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ORIGINAL PAPER

Ayushman Bharat National Health Protection Scheme: an Ethical Analysis

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Abstract

The Ayushman Bharat (Hindi for "India blessed with a long life") scheme is a government health insurance program that will cover about 100 million poor and vulnerable families in India providing up to INR 0.5 million per family per year for secondary and tertiary care hospitalization services. In addition, it also proposes to establish 150,000 health and wellness centers all over the country providing comprehensive primary health care. The beneficiaries of the hospital insurance scheme can avail health care services from both public and empanelled private health facilities. This scheme is one of the largest government-sponsored health insurance schemes in the world. Previous experience with government-financed health insurance schemes in India has shown that they are inequitable, inefficient, and do not provide financial protection. There is a lack of clarity on the budgetary provisions over the years when the utilization is likely to increase. The Ayushman Bharat scheme in its current form strengthens the "for profit" private health sector, requiring greater emphasis on its regulation. The scheme, which has primary, secondary, and tertiary care components, places a great focus on the secondary and tertiary care services and requires more investment in comprehensive primary health care. The potential problems of "profit-motivated" supplier-induced demand by private health care providers and corrupt practices are possible ethical burdens of the scheme. For the Ayushman Bharat to meet the ethical principle of justice, it should first address universal coverage of comprehensive primary health care and move on to hospital insurance in a progressive manner. The scheme should have provisions to strictly regulate secondary and tertiary care hospitalization in the private health sector to prevent misuse. It is the ethical responsibility of the government to ensure a strong and robust public health system, but the current provisioning of the Ayushman Bharat scheme does not do this and the reasons for this are explained in this paper.

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Introduction: Health System in India

The health system in India is characterized by a vast but weak public health system and a strong, profit-driven private health system. The public health system is financed by tax revenues and functions by state budgetary allocation. The private health system functions based on a household out-of-pocket payment for care model. In addition to these two major systems, health care is also provided through the Central Government Health Scheme (CGHS) for employees of the central government, and the Employees State Insurance Scheme (ESIC) for employees in companies who draw a salary of less than a fixed amount (INR 21,000 per month). While the CGHS is financed by tax revenue, the ESIC is financed by a tri-partite source of funds from the employee, employer, and the government (Ramani and Mavalankar 2006). Despite the presence of public health care, a major portion of health care (about 70%) in India is provided by the private health sector and paid for by patient out-of-pocket. Data from the 71st round of the National Sample Survey Organization (NSSO) conducted in 2014 revealed that about 70% of hospitalizations in urban areas and 60% in rural areas happen in private sector hospitals (Sundararaman et al. 2016). This leads to substantial out-of-pocket expenditure. Out-of-pocket health care expenditure is one of the major causes of catastrophic expenses and impoverishment in many households in India. The public expenditure on health care is very low at about 1.4% of the GDP (Rao et al. 2011a, b). This combined with the escalating cost of health care in the private sector has made specialty health care inaccessible for more than 30% of the Indian population who live below the poverty line.

Several important measures have been adopted since 2005 to improve health care provisioning in the country. One of the major health sector reforms that took place in 2005 is the launch of the National Rural Health Mission (Dasgupta and Qadeer 2005). This scheme was designed to strengthen the public health infrastructure in the rural areas of the country. Several important improvements happened as a result of this scheme. The health infrastructure—buildings, equipment, access to medicines and vaccines, and human resources were strengthened. Various major public health programs were integrated. Emphasis was placed on primary health care including maternal and child health, immunization, treatment of common minor ailments, and improvement of nutritional status. This led to substantial gains in various health indicators such as infant and maternal mortality rates (Nandan 2010). However, health care costs pertaining to secondary and tertiary health care continued to remain high and impoverishment due to health expenditure for complicated life-saving treatments continued to remain inaccessible to many segments of the society.

In 2008, the Rashtriya Swasthya Bhima Yojna (RSBY), a central government-financed health insurance scheme, was launched. This was intended to be a health insurance scheme targeting people living below poverty line, who on enrolment would be entitled to cashless treatment in public and empanelled private health facilities up to an amount of INR 30,000 (USD 425) (Devadasan et al. 2013). The RSBY increased health care utilization in several parts of the country but was mostly an unsuccessful

program due to operational inefficiencies, poor coverage of the target population, and wide inequities in coverage (Taneja and Taneja 2016).

