KPMG

ASSOCHAM INDIA

Ayushman Bharat

— A big leap towards Universal Health Coverage in India

December 2019

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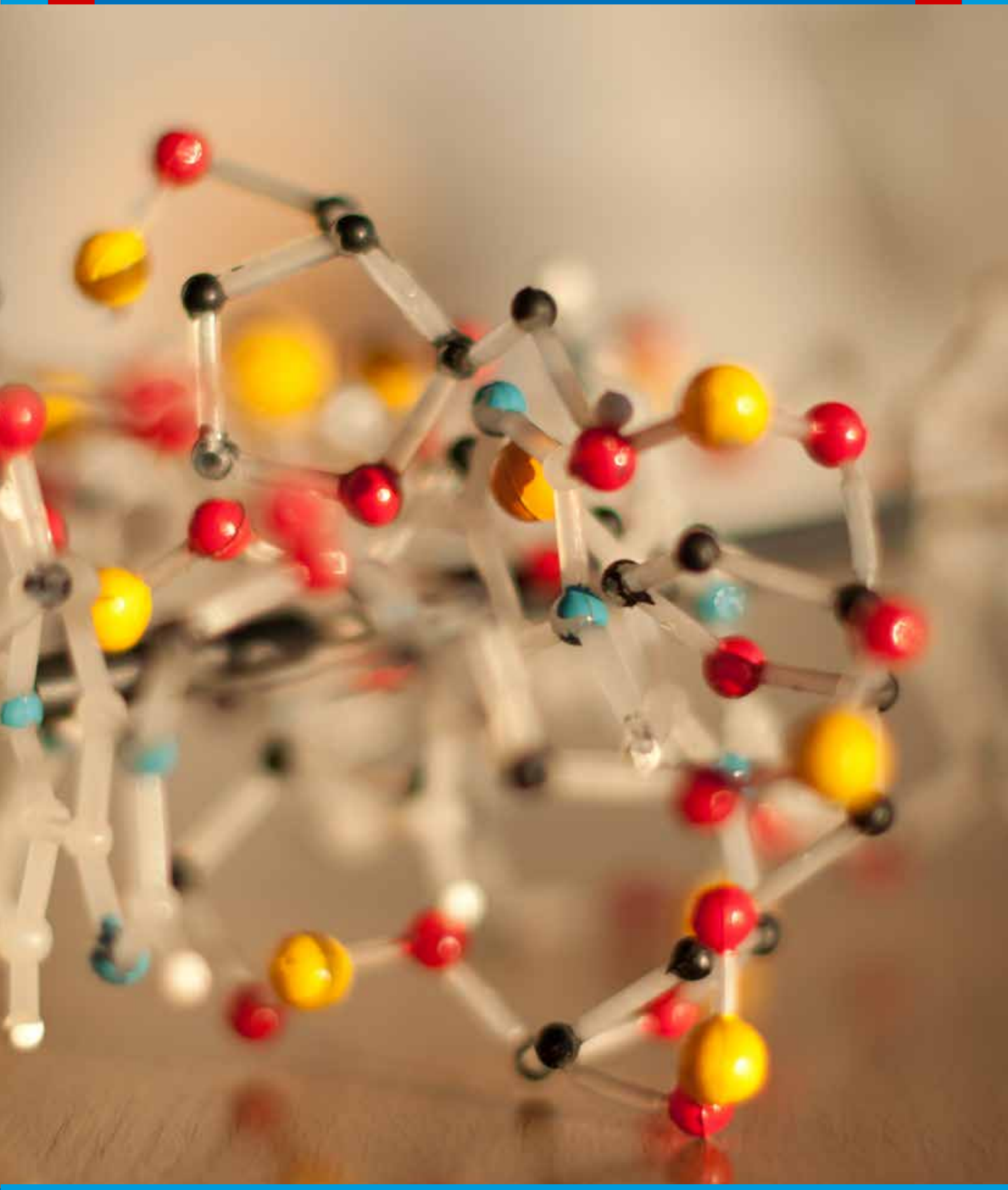

Foreword by ASSOCHAM President

Over the years India has improved immensely in health parameters such as life expectancy, mortality rates, health & sanitation, immunization, among others. However, the journey towards a healthier nation has only partially been traversed.Indian healthcare remainsbeset with challenges pertaining to disparities in accessibility, affordability, quality healthcare services, infrastructure, funding, which are creating increased pressure on the existing system.

While urban areas,to an extent,have been able to address some of these concernsin the form of emerging private healthcare institutions, those most needy and underprivileged in far-flung areas remain deprived of timely, quality and affordable medical interventions. It is to bring these segments into the fold of healthcare that the government had envisioned Universal Health Coverage.

To effect the realization of Universal Health Coverage, the government introduced the Ayushman Bharat Yojana to bring the healthcare services within the reach of the community. Considered as world's biggest government health programme, the scheme aims at providing secondary and tertiary hospitalization to poor and economically vulnerablefamilies across the county, in addition to establishing wellness centres. A commendable and far-sighted initiative of our political leadership, the scheme is an important milestone for India, which would benefit from an elevation of the overall healthcare system. From the social development perspective, the initiative would bridge the disparity among various segments and improve the nation's overall health indices. On other hand, the initiatives under Ayushman Bharat Yojana would support building a New India and ensure wellbeing of people,enhanced productivity,prevent wage loss, reduce financial hardship, create jobsand boost the healthcare sector.

For the implementation of the scheme, suitable models are being considered with the involvement of the private sector to ensure widespread and effective reach of the initiative. Such arrangements would focus on infrastructure development, service delivery, technologies, standardization of practices, capacity building and economies of scale. This would pave the way for a wider healthcare marketplace with diversified product offerings, encourage new market entrants in the wake of possible newer investment avenues.

Fostering a synergistic relationship between the public and private sector is key to achieving the vision of universal healthcare for our country and imparting the benefits of modern medicine across all segments. While India marches towards its ambitious economic goals, the implementation of the Ayushman Bharat Yojana would go a long way in balancing economic and inclusive growth agendas.

Balkrishan Goenka
President, ASSOCHAM
& Chairman, Welspun Group

Foreword by ASSOCHAM Secretary General

Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (PM-JAY) is one of the most ambitious and life-changing schemes for 50 crore Indians, enabling the country to achieve its avowed goal of Universal Health Coverge (UHC) by 2030. Billed as the world's largest scheme of its kind, the PM-JAY, launched on September 23, 2018 has a target of 10 crore families, extending them coverage of tertiary care hospitalisation . Within a year of its launch, the scheme which provides an annual coverage of Rs 5 lakh per family, as many as 46.5 lakh patients have already availed of the benefit.

It is not the health insurance coverage alone; equally important is another dimension of the scheme. Under Ayushman Bharat, 1.5 lakh health and wellness centres would be set up in the country, making it one of the largest public primary healthcare networks in the world.

ASSOCHAM along with KPMG undertook an exhaustive study into the entire gamut of the scheme which was bound to yield different takeaways. As it is not a one-off event, the scheme has to keep evolving, dealing with complexities of implementation on a mammoth scale as also throwing some pleasant results and generating vast amount of goodwill amongst the vulnerable families. India's healthcare sector largely depends on the private sector with gaps in public health infrastructure, resulting from less than 2 per cent of the GDP as public spending on healthcare. This makes it imperative for involvement of the private sector in a scheme, as large and ambitious as Ayushman Bharat. As the ASSOCHAM-KPMG study has pointed out, its success would depend on pragmatic policy prescriptions by the government ensuring fair return on investment by the private sector which must, in turn, follow complete transparency to win popular support for the high-stake national initiative.

Stakes are high because, only a healthy India can fully exploit the demographic dividends. Being the second most populous country in the world with 1.3 billion people, India has entered a demographic dividend phase in 2018. It means a significant bulge (over 66 per cent) of our population is in the high consumption/working age of 15-64 years. This advantage is going to last till 2055, as this study has highlighted. But then, people have to be healthy and educated so that India can boast of its human resource which is amongst the best in the world. Ayushman Bharat is a critical pillar here.

The ASSOCHAM-KPMG study, has delved into experiences and challenges ahead, making key recommendations to improve the outcome of the scheme which is amongst several flagship and important projects of Hon'ble Prime Minister Shri Narendra Modi. Along with Swachch Bharat, the Ayushman Bharat can immensely contribute to making India a Swastha Bharat.

Deepak Sood
Secretary General
ASSOCHAM

Foreword by KPMG in India

The health status of a nation is not only reflective of its citizen's well-being but also impacts its economic advancement. A healthy population is more productive and effectively contributes towards the overall progress of the country. This makes healthcare coverage for each citizen vital. The Indian Healthcare system is currently at a very critical juncture, where it not only needs to overcome key healthcare issues, but also needs to progress towards path of Universal Health Coverage (UHC). The current healthcare system of the country is burdened due to the limited access to healthcare, insufficient availability of manpower, sub-optimal quality of health services and high out-of-pocket (OOP) expenditure. In India, every year, nearly 50 million people are pushed below the poverty line owing to healthcare expenditure. A mere coverage of services is not enough to combat such a burden. Therefore, the current health system requires a mechanism for providing holistic quality care to patients that can fill major healthcare gaps, provide extensive healthcare coverage and improve health access for patients.[1,2]

With the release of National Health Policy 2017, the government laid the foundation of UHC in the country and the launch of Ayushman Bharat (AB) is a big leap towards the vision of 'health for all'. The design of Ayushman Bharat provides a comprehensive coverage in all the verticals of healthcare delivery - primary, secondary and tertiary care. It aims at developing a system that delivers entire range of preventive, promotive, curative, diagnostic, rehabilitative and palliative care services.

A closer look at Ayushman Bharat's implementation and performance in the last one year indicates that the initiative has the potential to effectively push the fundamental objective of UHC in a long run and can be augmented by developing a seamless collaboration with private players. Partnership with private sectors can be leveraged in all key areas such as ensuring patient engagement, provisioning of standardized care, grading performance of hospitals, mitigating fraudulent activities by leveraging innovative digital solutions, organizing referral pathways to make basic healthcare services available in every household, and developing future care models that can expand via access through technology, standardisation, skills mix and economies of scale.

Going by the proverb, well begun is half done, it's imperative that both the government and private players foster dialogue with each other by building a collaborative forum, which can be used to discuss learnings from the past experiences for effective execution; developing collaboration charters; building flexibility to sustain the partnership and setting up central agencies for evaluating PPP models as well as monitoring the impact.

The purpose of this whitepaper is to find ways to leverage partnerships between the government and private sector as both are important stakeholders contributing towards rapid and effective implementation of the scheme. The report also provides insights into challenges being faced during implementation of the scheme and suggests additional interventions that can be incorporated to accelerate India's journey towards universal health coverage. A synergetic relationship between the government and private sector will nurture the vision of 'Health for All' and will turn it into a reality.

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KPMG in India

1. Universal Health Coverage report 2017, World Bank and World Health Organization, accessed on 25 May 2018
2. A remedy to fortify India's debilitated healthcare system – Nilaya Varma, A Cecile Park Media Publication June 2018, accessed on 15 July 2018

List of Abbreviations

ASHAs	Accredited social health activists
AB-PMJAY	Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana
BPL	Below poverty line
BIS	Beneficiary identification system
CDU	Central Diagnostic Unit
CGHS	Central Government Health Scheme
CGRMS	Central Grievance Redressal Management System
CHCs	Community Health Centres
CHIS	Comprehensive Health Insurance Scheme
CHO	Community Health Officer
CPHC	Comprehensive Primary Healthcare
COHSASA	Council for Health Service Accreditation in Southern Africa
DBOT	Design, Build, Operate and Transfer
DGRC	Diagnosis-Related Group classification
DGHS	Directorate General of Health Services
EWC	Economically weaker section
e-LfH	e-Learning for healthcare
EHCP	EHCP: Empaneled healthcare provider
ESI	Employees' State Insurance
ESIS	Employment State Insurance Scheme
ECHS	Ex-servicemen Contributory Health Scheme
ECHO	Extension for Community Healthcare Outcomes
GNM	General Nursing and Midwifery
GDP	Gross Domestic Product
HBPs	Health Benefit Packages
HLEG	High-Level Expert Group
HMOs	Health Service Organisations
HWCs	Health and wellness centres
ISA	Implementing Support Agency
ICMR	Indian Council of Medical Research
IGNOU	Indira Gandhi National Open University
IMR	Infant mortality rate
ICT	Information and Communications Technology
IRDAI	Insurance Regulatory and Development Authority of India
JCI	Joint Commission International
MHC	Mandatory Health Coverage
MMR	Maternal Mortality rate
MHLP	Mid-Level Health Provider

List of Abbreviations

MoHFW	Ministry of Health and Family Welfare
MSMEs	Ministry of Micro, Small and Medium Enterprises
MPWs	Multi-Purpose Workers
MSA	Multisectoral approach
NABH	National Accreditation Board for Hospitals
NFSA	National Food Security Act
NHA	National Health Authority
NHCPs	National Healthcare Providers
NHI	National Health Insurance
NHIS	National Health Insurance Service
NHM	National Health Mission
NHPS	National Health Protection Scheme
NHRR	National Health Resource Repository
NHS	National Health System
NHSRC	National Health Systems Resource Centre
NICE	National Institute for Health and Clinical Excellence
NIN	National Institute of Nutrition
NPPA	National Pharmaceutical Pricing Authority
NQAP	National Quality Assurance Programme
NCDs	Non-Communicable Diseases
O&M	Operations and Maintenance
PMAM	Pradhan Mantri Arogya Mitra
PHCs	Primary Health Centres
QCI	Quality Control of India
RSBY	Rashtriya Swasthya Bima Yojana
ROHINI	Registry of Hospitals in Network of Insurance
RMNCH+A	Reproductive, maternal, newborn child plus adolescent health
SCHIS	Senior Citizen Health Insurance Scheme
SECC	Socio-Economic Caste Census
STG	Standard Treatment Guidelines
STWs	Standard Treatment Workflows
SHA	State Health Agency
SHCs	Sub Health Centres
SDGs	Sustainable Development Goals
TMS	Transaction management system
UTs	Union Territories
UHC	Universal Health Coverage

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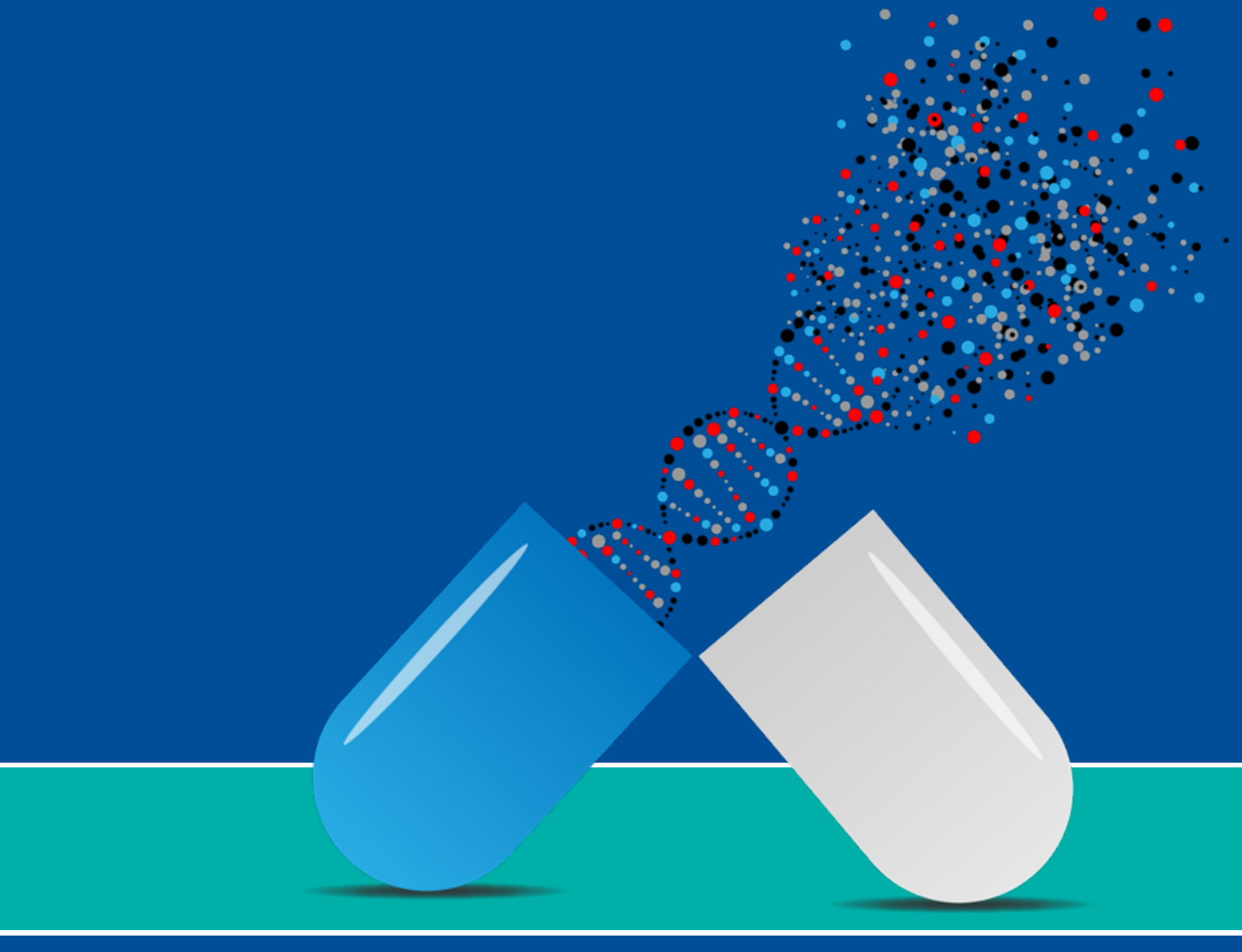

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Preface

Indian healthcare has evolved over the past three decades and is currently at a very critical juncture to achieve the 3As (Affordability, Accessibility and Availability) of healthcare. The government with its policies and frameworks has been consistently countering key challenges dilapidating the healthcare system such as increasing out-of-pocket expenditure, lack of quality healthcare services, increasing burden of non-communicable diseases and disparity in healthcare access. However, the quantum of issues is increasing with every passing minute. Among other priorities, the vision of Universal Health Coverage (UHC) has taken a front seat. The recently released report on health index by NITI Aayog assesses the overall performance and improvement in larger states, smaller states and UTs, and highlights the disparity in the performance on health index. States scoring high on the parameters (health index) for example, Kerala, Maharashtra, Andhra Pradesh, had an effective healthcare coverage scheme running since long. It clearly shows that health coverage and realisation of UHC can help tackle several healthcare challenges.

With the view to achieve UHC, the Indian government launched Ayushman Bharat (2018), which caters to all the verticals of healthcare service delivery – primary, secondary and tertiary care. While the health and wellness centres (HWCs) aim delivery of an expanded range of services close to the community, Pradhan Mantri Jan Arogya Yojana (PMJAY) focuses on providing secondary and tertiary care services to the underprivileged section of the society. So far, a lot has been achieved through the initiative including benefits to nearly 46.5 lakh treated beneficiaries after one year of completion of scheme. However, a lot needs to be covered in terms of bringing synergy in both the programmes, overcoming the hurdles for a smooth operation and ultimately improving the healthcare status.

The current design of the programme clearly calls for a synergetic collaboration between the government and private sector to nurture the vision and turning it into reality. Whether it is the involvement of private healthcare providers in ensuring quality secondary and tertiary care services to Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) beneficiaries or support for enabling digital health and screening programmes for strengthening primary healthcare in health and wellness centres (HWCs), private sector can be leveraged in all the aspects of the programme. Synergistic partnerships between the government and the private sector offer ways to contain the potential costs by capping commitments into the long term and leveraging ultra-lean models of care provision.

