POLICY BRIEF

#04

IMPLEMENTATION PROCESSES OF PUBLICLY FUNDED HEALTH INSURANCE SCHEMES IN INDIA—KEY LEARNINGS & IMPLEMENTATION CHALLENGES

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Background

Achieving Universal Health Coverage (UHC) in India is constrained by inadequate financial protection to a majority of its population who incur huge out-of-pocket expenditure (OOPE) at the point of care. OOPE that stands at 63.2% of current health expenditure has pushed millions of people to poverty—estimates ranging from 32 to 55 million. Despite high economic growth witnessed during the past several years, public health spending has remained low (1.28% of GDP) compared to many developed and developing countries of the world. In the past, both union and state governments introduced innovative financing schemes including RSBY by the union government, Rajiv Arogyasri by Andhra Pradesh, Yeshasvini in Karnataka and Comprehensive Health Insurance scheme (CMCHIS) in Tamil Nadu, to protect the vulnerable households from catastrophic health expenditure and increase access to care. Even though many states and union government have introduced publicly financed health insurance schemes, the coverage as well as financial protection is inadequate. As per the world bank report, by 2010 around 25% of India's population had access to some form of health insurance.

Against this backdrop, in the year 2018, the Union Government launched Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), considered to be the world's largest health insurance scheme, which aims at providing financial risk protection to around 10.74 crore poor and vulnerable families with a coverage of INR 5,00,000 (USD 7000). Most states and union territories are implementing the PMJAY scheme with exceptions, viz. New Delhi, Andhra Pradesh, Odisha and West Bengal. A few states like Karnataka and Maharashtra have tailored the scheme as per their requirements.

Why Implementation Research

The success of any health insurance scheme to achieve the desired objective is largely dependent on robust planning, well defined processes related to enrolment, empanelment, claims settlements, referral mechanism, quality control and meaningful interaction among various stakeholders –payers, providers and patients and finally acceptance of the programme by the community. The Implementation research provides an opportunity to describe the services that are delivered taking into the consideration of content, quality, quantity and the structure of services that a program is intended to deliver and the extent to which the targeted population receive the intended services. The PM-JAY is nearing to complete its second year and is at an evolving stage, implementation research can help examine the implementation models as well as successes and challenges associated with delivering services as designed. Largely, the local context influences the implementation design and this can be documented by understanding the reasons for, types of and results of such adaptations. Moreover, the findings from implementation research could help to introduce course corrections and improve the program design.

KEY MESSAGES

- High out-of-pocket expenditure (OOPE) leading to inadequate financial protection for a large section of the population constrains the achievement of Universal Health Coverage (UHC) in India.
- In this study, realist evaluation technique was used to understand program implementation, what works in which context and what is the mechanism of implementation across the states of Chhattisgarh, Karnataka and Odisha.
- The three states follow diverse implementation processes to run the corresponding schemes. The study suggests that scope exists for these states to learn from each other in order to improve the implementation process and reach of the scheme.
- Odisha's scheme is more universal in nature, whereas in Chhattisgarh and Karnataka, the scheme covers BPL population and partial financial coverage to APL population.
- Robust referral mechanism is in place in the three states. However, a review is suggested to improve utilization.
- Grievance redressal process needs to be streamlined in Odisha taking lessons from Karnataka for instance, which has better systems and long experience in managing insurance schemes.

Methodology

Realist evaluation technique was used to understand how the program is implemented, what works in which context and

what is the mechanism of implementation across three diverse Indian states namely- Chhattisgarh, Karnataka and Odisha. Karnataka and Chhattisgarh are implementing PMJAY scheme whereas, Odisha is implementing a state sponsored health insurance scheme- Biju Swasthya Kalayan Yojana (BSKY). Qualitative interviews were conducted with different stakeholders associated with the scheme design, implementation and delivery of services. Program and policy guidelines were reviewed and claims data were analysed. Three distinct processes—referral, payment and grievance mechanisms—were studied in detail.

