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A Study in the Effectiveness of National Public Health Insurance Fund of Government of India 'Ayushman Bharat - Pradhan Mantri Jan Aaryogya Yojna (PM-JAY)'

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ABSTRACT

India took a giant leap towards providing accessible and affordable healthcare to the common man with the launch of Ayushman Bharat – Pradhan Mantri Jan AarogyaYojana (AB-PMJAY) by the Prime Minister, Shri Narendra Modi on 23rd September, 2018 at Ranchi, Jharkhand. Under the vision of Ayushman Bharat, Pradhan Mantri Jan AarogyaYojana (AB-PMJAY) was implemented so that each and every citizen receives his due share of health care. With Ayushman Bharat – Pradhan Mantri Jan Aarogya Yojana, the government is taking healthcare protection to a new aspirational level. This is the "world's largest government funded healthcare program" targeting more than 50 crore beneficiaries. It was a component of the larger Ayushman Bharat scheme that was launched as per the recommendations of National Health Policy 2017 to achieve the vision of Universal Health Coverage. AB-PMJAY provides a cashless insurance cover of Rs. 5,00,000/- per year for secondary and tertiary care hospitalisation. About 100 million below poverty level families, who were part of the 2011 socio-economic caste census ("SECC") database list, are slated to be the beneficiaries of the scheme; the government has called it "the world's largest government funded healthcare program". The hypothesis of this study will help in examination of the efficiency and effectiveness of the governing principles of Ayushman Bharat – Pradhan Mantri Jan AarogyaYojana (AB-PMJAY); whether the said scheme has accomplished the target of achieving the said objectives or not.

I. INTRODUCTION

The concept of insurance has been prevalent in India since ancient times amongst Hindus. Overseas traders practiced a system of marine insurance. The joint family system, peculiar to India, was a method of social insurance of every member of the family on his life. The law

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relating to insurance has gradually developed, undergoing several phases from nationalization of the insurance industry to the recent reforms permitting entry of private players and foreign investment in the insurance industry.

The Constitution of India is federal in nature in as much there is division of powers between the Centre and the States. Insurance is included in the Union List, wherein the subjects included in this list are of the exclusive legislative competence of the Centre. The Central Legislature is empowered to regulate the insurance industry in India and hence the law in this regard is uniform throughout the territories of India.

(A) DEVELOPMENT & GROWTH OF THE INSURANCE INDUSTRY IN INDIA

The development and growth of the insurance industry in India has gone through three distinct stages.

1) Formation of the Insurance Industry in India

Insurance law in India had its origins in the United Kingdom with the establishment of a British firm, the Oriental Life Insurance Company in 1818 in Calcutta, followed by the Bombay Life Assurance Company in 1823, the Madras Equitable Life Insurance Society in 1829 and the Oriental Life Assurance Company in 1874. However, till the establishment of the Bombay Mutual Life Assurance Society in 1871, Indians were charged an extra premium of up to 20% as compared to the British. The first statutory measure in India to regulate the life insurance business was in 1912 with the passing of the Indian Life Assurance Companies Act, 1912 ("**Act of 1912**") (which was based on the English Act of 1909). Other classes of insurance business were left out of the scope of the Act of 1912, as such kinds of insurance were still in rudimentary form and legislative controls were not considered necessary.

General insurance on the other hand also has its origins in the United Kingdom. The first general insurance company Triton Insurance Company Ltd. was promoted in 1850 by British nationals in Calcutta. The first general insurance company established by an Indian was Indian Mercantile Insurance Company Ltd. in Bombay in 1907. Eventually, with the growth of fire, accident and marine insurance, the need was felt to bring such kinds of insurance within the purview of the Act of 1912. While there were a number of attempts to introduce such legislation over the years, non-life insurance was finally regulated in 1938 through the passing of the Insurance Act, 1938 ("**Act of 1938**"). The Act of 1938 along with various amendments over the years continues till date to be the definitive piece of legislation on

insurance and controls both life insurance[2] and general insurance. General insurance, in turn, has been defined to include "fire insurance business"[3], "marine insurance business"[4] and "miscellaneous insurance business"[5], whether singly or in combination with any of them.

2) Nationalization of the Insurance Business in India

On January 19, 1956, the management of life insurance business of two hundred and forty five Indian and foreign insurers and provident societies then operating in India was taken over by the Central Government. The Life Insurance Corporation ("LIC") was formed in September 1956 by the Life Insurance Corporation Act, 1956 ("LIC Act") which granted LIC the exclusive privilege to conduct life insurance business in India. However, an exception was made in the case of any company, firm or persons intending to carry on life insurance business in India in respect of the lives of "persons ordinarily resident outside India", provided the approval of the Central Government was obtained. The exception was however not absolute and a curious prohibition existed. Such company, firm or person would not be permitted to insure the life of any "person ordinarily resident outside India", during any period of their temporary residence in India. However, the LIC Act, 1956 left outside its purview the Post Office Life Insurance Fund, any Family Pension Scheme framed under the Coal Mines Provident Fund, Family Pension and Bonus Schemes Act, 1948 or the Employees' Provident Funds and the Family Pension Fund Act, 1952.

The general insurance business was also nationalised with effect from January 1, 1973, through the introduction of the General Insurance Business (Nationalisation) Act, 1972 ("GIC Act"). Under the provisions of the GIC Act, the shares of the existing Indian general insurance companies and undertakings of other existing insurers were transferred to the

[2] Section 2(11), Insurance Act, 1938: "***Life Insurance Business***" means the business of effecting contracts of insurance upon human life, including any contract whereby the payment of money is assured on death (except death by accident only) and the happening of any contingency dependent on human life, and any contract which is subject to payment of premiums for a term dependent on human life and shall be deemed to include: (a) the granting of disability and double or triple indemnity accident benefits, if so provided in the contract of insurance; (b) the granting of annuities upon human life; and (c) the granting of superannuation allowances and annuities payable out of any fund applicable solely to the relief and maintenance of persons engaged or who have been engaged in any particular profession, trade or employment or of the dependents of such persons."