Partnerships with private sector can be leveraged by maximising with increasing the output for government with limited public capital; ensuring quality healthcare services to the people and enabling sustainable return on their investment for private players. These collaboration can help ensure greater efforts towards developing future care models that can expand via access through technology, standardisation, skills mix and economies of scale. To gain maximum benefits out of these collaborations, there is a need for clearly setting priorities of the partnerships; setting objectives to incentivise high value in healthcare; choosing the right partner; and generating sufficient competition and contestability.

Ayushman Bharat with its key objectives also intends to elevate the overall healthcare system of the country and hence there is also a need to focus on bigger operational aspects such as provisioning of quality and standardised care, driving quality accreditation, emphasising on learning and capacity development, leveraging analytics and technology and imbibing learnings from across the globe. Focusing on these overarching aspects of operation, and will not only enable in effective implementation of the scheme but will also assist in shaping up the healthcare market place, encouraging new market entrants, relooking at regulatory framework, and developing new avenues of investment from multi-sectoral partners.

The report endeavours to unravel the journey of healthcare coverage in India and how the launch of Ayushman Bharat is aiming to achieve the vision of healthcare coverage for the underprivileged section of the society. Moreover, it focuses on providing a perspective and recommendations on leveraging the expertise of the private sector in strengthening key functional areas of the initiative. It also substantiates how lessons from proficient and innovative global healthcare systems can make Ayushman Bharat a success.

a. Healthy States and Progressive India, Niti Aayog, June 2019, accessed on 15 July 2019
b. Ayushman Bharat helped 39 lakh people save ₹12,000 crore: Harsh Vardhan, Live Mint, 22 August, accessed on 25 August 2019

1.0 Healthcare coverage in India – Journey so far

Economic growth and Sustainable Development Goals (SDGs) - The balancing act

India is one of the world's great economic triumph stories in recent times. It is already the fifth-largest economy in the world and as per current trajectory, it is poised to grow to capture the rank of the second major economy in the world by 2030. India, along with 193 countries, has also committed itself to adopt the SDGs at the United Nations in 2015 - to eliminate poverty, protect human dignity and wellbeing, protect the planet, and ensure prosperity for all as part of the new global sustainable development agenda to be fulfilled by 2030[1,2]

The vision for a prosperous and sustainable future was also reflected in the Prime Minister's address on India's seventy-third Independence Day, highlighting key issues to tackle such as population explosion, water scarcity and sanitation. India, in the coming times, will require significant efforts in carving out a balancing act in driving the economic growth and sustainable development agendas.[2]

Population dividend – A boon or a bane

It is now estimated that India will overtake China as the most populous country by 2025-30. India entered into the population dividend phase in 2018, wherein India's working-age population (15 to 64 years of age) has grown larger than the dependent population (children aged 14 or below as well as people above 65 years of age). This bulge in the working-age population is going to last till 2055, or 37 years from its beginning. However, the share of the population over the age of 60 years is expected to increase from 6.17 per cent in 2018 to 19 per cent in 2050[3]. India is running out of time to harness the potential of its youth to drive economic growth and as well as adequately plan for a large geriatric population to be housed by 2050. This is likely to create significant fiscal challenges for the government to deliver adequate physical infrastructure, invest in education and healthcare, and create a sustainable social environment.

Health status improving, but several systemic issues prevail

The current state of public health presents one of the largest impediments to India in achieving its potential. Though there are noteworthy improvements in health indicators such as life expectancy, infant mortality rate (IMR) and maternal mortality rate (MMR) due to increasing penetration of healthcare services across the country, extensive health campaigns, sanitation drives, increase in the number of government and private hospitals, improved immunisation, growing literacy and other health indicators, however, the journey towards a healthier nation has only been covered partially.

1. India to become 5th largest economy globally this year; 2nd in APAC region by 2025, The Economic Times, 03 June 2019
2. Transforming our world: The 2030 Agenda for Sustainable Development, United Nation, accessed on 15 July 2019
3. Statistical Year book, MOSHPI.gov, accessed on 15 July 2019
4. World Bank Data, India, accessed on 15 July 2019
5. 2018 Health SDG Profile: India, WHO
6. National Health Accounts Estimates for 2014-15, Oct 2017, MOHFW

The country's healthcare system has been grappling with key eight systemic issues.[4,5,6] These include:

Huge demand for healthcare services	• India with 1.35 billion (2018) population is the second-most populous country in the world. Large young population with 66.43 per cent (ages 15-64) and 6.18 per cent (ages 65+) of total population • India will overtake China as the most populous country by 2027 • Entered population dividend phase in 2018 wherein significant bulge in the working-age population that is going to last till 2055, or 37 years from its beginning • The share of the population over the age of 60 years is expected to increase from 6.176 per cent in 2018 to 19 per cent in 2050.
Healthcare expenditure	• Total Health Expenditure as a share of GDP is 4.2 per cent (2018), the lowest amongst BRIC nation • Government Expenditure on Health as a share of GDP is ~1.13 per cent in 2014-15 and increased to 1.18 per cent in 2015-16, however, required to increase up to 2.5 per cent of GDP by 2025 • Global average health expenditure (% of GDP) was 10.2 per cent (2016).
Catastrophic healthcare OOPE	• Healthcare out-of-pocket expenditure is estimated at around 62.6 per cent of total health expenditure • 17.3 per cent of people spent more than 10 per cent of their household's total expenditure on healthcare • About 5.5 crores Indians were pushed into poverty in a single year because of OOPE and 3.8 crores of them fell below the poverty line due to spending on medicines alone.
Changing disease profile	• Deaths due to non-communicable diseases (NCDs) have increased from 37.1 per cent in 1990 to 61.8 per cent and contributed to 55 percent of the overall disease burden in 2016 • Almost 23 per cent of the Indian population at risk of premature death due to NCDs • A large number of district hospitals do not provide services for NCDs and such patients are largely catered by private hospitals.
Health indices	• India made groundbreaking progress in recent years in reducing the MMR by 77 per cent, from 556 per 100,000 live births in 1990 to 130 per 100,000 live births in 2016. India's present MMR is below the MDG target and puts the country on track to achieve the Sustainable Developmental Goals (SDGs) target of an MMR below 70 by 2030 • India's infant mortality rate (IMR) has fallen from 42 in 2012 to 33 in 2017 • The life expectancy in India has gone up by five years, from 62.3 years for males and 63.9 years for females in 2001-2005 to 67.3 years and 69.6 years respectively in 2011-2015.
Healthcare infrastructure	• India has 1 hospital bed per 1,000 population, lowest among BRIC nations • The private sector accounts for 63 per cent of hospital beds and handles a dominant share of hospitalized cases (Rural: 58.1 per cent and Urban: 68.0 per cent) • Shortage of infrastructure and human resources for health has led to 72 percent of the population in rural areas and 79 percent in urban areas to seek out-patient services from the private sector; correspondingly 58 percent of people from rural areas and 68 percent in urban areas seek in-patient services in the private sector.
Healthcare workforce	• India has ~0.7 physician per 10,000 population, lowest among the BRIC nations • About 74 per cent of India's doctors cater to one-third of the population, which includes ~44.2 crore people housed in urban areas • India had a shortfall of 3,027 doctors at PHCs as of March 31, 2017.
The disparity of health status across India	• Among the Larger States, the overall Health Index score of the best-performing State is more than two and half times of the overall score of the least-performing State • Kerala championed the Larger States with an overall score of 74.01, while Uttar Pradesh was the least performing State with an overall score of 28.61 • Among the Smaller States, scores varied between 38.51 in Nagaland and 74.97 in Mizoram • Among the UTs, the scores varied between 41.66 in Daman and Diu to 63.62 in Chandigarh.

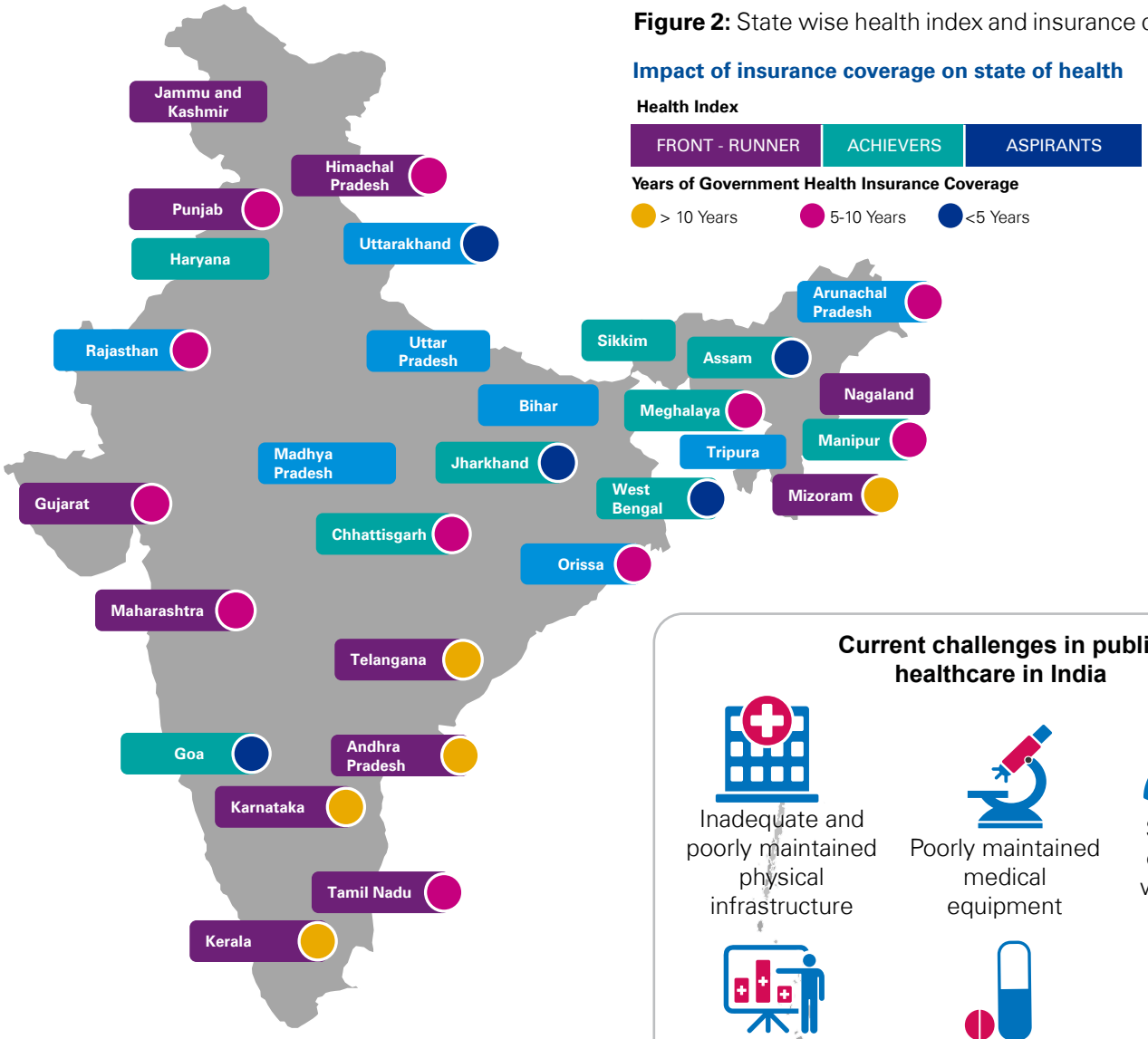
Figure 1: Key challenges of the public healthcare system

Healthcare coverage improves access to health leading to better outcomes

Recently released report on health index by NITI Aayog (June 2019), assessing the overall performance and improvement in larger states, smaller states, and UTs, highlights the disparity in the performance on health index. The report was prepared based on 23 key parameters grouped into domains of health outcomes, governance and information, and key inputs/processes. States such as Kerala, Maharashtra, Andhra Pradesh emerged as the top three performers across population health indicators (Figure 2).[7]

One common factor among the states scoring high on the parameters (Health Index) was that they all had a successful healthcare coverage scheme running for long. Kerala launched its comprehensive health insurance scheme (CHIS) in 2008; Andhra Pradesh launched Aarogyasri scheme in 2007; Maharashtra launched its 'Rajiv Gandhi Jeevandayee Aarogya Yojana' in 2010 – to provide free healthcare to the needy.

Figure 2: State wise health index and insurance coverage

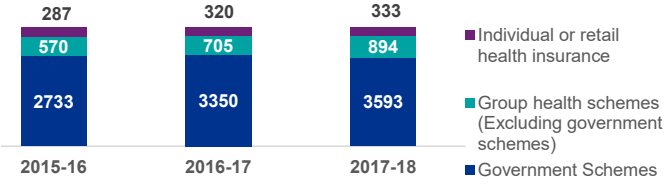


Source: KPMG in India Analysis, Healthy States and Progressive India, Niti Aayog, June 2019, accessed in July 2019 (Report on the Ranks of States and Union Territories)

Source: A remedy to fortify India's debilitated healthcare system, Cecile Park Media Publication, June 2018, accessed on 15 July

7. Healthy States and Progressive India, Niti Aayog, June 2019, accessed in July 2019

Figure 3: Health insurance person covered (in lakhs)



Source: Insurance Regulatory and Development Authority of India

As per 2017-18 IRDAI data, active health insurance policies cover a total of 48.20 crore lives (40 per cent of the Indian population) and growing rapidly. In terms of the number of covered, 75 per cent of the lives were covered under government sponsored health, while the rest of 25 per cent were covered by group & individual policies issued by general & Health Insurers. The coverage provided by government schemes has grown 31 per cent from 2015-16 to 2017-18, while the overall coverage witnessed an increase of 34 per cent. This shows a significant effort from government, especially states, towards extending the healthcare coverage.[8]

Attempts towards UHC in India

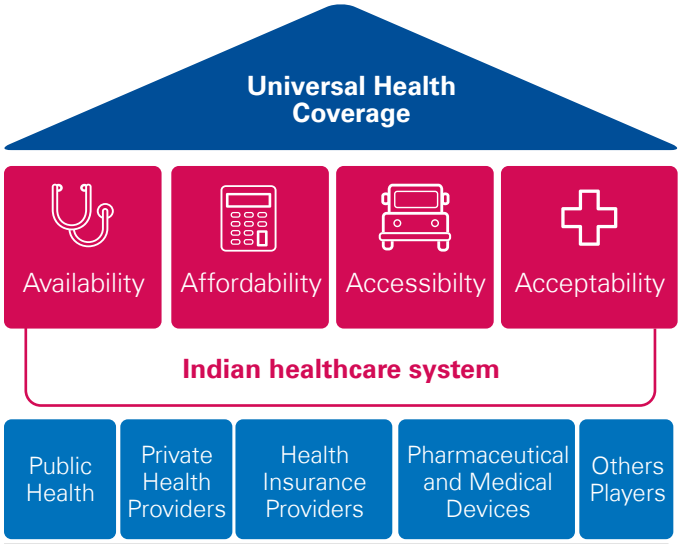
India, like many other countries, has committed to achieving UHC by 2030 in the context of the Sustainable Development Goals. This means ensuring that everyone, everywhere can access essential quality health services without facing financial hardship. Many government-financed healthcare coverage schemes were introduced by Central and various State governments to provide health security to vulnerable sections of the society. The Central Government launched the Rashtriya Swasthya Bima Yojana (RSBY) in 2008, which was adopted by a large number of various states. The population coverage under these various schemes expanded from almost 5.5 crores in 2003-04 to about 37 crores in 2014 (almost one-fourth of the population). Nearly two thirds (18 crores) of this population were those in the below poverty line (BPL) category. (represented in Figure 6)

The vision for UHC in India was substantiated with the constitution of High-Level Expert Group (HLEG) on UHC in 2010 by the Planning Commission of India. The committee developed recommendations on the six critical areas (represented in Figure 4)

One of the key recommendations on health financing and financial protection is to increase public expenditures on health to at least 3 per cent of gross domestic product (GDP) by 2022. Another key recommendation is to ensure the availability of essential medicines to all, at no cost.[9]

HLEG also indicated that RSBY and other public-funded insurance schemes were inadequate to achieve the vision of UHC, as they exclude primary care and outpatient care, which are the key contributors to out of pocket expenses. Therefore, there is a need to design a programme to ensure thorough healthcare coverage for a large section of the society, especially the underprivileged populations.

Figure 4: Key elements of UHC



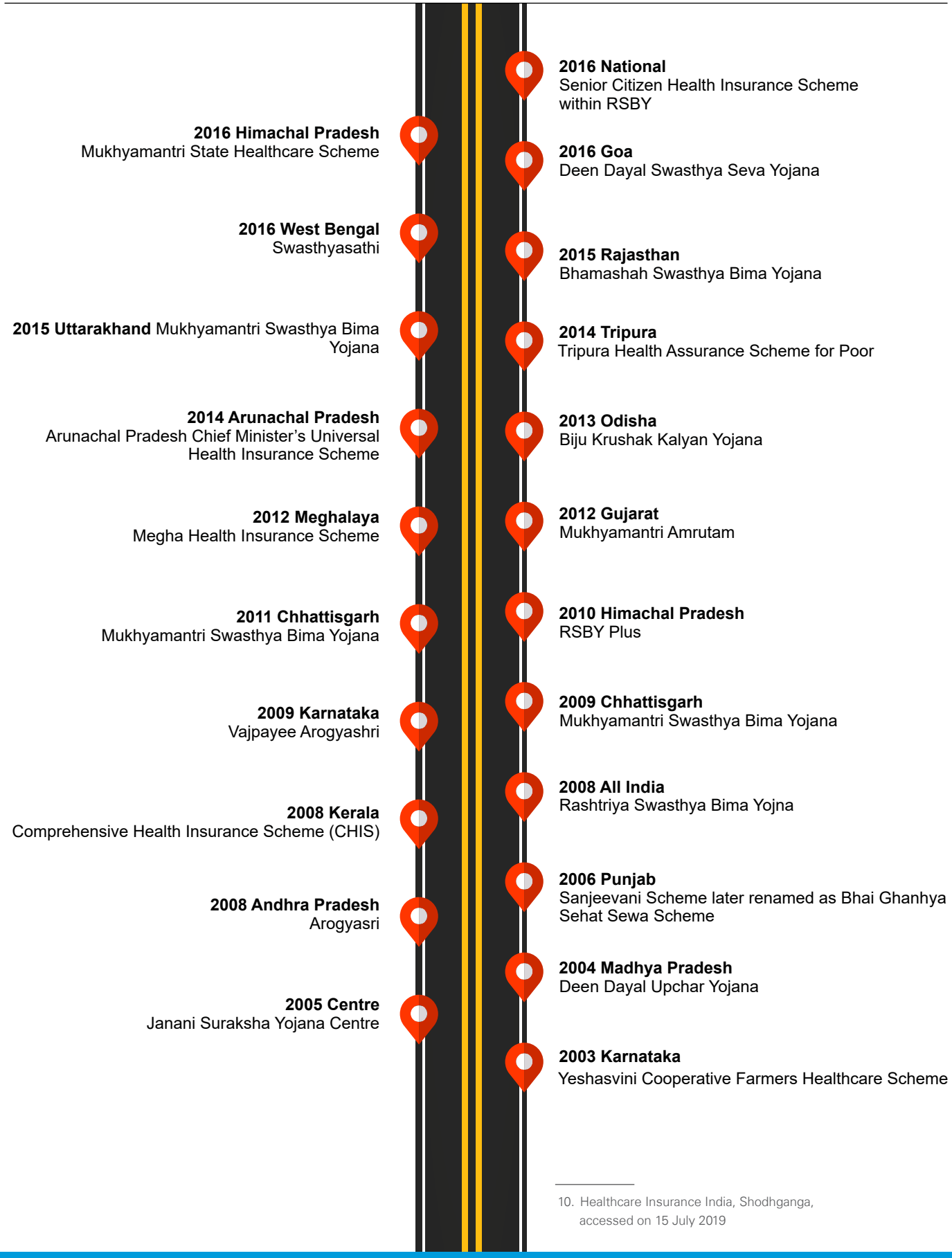
Source: Healthcare in India, Current state and key Imperatives, Review of National Health Policy 2015 (draft), KPMG, February 2015, accessed on 15 July 2019

