POLICY BRIEF 2022

ONE YEAR INTO PM-JAY IMPLEMENTATION (SUPPLY-SIDE)

BACKGROUND

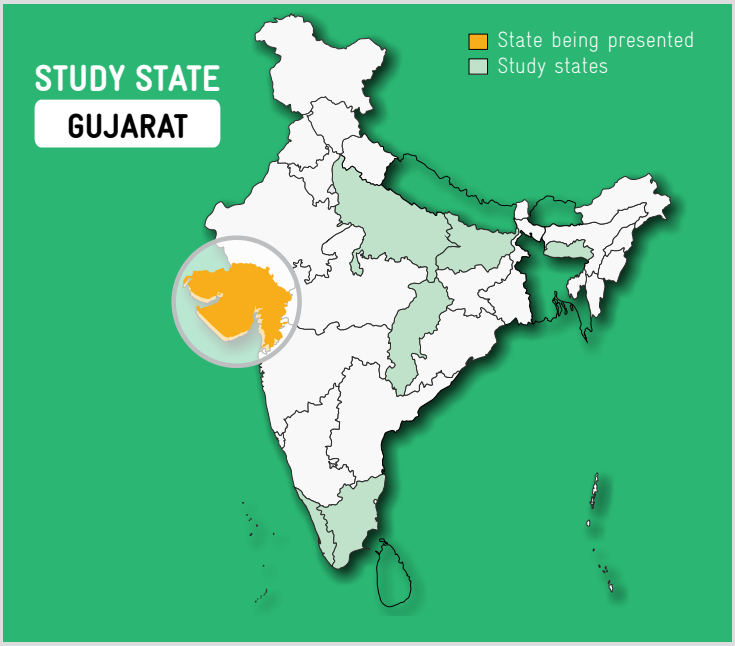
This policy brief presents findings from research commissioned in April 2018 by the Indo-German Social Security Programme (IGSSP), predecessor of the Indo-German Programme on Universal Health Coverage (IGUHC). The research evaluated the PM-JAY implementation from the supply-side, thereby providing performance evidence to India's National Health Authority (NHA).

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 IQVIA Consulting and Information Services India did the evaluation from January 2019 to July 2020.

The mixed methods research provides insights into hospital empanelment changes related to the state-funded social health insurance scheme, Pradhan Mantri Jan Arogya Yojana (PM-JAY), across eight Indian states, including Gujarat, approximately 14-16 months after its implementation in 2018.

The Study areas were:

- Hospital service quality inputs (i.e., infrastructure, staffing, consumables)
- Processes and outputs Processes and outputs (i.e., healthcare providers' and PM-JAY beneficiaries' experiences with the implementation of and service utilization under PM-JAY).



GUJARAT

APPROACH

Quantitative and qualitative data was collected from 24 hospitals in two districts in Gujarat (Ahmedabad and Surat) at two different time points (February to April 2019 and November 2019 to January 2020). Eighteen of these hospitals in the first round and 21 in the second round were empanelled under PM-JAY, with the remaining hospitals serving as comparisons. Data collection included structured questionnaires (for hospital directors, administrators, PM-JAY patients) and qualitative interviews (for hospital directors, general practitioners).

KEY FINDINGS

Quantitative

Service Quality Indicators (Hospital Survey)

Criteria most complied with

Nearly all empanelled and non-empanelled hospitals fulfilled criteria for minimum bed capacity, 24/7 availability of at least 1 doctor and 1 nurse, pharmacy, kiosk for PM-JAY beneficiaries, motor vehicle accessible road and obstetric and newborn care providers.

Criteria least complied with

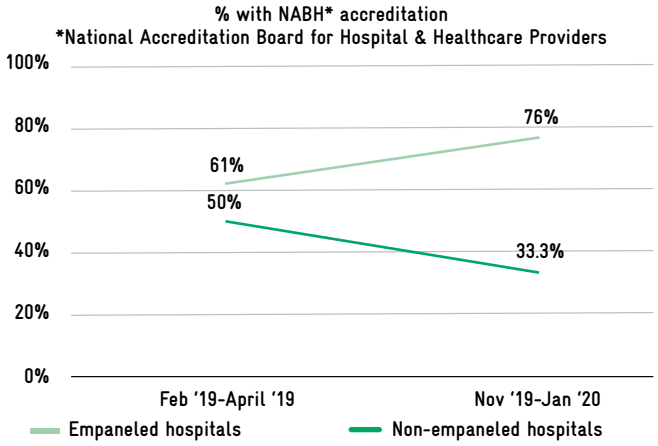
Both hospital groups showed relatively low levels for NABH accreditation, blood banks and essential equipment of labour rooms.