To reach the uncovered populations and make Universal Health Coverage (UHC) possible, the High-Level Expert Group (HLEG) on Universal Health Coverage in 2010 gave strategic recommendations to achieve this goal by greater engagement with contracted private health facilities in a public-private collaboration model in providing health care (Bang et al. 2011). The National Health Policy was revised and redrafted in 2017, which brought about three major policy shifts—strategic purchase of health care services from private health sector to achieve UHC, move from selective primary health care to comprehensive primary health care provision in health and wellness centers, and assured free drugs, diagnostics, and emergency care instead of imposing user fees aimed at cost recovery (Sundararaman 2017).

In this context, the government of India has announced the budgetary outlay for the Ayushman Bharat–National Health Protection Mission (AB-NHPM) in 2018 with a set of targets and objectives in order to achieve UHC. This paper will describe the AB-NHPM scheme and its provisions, experiences of government-financed health insurance schemes in India, the ethical problems in AB-NHPM, and steps to improve the feasibility of the scheme.

Ayushman Bharat–National Health Protection Mission

The AB-NHPM aims to cover a total of 100 million families, with roughly about 500 million beneficiaries under the health insurance. The scheme targets people below the poverty line as identified by the Socio-Economic and Caste Census (SECC) conducted by the government in 2011. All members of the families are covered irrespective of the number of members and irrespective of age. The beneficiaries are entitled to a total amount of INR 500,000 per family per year. The funding of the scheme will be on a 60:40 split between the central and state government budgets. In states where there is a pre-existing government-financed health insurance scheme (GFHIS), it will merge with this scheme. The scheme is to be operated either through an insurance model, where a private health insurance company will administer the claims and disbursements, or it is administered by a non-profit trust established by the states for this purpose. The health care is provided by the public or empanelled private health facilities through strategic purchase (Lahariya 2018). The AB-NHPM proposes to cover about 40% of the entire population of India. Once it achieves its target coverage, it is said that it will the largest GFHIS in the world (Chatterjee 2018).

The AB-NHPM provides secondary and mostly tertiary care treatments that require hospitalization in empanelled health facilities without involving any cost to the patient. It also covers pre- and post-hospitalization treatments. The coverage is portable across India at all empanelled hospital and is proposed to be completely digital and paperless. About 1350 treatment packages have been identified and pricing has been fixed for these treatments (Lahariya 2018; Chatterjee 2018; Bakshi et al. 2018). The total budget allocation for this component of the AB-NHPM is INR 20 billion and it is anticipated to increase to INR 100 billion in the next 5 years.

In addition to health insurance for hospitalization, the scheme also proposes to strengthen and develop about 150,000 health and wellness centers throughout the

country to provide comprehensive primary health care including maternal; child health care; childhood and adolescent health services; reproductive health services including family welfare and abortion services; management of communicable and non-communicable diseases; care of common eye, ear, nose, and throat diseases; oral health services; mental health services; and services for the elderly and palliative care. A total budget outlay of about INR 12 billion has been allotted for establishment and functioning of these health and wellness centers (Lahariya 2018; Chatterjee 2018; Bakshi et al. 2018).

In addition to these benefits, the AB-NHPM also proposes to bring about some major health sector changes including the establishment of uniform standard treatment guidelines across private and public health sector hospitals, regulation of cost of treatment packages, establishment of Registry of Hospitals in Network of Insurance (ROHINI) which will help identify and improve quality of empanelled hospitals, enhancement of the National Health Resources Repository (NHRR) that will help identify good human resources for health care provision, and strengthening of data capture through electronic health records (Lahariya 2018).

The AB-NHPM promises to be the panacea for the health care access problems in India. There are strong voices supporting these claims and equally strong ones raising concerns about them. The proponents of the scheme claim that the program will induce a healthy market competition between public and private health care providers and improve the quality of services. They also mention that the AB-NHPM will ultimately control the cost of health care and enhance the efficiency of delivery of secondary and tertiary care hospital-based services. On the other hand, the opponents of the scheme raise concerns of moral hazard, limited reach and exclusion of vulnerable populations due to ineffective targeting, inadequate regulation of private providers and private insurers, and the risk of supplier-induced demand for services.

Ayushman Bharat and Its Goal of Universal Health Coverage

The proposed goal of the AB-NHPM scheme is "…universal access to good quality health care services without anyone having to face financial hardship as a consequence." In other words, the scheme aims to provide UHC and financial protection through government-financed health insurance (National Health Authority 2018). The AB-NHPM is India's step towards the achievement of SDG target number 3.8 (Griggs et al. 2013), which aims to "…achieve universal health coverage including financial risk protection, access to quality essential health care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all."

