Working Paper - 019

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY): Design Contours, Emerging Patterns and Cost to the government

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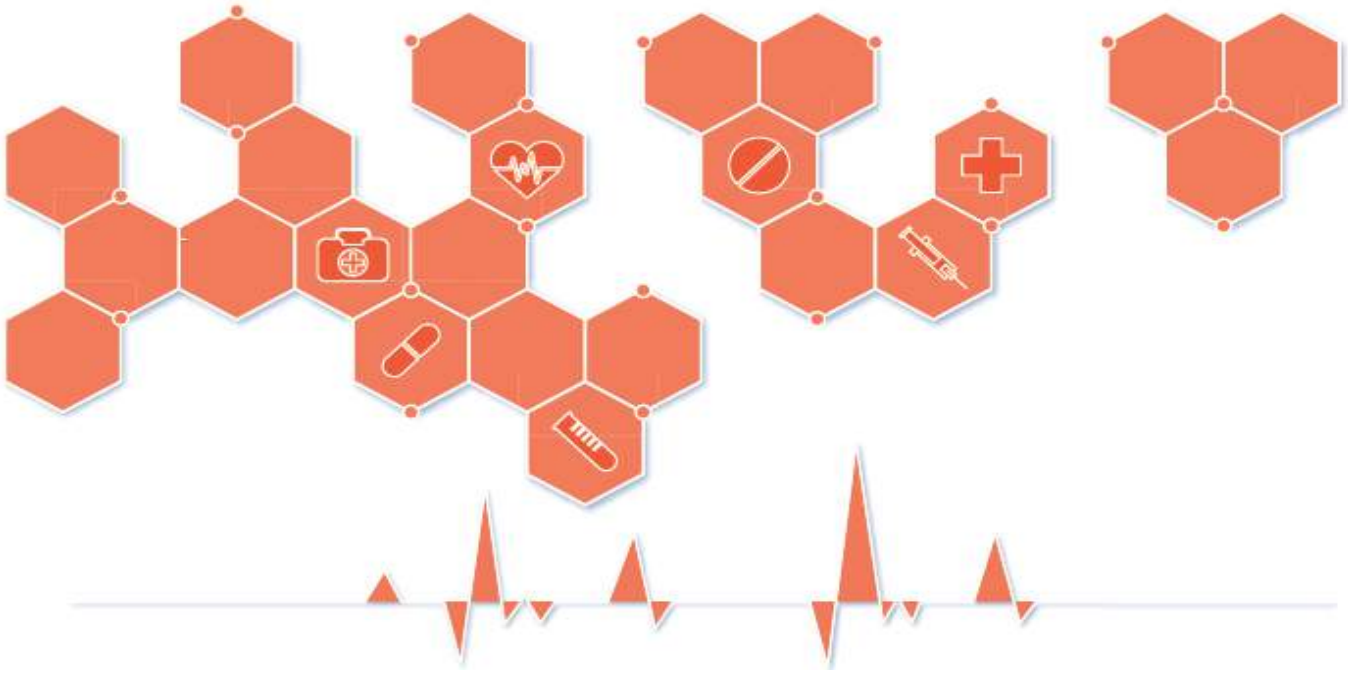

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Acknowledgements:

We are grateful to the National Health Authority for facilitating this study and sharing information for the analysis. We are particularly thankful to Dr. Ruchira Agarwal NHA, for coordinating the study. We also owe a special thanks to Dr. Nishant Jain for his insights during the conceptualization of this paper.

Abstract

This paper supplements emerging evidence on empanelment, claims and state specific models under PMJAY. The scheme has been able to provide significant insurance benefits for care at lower tiers of the health system pyramid. The enlarged benefits for lower levels of care have been facilitated by sizeable participation of secondary level public facilities and small to medium sized private hospitals. Further, various state specific models of public private engagement have unfolded within the skeletal umbrella model. In some States, despite a similar mix of public-private empanelment, claims in public *vs.* private facilities diverged significantly depending on the relative strengths of the two sectors. The differences in the maturity of health systems between EAG and non-EAG states have also led to a skewed incidence of insurance benefits in favour of the affluent States. Correspondingly, the distribution of fund transfers from the Union government on account of the scheme is tilted towards the well-off states. This is inconsistent with the 'equalization principle', which drive the rationale for resource transfers from Centre to States.

I. Introduction

The initiation of Pradhan Mantri Jan Arogya Yojana (PMJAY) was a landmark in expansion of publicly financed health insurance schemes (PFHI) in India. Launched in 2018, the scheme aimed at reducing financial hardships and impoverishment due to healthcare needs by expanding health insurance cover to the poorer 40 per cent of country's population. The then existing national scheme was limited in financial coverage, and state-level schemes were confined to their geographical limits. Health insurance cover for the poor was evidently inadequate as hospitalization rates were low among the lower economic strata and dependence of the poor on the public health system for inpatient care was high. Evidence also suggested that a substantial proportion of people were being pushed down below the poverty line due to out-of-pocket spending on healthcare. An enlarged domain of health insurance benefits was expected to relax financial constraints and ensure greater access to health care for the poor, which in turn could pave the way for universal health coverage.

The broadening of health insurance cover was expected to result in a pent-up demand for hospitalization among the targeted population. Consequently, the supply of health services had to be stepped up. Public systems were perceived inadequate and roping in the private sector was deemed necessary to meet the anticipated rise in demand. The involvement of private facilities was backed by the rationale that at appropriate package prices, private health facilities would be willing to utilize their excess capacity to complement the public health system. In areas where private facilities were not sufficiently available, it was presumed that business interests would steer greater participation by the private sector in delivery of hospitalized care.

Emerging evidence suggests that the uptake of the scheme has been comparatively low in States with high needs, i.e. with high poverty rates and disease burden (Smith et. al. 2019a). The higher penetration of the scheme in well-off States has been attributed to the fact that many of them had prior experience of PFHI schemes (referred to as 'brownfield States') and have better state capacity (Smith et. al. 2019a). The wider availability and spread of the private sector in these States combined with relatively better public health systems also provide a stronger supply-side infrastructure for operating the scheme (Choudhury and Datta 2020). The low penetration of the scheme in backward regions of the country is also mirrored in the fact that the volume of claims and empanelled hospitals is particularly low in the 'aspirational districts' of the country (Smith et. al. 2019b). Further, as of May 2019, bulk of the claims were not very high in value (Dong et. al. 2019). Only about 7 per cent of all claims in the country had a value of more than Rs. 30,000, and

about 1 per cent more than 1 lakh. These high value claims were skewed towards 'brownfield' States and tertiary and surgical care (Dong et. al. 2019). There were also indications that the high value claims were concentrated in a few districts and hospitals (Dong et. al. 2019). This is consistent with the evidence that specialized tertiary care hospitals are concentrated in selected districts of States (Choudhury and Datta 2020). Also, the degree of regional concentration of specialized hospitals is higher in poor States of the country than more affluent ones (Choudhury and Datta 2020).

This paper outlines the growth of PFHI schemes in India and delves deeper into the analysis of empanelment and claims under the scheme at the State-level. In addition, it highlights state-specific models emerging across States in India and gives an overview of the cost to the Union government and resource distribution to States on account of the scheme.

II. The Landscape of Publicly Funded Health Insurance Schemes in India

a. The Expansionary Phase

Two significant PFHI schemes were initiated in India in 1950s: Employees' State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS). In 1952, ESIS was initiated to provide health insurance benefits to factory workers and was funded by contributions from both the employees and the employers. CGHS was initiated in 1954 and was meant to cover a specific segment of the formal sector - Central government employees. Together in 2021, these schemes covered less than 10 per cent of India's population.

In the last two decades, there has been a rapid expansion of PHFI schemes for the poorer sections of the country's population. In 2003, the Ministry of Finance initiated a partially subsidized Universal Health Insurance Scheme (UHIS) to improve access to healthcare. Although the scheme was initially universal in nature, it was later targeted exclusively at the BPL population. It was implemented by public sector insurance companies and provided an insurance cover up to Rs. 30,000 per family on a floater basis.

Around the same time, a state subsidized health insurance scheme Yeshasvini, was initiated in Karnataka for co-operative farmers. Between 2007 and 2009, four major PFHI schemes were initiated in the States of Andhra Pradesh, Kerala, Karnataka and Tamil Nadu. In 2007, Andhra Pradesh, launched the 'Rajiv

Aarogyasri' scheme for secondary and tertiary level hospitalization. Initially rolled out in three districts, the scheme gradually expanded to cover about 86 per cent of the State's population by 2013. In 2008, Kerala initiated the Comprehensive Health Insurance Scheme (CHIS) and CHIS plus. Similarly, in 2009, Tamil Nadu started the Chief Minister's Kalaignar Health Insurance Scheme, which was later expanded substantially in 2012 and renamed Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS). Subsequently, in 2016, around 65 per cent of the State's population was covered under the scheme. In the same year, the government of Karnataka introduced Vajpayee Aarogyasri for the BPL population. Initiated in six districts, the scheme eventually expanded to cover the entire state by 2012. The schemes in both Tamil Nadu and Karnataka were largely targeted to cover the expenses related to high-end specialized healthcare procedures.

b. Rashtriya Swastha Bima Yojana (RSBY) and State level Schemes

In 2008, the first pan India fully subsidized health insurance scheme for the poor and informal workers - the Rashtriya Swasthya Bima Yojana (RSBY) was launched by Government of India. Unlike the earlier UHIS scheme where individuals were required to contribute a subsidized premium for the scheme, the premium in RSBY was entirely contributed by the government of India. The scheme was largely implemented through insurance companies and each BPL family was extended an annual hospitalization cover of Rs. 30,000 for five members on a floater basis. The entitled families had to pay Rs. 30 to get enrolled under the scheme with a smart card. It also provided some cover for costs related to transportation, pre-hospitalization diagnostics and post-discharge treatment. Unlike the state-level PFHI schemes which mostly covered tertiary care, the national scheme RSBY covered secondary level hospitalization care. Some States topped up the national–level scheme RSBY to provide cover for expanded population groups and disease conditions, particularly critical care. The scheme underwent a rapid expansion: from 2 states in 2008 to 28 states in 2013.

State-level PFHI schemes and RSBY had a few features in common. Both of them exclusively targeted to the poorer sections of the population with the premium contribution entirely subsidized by the government. While RSBY targeted the poor and informal workers across the country, state-level schemes covered similar population groups within States. In addition, both the state-level PFHI schemes and RSBY, issued smart cards to beneficiary family for accessing the benefits of the scheme.

There were also distinct differences between RSBY and PFHI schemes at the state level. Unlike the state-level PFHI schemes, which mostly covered tertiary care, the national scheme RSBY extended cover for secondary level hospitalization care. Correspondingly, the financial cover in most State-level PFHI schemes was far higher than RSBY; in State PFHI schemes, the family cover ranged between Rs. 70,000 in Kerala to Rs. 3,00000 in Rajasthan, while in RSBY, the coverage was limited to Rs. 30,000 per family[1]. Also, RSBY was predominantly implemented through insurance companies, while state-level PFHI schemes were mostly implemented through trusts set up for the purpose, particularly as the scheme matured. Moreover, in the case of RSBY, States bore only 25 per cent of the cost of the scheme, while the remaining 75 per cent was borne by the Central government.

The evidence on the effectiveness of RSBY and State-level PFHI schemes in reducing out of pocket expenditure on health was mixed. Much of the evidence suggested that RSBY did not result in a significant reduction in out-of-pocket spending on healthcare. It was argued that the realization of latent demand was partially responsible for this. The low financial coverage and the cap of five members for insurance in a family were also seen as impediments to reduction in OOPE. In addition, there was evidence of low level of awareness about the scheme among the poorer sections of the population.

c. The Ayushman Bharat – Pradhan Mantri Jan Aarogya Scheme (AB-PMJAY)

Building upon the momentum of RSBY, the government of India initiated an enlarged and modified version of the scheme, AB-PMJAY. The extent of financial coverage under the insurance was enhanced substantially: Rs. 5 lakhs per family without any restriction on family size. With augmented coverage, insurance coverage was extended for both secondary and tertiary care procedures. Benefits were extended to the poorest 40 per cent of the country's population, who were predominantly identified through the socio-economic caste census (SECC). Unlike RSBY, wherein the enrolment drive was through issuance of smart cards, the inclusion of the poor in AB-PMJAY was based on entitlement. All entitled families were automatically covered under the scheme[2]. A country-wide nodal agency 'National Health Authority' (NHA) was also setup to coordinate the implementation of the scheme[3]. This is also in contrast to RSBY, where

[1] Some of the states which implemented RSBY however, topped up the scheme with extended cover for critical care.
[2] In RSBY, prior issuance of a smartcard was mandatory to get enrolled in the scheme.
[3] NHA is currently an office attached to the Ministry of Health and Family Welfare (MoHFW) with complete functional autonomy on implementation of the scheme.

the scheme was directly operated by the Ministry of labour and Employment in the initial phase and later by the MoHFW. Further, the cost of the scheme was currently shared between the States and the Centre in the ratio of 60:40 for most States (90:10 for north-eastern and three hilly states). This is marginally more loaded towards the states than RSBY, where cost sharing between the Centre and States was in the ratio of 75:25.

Various flexibilities were also imparted to States under the new scheme. States could expand the population coverage under the insurance scheme at their own cost. Following this, many of the existing State-level insurance schemes were merged with AB-PMJAY to provide increased coverage. In addition, States were provided the flexibility to choose the mode of implementation of the scheme. They could implement the scheme through the trust mode, through insurance companies, or a hybrid model of the two. As of March 2020, 21 States/UTs were implementing the scheme through trust mode, 7 in insurance mode and 4 in hybrid mode.

III. Database and Methodology

Data for the study was provided by the National Health Agency (NHA). The information was based on the empanelment and claims status as on 31st March 2020. The database consisted of information on 21, 829 empaneled hospitals across states and districts by type (public and private) and claims by type of hospitals and specialty. Information on the number of beds in each hospital (an indicator of size) was also available in the database for about two-thirds of the private hospitals. No bed information was available for public hospitals. Four states which either opted out of the scheme or were in the initial stages of implementation of the scheme at the reference point of time[4] were excluded from the study. These include Delhi, Telangana, Odisha and West Bengal. The state of Rajasthan was also in the initial stage of implementation and empanelment and was excluded in the detailed analysis. In addition, small UTs in terms of population size (Lakshadweep, Andaman and Nicobar Island, Dadra and Nagar Haveli and Daman and Diu) have been excluded from the study.

Using information provided in names of health facilities provided by NHA, and lists of public facilities provided by state governments, we classified public hospitals into different types: Primary Health Centers

[4] 31st March 2020

(PHCs), Community Health Centers (CHCs), Sub-District Hospitals (SDHs), District Hospitals (DHs), Medical College and Tertiary Hospitals (MCTs) and other Government Hospitals (OGHs). The Sub-District Hospitals (SDH) include hospitals which are larger than Community Health Centres but smaller than District Hospitals and include sub-divisional hospitals, area hospitals, taluk hospitals and rural hospitals. Other government hospitals comprise of highly specialized facilities, which do not fall into any of the other categories viz., mother and child health centers or eye care centres. Different types of public hospitals cater to distinct size classes and is helpful in understanding the pattern of empanelment and claims by size of facilities. For private hospitals, we use information on number of beds to undertake size-class analysis. Private hospitals with missing bed information (about 34 per cent) had to be excluded from this part of the analysis. The use of a limited set of private hospitals for size-wise analysis must be borne in mind while interpreting these results. Also, for private hospitals, the nature of data provided by NHA did not facilitate cross-mapping of claims by size and specialty.

Information on district-level eligible beneficiaries was not available at the time of analysis. This constrained exploration of the pattern of empanelment and claims vis-à-vis the spread of eligible beneficiaries within States (district-level). At the State-level, beneficiaries included families identified through the Socio-Economic Caste Census (SECC) as well as additional families identified in States for coverage under PMJAY.

For assessing the cost to the government on account of the scheme, we focus exclusively on releases by the Union government. The State's share of releases towards the scheme was not distinctly documented in all State budgets at the time of this analysis. This restricted our attention to releases of the Union government. Given that the State shares would be proportional to releases of the Union government, the level and distribution of the cost of the scheme in the aggregate will not be very different from the pattern documented here.

IV. Empanelment and Claims: Public and Private Facilities

a. Public Empanelment

The shares of public and private facilities in both empanelment and claims were not starkly different under PMJAY. Public facilities accounted for 56 per cent of the empanelment and 47 per cent of the total number of claims under the scheme. The share of public empanelment was partly inflated by the

fact that in many states, primary health centers (PHCs) are automatically enrolled under the scheme. Despite the high share of empanelment, PHCs play a limited role under the scheme as their services are largely confined to primary care. PHCs constituted 42 per cent of public empanelment but accounted for only 5 per cent of total number of claims in public hospitals, and less than 3 per cent of all claims (Figure 1, Figure 2). The low share of claims can be partially attributed to the fact that the major focus of PHCs is primary care. Interestingly, the secondary health facilities in the public system were remarkably active in terms of the share in number of claims registered. They accounted for nearly half the total number of claims in public facilities and marginally less than a quarter of all claims in the country (Figure 2). In particular, the district and sub-district hospitals played a prominent role. Together, they accounted for nearly 40 per cent of total number of claims in public facilities and around 20 per cent of all claims in the country (Figure 2). The share of claims in CHCs were relatively small as they offer only limited secondary healthcare services. Tertiary level public facilities accounted for 45 per cent of the total number of claims in the country (Figure 2). With relatively few in number, but large and specialized in nature, the volume of claims was accommodated. This is reflected in the fact that nearly two-thirds of the total value of claims in public hospitals was registered in tertiary level public hospitals. Hospitals owned by Government of India (GoI), played a relatively insignificant role. They accounted for less than 0.5 per cent of total number of claims in the country and had a share of 5 per cent in empaneled public hospitals.

Figure 1: Distribution of Public Empanelment

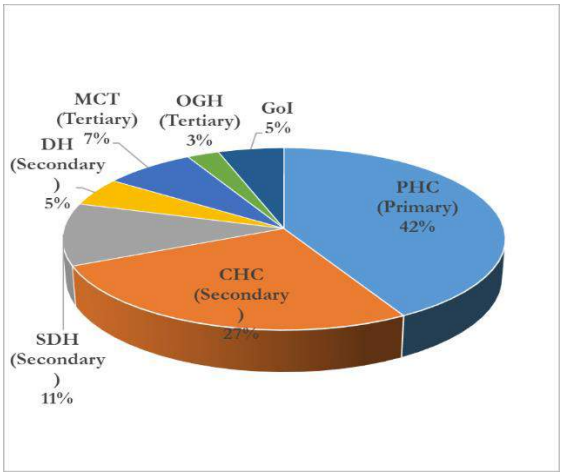


Figure 2: Distribution of Public Claims (Count)

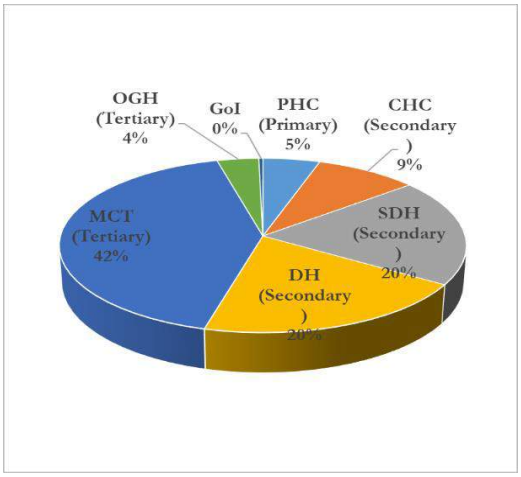


Figure 3: Distribution of Public Empanelment

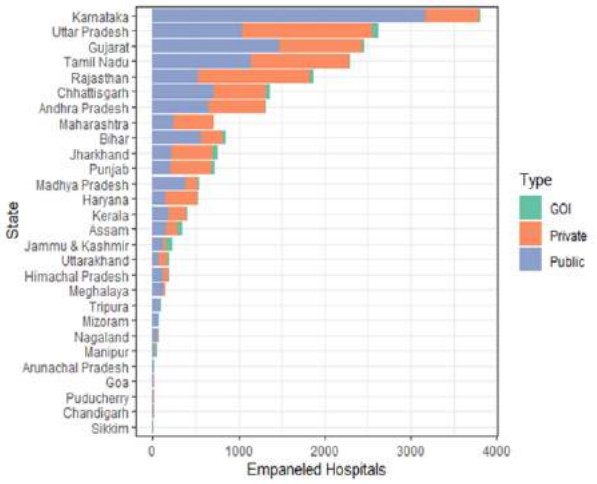
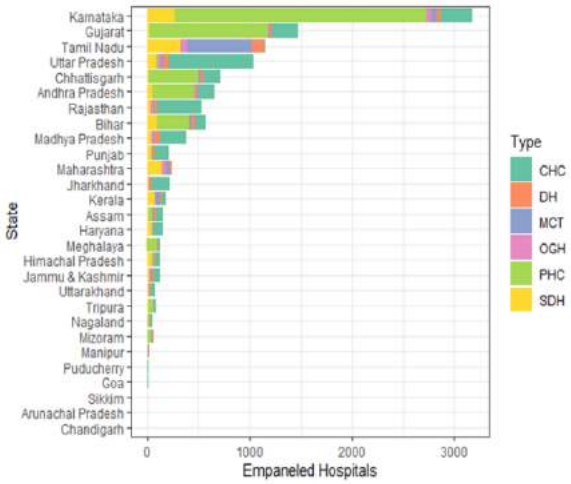


Figure 4: State-wise breakup of empaneled public hospitals



b. Private Empanelment

Most of the empaneled private hospitals were also relatively small to medium in size. In the absence of bed information for about 30 per cent of the empaneled private hospitals, the pattern of size distribution of private empanelment and claims can be stated with a lower degree of confidence. However, available information suggests that more than 70 per cent of the private hospitals which had bed information, were less than 50 bedded and nearly 50 per cent less than 30 bedded (Figure 5). The pattern was more reliable for 15 States, where bed information for more than 90 per cent of the empaneled private hospitals was available. In these States, 76 per cent of the empaneled hospitals were less than 50 bedded, and 57 per cent less than 30 bedded[5]. Notably, a significant part of private hospitals with missing bed information were confined to the major states of Tamil Nadu, Andhra Pradesh, Karnataka, Kerala and Gujarat. These hospitals with missing bed information also accounted for about 50 per cent of claims in private hospitals (Figure 6). This is indicative of the fact that private hospitals in these States catered to more specialized care and were relatively larger in size. Outside these states, empaneled private hospitals were small to medium in size.

[5] The 15 States include Assam, Bihar, Haryana, Jharkhand, Punjab, Uttar Pradesh, Sikkim, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura, Himachal Pradesh, Jammu and Kashmir and Chandigarh.

Figure 5: Distribution of Private Empanelment by Size

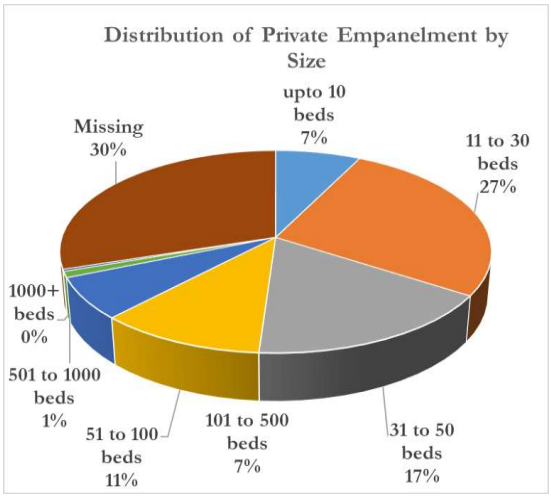
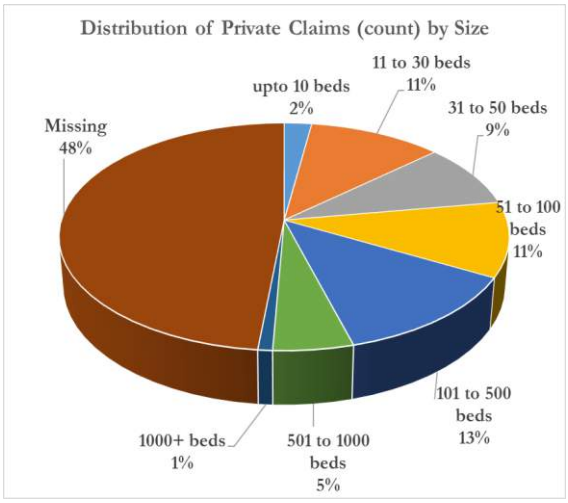


Figure 6: Distribution of Private claims (count) by size



c. Distribution of Empanelment and Claims across States

The scheme was particularly vibrant in better-off States of the country. The relatively rich non-EAG States of the country accounted for 60 per cent of the total number of claims under the scheme (Figure 7).[6] Of these, nearly 50 per cent were claimed in the four southern States of Tamil Nadu, Kerala, Andhra Pradesh and Karnataka (Figure 7). In terms of empanelment, the non-EAG states accounted for 56 per cent of the total, with the four southern States accounting for 36 per cent (Figure 7). Claims per eligible family was particularly low in the two non-EAG states of Gujarat and Maharashtra. Among the relatively poor EAG States, Chhattisgarh and Jharkhand has performed remarkably better than the rest (Figure 7). More than half the claims (count) in EAG States are in these states. Correspondingly, claims per eligible family is also among the highest in these two States within the group of EAG States (Figure 8). Strikingly, only 11 per cent of the claims in the country are in Bihar, Uttar Pradesh and Madhya Pradesh, the three EAG states which hold more than 26 per cent of the scheme's targeted families[7]. Consequently, claims per targeted beneficiary family is among the lowest in these States (Figure 8).

