POLICY BRIEF 2022

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

CHHATTISGARH

BACKGROUND

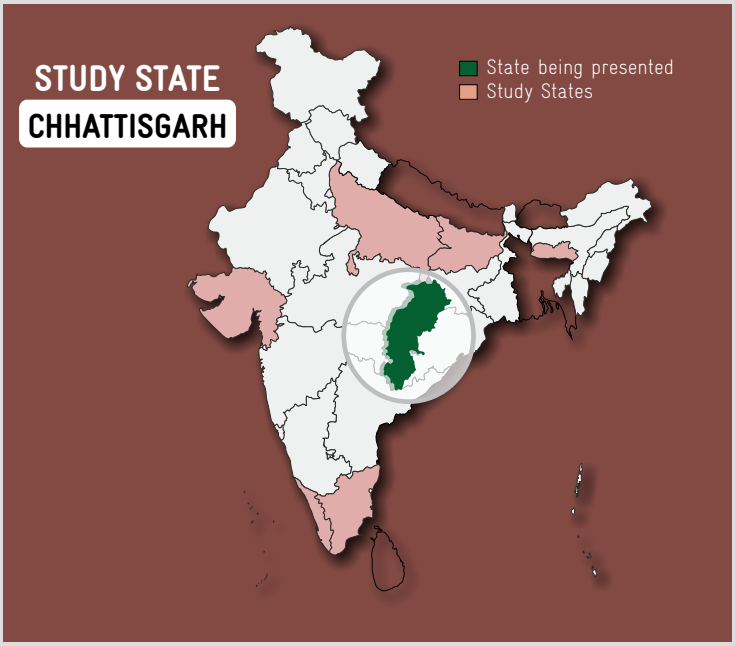
This policy brief presents findings from research commissioned by the Indo-German Social Security Programme (IGSSP), predecessor of the Indo-German Programme on Universal Health Coverage (IGUHC), in April 2018. The research evaluated the PM-JAY implementation from the supply-side, thereby providing performance 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 Chhattisgarh, approximately 14-16 months into 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)



APPROACH

Quantitative and qualitative data was collected from 24 hospitals in two districts in Chhattisgarh (Bilaspur and Raigarh) at two different time points (February to April 2019 and November 2019 to January 2020). Seventeen of these hospitals were empaneled under PM-JAY, while seven 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 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, 24/7 availability of a help desk, accredited laboratories, blood banks, fully equipped labour rooms and essential equipment of labour rooms.

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

Only 6% of empanelled hospitals had 24/7 availability of PM-JAY help desk clerk in the first round, which declined to 0% in the second round.

The total number of non-surgical specialties available remained more or less stable at around 4 out of 8 for both empanelled and non-empanelled hospitals.

Improvements over time

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

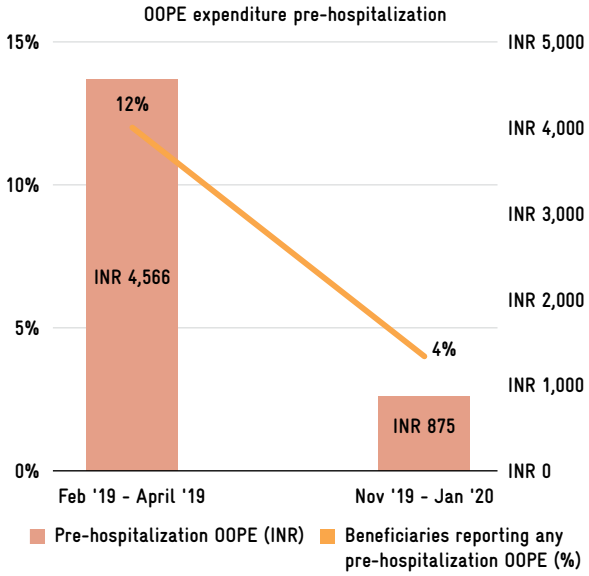
Deteriorations over time

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

Beneficiaries' Experiences (Exit interviews)