It is important to look closely at the difference between universal health coverage and universal health access. These two terms are often used interchangeably, but they are different. While "universal coverage" refers to all people receiving all the services, "universal access" stops short of all people having access to all services, irrespective of whether they receive it or not (Evans et al. 2013). Therefore, the goal of the AB-NHPM which emphasizes on "universal coverage" implies that the program will be successful only if all the targeted 500 million beneficiaries can avail of hospitalization services and comprehensive primary health care services of good quality without incurring financial hardships. Providing them access will not suffice. In the following discussions, it will be considered whether AB-NHPM will achieve UHC.

Do Government-Financed Health Insurance Schemes Provide Universal Health Coverage? Past Experiences in India

The performance of the RSBY program in India teaches several important lessons about the effectiveness of GFHIS in providing UHC. Claims ratio is an important indicator of the effectiveness of an insurance scheme. It is the ratio of total claims to the amount collected as premium. Several evaluations of the RSBY have consistently shown that while the claims ratios of private health insurance are around 58–67%, the claims ratio of GFHIS is always above 100%, ranging from 112 to 125%. This suggests that the GFHIS is financially unstable or is functioning by cross-subsidies from other sources of income. One of the important reasons for exaggerated claims ratio in GFHIS is adverse selection where people living below poverty line, who are more susceptible to illness because of adverse living conditions, are targeted and so likely to have greater claims. Another reason is overuse and performance of unnecessary procedures and surgeries by "for profit" private entities. This imbalance raises questions about the long-term sustainability of such a GFHIS without a progressive increase in budget premium allocation for the scheme (Selvaraj and Karan 2012; Hou and Palacios 2011).

One analysis of the Rajiv Arogyasri Community Health Insurance Scheme in the state of Andhra Pradesh (undivided), a GFHIS, showed that women had lower share of hospitalization (42%) and bed-days (45%) compared with men under sex-neutral conditions, thus indicating that social determinants such as gender have a strong influence on utilization of GFHIS even though access is provided to all (Rao et al. 2011a, b; Shaikh et al. 2018). The Chief Minister's Comprehensive Health Insurance Scheme of Tamil Nadu also revealed a utilization of 20–40% across various districts of the state for sex-neutral procedures (Karan et al. 2017).

Another study of RSBY in the state of Chhattisgarh showed that the districts which were highly vulnerable (due to geographically remote and populated by a majority of vulnerable communities) also had high insurance coverage. However, low availability of empanelled hospitals might have led to 3.5 times lesser insurance claims compared with districts which had low vulnerability. Thus, certain vulnerabilities will preclude UHC, despite providing access to GFHIS (Nandi et al. 2017; Nandi et al. 2018).

A different study of the RSBY in Chhattisgarh also revealed that 95% of insured patients who sought services in the private sector and 67% who used the public sector incurred out-of-pocket expenditure. More than 35% of the insured patients experienced catastrophic health expenditure (Nandi et al. 2017; Nandi et al. 2018). A systematic review of GFHIS in India showed that the insurance led to increased utilization of health services. But there was no reduction in out-of-pocket expenditure. In fact, two studies showed an increased out-of-pocket expenditure and even catastrophic health expenditure despite the presence of the GFHIS. Only one study evaluated health outcomes and it showed decreased mortality. Therefore, there is clear evidence of an increase in utilization, but unclear evidence on financial protection (Prinja et al. 2017).

Various reasons could be attributed to the lack of financial protection. Most of the increase in utilization of health services following GFHIS in India is through the private health sector. Given the fixed price per treatment package, patients are often asked to spend for medicines and medical products out of pocket to balance the costs incurred by the private hospitals. Another major factor is that only 37% of the population in

India have access to hospitalization service within 5 km of their residence and only 68% have access to outpatient services in the same distance (Guru 2018). Therefore, there are substantial indirect costs incurred, which are not covered by the insurance scheme (Shahrawat and Rao 2012).

