national health authority

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Pradhan Mantri Jan Arogya Yojana
Ayushman Bharat
PM-JAY

german cooperation
DEUTSCHE ZUSAMMENARBEIT

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One Year into PM-JAY Implementation

A Household Study Across Seven States in India

Executive Summary Report

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Address
B-5/1, 2nd Floor, Safdarjung Enclave
New Delhi – 110 029, INDIA
T +91 11 49495353

I: www.iguhc.in
I: www.giz.de

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Indo-German Programme on Universal Health Coverage (IGUHC)
IGUHC is giving technical advise to the Ministry of Health and Family Welfare (MoHFW), the National Health Authority (NHA) and other stakeholders on a national level on the further development of Pradhan Mantri Jan Arogya Yojana (PM-JAY) with a view of achieving Universal Health Coverage (UHC), improving health services and linking PM-JAY with other health insurance schemes. The programme is assisting its partners in improving the scheme's strategic orientation towards UHC. It also encourages convergence of existing insurance schemes, especially at state-level, under the flagship of PM-JAY as well as an integration of primary, secondary and tertiary levels of health care within a continuum of care.

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The study team included
NHA team: Basant Garg, Vipul Aggarwal, Kameshwar Rao, Ruchira Agrawal
Study Coordinators: Nishant Jain (GIZ), Sharmishtha Basu (GIZ)
Principal Investigator: Manuela De Allegri (HIGH)
Co-investigators: Swati Srivastava (HIGH), Stephan Brenner (HIGH), Diletta Parisi (HIGH), Divya Parmar (City, University of London), Christoph Strupat (DIE), Caitlin Walsh (HIGH), with the collaboration of Nielsen

Editors
Dr Sharmishtha Basu
Alexandra Humpert

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GIZ is responsible for the content of this publication.

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For more information please contact
Project Director
Mr. Amit Paliwal
E amit.paliwal@giz.de

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We would also like to thank Nielsen India Pvt Ltd for successful completion of the data collection. We hope that our recommendations based on interviewees' experiences will lead to better implementation of future health insurance projects and improve the lives of the poor.

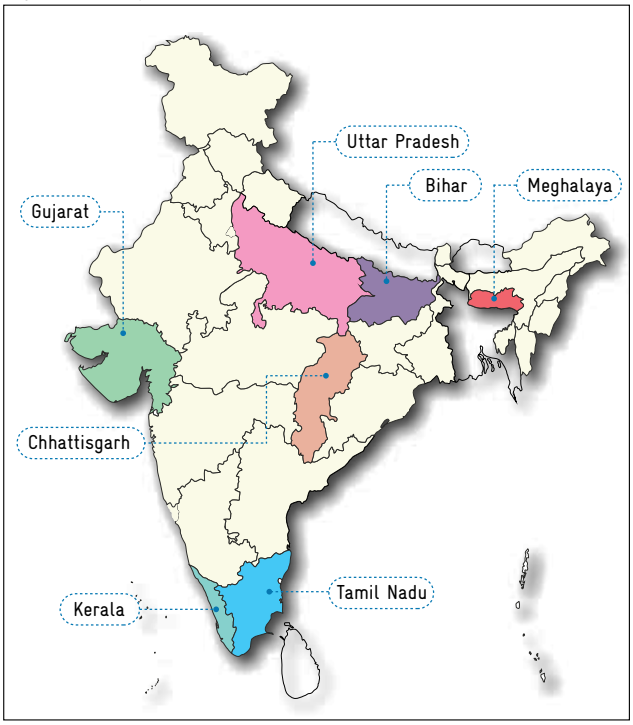
Background

Alongside the global push towards Universal Health Coverage (UHC), recent health sector reforms in India strive to leave no one behind in the attainment of health, including access to and use of health care services. India has made persistent efforts to develop national and state level social protection mechanisms, particularly through government-funded social health insurance schemes (SHIS), to provide access to quality health care while offering financial protection from the cost of illness to beneficiaries. The implementation of these schemes has culminated in a steady rise in insurance coverage, from approximately 5 percent of households in 2005 to 29 percent in 2011 (1). Other estimates indicate that insurance coverage has increased from 75 million persons in 2007 to over 400 million in 2016 (2).