Figure 5: Critical areas of UHC

Source: High Level Expert Group Report on Universal Health Coverage for India, Instituted by the Planning Commission of India, 2011, accessed on 15 July 2019

8. Insurance Regulatory And Development Authority Of India, Annual Report 2017-18
9. High Level Expert Group Report on Universal Health Coverage for India, Instituted by the Planning Commission of India, 2011, accessed on 15 July 2019

Figure 6: Indicative list of government sponsored healthcare coverage/insurance schemes[10]



10. Healthcare Insurance India, Shodhganga, accessed on 15 July 2019

2.0 Decoding Ayushman Bharat

1. National Health Policy, 2017, Ministry of Health and Family Welfare, accessed on 10 July 2019
2. Ayushman Bharat Yojana, nhp.gov,
3. Ayushman Bharat Yojana, nhp.gov.in, accessed on 15 July 2019
4. National Health Profile, 2018

National Health Policy 2017 – The statement of intent to embark on UHC journey

The National Health Policy released in March 2017, 14 years after the last National Health Policy, indicated four major changes in the Indian healthcare system and recognized the pivotal importance of SDGs and time-bound quantitative goals aligned to ongoing national efforts as well as the global strategic directions. (Figure 1)

The policy cemented the need and vision for UHC as a national priority. The policy advocated provisioning of free and comprehensive primary, secondary and tertiary care services, through the network of public hospitals or strategically purchased from private providers, wherever required.[1]

Figure 1: Major changes in Indian Health System

NHP, 2017 Four Major Changes in Indian Health System	
~	Changing health priorities due to the shift in disease burden
~	Emergence of a robust healthcare industry
~	Increasing incidences of catastrophic expenditure due to healthcare costs
~	A rising economic growth enabling enhanced fiscal capacity

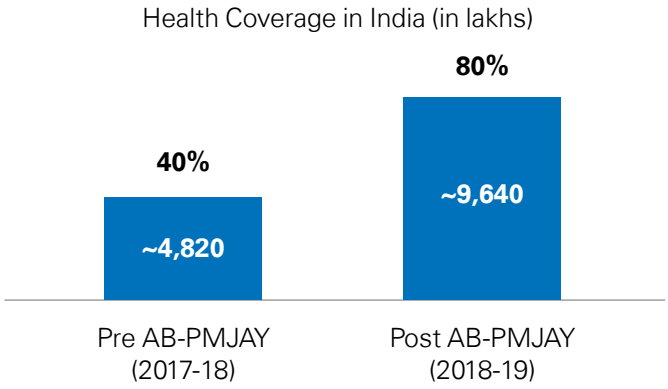
Launch of 'Ayushman Bharat' - World's biggest government health programme[2]

As envisioned under NHP 2017, the Union Budget 2018-19 announced 'Ayushman Bharat' for a healthy India. The Government of India announced two major initiatives in the health sector as part of Ayushman Bharat aimed at introducing path-breaking interventions to address health holistically, in primary, secondary and tertiary care systems, covering both prevention and health promotion.

The government of India envisioned that two health initiatives under Ayushman Bharat will build a New India 2022 and ensure enhanced productivity, wellbeing, prevent wage loss, financial hardship, create jobs and boost the healthcare sector.[3] With this the Indian healthcare system is poised for a great leap forward towards UHC. It is estimated that around 20 crores (80%) families will be covered under AB-PMJAY, private insurance and other government-funded health schemes such as CGHS, ESIS, Railways, and ECHS.*

*CGHS: Central Government Healthcare Scheme; ESIS: Employment State Insurance Scheme; ECHS: Ex-Servicemen Contributory Health Scheme

Figure 2: Change in Health Coverage after launch of Ayushman Bharat



Source: KPMG Analysis, IRDA 2017-18 Report, AB-PMJAY website

Healthcare

Comprehensive Primary Healthcare Services

Ayushman Bharat - Health and wellness centres (HWCs)

- Establish 1.5 lakh health and wellness centres providing CPHS
- Public Health had ~1,56,231 SHCs, ~ 25,650 PHCs and ~5,624 CHCs in India as on 31 March 2017[4]*
- Under the AB-HWCs initiative, existing SHCs and PHCs across rural and urban areas will be upgraded to health and wellness centres providing a wider scope of services with additional resources and infrastructure
- It was envisioned that health and wellness centres will bring the healthcare systems closer to the homes of people and enact a robust gatekeeping system
- The first part of Ayushman Bharat - Health and Wellness Centres, was launched on April 14 at Jangla in Chhattisgarh's Bijapur district.

* CHC: Community Health Centres: PHC: Primary Health Centres; SHC: Sub Health Centres

Secondary and Tertiary Care Services

Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)

- Covering approximately 10.7 crore families with INR 5 lakh annual coverage per family for secondary and tertiary care services
- Before the launch of AB-PMJAY, more than 20 states had existing health coverage schemes (RSBY*/RSBY Plus/State own Scheme) covering around 6.67 crore families
- Post-launch of AB-PMJAY, around 17 crores (68 per cent) families were estimated to be covered under AB-PMJAY and other government-funded health schemes combined
- AB-PMJAY was launched on 23rd September 2018 in Ranchi, Jharkhand.

*RSBY: Rashtriya Swasthya Bima Yojana
(Note: total families in India – estimated to be around 25 crores).

Clearly, the inception of Ayushman Bharat is expected to change the face of Indian healthcare. Top 10 achievements showcasing how it has worked towards its goal elevating the overall healthcare system.

'Ayushman Bharat' – India's giant leap towards universal healthcare coverage

1. World's largest health insurance programme

23 September 2018 was a historic day for India, that marked the launch of AB-PMJAY, providing cover to around 10.7crore (~50 crore beneficiaries) vulnerable entitled families with approximately USD7,000 annual coverage per family for secondary and tertiary care services.

2. Building one of the largest networks of primary care

Under Ayushman Bharat, India envisioned to create one of the largest public primary healthcare networks in the world by establishing 1.5 lakh health and wellness centres.

3. Enabling ~80 per cent health coverage in India

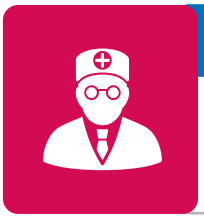
Approximately 20 crore (80 per cent) families of the total population are covered under AB-PMJAY, private insurance and other government-funded health schemes such as CGHS, ESIS, Railways, and ECHS.

4. Building institutions capacity

Herculean task of setting up of various government institutions like National Health Authority (NHA) at Central level and State Health Agencies in more than 30 states/UTs within few months of announcement of Ayushman Bharat.

5. Integrating AB-PMJAY with 30+ states/UTs

NHA was exposed to one of the biggest challenges of onboarding more than 30 states/UTs to join the scheme and drive integration of AB-PMJAY with state owned schemes.



6. Generate employment opportunities

It is estimated that Ayushman Bharat will create considerable employment opportunities across government sector, private hospitals, Third party administrators (TPAs), insurance companies and other such related sectors.

7. Enable new business models of care

It is envisioned that Ayushman Bharat will enable innovative business models, encourage new market entrants, encourage setting up of economical hospitals across tier-II and tier-III, new PPP models and large emphasis on strategic purchasing.

8. Drive medical equipment demand

Creation of envisioned new healthcare infrastructure across tier-II and III will potentially drive medical equipment demand.

9. Drive pharmaceutical and medical supplies demand

Increase in health coverage will potentially drive pharmaceutical and medical supplies demand.

10. Large scale capacity building

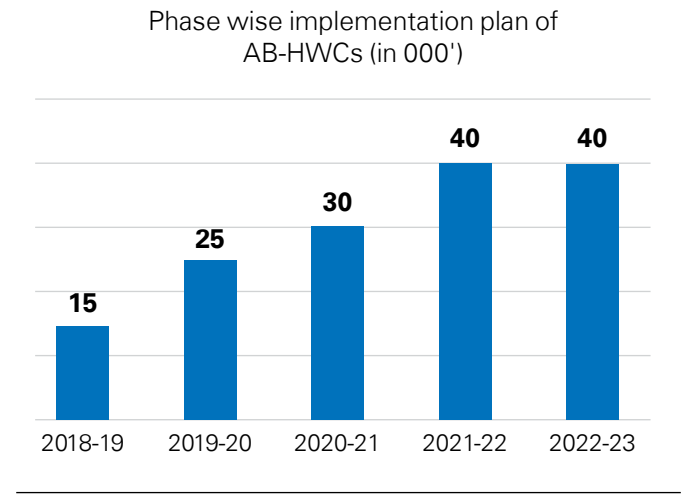
The launch of Ayushman Bharat witnessed one of the most extensive institutional strengthening programme and training of a large scale of staff, across greenfield and brownfield states/UTs.

2.1 Ayushman Bharat – Health and wellness centres

Building healthy foundation

"Health and Wellness Centres" (HWCs), the first pillar of Ayushman Bharat under which 1.5 lakh existing Sub Health Centres (SHCs) and Primary Health Centres (PHCs) are likely to be upgraded to deliver Comprehensive Primary Healthcare (CPHC). It is universal and free to users, with a focus on wellness and delivery of an expanded range of services close to the community.

Figure 1: Phase wise implementation plan of AB-HWCs

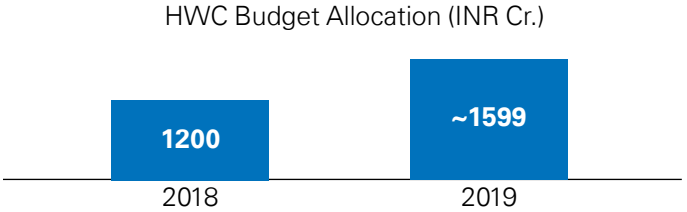


Source: Number of HWCs, AB-HWC Portal, 2019, accessed on 22nd July 2019

Phase wise implementation plan has been adopted to upgrade existing SHCs and PHCs and establish AB-HWCs to achieve 1.5 lakhs by 2022. As of 12 September 2019, a total of 20,942 AB-HWCs have been made operational across the country. Out of the total approved HWCs (60,206 as of 22 July 2010), 7,497 are SHC–HWCs, 2,318 are PHC–HWCs and10,025 are UPHC–HWCs.[1]

In 2018, a total of INR1200 crore was allocated for this transformation with an aim to increase the focus on providing wellness and comprehensive primary care services. In 2019, the government has allocated INR249.9 crore for establishing Ayushman Bharat-HWCs under the NUHM to provide comprehensive primary care, while INR1,349.97 crore has been assigned for setting up health and wellness centres under the NRHM.[2]

Figure 2: The HWC budget allocation



1. Number of HWCs AB-HWC Portal, 2019, accessed on July 22nd 2019
2. Budget 2019: Rs 62,398 cr outlay for health sector; Rs 6,400 cr earmarked for Ayushman Bharat-PMJAY, Financial Express, accessed 22 July 2019

In the first year, each SHC, PHC, and UPHC would be given a funding of INR17.5 lakh, INR 9.9 lakh, and INR15.3 lakh respectively for upgrading the facility, procuring IT equipment, conducting IEC (Information, education and communication) activities, providing incentives/salaries and upskilling the health workers.

The core component of the health and wellness centres are mentioned below:

1 The spectrum of services at HWCs

Overview

- Once the facilities (SHCs and PHCs) are upgraded to HWCs, it can enable the expansion of the services beyond reproductive, maternal, newborn child plus adolescent health (RMNCH+A) by including NCDs, palliative and rehabilitative care
- The range of services delivered at the PHC-HWCs would be higher than at the SHC-HWC
- These service packages will be rolled out in a phased manner and would evolve in different States/UTs, depending on their priorities, disease prevalence, community needs, and district/sub-district capacity
- Other services would evolve in different states, depending on the current scenario and district/ sub-district capacity.

Additional services

The expanded range of services to be delivered at HWCs is listed below:

- RMCH
- Management of communicable diseases including National Health Programmes
- Outpatient care for acute simple illnesses and minor ailments
- Screening, prevention, control and management of NCDs
- Care for common ophthalmic and ENT problems
- Basic oral healthcare
- Elderly and palliative healthcare services
- Emergency medical services
- Screening and basic management of mental health ailments
- Gatekeeping and referral management to CHCs/ FRUS/District Hospitals.

Key takeaways

Implementation
Implementation pace and service packages rolled out are largely dependent on a State/UTs with flexibility provided to prioritise the rollout of service packages in a phased manner based on the local epidemiological context and resources.

Transformation of Services
Implementing expanded range of services to be delivered at HWCs requires overall transformation of last-mile public health services with availability of skilled manpower, availability of drugs and supplies, well maintained medical equipment and cultivating public trust.

Exploring Partnerships
Partnerships with private player and NGOs are stated in the guideline for HWCs to develop proposed HWCs. However, partnership models are currently not defined or piloted on-ground to understand the sustainability, scalability and financial viability for the partners.

Major concern area *Medium concern area* *Low concern area*

2 Human resource at HWCs

Overview

- To meet the required objectives, the primary healthcare team positioned at the transformed HWCs will be strengthened
- The SHCs have been allotted one-time payment of INR1 lakh for the training of Mid-Level Health Provider and an added 10,000 for yearly refresher course
- MHLPs and team will be oriented to provide CPHC and will receive performance-linked payments – the salary of the MHLP would consist of a fixed component and an incentive component linked to key outcomes, which would be measured using data captured through an IT platform.

Additional human resources

The major additions to the team as per IPHS are:

- At SHC-HWC – One Mid-Level Health Provider (MLHP) or Community Health Officer (CHO) in addition to two Multi-Purpose Workers (MPWs) (female and male), and a team of ASHAs (one ASHA per 1000)
- At PHC-HWC medical officer, staff nurse, lab technician, pharmacist will be present at the centre along with a team of MPWs and ASHAs, deployed for outreach activities
- A new cadre of non-physician health worker, an MHLP/CHO would be a B.Sc. in Community Health or a Nurse (General Nursing and Midwifery (GNM) or B.Sc.) or an Ayurveda practitioner, trained and certified through IGNOU/other State Public Health/Medical Universities.

Key takeaways

Recruitment

- Among the 21 larger states, most reported more than 40 per cent of vacancies of staff nurses and vacancies for ANM was not more than 25 per cent.[3] As per the study, only 60 per cent PHCs are manned with a doctor against mandate of at least two doctors
- Also, around five per cent of total PHCs are operating without a single doctor.[4] The sanctioning of new posts, recruitment and onboarding of human resource is a long process in public health and would require streamlining and time-bound plan to fill the current vacancies and new positions.

Skilling and Change Management

Availability of skilled workforce to fill the vacancy of health professionals in relation to sanctioned positions, training of a large number of MHLP/CHO and adoption of new cadre in the system will present major challenge in delivering all components of CPHC.

Rebuilding Trust

The lack of manpower in public health facilities is one of the main reasons of healthcare underutilisation and the success of HWCs will largely depend on the manning of HWCs with skilled healthcare workforce at the earliest to rebuild the trust in public health system.

Major concern area *Medium concern area* *Low concern area*

3. Niti Aayog Health Index Report, 2019
4. Healthcare still inaccessible in rural India, Economic Survey 2018-19, accessed 20 July 2019

3 Drugs and supplies at HWCs

Overview

- To deliver comprehensive primary healthcare services to the population at HWCs, the list of essential medicines has been expanded
- The large emphasis on the adequate availability of essential medicines will be ensured with a new process of indenting and leveraging information and communications technology (ICT) system
- In the near future, demographics of patients collected through population enumeration will be incorporated in the e-Aushadhi software to enable linkage with patient wise consumption data to estimate real-time need.

Additional drugs and supplies

- At SHC-HWC – a provision of 91 medicines which will be made available to the patients for free. The list consists of a wide range of medicines ranging from anti-hypertensive, anti-diabetics, analgesics, anti-bacterial, anti-fungal, anti-malarial medicines to antidotes used in poisoning
- At PHC-HWC – Apart from the 91 medicines, PHC/UPHC-HWC will have an additional 43 medicines that will be used to treat hypertension, diabetes, epilepsy, COPD, diuresis and cardiovascular problems
- These medicines will be dispensed by the CHOs based on the treatment plan made by the PHC-Medical officer.

Key takeaways

Standardisation of EDL
Standardisation of the National and State level essential drugs list and establishing a uniform list for HWCs across various States is essential for uniform delivery of quality CPHC.

Supply chain management (SCM) – people, systems & process

- Adequate availability of drugs will determine the success and outcomes of HWCs. The current status of SCM in public health in India presents significant gaps in timely availability of adequate drugs and supplies till the last mile
- There is a need for extensive skill-building of SCM workforce, adoption of SCMIT system and reengineering of SCM processes in public health to drive transformation.

Major concern area *Medium concern area* *Low concern area*

4 Diagnostic services at HWCs

Overview

- The range of diagnostic services at HWCs has been expanded to broadly cater to primary healthcare needs
- A new range of diagnostic equipment and point of care diagnostics will subsequently be added to support the delivery of expanded services
- To support HWCs, one central diagnostic unit (CDU) or hub will be created at CHC or block-level PHC for 20–30 HWCs, depending on the distance and population served. CDUs will offer tests for hepatitis, blood urea, creatinine, lipid profile tests, x-ray, ultrasound and ECG.

Additional diagnostics services

The list of diagnostic services would include:

- SHC-HWC will offer seven investigations as per the Guidelines for National Free Diagnostic Initiative. Seven tests include rapid pregnancy test, urine dipstick, complete blood count, haemoglobin, glucose, RDK for malaria and dengue, sputum samples, and sickle cell test
- PHC-HWC will offer nineteen investigations. Apart from the ones offered in SHC-HWC, PHC–HWCs will offer disease-specific tests for HIV, tuberculosis, syphilis, and hepatitis B and C.

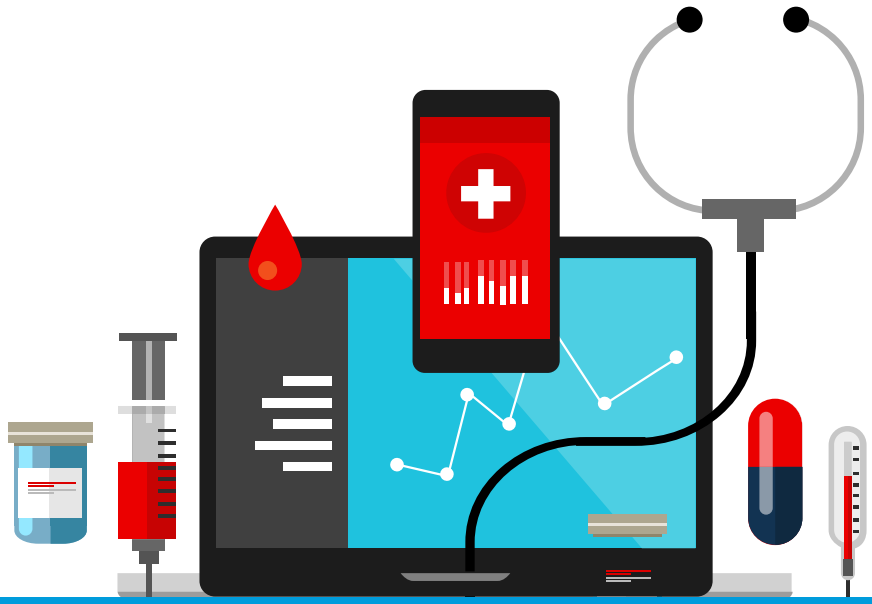
Key takeaways

Equipping
Equipping a large number of HWCs with new additional diagnostic equipment will be challenging, considering diverse geography and health status across states.[5]

Implementation of protocols
In terms of state-wide implementation of the HWCS guidelines, various states are yet to define specific protocols for peripheral collection of samples from HWCs and further training large number of the last-mile workforce will present a challenge in delivering quality services.