The RSBY also showed that reliance on private health insurance and purchase of health services from empanelled private health facilities led to corruption and malpractice. The system was inundated by fake patients and fake claims. The insurance providers were given the responsibility of creating awareness among beneficiaries and enrolling them, which they did preferentially in order to make maximum profits (Trivedi and Saxena 2013; Nandi et al. 2013). The RSBY aimed at strengthening digital health records, but studies have shown that the data capture under RSBY is of poor quality. The other major lesson learned from the RSBY experience was the inefficiency of targeting the poor for the insurance coverage. Enrolment of non-poor in the scheme was unavoidable. Moreover, people who were living just above the poverty line easily slipped into poverty because of catastrophic health expenditure but were unprotected. A large proportion of people in the middle-income group who were not covered by the GFHIS were unprotected from financial burden of health expenditure (Devadasan et al. 2013). Given these lessons learned from the experience of RSBY and other state GFHIS, the important question is whether investing on such a large scale GFHIS is prudent before addressing these issues carefully.

Feasibility of AB-NHPM in Achieving Universal Health Coverage in India

The AB-NHPM will require a rough annual budget of about INR 200 billion once it reaches its full coverage. However, in the annual budget proposed in February 2018, the budget allotted for the AB-NHPM was only INR 20 billion. Over the years, this budgetary allocation will gradually increase. The 2018 health budget already saw a 2% reduction in the budget allocation to the National Health Mission, the main public health program delivering predominantly primary care services in India (Jan Swasthya Abhiyan 2018). This 2% budgetary cut is due to the massive budget allocation to the AB-NHPM. Though the health and wellness cess in the income tax will increase some revenue that will be directed to health budget, it may not be enough to cover the amount required to finance the GFHIS. The National Health Policy of 2017 targets an increase in public spending on health to 2.5% by 2025. Unless there is a progressive increase in public investment in health to at least 3% of the GDP, the AB-NHPM may have to be financed with cuts in the primary health care budget.

The AB-NHPM, in alignment with the National Health Policy of 2017, promotes increased engagement of the public health system with private "for profit" providers of health care. Expansion of the private health care system is unlikely to bridge inequities in health care and improve UHC. This is because the health care market works based on supply-induced demand (Van Dijk et al. 2013). There is a heavy information asymmetry between the suppliers of health care and the population, with the suppliers having greater knowledge and information. This leads to providers deciding the type and amount of services that will be covered, without any inputs from the consumers. Therefore, an increase in demand is determined by what is supplied and how much

is supplied. The "for profit" private health care system will preferentially supply costlier and "profitable" services compared with common services. This is seen in an evaluation of a GFHIS in the state of Maharashtra. Among the portion of the insurance that was utilized, more than 30% was for cancer treatments, 19% for cardiac and cardiovascular treatments, and 15% was for expensive kidney disease treatments. Less than 1% of the claims were for other medical conditions (Hou and Palacios 2011).

The other related problem with engaging "for profit" entities is the problem of increased unnecessary procedures, surgeries, and treatments. This was seen in the previous RSBY scheme where several women were subject to unnecessary hysterectomies and gall bladder surgeries by the "for profit" providers (Pulla 2018). Moreover, due to caps on package rates, it was also observed that out-of-pocket expenditure was as high as a median of INR 4000 among insured patients who sought care in private health facilities (Nandi et al. 2017). Currently, private health sector in India works on a low-volume, high-margin profit basis. In allowing access to the private sector by AB-NHPM-insured patients, these providers will have to reorient their operation to high-volume, low-margin profit. These considerations will further compromise the effectiveness of the AB-NHPM in providing UHC.

This reliance and empowerment of the private health system will systematically weaken the public health system. Most of the private health providers are empanelled only on a voluntary basis. There is no mandate on these private facilities to provide care through the AB-NHPM. Therefore, if these private facilities stopped or withdrew from the scheme, this would leave no back-up option as the public health system would be highly weakened. Thus, the long-term impact of the weakening of the public health system could seriously impair health care access.

In a small number of states, the AB-NHPM will be operated on a for-profit health insurance model, whereas in most of the states (23 out of 28), it will be based on a non-profit trust set up by the respective states to register beneficiaries, empanel hospitals, monitor hospitals, verify claims, disburse verified claims, and check for frauds. This will substantially reduce misuse of the funds for unnecessary procedures as the trust functions on a non-profit basis. On the other hand, private insurance companies, with an aim to make profits for themselves, are known to be stricter in the way they handle and disburse claims, and in the absence of such a push to make the scheme effective, there is likelihood of inefficiencies in handling of the funds in the trust model. Moreover, many states do not have the expertise and experience of insurance companies in managing the claims and disbursements, which may lead to delays.