[3] Section 2(6-A), Insurance Act, 1938: "***Fire Insurance business***" means the business of effecting, otherwise than incidentally to some other class of insurance business, contracts of insurance against loss by or incidental to fire or other occurrence customarily included among the risks insured in fire insurance policies.

[4] Section 2(13-A), Insurance Act, 1938: "***Marine Insurance Business***" means the business of effecting contracts of insurance upon vessels of any description, including cargoes, freights and other interests which may be legally insured, in or in relation to such vessels, cargoes and freights, goods, wares, merchandise and property of whatever description insured for any transit by land or water, or both, and whether or not including warehouse risks or similar risks in addition or as incidental to such transit, and includes any other risks customarily included among the risks insured against in marine insurance policies.

[5] Section 2(13-B), Insurance Act, 1938: "***Miscellaneous insurance business***" means the business of effecting contracts of insurance which is not principally or wholly of any kind or kinds included in Section 2 (6-A), (11) and (13-A) of the Insurance Act, 1938."

General Insurance Corporation ("GIC") to secure the development of the general insurance business in India and for the regulation and control of such business. The GIC was established by the Central Government in accordance with the provisions of the Companies Act, 1956 ("Companies Act") in November 1972 and it commenced business on January 1, 1973. Prior to 1973, there were a hundred and seven companies, including foreign companies, offering general insurance in India. These companies were amalgamated and grouped into four subsidiary companies of GIC viz. the National Insurance Company Ltd. ("National Co."), the New India Assurance Company Ltd. ("New India Co."), the Oriental Insurance Company Ltd. ("Oriental Co."), and the United India Assurance Company Ltd. ("United Co."). GIC undertakes mainly re-insurance business apart from aviation insurance. The bulk of the general insurance business of fire, marine, motor and miscellaneous insurance business is undertaken by the four subsidiaries.

3) Entry of Private Players

Since 1956, with the nationalization of insurance industry, the LIC held the monopoly in India's life insurance sector. GIC, with its four subsidiaries, enjoyed the monopoly for general insurance business. Both LIC and GIC have played a significant role in the development of the insurance market in India and in providing insurance coverage in India through an extensive network. For example, currently, the LIC has a network of 7 zones, 100 divisions and over 2,000 branches. LIC has over 550,000 agents and over 100 million lives are covered.

From 1991 onwards, the Indian Government introduced various reforms in the financial sector paving the way for the liberalization of the Indian economy. It was a matter of time before this liberalization affected the insurance sector. A huge gap in the funds required for infrastructure was felt particularly since much of these funds could be filled by life insurance funds, being long tenure funds.

Consequently, in 1993, the Government of India set up an eight-member committee chaired by Mr. R. N. Malhotra, a former Governor of India's apex bank, the Reserve Bank of India to review the prevailing structure of regulation and supervision of the insurance sector and to make recommendations for strengthening and modernizing the regulatory system. The Committee submitted its report to the Indian Government in January 1994. Two of the key recommendations of the Committee included the privatization of the insurance sector by permitting the entry of private players to enter the business of life and general insurance and the establishment of an Insurance Regulatory Authority.

It took a number of years for the Indian Government to implement the recommendations of the Malhotra Committee. The Indian Parliament passed the Insurance Regulatory and Development Act, 1999 ("IRD Act") on December 2, 1999 with the aim "to provide for the establishment of an Authority, to protect the interests of the policy holders, to regulate, promote and ensure orderly growth of the insurance industry and to amend the Insurance Act, 1938, the Life Insurance Corporation Act, 1956 and the General Insurance Business (Nationalization) Act, 1972".

(B) NATIONAL HEALTH POLICY

In India, the first National Health Policy (NHP) was launched in 1983. It was created with the goal of establishing a system with primary care facilities and a referral system. In 2002, the updated NHP focused on improving the practicality and reach of the system as well as incorporating private and public clinics into the health sphere.

(C) AUNCH OF AYUSHMAN BHARAT – PRADHAN MANTRI JAN AAROGYA YOJANA (AB-PMJAY)

India took a giant leap towards providing accessible and affordable healthcare to the common man with the launch of Ayushman Bharat – Pradhan Mantri Jan AarogyaYojana (AB-PMJAY) by the Prime Minister, Shri Narendra Modi on 23rd September, 2018 at Ranchi, Jharkhand. Under the vision of Ayushman Bharat, Pradhan Mantri Jan AarogyaYojana (AB-PMJAY) was implemented so that each and every citizen receives his due share of health care. With Ayushman Bharat – Pradhan Mantri Jan Aarogya Yojana, the government is taking healthcare protection to a new aspirational level. This is the "world's largest government funded healthcare program" targeting more than 50 crore beneficiaries.

(D) OBJECTIVE OF THE STUDY

The objective of this study is to assess the awareness about and attitude towards the AB-PMJAY for treatment of disease(s). And it also aims to document the efforts taken by the Government of India to spread the awareness to achieve universal health coverage through AB-PMJAY and to the population. The aim of this review is to explore the AB-PMJAY program and to assess how far it could achieve the goal of universal health coverage.

(E) HYPOTHESIS

The hypothesis of this study will help in examination of the efficiency and effectiveness of the governing principles of Ayushman Bharat – Pradhan Mantri Jan AarogyaYojana (AB-PMJAY); whether the said scheme has accomplished the target of achieving the said

objectives or not.

