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Introduction of Health Care Services under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana AB (PM-JAY) - A literature Review

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Abstract:- The Indian government approved the ambitious Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) in March 2018. It aims to protect 500 million of the most vulnerable Indians financially from health-related costs and to stop the 50–60 million Indians who fall into poverty each year as a result of medical expenses. If India wants to achieve its declared goals of offering universal health coverage (UHC) for its people, extensive reforms across public and private sources of care are required. The public sector must be changed and given the resources to oversee the plan's implementation, delivery, and oversight if the programme is to be successful. Aim: To introduce Health care services under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana AB (PM-JAY) Methodology: Relevant literature was identified through a search on Medline and PubMed. Outcomes: The program's implementation and continuous operation require close supervision to guarantee that its goals are being sustained and that unfavourable side effects are being prevented. Conclusion: Despite the program's many obstacles, AB-PMJAY offers the country an opportunity to address ingrained, long-standing issues with governance, quality assurance, and stewardship. It also speeds up India's progress towards its designated goal of providing universal health care.

Keywords:- *AB-PMJAY, Universal Health Coverage, National Health Mission, Medical Expenses, Poverty.*

I. INTRODUCTION

The nation's leading effort to enhance health systems is the National Health Mission (NHM). Specifically for primary and secondary health care, one of its objectives is "achieving universal access to equitable, affordable, and quality health care which is accountable and responsive to people's needs." Investments were made in the early phases of the NHM with the intention of supporting RCH services and mitigating the increasing incidence of infectious diseases, including as TB, HIV/AIDS, and vector-borne disorders. Even though this kind of focus on particular primary health care interventions enabled improvements in key indicators related to RCH and certain communicable diseases, the range of services offered at the primary care level did not take increasing disease burden and rising costs of care due to chronic conditions into consideration.[1]

Studies show that only a small fraction of families in rural and urban areas—roughly 11.5% and 4%, respectively—reported obtaining any kind of outpatient therapy (OPD) in primary care facilities that were at or below the CHC level (unlike delivery). This implies that chronic diseases are not being treated using public health care.1. Based on estimates from the National Sample Survey, the number of households suffering catastrophic healthcare costs increased by 10% between 2004 and 2014. This might be explained by the fact that the private sector still provides the majority of the country's health services—more than 75% of outpatient care and 62% of inpatient treatment, respectively. Chronic non-communicable illnesses include cancer, diabetes, cardiovascular disease, respiratory problems, and other age-related diseases account for more than 60% of all cases in India. There, too, is the apparent change in demography and epidemiology.[2]

The significance of primary healthcare in improving health outcomes has been shown by international studies. It is important for the primary and secondary prevention of many diseases, particularly non-communicable diseases. By providing comprehensive primary health care, one may significantly save expenditures while also reducing morbidity and death and the need for further and tertiary care. To be deemed comprehensive, primary care has to address the areas of palliative, rehabilitative, curative, promotive, and preventive care. Beyond providing initial medical attention, primary health care is meant to ensure follow-up support for both individual and community health initiatives as well as promote bidirectional referrals (from main care physician to specialist care and back).[1]

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In addition to supporting the creation of "Health and Wellness Centres" as the cornerstone for Comprehensive Primary Health Care, the National Health Policy of 2017 recommended dedicating two thirds of the health budget to primary healthcare. In February 2018, the Indian government announced that the development of 1,50,000 Health & Wellness Centres (HWCs) through the conversion of existing Primary Health Centres and Sub Health Centres to provide Comprehensive Primary Health Care will be one of the two components of Ayushman Bharat. This was the first step in turning policy statements into a cash commitment.[5]

Under the supervision of a Mid-Level Health Provider (MLHP), a well-trained Primary Health Care team made up of ASHAs and male and female multi-purpose workers will staff and supply the HWC at the sub health centre level. By collaborating, they will be able to provide more services. In several jurisdictions, subhealth centres were previously upgraded to Additional PHCs. Additionally, these Extra PHCs will be transformed into HWCs.

A Primary Health Centre (PHC) that oversees a collection of Health Work Centres (HWCs) would serve as the HWCs' first point of referral for a variety of medical conditions. Additionally, it would be more capable of handling a larger variety of primary care services as an HWC.