Tele-diagnostics services
Adoption of tele-pathology and tele-radiology could enable the availability of expanded services at HWCs, however network connectivity and adoption of such solutions by HWCs will be a challenge.

Major concern area *Medium concern area* *Low concern area*



5. Operational Guidelines, Comprehensive Primary Healthcare through HWCs, 2017, accessed on 20 July 2019

5 Physical infrastructure

Overview

- The plan is undertaken major and minor repairs existing facilities being upgraded to HWCs to enable provision of sufficient space for delivery expanded services
- Provisions will also be made for designated space for wellness-related activities like yoga, physical activity, etc
- All facilities will be branded in terms of building colour, interiors & exteriors, IEC material as per the standard guideline for HWCs provided by Ministry of Health and Family Welfare (MoHFW).

Additional infrastructure

The major additions to physical Infrastructure as per IPHS are:

- At SHC-HWC –It will have an additional wellness and counselling and immunisation room and place/room for teleconsultation
- At PHC-HWC – It will have an additional general ward for surgical operations and place/room for teleconsultation.

Key takeaways

Up-gradation Pace

- As on 22 Jul 2019, the total approved HWCs were 60,206 and 19,840 (33 per cent) were upgraded across various states/UTs. 27 states/UTs had upgraded less than 50 per cent of approved HWCs as on 22 July 2019.
- Undertaking major and minor repairs to develop around 30,000 HWCs per annum for the next five year will be a herculean task considering diverse geography and current healthcare infrastructure status across states.

Maintenance of Infra

Maintenance of physical infrastructure after up-gradation of HWCs will be an important aspect of ensuring consistent delivery of services.

Procurement

Exhaustive and time-consuming public procurement and contracting processes could delay up-gradation of the facilities, procurement of telemedicine, ICT system and other infrastructure.

Major concern area *Medium concern area* *Low concern area*

6 Information and Communications Technology (ICT) system

Overview

- The proposed plan is to leverage information and communication technology at upgraded HWCs to deliver comprehensive primary healthcare services
- Patient management system to digitize patient records and data for larger assessment and analytics.

Additional ICT System

Proposed ICT systems to deliver additional services:

- Patient management system to digitise patient records and data for larger assessment and analytics
- Programmes such as ECHO (Extension for Community Healthcare Outcomes) are being conducted for supporting the MLHPs through handholding, troubleshooting, and problem-solving to enable building of technical competencies and sustaining motivation.

Key takeaways

Implementation of ICT Systems
The success of automation of the existing facilities (SHCs and PHCs) with patient management and other ICT systems will depend on timely procurement, installation and maintenance of such system till last mile.

ICT Literacy
ICT literacy and training of a large number of workforce across new ICT systems/modules will require large scale capacity building and hand holding exercise for existing and new workforce.

TeleHealth System
Telemedicine, telepathology and teleradiology system implementation and success will be highly dependent on timely procurement, availability of connectivity and training of workforce.

SCM IT System
There is varying progress across States in the adoption of e-Aushadhi/SCM IT system. Ineffective utilisation of e-Aushadhi/ SCM IT system due to connectivity in remote areas, skilled workforce and maturity of current SCM IT system will be critical challenges to be addressed by the government.

Major concern area *Medium concern area* *Low concern area*

7 Care Continuum

Overview

Huge emphasis on Community engagement as mentioned below:

- The expanded services will be available at the SHCs and PHCs upgraded to HWCs. The focus at the community level will be to promote wellness through social and behavioural change communication to emphasise the importance of preventive and promotive health
- Awareness regarding lifestyle modification through regular physical activity, including yoga, healthy diet, and reduced intake of tobacco and alcohol
- In addition, HWCs will undertake screening and early detection, dispensing of drugs and regular follow up for chronic conditions, including post-operative and rehabilitative care
- At HWCs, emphasis will be on the convergence of government initiatives such as Swachh Bharat Abhiyan, Yatri Suraksha, Nirbhaya Nari, etc. The coordination of such programs at HWCs will help in health promotion, community mobilisation and ensuring wellness.

Additional services

Population Enumeration and Empanelment of Families at HWCs:

- To ensure equitable population coverage and to address issues of marginalisation, the frontline workers would create population-based household lists and undertake registration of all individuals (referred to as empanelment) and families residing within the catchment area of a HWC

HWCs as a service delivery backbone for integration with AB-PMJAY and other government schemes:

- NHA and MoHFW are working to integrate HWCs with PMJAY so that patients get a holistic continuum of care from primary (preventive) to secondary and tertiary (curative) care
- The IT integration between both the pillars of Ayushman Bharat will allow ground-level workers to conduct follow-up visits on beneficiaries treated in higher referral facilities
- Key areas where HWCs would be leveraged include promoting yoga, mainstreaming of AYUSH and promoting healthy behaviours related to NCDs.

Key takeaways

Sustaining Community Engagement

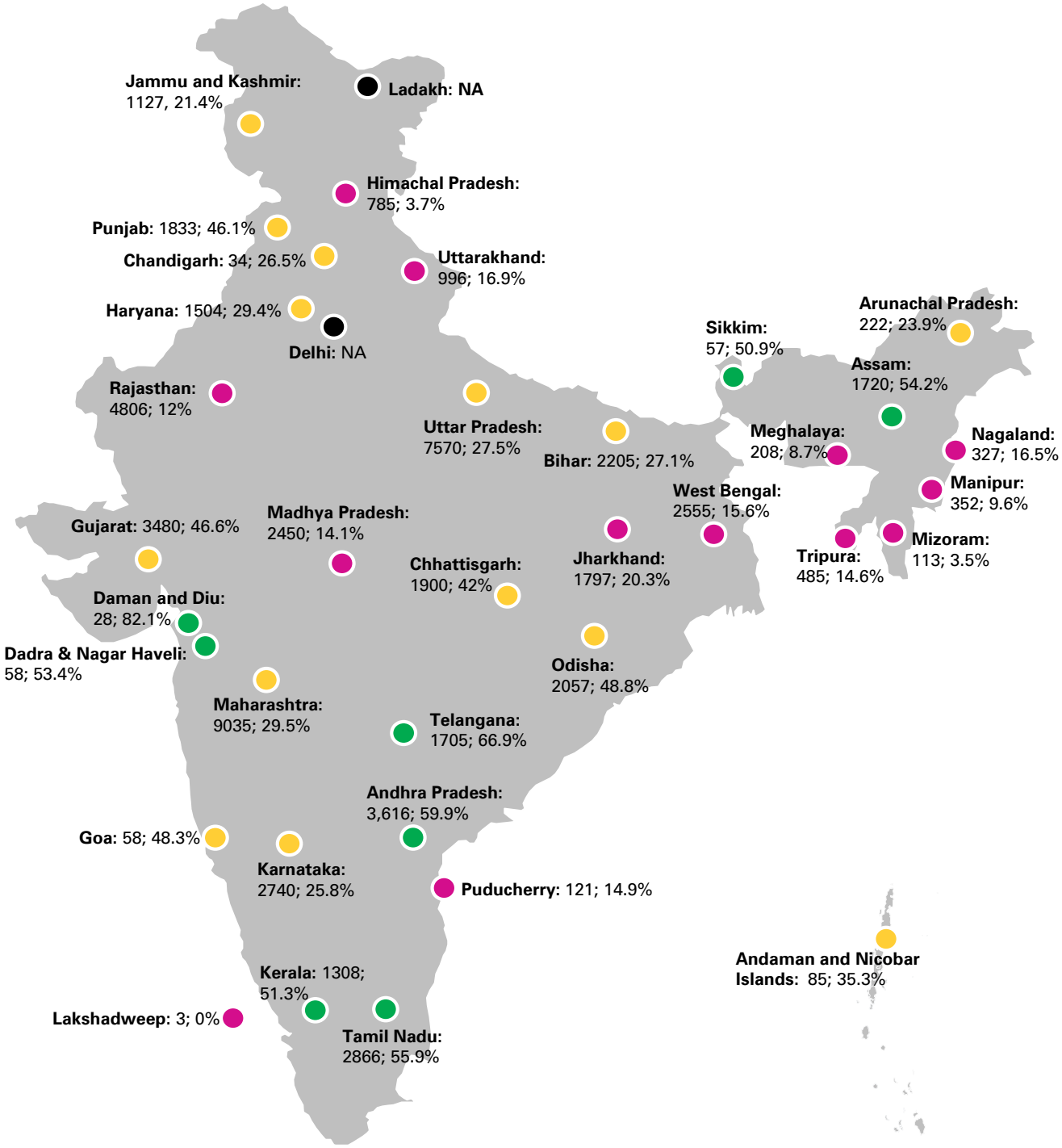
- Roll out of community-based outreach in urban areas owing to heterogeneous mix of population, varying health needs and proximity to the secondary level health facilities and private sector in urban areas
- Community engagement will require additional last-mile workforce, collaborating with partners (not for profit & profit), effective implementation of IEC and monitoring across various states.

Convergence with other Schemes and Ministries

The convergence of various healthcare schemes of MoHFW and non-healthcare schemes of other ministries will require a robust plan and implementation to onboard various stakeholders from top to last.

Major concern area *Medium concern area* *Low concern area*

Figure 3: State wise status of HWCs as on 22 July 2019



Total HWCs planned and upgraded as on 22.07.2019

Legend:

State Name: Total HWCs approved; % of HWCs upgraded under AB-PMJAY

NA: Not available

Upgraded >50% HWCs

Upgraded 30–50% HWCs

Upgraded <20% HWCs

Source: AB-HWC Portal, accessed on 22 July 2019

2.2 Ayushman Bharat Pradhan Mantri Jan Arogya Yojana

A big attempt to reduce catastrophic healthcare expenditure

AB-PMJAY, the second pillar of Ayushman Bharat, was launched on 23 September, 2018. The scheme aims to provide healthcare coverage to over 10 crore poor and vulnerable families (approximately 50 crore beneficiaries) providing coverage upto INR5 lakh per family per year for secondary and tertiary care hospitalisation. The AB-PMJAY has subsumed centrally sponsored schemes such as Rashtriya Swasthya Bima Yojana (RSBY) and Senior Citizen Health Insurance Scheme (SCHIS).

As per the National Health Accounts of 2014-15, government expenditure on primary care was 51.3 per cent, secondary care was 21.9 per cent and tertiary care was 14 per cent. The public health system in India lacks thorough healthcare facilities, especially with respect to coverage of secondary and tertiary care. Many of these services are provided by private healthcare providers eventually leading to high OOP expenditure. The scheme envisions to reduce catastrophic expenditures, elevating the public healthcare system and leveraging quality services of private healthcare providers across various levels of care.

The focus of providing comprehensive secondary and tertiary healthcare services under AB-PMJAY was further substantiated in budget announcement on 5 July 2019, when allocation for AB-PMJAY was increased from INR 2,400 crore in FY 2018-19 to INR 6,400 crore for FY 2019-20; which saw 166.6 per cent increase from the previous financial year[1].

1. Budget 2019: Government to allocate Rs 6,400 crore for Ayushman Bharat Scheme, Business Today, 03 July 2019, accessed on 10 July 2019 | *As of data on July 2019

Key components and enablers of the scheme are detailed below:

1 Beneficiaries covered

Overview

- AB-PMJAY is an entitlement-based scheme with no formal enrollment process
- AB- PMJAY was targeted to cover around 10.74, out of total targeted families 8.20 crore families are based in rural area and 2.33 crore families are based in urban area
- The latest Socio-Economic Caste Census (SECC), 2011 data was used to identify targeted poor, deprived rural families (D1, D2, D3, D4, D5, and D7) and identified 11 occupational categories of urban workers' families. (Details in Table A)
- Additionally, all such enrolled families under RSBY that do not feature in the targeted groups as per SECC data were included as well
- States covering a much larger population than the AB PM-JAY beneficiary list were mandated to ensure that AB-PMJAY beneficiaries are mapped and covered by the states
- Beneficiary can get AB-PMJAY e-card printed with the unique ID at empaneled healthcare providers, CSCs and other such designated places by State Health Agency (SHA)
- The guideline for identification of beneficiaries, process for generating an e-card and other aspects of beneficiary management is defined by the NHA.

AB-PMJAY beneficiaries

For rural

Total deprived households targeted for AB PM-JAY who belong to one of the six deprivation criteria amongst D1, D2, D3, D4, D5 and D7:

- Only one room with kuccha walls and kuccha roof (D1)
- No adult member between the age 16 to 59 (D2)
- Female headed households with no adult male member between age 16 to 59 (D3)
- Disabled member and no able-bodied adult member (D4)
- SC/ST households (D5)
- Landless households deriving major part of their income from manual casual labour (D7)

Automatically included

- Households without shelter, Destitute/living on alms, Manual scavenger families, Primitive tribal groups, legally released bonded labor.

For urban

Occupational categories of workers:

- Rag picker
- Beggar
- Domestic worker
- Street vendor/cobbler/hawker/other service provider working on streets
- Construction worker/plumber/mason/labour/painter/welder/security guard/coolie and another head-load worker
- Sweeper/sanitation worker/mali
- Home-based worker/artisan/handicrafts worker/tailor
- Transport worker/driver/conductor/helper to drivers and conductors/cart puller/rickshaw puller
- Shop worker/assistant/peon in small establishment/helper/delivery assistant/attendant/waiter/electrician/mechanic/assembler/repair worker/washer-man/chowkidar.

Key takeaways

Comprehensive coverage

Post the launch of AB-PMJAY, around 17 crore (68 per cent) families were estimated to be covered under AB-PMJAY and other government funded health schemes combined. (Note: total families in India – around 25 crore).

Data inconsistencies

- Beneficiary coverage is inconsistent across rural and urban areas since entitlement is based on deprivation categories for rural areas, whereas for urban areas, occupational criteria is used
- Due to non-availability or lack of seeding of complete details of beneficiaries, it has led to approval of beneficiary with low confidence/profile matching score
- Non-concurrence of beneficiaries with existing state-owned health schemes leading to miss out or duplication of beneficiaries
- Lack or limited training of staff issuing the e-card: It has led to generation of e-card with minimal confidence match, non-matching of identity proof documents and uploading of the wrong proofs.

Low concern area
Medium concern area
Major concern area

2 Health coverage under the scheme

Overview

- The AB-PMJAY scheme provides coverage upto INR5 lakh per family for secondary and tertiary care hospitalisation
- There is no cap on family size and age
- The coverage amount is provided on an annual floater basis
- The coverage amount will be renewed after end of year (the launch date of the scheme in a state), with no carry-over of the previous year's amount
- The coverage includes treatment for procedures under both secondary and tertiary care across any of the empaneled public and private healthcare providers.

Key takeaways

Coverage amount more than most of the state's schemes

The coverage amount under AB-PMJAY is adequate and more than double in comparison to most of the state-owned health schemes.

Provision on exhaustion of allocated limit

- Though the scheme endeavours to provide a comprehensive coverage in secondary and tertiary care, there still is a lack of provision for coverage for contingencies in case Rs. 5 lakhs limit is exhausted for the entitled family
- As of May 2019, 354 households had exhausted the INR5 lakh limit.

3 Funding model - Centre and states

Overview

- AB-PMJAY is centrally sponsored scheme, wherein the centre's contribution in the expenditure for beneficiaries (as per SECC data) covered under the AB-PMJAY is 60 per cent for all normal States
- However in case of UTs and north-eastern states share of centre in the expenditure is 100 per cent and 90 per cent respectively
- To ensure that the funds reach SHA on time, the transfer of funds from NHA is made through an escrow account directly.

Key takeaways

Funding by States

- State government is required to fund 40 per cent of expenditure under AB-PMJAY scheme
- In case a state government covers additional beneficiaries that are not covered under AB-PMJAY, 100 per cent expenditure for additional beneficiaries is borne by the state government
- For instance, in Maharashtra around 84 lakh families are covered under AB-PMJAY and 1.39 lakh families are covered under State owned scheme - Mahatma Jyotiba Phule Jan Arogya Yojana. The state covers large pool of beneficiaries and the major expenditure is borne by the state government.

Guidelines for fund allocation

- Lack of clarity on guidelines related to allocation of funds under various heads e.g. definite fund to be used for IEC has prevented many SHAs from adequate allocation and effective utilisation of the fund for the much-required IEC
- NHA should define sub heading level minimum and maximum budget allocation from the total budget to be used by greenfield and brownfield states to achieve uniform and effective implementation across all the participating states.

Major concern area *Medium concern area* *Low concern area*

4 Diseases and packages covered

Overview

- Overall, approximately 1,394 packages were designed and covered under the scheme for launch purposes till one year
- In September 2019, NHA released the revised health benefit packages list and addressed issues pertaining to package pricing, modification and inconsistencies
- The revised health packages have been developed with appropriate nomenclature. It categorizes nearly 24 specialties with ~880 packages and 1550 procedures across medical and surgical branches This was earlier defined only as 1394 packages
- Based on the learnings from one-year implementation, NHA in new health benefit packages have added nearly 237 new packages and discontinued 554 packages (with decision on packages of cataract still pending)
- The states have also been given the flexibility to modify the package list, pre-authorisation and reservation of procedures for public health facilities as per their requirements
- So far states have not adopted the revised health benefit packages. The revised list will be adopted by the states/UTs as per their readiness. NHA plans to conduct workshops to discuss the revised packages with all the states/UTs . The revised packages are expected to be rolled out by December 2019.

Key takeaways

- **Revised package list with appropriate nomenclature**
  The new health benefit packages have attempted to improve the nomenclature that was raising the scope of unnecessary services across the states
- **Addition of subsets of packages**
  Cost of implants/consumables have been separated from the cost of procedure to allow choice of implants and reduce financial burden on healthcare providers
- **Removal of aberrations**
  A lot of inconsistencies in terms of duplication have been removed. A total of 43 stratified packages have been adopted under the new list. Cross linkages of packages across specialties are also been provided for better understanding and utilisation

  With the release of new packages, most utilised packages under the category of 'unspecified packages' have been added in the package master to restrict abuse of the feature.

Clarity on Pre-authorisation on certain procedures

- Pre-authorisation for around 750 procedures has not been made mandatory under the scheme. However, many states have defined pre-authorisation for all procedures. While in case of brownfield states, they have used their existing pre-authorisation criteria for the packages to be covered under the scheme.

Major concern area *Medium concern area* *Low concern area*

5 Packages pricing

Overview

- Prices of the packages under AB-PMJAY are defined by NHA based on comparisons done with other state schemes, RSBY and CGHS rates. The rates are published on the NHA official website. The revised list of health benefit packages has 57 packages with reduced rates and 237 packages with increased rates
- Packages cover complete cost of hospitalisation covering care, medicines, food and other costs
- Package price also covers pre and post hospitalisation expenses. Expenses incurred for consultation, diagnostic tests/medicines before the admission of the patient in the same hospital and cost of diagnostic tests/medicines for up to 15 days after the discharge from the hospital for the same ailment/surgery
- As per the new health benefit packages, ~40 per cent lie within a range of INR20,000. Nearly 5 per cent of the packages are above INR 1 lakh and are mainly under the category of Cardiothoracic and Vascular Surgery (CTVS), Interventional Neuroradiology, Medical Oncology and Orthopaedics
- States have the flexibility to increase rates up to 10 per cent or reduce them as much as needed to suit local market requirements. Further, states have been advocated to retain their existing package rates, even if they are higher than the prescribed 10 per cent flexibility slab
- Provision is made to encourage EHCPs to attain quality milestones by incentivised payment structures (over and above base package rate) for select parameters such as – Entry Level Quality Certification (10 per cent), Full Accreditation (15 per cent), Aspirational/Backward districts (10 per cent) and Running PG/DNB course in the empaneled specialty (10 per cent).

