THE WEDNESDAY INTERVIEW | INDU BHUSHAN

'Healthcare costs should not financially destroy families'

The CEO of the Pradhan Mantri Jan Arogya Yojana on the challenges and scope of the health insurance scheme and responses from the States

BINDU SHAJAN PERAPPADAN

Indu Bhushan is the CEO of the world's largest government-funded health insurance scheme, the Pradhan Mantri Jan Arogya Yojana (PM-JAY), which was launched by Prime Minister Narendra Modi on September 23. Until his appointment as CEO of PM-JAY, Mr. Bhushan served as director general for the East Asia Department of the Asian Development Bank, before which he worked as a senior economist with the World Bank Group. Here, he explains how the scheme works and the challenges it faces. Excerpts:

V.V. KRISHNAN

After many months of preparation, talks and planning, India has finally launched its ambitious Ayushman Bharat insurance scheme to benefit the poorest of the poor. Where do we stand today in terms of coverage offered and hospitals empanelled?

■ It's true that before the scheme was rolled out, several ground-level surveys were carried out, research and planning was initiated, and a robust IT department was set up. The sheer scale at which Ayushman Bharat was to be rolled out made it necessary that we create a strong foundation on which we can operate, build and grow. The idea was to reach out to the poorest families who have no health cover. The bottom 40% is the group that we want to cover.

Since the scheme was announced, we have 79,000-plus beneficiary admissions and empanelled hospitals from across the country. We have issued more than a lakh PM-JAY e-cards to beneficiaries.

The scheme is for poor families and has identified the occupational category of urban workers' families: 8.03 crore in rural areas and 2.33 crore in urban areas, according to the latest Socio-Economic and Caste Census data.

I am not happy with the fact that the scheme hasn't seen the pick-up I expected in States like Uttar Pradesh and Bihar.

How has the backbone of the scheme, the IT department, performed till now? There was news about some hold-ups. When will the system see a smooth run?

■ When you bring in a scheme of this nature and at the scale that we have launched, there are bound to be some problems. There are thousands of hospitals still coming on board and there will be always be some problem in the sense that they have given some wrong names and IDs to some hospitals and we need to fix that. Hospitals are providing a number of packages but we have mapped different packages for these hospitals. And so on. Minor glitches will keep surfacing. So, there is nothing wrong with the IT system, but adapting that for each hospital, each State isn't simple.

In India, each State has a different system – like a mixed model (private/government), trust, insurance... each of them has a different flow. Manpower has to be trained and managed accordingly. Mapping these diversities, updating the technology as the flow eases out, adding features which we feel are useful, etc. is what we are doing now. And that will continue. I don't think we will reach total perfection in that sense. But by and large I am giving it four weeks to iron out the big clogs, and I think we should be in good shape by the end of October.

Here I would like to state that not just software but also the training of people is a very vital portion of the scheme. For example, I was at Safdarjung Hospital [in Delhi] where they told me that finding people's names using our software was taking 20 minutes. I told them that it can't be. I showed them and it took less than a minute. So, getting used to the system is equally important.

What have been the other challenges so far?

■ So far it hasn't been anything that has us very troubled. But having said that, I would like to highlight that I am not happy with the fact that the scheme hasn't seen the pick-up I expected in States like Uttar Pradesh and Bihar. I would expect that we have a pick-up rate of 10,000 cases a day. However, we are at 100 cases per day. We are working at bringing in more streamlined training and ensuring that the public health centres are equipped to deal with patients who may or may not have access and knowledge about the scheme.

After Punjab joined the scheme, what is the response of the other States which have so far opted to stay out?

■ Punjab recently joined the scheme but we still have Delhi which has not given us a specific reason for staying out. Delhi still hasn't given us clarity on the issue, which means that the city's robust medical care infrastructure, which would have been extremely beneficial, is lost to the national pool of resources. We are very positive and will probably be able to announce Kerala joining the scheme soon.