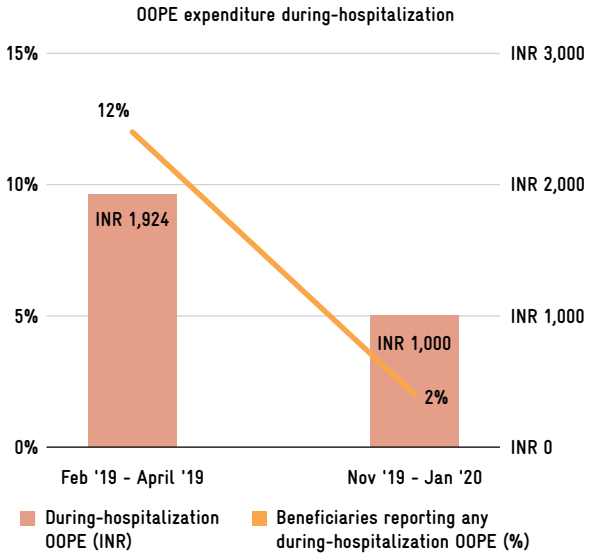
Expenditures prior to hospitalization

Pre-hospitalization OOPE decreased by 8 percentage points and the expenditure amount decreased by approximately 80 percent:



Expenditures during hospitalization

During hospitalization OOPE decreased by 10 percentage points and the expenditure amount decreased by approximately 48 percent:



Satisfaction with hospitalization

Services were received as good or very good, with a mean of 2.6 and 2.3 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.

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.

Clinical management

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

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.

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.

Quality improvement

Some hospitals conducted general training, monitoring of indicators, information management processes and adhered to standard protocols to promote quality of service provision.

The majority of hospitals were not accredited, while some expressed interest in acquiring 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.

Some package rates under PM-JAY prevented the provision of higher quality services, as the cost control mechanisms of these packages was perceived as too tight.

> *"Actually, when working with the schemes, I feel that many patients are benefitting from the scheme but the quality wise I feel it is lower because what treatment I am supposed to use sometimes I am not able to give to the patient because of the restrictions which are part of the scheme."*

Financial management

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

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 opined 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.

> *"They have little harassing attitude. Their attitude is that we should not have a greater number of cases. They are waiting it do rejection, they are waiting to find excuses to reject. Like if there is little overwriting and unnecessary document, which is not required at all, they ask for such things which the hospital has not done at all. They try to find excuses to do rejection so that they do not have to give money. This attitude is there since the beginning."*

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

Some package rates were too low to provide satisfactory treatment and incurred losses in treating PM-JAY beneficiaries. Certain packages did not cover common treatment modalities, co-morbidities, changes in treatment course, better medicines, or required 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 at times difficult to cope with, given the 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.

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.

> *"If a person comes to hospital in sedan car and wants treatment done through card, even if he insists for private room and says he is ready to pay more, it's like each person is trying to give a bribe."*

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

We are grateful to NHA for commissioning GIZ/IGSSP, later IGUHC, to undertake this PM-JAY Supply Evaluation study, which serves as a process evaluation for the PM-JAY. The SHAs of the study states (Bihar, Chhattisgarh, Gujarat, Kerala, Karnataka, Meghalaya, Tamil Nadu and Uttar Pradesh) have supported us immensely in implementing this study.

Guidance was provided by both NHA and SHAs of the study states during the inception phase as well as throughout the study period.

We are thankful to the Chief Medical Officers, state health societies, and district officials for their support and contribution in the study. We would also like to thank the study participants for sharing their experiences and providing information on their impression of the schemes.

We would also like to thank the data collection agency IQVIA for successful completion of the data. 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.

with technical support from

german cooperation
DEUTSCHE ZUSAMMENARBEIT

giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

Initiated by

national health authority

For more information please contact:

Mr. Amit Paliwal
Project Director
Indo-German Programme on
Universal Health Coverage

Deutsche Gesellschaft für International Zusammenarbeit (GIZ) Gmbh
B-5/1, 2nd Floor, Safdarjung Enclave,
New Delhi 110029, India

E: iguhc@giz.de
T: +91 11 4343 5353
F: +91 11 4949 5391
W: https://iguhc.in/

The study team included:

NHA team: Basant Garg, Vipul Aggarwal, Kameshwar Rao, Ruchira Agrawal

Principal Investigator:
Manuela De Allegri (HIGH)

Co-investigators: Nishant Jain (GIZ), Swati Srivastava (HIGH), Sharmishtha Basu (GIZ)

Scientific Team: Stephan Brenner (HIGH); Diletta Parisi (HIGH); Divya Parmar (City, University of London); Christoph Strupat (DIE); Caitlin Walsh (HIGH) with the collaboration of IQVIA