Pradhan Mantri Jan Arogya Yojana (PM-JAY): The Scheme and it's Potential to Reform India's Healthcare System

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1. Introduction

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) is a health insurance/ assurance scheme which was launched by the Government of India (GoI) in September 2018. It is the second component under Ayushman Bharat; a scheme envisioned to achieve Universal Health Coverage (UHC) in India. Together with the first component, Health and Wellness Centres (HWC), Ayushman Bharat envisages to address healthcare needs at the primary, secondary, and tertiary levels in a holistic manner (National Health Authority, n.d.).

PM-JAY is fully funded by the government and the costs are shared between the central and the state governments. It provides a health cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalisation through public and private empanelled hospitals in the country. It is specifically targeted at 10.74 crore poor and vulnerable families (approximately 50 crore beneficiaries). Through its insurance cover and cashless access to healthcare services, it aims to help mitigate catastrophic expenditure on medical treatment. The empanelled hospitals are paid based on pre-agreed health benefits package (HBP) rates. HBP covers costs of a specified treatment and includes 3 days pre- and 15 days post-hospitalisation expenses. The revised Health Benefits Package 2.0 now covers 867 packages split across 1573 procedures[2]. The responsibility of implementing the scheme has been entrusted with the National Health Authority (NHA) at the centre and the State Health Authorities (SHA) at the state level (National Health Authority, n.d.).

In this note, we briefly review the above described design of PM-JAY and explore three key questions – 1) Is PM-JAY designed to meet its stated objectives? 2) How can we tweak the scheme in a manner that allows it to punch above its fiscal weight? 3) What role can PM-JAY play in reforming India's healthcare system? Before attempting to answer these questions, we first look at some of the key performance measures of PM-JAY as it heads towards completing three years in September 2021.

2. Present Status of PMJAY – Overview of Key Parameters

Table 1: Key Parameters

Key Parameters	As of 22nd September, 2019	As of 6th September, 2020	As of 5th February, 2021
No. of e-cards issued	10.3 crore	12.6 crore	13.6 crore
No. of hospital treatments	0.5 crore	1.2 crore	1.6 crore

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[2] See Health Benefits Package 2.0, Frequency Asked Questions, December 2019. Available at: https://pmjay.gov.in/sites/default/files/2019-12/FAQ%20for%20website.pdf

Value of treatments provided	Rs. 7,490 crores	Rs. 15,579 crores	Not Available
Utilization Rate	4.9%	9.5%	11.8%
Average value per treatment	Rs. 16,107.5	Rs. 12,982.5	Not Available
No. of hospitals empanelled	18,236	23,311	24,243

Source: Ayushman Bharat-PM-JAY Annual Reports, National Health Authority, and author's own calculation

3. Scope for financial protection

NHA states the following as the vision of PM-JAY for the first five years of the scheme:

"Achieving SDG 3.8: Ensuring financial protection against catastrophic health expenditure and access to affordable and quality healthcare for all" (National Health Authority, n.d.).

It is noted by the GoI that healthcare expenditure is a leading cause of poverty in India, which either keeps people poor or pushes people into poverty. Through PM-JAY, it aims to offer protection from such unexpected financial shocks to the well-being of poor and vulnerable individuals. However, the ability of PM-JAY to deliver on this promise for the 50 crore identified beneficiaries is directly linked to the total funds required to implement the scheme and the willingness of the government to commit the required funds given competing budgetary priorities. Based on the enrolment and utilisation rates of the past two years (see Table 1) and accounting for medical inflation, this number comes to approximately Rs. 76,235 crores[3], which would be the GoI's share in the overall expenditure, assuming it would cover all the targeted beneficiaries in the next ten years[4]. This would then form more than half of the Ministry of Health and Family Welfare's budget, whereas, at present, PM-JAY accounts for just 9% of the budget allocated[5].

It is clear from the above numbers that if the scheme were to be implemented fully, the government would have to substantially increase its overall spending on health. Alternatively, it would require reallocation of funds from the already underfunded public healthcare system (Gupta et al., 2020; Hooda, 2020). However, given India's past record in healthcare spending[6], not all the identified beneficiaries will receive financial protection under the scheme or, there will be undercutting of tax-funded public healthcare system. The latter, for example, includes spending on communicable diseases, maternal and child healthcare, and maintenance and strengthening of public hospitals, all of which are essential to ensuring improved health outcomes for the population[7].

