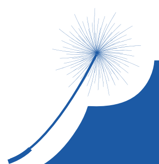

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Review Article

Universal Health Coverage Initiatives for Elderly - A Review of Ayushman Bharat Program in India

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ABSTRACT

The majority of elderly often do not have financial protection such as sufficient pension and another form of social security in India. Due to limited access, inadequate availability, poor quality and costly health care services, the government of India came up with Ayushman Bharat Program (ABP) in September 2018. In India, the majority of the elderly are illiterate, dependent on others, and unaware of new government schemes. Hence, there is very less participation by the elderly in government programs. If ABP implemented successfully and supplemented with additional interventions, the program can prove a potential platform to reform the Indian healthcare system and to accelerate India's journey towards universal health coverage. But in developing countries like India inclusion of elderly in the health insurance program is often the most challenging as most of time they are not in a position to pay any premium because of financial hardship and hardest to reach. ABP is an entitlement-based scheme where there is no advance enrolment process, making elderly aware of the scheme is the most critical aspect. Information, education and communication activities need to be carried out to inform elderly about the scheme. A detailed communication strategy needs to be developed for accessibility and adaptability of ABP by the elderly in India. This study will identify various factors that act as a facilitator or barrier for elderly in accessing and adapting ABP.

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1. INTRODUCTION

Universal Health Coverage (UHC) has been defined as the desired outcome of health system performance whereby all people who need health services receive them without undue financial hardships.[1] The health Sustainable Development Goal (SDG) aims to ensure healthy lives and promote wellbeing for all ages. One of its core targets is to achieve universal health coverage. According to World Health Organization (WHO), at least half of the world's population still does not have full coverage of essential health services. Over 800 million people spent at least 10% of their household budgets to pay for health care, and about 100 million people are still being pushed into poverty because they have to pay for health care.[2] If the current trend continues, 5 billion people will be unable to access health care by 2030.[3] However, elderly require different approaches to health care and are often less able to pay for these services.

Therefore, health systems will need to be realigned significantly to meet these targets.[4] Proportion and the absolute number of elderly in populations around the world is increasing dramatically. Between 2015 and 2050, it is expected that the proportion of the world's population over 60 years will double from about 12% to 22%.[1] In 2018, for the first time in history, the population of people aged 65 years or above outnumbered the children population under age five in the world. It is predicted that by 2050 population above 65 will be twice of the children under five. By 2050, the number of people aged 65 years or over globally will also outnumber adolescents and youth aged 15 to 24 years.[5] Population ageing has a significant effect on the socio-economic development of a country. The government has to be prepared for the increasing elderly population and deal with the decreasing young working population simultaneously. Health also plays an important role in the socio-economic development of the nation. Improvement in health accounts for 11% of economic growth in the low-income and middle-income countries.[6]

India is one of the world's great economic triumph stories in recent times. It is already the fifth-largest economy in the world and as per the current trajectory. It is poised to grow to capture the rank of the second major economy in the Asia-Pacific Region by 2025.[7] India, along with 193 countries, has also committed itself to adopt the SDGs at the United Nations in 2015 to eliminate poverty, protect human dignity and wellbeing, protect the planet, and ensure prosperity for all as parts of the new global sustainable development agenda to be fulfilled by 2030.[8] Healthcare in India has one of the lowest per capita spends. This has resulted in higher out of pocket expenditure, which pushes nearly 7% of the population into poverty every year.[9] Only 17% of citizen have health insurance, as a result, about 70% of healthcare expenditure is paid by people out of their own pockets, placing a significant burden on people and their families.[10] According to the National Service Scheme (NSS) report in 2017-18, it was revealed that 79.5% and 83.7% of rural and urban hospitalization cases used their household income and savings as a major source of financing for hospitalization expenses. It was also found out among the lowest 20% of the population, only 10.2% and 9.8% of rural and urban population respectively are covered with some kind of health expenditure coverage. Most of population are still suffer from different kind of diseases and and more than half are not able to pay their medical expenses.[11]

India has 103.9 million elderly which is about 8.5% of the population.[12] It is projected that India's older population will increase in 10-20% by 2060.[4] On contrast to the increasing population of the elderly, there are very limited resources and attention available to them health-wise. This research paper investigates various initiatives and research conducted for the health security of elderly in India and around the world, and tries to identify various factors that act as a facilitator or barrier for elderly for the adaptation of any public health insurance scheme in India.