[6] This share could be partly skewed as States like Odisha, Rajasthan, Telangana and West Bengal are excluded from the analysis.

[7] As on 31st March 2020

Figure 7: State-wise share of Total Claims (by count) and Empanelment in the Country (per cent)

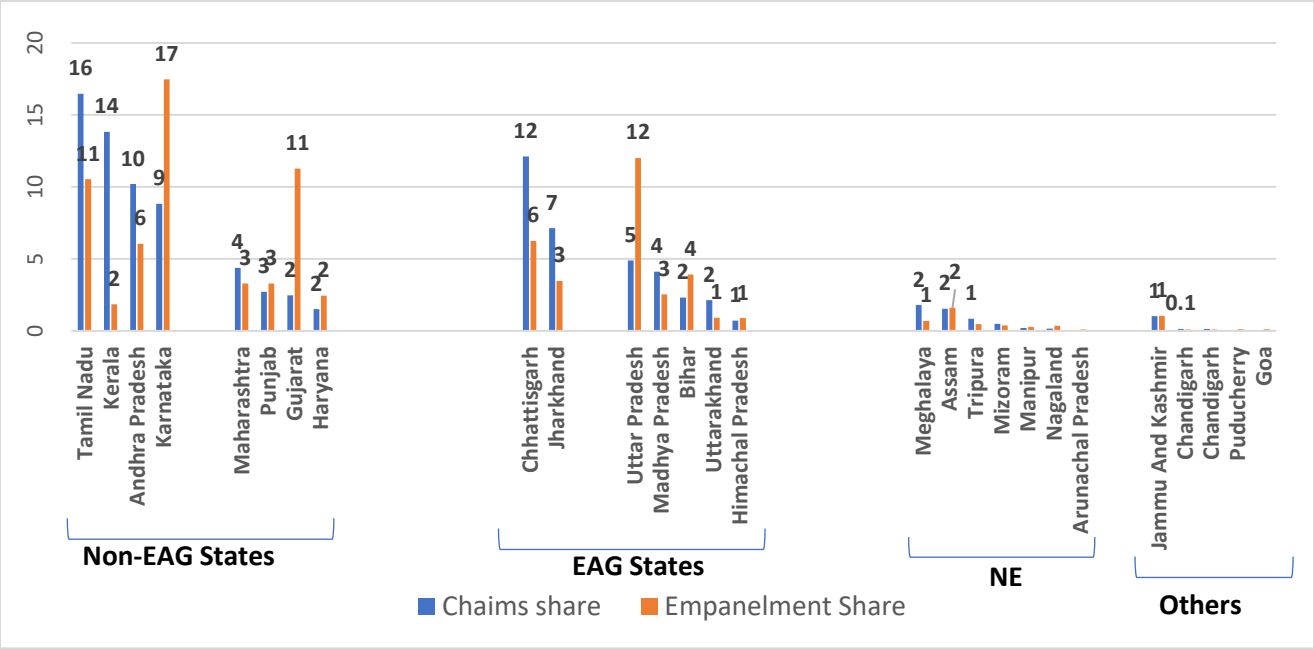
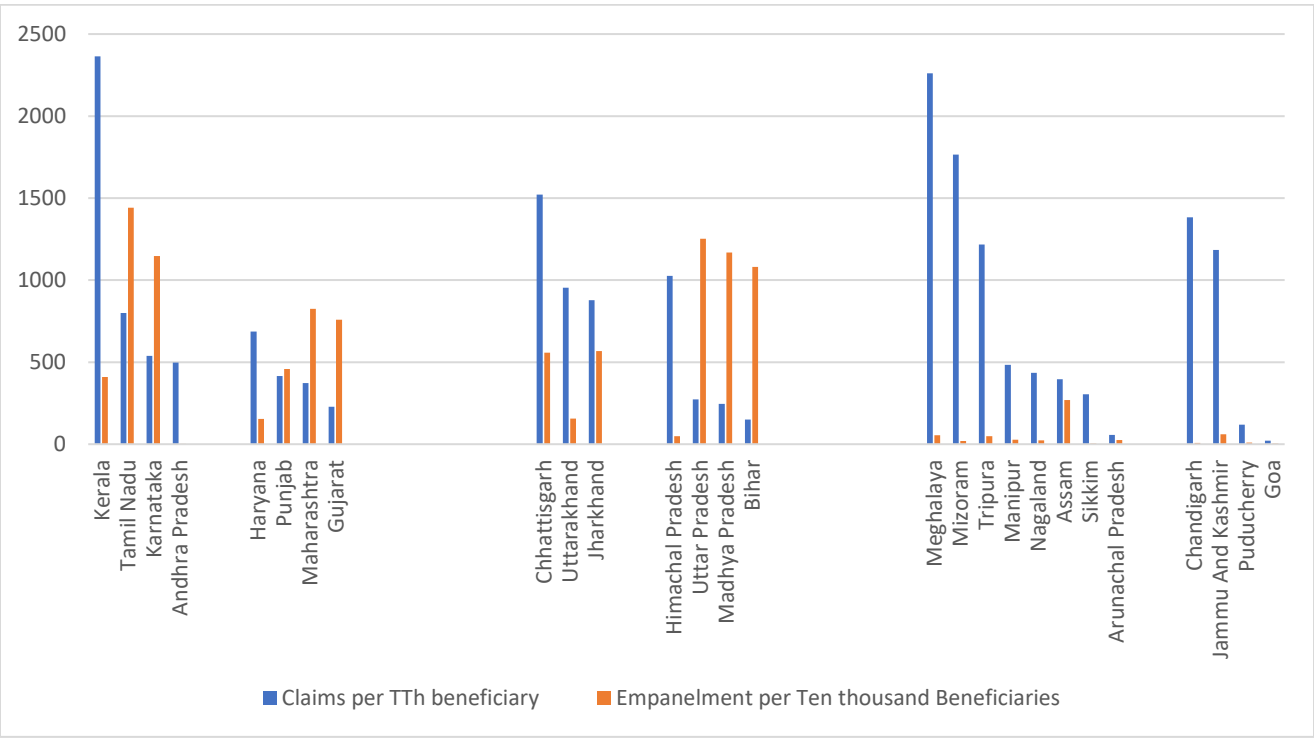
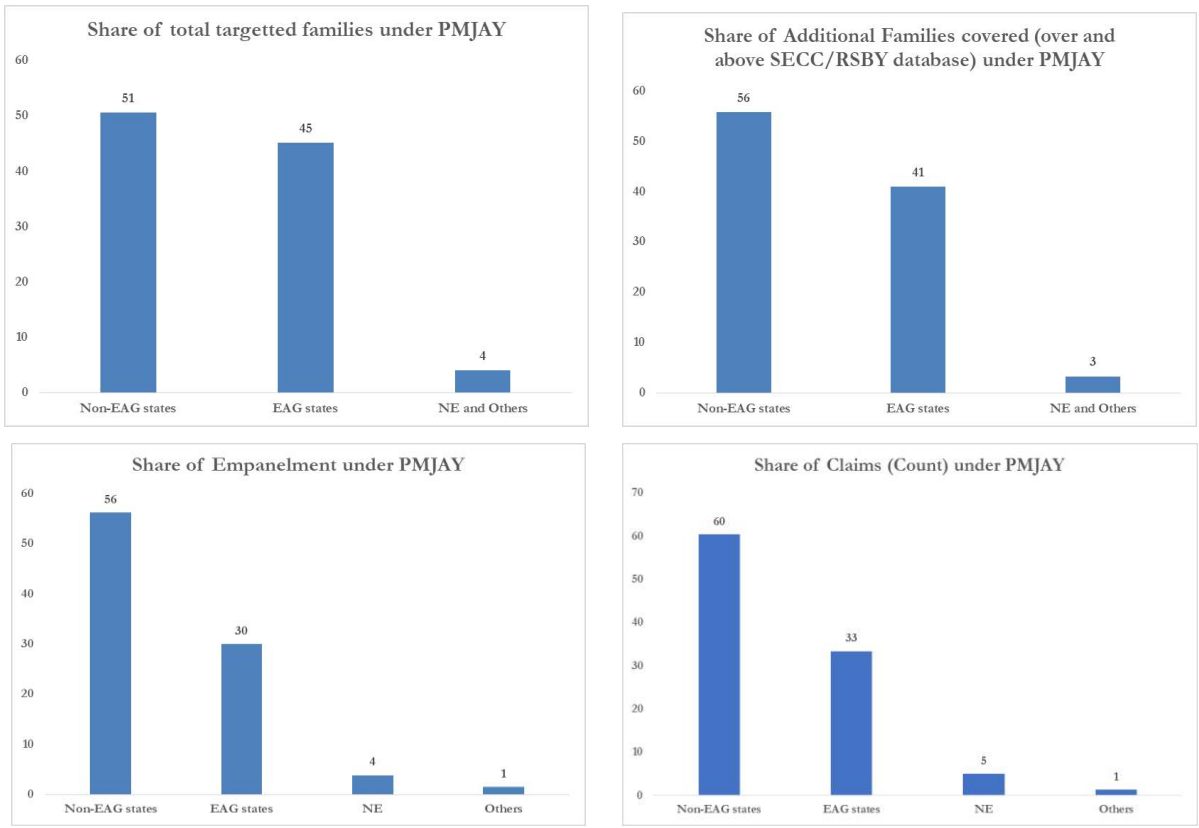


Figure 8: Number of Claims and Empanelment per Ten Thousand Beneficiaries



The concentration of targeted families under PMJAY in the non-EAG states is partly responsible for the high share of claims in these States. As of March 2020, half the targeted families under the scheme belonged to these States (Figure 9). This is partly because these states were more pro-active in extending coverage to additional families over and above those eligible as per SECC/RSBY database. The share of non-EAG states in total additional families covered across states in India (over and above SECC/RSBY), was about 15 percentage points higher than the relatively poor EAG States (Figure 9).

Figure 9: State of total targeted families under PMJAY



d. State health systems and Emerging models in States

Different models of public-private interplay have emerged in states depending on the specific structure of the health system (Refer figures of each state in Annexure). Despite a near about similar share of public empanelment in the three states of Kerala, Tamil Nadu and Andhra Pradesh, the distribution of claims was very different (Figure 10, Figure 11). In Kerala, around three-fourths of the claims were in public facilities. This is in contrast to Andhra Pradesh where only a quarter of the claims were in public facilities. The Tamil Nadu model was in between Andhra Pradesh and Kerala. In Tamil Nadu, public and private had a similar share in both empanelment and claims ((Figure 10, Figure 11).

Interestingly, in Karnataka, if one excludes the large number of PHCs empaneled, it exhibits a model like that in Kerala. The claims were heavily tilted towards public facilities. Similarly, the models were also starkly different in relatively poor states. In the two better performing states Jharkhand and

Figure 10: State-wise Share of Public and Private Empanelment

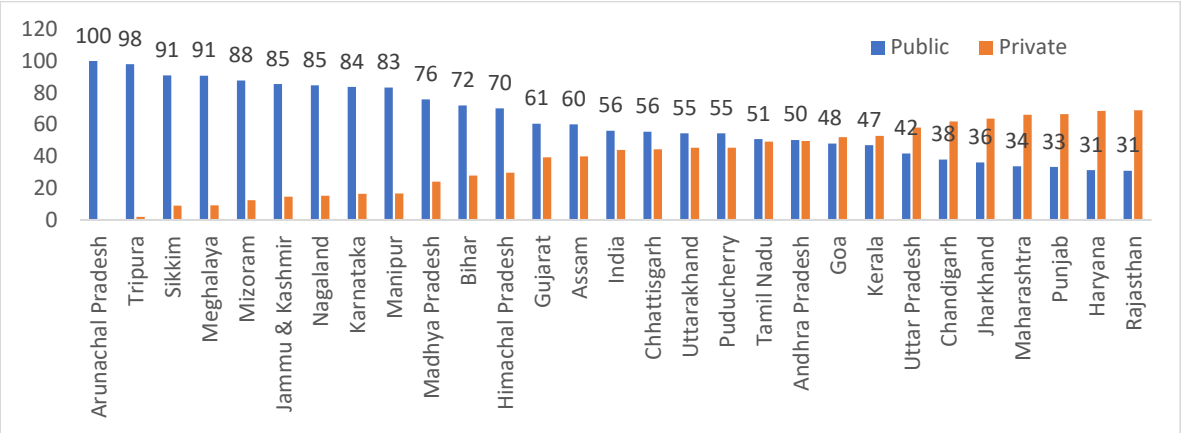
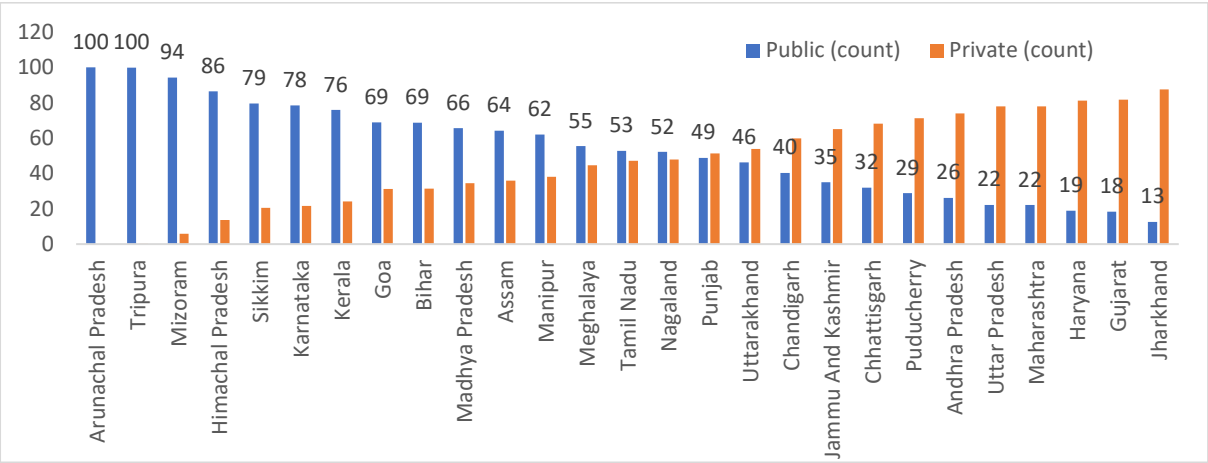


Figure 11: Share of Claims (count) in Public and Private



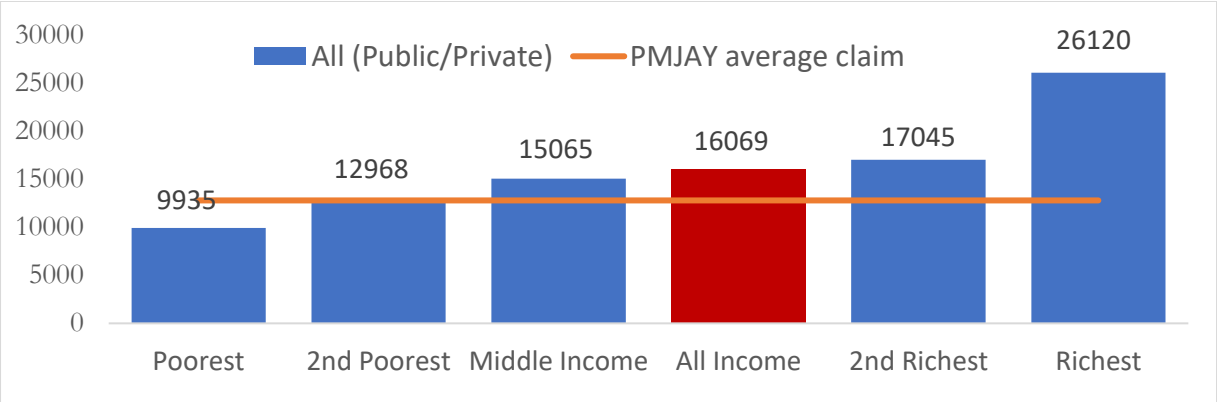
Chhattisgarh, if one excludes PHCs, both empanelment and claims were heavily skewed towards the private sector. In Uttar Pradesh too, private sector participation was higher than the public sector. About 57 per cent of empanelment and 87 per cent of claims were in the private sector. This is consistent with earlier evidence that the availability of the private sector was more in Uttar Pradesh than other EAG states (Choudhury and Datta 2020). In contrast, in Bihar and Madhya Pradesh, the dominant share of both empanelment and claims was in the public sector. Strikingly, about 25 per cent of the total number of claims in Bihar is in PHCs unlike any other State. In most of the north-eastern and hilly states of the country, bulk of the empanelment and claims were in the public sector.

In this regard, the only exception was Uttarakhand where the claims were marginally higher in the private sector.

e. Distribution and Size of Claims

Interestingly, a substantial number of claims under the scheme were for relatively lower-level health care services. This was unlike some of the earlier state-level government-sponsored health insurance schemes, which had a dominant focus on tertiary level care. In PMJAY, the four categories - general medicine, general surgery, OPD diagnostics and obstetrics and gynecology accounted for about 44 per cent of all claims under the scheme. The high share of insurance claims for relatively lower-level health services is a step in the positive direction. Specialized components like oncology, cardiology, cardiothoracic surgery/vascular surgery and neurosurgery accounted for only 10 per cent of all claims under the scheme. A similar share of claims (9 per cent) was towards ophthalmology and orthopedics. It must, however, be borne in mind that about 28 per cent of all claims could not be disaggregated by specialty and were classified as 'multi-specialty'.

Figure 12: Average cost of inpatient care per episode in different income quintiles, 2017-18, All India (Rs.)



Source: Authors' calculations based on unit-level data of the 75th round of Survey conducted by National Sample Survey Organization, 2017-18

Distribution of claim by amounts suggests that the size of claims in specialized components like oncology, cardiology, cardiothoracic surgery/vascular surgery and neurosurgery were substantially large. They constituted only 10 per cent of all claims by count, but 23 per cent by value of claims (Figure 13). In contrast, the components of relatively lower-level care (general medicine, general surgery, OPD diagnostics and obstetrics and gynecology) were comparatively small. Their share in total number of claims was 44 percent but constituted only 26 per cent by value of claims (Figure 13).

Variation in prices were higher for specialized components than for lower levels of care (Figure 14 a).

A cross-state comparison of average claim for accessing 'General Medicine' suggests that among the

Figure 13: Distribution of Claims

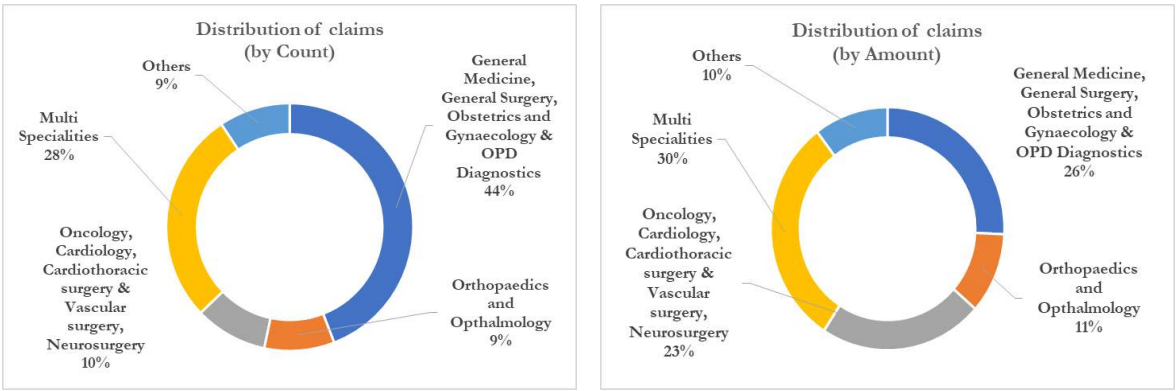
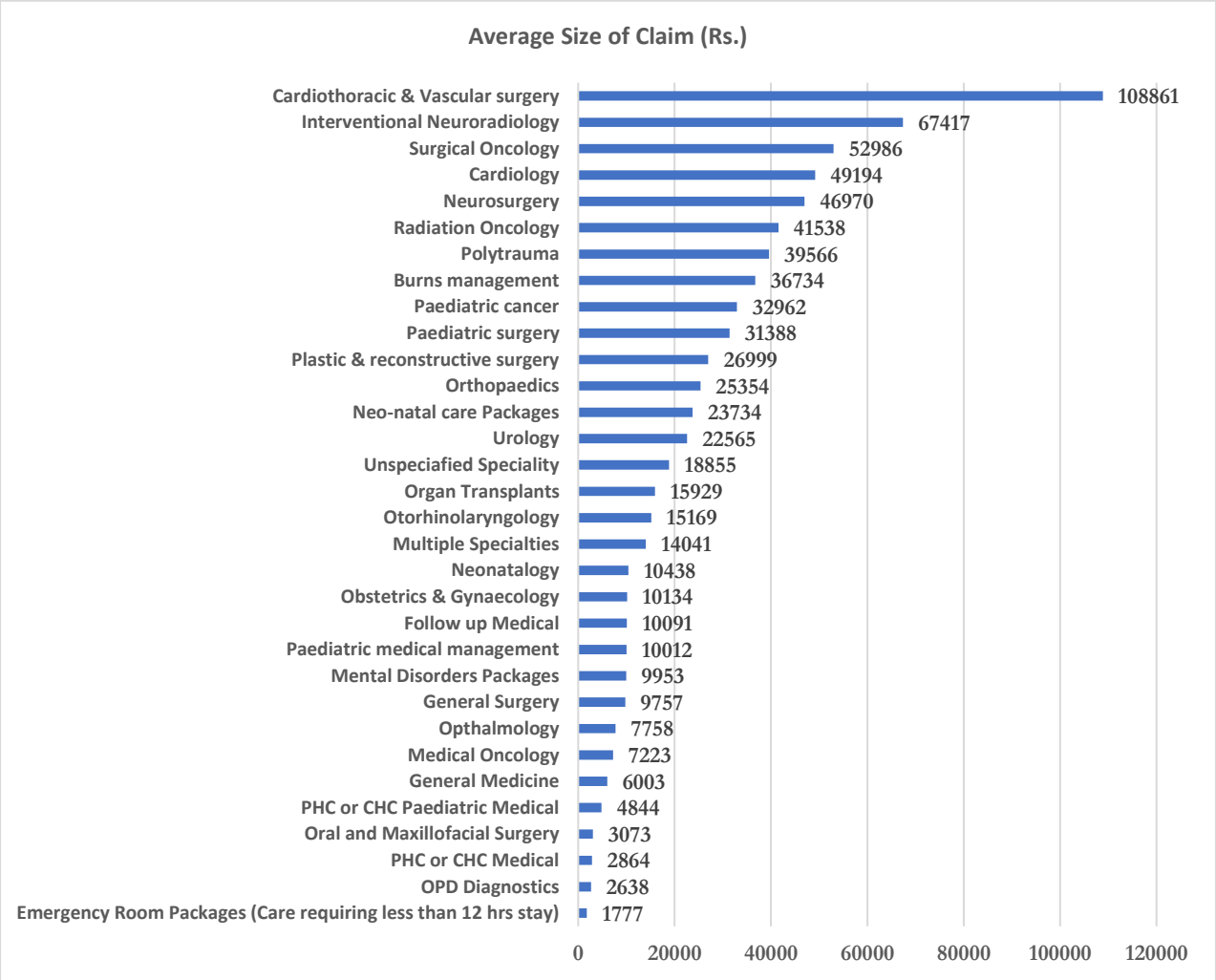
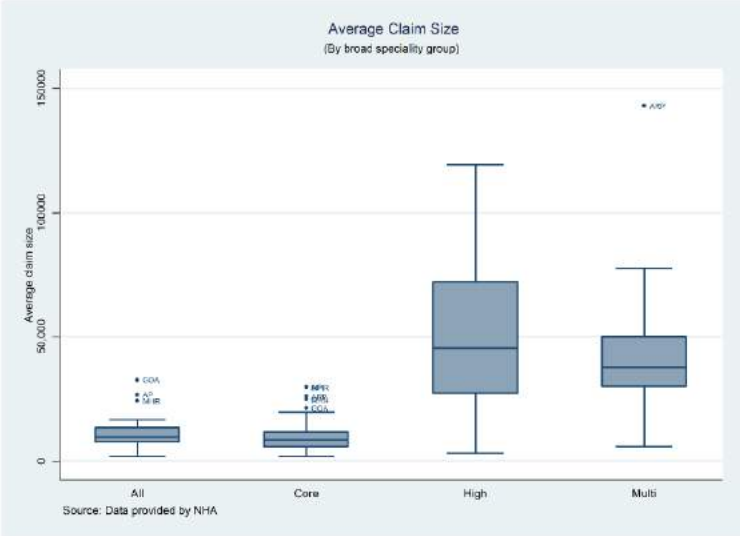


Figure 14: Average Size of Claims



major States, the cost is lowest in Kerala and highest in Andhra Pradesh (Figure14 b). Also, average size of claim for north-eastern region is also relatively larger (Figure 14 b). The average size of claims under PMJAY was about Rs. 12,800. This was around the average expenditure incurred per hospitalization episode by households in the 2nd poorest quintile as per the survey on 'Social Consumption: Health" conducted by the National Sample Survey Organization in 2017-18 (Figure 12).

