorus which comes from the top. We rush to develop consensus and compliance to a given set agenda. Will the Indian economy be able to sustain the double burden of UHC and the vertical programs? Or is it indeed the time dismantle the vertical programs. We must develop a nationalistic public health agenda which protects larger interests of the country and the population. Implementable health policies should come from Indian institutions. We should further develop capacity.

Raman Kumar[1]

[1]049, Crema Tower, Mahagun Mascot Crossing Republik, Ghaziabad, Uttar Pradesh, India

Address for correspondence: Dr. Raman Kumar, President, Academy of Family Physicians of India, 049, Crema Tower, Mahagun Mascot Crossing Republik, Ghaziabad - 201 016, Uttar Pradesh, India.
E-mail: dr_raman@hotmail.com

References

1. Ayushman Bharat – PMJAY. Available from: https://www.pmjay.gov.in/. [Last accessed on 2019 Apr 15].
2. National Health Programmes. Available from: https://www.nhp.gov.in/healthprogramme/national-health-programmes. [Last accessed on 2019 Apr 15].

Access this article online

Quick Response Code:

Website: www.jfmpc.com

DOI: 10.4103/jfmpc.jfmpc_310_19

How to cite this article: Kumar R. Universal health coverage – Time to dismantle vertical public health programs in India. J Family Med Prim Care 2019;8:1295-6.