Private hospitals could get up to 40 per cent higher rates for a procedure over rates prescribed by National Health Protection Scheme (NHPM) or Central Government Health Scheme (CGHS), provided they meet the following conditions:

- + 10% for NABH accredited hospitals
- + 10% for hospitals providing PG courses
- + 10% for hospital in 115 backward districts
- + 10% if state offers additional top-up

Key takeaways

Utilisation of high value claims

- Over 20 lakh claims have been preauthorised up to 15 May 2019. The mean claim size is around INR 13,000, and half of all the preauthorised claims are below INR 7,000. In contrast to the large number of low- and medium-size claims, 7 per cent are high-value claims (above INR30,000), and 1 per cent of total claims are very-high value claims (above INR1 lakh)
- Despite the relatively small volume, these high-value claims contribute 32 per cent of PM-JAY claim payout, amounting to nearly INR1,000 crore.[2]

Differential pricing structure

- Currently there is lack of gradation or differential pricing structure for EHCPs with respect to - geographical location of EHCPs in terms of tier 1 vs tier 2 and 3, and size of hospital (large and small healthcare organisation) within the same geography
- Need to define package price split across the components like – medicines, supplies and implants, etc.
- Need to standardise and define approved list of medicines, supplies and implant in terms of minimum or maximum usage for high volume and tertiary care procedures, approved generic/branded medicine, and quality of such medicines and supplies used by EHCP across India.

Major concern area *Medium concern area* *Low concern area*

2. PM-JAY Policy Brief 1: Raising the Bar: Analysis of PM-JAY High-Value Claims, July 2019

6 Empaneled healthcare providers

Overview

- All establishments with indoor admission facility are eligible to be empaneled healthcare provider (EHCP) under AB-PMJAY
- All public facilities (including ESI) with capability of providing inpatient services (CHCs level and above) are deemed empaneled
- The guidelines have been laid down for empaneling private healthcare providers with 10 inpatient beds and more. A tiered approach is adopted with two major categories namely – essential criteria and advanced criteria for e.g. Cardiology, Poly-trauma, Oncology, Neurosurgery, etc.
- State government has been given the flexibility to revise/relax the empanelment criteria barring minimum requirements of quality, on their local context, availability of providers, and the need to balance quality and access; with prior approval from NHA
- Provision for the states to auto-approve the already empaneled hospitals under an active RSBY scheme or state-owned scheme, provided they meet minimum eligibility criteria prescribed under AB-PMJAY
- The scheme also provides a provision of fast track empanelment of hospitals, which are NABH accredited post application submission on web portal and meeting the minimum criteria
- EHCPs are required to hire a dedicated person called Arogya Mitra to manage the help desk and facilitate the beneficiary in accessing the benefits under AB PM-JAY. The cost of the Arogya Mitras will need to be entirely borne by the private EHCPs.

Key takeaways

Building a bigger and strong network of hospitals

- All public hospitals are deemed empaneled in order to encourage participation and build capacity of the public sector
- As on 22 September 2019, around 18,236 (with nearly 52 per cent private) healthcare providers are empaneled with AB-PMJAY across India with almost equal numbers of providers from public and private sector
- From the scheme launch to 15 May 2019, 61 per cent of all claims submitted are from private hospitals, the share from private hospitals is higher for high-value (>INR30,000) claims (74 per cent), and very-high-value (>INR1 lakh) claims (82 per cent). Hospitals with a larger volume of high-value claims are concentrated in a few cities, and the top 20 hospitals account for 17 per cent of all high-value claims (and therefore over 5 per cent of total AB-PMJAY spending)[3]
- The eight districts with over 5,000 high-value (>INR30,000) claims are Bengaluru Urban, Mumbai Suburban, Ahmednagar, Aurangabad, Pune, Nashik, Chennai and Raipur.

Reluctance of hospitals from tier -1 cities

Despite more than 7000 private providers being empaneled with the scheme, there is limited participation of private healthcare providers across tier-1 cities such as Gurugram (17), Mumbai (29) and Bengaluru (28).

Need for better quality checks

With extensive network, the need for effective monitoring of quality, outcomes and practices across such large number of EHCPs requires extensive on field quality and medical audits, use of ICT system and analytics.

Major concern area *Medium concern area* *Low concern area*

3. PM-JAY Policy Brief 1: Raising the Bar: Analysis of PM-JAY High-Value Claims, July 2019

7 Models of Implementation

Overview

- The scheme implementation in a state is governed by participation MoU signed between NHA and the state/UTs government
- NHA has provided participating states/UTs with the flexibility to choose between three modes of implementation for the scheme – trust mode, insurance mode and hybrid mode
- Under trust mode – SHA makes payment to EHCPs for the claims approved
- Under insurance mode – Insurance company is appointed by SHA and makes payment to EHCPs for the claims approved
- Under hybrid mode – Insurance company is appointed by SHA for certain amount of coverage (e.g. up to INR 50,000 or upto INR1,50,000) and claims not covered under the insurance limit are paid directly by SHA to EHCPs.

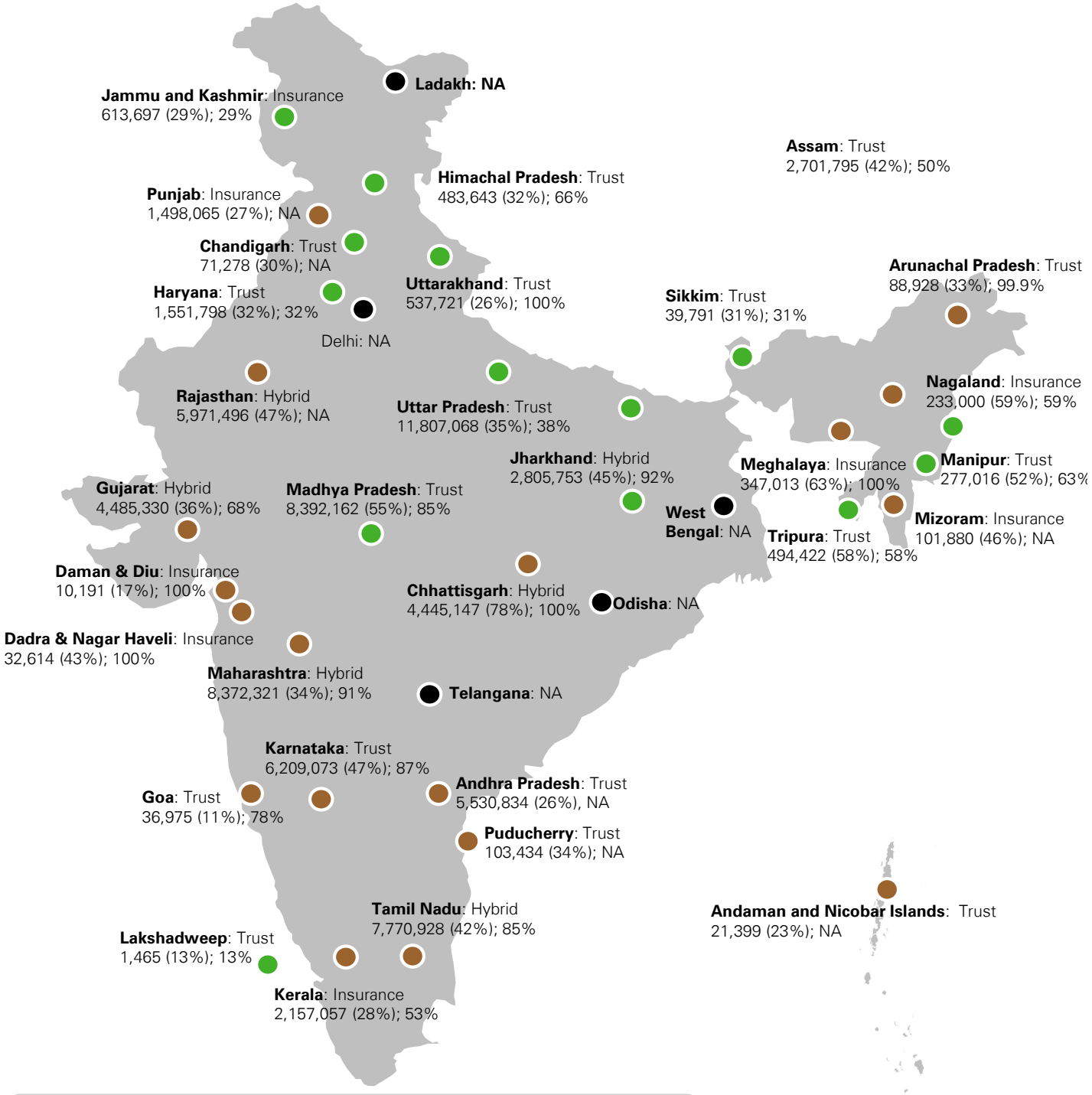
Key takeaways

Preferred mode of implementation – Trust mode

- As of August 2019, out of the 36 States and Union Territories (UTs), 32 states/UTs have signed the MoU and have AB-PMJAY operational at the moment
- It has been observed that 17 states/UTs have opted for a trust mode, 9 states/UTs have opted for insurance mode and 6 states/UTs have opted for hybrid mode.
- States/UTs such as West Bengal, Delhi, Telangana and Odisha are yet to participate in AB-PMJAY, although except Delhi, all three states have state owned health scheme currently operational.

  (Figure 1 on right depicts state-wise operating model and families covered under scheme)

Figure 1: Implementation mode and coverage of States and UTs as on 15 September 2019



State Fact Sheets, AB-PMJAY Website, accessed on 20 October 2019
Note: Data till Sep 2019; Information for some states was not available on the website

Source: State Fact Sheets, AB-PMJAY website, accessed on 30 September 2019

8 Package amount disbursement – Incentivisation of human resources

Overview

- The different models have been adopted for disbursement of package amount for the Public sector hospitals
- To incentivise public sector hospitals and workforce for catering to AB-PMJAY patients, a partial sharing of the total package price with respective workforce is recommended by NHA and SHAs
- Of the total package amount, few states are holding back certain percentage as a corpus at state level. For example, Madhya Pradesh holds back 40 per cent of package amount at State/ Trust level. Rest of the amount is released to public sector hospital and split across institutional strengthening and incentive payout to various human resources cadre
- Most of the states, release the complete package amount to EHCPs and split the same across institutional strengthening and incentivisation to human workforce. The incentive payout can be done upto maximum of 25 per cent of package amount as per the NHA guidelines
- The incentive payout is further split across various cadres such as doctors, nurses, other paramedics and Arogya Mitra involved in patient's clinical care. Some of the states like Bihar have gone a step ahead and incentivised ASHA workers also for referring the cases to respective public EHCPs.

Key takeaways

Focus on institutional strengthening and incentivising medical workforce

- Package disbursement to be used for institutional strengthening of public facilities in terms of infrastructure upgrade, purchase of requisite machinery, equipment, drugs & supplies, etc.
- Incentivisation of human workforce in order to motivate the personnel to adequately treat beneficiaries within the scheme
- States would have the flexibility to hire specialist doctors as and when required and payout to them on case to case basis. The same would ensure provision of specialist quality care to the entitled beneficiaries.

Need for adequate guidelines to streamline the process further

- Adequate guidelines need to be framed and released by NHA regarding incentive distribution across cadres, currently states are grappling with the same and payout has not been initiated adequately.

Major concern area *Medium concern area* *Low concern area*

9 Implementation partners

Overview

- Insurance companies work as partners within the insurance model. The state pays per family premium to the insurance company at the time of contract sign-off. Insurance company may have in-house TPA or appoints TPAs for purpose of claims processing and cases are settled. The payout against the raised claims is done by the insurance company to empaneled providers
- Implementing Support Agency (ISA) shall mean a Third-Party Administrator which has been selected pursuant to bidding process by SHA in assurance mode of implementation under the scheme. ISA is responsible for end to end scrutiny and processing of claims raised by EHCP and submit approved claims to SHA for processing payment to EHCP.

Key takeaways

Challenges in implementation with Trust mode for green field states

- Most of the greenfield states have adopted trust mode of implementation of the scheme and lacked institutional capacity to undertake rigorous selection, negotiation and contracting process leading to selection of ISA with L-1 financial quote without a lower baseline
- Inadequate institutional capacity at SHA and delay in onboarding of required staff at SHA and district level resulted in high dependence on ISA, NHA and other partners in implementing the scheme at state level.

Hybrid model worked with most of the states

In case of hybrid mode of implementation, insurance companies are boon for SHA in terms of capacity building and institutional support in implementing the scheme.

10 IT Platforms for AB-PMJAY

Overview

- For the scheme to provide cashless and paperless services, it needed a robust, interoperable and modular IT platform. The prerequisite was fulfilled by utilising an already mature platform of Arogayasri scheme by signing a MoU in June 2018, between the Centre and Telangana government
- IT platform has been used across all frontiers of beneficiary identification (BIS), hospital empanelment module (HEM), transaction management system (TMS), feedback and grievance redressal, information security and data privacy measures.

Key takeaways

Robust IT platform for efficient monitoring of the scheme

- Web based user-friendly portal for beneficiary identification and capture of complete patient journey and claims payout
- NHA to make state the custodian of platform and generate data for purpose of analysis and other initiatives
- NHA is also leveraging open API approach to support and provide data in a standardised formats for states to be used in their own software. So far, this has been used by 10 states
- NHA is currently on the verge of completing POC for fraud management platform/analytics and same shall be implemented in the coming times to enable real-time fraud detection
- NHA has a plan to develop an IT enterprise suite to automate day to day operations across NHA and SHA. There is a large opportunity to leverage real time interactive dashboard powered by data analytics at SHA level to enable better monitoring and decision-making
- Use of RADAR (Risk Assessment, Detection and Analytical Reporting) dashboard is one of the efforts towards building effective monitoring mechanism and analysis of utilisation patterns.

Source: Ayushman Bharat Annual Report 2018-19

Low concern area
Medium concern area
Major concern area

11 Portability of the scheme

Overview

- One of the most exemplary features of the scheme is portability, which allows beneficiaries to avail cashless and paperless treatment across all states and union territories in the country
- For beneficiaries availing treatment outside its native state, package rate of the treating state will be applicable and the amount will be covered by the native state
- The feature proves to be a blessing for beneficiaries whose native state lacks extensive healthcare facilities
- National healthcare providers empaneled under the scheme such as AIIMS, Delhi, PGIMER, Chandigarh, RML, Delhi are the pillars of portable services and have catered to maximum number of portable cases.

Key takeaways

Feature proving to be a life saver life saver for vulnerable patients

Claims raised from the scheme from the date of launch to 15 May 2019 indicate portability among patients is more common for high-value claims. While only 0.7 per cent of all claims are portability cases (across states), this percentage is 2.4 per cent for high-value claims and 5.3 per cent for very-high-value claims.

High value portability suggests service gaps in state's healthcare system

The higher portability for high-value claims reflect potential service gaps in many states, and patient preferences to go to larger hospitals in other regions to seek treatment.

12 Implementing structure – NHA and SHA

NHA

- In order to operationalise AB-PMJAY at a country level and to coordinate with state government for implementation, National Health Agency was established as a society in May 2018. NHA serves as an apex body for setting up guidelines and protocols, operationalise and monitor the scheme across the country
- In January 2019, National Health Agency was restructured to National Health Authority and have full responsibility, accountability and mandate to implement the scheme.[4]

SHA

- The participating state government shall set up the State Health Agency (SHA) or designate this function under any existing agency/trust/society designated for this purpose
- The day-to-day operations of the SHA will be administered by a Chief Executive Officer appointed by the state government and other required staff at SHA must as per the broad guideline from NHA
- The SHA will be responsible for implementation of the scheme at the state level. Some of the key responsibilities of SHA includes: convergence of state scheme with AB-PMJAY; generating awareness and creating demand for the scheme; institutional strengthening of the society and ensuring effective execution of scheme
- The structure of SHA comprises committees/units at district level to further operationalize the scheme at the ground level. These include district empanelment committee, district implementation unit and district grievance and redressal committee.

Key takeaways

NHA has well defined guidelines and administrative structure with required resources, roles and responsibilities for the proposed hierarchical structure for implementation of scheme.

Lack of institutional capacity at SHA level, to recruit and deploy requisite skilled manpower for effective working of the scheme especially for greenfield states.

Low concern area
Medium concern area
Major concern area

3. Cabinet approves restructuring of National Health Agency as "National Health Authority" for better implementation of Pradhan Mantri - Jan Arogya Yojana, 02 January 2019, accessed in July 2019

13 Information Education and Communications (IEC)

Overview

- Well defined policies and guidelines with respect to IEC activities to be carried by NHA and SHA levels
- NHA has a dedicated department for planning, implementation and monitoring the entire communication activities
- Templates and designs prepared and circulated across all SHAs for creating awareness amongst target beneficiaries and other key stakeholders like providers
- NHA has been supporting most of the SHAs across greenfield state in planning and driving IEC activities.

Key takeaways

Focus on IEC to enable better utilisation

- On ground implementation of IEC guideline, templates and practices has not been completely adequate and will require additional resources and monitoring to achieve the desired objectives
- At the state level, the institutional capacity to plan and undertake IEC has been limited.
- Limited IEC activities has resulted in limited awareness about the scheme, exploitation of beneficiaries and cropping up of fraudulent activities like charging money for providing the services.

14 Training and capacity building

Overview

- NHA has well defined different guidelines for training of various cadre at NHA, SHA and District level
- NHA has undertaken numerous training programmes for SHAs during the launch of the scheme and continuous capacity building workshops with the help of internal and external experts
- At the state level, SHA has conducted numerous training sessions for hundreds of Arogya Mitra, medical officers and other administrative staff for the implementation of the scheme.

Key takeaways

Lack of institutional capacity

- Lack of institutional capacity at SHA level, to recruit and deploy requisite skilled manpower for effective working of the scheme especially for greenfield states.
- There is a need to leverage external experts and private partners for training and capacity building around industry practices of insurance process management, fraud management, effective monitoring and evaluation practices.