Figure 14 (a): Average Claim Size (By broad speciality group)



Note: Core includes General Medicine, General Surgery, OPD Diagnostics, Obstetrics and Gynecology. High includes Cardiology, Cardiothoracic and Vascular surgery, Medical Oncology, Neonatology and Radiation Oncology. Multi is a mixed group of multispecialities.

Figure 14 (b): Average Claim Size in General Medicine (Rs.)

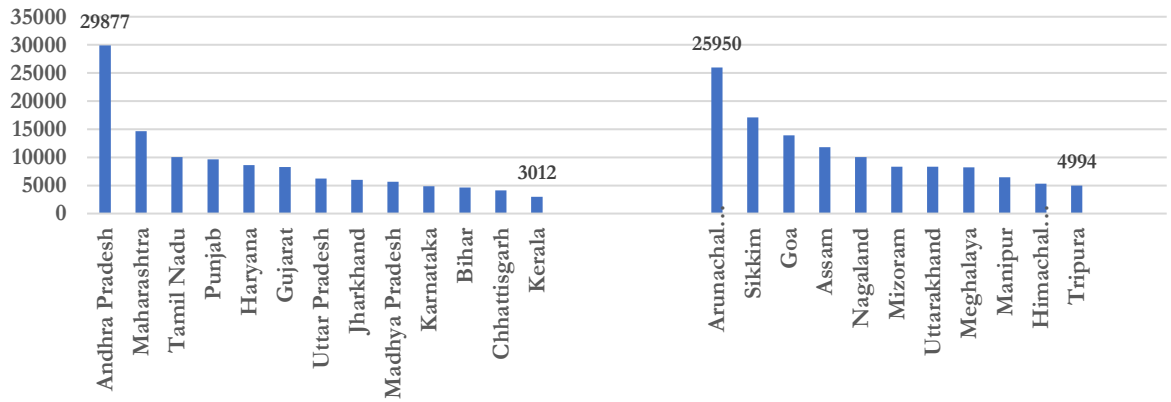


Figure 15: Private-Public Average Claim Size Ratio

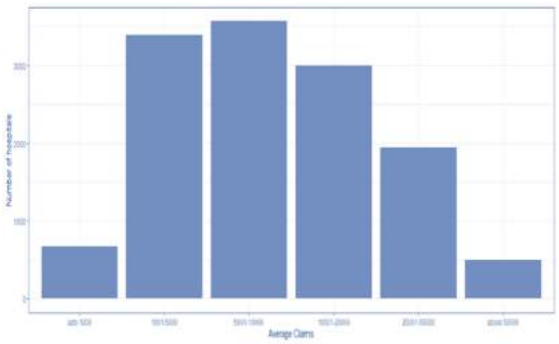
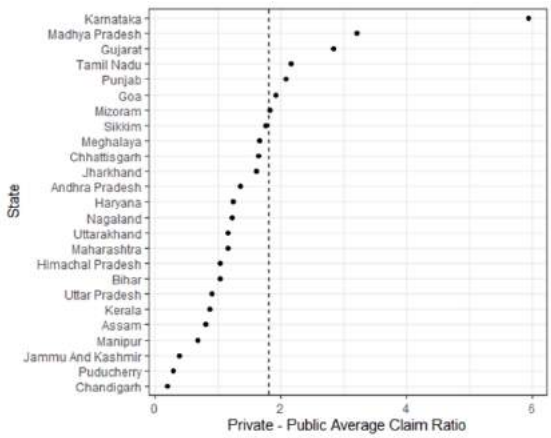


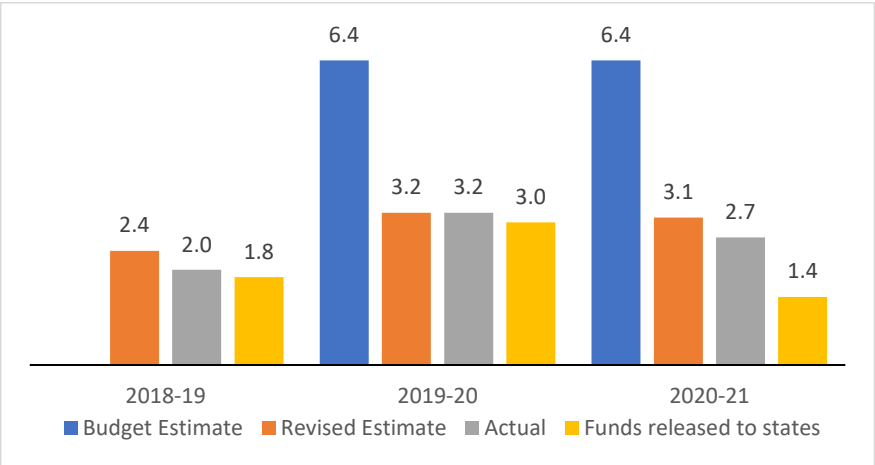
Figure 16: Distribution of Hospitals by Average Claim Size



V. Cost to the Government

AB PM-JAY is a centrally sponsored scheme where the cost is shared between the Centre and States in the ratio of 60:40 for states other than north-eastern and hilly states. For north-eastern and hilly states, this ratio is 90:10. State share of contributions to the scheme are not easily identifiable from state budgets, and therefore, the cost to the government had to be assessed through releases by the Union government to different States.

Figure 17: Resources directed to PMJAY by the Union Government (Rs. Crore)



Note: Union Budget Documents, various years

Figures reported in budgets of the Union government suggest that the actual expenditure on the scheme has been much lower than expected. In 2019-20 and 2020-21, the average actual expenditure (releases) by the Union government on the scheme was less than 50 per cent of the budgeted amount

(Figure 17). The dominant share of releases by the Union government was confined to the four southern states of Tamil Nadu, Andhra Pradesh, Karnataka and Maharashtra (46 per cent) (Figure 18). These states, together with Chhattisgarh accounted for more than half the total releases by the Union government (56 per cent) between the period 2018-19 and 2019-20 (Figure 18). Releases by the Union government in 2018-19 and 2019-20 (taken together)) was around Rs. 370 per beneficiary family.[8] Notably, the average amount released per beneficiary family was significantly lower than the national average in the states of Bihar, Uttar Pradesh and Madhya Pradesh. In contrast, in the states of Andhra Pradesh, Tamil Nadu and Maharashtra the releases per beneficiary family were higher than the national average.

Figure 18: Share of releases 2018-19 and 2019-20

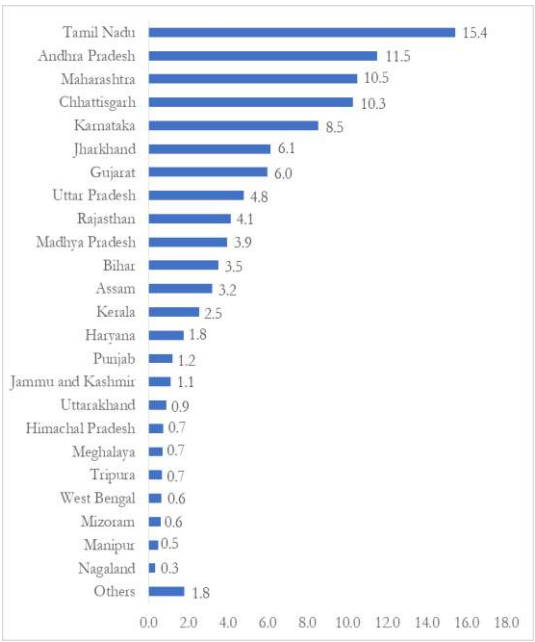
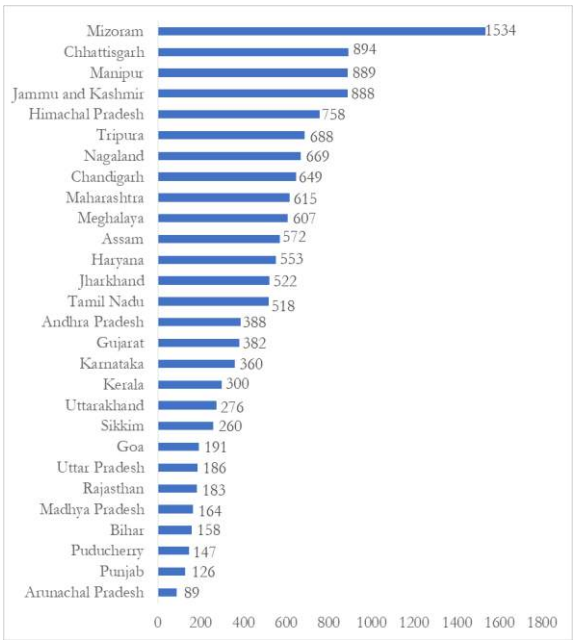


Figure 19: Releases in 2018-19 and 2019-20 per beneficiary family



[8] The figure of beneficiary family was as on March 2020.

The cost of the scheme has been relatively high in the better off states of the country where the presence of private sector is more vibrant and claims are high. In poor states like Bihar, Madhya Pradesh and Uttar Pradesh, the volume of claims is low and consequently, cost for the government is low. It must be borne in mind that the fiscal space available for health spending in poorer states of the country is low, and if the scheme picks up momentum in these States adequate fiscal space will be required to accommodate the additional cost of the scheme. Estimates suggest that if all the targeted beneficiaries are covered, estimates could range from Rs. 28,000 Crore to Rs. 74,000 Crore in 2019 and could be as high as 66,000 to 1,60,089 Crore in 2023 (XVth Finance Commission 2020). In the current state of maturity of the scheme, however, the fiscal burden is not a major concern.

Summary

- The study was based on information as of March 2020. At that point of time, the States of Delhi, West Bengal, Odisha and Telangana remained out of the scheme. Rajasthan was also in initial stages of implementation of the scheme and had limited information. In addition, the four UTs with small size of population Andaman and Nicobar Islands, Lakshadweep, Dadra and Nagar Haveli and Daman and Diu were excluded from the analysis. The exclusions need to be borne in mind while interpreting the findings.
- In PMJAY, both public and private facilities have played a near equal role in terms of both empanelment and count of claims. Within the public system, secondary health facilities have been remarkably active accounting for nearly half the total number of claims in public facilities. Small and medium size facilities accounted for the majority of claim counts within the private sector.
- The scheme has been able to provide significant insurance benefits for lower levels of care. About 44 per cent of all claims under the scheme were towards general medicine, general surgery, OPD diagnostics, obstetrics and gynecology.
- The average size of claims under PMJAY was about Rs. 12,800. This was around the average expenditure incurred per hospitalization episode by households in the 2nd poorest quintile in the survey on 'Social Consumption: Health" conducted by the National Sample Survey Organization in 2017-18.

- State-specific models of public-private interplay have emerged within the broad umbrella scheme of PMJAY. Despite a near about similar share of public empanelment in the three states of Kerala, Tamil Nadu and Andhra Pradesh, the distribution of claims was very different. In Kerala, around three-fourths of the claims were in public facilities. In contrast, in Andhra Pradesh, three-quarters of the claims were in private facilities. The Tamil Nadu model was in between Andhra Pradesh and Kerala. In Tamil Nadu, public and private had a similar share in both empanelment and claims. Interestingly, in Karnataka, if one excludes the large number of PHCs empaneled, it exhibits a model like that in Kerala.

- The scheme was more vibrant in non-EAG states than EAG states. More than 50 per cent of targeted families, 56 per cent of empanelment and 60 per cent of claims in the country belonged to the non-EAG states. Among the EAG states, Chhattisgarh and Jharkhand were comparatively more active than others; accounting for nearly half the number claims of EAG States. Bihar, Uttar Pradesh and Madhya Pradesh which hold more than 26 per cent of the scheme's targeted families accounted for only 11 per cent of total number of claims in the country. State health systems have an important bearing on such CSS schemes.

- The skewed distribution of the incidence of benefits and Central releases is inconsistent with the 'equalization principle' of inter-governmental transfers that aims to reduce inter-state inequalities in access to health care.

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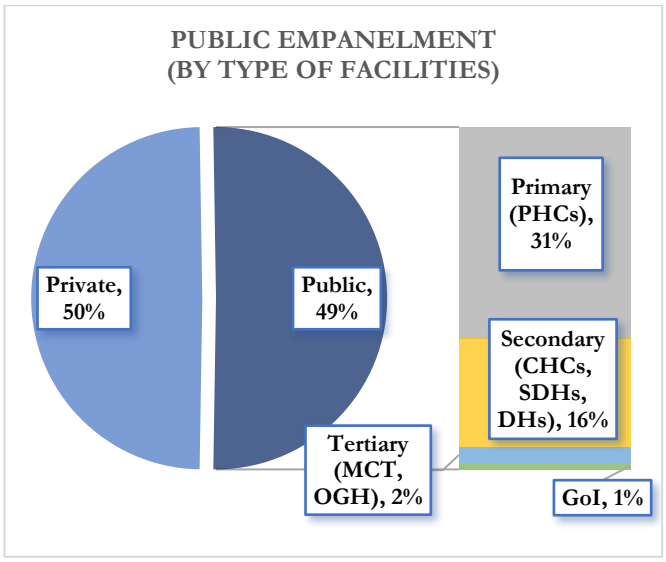
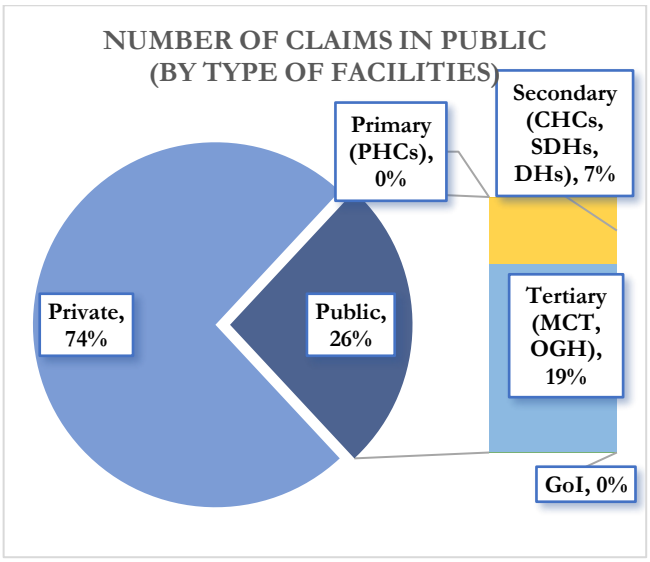
8. Jha R., Chhabra S. and Smith O. (2020). Empowering Government Hospitals: The Potential of Insurance, PM-JAY Policy Brief 6.

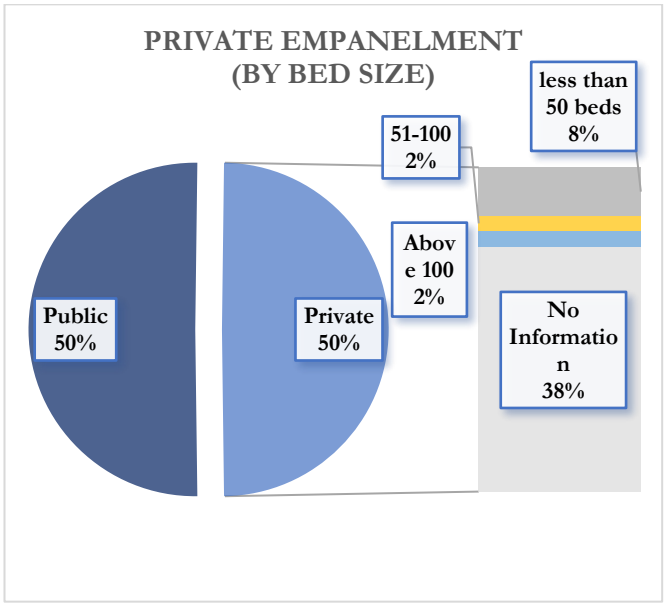
9. Smith O., Dong D., and Chhabra S. (2019). PM-JAY across India's states: Need and Utilization, PM-JAY Policy Brief 2.