II. AYUSHMAN BHARAT PRADHAN MANTRI - JAN AROGYA YOJNA

(A) BACKGROUND

The Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana ("**AB-PMJAY**") scheme was launched in India by Prime Minister Narendra Modi in September 2018 in Ranchi, Jharkhand.[6] It was a component of the larger Ayushman Bharat scheme that was launched as per the recommendations of National Health Policy 2017 to achieve the vision of Universal Health Coverage. AB-PMJAY provides a cashless insurance cover of Rs. 5,00,000/- per year for secondary and tertiary care hospitalisation. About 100 million below poverty level families, who were part of the 2011 socio-economic caste census ("**SECC**") database list, are slated to be the beneficiaries of the scheme; the government has called it "**the world's largest government funded healthcare program**".[7]

The main aim of the scheme is to reduce catastrophic expenditure for hospitalisations which impoverishes people. Another aspect of Ayushman Bharat, apart from the insurance scheme, is the creation of health and wellness centres by converting sub-centres and primary health centres. About 1,50,000 health and wellness centres are supposed to be created by 2022 to provide "comprehensive primary care" covering maternal and child health services as well as non-communicable diseases, including free essential drugs and diagnostic services.[8]

India's healthcare spending is amongst the lowest[9] in the world and lower than its own ambitions.[10] Currently, India's public healthcare spending is only 1.28% of its gross domestic product.[11] India's health-related out-of pocket expenditure, which pushes families into indebtedness and deeper poverty, is amongst the highest in the world. In a low-middle income group of 50 nations, Indians ranked sixth among the biggest out-of pocket health spenders in 2014.[12] Over 55 million Indians were pushed into poverty due to outpatient

[6] https://pib.gov.in/Pressreleaseshare.aspx?PRID=1546948
[7] Ibid.
[8] *Ayushman Bharat Scheme: 1,20,000 Community Health Officers to be Placed at HWC's by 2022*, Outlook (10/12/2019), available at https://www.outlookindia.com/newsscroll/ayushman-bharat-scheme-120000-community-health-officers-to-be-placed-at-hwcs-by-2022/1682125
[9] *Rs 3: Amount India Spends Every Day on Each Indian's Health, India Spend* (21/06/2018), available at https://www.indiaspend.com/rs-3-amount-india-spends-every-day-on-each-indians-health-53127/
[10] *Ministry of Health and Family Welfare, Government of India, National Health Policy 2017*, available at https://www.nhp.gov.in//NHPfiles/national_health_policy_2017.pdf
[11] *Ministry of Health and Family Welfare, Government of India, National Health Profile 2019*, available at https://www.thehinducentre.com/resources/article29841374.ece
[12] *V. Vivek, Indians Sixth Biggest Private Spenders on Health Among Low-Middle Income Nations, India Spend (08/05/2017)*, available at https://www.indiaspend.com/cover-story/indians-sixth-biggest-private-spenders-on-health-among-low-middle-income-nations-78476

expenditure, 69% of them due to cost of medicines alone.[13]

The National Health Policy of 2002 and 2017 suggested health insurance as a way of ensuring universal health care. However, the reality on the ground remains different, with only 14.1% persons in rural areas and 19.1% in urban areas covered by any form of insurance cover according to health consumption data released by 75th round of National Statistical Office.**[14]** Further, only about 10% of the poorest Indians in rural (10.2%) and urban India (9.8%) had any form of private or government health insurance.**[15]** It has to be noted that since the survey was conducted before the launch of PMJAY, the latest coverage of insurance scheme is yet to be recorded.

Since the aim of the PMJAY scheme is to reduce catastrophic health expenditure and the focus of the scheme still remains on hospitalisation, how effective the scheme will be to achieve this end would need assessment. India already has the experience of implementing Rashtriya Swasthya Bima Yojana ("RSBY"), which provided a cover of Rs 30,000 for below poverty level families since 2008 with limited success. Till 2013, 41 million families out of a targeted 65 million families were enrolled in RSBY. However, the scheme suffered from many problems, like low enrolment, inadequate insurance cover and the lack of coverage for outpatient costs; in fact, spending on outpatient expenditure increased by 30% for the beneficiaries of RSBY.**[16]** While most patients showed a preference for private hospitals, some studies showed that there was not a major difference in quality between public and private hospitals. Also, since there was no specific formal regulation of the scheme, states contracted out their functions to private insurance firms often leading to frequent contractual breaches.**[17]**

(B) WHAT WAS THE GOVERNMENTS' MOTTO BEHIND THE SCHEME – AN OVERVIEW[18]

In 2018, the Government of India launched the '**Ayushman Bharat**' scheme (as outlined by

[13] *P. Salve, Health Expenses Pushed 55 Million Indians into Poverty (19/07/2018), India Spend* (19/06/2018), https://www.indiaspend.com/health-expenses-pushed-55-million-indians-into-poverty-in-2017-2017/

[14] *Ministry of Statistics and Programme Implementation, Government of India, Key Indicators of Social Consumption in India: Health*¸ available at https://www.mospi.gov.in/sites/default/files/publication_reports/KI_Health_75th_Final.pdf

[15] Ibid.

[16] *A. Karan, W. Yip, A. Mahal, Extending health insurance to the poor in India: An impact evaluation of Rashtriya Swasthya Bima Yojana on out of pocket spending for healthcare,181 Social Science & Medicine, 83-92 (2017)*, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5408909/

[17] *S. Khetrapal, Assessment of the Public-Private-Partnerships Model of a National Health Insurance Scheme in India, Volume no. 243, Journal of Social Science and Medicine, (2019)*, https://www.sciencedirect.com/science/article/pii/S027795361930629X

[18] https://www.ibef.org/government-schemes/ayushmanbharat

the National Health Policy 2017) to make healthcare services more accessible and affordable to citizens and aid the country in achieving its target of universal health coverage (UHC) by 2030.