Patient's perception about the quality of care and their experiences on the services availed through PMJAY could not be explored as part of the exit interviews due to the COVID-19 pandemic which affected data collection process.

The study was conducted from August 2019 to October 2020.

What works in which context?

Referral process

- In Chhattisgarh, limited availability of private hospitals has led to free access to public and private hospitals with moderate restrictions on referral, whereas in Karnataka, adequate number of private hospitals has resulted in implementation of strict mechanism of referral. In Odisha, there are limited restrictions and defined referral packages for accessing services from private hospitals.
- Well defined referral processes implemented across states strengthens the gate-keeping mechanism and helps in checking unnecessary utilization of the scheme in three states. The practice of visiting the district headquarter hospital for referral advice sometimes delays the process in Odisha especially for beneficiaries located far away from the district hospital. Similarly, in Karnataka, the issuing of referral letter may be delayed in case of unavailability of specialist/medical superintendent of the government hospital.

Payment Process

- In Karnataka, there are different package rates for public and private hospitals, whereas in Chhattisgarh, there is no difference in package rate for public and private hospitals. In Odisha, there are no package rates for public hospitals and this is only applicable for private hospitals. In terms of mechanism of implementation, online platforms, standard SOPs and standard treatment guidelines are available across three states.
- The pre-authorisation processes based on package rates in Odisha (compulsory pre auth > INR 10,000) and mandatory pre-authorisation for all packages in Karnataka and Chhattisgarh along with well-defined IT platforms and SOPs are helping timely payment and control of medical costs. This could have an impact on the higher participation of private sector in the scheme in these two states. However, in Odisha, in spite of different well laid down processes, delay in payment as indicated by private providers has been a major concern.
- It is also observed that claim processes get delayed because of failure to submit appropriate documents on time by the private hospitals and this is more or less observed in all three states. Further, findings from Chhattisgarh and Odisha suggest that private hospitals accept deposits in advance from patients for any delay in pre-auth process causing difficulty in utilisation.

Grievance redressal process

- There are wide variations in the context and mechanism of implementation across three states. Karnataka and Chhattisgarh being the PMJAY states, structures and systems are in place for grievance redressal. Well organized State and District Grievance Redressal Committees (SGRC and DGRC) are helping these two states to resolve grievances at the district level. In comparison, in Odisha, the systems and structures are not yet developed fully to address grievances.
- In Chhattisgarh and Karnataka, there is an online platform and tracking mechanism to monitor the progress of grievances registered. This is helping the two states to control frauds and address the concerns of both beneficiaries and providers in the scheme

Go to the next page for flowcharts showing payment process and grievance redressal process