In September 2018, the Government of India launched a new government-funded social health insurance scheme, the Pradhan Mantri Jan Arogya Yojana (PM-JAY). PM-JAY was launched with the expectation of consolidating and spreading achievements made by these previous schemes by removing formal enrolment procedures and expanding coverage to the approximately 500 million people listed as vulnerable in the 2011 Socio-Economic Caste Census (SECC). As a result, unlike previous schemes, insurance coverage under PM-JAY is no longer subject to a fixed household size and has been expanded to INR 500,000 per household annually to include selective inpatient secondary and tertiary procedures. Services are provided by public and private empaneled providers. The scheme is governed by the National Health Authority (NHA) at the federal level and implemented by a State Health Agency (SHA) in each State, either through insurance companies or through state autonomous trusts/nodal agencies, with scope for state-specific adjustments. Given the strong emphasis on output-based financing and oversight by the NHA and SHAs, PM-JAY seeks to strengthen the delivery of quality health care and to further expand financial protection by promoting efficiency, transparency and accountability. It does so, by applying selective contracting and output-based payments linked to quality service outputs.

This report is based on the research performed by a consortium of institutions, led by the Heidelberg Institute of Global Health, Medical Faculty, Heidelberg University Hospital, including the cooperating institutions of City University of London, the Deutsches Institut für Entwicklungspolitik/German Development Institute and Nielsen India Private Limited. It was commissioned in April 2018 by the Indo-German Social Security Programme (IGSSP), predecessor of the Indo-German Programme on Universal Health Coverage (IGUHC). From January 2019 to July 2020, the research evaluated the state-funded social health insurance scheme, Pradhan Mantri Jan Arogya Yojana implementation from the demand-side. It provides insights on how households across seven Indian states experienced PM-JAY, approximately 14 to 16 months after its implementation in September 2018 (Figure 1).

Figure 1: Study States



Objectives

In this report, research findings are presented of work examining elements related to the demand-side, i.e. community responses to PM-JAY and beneficiaries' experiences of care under the new insurance scheme. The research upon this report is based aimed at describing access to health service, health care utilization and financial protection within the framework of PM-JAY. In addition, the study aimed at assessing the extent to which selected households still met the SECC criteria set in 2011 and used as a basis to determine PM-JAY eligibility, and at exploring household and community awareness and knowledge of this new insurance scheme.

Methods

To reach the abovementioned objectives, the study relied on a concurrent triangulation mixed-method design incorporating both quantitative and qualitative research components. In such design, quantitative and qualitative components hold equal weight and are conducted in parallel. The approach is rooted in a pragmatist stand oriented towards answering research questions emerging from the problem-oriented and real-world practice of implementing a nationwide health insurance scheme. The researchers have used quantitative methods to assess standard indicators on health care utilization and out-of-pocket-expenditures; awareness of PM-JAY and knowledge of PM-JAY features; and eligibility verification and registration processes. The researchers have used qualitative methods to gain in-depth insight into individual views and experiences of PM-JAY and gender dynamics in the use of PM-JAY. In addition, focus group discussions elicit knowledge on overall community attitudes, beliefs, and social constructions of the new scheme.

Data were collected during a single cross-sectional data collection round in seven States, namely Bihar, Chhattisgarh, Gujarat, Kerala, Meghalaya, Tamil Nadu and Uttar Pradesh (as shown in Figure 1). In each State, two districts were selected: Bilaspur and Raigarh (Chhattisgarh), Ahmedabad and Surat (Gujarat), Kannur and Palakkad (Kerala), East Khasi Hills and South West Garo Hills (Meghalaya), Coimbatore and Sivagangai (Tamil Nadu). In two States, Bihar and Uttar Pradesh, three instead of two districts were sampled, namely Muzaffarpur, Patna and Gaya (Bihar) and Allahabad, Ghazipur and Rampur (Uttar Pradesh).