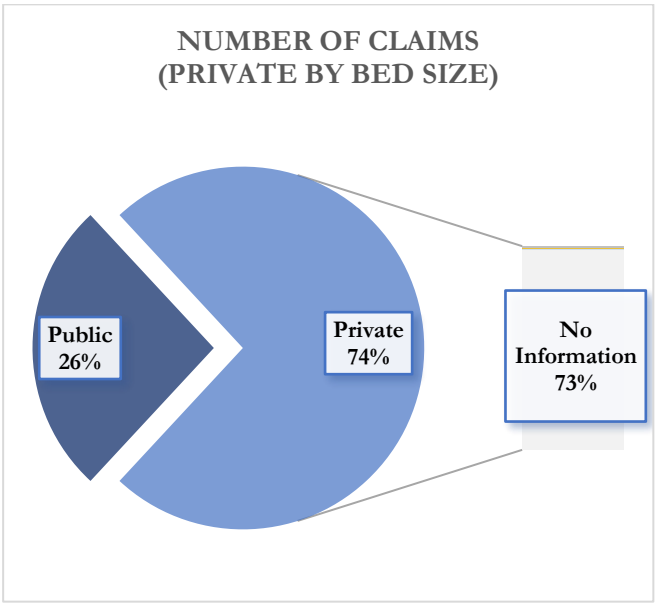
Annexures

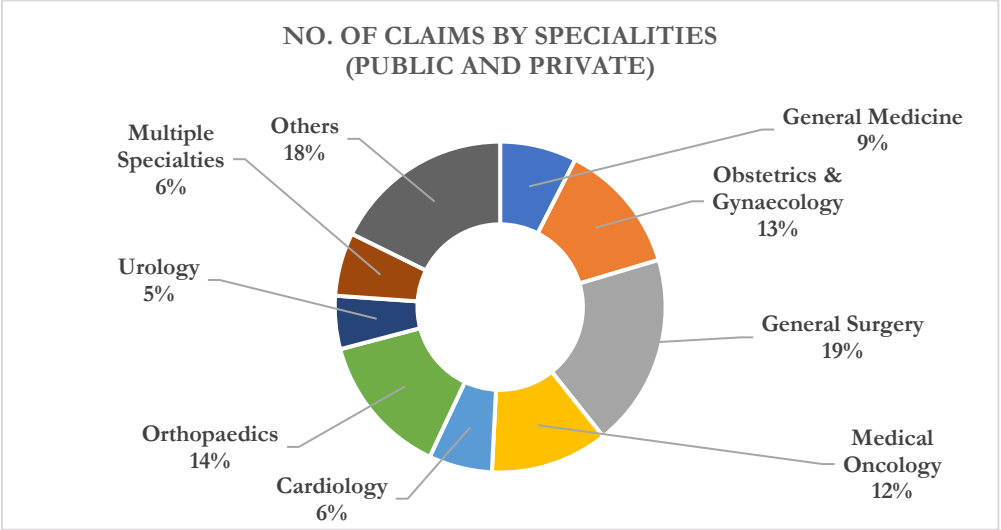
Andhra Pradesh



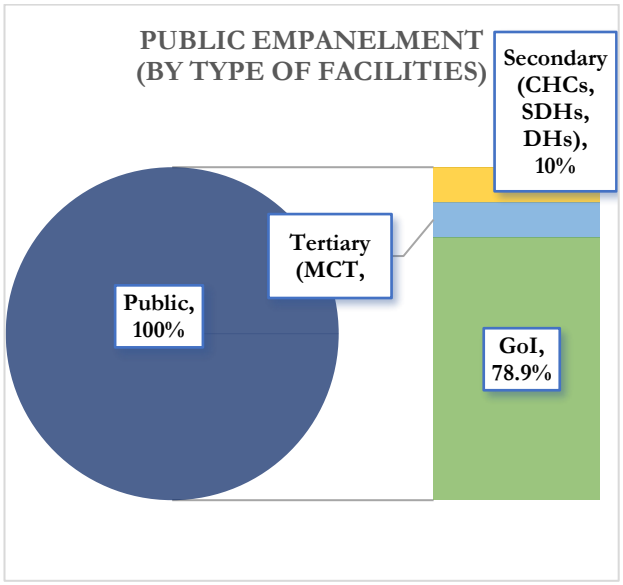


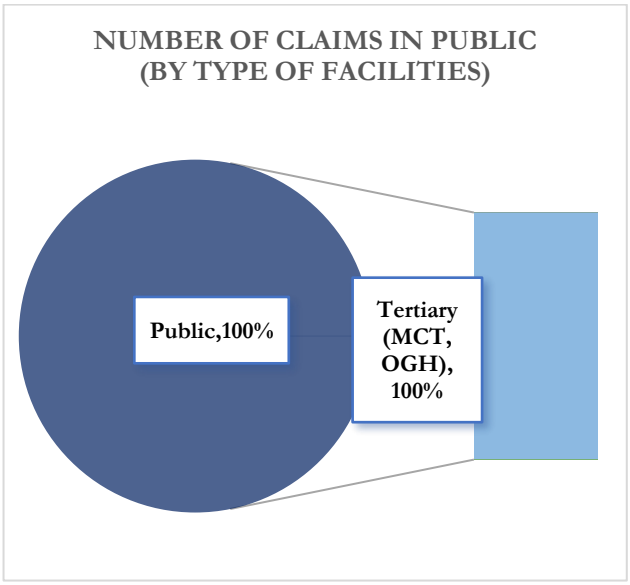


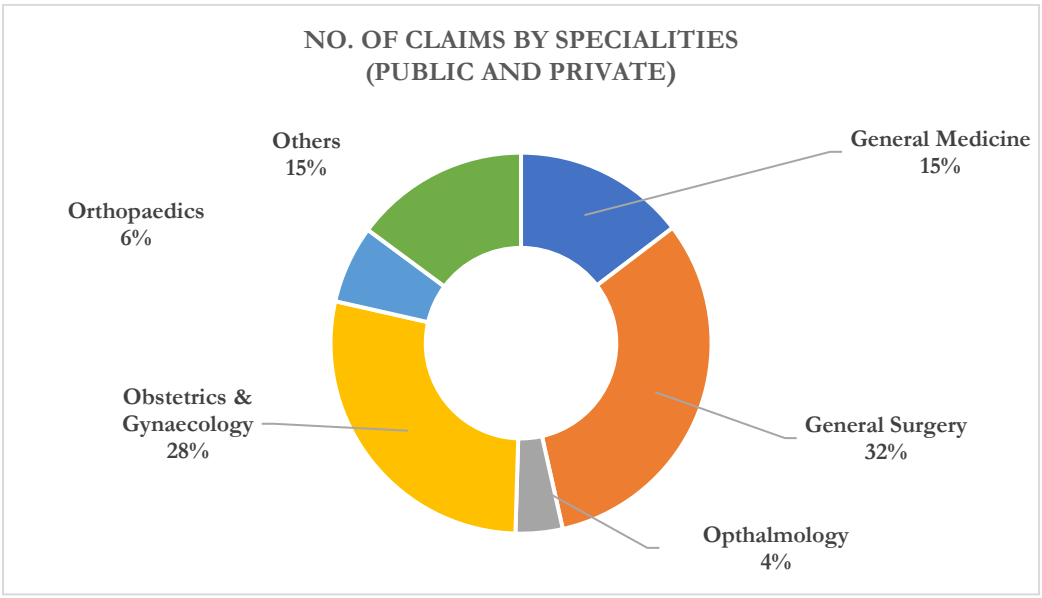




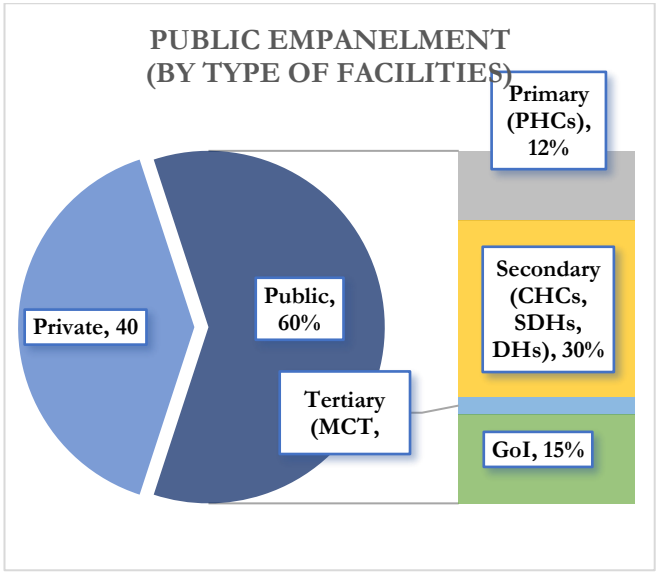
Arunachal Pradesh

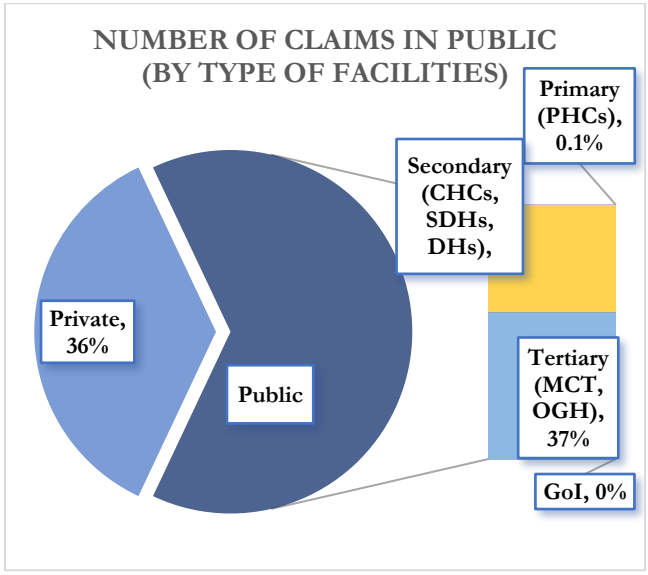


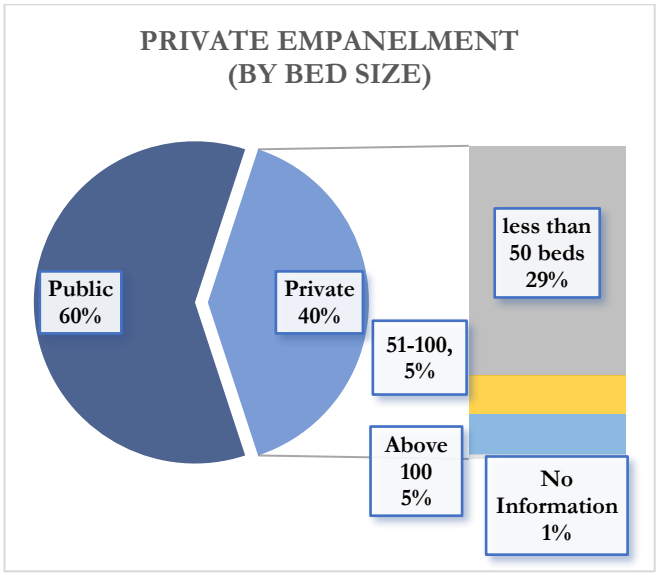


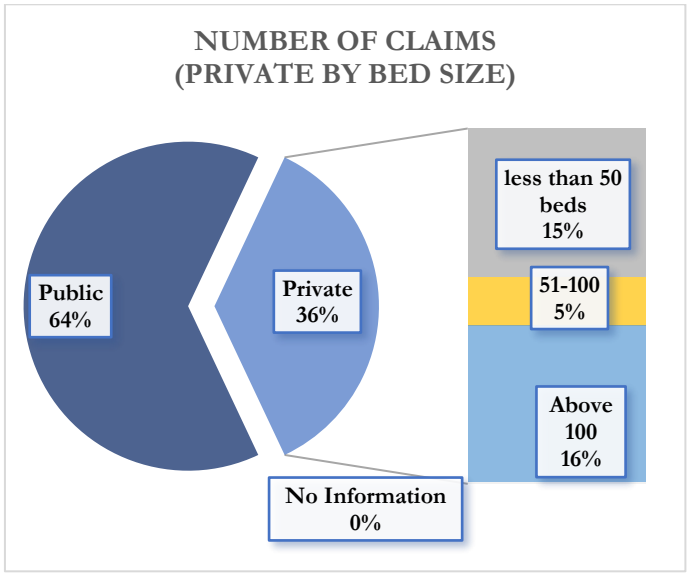


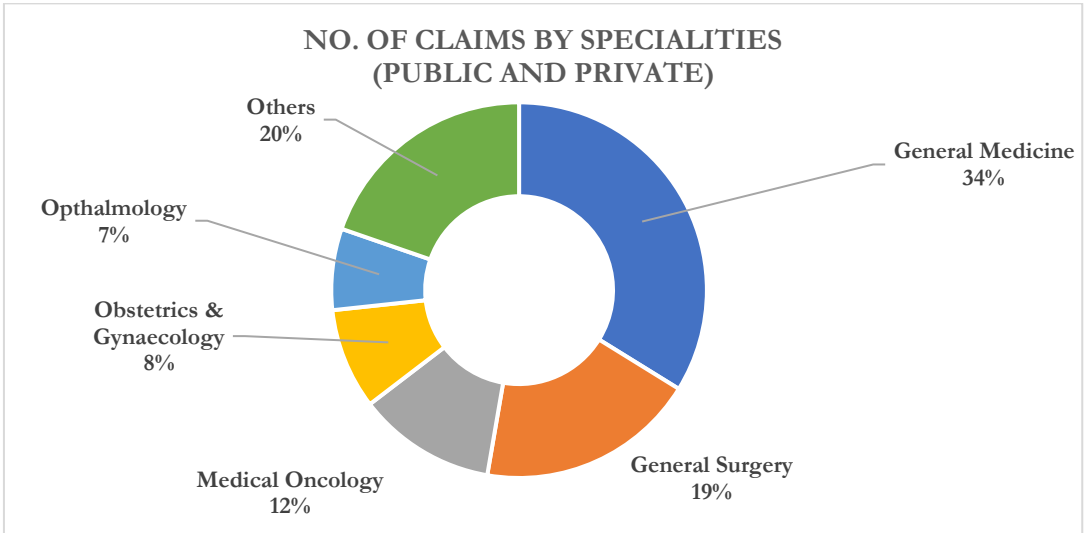
Assam


PUBLIC EMPANELMENT
(BY TYPE OF FACILITIES)
Primary (PHCs), 12%
Secondary (CHCs, SDHs, DHs), 30%
GoI, 15%
Tertiary (MCT,
Public, 60%
Private, 40


NUMBER OF CLAIMS IN PUBLIC
(BY TYPE OF FACILITIES)
Primary (PHCs), 0.1%
Secondary (CHCs, SDHs, DHs),
Tertiary (MCT, OGH), 37%
GoI, 0%
Private, 36%
Public

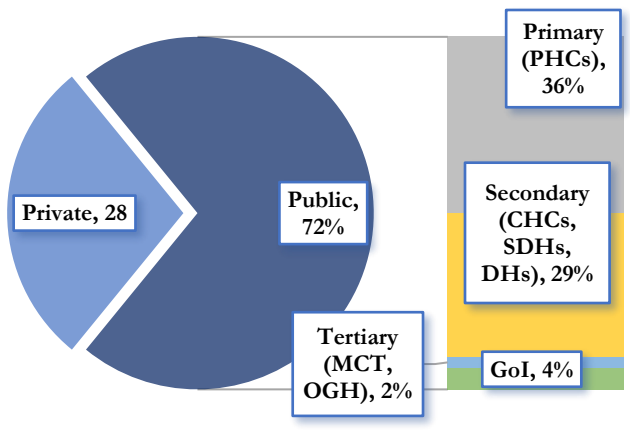

PRIVATE EMPANELMENT
(BY BED SIZE)
less than 50 beds 29%
51-100, 5%
Above 100 5%
No Information 1%
Public 60%
Private 40%


NUMBER OF CLAIMS
(PRIVATE BY BED SIZE)
less than 50 beds 15%
51-100 5%
Above 100 16%
No Information 0%
Public 64%
Private 36%

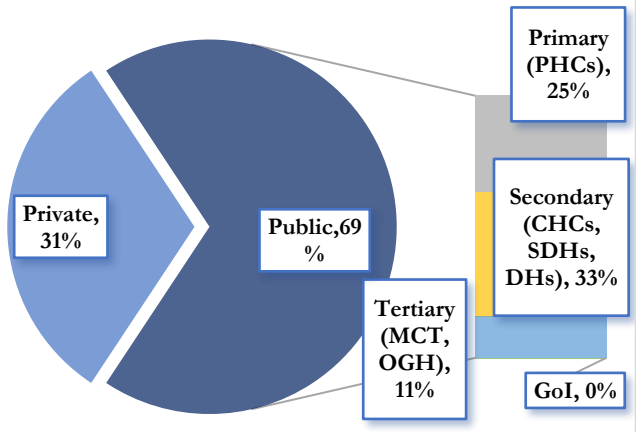

NO. OF CLAIMS BY SPECIALITIES
(PUBLIC AND PRIVATE)
Others 20%
General Medicine 34%
Opthalmology 7%
Obstetrics & Gynaecology 8%
Medical Oncology 12%
General Surgery 19%

Bihar

PUBLIC EMPANELMENT (BY TYPE OF FACILITIES)



NUMBER OF CLAIMS IN PUBLIC (BY TYPE OF FACILITIES)



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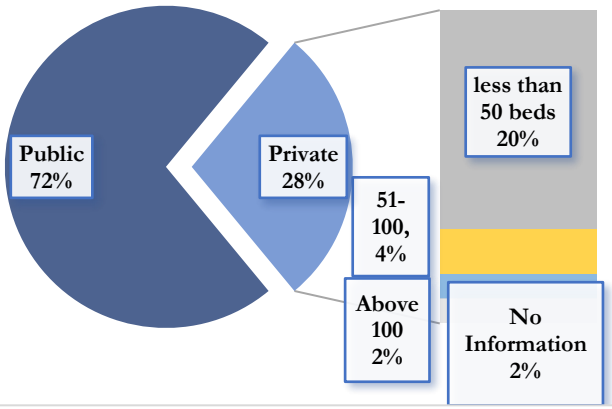
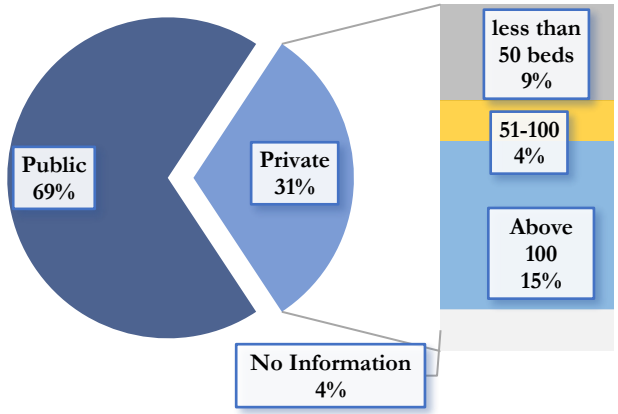
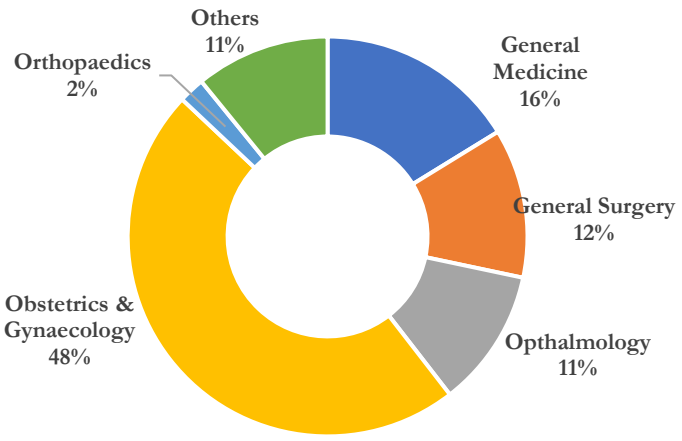


NUMBER OF CLAIMS (PRIVATE BY BED SIZE)

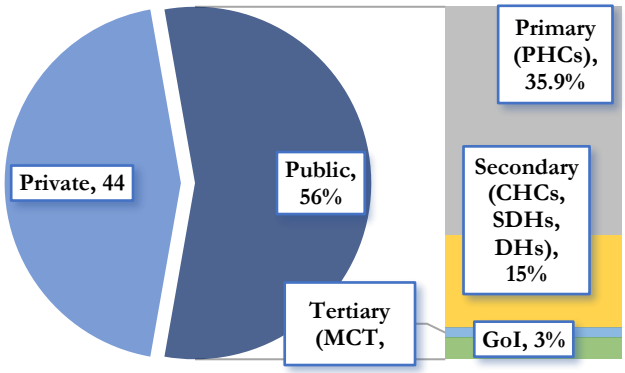


NO. OF CLAIMS BY SPECIALITIES (PUBLIC AND PRIVATE)

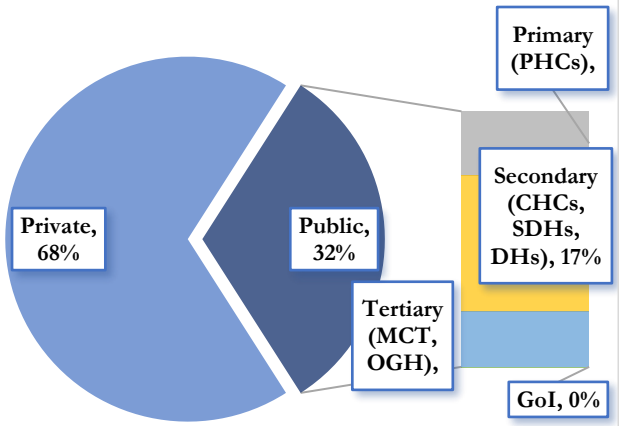


Chhattisgarh

PUBLIC EMPANELMENT (BY TYPE OF FACILITIES)



NUMBER OF CLAIMS IN PUBLIC (BY TYPE OF FACILITIES)



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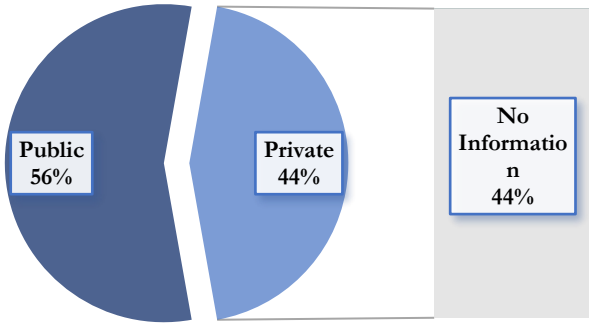
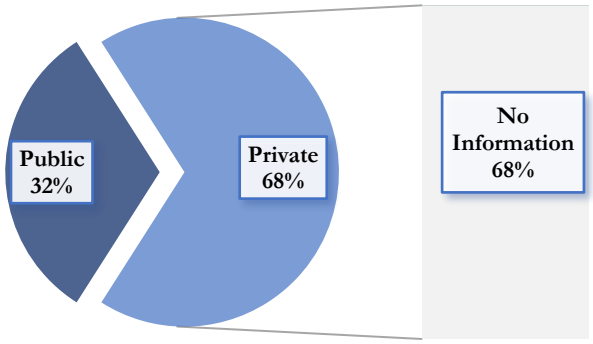
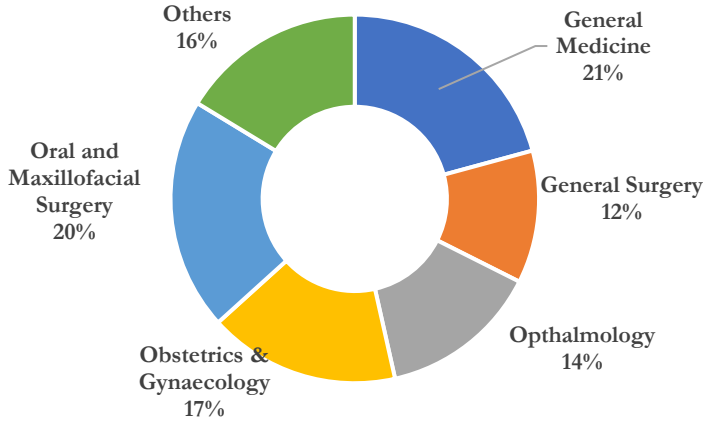


NUMBER OF CLAIMS (PRIVATE BY BED SIZE)

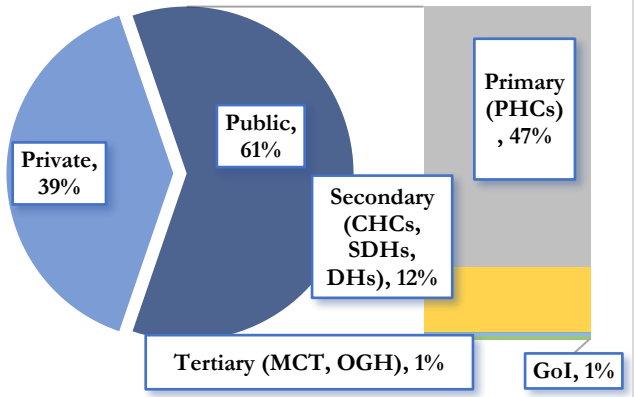


NO. OF CLAIMS BY SPECIALITIES (PUBLIC AND PRIVATE)



Gujarat

PUBLIC EMPANELMENT (BY TYPE OF FACILITIES)



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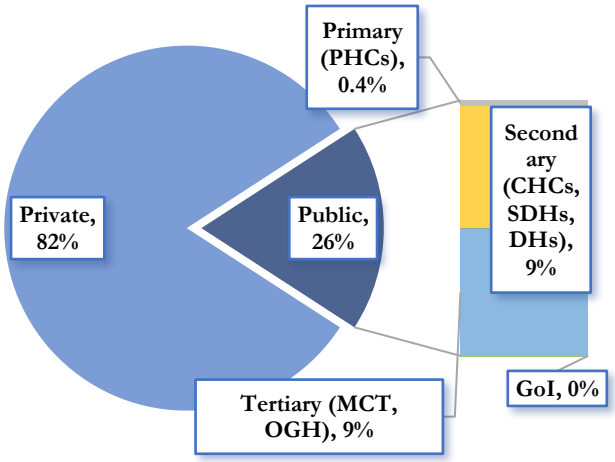

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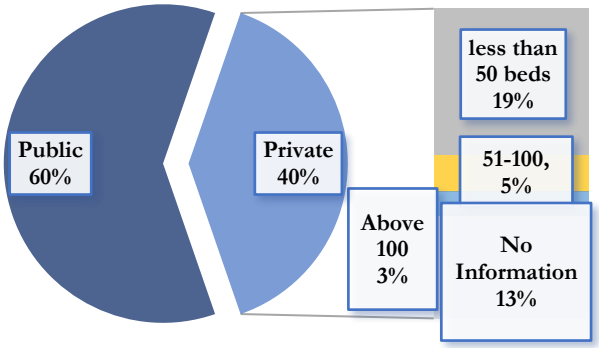
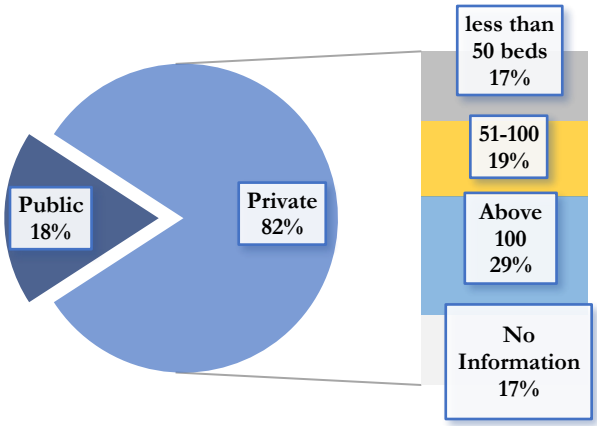


NUMBER OF CLAIMS (PRIVATE BY BED SIZE)



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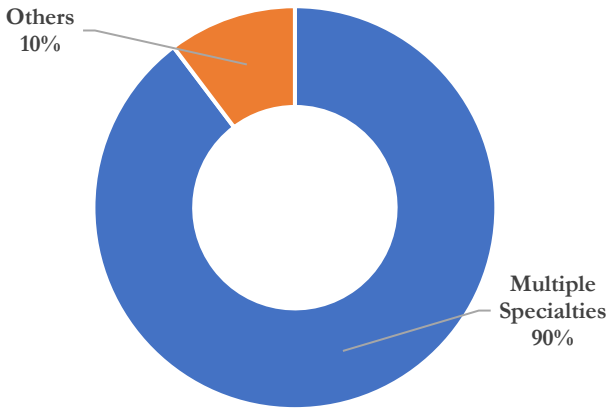
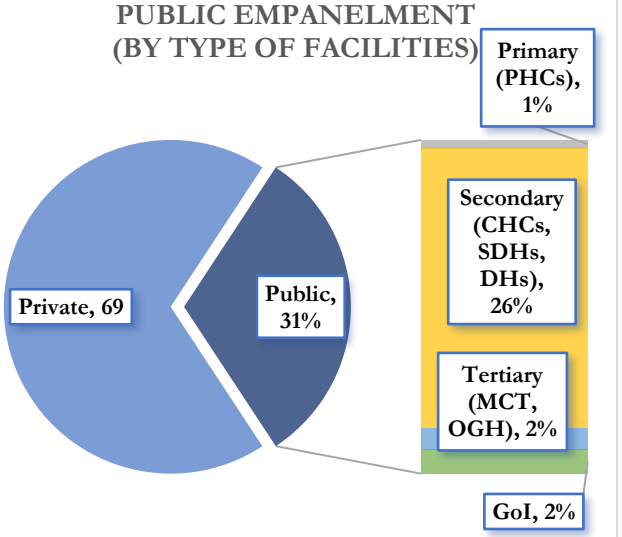


Haryana

PUBLIC EMPANELMENT (BY TYPE OF FACILITIES)



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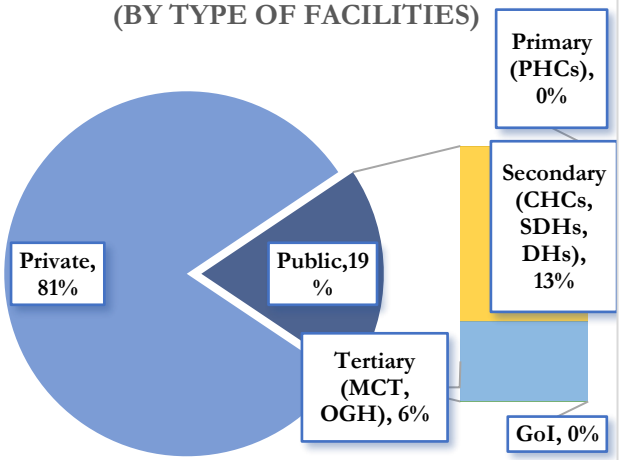

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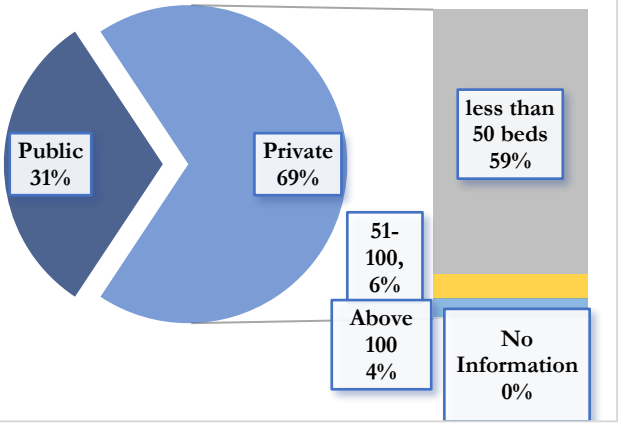

