POLICY BRIEF 2022

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

MEGHALAYA

BACKGROUND

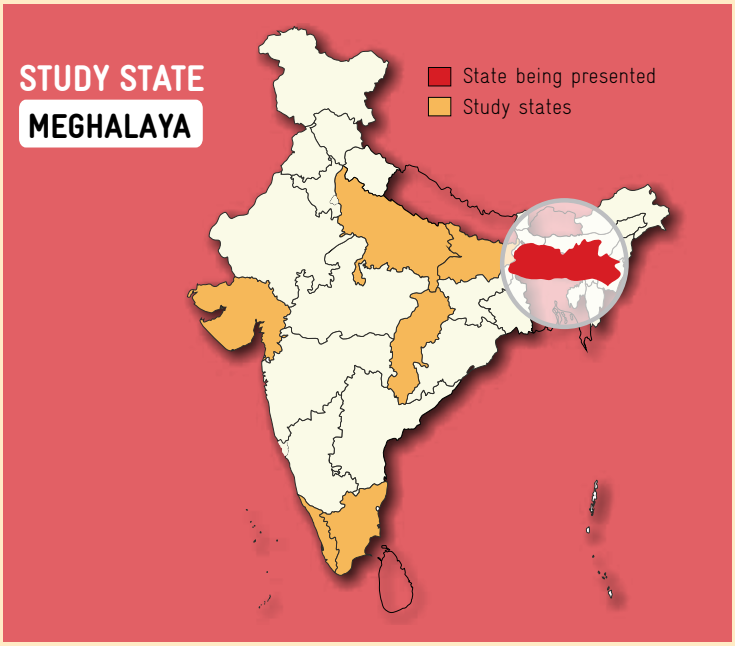
This policy brief presents findings from research commissioned in April 2018 by the Indo-German Social Security Programme (IGSSP), predecessor of the Indo-German Programme on Universal Health Coverage (IGUHC). The research evaluated the PM-JAY implementation from the supply-side, thereby providing performance 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 the supply-side elements of Pradhan Mantri Jan Arogya Yojna (PM-JAY) specifically changes in quality of care related to empanelment in PM-JAY, across eight Indian states, including Meghalaya, approximately 14-16 months after its implementation in September 2018.

The Study areas were:

- State of hospital service quality input (i.e. infrastructure, staffing, consumables) and selected process indicators
- Changes in quality indicators among empaneled and non-empaneled hospitals over time
- Experiences with the implementation of PM-JAY (processes and outputs i.e. healthcare providers' and PM-JAY beneficiaries' experiences).



APPROACH

Quantitative and qualitative data was collected from 20 hospitals in two districts in Meghalaya (East Khasi Hills and South West Garo Hills) at two different time points (February to April 2019 and November 2019 to January 2020). During the first round, 13 hospitals were empanelled under PM-JAY and 7 non-empanelled. During the second round, all 20 hospitals were empanelled under PM-JAY, with no additional hospitals to serve as comparison in the study districts. 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, obstetric and newborn care providers and fully equipped labour rooms.

⊖ Criteria least complied with

Overall, both hospital groups showed relatively low levels for 24/7 availability of a help desk and essential equipment of labour rooms. The total number of non-surgical specialties available remained more or less stable at round 3 out of 8 for hospitals in the second round. Even after empanelment expansion, hospitals had very low availability of 24/7 PM-JAY help desk clerk. The average number of beds reserved for PM-JAY patients was zero for both data collection rounds.

Improvements over time

The 24/7 availability of a patient reception desk increased by 19 percentage points. The availability of NABL accredited laboratory increased by 16 percentage points. The availability of a blood bank increased by 17 percentage points. The overall availability of a separate PM-JAY kiosk for beneficiary management increased by 49 percentage points over the two rounds of data collection (however, not its 24/7 availability).