[3] This is a rough estimation of the financial resources required and is based extrapolation of present enrolment and utilization rates.
[4] At present, the financing of the scheme is shared between the central and the state governments in the ratio of 60:40.
[5] For fiscal year 2021-22, PM-JAY has been allocated Rs. 6,400 crores as against a total budget of Rs. 71,269 crores allocated to the Ministry of Health and Family Welfare. See https://www.prsindia.org/sites/default/files/budget_files/DFG%20Analysis%202021-22_Health%20and%20Family%20Welfare.pdf
[6] India's public health expenditure stands at 1.1% of GDP in 2020-21 and as per Economic Survey 2020-21, India ranks 179th among 189 countries in prioritising healthcare in the government budget. See https://www.prsindia.org/sites/default/files/budget_files/DFG%20Analysis%202021-22_Health%20and%20Family%20Welfare.pdf
[7] All the above-mentioned schemes come under the ambit of National Health Mission (NHM) which is aimed at strengthening public health systems and healthcare delivery. See https://www.prsindia.org/sites/default/files/budget_files/DFG%20Analysis%202021-22_Health%20and%20Family%20Welfare.pdf

How then can the government punch above its fiscal weight and ensure financial protection to all its intended beneficiaries? Market failure on account of information asymmetry is a feature of healthcare markets at all levels, i.e., primary, secondary, and tertiary care, leading to sub-optimal outcomes in terms of efficiency in resource allocation. This is in addition to the fact that markets by themselves do not address the question of equity in access to healthcare. However, Filmer, Hammer, and Pritchett (2002) argue that not all market failures are equal, and this warrants careful consideration by governments in countries such as India in deciding their health policy interventions. They identify two categories of market failures with substantial welfare losses – traditional public health activities, for example, infectious disease control, and the absence of private health insurance markets, which require governments to either address the market failure or provide the healthcare services themselves. On the latter, they further go on to argue that consumption of expensive care would be most affected in the absence of insurance coverage. Hence, if high variability associated with health status of individuals (Arrow, 1963) and the high costs which cannot be managed at an individual level are considerations, high cost, low-frequency health expenditure such as those which fall under the category of tertiary care can be considered as most suitable for coverage through insurance.

As discussed earlier, the HBP 2.0 currently in force covers 867 packages split across 1573 procedures. Given the budgetary constraints, the government can instead explore the possibility of offering a thin tertiary care covering fewer, but costly procedures which are beyond the financial means of most sections of the population[8]. Additionally, it could extend this cover to the entire population instead of restricting it to the current 50 crore targeted beneficiaries, with deductibles being added to those who can afford to pay the premiums. Hence, a larger pool of contributions, partly funded by tax revenue, and partly by high-income individuals, can help reduce the overall costs of offering insurance. This way, the scheme can be redesigned to have maximum impact operating within the budgetary constraints it currently faces and still be able to make a dent on the out-of-pocket expenditures (OOPE) incurred on catastrophic health expenditure, especially by the poor.

As an added step, the government can consider opting out of the insurance model for offering less expensive secondary healthcare services to the identified beneficiaries and instead focus on making available quality secondary healthcare services free of cost, especially to the poor through public hospitals. This would be in addition to quality primary care offered through the public healthcare system.

A natural question that would arise from the above discussion is, how do we ensure quality of primary and secondary healthcare services offered through the public healthcare system? Additionally, given the budgetary constraints, how do we ensure that the limited resources are put to the most efficient use in meeting healthcare objectives? It must be noted that the issue of quality of healthcare and efficiency in delivering it, if not to the same degree as the public sector, is also applicable to the fragmented and unregulated private healthcare provider network in India (NITI Aayog, 2019).

Filmer et al. (2000) and (2002) and Hsiao (2007) argue that one of the weak links between governments spending on healthcare and actual improvements in health status is the institutional capacity required for effective translation of spending into actual delivery of healthcare services. The

[8] The idea of "universal thin tertiary care" has also appeared in the op-ed titled "Unleashing The Full Power Of PMJAY For Post COVID-19 India" authored by Dr. Nachiket Mor in Bloomberg Quint on February 12, 2021. See https://www.bloombergquint.com/bq-blue-exclusive/unleashing-the-full-power-of-pmjay-for-post-covid-19-india

larger issue here, however, is the inability of governments to monitor the provisioning of healthcare and the resulting lack of accountability (NITI Aayog, 2019).