The following are the two key components of 'Ayushman Bharat':

- ✓ **Establish Health and Wellness Centres (HWCs)**: Launched in February 2018, the scheme aimed to provide extensive healthcare services to citizens closer to their homes by establishing 1,50,000 Health and Wellness Centres (HWCs)
- ✓ **Pradhan Mantri Jan Arogya Yojana (PM-JAY)**: Launched in September 2018, the scheme aimed to offer secondary and tertiary care services to the vulnerable population in the society. The policy aimed to offer medical coverage of Rs. 5 lakh (US$ 6.63 thousand) per family per year for secondary and tertiary care hospitalisation to >10.74 crore poor and vulnerable families (*i.e.* 50 crore beneficiaries), which constitute the bottom 40% of India's population.

The government's increased focus to invest in the country's healthcare infrastructure and establish India as a global healthcare hub will further expand accessibility of healthcare services to the Indian population and strengthen the overall healthcare system. According to NITI Aayog, the Indian healthcare sector is likely to expand at a CAGR of 22% (3x) in 2016-2022 to reach US$ 372 billion in 2022, from US$ 110 billion in 2016. The government expenditure on healthcare increased by 137% YoY (Rs. 2,23,846/- crore (US$ 30.70 billion)) in BE 2021-22, as against Rs. 94,452 crore (US$ 12.95 billion) in BE 2020-21. The government is planning to increase public health spending to 2.5% of the country's GDP by 2025, from 1.8% in 2020.

Through numerous health initiatives under Ayushman Bharat, the government aims to establish a '**New India**' by 2022; thereby, increase growth & well-being, create employment and boost the healthcare sector of the country.

- **Need for Ayushman Bharat:-**

✓ The National Health Policy 2017 indicated the need to increase public healthcare spending in India due to rising demand for healthcare infrastructure & services and out-of-pocket expenditure.

✓ The government health expenditure (GHE) per person per year was estimated at Rs. 1,108 (US$ 14.70), (or Rs. 3 (US$ 0.040) per day), according to the National Health Accounts (NHA) estimates for 2014-15. This contrasts with the out-of-pocket

expenditure (OOPE) of Rs. 2,394 (US$ 31.77) for 2014-15, which accounts for 63% of the overall health expenditure.

✓ Further, as per Health financing profile 2017 by World Health Organisation, the healthcare out-of-pocket expenditure (OOPE) in India was estimated at 67.78% of the total health expenditure, higher than the world average of 18.2%, indicating high expenditure which leads to the high incidence of catastrophic expenditures and inequality.

✓ To improve the public's access to health services and meet the rising demand for healthcare infrastructure & services, the government introduced the 'Ayushman Bharat' scheme in September 2018. Following its launch, 17 crore (68%) families have been estimated to be covered under PMJAY and other government-funded health schemes (*e.g.* Rashtriya Swasthya Bima Yojana, (RSBY), RSBY Plus, stated-owned schemes).

- **Ayushman Bharat – Key Initiatives and Progress**

With the launch of Ayushman Bharat, India has reached a significant milestone in the pursuit for universal healthcare, as the scheme is ensuring extended services to all citizens through its twin pillars of Health & Wellness Centres (HWCs) and Pradhan Mantri Jan Arogya Yojana (PM-JAY) with bidirectional relations.

- **Health and Wellness Centres (HWCS)**

As of April 2021, 75,532 Ayushman Bharat Health and Wellness Centres (AB-HWCs) were operational across the country and registered a footfall of >44.24 crore, of which >23.8 crore women (53.7%) have accessed care at these centres. The government is planning to establish 1.5 lakh AB-HWCs by December 2022.

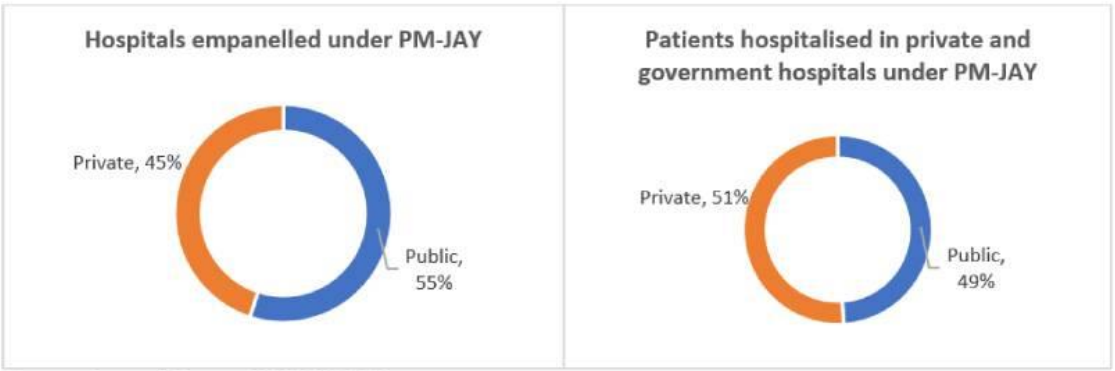
- **Pradhan Mantri Jan Arogya Yojana (PM-JAY)**

Under the Ayushman Bharat's Pradhan Mantri Jan Arogya Yojana (PM-JAY), 1.59 crore hospital admissions worth Rs. 19,714 crore (US$ 2.64 billion) were registered, as of February 2021.

Progress of PM-JAY	**As of February, 2021**
E-cards Generated	136,172,075
Authorised Hospital Admissions	15,885,194

(Count)	
Authorised Hospital Admissions (Value)	Rs. 19,714 crore (US$ 2.64 billion)

** According to Ayushman Bharat's Pradhan Mantri Jan Arogya Yojana (PM-JAY) newsletter, 24,666 hospitals were empanelled, as of December 2020.*



Source: Annual Report PM-JAY 2020

- **Status of Implementation of Ayushman Bharat**

Indicators	All India
Pradhan Mantri Jan Arogya Yojana (PM-JAY)	
Beneficiary families covered	13.13 crore
Total hospital admissions authorised	1.24 crore (includes 5.13 lakh hospital admissions for COVID-19 testing & treatment)
Health and Wellness Centres	75,532 (as of April 2021)

- **Union Budget 2021-22**

✓ In the Union Budget 2021-22, the government allocated funds worth Rs. 6,400 crore (US$ 848.86 million) to the Ayushman Bharat-PM Jan Arogya Yojana (PM-JAY).