➢ *Increased Service Offering*

- Pregnancy and childbirth care.
- Services for newborn and neonatal health care.
- Health care services for children and adolescents.
- Services related to family planning, contraception, and other reproductive health care.
- Control of communicable illnesses, such as national health initiatives.
- Management of Common Communicable Diseases and Outpatient care for acute uncomplicated diseases and mild ailments.
- Non-communicable disease screening, prevention, control, and management.
- Care for Common Ophthalmic and ENT Disorders.
- Fundamental dental care.
- Palliative and elderly healthcare services.
- Emergency Health Services.
- Mental health illness screening and basic care.

In many jurisdictions, the Primary Health Centre serves as the sub health centres' administrative hub and initial point of referral. However, in certain states, there is a direct connection between the Community Health Centre (CHC) and the Sub Health Centre at the block level (in certain blocks, the Block PHC may also serve this purpose). However, in all cases, it is imperative to ensure that administrative, technical/mentoring, and referral support is provided by MBBS Medical Officers in a hospital that is near the HWC cluster and has the capabilities to manage HWC referral assistance. Thus, it might be a PHC or a CHC.

Likewise, in order to offer Comprehensive Primary Health Care, Urban Primary Health Centres or Urban Health Posts would be strengthened as HWCs if they exist. It will be feasible to provide outreach programmes, preventive and promotional care, and home and community-based services with one MPW-(F) per 10,000 persons, supported by four to five ASHAs. Thus, in an urban context, the ASHAs and MPWs (F) team would be considered the equivalent of a front-line provider team, with the UPHC acting as the first point of referral for about 50,000 individuals. All of the aforementioned HWC elements are beneficial for PHCs situated in urban environments. The first step in converting U-PHCs to HWCs would be to increase staff and field officials' capabilities in the extended range. PHCs located in metropolitan settings can benefit from all of the above-mentioned HWC fundamentals. The first step in converting U-PHCs to HWCs would be to train staff members and field workers on the wider range of services. There would also be a need for illness screening, empanelment, and population enumeration. These might be used as a tactic to ensure continuity of treatment in many places where nighttime OPDs on predetermined days now provide specialist consultation. States, however, are allowed to make changes that work best for their particular circumstances.[4]

Planning for HWCs requires states to carefully explore how to increase geographic accessibility so that the services offered at the primary health care level completely achieve the promise of greater variety and corresponding results. They also have to make sure that all employees are present at all times, support ongoing capacity growth and supportive supervision, and guarantee a steady supply of prescription drugs and diagnostic equipment.

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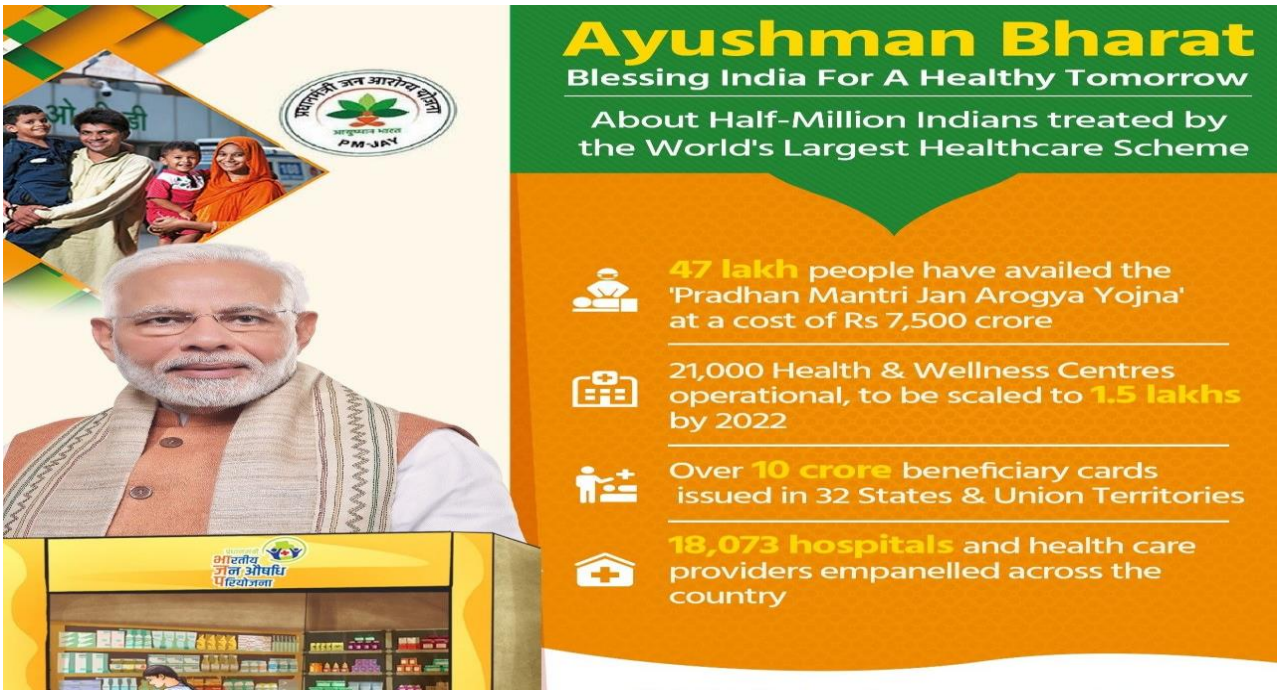