The health infrastructure in India is still not robust. Every 10,000 persons has access to only nine hospital beds and six doctors. More than 80% of doctors and 75% of health dispensaries serve urban India. In this context, the AB-NHPM will lead to an increase in burden of patients utilizing health facilities and services in a short period of time. This will adversely affect both the health facilities as well as the patients accessing them. There is an urgent need to strengthen and increase the capacity of health facilities and health infrastructure in the country to meet the demands that will be produced by the AB-NHPM. The experience of Thailand is instructive here. Thailand introduced the concept of Universal Health Coverage almost two decades ago in 2001. The health protection scheme worked through four insurance models, one for government employees, tri-partite contributory insurance for private employees, insurance for work-related illnesses and injuries, and the universal coverage scheme for other unemployed

and informal sector employees. There are some essential lessons to be learned from the Thai model of UHC. The primary health care provider is the contractor and the main unit of registration for all families. This automatically strengthened the primary health care and regulated the referrals to secondary and tertiary care and hospitalizations. This prevented unnecessary tertiary care utilization. The system operates mainly through public provision of health services. A very small proportion of health care is provided by the private sector. Most outpatient service utilization is public and even in in-patient services, very little is private. Preventive services, screening services, and annual health check-up are included in the insurance. The utilization of claims is maximum in the strong and comprehensive primary care units compared with the secondary and tertiary units. The primary care facilities and district level health facilities were all well established and strengthened before the implementation of the UHC program. All these major strengths of the program contributed to successful UHC in the country. Although the substantially smaller population size of the country was a contributing factor for its successful implementation of UHC, the important contribution focuses on primary health care, strengthening of the public health system, and utilization of work-based insurance which cannot be undermined (Khanna 2011).

More than 25% of the health budget will go to AB-NHPM and this will address only hospitalization, which comprises only 2% of the health needs of the population. From this amount, about 75% will go towards strengthening and feeding the "for profit" private health sector (Ghosh 2018). A disproportionately small amount has only been allotted for the health and wellness centers. It is very well known that about 60% of health expenditure happens in primary care and preventive health services in the country. This disproportionate budgetary allocation must be considered carefully and reconciled. Unless there is a proportionate increase in budget allocation to comprehensive primary health care through the health and wellness centers, this imbalanced distribution of benefits will be an ethical problem.

Addressing the Challenges Confronting Ayushman Bharat

There are important ethical considerations in the movement towards UHC in India. While the AB-NHPM will help to make secondary and tertiary care accessible to about 40% of the Indian population and promote the establishment of health and wellness centers, whether it leads to wide utilization depends on active community engagement, increasing awareness of the entitlements, empowering communities, and creating measures for quality control and regulation of services. AB-NHPM should focus on access, quality, appropriate services, active community participation, and financial protection in the form of preventing out of pocket expenditure.

One of the major ethical burdens faced by AB-NHPM in India will be the increasing budgetary requirement that it will face over the years. The government should commit to a gradual increase in public expenditure on health for it to be able to address this increasing budget requirement without compromising other components of the health budget. The scheme should initially focus on expanding comprehensive primary health care throughout the country with a greater budget allocation and slowly expand the insurance for secondary and tertiary care. This will ensure that the pyramidal structure of the health care services is not distorted. Health care services in any population should

be organized in a pyramidal manner with maximum services offered at the primary care level and lesser and lesser services in the secondary and tertiary care levels (Chokshi et al. 2016). Moreover, if the primary care is strong and services are provided effectively, the need to provide secondary and tertiary care services will reduce. AB-NHPM should initially focus on the health and wellness centers that are proposed all over the country. These health and wellness centers should become the points of contact for all the beneficiaries who will be covered by the scheme. This will substantially reduce the moral hazard of overuse of unnecessary costly secondary and tertiary care services. Moreover, several successful models of UHC such as Thailand, Brazil, and Iran have shown that a strong primary health care infrastructure is essential. Therefore, to move ethically forward towards UHC, AB-NHPM should focus first on primary health care. There is also a need to increase the doctor-to-patient ratio and the hospital bed-to-patient ratio in many rural and remote areas of the country. This will help address the inequities in utilization of the hospitalization services under the scheme. Only then, the goal of UHC can be achieved through AB-NHPM.

The AB-NHPM targets those living below the poverty line. This is based on the ethical principle of protecting the interest of the worse off in a community. However, in a health system that is dominated by the private health care sector, those living just above the poverty line or those in the middle class are also subject to severe financial hardships and often are pushed into poverty due to catastrophic health expenditures. Therefore, targeting the poor will unjustly put a large segment of the middle class in a very vulnerable position, because their options now will only be the private sector, as the public health sector would have been systematically weakened by the AB-NHPM.