✓ The government also announced that the NHA's National Anti-Fraud Unit will implement artificial intelligence (AI) and machine learning (ML) techniques to monitor risk scoring models, social network analysis, image analytics and cluster & peer analysis. According to the government, implementing and deploying AI and ML techniques will enable to effectively diagnose diseases and prevent fraud.

- ✓ In addition, the government included TB screening in the Community Based Assessment Checklist (CBAC), as part of Ayushman Bharat's Health & Wellness Centre programme.

- **The Road Ahead**

As part of sustainable development goals, India is focused on achieving universal health coverage for all citizens. The government allocated Rs. 2,23,846/- crore (US$ 29.69 billion) for health and well-being in the Union Budget 2021-22, up from Rs. 94,452 crore (US$ 12.53 billion) in the previous budget. India's public health expenditure as a percentage of GDP increased from 1.2% to 1.8% between FY15 and FY21 BE.

With the help of Ayushman Bharat, the government is planning to further expand its benefits to millions by offering free medicines and diagnostics at HWCs and cover most secondary and tertiary procedures under the PM-JAY. The government's initiative such as inclusion of AYUSH Health and Wellness Centre (AYUSH HWC) as component of Ayushman Bharat in National AYUSH Mission (NAM), would enable establishment of 12,500 Health and Wellness Centres (HWCs) by the Ministry of AYUSH, under the Ayushman Bharat Scheme, in a phased manner between FY20 and FY24.

Further, amid the COVID-19-induced lockdown in 2020, the scheme was widely used by migrant workers, particularly after the implementation of portability, which allowed beneficiaries to use cashless treatment facilities in any state, with the goal of providing access to healthcare.

With the government's continuous efforts to increase AB's awareness and strengthen the infrastructure, the Ayushman Bharat scheme is expected to gain higher momentum in the future and yojana meet its goal of achieving universal health coverage.

(C) HEALTH AND WELLNESS CENTRES – PERFORMANCE SO FAR

Under the Ayushman Bharat scheme, 1.5 lakh health and wellness centres are to be made operational by the end of year 2022 and phased targets for each year have been set. At the end of 2020, the target is for 40,000 health and wellness centres to be operational; according to the scheme's dashboard, there are about 28,000 operational in January 2019.[19] The states with the highest score in state-wise ranking based on fulfillment of criteria and following the guidelines were Andhra Pradesh, Gujarat, Odisha, Tamil Nadu and Haryana, as per rankings

[19] *Ministry of Health and Family Welfare, Government of India, Ayushman Bharat - Health and Wellness Centre*, available at https://ab-hwc.nhp.gov.in/#documents

in September 2019.[20]

Apart from Odisha, the other states were high income states with fairly good infrastructure. Other than the exception of Uttar Pradesh, which has the highest number of health and wellness centres according to the dashboard, most of the health and wellness centres are in other highincome states like Gujarat, Maharashtra and Tamilnadu.[21] Also, the allocation for health and wellness centres in 2019-2020 was Rs. 1600 crores, nearly a fourth of the budget allocated to PM-JAY.

III. PMJAY – THE PERFORMANCE SO FAR

The National Health Authority ("NHA"), which was created by the Union Cabinet, is responsible for the design, rollout, implementation and management of PM-JAY. Headed by a full-time CEO at the level of secretary, NHA is governed by a governing board chaired by the Union Health Minister with 11 other members. Its chief functions include: formulation of policies, development of operational guidelines, implementation mechanisms, and coordination with state governments, monitoring and oversight, among others.

Till December 2, 2019, PMJAY has issued over 67 million e-cards to beneficiaries, according to the PMJAY website and the NHA.[22] The scheme is operational in all states except Odisha, Telangana, West Bengal and New Delhi. Almost 53% of 18,500 hospitals empanelled are private sector hospitals.[23] It has covered over 6.8 million hospitalisations worth Rs 7,160 crore and has led to the saving of Rs 16,000 crore, as of October 2019, according to the National Health Authority. Majority of the treatments have taken place in the areas of cancer, heart ailments, bone related problems and kidney ailments.[24] Among the top specialties under which patients have availed benefits are oncology, cardiology, orthopaedics, and urology.

At the state level, there is a State Health Authority ("SHA"), headed by a chief executive officer appointed by the state government, which is responsible for implementing the scheme in the state. The states have the flexibility to choose between a trust mode, insurance mode

[20] *Ministry of Health and Family Welfare, Government of India*, available at https://ab-hwc.nhp.gov.in/download/document/Ayushman_Bharat_-HWCs.pdf
[21] Ibid.
[22] *Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana, National Health Authority*, available at https://www.pmjay.gov.in/
[23] *Ministry of Health and Family Welfare, Government of India, One Year of AB-PMJAY: 50 lakh Hospital Treatments with an Eye towards Universal Health Care*, available at https://blog.mygov.in/one-year-of-ayushman-bharat-pradhan-mantri-jan-arogya-yojana-50-lakh-hospital-treatments-with-an-eye-towards-universal-health-coverage/
[24] *ASSOCHAM - India, Ayushman Bharat - A Big Leap towards Universal Health Care in India, KPMG*, available at https://assets.kpmg/content/dam/kpmg/in/pdf/2019/12/universal-health-coverage-ayushman-bharat.pdf

and mixed or hybrid mode.[25] In the trust mode, SHA makes the payment to the empanelled hospitals for the claims approved; in the insurance mode, the insurance company makes the payment; and in the hybrid mode, the insurance company makes the payment up to a coverage limit and the claims higher than the limit are paid by the SHA.[26] While 17 States or union territories are implementing PM-JAY via the Trust Mode, 9 states or union territories via Insurance Mode and 6 States or union territories are using the Mixed Mode which is a combination of Trust mode and Insurance mode.