Major concern area *Medium concern area* *Low concern area*

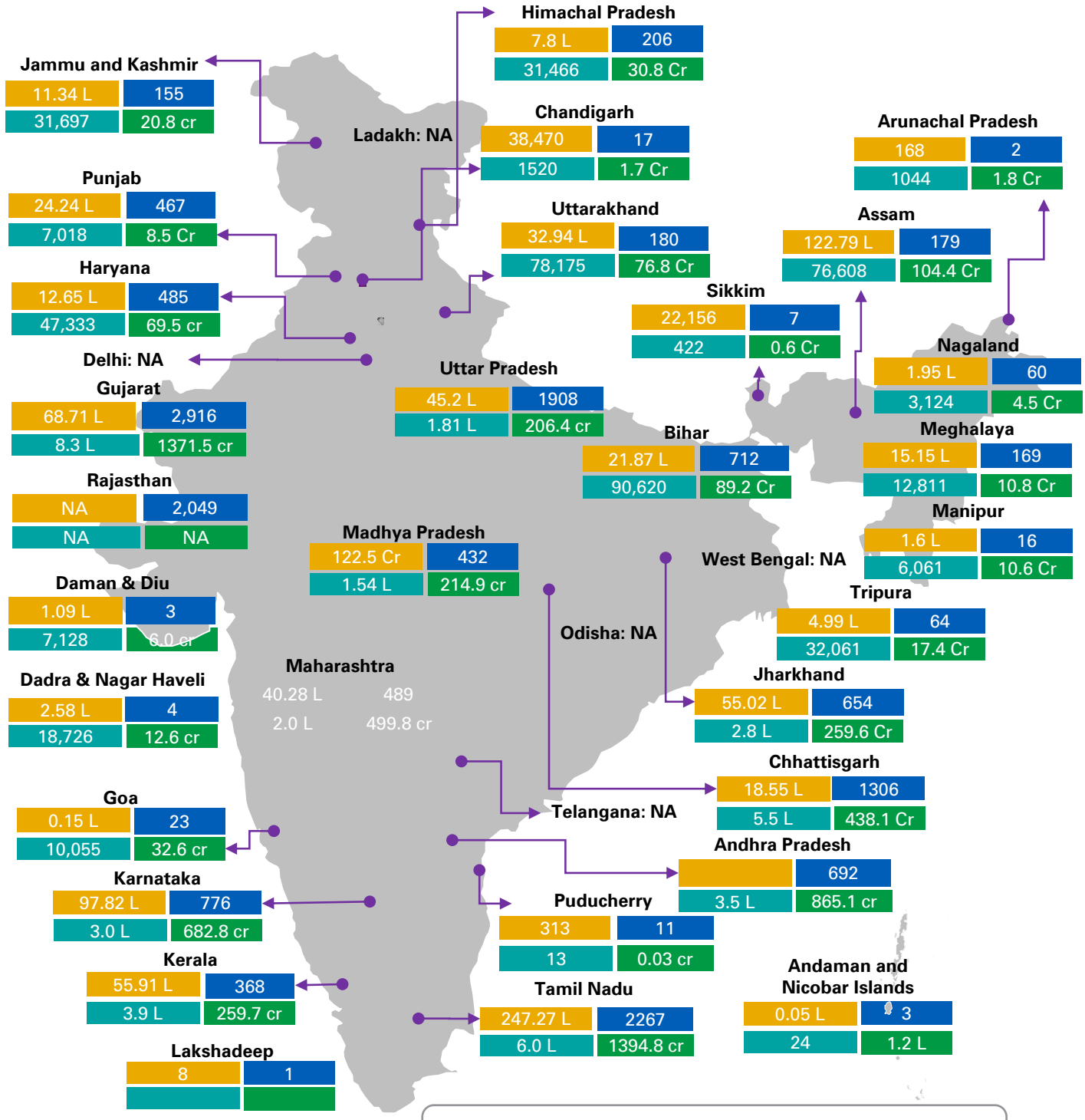
Performance of AB-PMJAY so far

On 23 September 2019, AB-PMJAY marked its one-year anniversary. The scheme is gradually transitioning into its exponential phase after incubation period, where it worked on strengthening capacities, creating awareness, and ensuring effective operations of the scheme's machinery. Though the scheme has been witnessing a number of contentions on achievements so far, clearly it has struggled through all the interruptions and is set to perform on expectations in the coming time.

Beneficiaries identified/e-cards issued	10.3 crores
Hospital empaneled	18,236
Patients treated	46.5 lakhs
Top specialties	Medical oncology, cardiology, orthopedics, urology and radiation oncology

- As on 22 September 2019, around **10.3 crore beneficiaries** have been issued an e-card, empaneled more than 1800 hospitals and provided benefits to approximately **46.5 lakh beneficiaries** . Majority of the treatments have taken place in the areas of cancer, heart ailments, bone-related problems and kidney ailments. Among the top specialties under which patients have availed benefits include oncology, cardiology, orthopaedics, and urology
- The progressive trends can be measured in terms of golden cards generated, pre-auth raised and claims submitted and approved (Figure 2 depicts scheme's performance across critical parameters). Pre-auths generated and claims submitted have also doubled since January 2019; attributed to extensive awareness drives and increased ownership of scheme
- Over the last few months, uptake of tertiary care specialties has grown leaps and bounds both in terms of volumes and pre-auth amount; with approximately **75 per cent of pre-auth amount being drawn towards tertiary care procedures**. The top 5 tertiary care specialties being utilised under the scheme includes: **medical oncology, cardiology, orthopedics, urology and radiation oncology**
- The increasing trend for uptake of tertiary care specialties augments well with the healthcare scenario of the country where the trends for morbidity and mortality patterns have shown an increase with respect to specialties such as Cardiology, Oncology, etc. Moreover, package price design will also ensure rationalisation amongst industry with an aim to further streamline and provide services effectively to entitled beneficiaries
- The implementation of the scheme across states has been varying owing to dynamics of the states. To assess how states have performed over key parameters, they need to be evaluated basis their characteristics of being green or brownfield. While states such as Gujarat, Kerala, Tamil Nadu, and Chhattisgarh among the brownfield states have been among the top performers; amongst Greenfield states Madhya Pradesh, Uttar Pradesh and Haryana have been the front runners (Figure 2 depicts state wise performance on key parameters)

Figure 2: The performance of AB-PMJAY on key parameters of states and UTs as on 15 September 2019



State Fact Sheets, AB-PMJAY Website, accessed on 20 October 2019

Note: Data till 15 Sep 2019 for beneficiaries identified, preauths and preauth submitted amount; and private and public hospitals. Information for some states was not available on the website

NA: Not available

Source: State Fact Sheets, AB-PMJAY website, accessed on 20 October 2019

Key initiatives envisioned for effective implementation AB-PMJAY

The scheme has witnessed significant promptness in adopting strategies and initiatives for its overall development. NHA has taken considerable steps in addressing areas of concerns, specifically in the domain of data analytics and fraud management, package pricing, private hospital on-boarding and awareness about the scheme.

Some of the key initiatives include:

1. Building effective workforce for implementation

- In June 2019, NHA signed an MoU with a CSR foundation of a banking group for capacity building of State and District personnel (including PMAM) with an aim to provide training to more than 15,000 personnel over one year
- NHA is planning to develop e-learning platform for systemic delivery and tracking of learning process of various stakeholders. NHA is also planning to leverage partnerships with developmental agencies educational institutes and other ministries for capacity building.

2. Building effective screening mechanism for AB-PMJAY beneficaries

- In June 2018, Minstry of Health and Family Welfare signed an MoU with a trust and a computer technology company to develop a tecnology platform for prevention, control, screening and management program of Non Communicable Diseases (NCDs) to ensure continuum of care and effective linkage of health and wellness centres with the scheme.

3. Expanding the network of AB-PMJAY providers

- In February 2019, NHA collaborated with apex healthcare body NATHEALT-Healthcare Federation of India for better implementation of the AB-PMJAY and getting more private hospitals on-boarded
- NHA has empaneled PSUs and National Healthcare providers (NHCPs) under Ayushman Bharat by signing MoUs with organisations such as Railway Board, Coal India, North Municipal Corporation and New Delhi Municipal Council.

4. Enhancing the quality of care provided under the scheme

- In June 2019, an MoU was signed with Quality Control of India (QCI) for providing digital certification of empaneled hospitals
- NHA has developed phased quality certifications – Bronze, Silver and Gold – to ensure that hospitals comply with certification criterion. The levels differ in terms of their certification criteria, financial incentivisation, and provides leverage to the empaneled hospitals that are already certified by nationally recognised accreditation bodies (NQAS/NABH)
- In October 2019, three hospitals – UN Mehta Institute of Cardiology and Research Centre based at Ahmedabad, Cygnus Super Speciality Hospital in Haryana and Spine Institute of Orthopaedic in Ahmedabad – were rewarded gold certificates.

5. Robust and structured mechanism to resolve grievances in timely and effective manner

- The NHA released a detailed grievance redressal guideline in January 2019 to ensure that grievances of all stakeholders are redressed within the time frames prescribed in the grievance redressal guidelines
- The new portal has better user interface which allows for selection from standardised drop-downs, auto fetching of beneficiary details, list of empaneled hospitals, etc.

6. Using AI to develop robust monitoring and fraud detection mechanism

- The government has decided to put in place extra layers of protection by using artificial intelligence (AI), monitoring utilisation trends, and forming standard treatment protocols to check irregularities
- Five analytical firms had been shortlisted out of the 24 applicants by NHA based on POC done for fraud management
- NHA has developed strong real-time online Management Information System (MIS). The MIS has been set up at a national level to review KPIs through various dashboards such as Operations dashboard, State and district performance dashboard, District dashboard and Portability dashboard. The dashboards are developed by the insights team and help in identifying the gaps and provide an overview of the performance

  Furthermore, NHA has developed Risk Assessment, Detection and Analytical Reporting (RADAR) tool, which is series of three dashboards for monitoring overall performance and fraud control for AB-PMJAY scheme. It is developed by National Anti-Fraud Unit and shall help SHAs to further drill down and monitor the utilisation of services under AB-PMJAY.

7. Revision of packages to better address the issues faced during current implementation

- NHA constituted a committee of experts from various eminent institutions across country to further revise the Health Benefit Package (HBP) list both in terms of procedures and their pricing; in order to further make the scheme viable and ensure more participation of private sector
- NHA has released health benefit package 2.0 edition and have revised the packages for specialities such as General Medicine, Paediatric Medical Management, Neo-natal Care, Emergency, and Polytrauma. Some of the major changes were defining guidelines for utilisation of unspecified packages, separation of cost of implant and consumables from cost of procedure to allow for choice of implants and provision of booking follow-up packages post hospitalisation.

8. Leveraging transportation and delivery channels for spreading awareness

- In February 2019, NHA also entered into an MoU with a cab service provider to levarage its vehicle network to spread awareness about the scheme and reach out to 5 lakh drivers
- It also plans to tie up with other food delivery and travel booking platforms to publicize about the scheme and enrolling eligible beneficiaries from its staff (including delivery boys and cleaning staff).

9. Collective bargaining for medical devices and drug supplies

- NHA is also considering the option of adopting the policy of collective bargaining with pharmaceutical companies and medical device manufacturers to negotiate prices at a country level. NHA intends to explore this further in coordination with the nodal body, National Pharmaceutical Pricing Authority (NPPA).

10. Law for Ayushman Bharat

the implementation of PMJAY. However, the current status of the progress is not known at this point.

Learnings from veterans and beginners

The implementation of mass health insurance scheme with such target population is a huge task. The realisation of the desired outcome will take its course of time. For now, the focus area should be to assess what works where. Actual implementation of the scheme at the state level can be strengthened by cross learnings and assessing the strategies adopted by veterans in the domain of mass health insurance scheme implementation (such as Karnataka, Maharashtra, Andhra Pradesh). The experience and strategies of these brownfield states can serve as learning for the greenfield states. Also, a number of green field states have been deploying innovative strategies to strengthen the overall healthcare system with the implementation of the scheme.

Some of the key takeaways comprising both challenges faced, and strategies adopted for implementation of the scheme are as follows;

Greenfield states

Parameters	Madhya Pradesh	Uttar Pradesh	Bihar
Scheme details			
Name of the scheme	Ayushman Bharat – Niramayam	Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana	Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana
Launch year	September 2018	September 2018	September 2018
No. of beneficiaries covered	1.17 crore families	1.18 crore families	1.08 crore families
Amount of coverage	INR5 lakh	INR 5 lakh	INR 5 lakh
No. of packages	1,399	1,393	1,393
Implementation mode	Trust	Trust	Trust
Key takeaways	• Addition of Sambal & NFSA (National Food Security Act) beneficiaries with an aim of achieving UHC • Pre-auth approval mandatory for all procedures to prevent leakages • One-third procedures are reserved for public sector with an aim of strengthening the government setups and minimising fraudulent cases • Only NABH accredited private hospitals empaneled; limiting number of providers to join hands initially. However, this is likely to go a long way in ensuring provisioning of quality healthcare services	• Appointment of a team of specialists from AIIMS to provide inputs on cases as and when required, on a per-case payment basis • Claims processed by ISA, reviewed and audited by M&E team and doctors for cross verifying and reducing fraudulent cases • Imposing of penalty on ISAs for wrongly processed cases and defined TAT violations • Development of 'Ayushman Saarthi' app in Hindi to help beneficiaries locate nearest EHCP • Allocation of corpus funds to medical colleges for participation within the scheme and setting up of kiosks for beneficiary awareness	• Incentivisation of medical workforce along with PMAM and ASHA • Empanelment of healthcare facilities upto PHC level • Development of 'BISWASS' app for audit of empaneled hospitals by SHA • Greenfield state with lack of prior experience and inadequate institutional strengthening at SHA level • Inefficient ISA functioning in terms of manpower deployed and pendency clearance for BIS and pre-auths • Skepticism of private hospitals to get onboard due to prior experience with RSBY

Source: State Fact Sheets, AB-PMJAY website, accessed in October 2019; KPMG Analysis

Brownfield states

Parameters	Karnataka	Gujarat	Chhattisgarh
Scheme details			
Name of the scheme	Ayushman Bharat Aarogya Karnataka	Ayushman Bharat	Ayushman Bharat
Launch year	2018	2018	2018
No. of beneficiaries covered	• All the residents of Karnataka except those covered under ESIS, CGHS, those under insurance policy of their employers, employees of state government under medical attendance rules	• SECC, 45 lakh families	• 44.4 lakh families covered under AB-PMJAY
Amount of Coverage	• Eligible households (SECC & NFSA) INR 5 lakhs per family per annum • General (non SECC, non NFSA) INR 1.5 lakh per family per annum on co-payment basis, 30% package rates prescribed paid by Government and 70 per cent by the beneficiary	• INR5 lakh	• INR5 Lakh
No. of Diseases Covered/ Packages	1,628	1,393	1,540
Implementation Mode	Trust	Hybrid	Hybrid
Key takeaways	• Prioritisation of essential packages and phase wise introduction of procedures and increase in scheme budget • Claims settled via electronic transfer of money directly to EHCPs, with no kickbacks or commissions • Ensuring settlements happen on time with defined timelines for claim submission and payout. EHCPs were penalised for delays in non-submission of claims • Building in-house capacity and transition from Insurance model to in-house model for efficient working of scheme.	• More than 3,000 empaneled hospitals out of which approximately 38 per cent are private. Approximately 11 per cent hospitals are accredited by NABH, NQAP, JCI, etc. • Efficient utilisation of portability feature with treatment of more than 6,500 patients from various other states • Regular workshops & training for all stakeholders incorporated as part of HR strengthening activity • Addition of approximately 400 packages to existing PM-JAY package list, making it 1,805 packages with well-defined pre and post investigations, and rates • Incentivisation of medical workforce along with ASHA workers.	• Branding standardisation - Establishing uniformity with reference to branding of the scheme • Coordinated outdoor publicity with Out of Home advertising • Developed mechanism for conducting an audit with support of the NHA fraud audit team • Ensuring optimum number of qualified human resource at SHA and districts along with building capacities • Optimisation of number of hospitals empaneled to ensure availability of clinical infrastructure, capacity to deliver quality services along with strengthening IT infrastructure.

3.0 Potential role of private sector in Ayushman Bharat – Marching hand-in-hand

Role and contribution of private sector in Ayushman Bharat and UHC journey

After the launch of Ayushman Bharat, India stands at the same juncture as many other countries through their journeys towards Universal Health Coverage. There is a need to design a thorough health strategy with public and private sector weaved together particularly in underserved areas. The National Health Policy of 2017 states "there are many critical gaps in public health services which would be filled by "strategic purchasing''. Such strategic purchasing would play a stewardship role in directing private investment towards those areas and those services for which currently there are no providers or few providers".

The private healthcare sector in the last few decades has grown exponentially in India and remains an untapped key partner for Ayushman Bharat and in the journey towards Universal Health Coverage. The following are some of the critical success factors for Ayushman Bharat that would require adopting multisectoral approach (MSA) to leverage private sector (commercial and non-commercial) and creating healthy partnership between public and private sector to nurture implementation of the initiative and benefit public at large.

Provisioning of primary care services

The Government of India has a huge task at hand of developing, equipping and manning 1.5 lakh health and wellness centres in the next few years. Though at present the government has a vast primary care infrastructure in rural India, yet the common man still depends on private sector to large extent. Private General Practice is the most commonly used healthcare service by patients in both rural and urban areas. At some point, the government needs to explore and adopt a multi-pronged approach including partnership with large network of general practitioners, diagnostic and imaging centres, poly-clinics, nursing homes and other such small healthcare organisations to enable high-quality primary healthcare services across rural and urban areas. Some of the areas of partnership that could be evaluated by the government are:

a. Developing Health and Wellness Centres with Private Partner

Public sub-centres and primary care centres could be developed by private partners with hub and spoke model. If possible local/ regional private partner could be evaluated for partnership under various models like design, build, operate and transfer (DBOT), operations and maintenance (O&M) and others. However, the preferred model is likely to be O&M considering capital constraints of private players in rural areas. The government shall be responsible for developing/ upgrading and equipping such centres. A private partner could be made responsible for staffing and day to day operations management of such centres. A private partner to operate HWCs with a cluster-based model for optimal utilisation of resources and leveraging telemedicine, point of care diagnostic and IT system. Payout models could be **a) fixed user charges with minimum assured volume or payout b) fixed monthly payout to cover operations cost and variable/ incentive component for performance or additional volume.**

b. Nurturing the entrepreneurship model to develop health and wellness centres

The Government of India and many state governments have provision to encourage entrepreneurship across start-ups, Micro, Small and Medium Enterprises (MSMEs) and other sectors. It would be worth considering entrepreneurship programme for medical practitioners to set-up HWCs with the government mainly in rural and semi-urban areas. Initial capital and upfront payment mechanism for such entrepreneur doctors to mitigate capital constraints. The government could look at the O&M model considering limitation of individual general practitioners and small organisations to invest capital cost. The model to permit a private player to expand services and also cater to paid patients for additional services could also be considered. Payout model could be a) fixed user charges with minimum assured volume or payout b) fixed monthly payout to cover operations cost and variable/ incentive component for performance or additional volume.

c. Strategic purchasing of primary care services

Working towards "primary care for all" agenda is likely to give a boost to Ayushman Bharat in India. One of the potential ways of approaching such agenda is to enter into strategic purchasing contracts with the existing large network of private primary care providers consisting of general practitioner/ specialist clinics, nursing homes and diagnostic centres. A network of private primary care provider with strategic purchasing contract to cater to the vulnerable population for certain hours per day or number of patients per day at their clinics or HWCs. A connected patient management system and robust IT system could be required to enable such a model.

Provisioning of secondary and tertiary care services

Over the last two decades, India has witnessed excellent healthcare and clinical facilities in the private sector, as a result of which it is one of the preferred medical destinations globally. India currently has around **38 JCI accredited hospitals, 615 NABH accredited hospitals, around 750 applicant hospitals for NABH accreditation, around 1050 accredited medical laboratories and various Centre of Excellence of national and international repute.**[1,2] A large number of secondary and tertiary care infrastructure, and super specialists are housed in the private sector and handle a dominant share of hospitalized cases (Rural: 58.1 per cent and Urban: 68 per cent).[3] Most of the district hospitals across public health struggle to provide complete secondary care services and tertiary care services and patients are majorly referred to government medical colleges or private providers. Leveraging private sector providers to provide quality secondary and tertiary care services mainly in tier-II and tier-III cities could prove to be a big boon for Ayushman Bharat by creating healthy partnership models.