2. HEALTH SECURITY INITIATIVES FOR ELDERLY WORLD OVER

The 2030 agenda for sustainable development is an opportunity for governments and the international community to renew their commitment to improving health as a central component of development.[13] Health system strengthening is a means to progress towards UHC. A functioning health system is organized around the people; institutions and resources that are mandated to improve maintain or restore the health of a given population.[14] In recent years, many countries have adopted UHC as a national aspiration. The two-year multi-country study shows that UHC is a complex process, fraught with challenges, many possible pathways, and various pitfalls that are also feasible and achievable. Countries have a better chance of moving forward if they have leaders who show political commitment to reform, a clear understanding of the political economy challenges and a willingness to learn from experience and adapt.[15] The support for UHC by the public also depends on demographic and attitudinal factors. People showed a high level of support based on their demographic condition such as their location, plus attitudinal factors such as opinions on the government prioritizing healthcare, healthcare being free at the point of access, taxes being increased to provide care free at the point of access, and how well informed participants felt about UHC were associated with agreeing with the introduction of UHC.[16] The WHO survey on global ageing and adult health in China, Ghana, India, Mexico, the Russian Federation and South Africa documents that households with people older than 50 years experienced greater financial burden due to health costs,[17] compared to households without elder, including higher rates of impoverishment, catastrophic health expenditures and borrowing of money to pay for health services. For the same countries, health insurance generally increased access to care but gave insufficient protection against financial hardship.[18] Primary Healthcare (PHC) is essential for equitable access and cost-effective healthcare. This makes PHC a key factor in the global strategy for UHC. Six countries were taken as samples and they all face same challenges in securing robust PHC & UHC. In conclusion, four priorities were identified. They are advocacy for community-based PHC to policymakers, including the importance of coordination of healthcare at the community level and UHC to respond to the needs of populations; collaboration with universities to include PHC as a core component of every medical

curriculum; collaboration with communities to improve public understanding of PHC and engagement with the private sector to focus on PHC and UHC.[19]

Aging is frequently associated with increased healthcare utilization and costs. But when people have to pay fees or copayments for health care, the amount can be very high in relation to their income particularly due to the occurrence of multiple complex health conditions or the need for long term care later in life that it results in 'financial catastrophe.' By adopting affordable, integrated and person-centered service delivery models and comprehensive systems of long-term care, based in the communities where elders live, we can accelerate progress towards UHC and SDG.[20] Health insurance plays an important role in achieving UHC. There are certain factors which affect its effectiveness, especially distance to healthcare facilities and household expenditure are vital in the enrollment National Health Insurance Scheme. Local infrastructure needs to be improved for the successful implementation of the scheme.[21] Achieving equity within the UHC is also a major task for UHC to be successful. Both in developed and developing nations, a key area is common in which inequality may arise which is disparities in quality of care and access to specialized clinical services. Poor people have limited access to a choice of the service provider, inadequate referrals and hence a potentially restricted package of benefits.[22]

3. HEALTH SECURITY STATUS OF ELDERLY IN INDIA

In India, financial risk protection was only 17.9% and prevention and treatment coverage for selected health conditions was 83.5%.[23] One of the reasons for the high rate of out-of-pocket payments (OOPs) healthcare expenditures is limited access to healthcare in the public sector, which compels patients to seek care in the private sector.[24] Utilization of healthcare improved among those enrolled in the government scheme, there is no clear evidence that suggests that these have resulted in reduced OOP expenditure or higher financial risk protection.[25] A study which used two rounds of NSS data showed that outpatient (OOP) expenses may be less compared to hospitalization expenses, but their cumulative figures over an entire year can be substantial, especially for households that have elderly or chronic diseases members.[26]