- **Fraudulent Transactions**

Previous experience has shown that insurance schemes are often plagued with fraudulent activities. Apart from publishing the anti-fraud guidelines and having fixed packages, NHA has initiated mandatory preauthorisation and use of artificial intelligence to spot suspicious trends. Moreover, two bodies, the National Anti-Fraud Unit ("NAFU") and the State Anti-Fraud Unit ("SAFU") were formed to monitor the system at the centre and state levels, respectively. NAFU teams often flag suspicious cases with the states for medical audits. Till now 0.25% of total admissions have been flagged by NAFU, out of which 0.07 have been confirmed as fraud.[27] In the first year, 171 hospitals were depanelled due to fraudulent practices and Rs 4.5 crore penalties was levied on them.[28] Also, 390 hospitals were served show-cause notice in different states and six hospitals had first information reports filed against them.

Furthermore, a working paper analysing the pattern of utilisation of hysterectomy procedure in the first year showed that about three-fourths of all claims have been generated in six states, Chhattisgarh (21.2%), Uttar Pradesh (18.9%), Jharkhand (12.2%), Gujarat (10.8%), Maharashtra (9%) and Karnataka (6.6%), and more than two thirds of the claims were from the private sector.[29] Uttar Pradesh accounted for 18% of all hysterectomy claims under PMJAY, and only 5% of total claims. Also, most of the procedures involved oophorectomy – removal of ovaries – which leads to premature menopause; median age of the women undergoing hysterectomy and use of oophorectomy should be "monitored closely," said the

[25] *Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana, National Health Authority*, available at https://pmjay.gov.in/about/pmjay
[26] Ibid.
[27] *Joe C Mathew, Ayushman Bharat Fraud: NHA Delists 171 Hospitals over Alleged PMJAY Scam, Business Today (06/01/2020)*, available at https://www.businesstoday.in/latest/economy-politics/story/ayushman-bharat-fraud-nha-delists-171-hospitals-over-alleged-pmjay-scam-241944-2020-01-06
[28] Ibid.
[29] S. Kaur, Dr. N. Jain, Dr. S. Desai, *Patterns of utilization for Hysterectomy: An analysis of early trends from Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY)*, Working Paper 001, National Health Authority (2019)

report.

- **Big Private Players Are Still Absent**

PMJAY, in its truest sense, is a "partnership of public and private sector health systems" according to the NHA.[30] However, there has been reluctance on the part of big private sector hospitals in empanelling themselves in the scheme especially in tier-one cities. According to KPMG's analysis, the participation of private hospitals has been as follows: Gurugram (17), Mumbai (29) and Bengaluru (28). Till June 2019, major corporate hospitals like Max Healthcare, Apollo Hospitals, Medanta had not joined the scheme.[31]

This is because most of the package rates in PMJAY were not viewed to be viable by the private hospitals. The reimbursement tariffs offered under the scheme do not cover more than 40-80% of the total costs, according to a 2019 report by FICCI.[32] If hospitals had to allocate 25% of their beds to PMJAY patients, they would lose up to 15-25% of revenue per bed each day, the FICCI report said.[33] The delay in settling bills could also scare off the private players. While 85% of PMJAY claims have been settled within 30-45 days cut off, cashless treatment under the Central Government Health Scheme ("CGHS") and Ex-servicemen Contributory Health Scheme (ECHS) has often been delayed.[34] For instance, Fortis, Max and Medanta had threatened to discontinue cashless treatment under CGHS and ECHS due to non-payment of dues up to Rs. 1700 crores in December 2019.[35]

On the other hand, Indian Medical Association has said that public hospitals should be out of the ambit of PMJAY since the government can directly fund them, and has criticized the current insurance model which, according to the Indian Medical Association, should be replaced by universal health coverage.[36]

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[30] One year of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana: 50 lakh hospital treatments with an eye towards universal health coverage, ABPMJAY, Government of India, https://www.pmjay.gov.in/One%20year%20of%20Ayushman%20Bharat

[31] P. Aggarwal, *Govt. to Revise Ayushman Bharat Rates as Several Hospitals Back Off*, The Quint (28/06/2019), available at https://www.thequint.com/news/india/ayushman-bharat-pmjay-rates-to-be-hiked-to-get-big-hospitals-on-board

[32] *Re-engineering Indian Healthcare 2.0*, FICCI Heal, https://ficci.in/spdocument/23111/Re-engineering-Indian-healthcare-2.0_FICCI.pdf

[33] Ibid.

[34] Ministry of Health and Family Welfare, Government of India, *Saal Ek Ayushman Anek*, available at https://www.pmjay.gov.in/sites/default/files/201910/3_Press%20release%201%20year

[35] H. Chandna, *Fortis, Max, Medanta Want to Scrap Cashless CGHS Treatment as Govt Dues Touch Rs 1,700 Cr*, The Print (06/12/2019), available at https://theprint.in/health/fortis-max-apollo-want-to-scrap-cashless-cghs-treatment-as-govt-dues-touch-rs-1700-crore/330968/

[36] *Restrict Ayushman Bharat to the Private Sector: IMA*, Business Line (29/09/19), available at https://www.thehindubusinessline.com/economy/policy/restrict-ayushman-bharat-to-the-private-sector-ima/article29550117.ece#

IV. DOES PM-JAY PROVIDE CARE FOR THE POOREST TO TAKE CARE OF THEIR CATASTROPHIC EXPENDITURE?

(A) EXCLUSIONS WITHIN THE SYSTEM

While the scheme has expanded widely, it still does not cover all the eligible poor households in the country. The PMJAY relies on SECC 2011 to determine eligible beneficiaries which is how the scheme was targeted to cover 100 million households. Based on the SECC 2011 data, for rural areas, households had to meet six deprivation criteria, while households in urban areas had to meet eleven occupational criteria. However, an analysis of the SECC 2011 shows that the number of poor in the list is highly underestimated; for example, while the number of homeless households according to Census 2011 are 4.7 million, SECC 2011 only counts 1.65 million as households without shelter.[37] There are as many as 20 million households which have been left out of SECC 2011 despite being poor.[38] Additionally, there are several households which are rich but have made it to the list.