As mentioned above, the ESIC is an enormous platform with a potential for achieving UHC. This is a scheme where all employees of companies, their employers, and the government contribute to a premium which covers health care for the employees and their families. The system has been functioning inefficiently because it is targeting employees below a certain income range (Dash and Muraleedharan 2011). It is also covering only employees who work in the organized sector. Though the ESIC is supported by law, it has still not reached complete coverage. The scheme is itself financially well-endowed and can expand and offer robust primary, secondary, and tertiary care services. Here again, the Thai experience is instructive. The Thai employees' insurance scheme has been successful because it was non-targeted, and all employees were covered. If the ESIC is implemented more systematically and appropriate reforms are introduced, it can complement the AB-NHPM and together they can better accomplish UHC.

AB-NHPM should also work towards strict measures to regulate the private health sector and insurance providers. Most states in India have not adopted the Clinical Establishments Act of 2010. Even those states who have adopted this legislation have not put plans in place for its implementation. This law will ensure that all clinical establishments are registered and ensure that there is standardization of medical practice as well as prices. Quality accreditation should also be made mandatory for all hospitals that are empanelled in AB-NHPM. In most states, the scheme will operate on the trust model rather than the private-insurance model. While this has its advantages as seen before, its disadvantages should be closely evaluated. At least initially, it would be useful to have robust standard operating procedures that insurance companies follow,

for claims and disbursements, in order to increase the efficiency of administration of the scheme. There should also be a policy of transparency in the operations of the trust.

Like the National Institute of Health and Care Excellence (NICE) for the National Health Services (NHS) in the UK, AB-NHPM should invest on establishing standard treatment guidelines for clinical conditions and strictly regulate that all empanelled hospitals follow these guidelines. This will largely limit unnecessary treatments and overuse of treatments, medicines, and procedures. If AB-NHPM must function in a true sense of cooperative federalism, where there is cooperation between the central and state governments, the state governments should be given greater autonomy in operating the scheme as per their needs. The recent development of West Bengal state withdrawing from AB-NHPM because of its disagreements with the way the scheme was branded and publicized, as the Prime Minister's scheme under the prime minister's name and banner, is an example of how the true sense of cooperative federalism is essential for the success of the program. If states withdrew from the scheme, it would hamper the national portability of the insurance program across the states.

Conclusion

The Ayushman Bharat is an ambitious health protection scheme proposed by the government of India towards achieving UHC. Experience from the previous GFHIS shows that some of the important goals of UHC such as quality health services, universality of coverage, equity in access, and financial protection could not be achieved. The new and expanded Ayushman Bharat needs to carefully evolve its strategies to ensure that the factors that influenced the failure of the previous program are not repeated. The new scheme has addressed several of the previous concerns. By providing the option of a non-profit trust model for administering the scheme, it has attempted to address the profiteering and corrupt practices that were inherent in the private insurance model. By including a component of comprehensive primary health care expansion, it has taken care that the health system strengthens from bottom-up rather than from top-down. By pronouncing clear steps for regulation of private health care, it has set the route for reducing the misuse of the funds. The AB-NHPM is not even a year old and much remains to be seen about how it will pan out over the years. Though some progressive initiatives have been taken to make the scheme ethical and effective, a careful and cautious monitoring is required to see if the plans will be implemented. For Ayushman Bharat to effectively achieve UHC in India, it should initially focus on comprehensive primary health care and gradually expand the secondary and tertiary care hospitalization insurance. The scheme should ensure that the public health system is not rendered weak and dysfunctional. The public expenditure on health care should progressively increase to above 3% of GDP to address the increasing demands on the budget of the AB-NHPM. Ethical implementation of the scheme will ensure that UHC is realized in India.

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References

Bakshi, Harsh, Rashmi Sharma, and Pradeep Kumar. 2018. Ayushman Bharat initiative (2018): what we stand to gain or lose! *Indian Journal of Community Medicine* 43: 63. https://doi.org/10.4103/ijcm.IJCM_96_18.

Bang, Abhay, Mirai Chatterjee, Jashodhra Dasgupta, Anu Garg, Yogesh Jain, A. K. Shiva Kumar, Nachiket Mor, Vinod Paul, P. K. Pradhan, M. Govinda Rao, et al. 2011. *High level expert group report on universal health coverage for India*. New Delhi. Available from: http://planningcommission.nic.in/reports/genrep/rep_uhc0812.pdf. Accessed 29 Mar 2019.