The population of the elderly is increasing day by day and simultaneously the health issues of the elderly are also increasing. The elderly population in India grew about 3.5% per year, double the rate for the population as a whole. A 2018 report by the non-profit HelpAge India shows that India is undergoing a demographic transition. 8% of its population was recorded 60 years and above in the 2011 census, it is expected to increase its share to 12.5% and 20 % by 2026 and 2050 respectively.[27] Exhaustive data collected over the years by Agewell foundation that is an Non-Governmental Organization (NGO), across the country show that in India, more than 65% of elderly have to depend on others for their day-to-day maintenance. Less than 20% of elderly women but the majority of elderly men were economically independent. It is estimated that almost two-thirds elderly population who undergo financial crisis usually belong to the middle, lower-middle or lower classes. Four-fifths of them depend on their children, relatives or others in old age. This section of the older adult population has already suffered a lot of problems, particularly due to their poor financial situation even in their younger age.[28]

Projections indicate that during 2000-2050 the population of 60 plus will grow by 326% in India. During the same time, the population of 80 plus will grow 700% with a predominance of widowed and highly dependent very old women. About one-fifth of the elderly either live alone or only with the spouse, hence they have to manage their material and physical needs on their own. Data indicates that 26% of elder men and 60% of elder women do not have any personal income. About 50% have some personal income but not sufficient to fulfill their basic needs and therefore they are financially dependent on others. About three-fourth of the elderly either fully or partially depend on others. It appears that the elderly still depend greatly on their earnings to support themselves. Overall, health-related vulnerabilities are high in old age. The acute and chronic diseases increase with age and the cost of treatment imposes a significant burden in the absence of health insurance or social security.[29] In India, less than two of every hundred elderly are covered under public and private health insurance, and this is a serious issue. Health insurance among this population remains significantly low in India. Low literacy rate and dependency on others also have an adverse effect on health.[30] Lack of employment and income affect elderly utilization of medical insurance as these populations are often incapable of paying regular insurance premiums. Insurance companies often explicitly exclude elderly due to age limits or eligibility restrictions for those with pre-existing conditions. This results in heightening the estrangement of the aged from a healthcare system and policy environment that has historically lagged in supporting the financially weak.[31] There are multiple factors such as income insecurity, physical and economic dependency, age-related morbidity make elderly vulnerable especially women. Family income is the first source of support when it comes to expenditure related to the elderly. Also, children are preferred over institutional care when ranked. 46.4% elderly expressed that the government should provide support at old age. It was also found that only one-fourth of the elderly were aware of the existing social welfare schemes with a negligible

amount of reach.[32] UHC can be achieved if the health system is more people-centered, strong and efficient, services are more affordable and available to all through well trained and motivated workers and easily available.[33]

4. AYUSHMAN BHARAT PROGRAM IN INDIA

To address these challenges, the government of India started National Health Policy (NHP) in 2017. NHP 2017 aims to ensure UHC and reinforce the trust in the public healthcare system by strengthening and expanding the services. It aims to increase government health expenditure as a percentage of gross domestic product from the current 1.15% to 2.5% by 2025.[34] In September 2018, government of India launched the Ayushman Bharat Program (ABP), which is India's commitment to UHC. It is the largest health insurance scheme in the world which is fully financed by the government. ABP has two components - Health and Wellness Centre and National Health Protection Scheme, aiming to increased accessibility, availability and affordability of primary, secondary and tertiary healthcare services in India. Afterwards, the second component has been renamed as Pradhan Mantri Jan Arogya Yojana.[35]

The first component is the Health and Wellness centre, which is created to provide Comprehensive Primary Health Care (CPHC). They are created by transforming the existing Sub Centers and Primary Health Centers. The main purpose is to provide an expanded range of primary health care services to the entire population of the target area leading to universality, equity and larger access of the community.

