CHAPTER 12

Health Policy & Health Insurance

12.1 HEALTH POLICY

The National Health Policy, 2017 draft received endorsement of the Central Council for Health & Family Welfare, the apex policy making body, in its Twelfth Conference held on 27th February, 2016. After which the Union Cabinet on 15th March, 2017 approved the new Policy.

The main objective of the National Health Policy, 2017 is to achieve the highest possible level of good health and well-being, through a preventive and promotive health care orientation in all developmental policies and to achieve universal access to good quality health care services without anyone having to face financial hardship as a consequence.

The National Health Policy, 2017 has specific quantitative and time bound goals and targets to be achieved in the health sector, some of which are as under:

- Increase Life Expectancy at birth from 67.5 to 70 by 2025.
- Reduce Under Five Mortality to 23 by 2025 and MMR from current levels to 100 by 2020.
- Reduce Infant Mortality Rate to 28 by 2019.
- To achieve and maintain a cure rate of >85% in new sputum positive patients for TB and reduce incidence of new cases, to reach elimination status by 2025.
- Increase health expenditure by Government as a percentage of GDP from the existing 1.15% to 2.5 % by 2025.

The Policy has a patient centric thrust with focus on continuum of care, making public health care system predictable, efficient, affordable and effective with a comprehensive package of services and products that meet immediate health care needs of most people.

The National Health Policy, 2017 seeks to strengthen the role of Government for holistic development of the health sector for the attainment of highest possible health and well-being to all, across all ages. Primary healthcare is sought to be made more comprehensive covering preventive, promotive, curative, palliative, geriatric and rehabilitative care.

The National Health Policy, 2017 assures availability of free, comprehensive primary health care services, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable, non-communicable and occupational diseases in the population. Towards urban health, the policy lays emphasis on addressing the primary health care needs of the urban population with special focus on poor populations living in listed and unlisted slums and other vulnerable populations.

The Policy seeks to ensure improved access and affordability of quality secondary and tertiary care services through a combination of public hospitals and strategic purchasing in healthcare deficit areas from accredited Non-Governmental healthcare providers, achieve significant reduction in out of pocket expenditure due to healthcare costs, reinforce trust in public healthcare system and influence operation and growth of private healthcare industry as well as medical technologies in alignment with public health goals. The Policy also advocates for engagement with private sector for critical gap filling for achieving national health goals, through inter-alia collaboration for strategic purchasing, capacity building, awareness generation, disaster management, skill development programmes, etc.

The Policy supports pluralism and advocates access to AYUSH remedies through co-location in public health facilities and recognizes the need to nurture AYUSH systems of medicine.

The policy adopts a holistic approach addressing

infrastructure and human resource gaps along with leveraging digital technology in strengthening the health systems. The policy further recommends compliance to right of patients to access information about their condition and treatment, maintaining adequate standards of diagnosis and treatment and developing standard guidelines of care applicable both to public and private sector. Towards providing speedy resolution of disputes and complaints, the policy has recommended for setting up of a separate empowered medical tribunal.

To ensure quality of care, the policy recommends that Public Hospitals and facilities undergo periodic measurements and certifications of levels of quality. It recognizes development of standard guidelines of care and grading of clinical establishments and adoption of standard treatment guidelines. The policy accordingly recommends establishing National Healthcare Standards Organization for maintaining adequate standards of diagnosis and treatment.

For attracting and retaining doctors in remote areas, the policy recommends financial and non-financial incentives, creating medical colleges in rural areas, preference to students from under-serviced areas, realigning pedagogy and curriculum to suit rural health needs, mandatory rural postings, etc. It also recognises establishing cadres like nurse practitioner and public health nurses to increase their availability in most needed areas. The policy recommends development of a cadre of mid-level care providers as a complementary human resource strategy for expansion of primary care from selective care to comprehensive care. Additionally, it proposes for a planned expansion of allied technical skills as a key policy direction and also creation of a Public Health Management Cadre for better public health management.

The policy also seeks to address health security and 'Make in India' for drugs and devices. It also seeks to align other policies for medical devices and equipment with public health goals.

Towards addressing the health needs of the vulnerable groups, the National Health Policy has situation specific measures in provisioning and delivery of services to take care of special health needs of tribal and socially vulnerable population groups. Towards this, the policy advocates for research and validation of tribal medicines and envisions for a systematic approach to address heterogeneity in micronutrient adequacy across regions in the country with focus on the more vulnerable sections of the population. It, further, recommends focused interventions in high risk communities and recommends for strengthening women's access to healthcare needs, by making public hospitals more women friendly and ensuring that the staff have orientation to gender – sensitivity issues. Additionally, the policy recommends that health care to the survivors/victims need to be provided free and with dignity in the public and private sector. The policy also provides greater focus on occupational health-physical, chemical and other workplace hazards. Work-sites and institutions would be encouraged and monitored to ensure safe health practices and accident prevention, besides providing preventive and promotive healthcare services.

Towards addressing the healthcare needs of geriatric population in rural areas, it recommends that primary healthcare to be comprehensive which includes geriatric care, palliative care and rehabilitative care services and recognizes the growing need for palliative and rehabilitative care for all geriatric illnesses and advocates the continuity of care across all levels.

12.2 RASHTRIYA SWASTHYA BIMA YOJANA (RSBY)

The Rashtriya Swasthya Bima Yojana (RSBY) is a centrally sponsored scheme that was implemented by Ministry of Labour & Employment (MoLE) from 2008 under the Unorganized Workers' Social Security Act 2008 to provide health insurance coverage to Below Poverty Line (BPL) families. Initially the scheme was designed for BPL families, but later it included 11 other categories of Unorganized Workers (UOWs) (MGNREGA workers, construction workers, domestic workers, sanitation workers, mine workers, licensed railway porters, street vendors, beedi workers, rickshaw pullers, rag pickers and auto/taxi drivers). The scheme has now been transferred to the Ministry of Health & Family Welfare on an "as is where is" basis with effect from 01.04.2015.