4. Purchaser-provider split and strategic purchasing

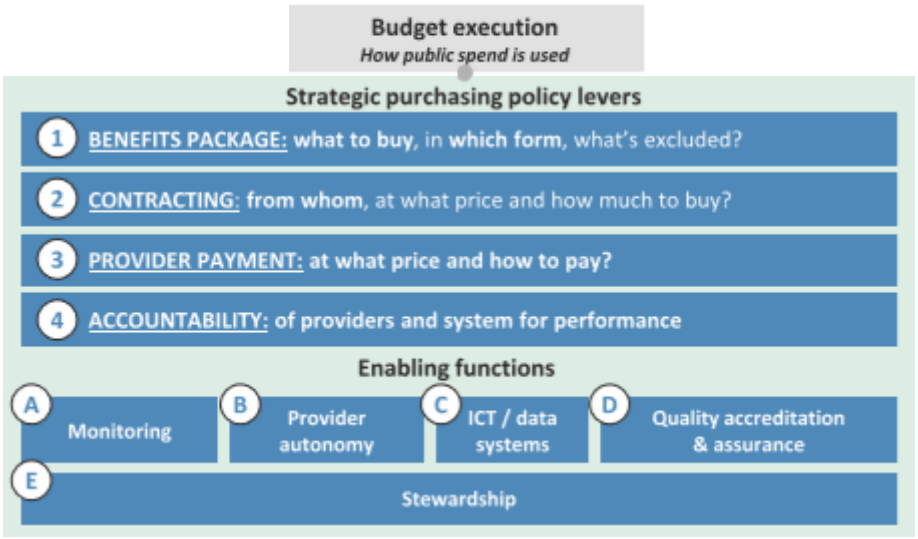
Health financing has a critical role to play in determining how different components of a healthcare system function. These include pooling of health risks and finances, resource allocation for the purchase of healthcare services, and payment methods used to compensate healthcare providers (Hsiao, 2007). While we have discussed the aspect of pooling of resources for tertiary care under PM-JAY, and in general about financing of primary and secondary healthcare, in this section, we look at payments system as a tool for resource allocation and for incentivising healthcare providers to drive effective, efficient and quality health outcomes.

Going back to the questions on quality and efficiency of healthcare services raised at the end of the previous section, different countries have adopted different approaches to deliver healthcare. Broadly, there are two methods that have been identified – direct, and indirect provisioning of healthcare. Under the direct method, financing and delivery of healthcare services are the responsibility of one organisation. On the other hand, the latter involves separating the two functions, purchasing and providing, which are handled by two different organisations (Hsiao, 2007).

At present, in India, the pre-dominant model in the case of publicly financed healthcare system follows the direct method, where the government both finances and delivers healthcare through primary healthcare centres, dispensaries, and public hospitals. Here, the payment model is driven by supply side, and central planning and line-item budgeting (against inputs such as salaries, drugs, facilities, etc.) are used as means to allocate resources to the public healthcare system. This passive resource allocation exercise is however not linked to outcomes such as quality of healthcare service delivered or efficient use of resources and lacks accountability (NITI Aayog, 2019).

Under the indirect method, the purchaser, which is generally a government ministry, or an agency of the government, relies on the market to organise hospitals and clinics, which compete for patients (Hsiao, 2007). Under a model such as this, strategic purchasing is seen as an effective system to organise health policy priorities, allocate resources, design incentives, and create accountability for allocated resources (see Figure 1). Specifically, contracting and provider payment methods are two key levers which can help set quality, price, and data reporting standards and incentivise providers to deliver on health policy objectives. Hence, the payment system under this method is demand driven, i.e., money follows the patient, and providers have to necessarily compete for government resources based on monitored outcomes.

Figure 1: Strategic Purchasing and Policy Levers



Source: NITI Aayog, 2019

In India, although limited to the scheme, PM-JAY marks a shift at the national level towards strategic purchasing of secondary and tertiary healthcare services. With the creation of NHA at the centre and SHA at the state level, a separation has been brought into effect between the government, which purchases healthcare through these agencies on behalf of beneficiaries, and providers, comprising of private and public empanelled hospitals. This has created the space for using various provider payment mechanisms such as the current method of package rates covering costs associated with a specific procedure and capitation payments for primary care services which essentially makes one payment per person to the provider for a bundle of services covering a fixed period. These different payment methods, while pre-defining what healthcare services are covered, can evolve over time to reflect the disease burden in the population and can also be used to contain cost and drive efficient use of allocated resources. The process of empanelment of hospitals, on the other hand, can ensure that minimum healthcare infrastructure and quality healthcare services are made available through government-contracted providers.