Within each selected district, the quantitative sampling strategy included both a representative sample of PM-JAY eligible households at the district level and a sufficiently representative sample of those eligible households having advanced a claim under PM-JAY by the time of data collection. Within all abovementioned districts, the Primary Sampling Unit (PSU) included villages in rural areas and medium/small urban areas with less than 7,500 inhabitants (based on the observations of the pilot surveys, a cutoff at 7,500 inhabitants was set to exclude larger urban areas in which administering the survey was not operationally feasible). Sampling adopted a three-step approach. First, information from the 2011 SECC was used to randomly select 50 PSUs that are representative of the entire district with regards to the following district characteristics: number of PM-JAY eligible households, number of PM-JAY eligible individuals, number of PM-JAY claims, share of urban households, share of women; share of children, share of adults, share of elderly and share of married people. Second, using the selected PSUs and SECC information, 15 households per PSU were randomly selected to reach a total representative sample of 750 eligible households per district. Third, 20 additional PSUs were identified among those with the highest number of claims across all remaining PSUs in a district. In order to ensure a sufficient sample of households with a filed claim under PM-JAY, 20 claim households were selected in each of these 20 PSUs, to reach a total sample of 400 claim households per district. The sample of the eligible households is 750 households. This strategy helped to reach 1,150 households per district.

Quantitative data were collected via a household questionnaire containing questions on household socio-demographics, household loans and consumption expenditure, illness reporting (for acute and chronic illnesses and related inpatient hospitalizations), health service use, out-of-pocket spending on health, and PM-JAY awareness and experiences. Given the insurance scheme's focus on secondary and tertiary care, the survey included questions on inpatient hospitalizations (both surgical and non-surgical) over the prior 12 months. A specific module was built within the survey to assess women's experiences with the scheme and its role in mediating household decision making and enhancing women's empowerment. Data were collected by trained interviewers relying on the Computer-Assisted Personal Interviewing on digital devices. The survey was translated in all concerned local languages and administered by local interviewer teams fluent in these languages and recruited from the study districts.

Given the reliance on a single round of data, the quantitative analysis could not aim at distilling the impact of PM-JAY on the outcomes of interest, but was more simply oriented towards describing patterns of knowledge and health service utilization during the early implementation phase. As such, the analysis relied primarily on descriptive statistics, capturing,

for each outcome of interest, the share of the population reporting a given answer. Out-of-pocket expenditure (OOPE) was captured in INR. To provide a sense of the financial protection granted by the scheme, SHIS coverage were further investigated, including PM-JAY, and it was estimated what proportion of individuals including PM-JAY, and estimated what proportion of individual yearly consumption expenditure was captured by a hospitalization case.

Qualitative data collection was carried out across the abovementioned districts, specifically in a subset of communities (2 villages per district) targeted by the quantitative survey as having relatively high numbers of PM-JAY eligible persons. The sampling strategy relied on a combination of Key Informant Interviews (KIIs), Focus Group Discussions (FGDs) and In-depth Interviews (IDIs). KIIs were carried out with Community Health Workers (CHWs) who have been involved in or have knowledge of PM-JAY community dissemination and support activities. The types of CHWs who participated in interviews varied by State and included Accredited Social Health Activist (ASHA), Mitanin, Village Health Nurse (VHN) and Male Health Workers. FGDs with PM-JAY eligible community members and beneficiaries provided insight into community perceptions of and experiences with PM-JAY while IDIs with individuals who have utilized services under PM-JAY offered valuable information about personal knowledge of and experience with the scheme.

The researchers conducted KIIs with two CHWs per district (N= 2 x 16 districts= 32 KII; 30 female and 2 male). These key informants provided information on overall scheme rollout and implementation, community knowledge and perceptions of PM-JAY and helped us to identify respondents for the FGDs and the IDIs. The researchers conducted two FGDs in each district, one in a rural and one in an urban setting (N=2 x 16 districts = 32 FGD), with 8-15 participants in each FGD, specifically selecting PM-JAY eligible individuals and beneficiaries with or without PM-JAY service use experience. Given the specific cultural context within which the study takes place as well as to maintaining a specific focus on gender dynamics throughout the study, FGDs were either all female or all male (with a total of 18 female FGDs and 14 male FGDs carried out across the states). From each FGD, the researchers selected one or two information-rich cases, i.e. individuals whose experience with PM-JAY service use appeared to be particularly poignant in relation to the underlying research questions (for example those who have experienced high-cost treatments or have lodged grievances under PM-JAY) and followed them up with a request to engage in an additional IDI. The researchers conducted a total of 64 IDIs (32 with females and 32 with males) across the States, averaging 4 IDIs in most districts.