Chatterjee, Patralekha. 2018. India launches Ayushman Bharat's secondary care component. *Lancet* 392: 997. https://doi.org/10.1016/S0140-6736(18)32284-0.

Chokshi, Maulik, B. Patil, R. Khanna, Sutapa Bandyopadhyay Neogi, Jyoti Sharma, V.K. Paul, and Sanjay Zodpey. 2016. Health systems in India. *Journal of Perinatology* 36 (Suppl 3): S9–S12. https://doi.org/10.1038/jp.2016.184.

Dasgupta, R., and I. Qadeer. 2005. The National Rural Health Mission (NRHM): a critical overview. *Indian Journal of Public Health* 49 (3): 138–140.

Dash, U. and V. R. Muraleedharan. 2011. *How equitable is employees' state insurance scheme in India?: a case study of Tamil Nadu*. London: Consortium for Research on Equitable Health Systems (CREHS). Available from: http://www.crehs.lshtm.ac.uk/india_esis_12jul.pdf. Accessed 29 Mar 2019.

Devadasan, Narayanan, Tanya Seshadri, Mayur Trivedi, and Bart Criel. 2013. Promoting universal financial protection: evidence from the Rashtriya Swasthya Bima Yojana (RSBY) in Gujarat, India. *Health Research Policy and Systems* 11: 29. https://doi.org/10.1186/1478-4505-11-29.

Evans, David B., Justine Hsu, and Ties Boerma. 2013. Universal health coverage and universal access. *Bulletin of the World Health Organization* 91 (8): 546–546A. https://doi.org/10.2471/BLT.13.125450.

Ghosh, Soumitra. 2018. Publicly financed health insurance schemes. *Economic and Political Weekly* 53 (23): 16–18.

Griggs, David, Mark Stafford-Smith, Owen Gaffney, Johan Rockström, Marcus C. Öhman, Priya Shyamsundar, Will Steffen, Gisbert Glaser, Norichika Kanie, and Ian Noble. 2013. Policy: sustainable development goals for people and planet. *Nature* 495 (7441): 305–307. https://doi.org/10.1038/495305a.

Guru, G. 2018. Ayushman Bharat—long live private healthcare. *Economic and Political Weekly* 53 (46): 8 Available from: https://www.epw.in/journal/2018/46/editorials/ayushman-bharat—long-live-private.html%0A. Accessed 29 Mar 2019.

Hou, Xiaohui, and Robert Palacios. 2011. Hospitalization patterns in RSBY: Preliminary evidence from the MIS. In *India's health insurance scheme for the poor: evidence from the early experience of the Rashtriya Swasthya Bima Yojana*, ed. Robert Palacios, Jishnu Das, and Changqing Sun, 117–152. New Delhi: Centre for Policy Research.

Jan Swasthya Abhiyan. 2018. Abandon Ayushman Bharat. *Economic and Political Weekly* 53 (39): 5.

Karan, Anup, Arpita Chakraborty, Hema Matela, Swati Srivastava, Sakthivel Selvaraj, Elna James Kattoor, Lakshmi Ramakrishnan, Tirumaal Arumugam, Umakant Dash, V.R. Muraleedharan, and Girija Vaidyanathan. 2017. *Process evaluation report of Chief Minister's comprehensive health insurance scheme, Tamil Nadu*. New Delhi: Public Health Foundation of India.

Khanna, Renu. 2011. Universal health coverage in Thailand: what lessons can India learn? *Medico Friend Circle Bulletin* 342–344 (Aug2010-Jan2011): 34–42 Available at: http://www.mfcindia.org/main/bgpapers/bgpapers2011/am/bgpap2011r.pdf. Accessed 29 Mar 2019.

Lahariya, Chandrakant. 2018. 'Ayushman Bharat' program and universal health coverage in India. *Indian Pediatrics* 55: 495–506 Available at: https://indianpediatrics.net/june2018/june-495-506.htm. Accessed 29 Mar 2019.

Nandan, Deoki. 2010. National rural health mission: turning into reality. *Indian Journal of Community Medicine* 35 (4): 453. https://doi.org/10.4103/0970-0218.74338.

Nandi, Arindam, Ashvin Ashok, and Ramanan Laxminarayan. 2013. The socioeconomic and institutional determinants of participation in India's health insurance scheme for the poor. *PLoS One* 8 (6): e66296. https://doi.org/10.1371/journal.pone.0066296.