Empanelled hospitals have low availability of 24/7 availability of PM-JAY help desk clerk.

The total number of non-surgical specialties available remained more or less stable at around 5 out of 8 for both empanelled and non-empanelled hospitals.

Improvements over time

NABH increased by 15 percentage points in empanelled hospitals:



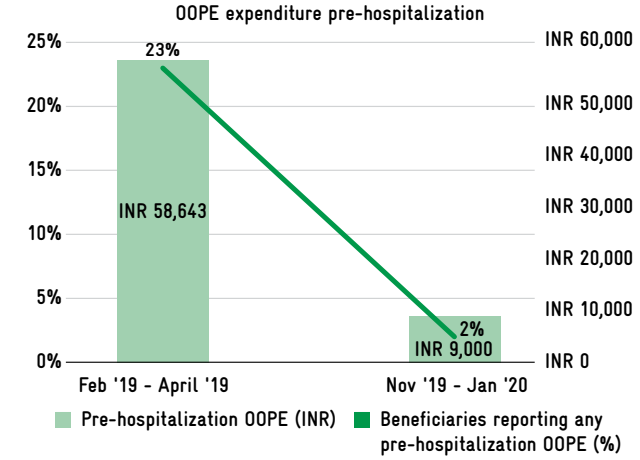
Deteriorations over time

There have been no substantial deteriorations in empanelled hospitals once compared to non-empanelled hospitals.

Beneficiaries' Experiences (Exit interviews)

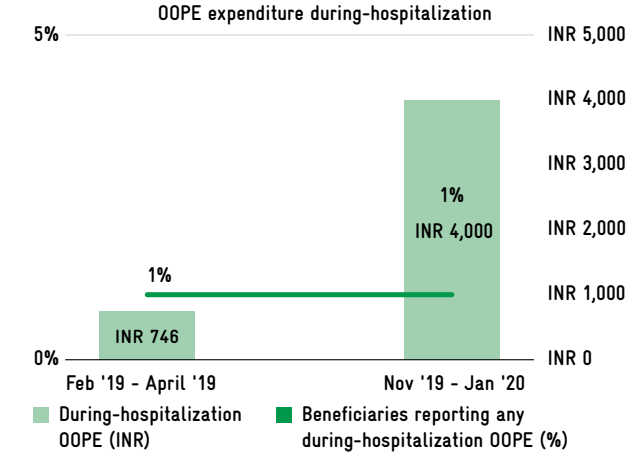
Expenditures prior to hospitalization

Pre-hospitalization OOPE decreased by 21 percentage points and the expenditure amount decreased by 85 percent:



Expenditures during hospitalization

During hospitalization, the number of beneficiaries incurring OOPE stagnated at a very low level. The expenditure amount increased by five times:



Satisfaction with hospitalization

Services were received as excellent, good or very good, with a mean of 1.7 and 2.1 on a scale of 6 (very poor) to 1 (excellent).

Qualitative

Experiences of hospital administrators and general practitioners with PM-JAY implementation:

Beneficiary management

Beneficiary management closely followed PM-JAY guidelines using the Beneficiary Identification System. After identification, pre-authorization, blocking of packages, hospitalization and treatment, discharge and follow-up processes aligned with PM-JAY guidelines.

Beneficiary management gradually improved as staff became more familiar with procedures.

Hospitals reported increases in patient loads since PM-JAY was launched, with increases in outpatient service load, even among non-beneficiaries. Beneficiaries were increasingly more aware about PM-JAY.

However, beneficiary awareness about PM-JAY entitlements and features was very poor. Many respondents reported better-off and middle-class households increasingly utilizing services through PM-JAY.

PM-JAY support team

Hospitals interacted with the state nodal agency support team for blocking of treatment packages, claim processing and claim settlement. Majority of hospitals reported good and supportive engagement with PM-JAY support team in respect to timely response resolutions.

A large number of respondents highlighted issues related to delays in response (for both pre-authorization and claim processing), unsatisfactory responses, unnecessary queries or requests for additional documentation and investigations, and inadequate support at night.

Many respondents observed that response times were increasing, and many support team staff appeared unqualified to perform their activities.

Clinical management

Most commonly discussed patient management aspects referred to patient admission, treatment and discharge.

Most hospitals which witnessed increases in patient footfall conducted additional staff training or hired new staff; some mentioned having to increase infrastructure and more frequent stockouts of medicines and consumables.

Two procedural differences from the previously-implemented MAA Yojana were highlighted: first, transportation allowance to beneficiaries but was no longer given under PM-JAY, which resulted in fewer patients attending follow-up care (as they could no longer bear travel expenses), while some hospitals covered these expenses directly; and second, hospitals are no longer able to provide additional treatments for complications, as under PM-JAY separate admissions and claims had to be processed for patients with complications.