This could have been solved had there been a grievance re-dressal mechanism to solve the inclusion errors as was suggested by the expert group constituted by the Ministry of Rural Development.[39] However, in the current form, there is no process to include households that meet the criteria but are not included in the SECC 2011 list. Notably, there were 6.5 million households out of 10.74 million poor vulnerable households which were untraceable when the NHA was preparing the list of eligible beneficiaries.[40]

(B) POOR AWARENESS

Even among the beneficiaries who are eligible and included in the scheme, there seems to be very low awareness regarding the scheme. A two-page letter by Prime Minister Narendra Modi was sent to 100.7 million households included under the scheme. However, a survey conducted a year later by NHA found the awareness regarding the scheme as low as 20% in Bihar and Haryana.[41] Even though they received the letters, many beneficiaries could not

[37] NC Saxena, *Socio Economic Caste Census: Has It Ignored Too Many Poor Households*, 50(30) Economic and Political Weekly (25/07/2015), available at https://www.epw.in/journal/2015/30/commentary/socio-economic-caste-census.html
[38] Ibid.
[39] Ministry of Rural Development, Government of India, *Report of the Expert Group on Socio and Economic Caste Census*, available at https://rural.nic.in/sites/default/files/Report_of_the_expert_group_on_SECC_2011_
[40] R. Kaul, *6.5 Million Beneficiaries Missing from Ayushman Bharat First List*, Hindustan Times (31/07/2019), available at https://www.hindustantimes.com/india-news/6-5-million-beneficiaries-missing-from-ayushman-bharat-first-list/story-SJDi1EoiXrcuCJamYHrDeJ.html
[41] N. Sharma, *Ayushman Bharat Awareness 80% in TN, barely 20% in Bihar and Haryana*, The Economic Times (03/09/2020), available at https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/ayush

understand what was due to them and many had not opened the letters with their health cards. Despite the fact that Bihar had seen an Acute Encephalitis Syndrome epidemic in June-August, 2019, only 36 patients availed of the scheme during the epidemic.

(C) DISEASE EXCLUSIONS

In its current form, the PMJAY covers 1350 medical packages, and according to the NHA, 75% of the pre-authorisation amount is towards tertiary care procedures, including medical oncology, cardiology, orthopaedics, urology and radiation oncology. On the other hand, several illnesses, like end-stage kidney disease, chronic liver disease and blood cancer, are not even covered under the scheme. Further, these patients are not able to avail the benefit of Rashtriya Arogya Nidhi ("RAN"),[42] a scheme that provides financial assistance up to Rs. 15 lakh to people below the poverty line, as they are covered under PMJAY; a proposal to allow this was rejected by the Union Health Ministry.[43]

Also, since PMJAY allows coverage of medicines for just 15 days after hospitalisation, it leaves out a number of patients, like cancer patients, who may require long-term medication on an outpatient basis. "This has not only restricted the reach of the benefits to the poorest of the poor, but has also worked against the principles of the RAN umbrella scheme, which is to give financial benefit to the poor in the treatment of cancer," wrote Shah Alam Khan, of Orthopaedics Department in All India Institute of Medical Sciences, Delhi in Economic and Political Weekly.[44]

(D) GEOGRAPHICAL EXCLUSIONS

The fact that there are large scale regional disparities in the health infrastructure in the country is also reflected in the empanelled hospitals under the scheme. States with low per capita incomes have lower empanelment of private hospitals by insurance companies despite having a large proportion of eligible beneficiaries under AB-PMJAY.[45] For example, West Bengal which has 10.6% of all PM-JAY beneficiaries only has 588 private hospitals empanelled, while New Delhi has 0.6% of all PM-JAY beneficiaries and 510 private

[42] *Guidelines Regarding Implementation of Umbrella Scheme of RashtriyaArogyaNiti (RAN)*, Ministry of Health and Family Welfare Notification (2019), available at https://www.mohfw.gov.in/sites/default/files/RAN_Guideline_2019.pdf

[43] *NHRC Seeks Report OverAyushman Bharat Beneficiaries not able to avail High-cost Treatment under RAN*, The Economic Times (26/12/2019), available at https://economictimes.indiatimes.com/news/politics-and-nation/nhrc-seeks-report-over-ayushman-bharat-beneficiaries-not-able-to-avail-high-cost-treatment-under-ran/articleshow/72979534.cms

[44] S. A. Khan, *Ayushman Bharat: Hurdles to Implementation One Year On*, 54(47) Economic and Political Weekly (30/11/2019), available at https://www.epw.in/journal/2019/47/commentary/ayushman-bharat.html

[45] M. Chaudhary and P. Datta, *Private Hospitals in Health Insurance Network in India: A Reflection for Implementation of Ayushman Bharat*, NIPFP Working paper series, Working Paper 254, National Institute of Public Finance and Policy (2019)

hospitals empanelled. Further, even among states with a high number of empanelled hospitals, the distribution of private hospitals is concentrated in a few districts which accounted for the majority of claims.

Analysis of the schemes showed that 61% of all claims are from private hospitals and the share of high value (more than Rs. 30,000) and very high value claims (more than Rs. 100,000) is 74% and 82% respectively. In fact, top 20 hospitals in a select few cities accounted for 17% of all very-high value claims. While the unique provision under PMJAY has been portability where patients can avail cashless treatment in empanelled hospitals across the country, till September 2019, 50,544 transactions or only about 0.7% of all hospitalisations had availed of the provision.[46] This means that the much lauded feature of the scheme also needs more awareness and demand generation.