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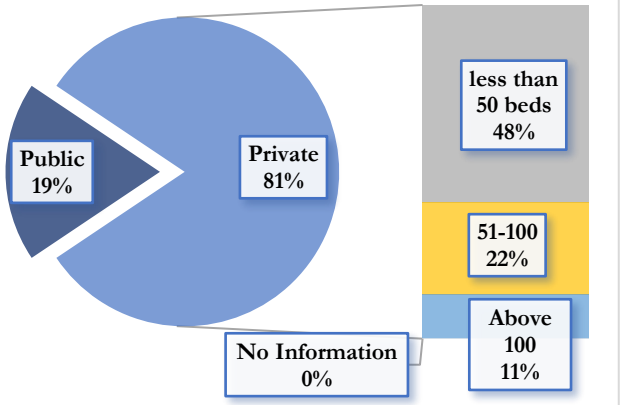

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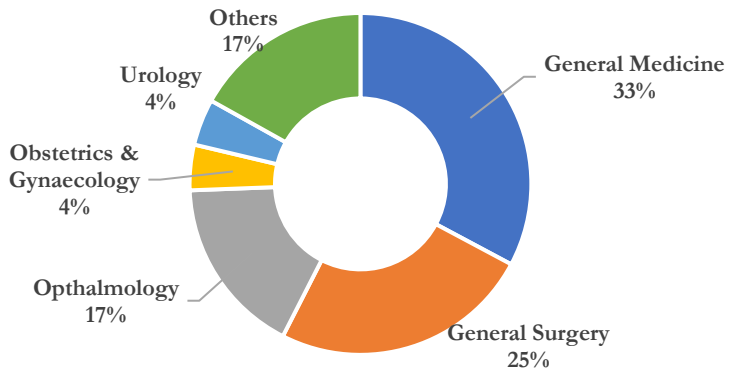
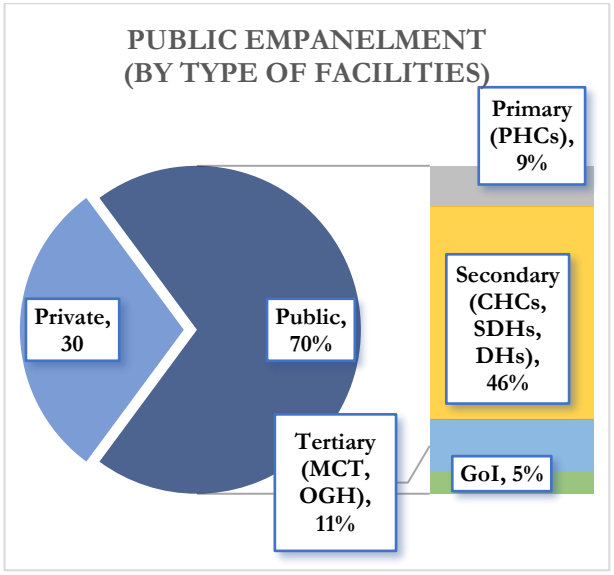
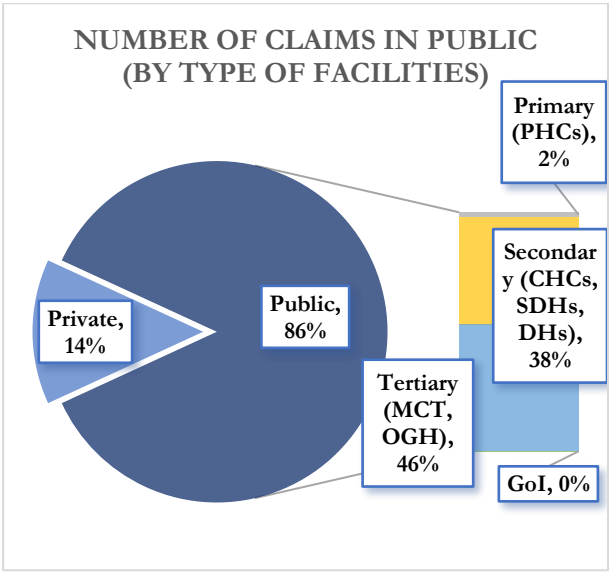
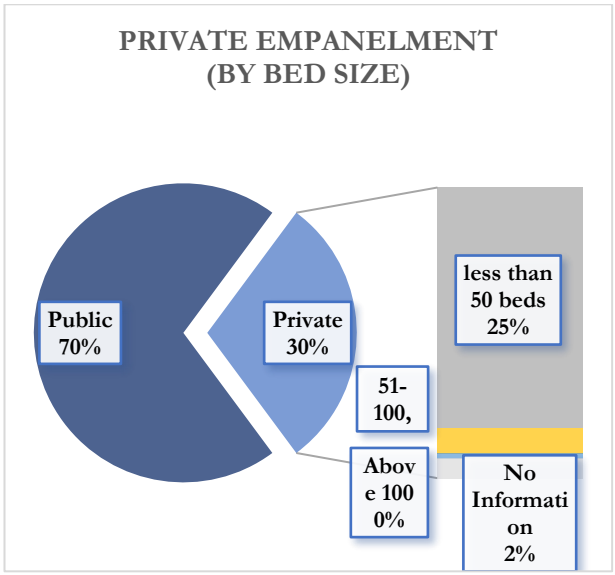
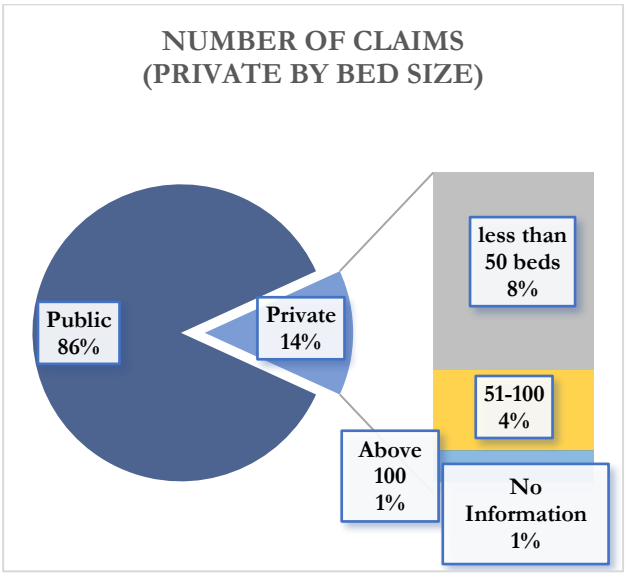


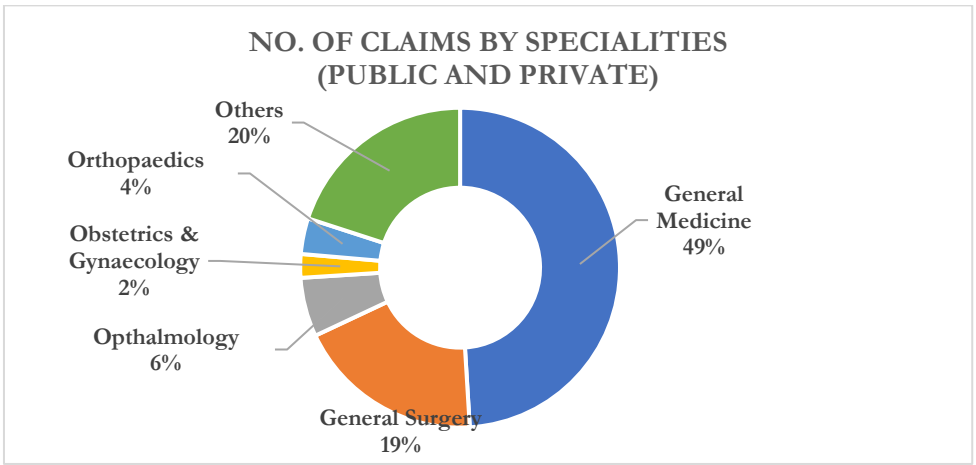
Himachal Pradesh





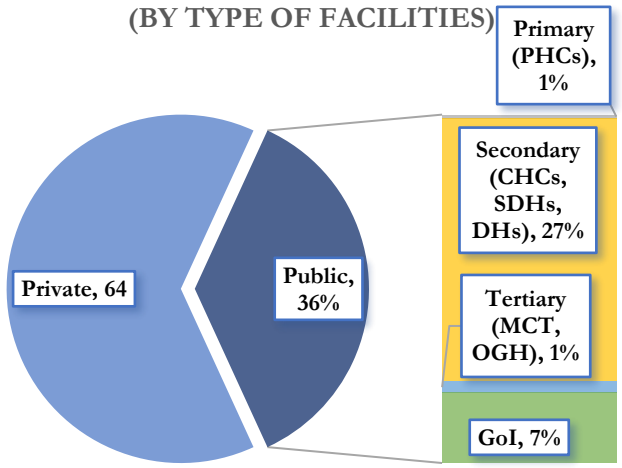




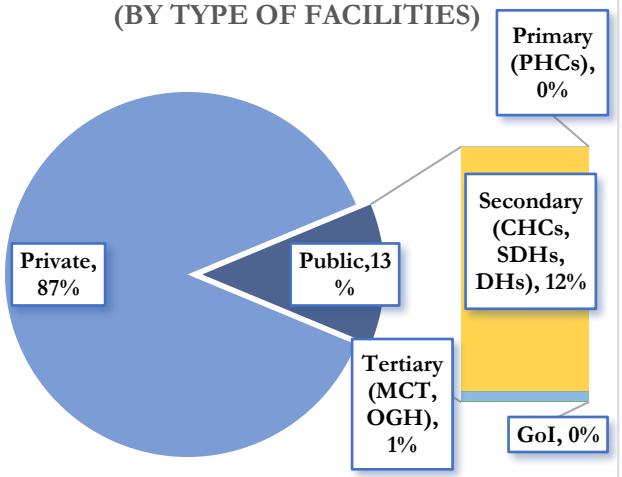


Jharkhand

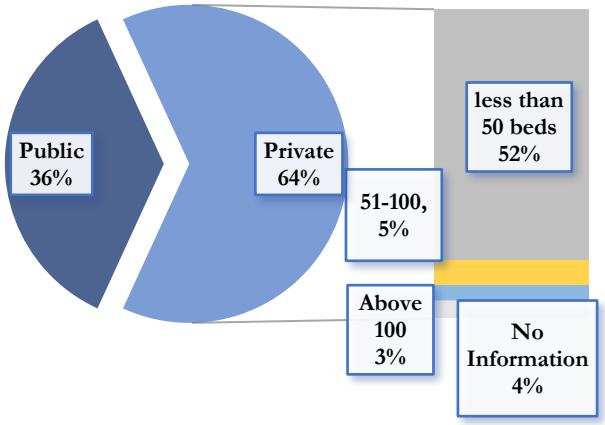
PUBLIC EMPANELMENT (BY TYPE OF FACILITIES)



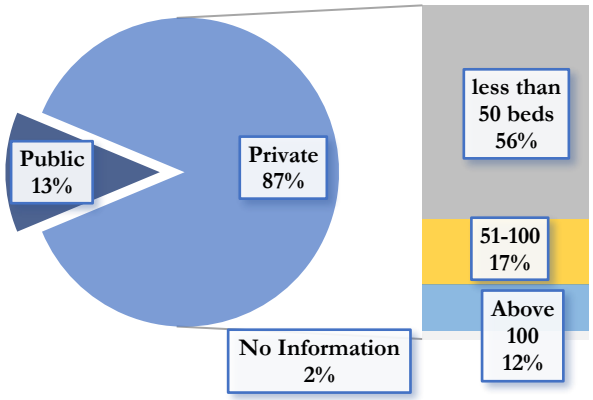
NUMBER OF CLAIMS IN PUBLIC (BY TYPE OF FACILITIES)



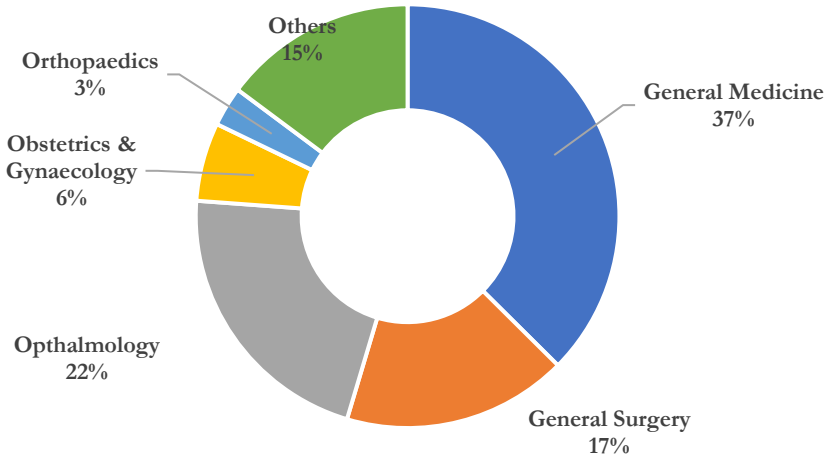
PRIVATE EMPANELMENT (BY BED SIZE)



NUMBER OF CLAIMS (PRIVATE BY BED SIZE)

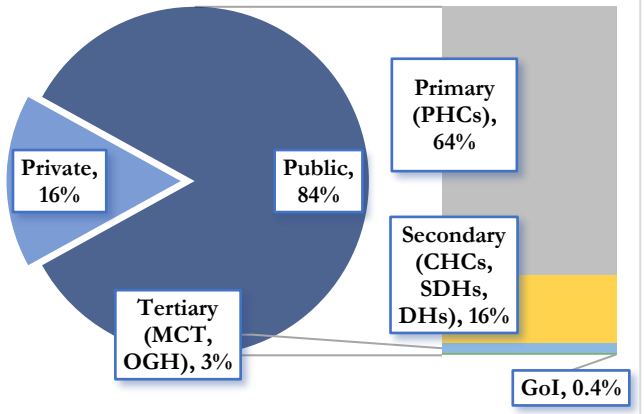


NO. OF CLAIMS BY SPECIALITIES (PUBLIC AND PRIVATE)

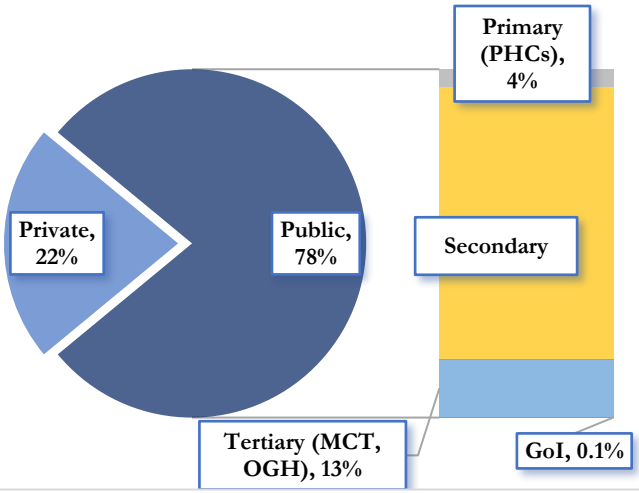


Karnataka

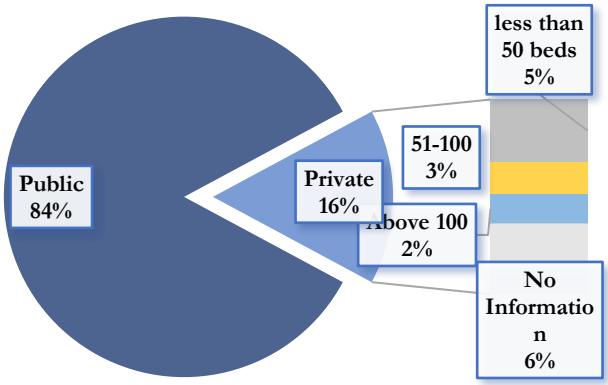
PUBLIC EMPANELMENT (BY TYPE OF FACILITIES)



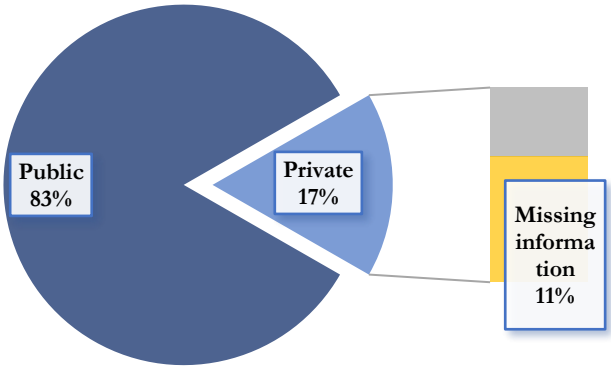
NUMBER OF CLAIMS IN PUBLIC (BY TYPE OF FACILITIES)



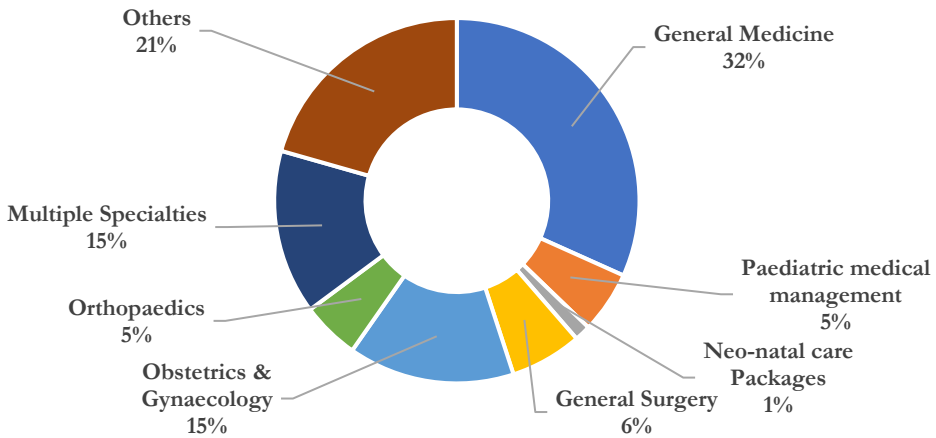
PRIVATE EMPANELMENT (BY BED SIZE)



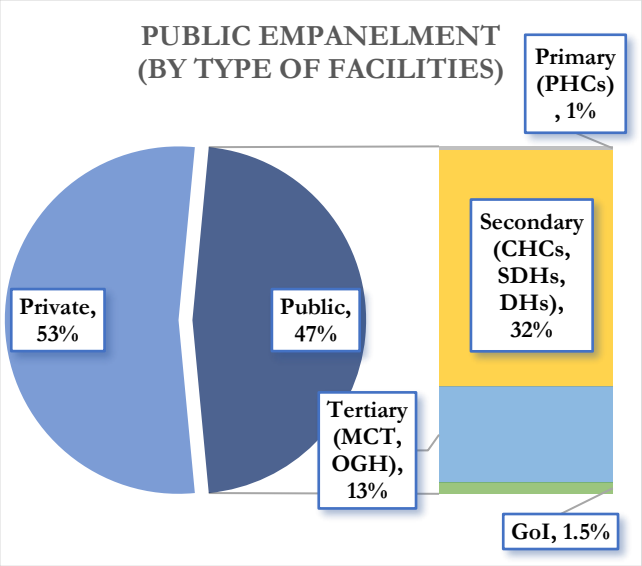
NUMBER OF CLAIMS (PRIVATE BY BED SIZE)

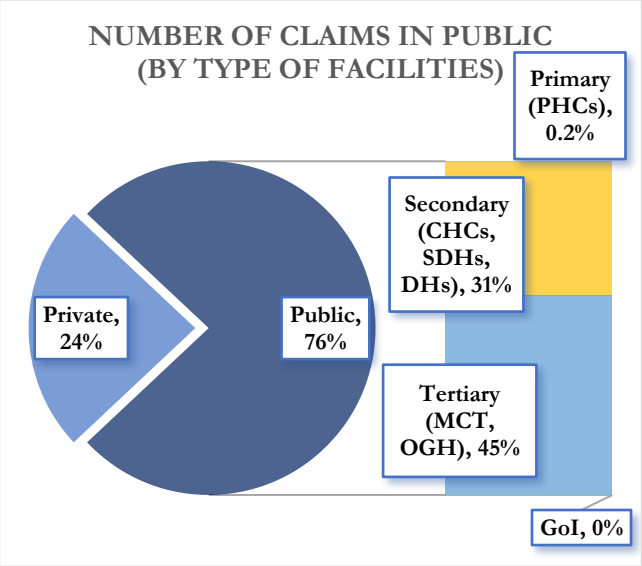


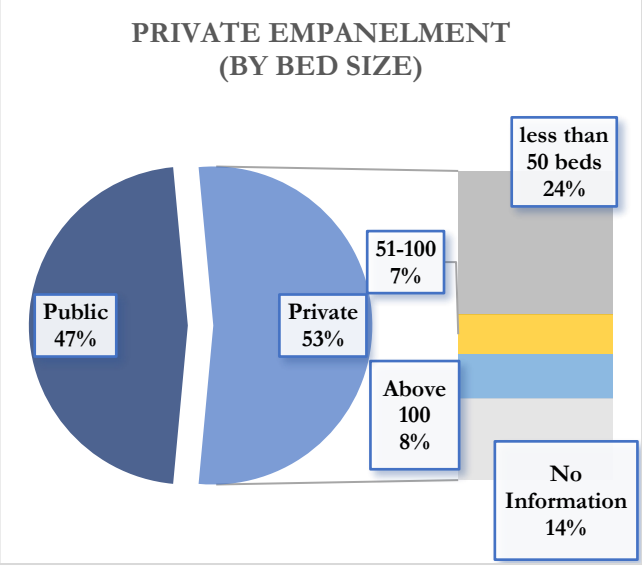
CLAIMS BY SPECIALITIES (PUBLIC AND PRIVATE)

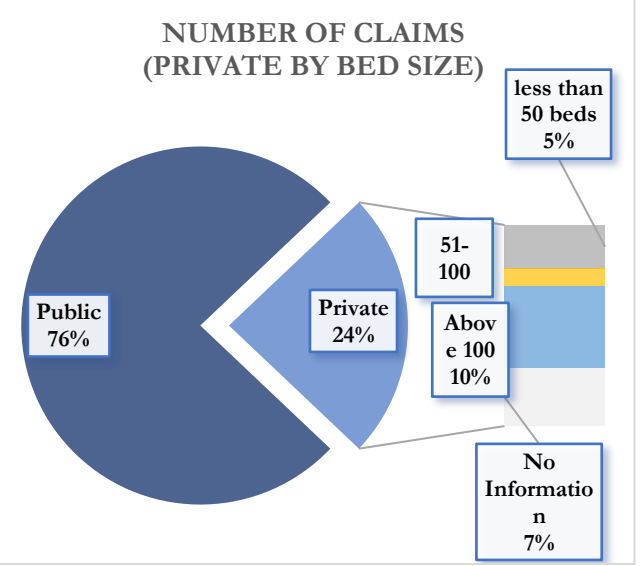


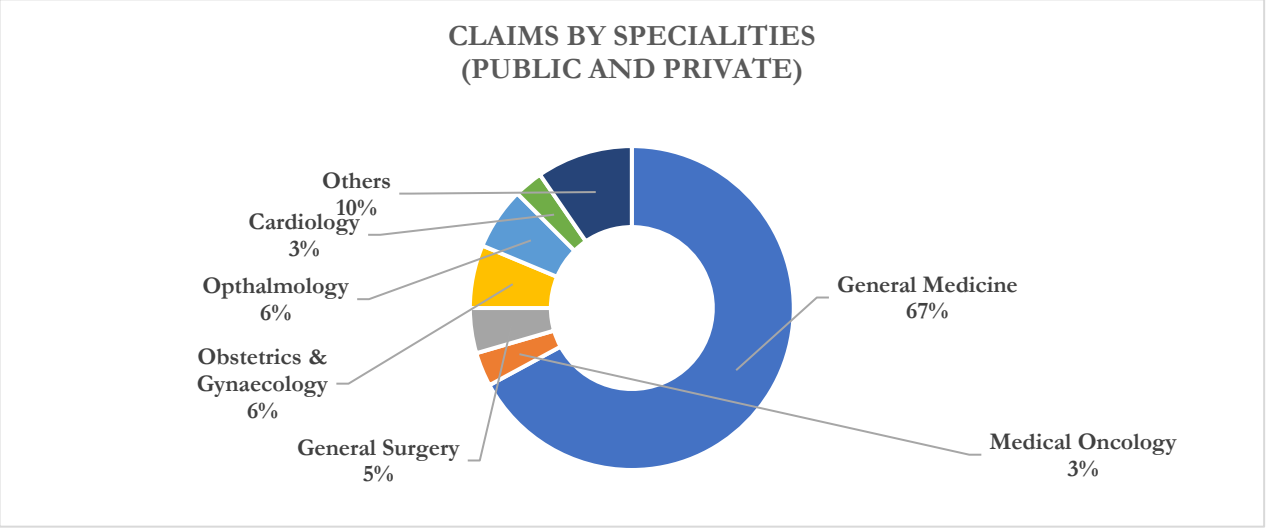
Kerala


PUBLIC EMPANELMENT
(BY TYPE OF FACILITIES)
Primary (PHCs), 1%
Secondary (CHCs, SDHs, DHs), 32%
Private, 53%
Public, 47%
Tertiary (MCT, OGH), 13%
GoI, 1.5%