In Delhi, which is yet to come on board, we have empanelled three Central government hospitals: Safdarjung, the All India Institute of Medical Sciences, and Ram Manohar Lohia. Now we will be seeing a lot more cases from Safdarjung Hospital. Even AIIMS has identified 50 cases which can benefit from the scheme. But I have told them that instead of waiting for these cases [whose dates come up late due to the heavy patient load there], they should identify cases that are currently in the in-patients list and bring them under the scheme so that people can immediately start benefitting from the scheme. The promise and potential of the scheme is making available secondary and tertiary healthcare to people who never thought they could access this through government schemes. It is also to ensure that people don't go under the poverty line accessing quality healthcare. We are providing medical healthcare services – heart operations, knee replacements, stents, etc. – which are unimaginable for people who form the 40% of those who cannot afford anything beyond primary healthcare.

Think of this when we will be able to implement this scheme in its totality – 500 million people, 30,000-40,000 cases every day. Then there will be a lot of hip transplants, knee replacements, open heart surgeries, cancer cases... I think it will change the face of the health sector in a big way.

Are we working backwards by focussing too much on secondary/tertiary healthcare and not giving the thrust that primary healthcare and preventive care need?

■ Well, that is going on. One important aspect of Ayushman Bharat is health and wellness centres which actually look at prevention and the primary healthcare sector.

Our policy of 2017 very clearly says that we will increase our budget for health to 2.5% of the GDP and two-thirds (66%) of that will be for primary healthcare. So there is a plan to increase our support for primary healthcare in a big way. Now we have never reached 2% of GDP for the healthcare sector; we have been hovering around 1 or 1.2%.

Also, we know that there is a demand for secondary and tertiary healthcare irrespective of how much we do for primary healthcare. People are going to get sick, there will be cancer cases, heart ailments, diabetes-related complications, lung disease and other diseases that will need surgeries. And so, when this happens to poor people, they have no option. This scheme will give them that option. Right now we understand that we don't have the capacity to cater to the entire load of secondary and tertiary healthcare demand but we are hoping that the demand will create the supply.

To cater to the growing demand from the government's side we are bringing in more AIIMS-like institutions across the country, more medical colleges, a lot of public-private partnerships, encouraging private hospital chains to open up centres in tier-2 and tier-3 cities, etc.

In the larger scheme of things we have to ensure that primary healthcare stays robust to keep secondary and tertiary healthcare requirement low.

Are you seeing any major north-south disparities which the scheme would like to iron out?

■ It is no secret that south India has a robust healthcare system and there are many things to learn from them. But we aren't seeing any major disparities that are insurmountable.

Meanwhile, what this scheme brings to people is the ability to aspire for treatment that was previously unimaginable. There are several programmes that are running successfully in the south of India which can be adapted and integrated to benefit a much wider population. We are open to, and in talks with, various States and private parties to ensure that we are able to improve our reach and ensure that within the country, people are able to move from one State to the other and still have access to quality and standardised treatment. The idea, as of now, is to balance the demand and supply across the country and make affordable healthcare a reality.

The thought and intent behind the scheme is to build a system that is strong, accessible and stable. And to make sure that secondary and tertiary healthcare costs don't financially destroy families or force people to go without treatment.

Can we sustain this ambitious scheme financially over the long term?

■ As I have said before, funds will not be a problem. The overall health expenditure by the government is also due for expansion and this is a scheme that benefits the poorest most directly. In the larger scheme of things we have to ensure that primary healthcare stays robust to keep secondary and tertiary healthcare requirement low.

We will also have our ongoing surveys that will give us an idea of the kinds of diseases that we are dealing with. Right now there are few studies on the bottom 40% and the ailments that they grapple with.

This scheme will also give us that feedback and we will be able to see the pattern of diseases for at least the bottom 40% and that will definitely help us form policies and predict demand in the future.

SINGLE FILE

Model institutions

Cover-ups by institutions only lead to speculation. This can be difficult for survivors of sexual harassment

SHUBASHREE DESIKAN

GETTY IMAGES/ ISTOCK

Raya Sarkar's list of alleged sexual predators in Indian universities, published in 2017, set off a debate, including among feminists, on whether labelling someone a perpetrator without going through the due process of establishing guilt was the right approach. Opinion was divided, but need not be, for the #MeToo campaign's practice of publicly naming alleged abusers has promoted a conversation on which a toxic silence prevailed earlier.