The second component of this scheme is Pradhan Mantri Jan-Arogya Yojna (PM-JAY). ABP is a major government policy initiative for the deprived section of society. It is targeted at poor, deprived rural families and identified the occupational category of urban workers' families. As per the Socio-Economic Caste Census (SECC) 2011 data, 8.03 crore families in rural and 2.33 crore in urban areas will be entitled to be covered under the scheme,in other words, it will cover around 50 crore people. It has a defined benefit cover of Rs 5 lakh per family on a family floater basis per year for secondary and tertiary care hospitalization.[36] It also covers 3 days pre-hospitalization and 15 days post-hospitalization expenses such as medicines. All pre-existing conditions will be covered from day one. One of the very important aspects in this scheme is that the benefits are portable across the nation, that is a beneficiary can avail benefits of this scheme from any empanelled hospital under this scheme across the nation, there are no state constraints. In it, almost 1393 procedures are included covering all the expenses related to treatment. It will subsume the existing Rashtriya Swasthya Bima Yojna (RSBY) launched in 2008. To ensure that nobody is left out, especially women, children and elderly, there will be no cap on the family size and age under the ABP. The scheme is cashless and paperless at public hospitals and empanelled private hospitals.

To include the most vulnerable of the populace, the government has used two different criteria for urban and rural beneficiaries namely deprivation and occupational criteria of the Socio-Economic Caste Census 2011 (SECC 2011) for rural and urban areas respectively. It also included those families that were covered in the RSBY but were not present in the SECC 2011 database.

One of the main objectives of ABP is to harmonize and standardize healthcare services across India. Before the introduction of this scheme different states were using their individual schemes with different benefits and criteria. To implement ABP states has been given the independence of using their own data or the data of the SECC 2011, given that the states will provide coverage to all those who come under SECC 2011. For implementation, PM-JAY provides the states with the flexibility to choose their implementation model because different states have varying capacities and level of readiness to deal with the healthcare services, so they can choose implementation model according to their need. They can implement the scheme through an assurance/trust model, insurance model or mixed model. These models are different on the basis of implementing agency such as in Assurance Model, the scheme is implemented directly by State Health Agency (SHA). There is no involvement of any insurance company, and healthcare providers get reimbursed directly by the SHA, and the cost of implementing the scheme is bear by the state government. SHA can take the help of Implementation Support Agency (ISA).

Another one is Insurance Model. In this model, SHA selects an insurance company through a competitive tendering process to manage PM-JAY in the concerned state. Insurance company bears the financial risk and deals with the claim settlement and payments on the behalf of SHA. In return, SHA pays a premium to the insurance company based on the market price per eligible family.

Last but not least is the Mixed Model. As the name suggests this is the mixture of Assurance and Insurance Model. This model is usually employed by those states which had existing schemes covering a larger group of beneficiaries. This is used with the aim of being more economic, efficient, providing facility and allowing convergence with the state scheme.

This scheme is fully funded by the government and the cost is shared between the central and the state governments in a fixed ratio which is decided by the directives issued by the finance ministry from time

to time. The administrative cost of implementing this scheme at the state level is also shared between central and state in the same ratio. The current sharing ratio is 60:40 for states and union territories with the legislature (other than the North Eastern States and three Himalayan States). For North Eastern States and three Himalayan States namely Jammu and Kashmir, Himachal Pradesh and Uttarakhand the ration is 90:10. For union territories without legislatures, the central government may provide up to 100% on a case-to-case basis.[37]