Key to driving accountability for quality of healthcare delivered under strategic purchasing is to have in place systems for reporting and monitoring of data on health outcomes from the provider network, while also issuing standardised guidelines for treatments. Currently, in India, monitoring of healthcare services delivered through publicly financed healthcare system is very limited and contributes to the lack of accountability discussed earlier (NITI Aayog, 2019). However, with the launch of PM-JAY, steps have been taken in this direction. These include efforts towards issuance of Standard Treatment Guidelines for each condition covered under the scheme, which are to be used as a tool by the empanelled provider network and push towards National Digital Health Mission aimed at digitising and integrating health records (National Health Authority, n.d.; National Health Authority, 2020)

The organisational structure that has been put in place with PM-JAY and the capabilities and infrastructure sought to be built through it are currently restricted to secondary and tertiary healthcare services covered under PM-JAY. However, this has also created an opportunity to address issues of accountability for quality and efficiency of primary and secondary healthcare services delivered through the public healthcare system. Over a period of time, NHA and SHA can take on the role of purchaser of these healthcare services and thereby create an internal market of public

providers where government funds will follow patients to primary healthcare centres, dispensaries, and public hospitals, which demonstrate improvements in health outcomes for its beneficiaries[9].

5. Conclusion

Given the amount of financial resources that the government will have to commit to implement PM-JAY completely, there are questions around whether it will be able to meet its objective of providing health cover to 50 crore targeted beneficiaries. However, with carefully planned tweaks to the design of the scheme and its proper implementation, it has the potential to provide financial protection from expensive tertiary healthcare expenditure to not just the targeted beneficiaries, but to all sections of the population. The system and the capabilities sought to be built for the implementation of the scheme have the potential to help reform the healthcare system in India at all levels, including primary healthcare. Key to this reform would be a move towards outcome-oriented health financing with quality and efficiency driving resource allocation.

[9] The idea of "internal markets" for healthcare delivery has also appeared in the op-ed titled "Unleashing The Full Power Of PMJAY For Post COVID-19 India" authored by Dr. Nachiket Mor in Bloomberg Quint on February 12, 2021. See https://www.bloombergquint.com/bq-blue-exclusive/unleashing-the-full-power-of-pmjay-for-post-covid-19-india

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Appendix

Post publication of this note as a pre-read for the fourth webinar in the webinar series on Health Financing in India, we received the following feedback and comments on some of the ideas that we have proposed in the note. We would like to acknowledge and record them here to inform the readers of this note of different viewpoints expressed.

1. Scope for financial protection - It was expressed that the government being unable to fund the scheme to achieve full implementation is at this point a non-issue as we have a long road ahead of us before the scheme is able to achieve full enrolment of all the beneficiaries and see actual utilisation of services offered. It was pointed that there are demand- and supply-side issues which need to be resolved at present. Some of the demand-side issues include preference for hospitalisation in the same district as the patient residence, which in some cases are driving the low utilisation rates. This is especially the case in rural areas. On the supply-side , availability of doctors, low utilisation of public hospitals, and delay in the processing of claims submitted by private hospitals were some of the issues cited.
2. Removal of secondary care from the insurance model offered through PM-JAY – On this suggestion, concern was expressed around how the definition of catastrophic health expenditure (exceeding 10% of household consumption) would mean that secondary healthcare services for the poor and vulnerable would lean more towards high-cost, low-probability healthcare, much like tertiary healthcare, and therefore suffers from the issue of insurance market failure. Hence, removing this component from PM-JAY can be a potential cause for concern. It was also pointed out that tertiary care is less cost-effective (health-per-rupee-spent) than secondary care.
3. Universal thin tertiary care – It was pointed out that any proposal to have a voluntary insurance system for those who can afford would have to contend with adverse selection, which can undermine the financial sustainability of the programme. Additionally, a shift to a tertiary care-only scheme would make the scheme more private hospital focussed and less pro-poor as there are fewer- and more urbanised- hospitals providing these services. It was observed that hospitalisations in India, for the most part, happen in the same district as the patient residence making it harder for those in aspirational districts to avail of the scheme.