Due process is nevertheless necessary, as it is the way to establish safe and equitable work environments for all. We must consider both ways of addressing the problem. Even as M.J. Akbar stepped down as Minister of State for External Affairs after allegations of sexual misconduct and harassment mounted against him, a professor from the Indian Institute of Science (IISc), Bengaluru, faces possible dismissal following the investigation of complaints that he sexually harassed a PhD student. News reports have pointed out that there are some other such cases being dealt with in IISc, and that a high number of cases were reported in the institution in 2014-15.

While this is certainly disturbing, it also reflects the faith that the complainants have in their institute and, in fact, in due process. It is commendable that IISc is taking quick action on the complaints. If proven guilty, the professor's dismissal will send a strong message that the institute has zero tolerance for sexual misconduct. In the context of academia and research institutions where women students and researchers are reluctant to speak to Internal Complaints Committees about sexual harassment because they feel that it might be ineffective and counterproductive, such an action on the part of IISc would be a sign of improving conditions.

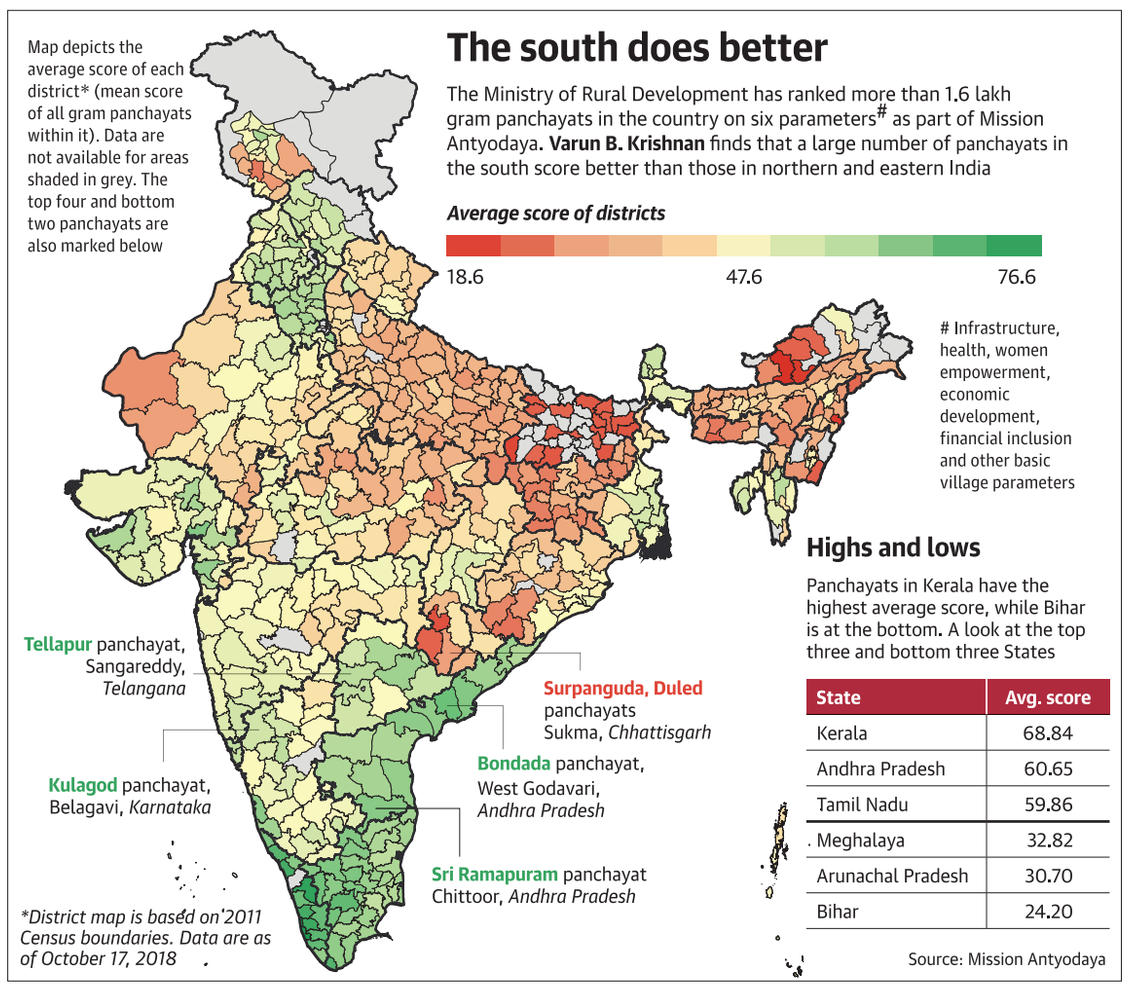
In a sense, government-funded institutes such as IITs and NITs have been active in dealing with complaints of sexual harassment. If IISc takes definitive action and ensures that the survivor's interests are protected, research institutes that are loath to act on such complaints may also absorb this culture.