Fig 1 Ayushman Bharat

II. MODEL FOR EXECUTION

Various governments are using various strategies to establish their own health insurance and assurance systems. Some of them employ insurance companies' services, while others actively manage the programmes in their states.

Considering that States vary with regard to their preparedness and capacity to manage these initiatives, PM-JAY allows the States to choose the model of execution. To carry out their plan, they can choose an assurance/trust model, an insurance model, or a hybrid strategy.

Most women require low-intensity mental health support that can be provides in MCH services. For example, they may be given information about the management of stress and use of support from friends and family. Some women may experience mental health difficulties over a longer period, and they will require additional support either in MCH services or by specialized mental health care providers through referral, when possible.[11]

A. Assurance/Trust Model

This is the implementation technique that most States have adopted as the most common. Under this arrangement, the SHA carries out the plan directly, without the insurance company serving as a middleman. Under this model, the financial risk of running the system falls on the government. To put it simply, SHA pays doctors directly. Even though no insurance company is involved, the SHA utilises an Implementation Support Agency (ISA) for claim management and related responsibilities. Because there is no insurance carrier, the SHA is in charge of managing the program's day-to-day operations as well as certain tasks including hospital empanelment, beneficiary identification, claims administration, audits, and other related functions.

B. Insurance Model

The insurance idea states that the SHA selects an insurance company to manage PM-JAY in the State through a competitive tendering process. For the term of the policy, SHA pays each eligible family's premium—set by the market—to the insurance firm. After then, the insurance company takes care of paying the service provider and settling claims. This idea also includes the insurance provider taking on the financial risk of carrying out the strategy. However, the plan has a mechanism in place that limits the amount of premium that insurance companies may keep for their profit and overhead, so as to prevent the business from making unwarranted profits.

After settling all claims and subtracting a certain percentage for administration charges (which covers all expenses excluding service tax and any applicable cess), the insurer must return any excess money to the SHA within 30 days. The percentage that needs to be refunded will be determined by the following:

- In States included in Category A (when administrative expenses are 20% or less)
  - If the claim ratio is less than 60%, 10% of administrative costs are allowed.
  - 15% can be spent on administrative costs if the claim ratio is between 60% and 70%.
  - 20% of claim ratio falls between 70 and less than 80% should be allowed for administrative expenditures.

- In States included in Category B, wherein administrative expenses are limited to 15%.
  - If the claim ratio is less than 60%, 10% of administrative costs are allowed.
  - Administrative expenses may be charged at a rate of 12% if the claim ratio falls between 60 and less than 70%
  - If the claim ratio is between 70 and less than 85%, 15% of the total budget may be spent on administrative costs.

If the claim settlement ratio went beyond 120% (or 115% for State governments in Category B) throughout the duration of the policy, the insurance company and the State Government/Union Territory would first split the excess amount equally. Subsequently, the Central Government will allocate the extra burden amount borne by the State Government or Union Territory based on the sharing pattern ratio.

The Central Government's total contribution, premium share, or excess burden amount of the claim cannot exceed the maximum ceiling amount of the Central Government's share that applies to that particular State or UT. The insurance firm is required to cover any amount above the payments given by the federal and state governments, respectively.

C. Modified Model

In accordance with this, the SHA uses the assurance/trust and insurance models in a variety of ways in an effort to be more flexible, economical, efficient, and to enable convergence with the State plan. Typically, brownfield states that had pre-existing programmes that served a wider range of clients use this paradigm.