Each family enrolled in the scheme is entitled to hospitalization benefits of upto Rs. 30,000 per annum including maternity benefits on a family floater basis (a unit of five) in Government empanelled hospitals

(includes both private and public). Pre-existing conditions are covered from day one and there is no age limit. Transportation Cost upto Rs. 100 is also provisioned under the scheme.

The Scheme is implemented at State level through a contractual arrangement between insurance companies and State Government represented by the State Nodal Agency (SNA). At present the State Nodal Agency is primarily responsible for overseeing the implementation of the RSBY at the State level which includes managing the process of bidding, selection of insurance companies, overseeing enrolment process, supporting the empanelment of providers, redressal of grievances and periodic review of the scheme on ground. With effect from 2015-16, Central Government bears 60% of insurance premium cost and remaining cost is borne by the State Government. In case of North Eastern and three Himalayan States the sharing pattern shifts to 90% support of insurance premium cost from Centre. In respect of Union Territories (without legislature), the Central Government share is 100% while in those with legislature, the Central share will be 60%.

Senior Citizen Health Insurance Scheme (SCHIS), provides insurance cover to senior citizens (aged 60 years and above) as a top-up over the existing RSBY Scheme and has been implemented w.e.f. 01.04.2016. It will provide an enhanced coverage of upto Rs. 30,000 per senior citizen in the eligible family. The premium of the scheme would be met from the Senior Citizens Welfare Fund administered by the Ministry of Social Justice and Empowerment. The premium for the implementation of SCHIS will be paid by the Centre and States in the ratio 60:40 except the North Eastern States and 3 Himalayan States where it is 90:10.

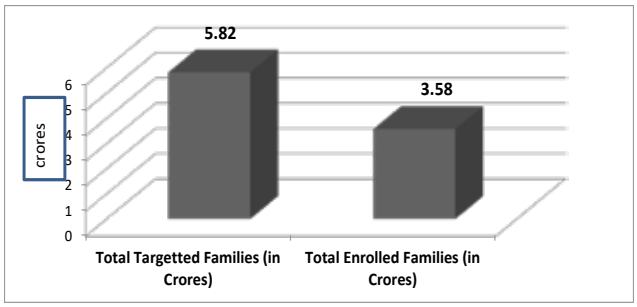
The basic features of the scheme are as follows:

- The beneficiary family pays Rs. 30 per annum per family as registration/renewal fee. This amount is used by the State Government to take care of the administrative cost for the scheme.
- Coverage of all pre-existing diseases.
- Coverage of hospitalization expenses.
- Maximum premium payable is Rs. 750 per family.
- Provides only for secondary care hospitalization procedures.
- More than 1500 standard packages are included.
- Both public and private hospitals are empaneled under the scheme.

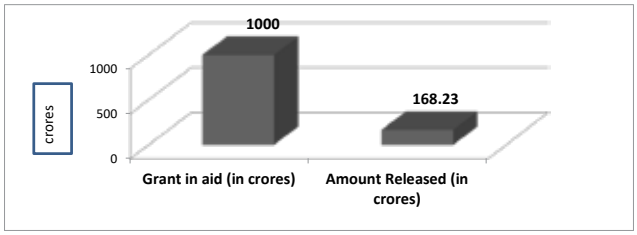
Benefit Scenario: Based upon the performance during the year 2017-18 (as on 30.09.2017)

1. Out of the total target beneficiary of 5.82 crore families spread across 14 States, 3.58 crore families were enrolled, resulting in the enrolment conversion ratio of 61.65% as on 31.07.2017. (See Graph below)
2. More than 146 lakh beneficiaries took the benefits of the scheme since inception of RSBY Scheme.
3. The Central Government had incurred an expenditure of Rs. 168.23 crore as the Central Government's Share of Premium as on 30.09.2017. (See Graph below)
4. A network of hospitals has been developed across implementing States/UTs by empaneling 4860 private hospitals and 3677 public hospitals under RSBY scheme. (See Graph on next page)

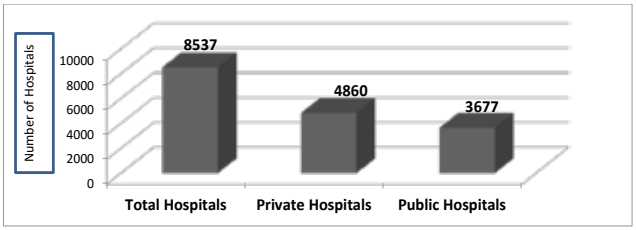
No. of Beneficiary enrolled under RSBY during the year 2017-18 across 14 States (as on 31.07.2017)



Financial Achievement during the year 2017-18 (as on 30.09.2017)



Hospitals Empaneled under RSBY during the year 2017-18 (as on 31.07.2017)



The Finance Minister announced in the budget speech for the year 2016-17 to launch a new health protection scheme which will provide health cover up to Rs.1 lakh per family per year for poor and economically weak families. For senior citizens of age 60 years and above belonging to this category an additional top up package upto Rs. 30,000 will be provided.

Hon'ble Prime Minister in his speech on 70th Independence Day announced an important scheme for poor families wherein Government will provide coverage upto Rs. 1 lakh per year for medical facilities.

The RSBY Scheme may be replaced by National Health Protection Scheme which is expected to have a higher coverage of Rs. 1,00,000/-, no cap on family size, change in data base from BPL to SECC data base and also SCHIS providing additional coverage of Rs. 30,000/- per senior citizen belonging to NHPS Beneficiary Family.