The government of India has made a commitment to SDG3, which strives to ensure healthy lives with the ultimate goal of UHC, which in turn contributes towards a reduction in inequality SDG10. Crucial to the success of these SDGs is enhancing the financial health of India's low-income population, mostly in the informal sector, through improving access to healthcare and reducing related OOP expenditure.[38] As on 5th Feb 2019, 33 states/UTs have signed Memorandum of Understanding (MoU) with National Health Authority, the implementing body for ABP, only states of Telangana, Odisha and Union Territory of Delhi have not signed the MoU.[39] According to a study, the implementation of Ayushman-Bharat scheme which included both public and private hospitals along with 5 lakh insurance coverage, preference for private hospitals is rising. Also, additional bed facilities are provided in tier-II cities. This will result in the expansion and development of hospital firms, ultimately leads to the increase in demand and adoption of the scheme.[40]

5. DISCUSSION

It is estimated that India will become the most populous country in the next six years, surpassing China. A country so vast as India, PMJAY, if implemented effectively, will prove as a panacea in the health care sector especially, for the poor of the poorest. And if not it will lead to the catastrophic blunder which resulted in extensive misuse of scarce resources. This vision of AB-PMJAY has various hurdles on its path, first and foremost is the vastness of the target population, with most of them residing in the rural areas, it is a continuous rigorous process to empanel new hospitals under this scheme to cover wider geographical area and to provide services to the target beneficiaries within their reach. One of the major issues faced by the healthcare sector especially by the public healthcare sector is lack of adequate resources both in terms of skilled personnel and in infrastructure, because of this for some specialised services masses have to go to the private sector for the treatment and also causes overcrowding in some hospitals. Government has to invest in both of these areas to increase the efficiency of the scheme. Another deciding factor is the public-private partnership in the PMJAY. Since many private hospitals are empanelled under this scheme to provide various specialised and preventive services to cater the needs of vast population, it is imperative that there should be a healthy hand-in-hand coordination and support system maintained with the private players. Similarly, the first challenge is the pricing of packages offered under PMJAY. From the point of view of private hospitals rates of packages are not viable to sustain, they are quite low as opposed to the cost bear by them for the same. Government has already revised some of the packages, and currently working on other areas too. Malpractices by the empanelled hospitals is another issue. Although there is a strict mechanism laid by the governing body to ensure blockage of malpractices, there are still cases for the same. There should be strict actions against the preparator of corruption and also a strong monitoring system to discourage similar cases to arise in the future. Measurement of quality of services provided under this scheme is also a challenge for the governing body since, without it, the policy will lack one thing, it should not that is evaluation. To evaluate the quality of services there should be a standard criterion to differentiate between good and bad services provided under this scheme.

To successfully implement AB-PMJAY, the government has to overcome all these challenges. If this program works effectively and rigorously, it will result in the most widely spread successful universal health coverage in India.

6. SUMMARY

There is a strong need for filling the gap between supply and demand sides of ABP and the social security of elderly the in India. The current gap between existing health insurance policies and low take up of health insurance by the elderly suggests a promising research agenda for filling this research gap. Elderly are often perceived as an ocean of wisdom and intelligence and also perceived as a deadly desert with disease, disability and decomposed fraternity. Therefore, social security and health security of elderly are very important issues for society as well as for the government. A number of social security measures have been taken by the Indian government for the elderly but most of the programs did not get the response from the elderly. Social and physical barriers are exist with the elderly that create many obstacles for successful implementation of any government policy for social security.

Information, education and communication (IEC) strategy and its effective implementation is likely to be one of the most important success factors for the huge mammoth program like Ayushman Bharat

especially for the elderly. Mass health awareness program requires a significant number of last-mile workforce and a huge budget. Various modes of communication such as leaflets, booklets, hoardings, television and radio are important elements for creating a comprehensive communication strategy for disseminating the desired messages across the elderly in India. Presence of a large number of private-sector organization sector organizations till the last mile and significant experience of executing large scale community programs is worth leveraging the government. Public-private partnership model can play a crucial role in spreading comprehensive awareness about Ayushman Bharat program benefits for the elderly in India up to the last mile.

CONFLICT OF INTEREST

The authors declared no conflict of interest.

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