Qualitative data were collected by trained interviewers recruited in the study States and relied on semi-structured qualitative data collection tools developed by the study team and subsequently translated into the relevant local languages. Data collectors worked under the close supervision of senior researchers, who adopted systematic debriefing procedures to closely follow field data collection and to identify and resolve challenges in a prompt manner. All interview material was transcribed verbatim and translated into English for analysis by the interviewers. Transcriptions were checked for quality and consistency by senior researchers. The core team of senior researchers was in charge of analysis. They applied systematic coding to the transcribed material to cluster emerging findings into main thematic areas.

Findings

Out of a total of 72,636 individuals included in the quantitative survey, 35 percent were registered in any SHIS including PM-JAY (given different labelling and registration strategies across States, the researchers are obliged to count overall registration in a SHIS and not PM-JAY alone). Further, 2 percent of respondents did not know if they were registered at all and 2.6 percent reported being enrolled in a community-based insurance scheme.

Almost the entire sample was located in rural areas and was balanced in terms of gender composition. Approximately 52 percent of respondents were in the age group 15-49 years, with an average household size of about five persons per family. Some heterogeneity was observed across States. The highest registration rate was observed in Kerala where half of the sample reported being enrolled. However, this high rate is likely driven by the fact that in this State, due to challenges to field operations, the sample included almost exclusively households who had previously presented an insurance claim.

Second highest registration rates were observed in Bihar and Chhattisgarh. The lowest rates were observed in Meghalaya and Tamil Nadu.

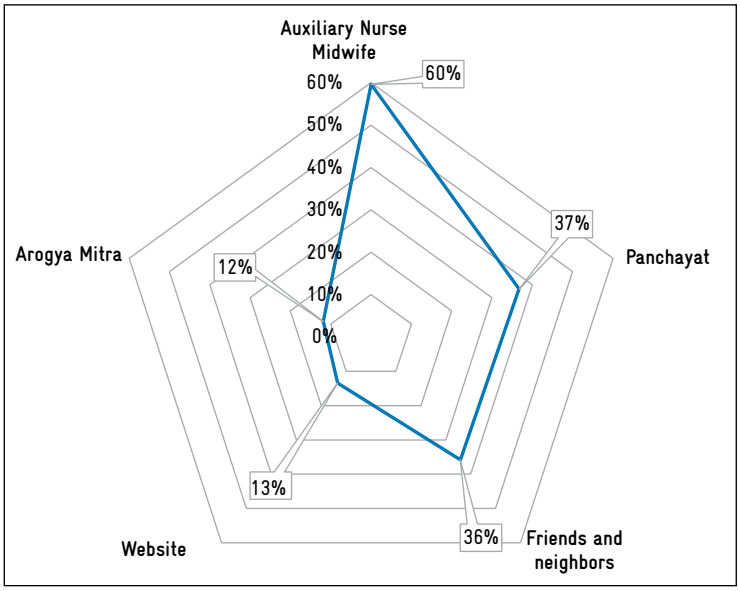
Considering PM-JAY eligibility, 78 percent of rural households included in the sample (and hence specifically sampled among households deemed eligible by the State authorities) actually still fulfilled at least one out of the six PM-JAY eligibility dimensions and/or the criteria for being automatically included households. On average, the largest share of rural households was considered eligible for PM-JAY because they belonged to a scheduled caste or tribe, and secondly, because they were landless households deriving a majority of their income from manual casual labor. Only 1 percent of the entire rural sample was automatically included. Most of the households the researchers surveyed, however, also fulfilled at least two exclusion dimensions. More specifically, 99 percent of the households had at least one member earning more than INR 10,000 per month; 71 percent of the households owned at least five acres of irrigated land; and 32 percent of the households lived in houses with at least three rooms with pucca walls and roofs.

Looking at awareness, 62 percent of household heads reported being aware of PM-JAY, the main channels of first hearing about the scheme being friends and neighbors, ASHA workers and the Prime Minister's Letter. Many people knew that PM-JAY covered hospitalization costs (59 percent) and were familiar with the ceiling amount of INR 5 lakh per family (34 percent). Approximately 28 percent of household heads interviewed did not know any feature of the scheme. Substantial heterogeneity regarding awareness and knowledge indicators across the States was observed. For instance, considering the main sources of awareness of PM-JAY, friends and neighbors were one of the main sources across most States, while hospitals were the main source of knowledge in Chhattisgarh and Kerala, and TV was among the first three sources only in Tamil Nadu.