Figure 1: Payment Mechanism

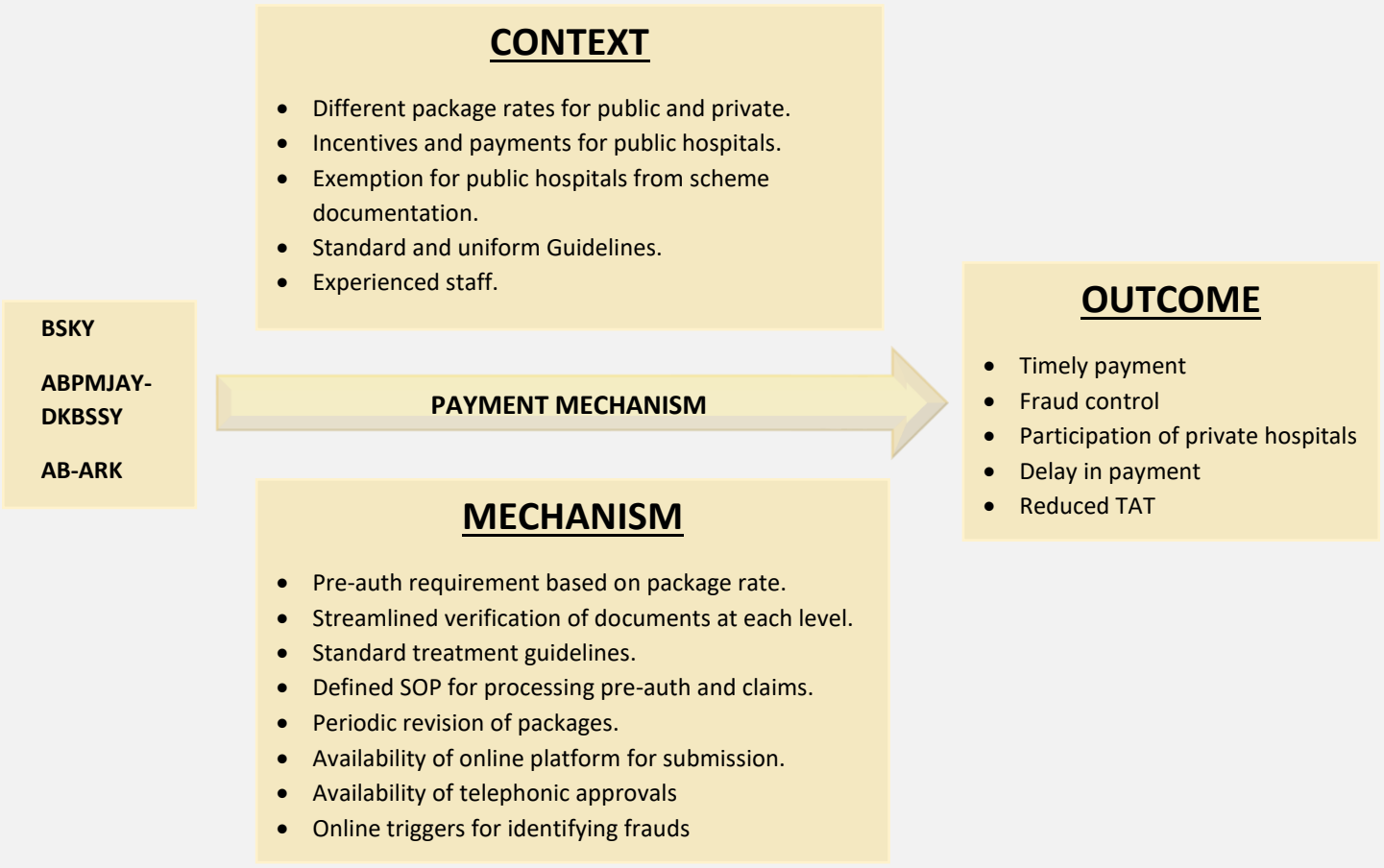
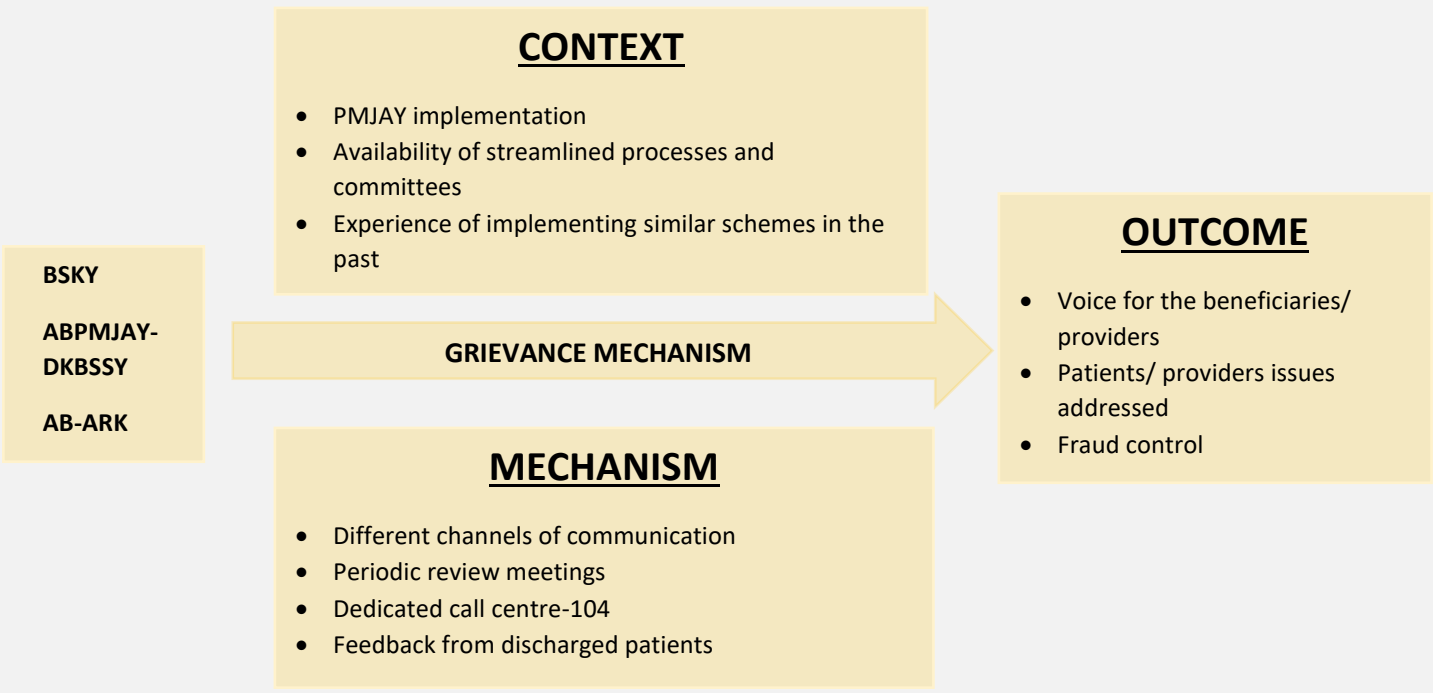