1. JCI accredited Hospitals, Joint Commission International, accessed on 15 July 2019
2. National Board of Accreditation, NAHB.co website, accessed on 15 July 2019
3. NCD PPP Guideline, Niti Aayog, accessed on 15 July 2019

a. Strategic purchasing of clinical program management services

The government shall evaluate up-gradation of facilities at existing district hospitals wherever either all secondary care and/ or tertiary care services are not available. Such district hospital could be upgraded with a new facility with 50 beds/75 beds/100 beds/125 beds depending on the demand for such services. The government shall build, equip and operate such a facility and evaluate strategic purchasing of clinical programme management services from single or multiple partners like individual specialist/ super-specialist or private providers on fees for service model. The fees for service model is prominent across private healthcare providers and a similar model of sharing the fees out of the total package rate depending on the speciality and complexities. The empaneled individual super-specialist/private provider is to assist in capacity building and training of medical officers, nurses and other staff at such government facility. In the initial stage, certain specialities with low patient load and possibility of elective surgeries, could be planned on fixed days of every week. Pre and post-surgery care could be imparted by doctors and nurses trained by such individual super specialists/ private providers. The revenue generated by such a facility could be used for managing operational expenses and upkeep of the facility. This model enables the government to invest and own such a facility and the private sector could cater to AB-PMJAY patient without investing in building such a facility. The model purely focuses on strategic purchase of clinical programme management on fees for service engagement model.

b. Developing ' Ayushman Bharat Hospitals' – District/regional level

Provisioning of tertiary care services in every district could be the ideal state for AB-PMJAY patients and same could be approached with the help of partnership model with the private sector and in a phased manner. Initially, the government and private player could look at setting up tertiary care services at regional level to cater to three to five districts depending on the population, geographical connectivity and availability of specialist/ super-specialist. The regional tertiary care and super speciality facility could be housed at either district hospital campus or any other land parcel provided by the state government. Such facility is to be developed with a single partner or multiple partners depending on the availability of private partner and viability of the project. In a single private partner model, the entire facility shall be developed and/ or operated by one provider including bringing in all required workforce. In a multi private partner model, various specialities shall be developed and/ or operated by different providers and shall manage respective specialities with designated beds/ floor(s). Such facility could be developed under various possible models like DBOT/O&M/purchasing of Services/ any other as outlined in Niti Aayog's Guidelines for PPP for NCDs facilities.

Role in continuum of care

AB-PMJAY has a provision for inclusion of pre- and post-hospitalisation care in every procedure/ treatment package. Every package cost covers pre-hospitalisation services like consultation, diagnosis and medicines prior to hospitalisation, and up to 15 days of post-hospitalisation medicines are provided to every patient by treating hospital. However, in case of certain procedures/ treatment a patient would often require post-hospitalisation follow-up consultation, diagnostics, continuous monitoring, rehabilitation, continuous medications and other care. As many of the secondary care and tertiary care facilities are present in urban areas and it requires patients to travel long distances for availing post-hospitalisation care. In near-term, provisioning for continuum of care for certain procedures/ treatment to further augment the underline objectives and clinical outcomes under AB-PMJAY.

a. Leveraging HWCs for pre and post hospitalisation care

One of the additional services that could be rendered at HWCs developed with the government or private partner is to cater to AB-PMJAY patients. Pre and post hospitalisation consultation, telemedicine-based consultation with specialist, diagnostic services, medicines and other services could be rendered. Leveraging IT system such as patient management system, telemedicine, connected system with AB-PMJAY and empaneled healthcare providers under PM-JAY scheme can enable accessibility and continuum of care.

b. Creating a network of private providers for pre and post hospitalisation care

A network of private providers consisting general practitioner/ specialist clinics, diagnostic centres and other such health facilities could play a vital role

in bridging the gap in continuum of care for AB-PMJAY patients. Pre-hospitalisation up to 15 or 30 days before hospitalisation and post-hospitalisation between 15 to 60 days could be served at these network private clinics/centres. Provision for a cashless pre- and post-hospitalisation services at pre-negotiated rates for health services could be evaluated by the government.

Provisioning for diagnostic and specialised care equipment

Availability of thorough diagnostic services and specialised care equipment at public health and private empaneled healthcare providers under AB-PMJAY is critical for provisioning secondary and tertiary care. Medical equipment players could play a vital role in areas like diagnostics, radiology and imaging services, cardiac care, gastro and minimal accesses surgery, dialysis, ortho & joint replacement and other specialities.

a. Developing public health infrastructure with medical equipment players

Government or private providers developing healthcare facilities under AB-PMJAY could evaluate a model with medical equipment players to lease or pay per use for capital intensive medical equipment such as Cath lab, CT scan MRI and other equipment. Private financing investment-based model with medical equipment players and private providers with strategic purchasing of services by the government for AB-PMJAY patients could be developed. The model could also permit a private player to expand services and also cater to paid patients to further augment the viability. Payout models could be **a) fixed user charges with minimum assured volume or payout b) fixed monthly payout to cover operations cost and variable/incentive component for performance or additional volume.**

Capacity building

Availability of well-trained, knowledgeable and skilled healthcare workforce providing care at primary, secondary and tertiary levels in both the public and private sectors may largely determine the outcomes of Ayushman Bharat. New cadre and job roles are shaped under Ayushman Bharat further pushing the need for adequate training and capacity building from administrative staff to last-mile care providers. The government will have to look at different approaches, structures and methods that are more technologically enabled, expanding the range of learning methods and tools that make the most sense to the healthcare workforce. Private sector players could play a big role in creating a skilled healthcare workforce. Apart from medical and paramedical institutes, there are a large number of private health providers, pharmaceutical companies, medical devices and equipment players, digital health IT, insurance, health analytics, NGOs and education technology organisations that could work hand-in-hand with the government to bridge the current gap of workforce availability and skilling.

a. Learning and development portal with private sector

Developing a national/state level learning and development portal utilising e-content, innovative tools, online and classroom-based interactive learning, gamification, on-demand training videos, learning pathway, etc. could be useful. The platform can not only serve as an upskilling and training source but also monitoring tool for the healthcare workforce. The private sector brings in rich knowledge and content in disease management, clinical care pathway, logistics and supply chain, quality management and various other relevant areas. A robust e-portal that incorporates lessons and learnings from all stakeholders including the industry can help overcome the skill gap in the current healthcare workforce. Such a portal could be leveraged to host content sourced from the private sector to provide mandatory and on-demand skilling training and certification.

b. Centre for learning and development in healthcare with private players

Establishing a centre for learning and development, up-skilling and training of the healthcare workforce with consortium of private partners consisting of providers, pharmaceutical, medical equipment and other such players. Leveraging private sector for such a centre at state level would provide big boon in strengthening learning and development of healthcare workforce in a state. Such a centre could act as a hub and regional spoke could leverage online and classroom-based skilling programmes. Private players can help the workforce to get trained on handling of machines, disease management, clinical care areas, quality and other areas thereby reducing errors in treatment cycle.

Information, Education and Communication

Information, Education and Communication (IEC) strategy and implementation is likely to be one of the most important success factors for huge mammoth programme like Ayushman Bharat. Most of the green field states implementing AB-PMJAY lack institutional organisation to implement and undertake statewide IEC activities till last mile reach. Availability of workforce is a big challenge at SCs/PHCs and undertaking mass health awareness and screening programme requires significant number of last-mile workforce. Presence of a large number of private sector organisations till the last mile and significant experience of executing large scale community programmes is worth leveraging by the government. Private sector can play a crucial role in spreading comprehensive awareness about Ayushman Bharat to the last mile.

Augmenting Supply Chain Management

In the last decade, MoHFW, state governments and various partners have worked together to strengthen the public health supply chain and logistics system in India. However, it remains one of the weakest links in the health system delivery despite various efforts by the government. Timely availability of good quality drugs and medical supplies can be a key determinant for Ayushman Bharat. It will be worth assessing partnerships with private sector to leverage the experience of supply chain management that has evolved through stages of maturity and improved business processes, adopting innovative technologies, analytics and end-to-end integration. Various private supply chain management institutes, pharmaceutical and medical supplies manufacturer, distributors, warehousing and logistic players and technology players have a lot to contribute to the success of the Ayushman Bharat.

Centre for supply chain and logistic in healthcare with private players

Establishing a centre for supply chain and logistic in healthcare for up-skilling, training, certification and accreditation of both workforce and public health supply chain points is necessary. Such a centre could be developed with consortium of public and private partners contributing knowledge, resources and implementation support in these areas. Such a centre shall also work on designing, implementing and monitoring of innovative practices and technologies for public health supply chain and logistics system. Certifying workforce and each supply chain point independently by such a centre could play a big role in transforming the public health supply chain system. A robust e-portal that incorporates lessons and learnings from all stakeholders including the industry can help overcome the skill gap of supply chain management in the current healthcare workforce.

Supply chain management services by private partner

In India, there is number of private sector supply chain management organisations having significant experience of managing large scale supply chain, warehouses and logistics system across sectors and geographies that could be potential partners for public health. Such management service organisations could support public health in managing and manning entire post procurement processes by leveraging dynamic, real-time and integrated e-supply chain information system with connecting logistics fleet using IoT and sensor technologies. Private partner could bring experts, ICT system and robust SCM practices to augment existing public health SCM.

Digital health

There is a new and rapidly changing healthcare landscape globally as well as in India, where digital health is becoming increasingly normalised into the everyday delivery of healthcare. In line with WHO's Global Strategy on Digital Health 2020-2024, the MoHFW, GOI released draft of National Digital Health Blueprint in July 2019. It emphasises on the digitisation of healthcare services, with a wider range of smart devices and connected equipment being used, together with other innovative and evolving concepts and emerging technology. India has witnessed emergence of large number of digital health players in the last five years. Some of the digital health players have adopted innovative technologies and business models breaking the barriers of distance, infrastructure and human resources.

Digital health service and solution players

Increasing virtual consultation, telemedicine, health ATMs, e-PHCs, digital dispensaries and digital health technology players have showcased huge potential to bridge current challenges in public health. Increasing usage of Artificial Intelligence, Machine Learning and sensor technologies in areas of early detection of diseases, disease management and treatment. Such digital health private players could be leveraged for HWCs and also AB-PMJAY in terms of fraud management, analytics, and technology-enabled third-party monitoring and evaluation of the scheme. Pay-per-use and other payment models could be evaluated to augment public health delivery.

Scheme administration

AB-PMJAY provides the flexibility of mode of implementation (trust/insurance/hybrid) to its participating state. Many participating states are greenfield and have faced several challenges in planning, implementing and monitoring of the scheme mainly due to lack of experience and institutional capacity to execute such a scheme and manage various stakeholders (ISA, etc.). Insurance players (public or private) could play a very important role in administration of the scheme and the government could play a role of payer and regulator. A number of countries have used insurers to operate all or part of their national health insurance programme. In an insurance or hybrid model, the government is able to limit its financial liability, relatively lower managerial costs, enhanced monitoring of the scheme and at the same time gain from Insurance players experience in dealing with hospitals, developing a robust IT system for fraud mitigation. Insurance players are highly regulated by IRDA and it enacts standard operating procedures and compliances to safeguard the beneficiaries/ payer. Adoption of such a model to be as per the NHA guideline and parameters. However, financial viability and other aspects must be duly evaluated by the government and accordingly partnership should be considered.

4.0 Key recommendations to strengthen Ayushman Bharat

A closer look at Ayushman Bharat (AB-HWCs and AB-PMJAY) implementation and performance in the last one year indicates that the initiative has the potential to achieve its fundamental objective of providing thorough coverage to the vulnerable population and reducing catastrophic healthcare expenditure. However, the reach and outcomes of the initiative may be limited by the current status of public health services, skewed healthcare infrastructure in urban areas, limited participation of private sector and agility to respond to existing and emerging constraints.

The initiative is at a very important juncture and vital decisions around the four pillars of healthcare — availability, affordability, accessibility and acceptability — need to be made to tackle present-day healthcare challenges. The government has enabled the comprehensive health coverage to the large vulnerable population, and the next enablement shall focus on making quality care and providers available across geographies, at current pricing, within the reach of rural and semi-urban patients, and acceptable to all stakeholders.

Though the scheme is a huge step toward the UHC, however, the key lies in the implementation. Basis the current structure and on-ground implementation of Ayushman Bharat, following are various potential areas to strengthen the current implementation for better outcomes

1. Drive citizen/patient engagement

Active engagement provides the right to hold others accountable, and accountability in the course of engaging in participation. It seeks higher responsibility from service providers through increased dialogue, awareness, consultation and by monitoring and assessing performance externally and mutually.[1]
The success of Ayushman Bharat largely depends on citizen/patient engagement, higher awareness of the initiative, entitlements, basic understanding of inclusion and exclusion that shall enable better patient navigation and prevent from fraudulent traps. As per latest recommendations, there are plans for investing a minimal of Rs. 50 per beneficiary in States for IEC activities for huge impact. However, there is a need for mandating clear budget and a roadmap to enable state government to undertake aggressive IEC activities. Leveraging private partners for patient engagement using innovative technologies can enable to undertake omni-channel engagement campaigns, sending

1. Framework for Citizen Engagement in eGovernance, MEITY, GOI

periodic updates and healthcare tips, or trigger-based appointment or prescription refill reminders, post-diagnosis notes and more. The multi-channel reach of their choice –phone calls, text messages, patient portals or other channels can drive higher citizen engagement.

2. Provisioning of standardized care

Provisioning of standardised care will be a key priority under Ayushman Bharat in coming times. Diverse nature of empaneled healthcare providers may result in diverse treatment practices and clinical outcomes mainly due to varied skills of workforce, medical technologies, drugs and medical supplies used and quality of infrastructure. In the recent past, MoHFW, GOI had developed Standard Treatment Guidelines (STGs) for various diseases under the taskforce led by National Health Systems Resource Centre (NHSRC) and other important stakeholders like ICMR, DGHS, civil society organisations and academic institutions and technical support of NICE, UK.* More recently, NHA had also constituted Specialist Committees pertaining to Standard Treatment Workflows (STWs) for procedures under the scheme. AB-PMJAY can benefit largely by adopting STGs not only for secondary and tertiary care procedures but also for preventive and primary care. Mandating the implementation of STGs and robust monitoring is likely to drive quality and standardize care across unstandardized providers.

3. Grading providers–'Hospital Performance' and 'Quality Index'

Currently, providers under AB-PMJAY and AB-HWCs are not assessed and classified basis their infrastructure, workforce, geographic location and outcomes. Patients do not have any information regarding EHCPs, doctors, their credentials, past performance and evidence of their competence. Adopting grading system designed to assess hospital performance and develop quality index with rating awarded to each EHCP. Such grading index and rating shall provide navigation support to every patient on the quality of healthcare services imparted by a hospital. Developing a National Hospital Performance and Quality Index with enable rating of EHCPs basis on mandatory reporting of certain indicators and information analysis from the IT system. Such hospital index can be a powerful tool for improving provider performance, peer benchmarking and would reduce the need for more resource-intensive regulation.

*ICMR: Indian Council of Medical Research; DGHS: Directorate General of Health Services; NICE: The National Institute for Health and Care Excellence

4. Devising a National Pricing Index System

Looking at the current EHCP pool, it indicates that the private sector is still yet to gear up and participate wholeheartedly in Ayushman Bharat. One of the major disconnects between public and large private sector players is the lack of agreement on sustainability of pricing in the current private sector landscape that has mainly capital-intensive facilities and located in urban areas. It will be good attempt to establish the National Health Pricing Forum for assessing and agreeing to fair pricing under AB-PMJAY. Stakeholders, including senior authorities, policy-makers, representatives from providers, other relevant industry and patient organisations, could discuss options for a fairer pricing system that is sustainable for public health systems, patients, and the private sector.

Secondly, developing a differential and privileged pricing system in the form of 'National Health Pricing Index' can create a matrix of gradation system or differential pricing for geographical, facility-level variation, etc.

Devising a national pricing index system using parameters like:

1. **Reference pricing** - Reference price could be based on activity-based cost data (direct/indirect costs etc.) or benchmarking of historical prices.
2. **Provider grading** - Provider Grading the providers with reference to
   i. the geographical location in terms of tier-I, tier-II & III areas (currently only Delhi and aspirational district are considered in the differential pricing)
   ii. size of facilities in terms of 10 to 50 beds, 50 to 100 beds, 100 to 200 beds, over 200 beds, etc. (currently no such differential pricing)
   iii. Accreditation in terms of NABH, etc. (it is already considered in the differential pricing)
   iv. Premier institute/centre of excellence/super-speciality Institutes (currently teaching hospitals are considered in the differential pricing)
3. Quality adjustment - bonus or penalty based on key quality and service KPIs, provided robust monitoring and IT system are deployed.
4. Any other factor weighing as deemed suitable by NHA, SHA and National Health Pricing Forum.

5. Ayushman Bharat learning academy and e-learning system

Ayushman Bharat's success is underlined by the availability of a skilled workforce from specialist to administrative till the last mile. This will need a focused plan embedded by innovative approaches, technologies and leveraging private sector expertise, adopting learning mode, methods and tools that make the most sense to the healthcare workforce. Also, the system can be strengthened further by developing national/state level learning and development portal utilising e-content, innovative tools, online and classroom based interactive learning, gamification, on-demand training videos, learning pathway, etc. A mix of campus and e-learning system could be leveraged to host content sourced from multi-sectoral partners to provide mandatory and on-demand skilling training and certification. Ayushman Bharat could look at the NHS leadership academy and e-Learning for healthcare (e-LfH) established in partnership with NHS.

6. Leveraging integrated technology and health analytics

Integrated technologies, data analytics, artificial intelligence and machine learning has a big play in the initiative of this scale to ensure effective delivery, microscopic monitoring and monetising rich data for population health management and health system planning. Technologies will be key enablers in this initiative and journey considering various constraints including skilled workforce. Population health screening data from AB-HWCs shall enable public health system planning and responding to current and future disease landscape. Similarly, AB-PMJAY needs an immediate implementation of fraud management system to prevent any exploitation of the beneficiaries and the system. There is a need for time bound plan to implement integrated and advance technologies right from the initial phase of Ayushman Bharat implementation to adoption of preventive approach instead of coping with bigger challenges in the future.

7. Mandatory healthcare coverage for all

India will have to consider mandatory health coverage for all to ensure every individual is covered with basic and minimum coverage. Mandatory Health Coverage (MHC), similar to that of a car insurance, can not only act as a safeguard against financial hardship but also help decrease the cost of a health insurance. Currently many state governments cover additional beneficiaries that are not covered under AB-PMJAY. A proposal can be considered to expand AB-PMJAY to include non-covered economically weaker section (EWS) to be financed by the government (either full or co-payment) and mandating remaining individuals to self-finance a minimum essential coverage for self and for his/her dependents. Also, linking of every individual's health coverage with his/her Aadhar Number or UHID should be considered. This equity option can act as an essential arsenal in helping India achieve UHC, emancipating the deprived sections of the society from this financial burden, and aiding in achieving an ideal healthcare state for the nation. The Netherlands model of mandatory health insurance has demonstrated that providing guaranteed quality and affordable healthcare is possible – an effort which has been praised around the globe This model can stimulate Indian policymakers to embrace a health security model that aspires to deliver healthcare without having one to suffer any fiscal hardship.

8. Shaping healthcare marketplace

The governments across the globe have used UHC/ National Health Insurance (NHI) journey as a healthcare market-shaping opportunity with redesigning of national strategy, augmenting public investment, drive quality, renegotiating prices, creating new care models, encouraging new market entrants, relooking at regulatory framework, developing new avenues of investment from multi-sectoral partners, expanding the coverage market to reduce/ containing the cost and redefining the healthcare market landscape. It is important to continue bending the curve of current large number of constraints across public health in India. We also need to leverage the capabilities and resources of the public, private, and nonprofit sectors to harness innovation and break down barriers to progress. Adopting a market-shaping approach can address previously insurmountable market barriers at scale. The market-shaping field requires additional coordination and leadership to uncover potentially transformational approaches and it needs to be carefully thought through. Ideally, every intervention would create lucrative situation, but typically the actions of one part of the health sector, or even of a single organisation, will have both positive and negative ripple effects. A thorough view and strategy to shape the Indian healthcare market with Ayushman Bharat are essential for not only to achieve success of the initiative but also in our journey to UHC.