The Central and State Governments split the costs of the PM-JAY Scheme, which is fully financed by the Government. The upper limit of the central share of the contribution is set by the Government of India, which establishes a nationwide ceiling amount per household. The Central Government and the States/UTs would split the actual premium uncovered through the open tendering process, or, if less, the maximum ceiling of the estimated premium decided by the Government of India for the implementation of PM-JAY, in accordance with the current directives issued by the Ministry of Finance from time to time. Furthermore, the programme provides for administrative costs to be paid equally between the State and the Centre in order to administer the system at the State level.

For States (except from the Northeastern States and the three Himalayan States) and Union Territories with legislatures, the current sharing system is 60:40. The ratio is 90:10 for the Northeastern States and the three Himalayan States (Jammu & Kashmir, Himachal Pradesh, and Uttarakhand). On a case-by-case basis, the Central Government may supply up to 100% for Union Territories lacking legislatures.[6]

- Payment of the Central Share Insurance Model: Regardless of the number of PM-JAY members in a family, the State Government receives a predetermined payment, which it then distributes to the insurer based on the number of eligible households.

- Model of assurance: The core component of the payment is subtracted based on the actual cost of claims or the lower of the ceiling. If the State utilises an Implementation Support Agency, the Centre and the State divide the ISA cost, which is determined through a tender.

➢ *Extension of State Coverage Under PM-JAY, Convergence, and State Flexibility*

Throughout the previous several decades, some States have been putting their own health insurance or assurance programmes into place. Only tertiary care problems are covered by the majority of these plans. With a few modest exceptions, when a few hospitals beyond the state borders have been empanelled, the benefit coverage of these schemes is mostly available inside state limits. A considerable number of States continued to operate autonomously, and very few had combined their programmes with the previous RSBY model. The RSBY's rigid design, which at first facilitated rapid scale-up but eventually proved problematic and provided the States with little flexibility, was the cause of this. States differed greatly in terms of eligibility requirements and databases, despite the fact that these programmes catered to the impoverished and disadvantaged. A few states used the food subsidy database, but others had built a different database specifically for their welfare programmes.

➢ *Hospital Enrolment*

The supply of healthcare services under PM-JAY must be ensured by well selected, equipped, and prepared institutions in order to deliver the benefits. In addition, the hospitals must be sufficiently distributed around the area to offer the optimum accessibility for the families that meet the requirements.

Meeting the rising demands under PM-JAY and ensuring beneficiaries receive high-quality treatment need developing and growing a network of hospitals that also satisfy the quality requirements and criteria. Therefore, pre-enrolment is required at hospitals to guarantee that beneficiaries' rights are maintained in the most sensible, cashless, and superior manner conceivable.

➢ *Standards for Empanelment*

Given the supply side characteristics (almost 71% of hospitals are proprietorships with fewer than 25 beds and offer general clinical care that is not specialist), two types of empanelment criteria have been devised. The Clinical Establishment Act of 2011, state-specific quality-of-care rules, and the lessons learned from other publicly financed health insurance systems have all influenced these criteria throughout time.

- General requirements: For medical facilities offering general surgery and medical treatment without specialisation, as well as emergency and intensive care units.

- Special Criteria (for Clinical Specialties): A distinct set of standards has been established for each specialty. A hospital cannot apply for certain specialties under PM-JAY; instead, it must consent to provide all of its specialisations to PM-JAY beneficiaries. This is because the hospital is not permitted to choose the risk. However, as stated in the unique criterion created under PM-JAY for the same, the hospital needs to have the required particular infrastructure and HR in place in order to provide a specialist clinical service.

➢ *Observation and Communication*

Given that PM-JAY is an entitlement-based scheme without an upfront enrollment procedure, educating beneficiaries about it is crucial. To enlighten participants about the scheme, informative, educational, and communicational campaigns must be carried out. For a comprehensive communication plan to reach the target audience and effectively communicate the desired messages, a range of media must be used, including radio, TV, hoardings, pamphlets, brochures, and more.

Both the federal and state governments will implement the comprehensive communication strategy that NHA has developed. NHA is also working on general collaboration and capacity-building with the States in order to implement and develop the communication plan required to promote awareness at the State level.

➢ *Convergence of the National Health Authority (NHA) and Employees State Insurance Corporation (ESIC)*

The National Health Authority (NHA) and the Employee's State Insurance Corporation (ESIC) have forged a partnership. Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) and the Employees State Insurance Scheme (ESIS) will collaborate to create an ecosystem that would enable ESIC participants to receive services at hospitals associated with ABPM-JAY and vice versa.