Nandi, Sulakshana, Helen Schneider, and Priyanka Dixit. 2017. Hospital utilization and out of pocket expenditure in public and private sectors under the universal government health insurance scheme in Chhattisgarh state, India: lessons for universal health coverage. *PLoS One* 12: e0187904. https://doi.org/10.1371/journal.pone.0187904.

Nandi, Sulakshana, Helen Schneider, and Samir Garg. 2018. Assessing geographical inequity in availability of hospital services under the state-funded universal health insurance scheme in Chhattisgarh state, India,

using a composite vulnerability index. *Global Health Action* 11 (1): 1541220. https://doi.org/10.1080/16549716.2018.1541220.

National Health Authority (NHA). 2018. About Pradhan Mantri Jan Aarogya Yojna (PM-JAY). [cited 7 January 2019]. Available from: https://www.pmjay.gov.in/about-pmjay. Accessed 29 Mar 2019.

Prinja, Shankar, Akashdeep Singh Chauhan, Anup Karan, Gunjeet Kaur, and Rajesh Kumar. 2017. Impact of publicly financed health insurance schemes on healthcare utilization and financial risk protection in India: a systematic review. *PLoS One* 12: e0170996. https://doi.org/10.1371/journal.pone.0170996.

Pulla, Venkat. 2018. Unwanted hysterectomies in India: paid by public insurance schemes. *Space and Culture, India* 6: 1–6.

Ramani, K.V., and Dileep Mavalankar. 2006. Health system in India: opportunities and challenges for improvements. *Journal of Health Organization and Management* 20: 560–572. https://doi.org/10.1108/14777260610702307.

Rao, M., S.S. Ramachandra, S. Bandyopadhyay, A. Chandran, R. Shidhaye, S. Tamisettynarayana, A. Thippaiah, M. Sitamma, M. Sunil George, V. Singh, S. Sivasankaran, and S.I. Bangdiwala. 2011a. Addressing healthcare needs of people living below the poverty line: a rapid assessment of the Andhra Pradesh Health Insurance Scheme. *National Medical Journal of India* 24 (6): 335–341.

Rao, Mohan, Krishna D. Rao, A.K. Shiva Kumar, Mirai Chatterjee, and Thiagarajan Sundararaman. 2011b. Human resources for health in India. *Lancet* 377: 587–598. https://doi.org/10.1016/S0140-6736(10)61888-0 .

Selvaraj, Sakthivel, and Anup K. Karan. 2012. Why publicly-financed health insurance schemes are ineffective in providing financial risk protection. *Economic and Political Weekly* 47 (11): 60–68.

Shahrawat, Renu, and Krishna D. Rao. 2012. Insured yet vulnerable: out-of-pocket payments and India's poor. *Health Policy Planning* 27 (3): 213–221. https://doi.org/10.1093/heapol/czr029.

Shaikh, Maaz, Sanne A.E. Peters, Mark Woodward, Robyn Norton, and Vivekanand Jha. 2018. Sex differences in utilisation of hospital care in a state-sponsored health insurance programme providing access to free services in South India. *BMJ Global Health* 3 (3): e000859. https://doi.org/10.1136/bmjgh-2018-000859.

Sundararaman, Thiagarajan. 2017. National Health Policy 2017: a cautious welcome. *Indian Journal of Medical Ethics* 2 (2): 69. https://doi.org/10.20529/IJME.2017.018.

Sundararaman, Thiagarajan, V.R. Muraleedharan, and Indranil Mukhopadhyay. 2016. NSSO 71st round data on health and beyond: questioning frameworks of analysis. *Economic and Political Weekly* 51 (3): 85.

Taneja, Pawan Kumar, and Shallini Taneja. 2016. Rashtriya Swasthya Bima Yojana (RSBY) for universal health coverage. *Asian Journal of Management Cases* 13 (2): 108–124. https://doi.org/10.1177/0972820116653335.

Trivedi, Mayur, and Deepak B. Saxena. 2013. Third angle of RSBY: service providers' perspective to RSBY-operational issues in Gujarat. *Journal of Family Medicine and Primary care* 2 (2): 169–172. https://doi.org/10.4103/2249-4863.117415.

van Dijk, Christel E., Bernard van den Berg, Robert A. Verheij, Peter Spreeuwenberg, Peter P. Groenewegen, and Dinny H. de Bakker. 2013. Moral hazard and supplier-induced demand: Empirical evidence in general practice. *Health Economics* 22 (3): 340–352. https://doi.org/10.1002/hec.2801.