Figure 2: Grievance Mechanism



BSK-Biju Swasthya Kalyan Yojana-Odisha; ABPMJAY-DKBSSY- Dr. Khoobchand Baghel Swasthya Sahayata Yojana (DKBSSY)- Chhattisgarh; AB-ARK- Ayushman Bharat- Arogya Karnataka- Karnataka; SOP- Standard Operating Procedures; TAT- Turn Around Time

Implementation Considerations

Chhattisgarh, Karnataka and Odisha follow diverse implementation processes to run the corresponding schemes. There is scope for these states to learn from each other in order to improve the implementation process and reach of the schemes. Based upon the evaluation, the following policy recommendations are made:

- The referral mechanism can be streamlined, across the three states. In Karnataka, the beneficiary identification and mismatch of data in BPL and Aadhaar card needs to be looked into. In Odisha, referral advices only from DHH is creating delay in accessing services. To overcome these challenges, referral advices from hospitals below DHH level in Odisha and accepting other government issued IDs in Karnataka can be considered.
- Many private hospitals realize deviations in the payment compared to what was approved during pre-authorization process. Necessary steps should be taken to scrutinize the documents at pre-authorization level so as to avoid any deviation in the payment during final claims settlement. T enabled payment procedures should be strictly adhered in each stage of payment process to ease the process.
- The schemes can periodically orient the staff of empanelled hospitals about common mistakes during, uploading of appropriate documents and raising pre-authorizations and claims.
- The schemes can take necessary steps to discourage the practice of collecting money by private hospitals from the beneficiary as “deposit” due to delay in pre-authorization approval as well as rejection in some cases. This has been observed in Chhattisgarh and Odisha.
- Formation of grievance redressal committees at all levels can provide timely feedback to undertake course corrections.

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