Qualitative findings confirmed that awareness of the scheme fell short of what would have been expected and more importantly that knowledge of the single scheme features was rather erratic, with some community members knowing few features, but not others. Not surprisingly, the qualitative study component indicated that awareness of the scheme and its features was generally higher among individuals who had sought care under the scheme or knew someone who did. Similarly, the qualitative study revealed that PM-JAY could more easily be named in States where there was no prior or active State scheme, such as in Bihar and Uttar Pradesh, than in States where PM-JAY was integrated into an existing SHIS, such as in Tamil Nadu. Qualitative findings confirmed that CHWs generally had higher, yet imperfect, knowledge of the new scheme, hence they also struggled to act as informants for the communities they served.

Considering eligibility, 78 percent of household heads reported knowing that they were eligible for PM-JAY, the sources of hearing about the family eligibility being mainly the auxiliary nurse midwife, the Panchayat and friends and neighbors (Figure 2). Nevertheless, only 55 percent of household heads had verified the eligibility of their household. Respondents reported that community centers, empaneled hospitals and PM-JAY kiosks acted as the main location for eligibility check. The vast majority (89 percent) of individuals having gone through the verification process (beneficiary identification system) were deemed eligible for PM-JAY. Overall, the experience with this process was rated as "very good" by household respondents. The researchers observed substantial heterogeneity in terms of

Figure 2: Main sources of information about the family Eligibility for PM-JAY in pooled States



verification experience across the States. For example, Gujarat had the highest verification rate (89 percent) followed by Meghalaya (87 percent). The lowest rates were observed in Kerala and Bihar (18 percent and 28 percent respectively). In Tamil Nadu, these questions were not asked.

Qualitative findings presented a more nuanced picture of knowledge of eligibility and the related verification experience. A large gap was observed in awareness and varied experience with how the eligibility procedure had been managed. Individuals were generally unaware of how entitlement to the scheme benefits was being enabled through a structured verification process. Respondents often indicated initiating the procedure only upon falling ill, and therefore reported incurring into unnecessary delays in the process of seeking and obtaining care.

Pooling data across States, it was observed that 7 percent of all individuals in the sample had used hospital services (i.e. had incurred a hospitalization) over the prior 12 months. Counting only individuals that were randomly selected on the basis of their eligibility and not on the basis of having incurred a hospitalization, this proportion dropped to 3.5 percent. The household survey revealed that satisfaction with the quality of the services received was generally very high across all States.

Among individuals who reported a hospitalization, 84 percent had incurred OOPE (including pre-, during-, and post-hospitalization expenditure). Since the measure of hospitalization included maternal care services, women in the sample reported substantially higher utilization rates than men. No differences, however, were observed between men and women in relation to the probability of incurring OOPE nor the actual OOPE amounts paid. Individuals whose hospitalization was not covered by any SHIS including PM-JAY were more likely to incur any OOPE (95 percent of cases compared to 76 percent of cases respectively) and spent on an average a larger amount (18,976 INR compared to 9,125 INR). When probed, individuals whose hospitalization had not been covered by any SHIS reported that this had been the case mostly because they did not know of PM-JAY at all or had not undergone the verification process (i.e. the beneficiary identification system). In some instances, however, individuals simply had no idea why their hospitalization had not been covered. On average, individuals that incurred a hospitalization spent the equivalent of 26 percent of annual per capita household expenditure on the hospitalization. Individuals who were not covered by any State Health Insurance Scheme spent on average a larger share of their annual per capita household expenditure (more than 30 percent). Tamil Nadu presents the exception to the overall pattern observed in the other States: hospitalization episodes not covered by any SHIS incurred OOPE less frequently and spent a lower amount on seeking care. In Tamil Nadu, the average proportion devolved to cover hospitalization costs was 30 percent of the total annual expenditure for the hospitalization covered by any SHIS compared to about 20 percent of the cases not covered by any health insurance scheme. This apparently surprising pattern can be explained by the nature of the PM-JAY benefit package in the State, focusing on high-risk low-frequency events. A similar pattern was also observed in Kerala where cases covered by any SHIS and cases not covered by SHIS absorbed on average 20 percent and 10 percent respectively of annual per capita household expenditure. This finding, however, needs to be handled with caution since in Kerala, only very few hospitalization episodes not covered by any SHIS were captured.