V. CONCLUSION

India has been amongst the lowest spenders on healthcare, yet there have been increased allocations on healthcare in the last couple of decades. This, along with ambitious schemes, does improve the government's ability to meet the needs of the population, but there is a debate to determine what the money should be spent on. India has adopted the insurance-based model for healthcare, as mentioned in various National Health Policy documents. With Ayushman Bharat, the idea expanded to providing a more comprehensive cover as well as a robust healthcare infrastructure for the most vulnerable sections of the society. India has had mixed success with the model till now, and there are still fundamental problems that the scheme has been unable to tackle. Reducing catastrophic expenditure without covering outpatient expenditure seems to be a fundamental folly, especially given the fact that most Indians rely on private healthcare for their health needs. The fact that more Indians have died from poor quality medical care than due to lack of medical care should explain why there is little faith in the public system.[47] While the government aims to tackle the problem of primary healthcare through the establishment of health and wellness centres, the budget allocation shows that it has not been allocated the resources that will be needed to overhaul the primary healthcare system or maintain its quality.

Focusing only on the efforts of the government to provide tertiary care, we find that it would not succeed in giving healthcare coverage to the most deprived because the database on

[46]S. Yadavar, *Ayushman Bharat Working to Identify those Left Out*, India Spend (08/12/2019), available at https://www.indiaspend.com/ayushman-bharat-working-to-identify-those-left-out/

[47] S. Yadavar, *More Indians Die of Poor-Quality Care Than Due to Lack of Access to Healthcare: 1.6 Million*, India Spend (06/09/2019), available at https://www.indiaspend.com/more-indians-die-of-poor-quality-care-than-due-to-lack-of-access-to-healthcare-1-6-million-64432/

which the beneficiaries are determined is flawed and does not include the most vulnerable. This is because the government is using the same SECC 2011 database to even determine which households do not have latrines for the Swachh Bharat Abhiyaan; a calculation which has allowed villages and districts to be declared open defecation free even as many households do not have latrines or do not use them.[48] This is why there is an urgent need to allow provisions to include the beneficiaries that have been left out and update the database to only include the deserving.

Also, even if the base of the beneficiaries increases, much more needs to be done to increase awareness about the scheme to the public. Currently, only a small portion of the beneficiaries who have even received the card seem to be aware of the scheme. This means that the poor would continue to delay or seek care at the risk of indebtedness. Also, the issue of inequitable access to care also needs much to be desired. There is a clear concentration of empanelled hospitals in certain states and certain districts, a small proportion of them are also the ones who charged the highest number of claims for expensive specialised medical procedures. Even though the portability feature does seem to address this gap, low utilisation of this feature points to the fact that very few beneficiaries know about it and can afford to travel for the procedure.

While PM-JAY considers the private sector to be a very important part of the engagement of the scheme, to rely on private sector hospitals especially when it comes to quality and price is not advisable. Also, the NHA has not yet responded to all the concerns of the private players when it comes to the viability of the scheme. Even if all the private players are satisfied with the package rates and decide to come on board, previous experience has shown that the scheme has high chances of being exploited, despite the anti-fraud mechanism in place, because of the fundamental aim of profit generation in the private hospitals and virtually no regulatory mechanism in place. Even the presence of public-private partnerships in the public sector has shown that the private sector has not been successful in providing the kind of care stipulated in the contract. In fact, the government has had to roll back the scheme and manage the hospitals in many cases.

Despite the apparent gaps and challenges, PM-JAY is the most ambitious scheme and the one that has received more political attention and finance than ever before. Also, given that it has only been a year and a half, it is expected that the scheme will both mature and grow strong

[48] S. Yadavar, *After 4 Years of Swachh Bharat, Open Defecation Down 26 Percentage Points, But Toilet Use Does Not Match Construction Spree*, India Spend (07/01/2019), available at https://www.indiaspend.com/after-4-years-of-swachh-bharat-open-defecation-down-26-percentage-points-but-toilet-use-does-not-match-construction-spree-false-claims-evident/

in times to come. Furthermore, since the NHA has been transparent about their findings and sharing data, there is scope to analyse PM-JAY's performance more critically and provide feedback.

There is already discussion to provide health insurance coverage to the middle class and move towards universal healthcare by making that a paid feature.[49] However, it is too early to expand the scheme to other groups even before understanding the impact of the scheme on the goals that it set out to achieve. We would need more time to decide if PM-JAY succeeds in reducing catastrophic expenditure among the poorest of the poor, but to do so it will need to overcome its apparent challenges in terms of covering the most vulnerable and solving the problem of inequitable healthcare in the count.

➢ CONCLUSION

From the above discussions it is very imperative that creating awareness about the various components of AB-PMJAY is very much needed. The duty of the Government does not end by just by implementing health insurance schemes. The health system should be regulated and higher amount of transparency and standardization needs to be ensured. Because in the words of Elizabeth Edwards "Successful health reform must not just make health insurance affordable, affordable health insurance has to make health care affordable".

Universal Health Coverage has become a key guiding target of health care across the world under Sustainable Development Goals to improve health of the global population and to overcome the scourge of medical related impoverishment. PM-JAY can be a success if funds are being managed appropriately and quality care is assured to the beneficiaries under the scheme. Both public and private sector should work hand in hand to carry the scheme forward. Health insurance schemes like these are essential in the developing world with new diseases being encountered on regular basis.

➢ RECOMMENDATION

PMJAY focus on comprehensive primary health care rather than disease specific and reproductive and child health. Lessons from successful countries and strategies such as prior experimentation, pay-for-performance, good information system and strong verification process could be followed to achieve the goal of Universal Health care affordable to all.

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[49] *NITI Aayog Mulls Healthcare System for Middle Class*, Business Today (18/11/2019), available at https://www.businesstoday.in/latest/policy/story/niti-aayog-mulls-healthcare-system-for-middle-class-238761-2019-11-18