The merging of PM-JAY and ESIC is a significant step towards improving the country's health system. In order to standardise services across schemes, this would make advantage of the predetermined health benefit packages and the reputable network of top-notch service providers under PM-JAY.7.

III. CONCLUSION

Despite the program's many obstacles, AB-PMJAY offers the country an opportunity to address ingrained, long-standing issues with governance, quality assurance, and stewardship. It also speeds up India's progress towards its designated goal of providing universal health care.

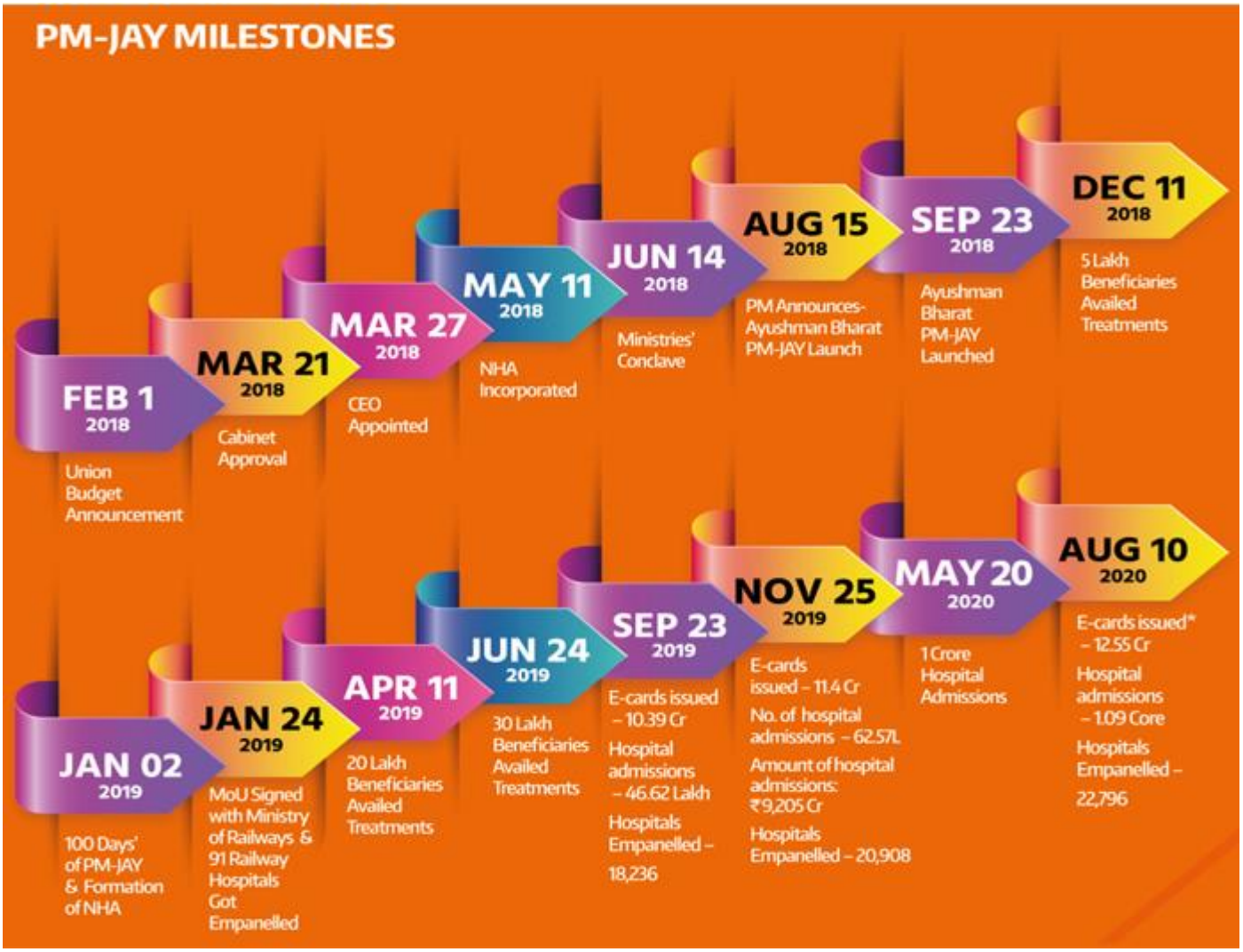

Fig 2 PM-JAY Milestones

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