9. Rethinking ‘private’ as partners

It is clear from the current pool of EHCPs and partners associated with both the initiatives of Ayushman Bharat that many of the large private healthcare players with significant capacity, and investment are yet to shift their business model and strategy. The current mixed picture raises the question of who else may be willing to take up the opportunities created by Ayushman Bharat and suggests that there may be space for new market entrants. While hospital operators, diagnostic service players and not-for-profit partners have traditionally dominated in the public-private partnership deals, new providers — including organisations from non-health sectors — are increasingly looking to break into the rapidly expanding healthcare market. The government also have much to improve in the way they engage private providers on the journey to UHC. At this juncture, it is critical for government to engage with private healthcare players, investment community and explore new entrants to take up the opportunities created by Ayushman Bharat. A lot of consideration and resourcing goes into the design and technical aspects of policy reforms and programme implementation but more fundamental building blocks between partners such as trust, dialogue, considerations and relationships are often forgotten

5.0 Global learnings for universal health coverage

Poor health indicators are not only a pressing priority for the country, but it is a commercial opportunity for both private and public-sector stakeholders. With a new global push to achieve UHC by 2030 in the context of the Sustainable Development Goals, there is an urgent need to build effective partnerships with the private health sector in India. Although there is wide recognition of this role, in many developing countries aspiring for UHC, it has not been possible to formulate evidence-based policy and strategy to make use of the private health sector to expand service coverage. Across the world, countries such as the U.K., South Korea, Singapore and Israel have adopted various models of UHC implementation the implementation of UHC. These countries present one or more key ingredients for an excellent UHC plan. Though Ayushman Bharat has been comprehensively designed, a few learnings from the frontrunners of UHC can enable efficient and effective execution of the initiative and move toward the path of UCH in India.

Some of the key features of countries across the globe implementing UHC include

The UK	South Korea	Singapore
Pioneer in primary healthcare, where every household is registered with a 'general practice' which has about five GPs supported by two to three nurses and six support staff	Inspiration for extensive healthcare, big data analysis and robust system for insurance management	Financing system that provides affordable healthcare for all coupled with screening programmes and increased access to healthcare information

Nordic countries	Switzerland	Israel
Highly coordinated care programmes that are connected not only between national bodies and local municipalities but, increasingly, the public and private sector	Follows the maxim 'you get what you pay for' by focusing on capitation and bundled payments	Membership to state-mandated healthcare provided through a strong public health orientation

The United Kingdom – National Health System (NHS)[2,3]

NHS has been providing Universal Health Coverage to the population of England for the past 70 years. It is funded through redistribution of tax revenue and by the government (single-payer). NHS owns almost all the providers operating within its system and spends only 10 per cent of its budget on non-NHS providers (community service providers). Some of the key learning from NHS

Key takeaways

- **Incentivising primary care practitioners**
  - NHS provides incentives to GPs in unprivileged and underserved areas. It also prevents new GPs from setting up practices in affluent and saturated areas.
  - It focuses on secondary prevention and prevents costly interventions. It incentivises primary care practitioners to undertake activities such as wellness checks, vaccinations and proactive disease management. This has helped the system to reduce cost and effective management of emergency admissions, encouraging and retaining primary care physicians and enhanced data collection.
- **Task shifting to optimally utilise the healthcare workforce**
  - Recruiting and retaining the staff has been a major challenge in most of the healthcare systems such as India. One of the key learnings from the NHS model has been ways to increase the productivity of the existing staff. Shifting the task of a traditional doctor to other staff, for example, clinical nurse specialist supported with decision aids (such as clinical decision support system) was found to be effective in emergency beds days, medication errors and achieving a high level of patient satisfaction.
- **Tighter accountability for quality**
  - In 1998, NHS adopted a framework of clinical governance, to continuously improve the quality of the care and maintaining high standards of care. It has also developed evidence-based clinical guidelines for new treatments, mainly through the National Institute for Health and Clinical Excellence (NICE). Further, it leverages publicly reported rating of provider and performance-related financial incentives for quality.

1. In Search of a Perfect Healthcare System, KPMG, accessed on 15 July 2019
2. Achieving high-quality universal health coverage: a perspective from the National Health Service in England, BMJ Global Health, May 2018, accessed on 15 July 2019
3. KPMG Analysis

South Korea – National Health Insurance (NHI)[4]

South Korea achieved Universal Healthcare Coverage (UHC) in just over 12 years post its rollout. The National Health Insurance (NHI) of South Korea is single-payer programme and effectively reviews and assesses service provision and claims, as well as manages enrollees and service providers, based on an effective information system.

Key takeaways

- **Leveraging healthcare big data**

  Patient data is accumulated in a single organisation, as NHI is a single compulsory insurance system. National Health Insurance Service (NHIS) provides information about health risk factor and personal health through big data analysis. The system also runs health promotion centres, which analyses health insurance big data to identify health risk factor carriers as recipients. When the recipients visit these promotion health centres, they are provided with fitness examinations and medical counselling.

- **Patients' health bank**

  NHIS also provides personal health record service named 'My Health Bank'. This account allows people to check their health records. The system also provides personalised health risk prediction services using patients' health data, by analysing factors such as medical history, family history, environmental factors, etc.

Singapore – Three-tiers of healthcare financing

Singapore has multiple tiers of healthcare protection aimed at providing universal healthcare coverage to all citizens, with a financing system anchored on the twin philosophies of individual responsibility and affordable healthcare for all

Key takeaways

- **Increased access to healthcare information which successfully improved health outcomes and patient empowerment**
  - Singapore introduced the National Electronic Health Record in 2011 which enabled the hospitals, community facilities, general practitioners and long-term care homes to get connected, and together analyse clinical, financial and operational data for health outcomes.
  - A direct correlation of patient empowerment can be seen in a country's life expectancy. According to the University of Washington's Institute for Health Metrics and Evaluation, it is estimated that by 2040, the average lifespan would have increased to 85.4 years and roughly 85 per cent of people aged over 65 years will be healthy and reasonably active. This was made possible by including free exercise programmes in the central business district – along with more community support.
- **Developing public infrastructure to reduce the healthcare gap envisaged due to income disparity**
  - There are three major government-operated healthcare financing schemes, known as the 3Ms: Medisave, MediShieldLife and Medifund. Medisave is a straightforward savings scheme enabling citizens to put aside money for themselves and their families' healthcare expenses. Medishield is a low-cost insurance scheme; premiums can be paid out of Medisave accounts because it is intended that patients can buy this additional cover if their Medisave funds are insufficient. Medifund is a safety net for those who cannot afford their part of subsidised healthcare expenses.
  - Due to one of the highest income disparities in the world, Singaporeans emphasize on personal payment of medical expenses. To remove this divide, Singapore is focused on expanding healthcare capacity. As part of its Healthcare 2020 Masterplan, public hospital beds will increase by 30 per cent while community hospital beds will double, as well as long term care services, nursing homes and domiciliary care and rehabilitation facilities.

4. NHIS Big Data and Health Services - Consolidated Ageing Well Strategy in Korea, accessed on 15 July 2019

Nordic countries – Public-dominated healthcare scheme to promote the welfare state

The Nordic countries perform strongly on the behavioural risk factors associated with poor health; smoking, alcohol consumption, obesity rates and exercise. According to the 2019 edition of the Bloomberg Healthiest Country Index, three Nordic nations were among the top 10 in 2019: Iceland (third place), Sweden (sixth) and Norway (ninth). The index grades nations based on variables including life expectancy while imposing penalties on risks such as tobacco use and obesity.

Key takeaways

- **Based on the welfare policy where insurance is delivered by the state-funded universal healthcare system**
  - In 2014, all Nordic countries signed the Trondheim Declaration committing them to stronger collaboration to achieve equitable health and well-being in the Nordic region and reduce global health inequities. This type of collaboration dates back to 1987, demonstrating their longstanding commitment to joint action between countries, counties, municipalities, public and private sector organisations and citizens.
  - The authorities are also engaging in contractual agreements with privately owned for-profit hospitals, which provide a wide array of both in-patient and ambulatory care services authorities.
  - In Norway, most GPs and specialists working outside hospitals are private but work under contract within the public system in return for grants and fees for service.
  - In 2010, the Swedish government decided that all county councils should allow free choice, giving private companies the right to set up large GP-style services anywhere in the country – and to be paid for them out of taxpayers' money. Since then firms have established around 200 GP-style healthcare centres, most of which are in the wealthier areas. It is now estimated that 12 per cent of county council healthcare expenditure is on independent organisations.

Switzerland – Perfect example of the maxim 'you get what you pay for

Switzerland ranked second to the UK in the most recent US-based Commonwealth Fund report on comparative health systems performance, while its life expectancy is one of the highest in the world – 82.4 years, just behind Japan, Honk Kong and Iceland. It is the second most expensive system in the world, with health spending representing 12.3 per cent of GDP; health spending per person, at USD9,863, is slightly above that of the US.

Key takeaways

- **Fragmented healthcare infrastructure due to a decentralized political system**

  Switzerland has a highly decentralised political system through the 26 cantons, which are largely responsible for the funding, delivery and administration of healthcare, including licensing providers and hospital planning. It is this that drives the fragmentation of the system, with around 300 public and private hospitals serving a population of barely eight million (80 lakhs). The federal government oversees regulation while the communes – all 2,596 of them – are responsible for the care of the elderly in the community.

- **Focus on bundled and capitation payments**

  Most of the hospitals are paid by a system based on the case mix (using a Diagnosis-Related Group classification for each treatment) while general practitioners are paid either a fee for service or a bundled/capitation payment if they belong to one of the health maintenance organisation (HMO). These have been gaining popularity as insurance premiums and co-payments have increased.

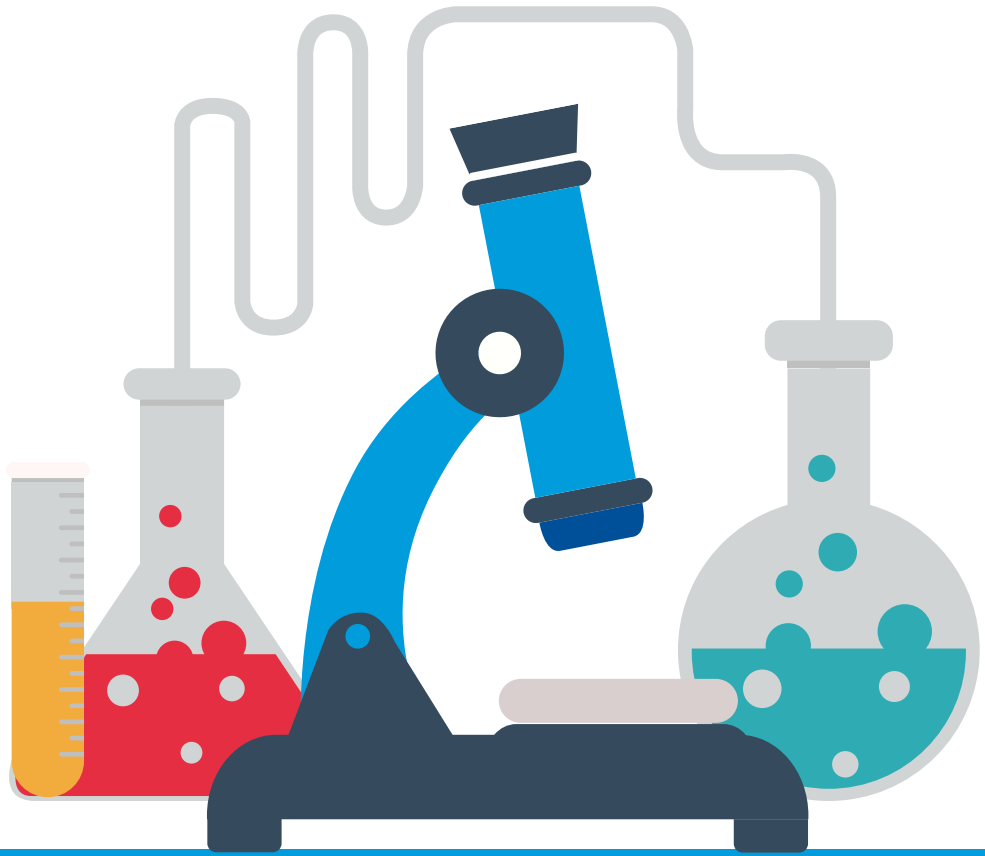
Israel - High performing blend of state-inspired universal healthcare

Among all the countries, Israel has one of the most progressive primary care services, ably facilitated by their health maintenance organisations (HMOs) and provided through a strong public health orientation.

Key takeaways

- **Compulsory membership to Israel's four state-mandated HMO**
  - National Health Insurance Law was passed in 1995 made membership of one of the four existing HMOs – Clalit, Maccabi, Leumit and Meuhedet – compulsory, although citizens can choose which one to join, and the law determined a uniform benefits package available to all irrespective of age or health status.
  - This insurance based system is financed with earmarked taxes and contributions paid out of salaries at a progressive rate, supplemented by state funding. Premiums are collected by the National Insurance Institute and are transferred to the four non-government, not-for-profit HMOs based on a capitation formula, who purchase and provide services. Citizens can top-up their mandatory insurance by paying a premium to access additional services from the HMO or buying private insurance.
- **Adoption of sophisticated technology**

  Part of the success of Clalit and Maccabi (two of Israel's four state-mandated HMOs) rests their early adoption of technology, for both patient choice and care. They invested intensively in online personal medical records which enable the patient and specialist to engage in discussion, treatment and follow-up, and have developed innovative telemedicine programmes which complement Israel's position as a global technology innovator.



6.0 Way forward – Forging a healthy partnership

Policy-makers around the world now understand that the government alone cannot drive the UHC agenda. With 88 per cent of the global population consuming just 27 per cent of its healthcare resources, the challenge is one of both investment and expertise. If every country without UHC were to increase health spending per capita to the average OECD level, by 2030 the world would be spending USD27 trillion extra on healthcare — a 400 per cent increase in total worldwide health spending today.[1] This seems unrealistic. Instead, countries are looking at how private sector partners can help to not only build up the necessary infrastructure for UHC but also develop innovative, ultra-efficient models of service delivery that can make the costs affordable over the long term. Across Asia, in particular, but also Latin America, the Middle East and Africa, there is interest and ambition to use private health sector at almost every stage of the UHC journey.

Clearly, the current progress for Ayushman Bharat entails a substantial drive and larger support to realise objectives of the initiative and eventually provide 'Health for All'. Throughout the report, recommendations have been provided for fostering synergistic relationships between the government and the private sector in key functional domains for effective implementation of Ayushman Bharat. However, the way forward to achieve the vision requires overarching recommendations to increase the benefits and bring a sustainable approach on the table.

1. What Works, The Triple Win, KPMG, accessed on 15 July 2019

Suggested below are ten way forward points for developing 'healthy partnership' leveraging our analysis of such partnership and practices in India and globally:

1 Accept and acknowledge the role of private sector in Ayushman Bharat and UHC journey

The key learning from the UHC journey across the globe entails the importance of defining a strategy for the UHC journey to outline clarity over the direction, approach and role of each stakeholder. It is important for the government to decide whether to fill gaps in provision through a 'build' strategy of healthcare infrastructure and services in public health or a 'purchasing' strategy of working with private organisations. Clarity on build and purchasing for primary, secondary, tertiary care can enable channelisation of resources from both public and private sector. Such clear strategy can enable creating of new models of care across new geographies assured by the government committed roadmap for UHC.

2 Forum to foster dialogue between partners

One of the biggest barriers in building constructive collaborations between the government and the private sector is mistrust. There is a need for professional negotiation, support and appeasement for efficient and faster means of collaboration. Support could include early-stage relationship building, aligning the vision towards future goals, commercial negotiations and grievance management. Setting up of 'National Health Forum' under MoHFW to provide formal and structural recognition of such forum can enable effective communication between the partners.

3 'Collaboration charter' between partners

Setting up a thorough collaboration charter can clearly set out the key activities and commitments for both government and private sector can provide prompts for creating a conducive environment for collaboration. This also includes creating the target operating models and sharing of risk/reward to future proof any agreement and delivery services.

4 Learnings from past experience of partnerships

Past experiences of healthcare public-private partnership initiatives across primary care, specialty hospital, telemedicine, etc. by central and state governments can be used to develop learnings for effective PPPs. Some worked well and some failed, leading to a mix in perception and experience around PPPs ultimate benefits. National repository and learning developed by third party evaluation to present realistic challenges and success elements of such partnership can enable better future partnership decisions.

5 Understand ultimate goals of partners

It is important for developing and successfully executing a healthy partnership that all involved partners understand and acknowledge. The eventual goal for a healthy partnership is a 'triple win' of all partners:

1. for governments: increased benefit from limited public resources and capital
2. for patients and the public: higher- quality health services at a competitive cost
3. for private players: a sustainable return on their investment and expertise

6 Embrace, rather than resist

Policymakers, private partners and public have a different perception of public-private partnerships. Developing normalised understanding of such partnerships is the first step, however embracing such partnership is the only away to realise the success or failure in a diverse country like India. Entering into a partnership needs full disclosure before committing completely. Not all partnerships may fructify, sometimes only after a comprehensive assessment, building a risk appetite for entering into innovative partnerships models, implementing it on a pilot scale and evaluating it with its on-ground outcomes can the true value of collaborations, be ascertained.

7 Shift from procurement mode to partnership mode

The government often views and approach private partnerships as one of the procurement processes and retreat into 'tender mode'. Adhering to tendering processes and systematic procurement are an essential part of ensuring value for money and getting the benefits of competition. However, governments need to understand that dialogue and engagement are needed to bridge the divide of objectives to the bottom of what problem the public sector is trying to solve and what kind of appraoch could work. Engagement building exercise is also an important part of finding private sector partners that share the same values as the public sector. Even the most watertight of contracts still need trust and mutual understanding to function well.

8 Fair assessment and building flexibility to sustain partnership

A proper evaluation of various partnership models across India and the globe will showcase that there are two deal-breakers mainly a) underlying assumptions considered for techno-commercial feasibility study b) rigidity of the contracts build in without contingencies for unknown or uncontrollable. It is important to factor the project's objectives, goals of each partner, setting realistic expectations and assumptions, challenging feasibility study with scenario analysis, considerate of future dynamics, and building flexibility to sustain and renegotiate if any untoward situation arises in the future. A healthy partnership is not just for the project outsourcing or contracting, but to strengthen the case for future use of partnership model as part of UHC.

9 Central agency for driving and governing partnership

Setting up a 'National Health PPP Agency' entrusted to develop an innovative partnership, engage with private sector, support state governments, evaluate PPP proposals and monitor the impact of the collaboration, achievement of the milestones, timely alignment in all the domains to identify disparity and devise ways to bring efficiencies can help ensure success of the partnerships. Robust continuous independent monitoring and evaluation intelligence are key for such partnerships — not just for the project they are about, but to strengthen the case for future use of partnership models as part of UHC.

10 Safeguarding of partnership

In the past, many healthcare partnership initiatives have witnessed challenges due to a change of political and bureaucratic regime. Over a period of time, a host of legal, political, economic and operational risks are compounding to make these partnerships far too challenging for private or commercial partners to have the confidence to invest. There is dire need for establishing the legal framework and special status to healthcare partnership that may take place in coming times.

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