Qualitative findings confirmed the picture of health service utilization patterns which emerged from the quantitative analysis and revealed that not being duly informed of their entitlements, eligible households often lacked knowledge as to where and how to seek care. Qualitative findings confirmed that OOPE remained high and continued to represent an important barrier to access, forcing households to reduce consumption on other essential items and/or to borrow money to pay for the high cost of care. As frequently observed in resource-limited settings, when asked to describe their experiences of care, respondents did not provide the same rosy picture which emerged from the quantitative analysis and expressed concerns about the quality of the service delivered. These concerns mostly reflected weaknesses in provider-patient interaction and persistence of disrespectful behaviors towards the poor, more so than actual deficiencies in the technical aspects of service provision. Across States, respondents also felt that as poor people, they were largely disempowered and lacked the means to voice their concerns and suggestions on how the scheme could operate.

Recommendations and way forward

Looking at findings across States and appraising them across strains of analysis, i.e. quantitative and qualitative, it is observed that the proportion of households reporting insurance coverage in the sample is much higher than what was reported in estimates from prior national surveys. The researchers note, however, not only that prior estimates precede the launch of PM-JAY, but also that the sample is purposely intended to be representative of the PM-JAY population and not of the overall country population. As such, the estimates can be taken to be representative of coverage rates among PM-JAY eligible populations in the selected study States, but not of overall population coverage nation-wide. Further, in States with previously implemented SHIS, PM-JAY coverage and state-specific SHIS coverage largely overlap, albeit many respondents in the study were not aware of it. The researchers further note that while 78 percent of rural households in the sample still met at least one eligibility criteria based on the 2011 SECC, more than 99 percent also met at least one exclusion criteria. This induces to question the applicability of the 2011 SECC criteria as an exclusive basis for targeting and calls for further research and policy action into identifying complementary strategies to ensure effective targeting.

Across States, low awareness of PM-JAY and its features emerges as an overarching problem, possibly largely acting as the single largest barrier to effective access to healthcare services and OOPE. As such, lack of awareness appears to be as the most relevant impediment for the scheme to achieve its full social health protection potential. Nonetheless, the findings also reveal that many people who might have forgone care in the absence of PM-JAY were able to access the secondary and tertiary services they needed and were mostly satisfied with the care they received. The fact that utilization of hospitalization services remains relatively low, at 3.5 percent considering only individuals in randomly selected PM-JAY eligible households, however, indicates that additional barriers, beyond financial ones, are at play in limiting access to specialized care for the poor. Further research needs to be undertaken to understand how additional measures, complementary to insurance coverage, can be implemented to facilitate access and hence allow the scheme to maximize health benefits for the target population.

Furthermore, the findings indicate that SHIS coverage, including PM-JAY, can be instrumental in reducing OOPE among individuals who need highly specialized care and is therefore essential to secure social health protection. Nonetheless, further efforts ought to be channeled towards understanding the reasons for continuing high OOPE among SHIS beneficiaries and strategies to overcome existing challenges and further reducing the probability that beneficiaries seeking care incur high OOPE. It needs to be noted that across almost all States, OOPE remained even higher among individuals whose hospitalization case was not covered by SHIS/PM-JAY. This points again at the need to increase awareness and facilitate registration and claim procedures to ensure that people make use of their entitlement to care.

In light of all the findings presented above, it is recommended that:

- **Further strategies are developed to increase awareness of the scheme and knowledge of the scheme features as the first step towards enabling effective access to healthcare;**
- **Additional efforts are channeled towards understanding and addressing barriers to access to healthcare services to ensure that all people in need of specialized care receive care;**
- **Replicating experiences from other settings, solutions are sought to integrate insurance navigators, i.e. dedicated staff to guide and assist beneficiaries from verification of eligibility process to the hospitalization experience;**
- **Detailed facility-based assessments are carried out to investigate the root causes of persisting OOPE and identify strategies to address them;**
- **Communication and feedback channels are established and actively promoted to allow beneficiaries to voice their concerns and strategies are developed to integrate their point of view into the functioning of the scheme, resulting in increased responsiveness and accountability.**

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Deutsche Gesellschaft für
International Zusammenarbeit (GIZ) GmbH

B-5/1, 2nd Floor, Safdarjung Enclave
New Delhi – 110 029, INDIA
T +91 11 49495353

I: www.iguhc.in
I: www.giz.de