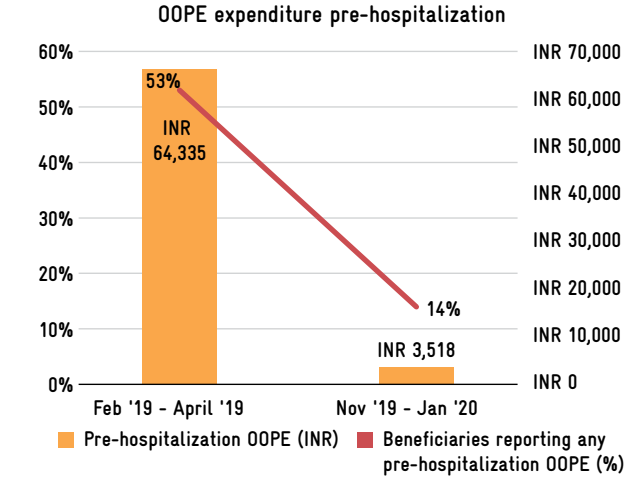
Deteriorations over time

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

Beneficiaries' Experiences (Exit interviews)

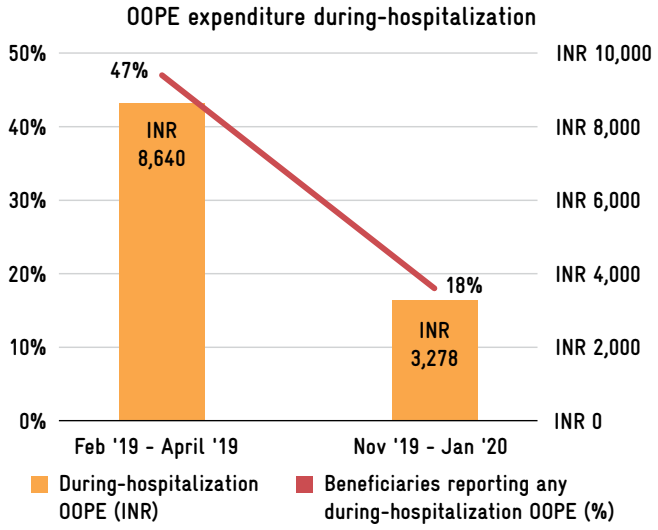
Expenditures prior to hospitalization

The proportion of people incurring any pre-hospitalization OOPE decreased by 39 percentage points. Further, the average amount spent has also declined from an average of 64,000 INR to 3,500 INR.



Expenditures during hospitalization

The proportion of people incurring any hospitalization OOPE decreased by 29 percentage points. However, the average amount spent has increased from 9,500 INR to 12,000 INR.



Satisfaction with hospitalization

Services were received as good or very good, with a mean of 2.5 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 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 positively engaged with the PM-JAY support team.

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.

For government hospitals, it was not always possible to adhere to the requirements of the support team, because beneficiaries often did not provide necessary documentation, or hospitals lacked facilities to carry out obligatory investigations or operational processes.

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.

A few hospitals mentioned that the increased patient load under the scheme compelled them to conduct additional staff training or hire new staff; some mentioned having to increase infrastructure and more frequent stockouts of medicines and consumables.

Respondents opined that the workload for beneficiary management had increased substantially, but processes were still not streamlined and beneficiaries frequently had to be admitted for long periods before they were cleared for discharge from the insurance company.

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.

The majority of hospitals were not accredited, although 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.

> *See before this, it was like do whatever you want. But with the advent of this process, documentation is very important. Since we are noting documents right from the time of admission, for proper auditing.*

Financial management

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

For public hospitals, reimbursements through PM-JAY was considered additional income and used for staff incentives, to improve hospital infrastructure, or as buffer savings for leaner times.

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.

Delays in reimbursement disrupted procurement cycles for hospitals without adequate capital to purchase necessary supplies and consumables.

Achievements Related to PM-JAY Implementation

- Respondents found the use of PM-JAY funds for hospital upgradation to be a key achievement, leading to better staff morale and accountability
- Increased awareness and increased health seeking behaviour among beneficiaries were reported as important achievements, coupled with greater access to proper medical treatment for poor patients.

> *But ultimately the end result is what the patient is getting what they deserve. The card has empowered them. We have the poorest and the richest who come here. But when they come here, they are treated equally and that is the basic thing that we are doing here.*

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 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 a prolonged and delayed procedure and hospital stay that stymied beneficiaries and hospital staff alike.
- Claims processing 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 not coming to hospitals with the requisite documentation.

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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