Quality improvement

Some hospitals conducted general training, monitoring of indicators, information management processes and adhered to standard protocols to promote quality of service provision. Many hospitals were accredited and followed quality monitoring and improvement as necessitated by the accreditation, but unrelated to PM-JAY requirements.

The majority of hospitals were either accredited or in the process of obtaining entry-level accreditation, and some expressed interest in working towards obtaining accreditation.

Managers in public hospitals reported upgrading their infrastructure, including information systems, supplies, consumables and other equipment, and hiring additional staff using PM-JAY funds, and sometimes, in response to the increased patient load.

Procedural changes required by PM-JAY necessitated more detailed documentation (case sheets, discharge summaries and other beneficiary records), which were perceived cumbersome, as clinical staff had to take care of these additional, and time-consuming responsibilities alongside their regular duties. The discharge process was also reported to take longer than before.

> *"There are many benefits like the claim funds are utilize in our hospitals and for hospital infrastructure and patient development. So, this fund is very helpful."*

Financial management

Most hospitals monitored financial activities (procurement of funds, utilization of funds, accounting, payments and risk assessments) through profit loss monitoring.

PM-JAY claims were not settled in the state from January-March 2019. This and subsequent delays in reimbursement disrupted the hospital procurement cycles, with these hospitals not having adequate capital to purchase necessary supplies and consumables.

Some hospitals reported receiving assistance from the PM-JAY support team for financial management, including training.

Claims processing and payments were delayed with no reasons for delays in payments or rejection of claims. Reimbursements were bundled without any information on what payment was made for which claim. Reimbursed amounts were perceived to be always less than that was claimed.

Achievements Related to PM-JAY Implementation

Respondents found the use of PM-JAY funds for hospital upgradation to be a key achievement.

The ability to treat patients from different states (portability of scheme benefits) was mentioned as notable achievements by some other respondents.

> *"Experience with the MA Yojana was better than the PM-JAY. Claims were settled on time, and we can track the claim record of settled and pending patients."*

Challenges related to PM-JAY implementation (Processes and procedures)

Most commonly, these pertained to the low reimbursement rates of treatment packages; many respondents opined that the package rates were too low to provide satisfactory treatment and hospitals had to incur losses to treat PM-JAY beneficiaries.

Some package rates were too low to provide satisfactory treatment and hospitals incurred losses in treating PM-JAY beneficiaries. Certain packages did not cover common treatment modalities, co-morbidities, changes in treatment course, better medicines, or expected too short or long admission periods.

Software, transaction management and information management systems seemed not sufficiently transparent and should be simplified.

The added workload of PM-JAY processes was difficult for many hospitals to cope with, with many having limited resources to add dedicated staff, or having to burden existing staff with more responsibilities.

Challenges related to implementation of claim settlement and beneficiary management

Many respondents reported unnecessary queries, requests for unnecessary investigations, non-response or response delays for both regular and emergency cases including pre-authorization, etc., leading to prolonged and delayed hospital stays.

Some respondents stated that claims were often rejected after the beneficiary had been discharged, or challenged/rejected due to minor issues. The process was reported to be tedious and complicated with many respondents wanting it to be simplified.

Many beneficiaries were found unaware about the scheme features and coming to hospitals without the requisite documentation. Some beneficiaries demanded unnecessary treatments and procedures, and misbehaved when these were not provided.

Respondents highlighted issues with beneficiary identification, including more well-off patients fraudulently availing treatment under the scheme.

RECOMMENDATIONS

Drive quality service provision

Drive quality service provision, via: identifying important amenities and infrastructural parameters and focusing empanelment and dis-empanelment on their basis.

Encourage accreditation

Encourage hospitals to undergo accreditation as a means of ensuring adherence to higher quality standards, via: privileging empanelment of accredited hospitals and/or designing strategies.

Improve adherence to PM-JAY processes

Facilitate hospitals to improve adherence to PM-JAY processes, via: reviewing reported bottlenecks in PM-JAY processes like beneficiary management, claims submission and processing, and documentation requirements.

Ensure adequacy of packages and rates

Ensure the adequacy of the current treatment packages and related case-based rates, via: investigating cost structures and applying changes if required.

Identify reasons for OOPE

Explore reasons for continued OOPE in patients utilizing services under PM-JAY, via: investing in an in-depth exploration of the reasons, including before and during hospitalization.

Increase awareness

Make beneficiaries aware of their entitlements, understand and comply with PM-JAY specific documentation, verification, and hospitalization requirements, and empower them to utilize services through PM-JAY, via: advocating for increased awareness generation and promotional activities among beneficiaries.

ACKNOWLEDGEMENT

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We would also like to thank IQVIA 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.

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