POLICY BRIEF 2022

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

BACKGROUND

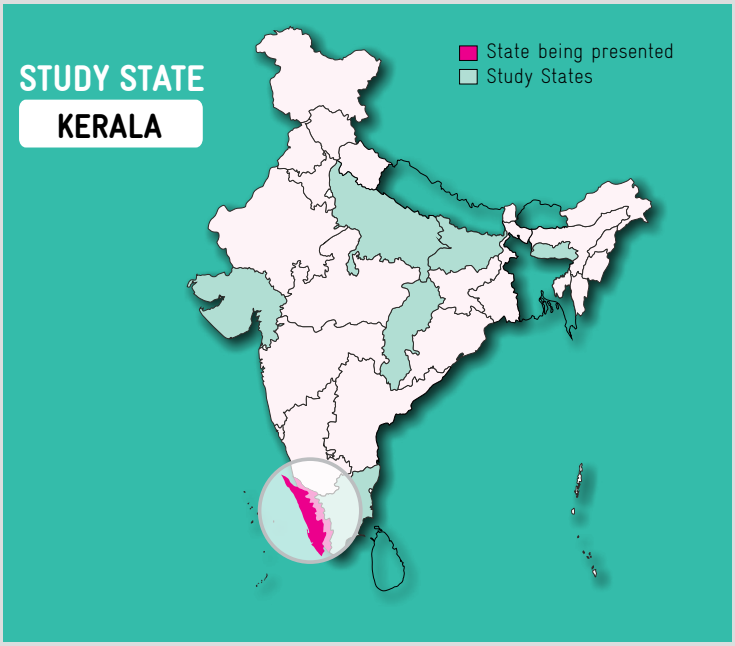
This policy brief presents findings from research commissioned in April 2018 by the Indo-German Social Security Programme (IGSSP), predecessor of the Indo-German Programme on Universal Health Coverage (IGUHC). The research evaluated the PM-JAY implementation from the supply-side, thereby providing performance 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 Kerala, 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 (i.e., healthcare providers' and PM-JAY beneficiaries' experiences with the implementation of and service utilization under PM-JAY)



KERALA

APPROACH

Quantitative and qualitative data was collected from 24 hospitals in two districts in Kerala (Kannur and Palakkad) at two different time points (February to April 2019 and November 2019 to January 2020). Thirteen of these hospitals were empanelled under PM-JAY, the remaining hospitals served 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 minimal bed capacity, 24/7 availability of at least 1 doctor and 1 nurse, motor vehicle accessible road and obstetric and newborn care providers.

Criteria least complied with

Both hospital groups showed relatively low levels for blood banks. The total number of non-surgical specialties available were low at round 4 out of 8 for empanelled hospitals.

PM-JAY specific facility amenities

Only 46% of empanelled hospitals had 24/7 availability of a PM-JAY help desk clerk. There were approximately 4 beds reserved for PM-JAY patients.

Empanelled versus non-empanelled hospitals

Empanelled hospitals compared poorly to non-empanelled for NABH accreditation and presence of accredited laboratories.

Non-empanelled hospitals had higher availability of 24/7 availability of patient reception desk, pharmacies, fully equipped labour rooms and minimum amenities for maternity service capacity.

Beneficiaries' Experiences (Exit interviews)

Expenditures prior to hospitalization

23% of PM-JAY beneficiaries interviewed upon exiting the hospital incurred any pre-hospitalization OOPE (mean of INR 2,063).

Expenditures during hospitalization

7% of beneficiaries interviewed upon exiting the hospital incurred OOPE during hospitalization (mean of INR 777).

Satisfaction with hospitalization

Most beneficiaries interviewed upon exiting the hospital rated the services received as good or very good, with a mean of 2.6 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.

Many respondents mentioned that the increased need for detailed documentation under PM-JAY made the admission procedure more time-consuming and resource-intensive.

A vast majority of respondents reported increases in patient loads since PM-JAY was launched, not only in the hospital, but also for outpatient care services, as well as among non-beneficiaries.

Beneficiaries seemed more aware about PM-JAY, and exhibited a better health seeking behaviour.

PM-JAY support team

Hospitals interacted with the state nodal agency support team for blocking of treatment packages, claim processing and claim settlement. The majority of hospitals reported a good and supportive engagement with the PM-JAY support team, with satisfactory response resolutions within good time.

Many respondents reported 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.

Some respondents felt that the support team operated with the motive to reject claims, rather than to facilitate their processing.

Clinical management

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

Public facilities especially stated that the additional funds received from PM-JAY had been utilized for the upgradation of facility supplies, consumables and infrastructure, and this could anecdotally contribute to better quality of service provision.

Quality improvement

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

Although the majority of hospitals were not accredited, many expressed interest in becoming accredited in the future, or were currently in the process of obtaining an 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.

> *"The basic thing is even CGHS [Central Government Health Service] rates were quite low. The CGHS rates which they were giving are from 2014; they must revise these in 4 years or 5 years. In 2018, so far, they have not revised and the Ayushman rate is less than what the CGHS rate is. If you compare that, then viability of the hospital will be difficult, so either you have to compromise on the quality and no hospital will like to compromise, even no government should allow to compromise on the quality."*

Financial management

Some hospitals monitored financial activities (procurement of funds, utilization of funds, accounting, payments and risk assessments) through profit loss monitoring. Many hospitals reported utilizing the claim reimbursements to improve hospital infrastructure, procurement of medicines and as staff incentives.

The majority of private hospitals found no effect on their overall finances. However, some of them felt that they were running at a loss due to the low package rates of the scheme.

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

Many respondents found that the increased awareness and increased health seeking behaviour among beneficiaries were important achievements, coupled with greater access to proper medical treatment for poor 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.

Further, respondents highlighted that certain packages were not well designed and did not cover the common treatment modalities, co-morbidities, changes in treatment course or better medicines; they also had irrationally short or long length of stay in the hospital.

Many respondents highlighted the lack of staff, resources and training to adhere to PM-JAY guidelines and procedures, and found the increased workload due to documentation, claim processing and other procedures as taxing without additional resources. This was often aggravated by PM-JAY software issues such as software sessions expiring, need for repeated log-ins, maintenance shutdowns, etc.

Challenges related to implementation of claim settlement and beneficiary management

Many respondents stated that there were 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 procedures and hospital stays that stymied beneficiaries and hospital staff alike.

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.

Hospitals reported that beneficiary management was challenging, with many beneficiaries unaware about the scheme features and coming to hospitals without the requisite documentation.

> *The patients think that the PMJAY card that they carry is like an ATM (Automated Teller Machine) card which is connected to an account containing Rs. 5 Lakh for each of them. That is why if the patients see any problem in their health, they immediately rush to the hospital to get a surgery.*

RECOMMENDATIONS

Drive quality service provision

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

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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