News reports have, however, not quoted any official from IISc. In the age of active voices on social media, this reluctance of the directors to communicate the situation to the media is problematic. This silence is not just going to give rise to speculation, but it is also part of the suffocating stranglehold of patriarchal values that protects perpetrators, even alleged ones.

As everyone knows, closing a wound only leads to severe infection. This applies to sexual harassment too. Cover-ups make for a more violent impact on the victim. Perhaps the government too can take a cue from institutions such as NIT Surat, IIT Madras, IIT Bombay, and now IISc and adopt proactive, decisive and just methods to address complaints of sexual harassment.

The writer covers science for The Hindu

DATA POINT



FROM The Hindu. ARCHIVES

A HUNDRED YEARS AGO OCTOBER 24, 1918.

Nizam's Charter to Osmania University

H.E.H. The Nizam has granted a firman or charter to the Osmania University – about which some little speculation has been rife – which was opened on the 6th October current synchronizing with the 1st Mohorrum, Hegira 1887. The objects of the University are to teach religion, moral science, philosophy, natural science, history, medicine, law, agriculture, commercial and other higher scientific subjects, industrial and research work. The outstanding peculiarity of the University, and it is a most healthy sign that H.E. Highness has determined to make a departure which from a national point of view is a very important one, is that the entire medium of instruction will be Urdu with English as a compulsory second language. The preference given to English over the vernaculars has had a distinctly denationalizing tendency in India and it is satisfactory that the Princes and publicists in this country are making some attempt to stem this process by drawing attention to the absolute necessity of Indian communities learning in a thorough manner their mother tongues.

A Case Under Factory Act.

At the Mazagaon (Bombay) Police Court, Rao Bahadur C.H. Setalvad, Second Presidency Magistrate, has delivered judgment in two cases in which the Inspector of Factories charged Mr. P.A. Babtista of Morarji Goculdas Mills and Mr. Guthrie of Sassoon Spinning and Weaving Mills with having employed a number of minor boys as half time workers without being in possession of medical certificates showing that the boys were not under nine years of age and were medically fit. The chief point involved was whether a mill or factory could legitimately employ children under 9 years of age as half time workers without being in "actual" possession of certificates that they were not less than 9 years of age and are medically fit. The Factory Act requires such certificates to be kept and produced when required by Factory Inspectors in the course of their inspections.

CONCEPTUAL

O-ring theory

ECONOMICS

Also known as the O-ring model of economic development, this refers to the theory that even the smallest components of a complex production process must be performed properly if the end product of the process is to have any useful value. In other words, a mistake that creeps into even the smallest of tasks can cause the final product to possess absolutely no value to users. The O-ring theory derives its name from a 1986 incident in which the Challenger space shuttle was completely destroyed as a result of the failure of a simple gasket, or O-ring, to work properly. It was first proposed by American development economist Michael Kremer in 1993.

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