A hospital for the patient

To incentivise adoption of Ayushman Bharat, government must address the operational dynamics of the scheme

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DESIGNING A GOVERNMENT-SPONSORED health insurance scheme for the poor is a challenging task. The ignorance of the poor and the information asymmetry between doctors and patients creates a fertile ground for denying benefits to the poor to serve vested interests. A recent report of deceiving poor patients in Safdarjung Hospital ('Bypassing Ayushman Bharat, doctor at top govt hospital duped patients, made killing on implants', IE, July 20) is one such example.

The report throws light on two facts about the Pradhan Mantri Jan Aarogya Yojana (PMJAY) scheme. First, it highlights the key role of the treating doctor in deciding the type of medical package to be booked for a patient, and whether a patient will be registered under a PMJAY package at all. Second, the report reveals how a doctor can mislead the patient on the premise that "Ayushman Bharat Clearance would take months."

As per the guidelines of the National Health Authority (NHA), a percentage share of the claim revenues transferred by the state health agency to public facilities is to be distributed among the medical personnel as staff incentives. This share could vary across states. Consequently, a treating doctor also receives a financial incentive. Yet, it may not incentivise a doctor adequately to register a patient in the scheme. The decision to book a medical package critically hinges on the financial incentives received by the doctor on treating a patient under the scheme vis-à-vis the financial gains from engaging in rent-seeking via alternative private channels. In the Safdarjung case, the financial benefits through the racket of private players outweighed the gains for the doctor from the scheme.

During April and May 2023, we visited 10 public facilities spread over three districts of Bihar. The facilities comprised three district hospitals, one medical college, four sub-divisional/referral hospitals, and two primary health centres. Our reflections are based on information collected for the 10-12 month period prior to the visit.

Contrary to popular perception, the time taken to settle claims in public facilities was not unduly high. Of the claims registered across all facilities, 54 per cent were settled. The average time taken for settlement of these claims was about 21 days.

However, there were indications of a lack of active interest in the scheme by the medical team in public facilities. District-level aggregate figures indicated that the proportion of claims settled in public facilities was significantly lower than their private counterparts. The settlement of claims requires appropriate documentation of the clinical activities of the patient and follow-up of queries (if any) raised by the state-level agency on the submitted claims. The relatively high share of unsettled claims in public facilities suggests that either the personnel in the public facility could not provide the required documentation within the designated period or did not take an active interest in following up with the queries. In either case, it mirrors a lack of active interest.

A host of factors within a public facility contribute to this lack of active interest by the medical team in the scheme. With relatively modest physical infrastructure and human resources, the medical team was often stretched with clinical activities. The only supporting staff for the scheme was an Arogyamitra, whose responsibility was to register patients under an appropriate package in consultation with the treating doctor. The Arogyamitra's remuneration was linked to the number of cases he can successfully register under the scheme (pre-authorisations), and not to the final settlement of claims. As a result, the Arogyamitra had little incentive to follow-up the claims with the required documentation at subsequent stages and ensure settlement.

The hospital staff had a greater stake in ensuring the settlement of a claim as it generates additional revenue for the facility. Moreover, the medical personnel treating the patient could receive a share of the funds reimbursed to the facility, which in turn could incentivise them to take a greater interest in the scheme. However, the overall quantum of revenue generated in these facilities was possibly not large enough to drive these incentives. Most facilities provided only selected services, which limited the potential revenues that could be generated from the scheme.

Addressing the incentive structure and operational dynamics of the scheme within public facilities can unleash the full potential of the scheme. An active interest in the scheme by public facilities can ensure a substantial volume of additional revenues, which could then be utilised for infrastructure development and establishment of better amenities setting in a virtuous cycle. The improved infrastructure could enhance the facilities' potential to cater to more packages and ultimately improve health coverage for the poor. This is in addition to ensuring that no poor person is excluded due to database errors in eligibility. Besides, state governments must play a complementary role by providing adequate manpower and enforcing accountability to ensure a higher volume of services in public facilities.

While much of the discussion on the potential of PMJAY has centred around private hospitals driven by profit motives, not much focus has been laid on the underlying operational dynamics in public facilities. This warrants earnest attention.

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