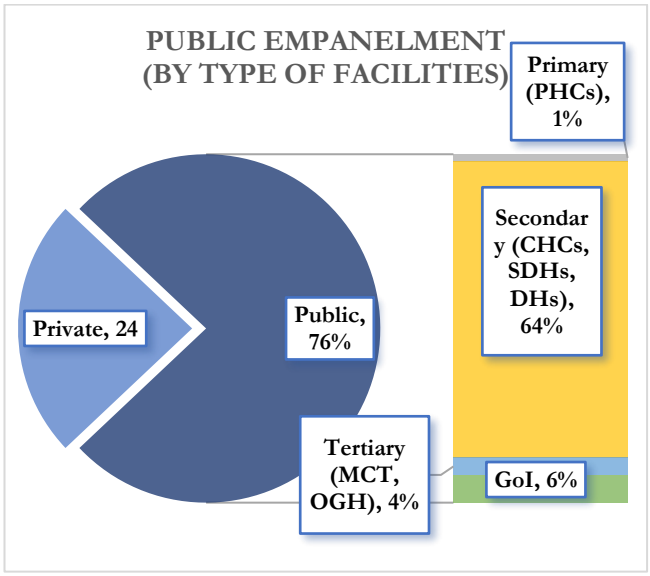

NUMBER OF CLAIMS IN PUBLIC
(BY TYPE OF FACILITIES)
Primary (PHCs), 0.2%
Secondary (CHCs, SDHs, DHs), 31%
Private, 24%
Public, 76%
Tertiary (MCT, OGH), 45%
GoI, 0%

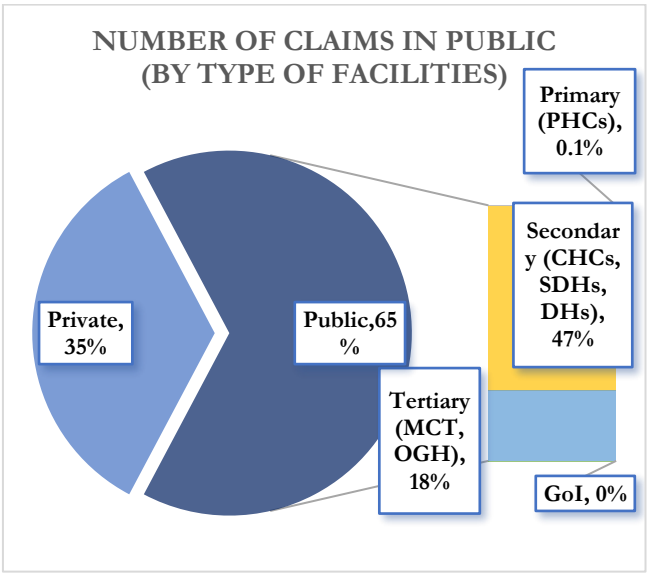

PRIVATE EMPANELMENT
(BY BED SIZE)
less than 50 beds 24%
51-100 7%
Public 47%
Private 53%
Above 100 8%
No Information 14%

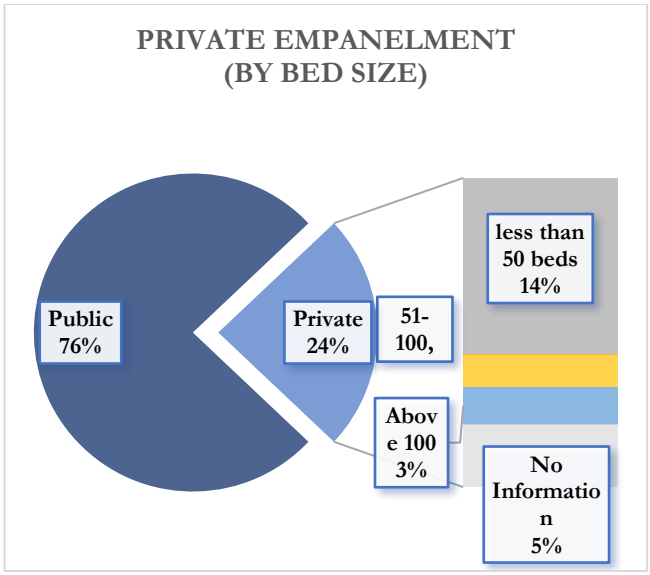

NUMBER OF CLAIMS
(PRIVATE BY BED SIZE)
less than 50 beds 5%
51-100
Public 76%
Private 24%
Above 100 10%
No Information 7%

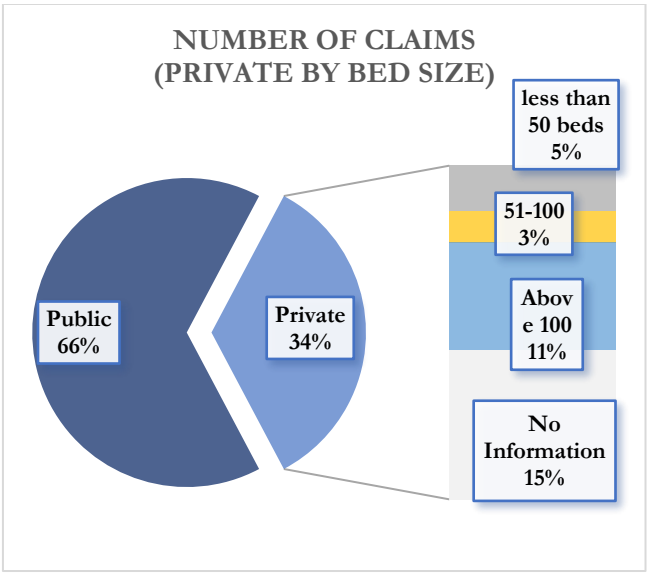

CLAIMS BY SPECIALITIES
(PUBLIC AND PRIVATE)
Others 10%
Cardiology 3%
Opthalmology 6%
Obstetrics & Gynaecology 6%
General Surgery 5%
General Medicine 67%
Medical Oncology 3%

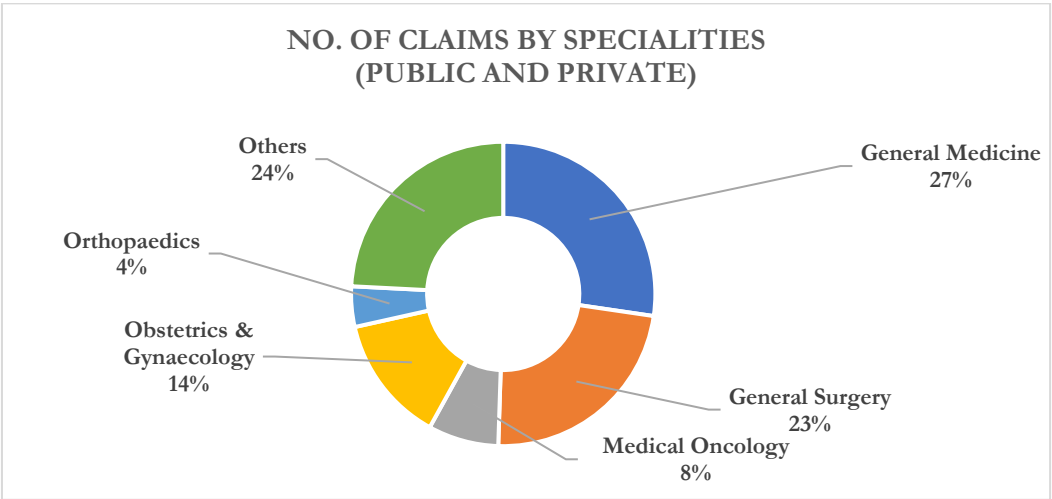
Madhya Pradesh









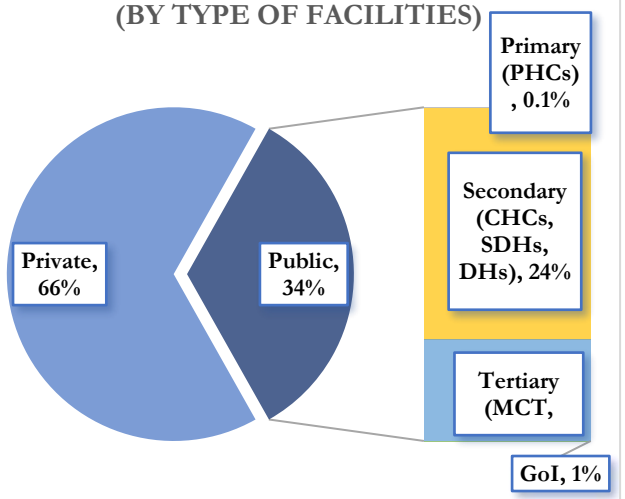


national health authority

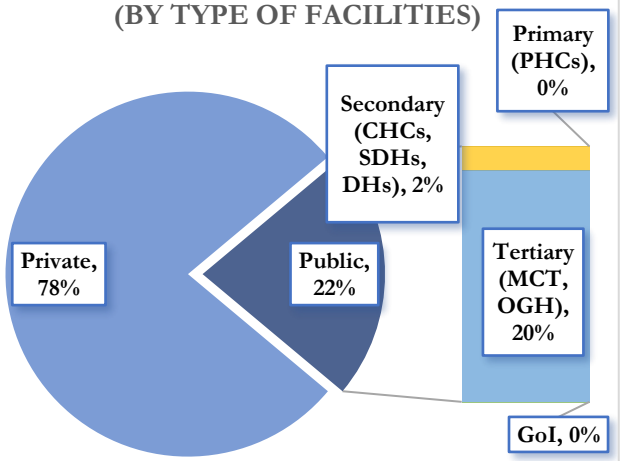
Maharashtra

Pradhan Mantri Jan Arogya Yojana
Ayushman Bharat
PM-JAY

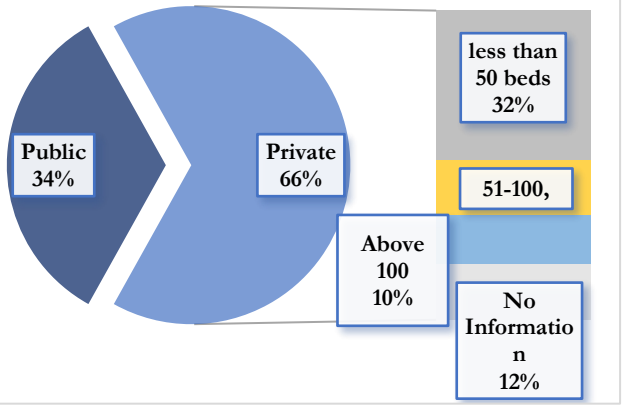
PUBLIC EMPANELMENT (BY TYPE OF FACILITIES)



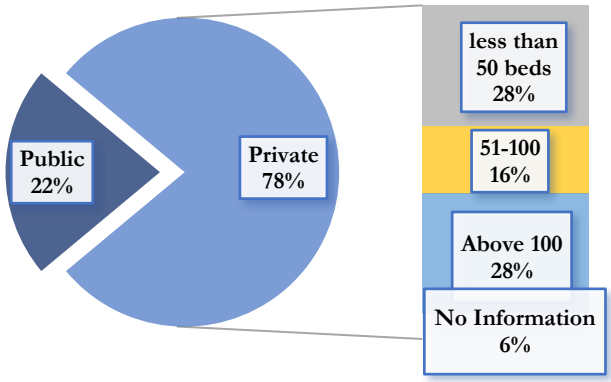
NUMBER OF CLAIMS IN PUBLIC (BY TYPE OF FACILITIES)



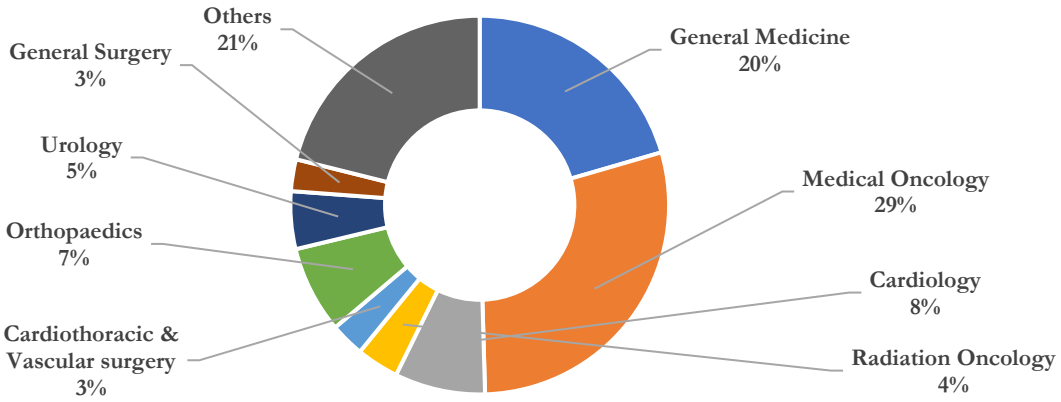
PRIVATE EMPANELMENT (BY BED SIZE)



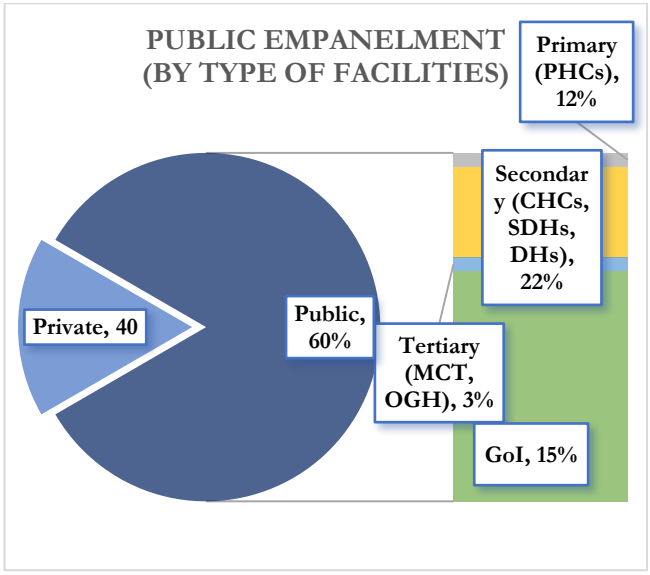
NUMBER OF CLAIMS (PRIVATE BY BED SIZE)

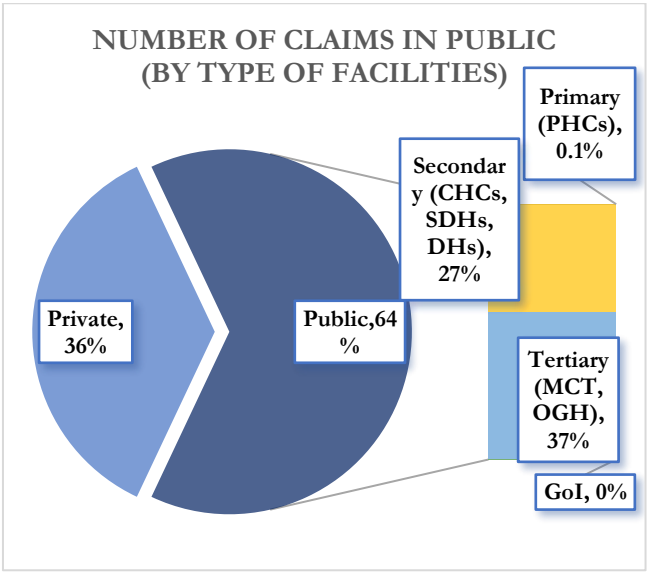


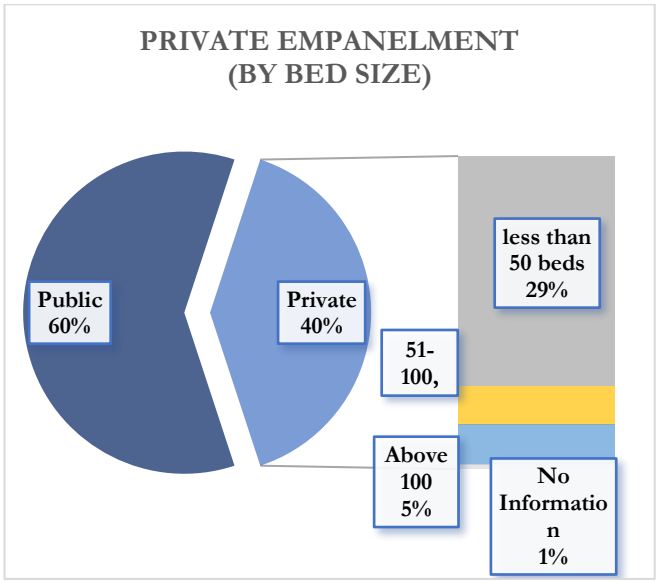
NO. OF CLAIMS BY SPECIALITIES (PUBLIC AND PRIVATE)

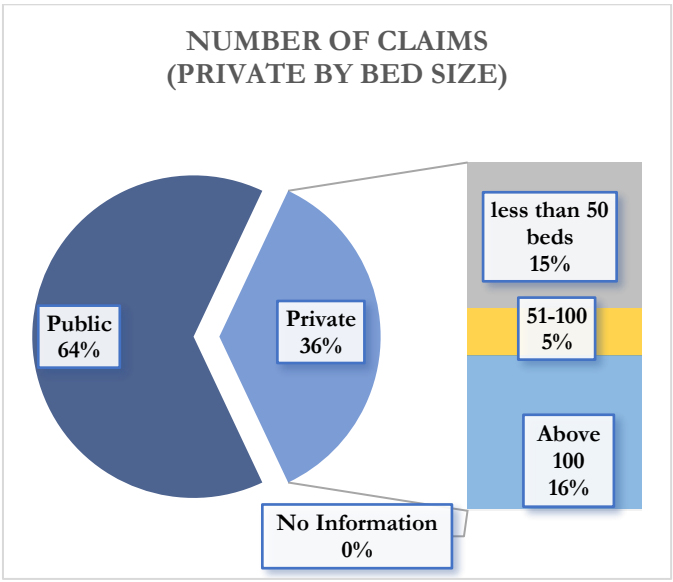


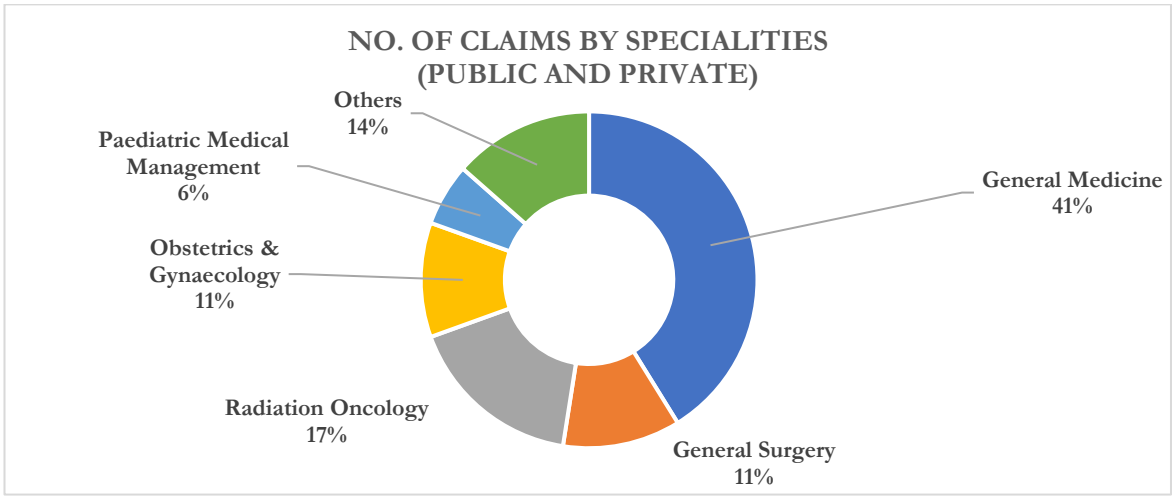
Manipur


PUBLIC EMPANELMENT
(BY TYPE OF FACILITIES)
Primary (PHCs), 12%
Secondary (CHCs, SDHs, DHs), 22%
Tertiary (MCT, OGH), 3%
GoI, 15%
Public, 60%
Private, 40


NUMBER OF CLAIMS IN PUBLIC
(BY TYPE OF FACILITIES)
Primary (PHCs), 0.1%
Secondary (CHCs, SDHs, DHs), 27%
Tertiary (MCT, OGH), 37%
GoI, 0%
Public,64 %
Private, 36%

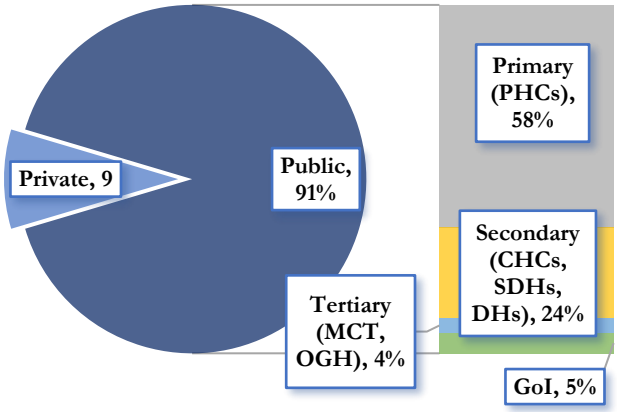

PRIVATE EMPANELMENT
(BY BED SIZE)
less than 50 beds 29%
51-100,
Above 100 5%
No Information 1%
Public 60%
Private 40%


NUMBER OF CLAIMS
(PRIVATE BY BED SIZE)
less than 50 beds 15%
51-100 5%
Above 100 16%
No Information 0%
Public 64%
Private 36%

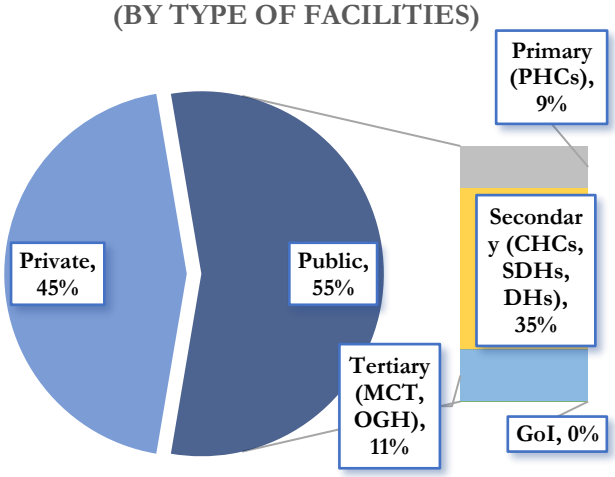

NO. OF CLAIMS BY SPECIALITIES
(PUBLIC AND PRIVATE)
Others 14%
Paediatric Medical Management 6%
Obstetrics & Gynaecology 11%
Radiation Oncology 17%
General Surgery 11%
General Medicine 41%

Meghalaya

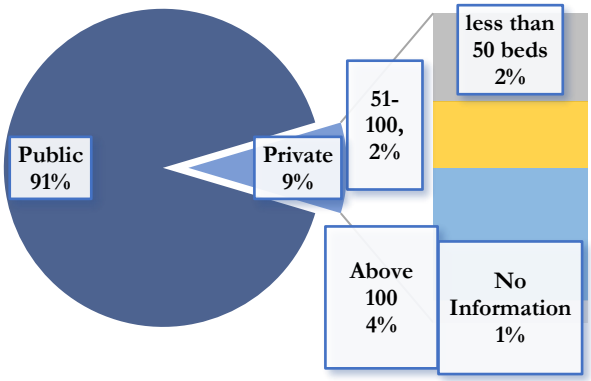
PUBLIC EMPANELMENT (BY TYPE OF FACILITIES)



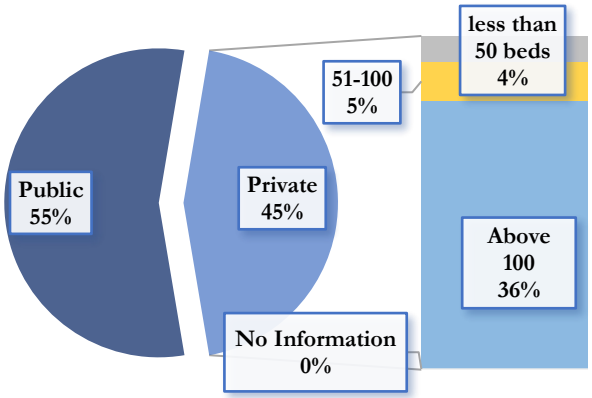
NUMBER OF CLAIMS IN PUBLIC (BY TYPE OF FACILITIES)



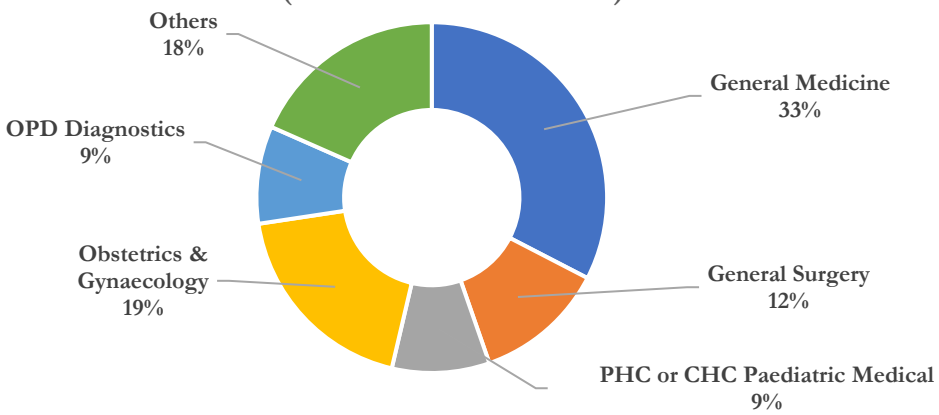
PRIVATE EMPANELMENT (BY BED SIZE)



NUMBER OF CLAIMS (PRIVATE BY BED SIZE)

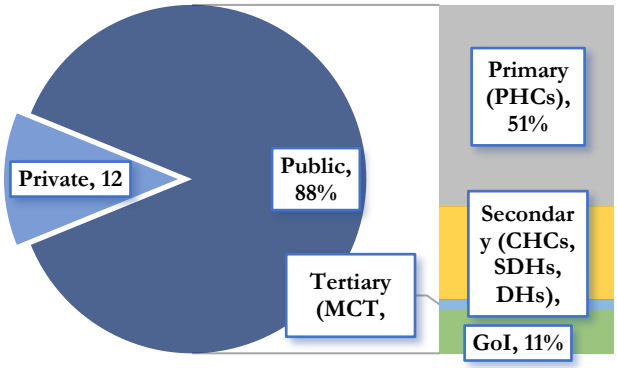


NO. OF CLAIMS BY SPECIALITIES (PUBLIC AND PRIVATE)

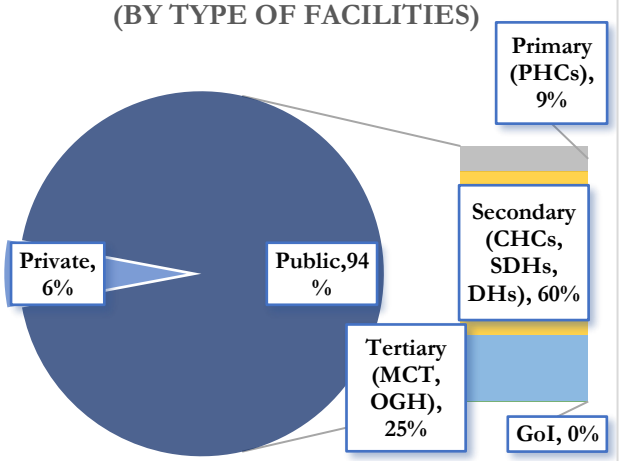


Mizoram

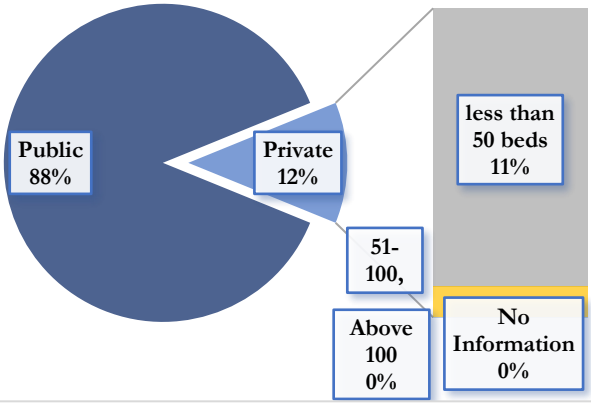
PUBLIC EMPANELMENT (BY TYPE OF FACILITIES)



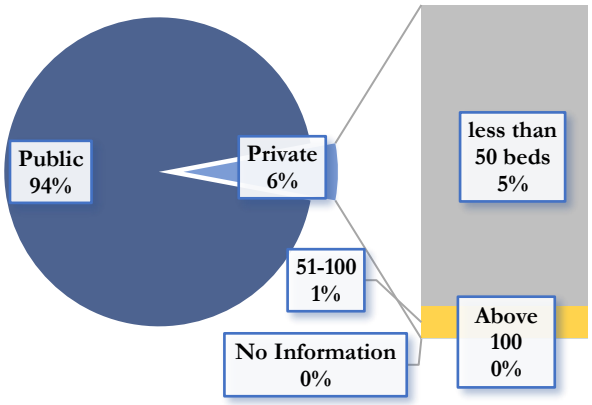
NUMBER OF CLAIMS IN PUBLIC (BY TYPE OF FACILITIES)



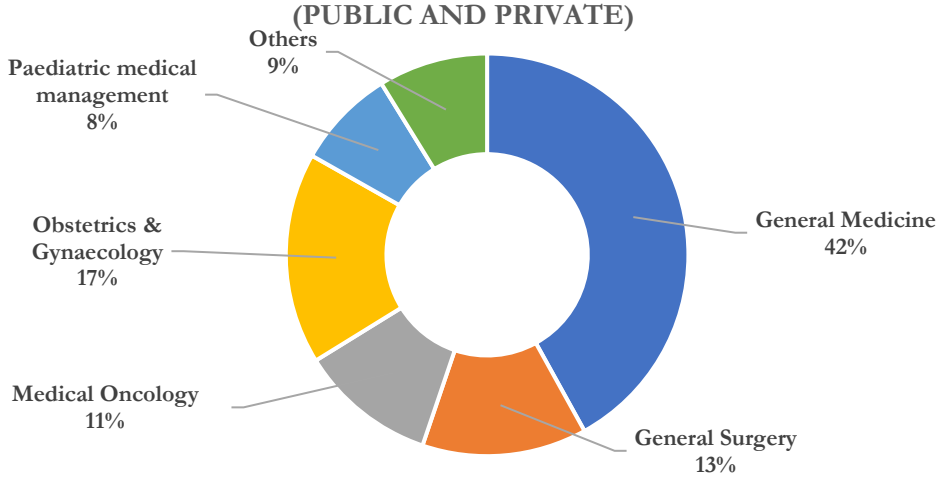
PRIVATE EMPANELMENT (BY BED SIZE)



NUMBER OF CLAIMS (PRIVATE BY BED SIZE)

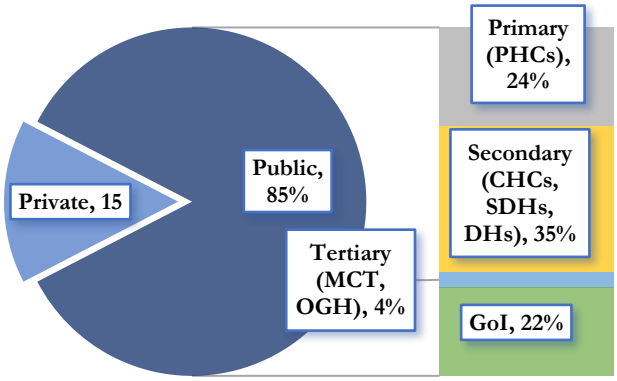


NO. OF CLAIMS BY SPECIALITIES (PUBLIC AND PRIVATE)

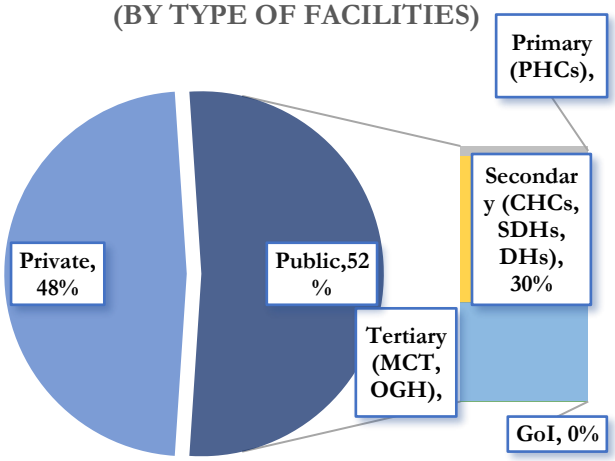


Nagaland

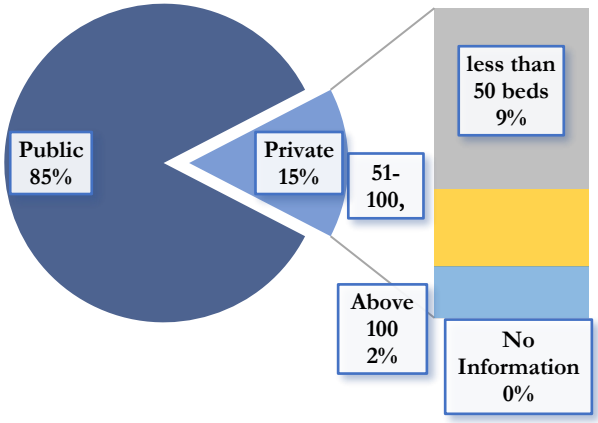
PUBLIC EMPANELMENT (BY TYPE OF FACILITIES)



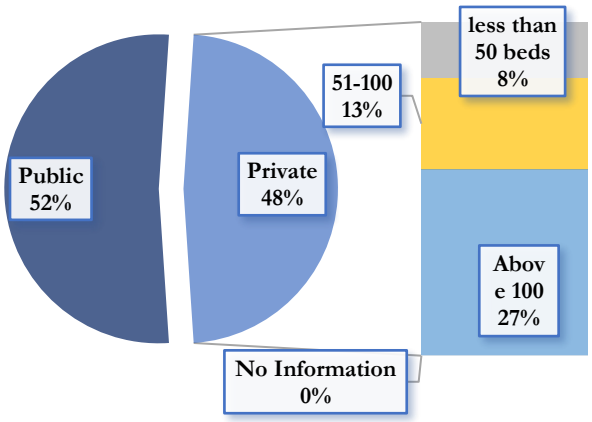
NUMBER OF CLAIMS IN PUBLIC (BY TYPE OF FACILITIES)



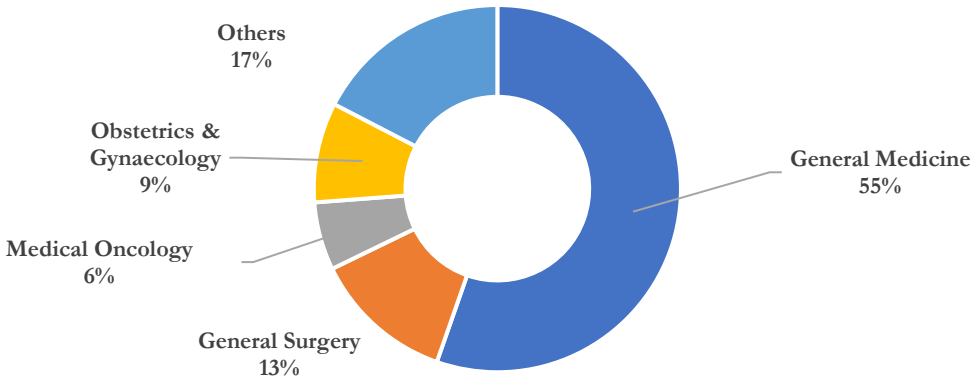
PRIVATE EMPANELMENT (BY BED SIZE)



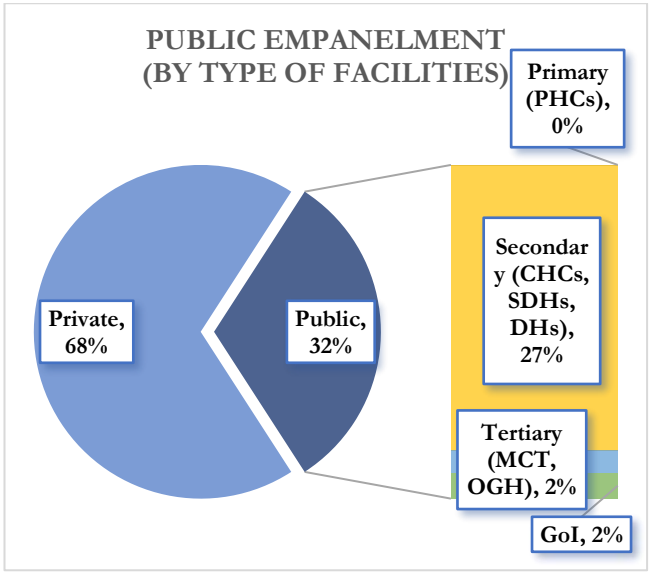
NUMBER OF CLAIMS (PRIVATE BY BED SIZE)

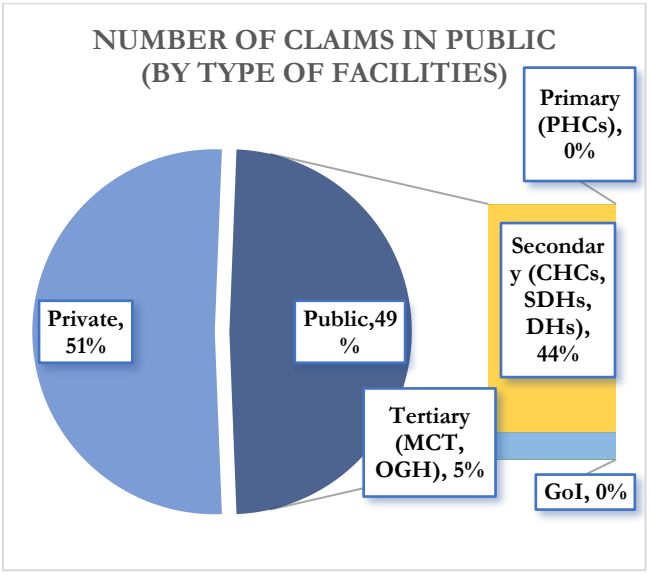


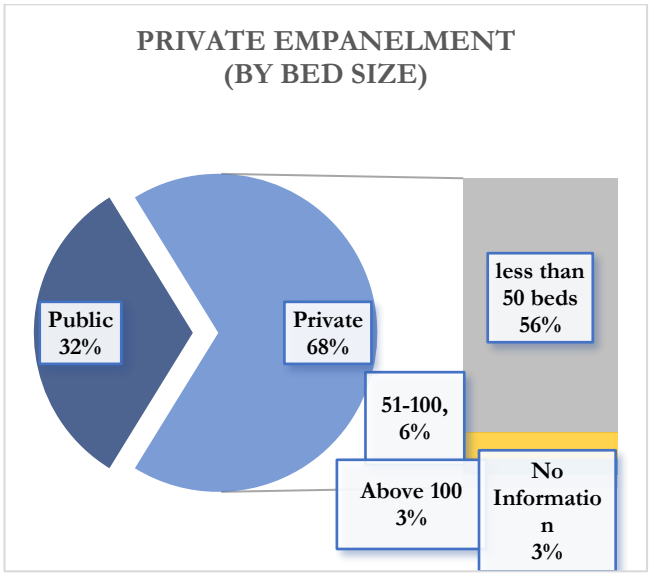
NO. OF CLAIMS BY SPECIALITIES (PUBLIC AND PRIVATE)

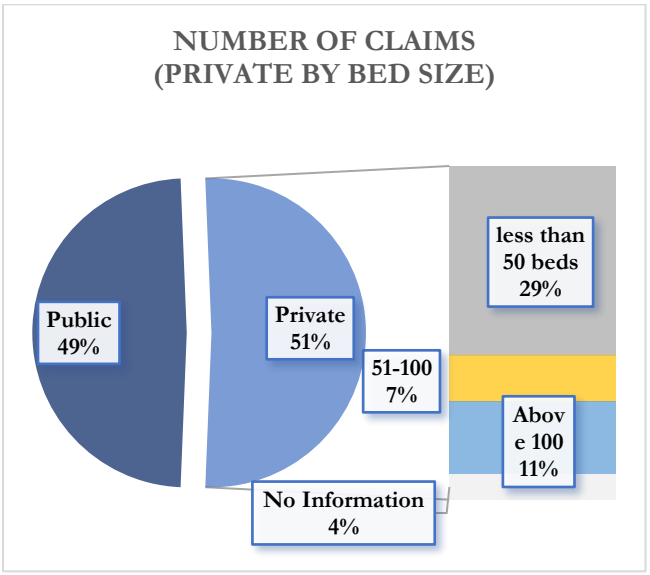


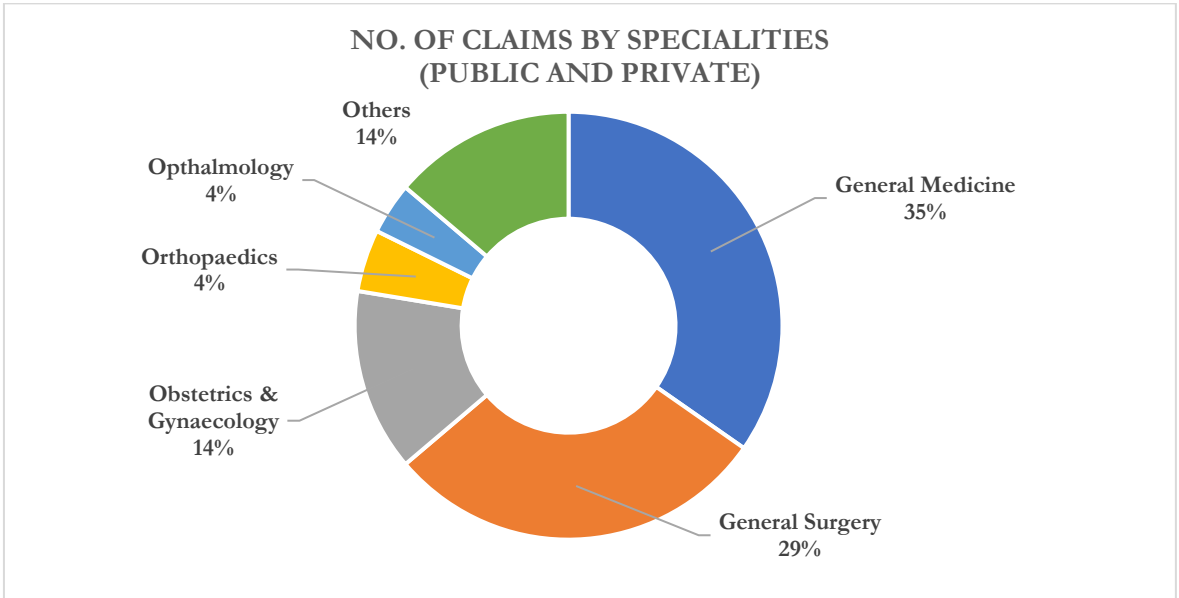
Punjab


PUBLIC EMPANELMENT
(BY TYPE OF FACILITIES)
Primary (PHCs), 0%
Secondary (CHCs, SDHs, DHs), 27%
Tertiary (MCT, OGH), 2%
GoI, 2%
Private, 68%
Public, 32%

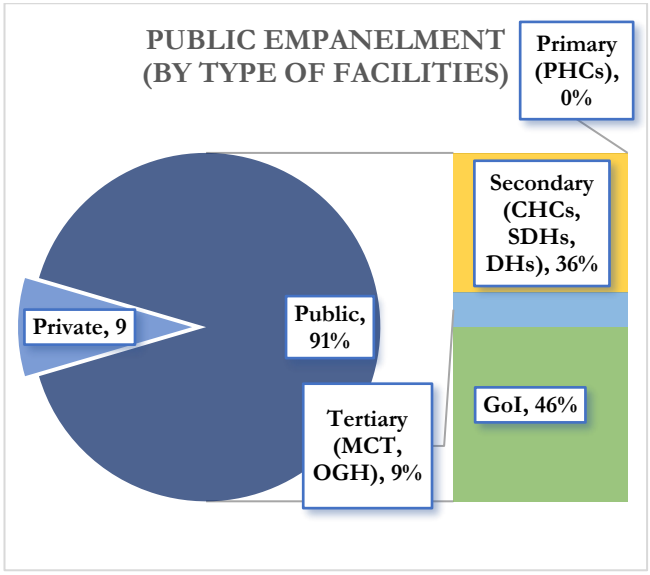

NUMBER OF CLAIMS IN PUBLIC
(BY TYPE OF FACILITIES)
Primary (PHCs), 0%
Secondary (CHCs, SDHs, DHs), 44%
Tertiary (MCT, OGH), 5%
GoI, 0%
Private, 51%
Public,49 %

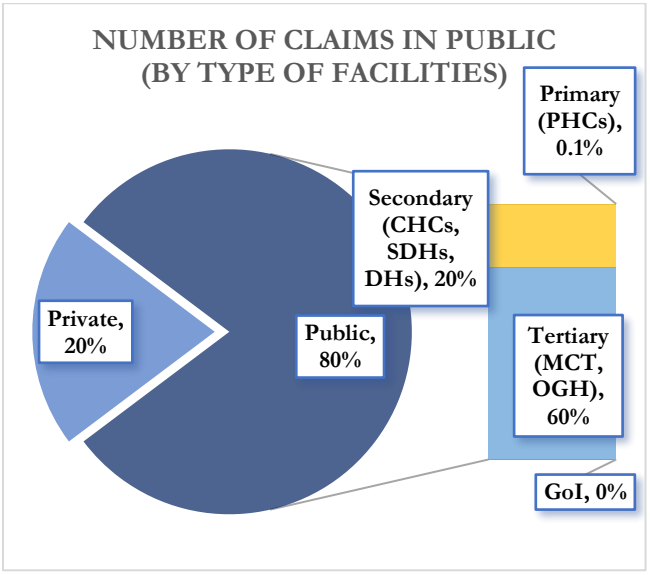

PRIVATE EMPANELMENT
(BY BED SIZE)
less than 50 beds 56%
51-100, 6%
Above 100 3%
No Information 3%
Public 32%
Private 68%

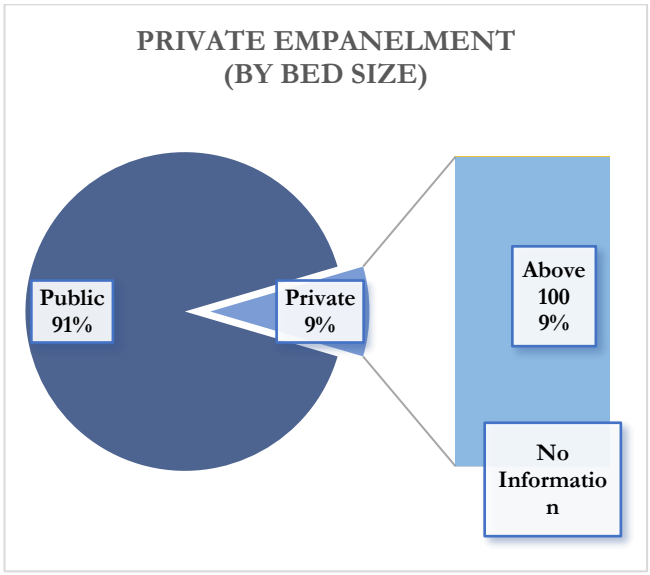

NUMBER OF CLAIMS
(PRIVATE BY BED SIZE)
less than 50 beds 29%
51-100 7%
Above 100 11%
No Information 4%
Public 49%
Private 51%

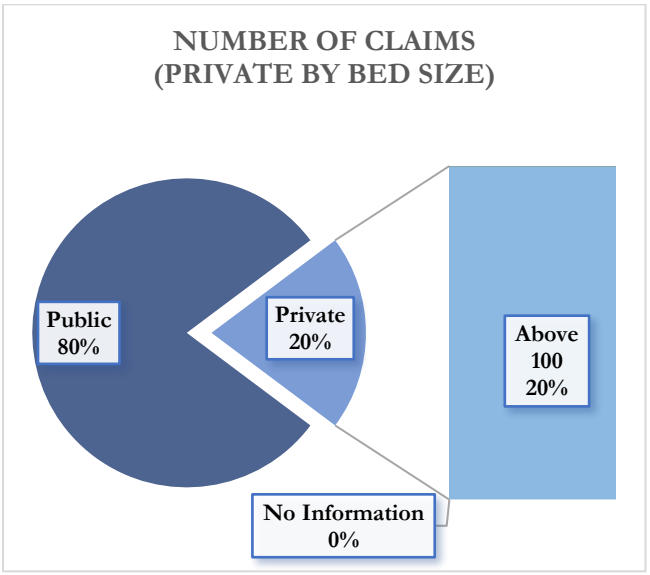

NO. OF CLAIMS BY SPECIALITIES
(PUBLIC AND PRIVATE)
Others 14%
Opthalmology 4%
Orthopaedics 4%
Obstetrics & Gynaecology 14%
General Medicine 35%
General Surgery 29%

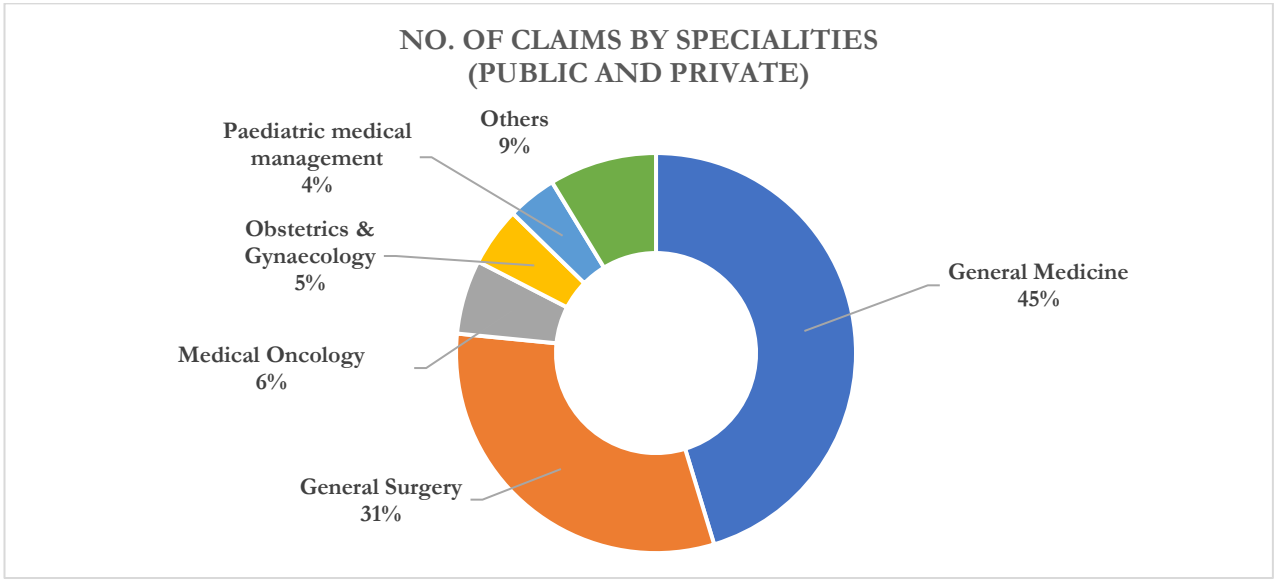
Sikkim


PUBLIC EMPANELMENT
(BY TYPE OF FACILITIES)
Primary (PHCs), 0%
Secondary (CHCs, SDHs, DHs), 36%
Private, 9
Public, 91%
Tertiary (MCT, OGH), 9%
GoI, 46%

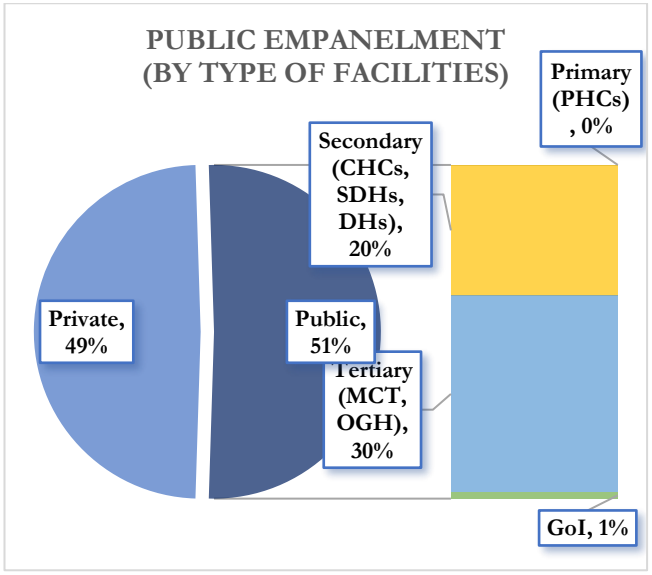

NUMBER OF CLAIMS IN PUBLIC
(BY TYPE OF FACILITIES)
Primary (PHCs), 0.1%
Secondary (CHCs, SDHs, DHs), 20%
Private, 20%
Public, 80%
Tertiary (MCT, OGH), 60%
GoI, 0%

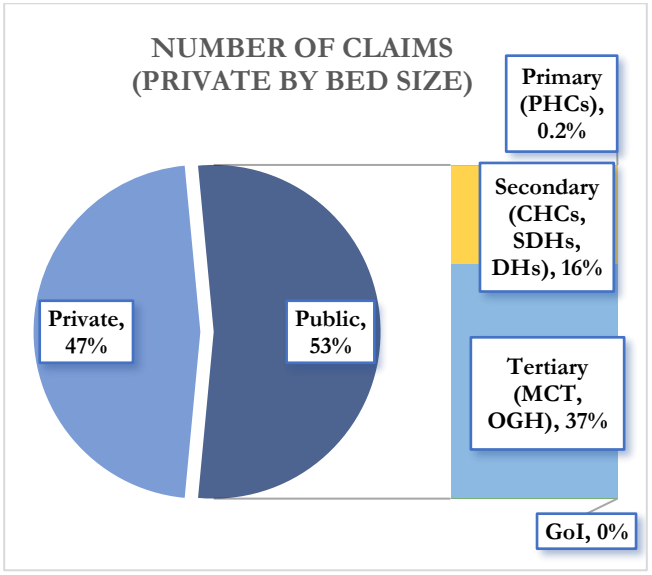

PRIVATE EMPANELMENT
(BY BED SIZE)
Public 91%
Private 9%
Above 100 9%
No Informatio n

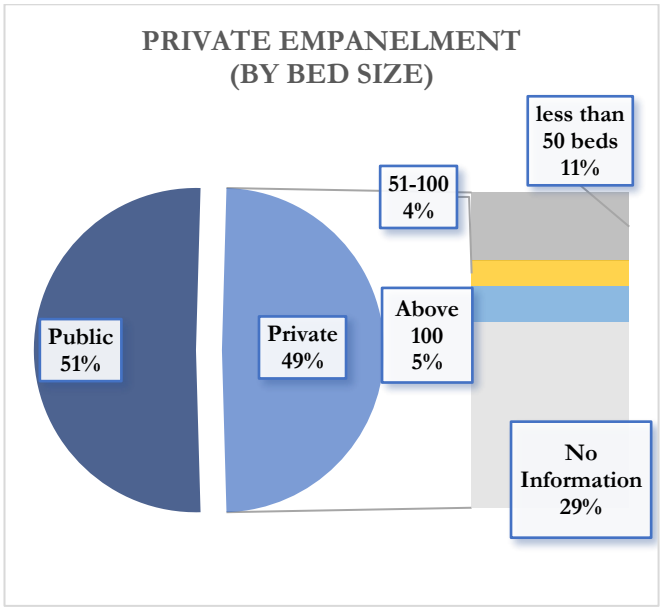

NUMBER OF CLAIMS
(PRIVATE BY BED SIZE)
Public 80%
Private 20%
Above 100 20%
No Information 0%

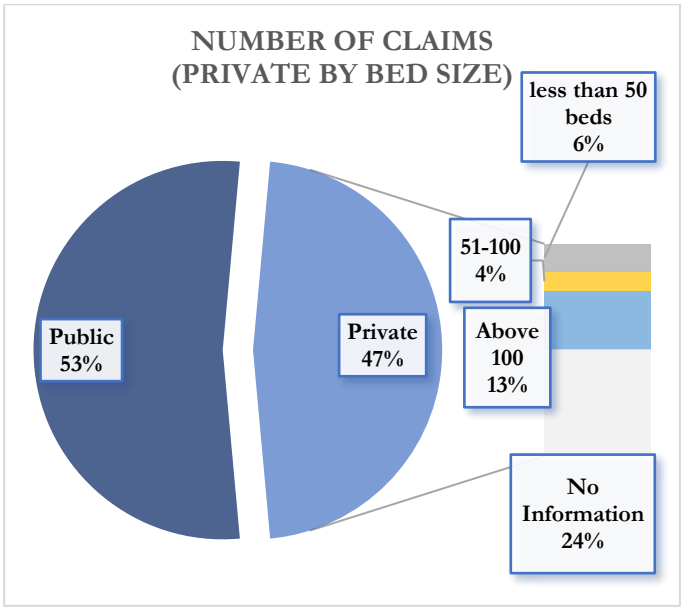

NO. OF CLAIMS BY SPECIALITIES
(PUBLIC AND PRIVATE)
Paediatric medical management 4%
Others 9%
Obstetrics & Gynaecology 5%
General Medicine 45%
Medical Oncology 6%
General Surgery 31%

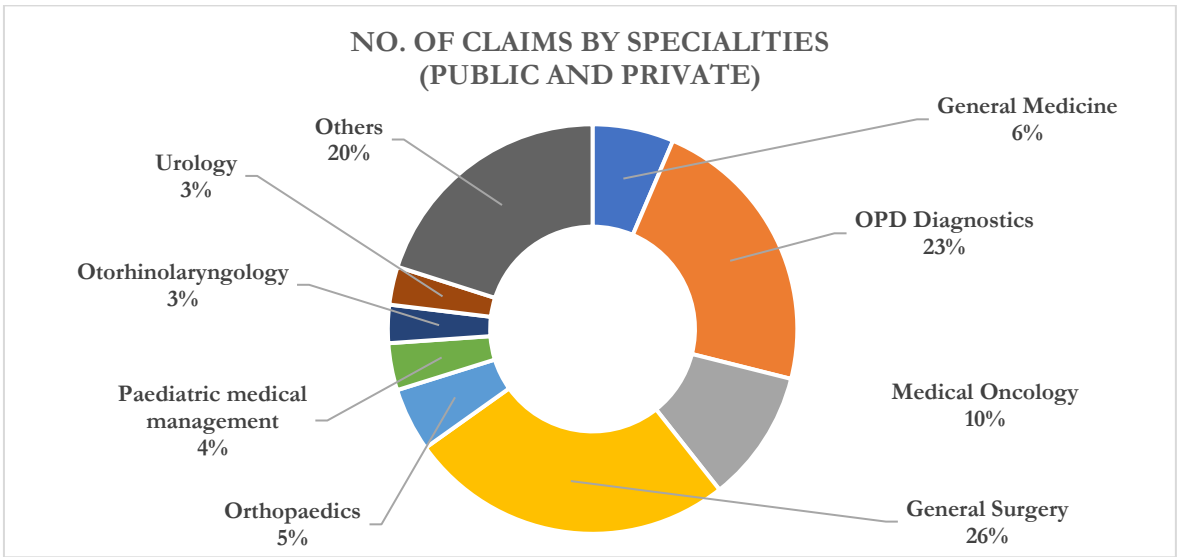
Tamil Nadu


PUBLIC EMPANELMENT
(BY TYPE OF FACILITIES)
Primary (PHCs), 0%
Secondary (CHCs, SDHs, DHs), 20%
Private, 49%
Public, 51%
Tertiary (MCT, OGH), 30%
GoI, 1%

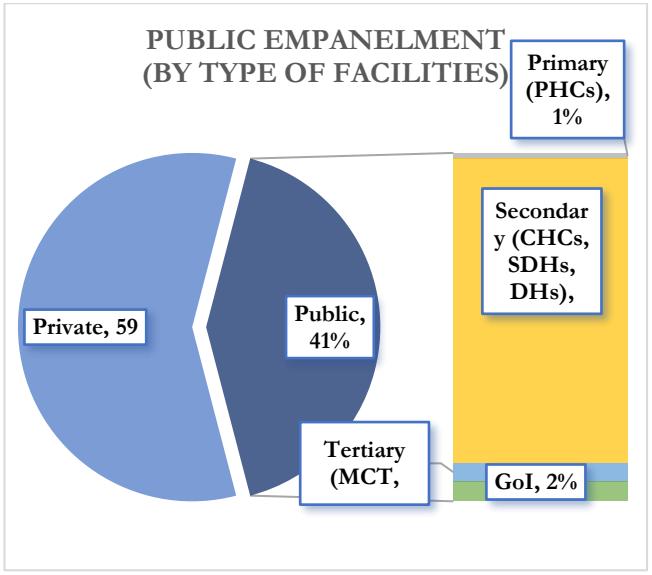

NUMBER OF CLAIMS
(PRIVATE BY BED SIZE)
Primary (PHCs), 0.2%
Secondary (CHCs, SDHs, DHs), 16%
Private, 47%
Public, 53%
Tertiary (MCT, OGH), 37%
GoI, 0%

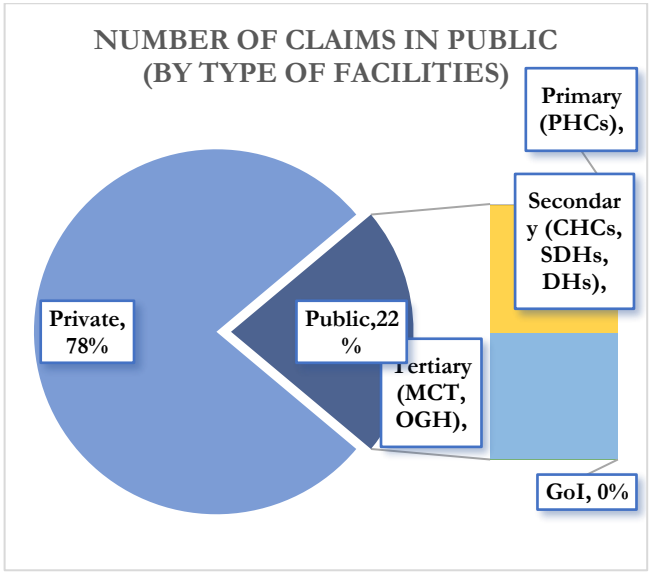

PRIVATE EMPANELMENT
(BY BED SIZE)
less than 50 beds 11%
51-100 4%
Above 100 5%
Public 51%
Private 49%
No Information 29%

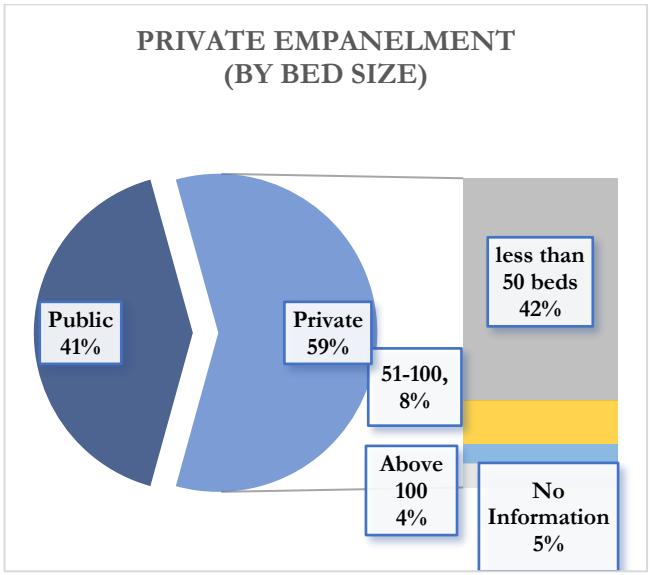

NUMBER OF CLAIMS
(PRIVATE BY BED SIZE)
less than 50 beds 6%
51-100 4%
Above 100 13%
Public 53%
Private 47%
No Information 24%

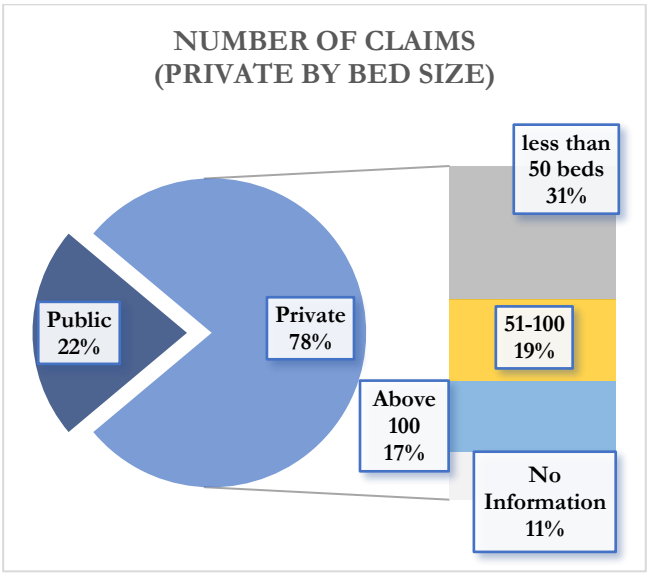

NO. OF CLAIMS BY SPECIALITIES
(PUBLIC AND PRIVATE)
General Medicine 6%
OPD Diagnostics 23%
Medical Oncology 10%
General Surgery 26%
Orthopaedics 5%
Paediatric medical management 4%
Otorhinolaryngology 3%
Urology 3%
Others 20%

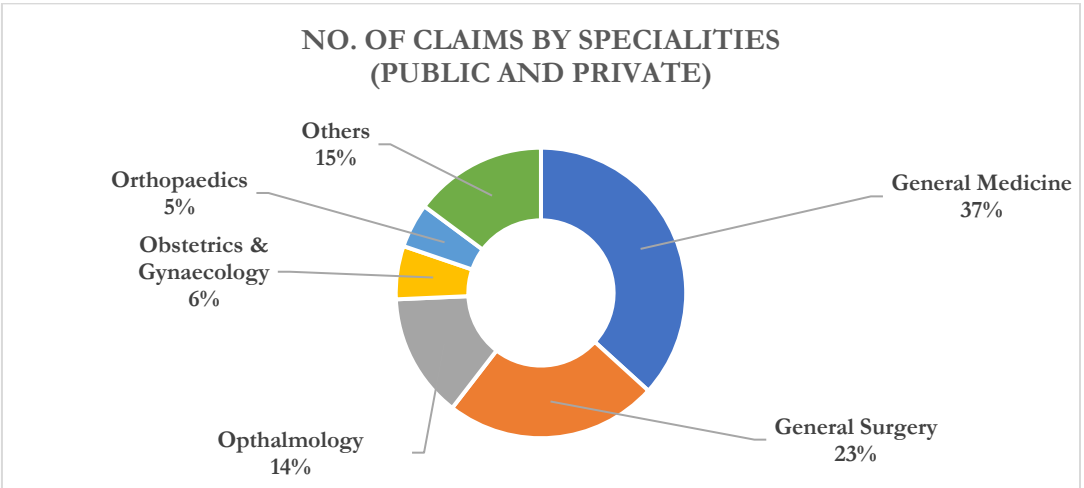
Uttar Pradesh









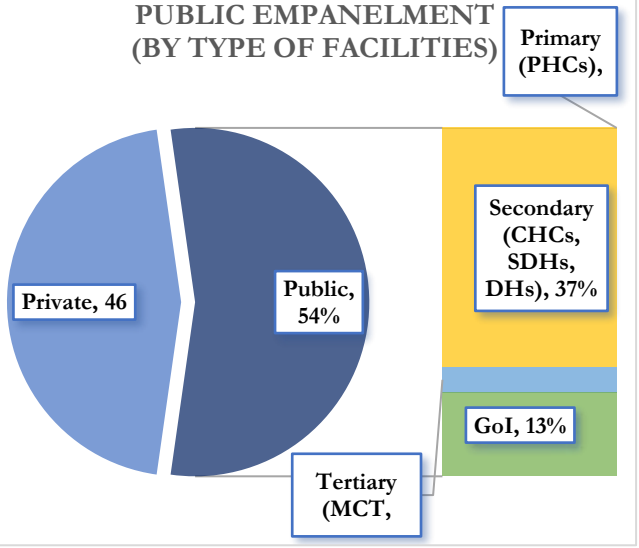


national health authority

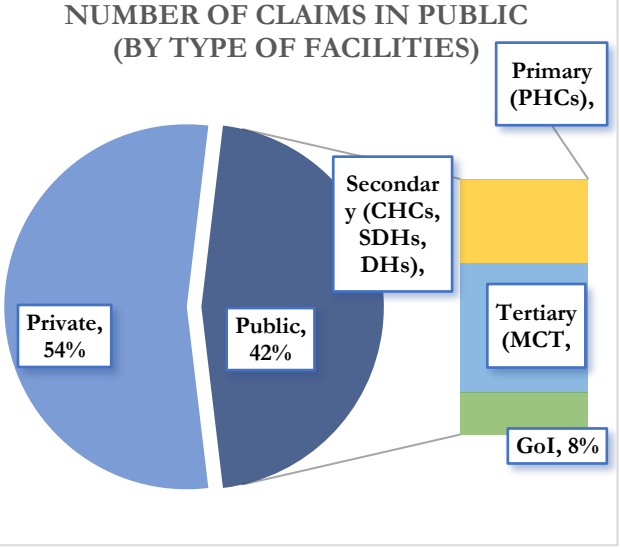
Uttarakhand

Pradhan Mantri Jan Arogya Yojana
Ayushman Bharat
PM-JAY

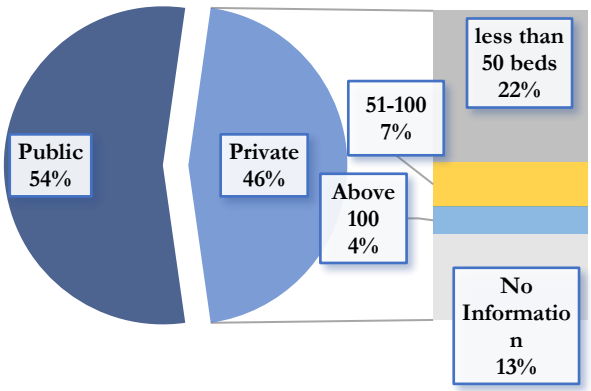
PUBLIC EMPANELMENT (BY TYPE OF FACILITIES)



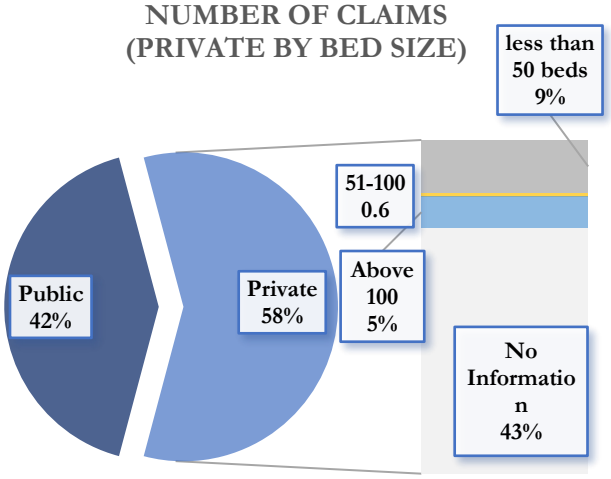
NUMBER OF CLAIMS IN PUBLIC (BY TYPE OF FACILITIES)



PRIVATE EMPANELMENT (BY BED SIZE)



NUMBER OF CLAIMS (PRIVATE BY BED SIZE)



NO. OF CLAIMS BY SPECIALITIES (PUBLIC AND PRIVATE)