REPORT NO.

151

PARLIAMENTOFINDIA
RAJYA SABHA

DEPARTMENT-RELATED PARLIAMENTARY STANDING COMMITTEE ON HEALTH AND FAMILY WELFARE

ONE HUNDRED FIFTY-FIRST REPORT

ON

IMPLEMENTATION OF AYUSHMAN BHARAT

(Presented to the Rajya Sabha on 19th December, 2023)
(Laid on the Table of Lok Sabha on 19th December, 2023)

Rajya Sabha Secretariat, New Delhi
December, 2023/ Agrahayana, 1945 (Saka)

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3. Shri Sanjeev Arora
4. Dr. L. Hanumanthaiah
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2.	Shri Shashi Bhushan	Director
3.	Dr. Saket Kumar	Deputy Secretary
4.	Smt. Noyaline Vinitha F.C.	Joint Director
5.	Shri Roshan Lal	Assistant Committee Officer

PREFACE

I, the Chairman of the Department-related Parliamentary Standing Committee on Health and Family Welfare, having been authorized by the Committee to present the Report on its behalf, present this One Hundred Fifty-first Report on the subject "Implementation of Ayushman Bharat" which was adopted by the Committee in its meeting held on the 11th December, 2023.

2. Even after the economic gains made in recent years, public health spending has not kept pace resulting in many people being left behind. India's health sector is characterised by a low rate of public investment and an overburdened public healthcare system. While progress has been made, significant disparities in healthcare access and outcomes still exist. Furthermore, the COVID-19 pandemic highlighted the need for a stronger and more resilient healthcare system. The government continues to work on expanding and improving healthcare services for all citizens. In this direction, Ayushman Bharat is a health scheme of the Government of India launched on the 23rd September 2018 to achieve Universal Health Coverage (UHC) as recommended in the National Health Policy 2017 and the Sustainable Development Goals (SDG).The primary objective behind identifying the subject, "Implementation of Ayushman Bharat" by the Committee was, therefore, to examine the healthcare access and affordability in India, the progress made in achieving the UHC, challenges being faced and potential areas of improvement in the implementation of Pradhan Mantri Jan Arogya Yojana to achieve the SDG goals by 2030.

3. The Committee held deliberations with the representatives of the Ministry of Health & Family Welfare and the National Health Authority during its meeting held on the 13th June 2023 for holistic examination of the subject. Besides, the Committee had undertaken study visits to Chennai, Thiruvananthapuram and Bengaluru from the 23rd May to 26th May 2023, and to Mumbai and Goa from the 10th July to 11th July 2023 to assess the ground realities related to the scheme in the country and implementation problems thereof. During the study visits, the Committee also interacted with the insurance companies and the PSUs to examine the aspects related to the role of insurance companies in the implementation of the scheme and the utilization of the Corporate Social Responsibility funds respectively.

4. For facility of reference and convenience, the observations and recommendations of the Committee have been printed in bold letters in the body of the Report and reproduced at the end of the Report at 'Observations/Recommendations-at a Glance'.

5. On behalf of the Committee, I extend special thanks to the Secretary of the Department of Health and Family Welfare, and the CEO of the National Health Authority. I also acknowledge the contribution of the stakeholders for their deep insight and valuable suggestions during interactions. I further extend special appreciation of the officers of the Committee Section for their valuable efforts in assimilating all relevant information and enabling the Committee to produce this quality Report.

New Delhi
December, 2023
Agrahayana, 1945 (Saka)

BHUBANESWAR KALITA
Chairman,
Department-related Parliamentary Standing
Committee on Health and Family Welfare

ACRONYMS

ABDM	Ayushman Bharat Digital Mission
ABHIM	Ayushman Bharat Health Infrastructure Mission
ACA	Affordable Health Care Act
APL	Above Poverty Line
BIS	Beneficiary Identification System
BMS	Beneficiary Management System
CAG	Comptroller and Auditor General of India
CFAR	Centre for Advance Research
CGHS	Central Government Health Scheme
CGRMS	Central Grievance Redressal Management System
CSMBS	Civil Servant Medical Benefit Scheme
CSR	Corporate Social Responsibility
DEC	District Empanelment Committee
DGNO	District Grievance Nodal Officer
DIU	District Implementation Unit
DPCs	District Project Coordinators
DQAS	Daily Quick Audit System
EHCPs	Empanelled Health Care Providers
ESIS	Employees' State Insurance Scheme
HBP	Health Benefit Packages
HEM	Hospital Empanelment Management
HWCs	Health and Wellness Centres (Ayushman Arogya Mandirs)
ISA	Implementation Support Agencies
LMIC	Lower and Middle-Income Countries
NAFU	National Anti-Fraud Unit
NFSA	National Food Security Act
NGNO	National Grievance Nodal Officer
NHA	National Health Authority
NHM	National Health Mission
NLEM	National List of Essential Medicines
NRCMS	New Rural Cooperative Medical Scheme
NUHM	National Urban Health Mission
OOPE	Out-of-Pocket Expenditure
PHC	Primary Health Care
PHI	Primary Health Institutes
PMJAY	Pradhan Mantri Jan Arogya Yojana
PMS	Provider Management System
PPP	Public-Private Partnership
RMNCH+A	Reproductive-Maternal- Neonatal-Child and Adolescent Health
RSBY	Rashtriya Swasthya Bima Yojana
SAFUs	State Anti-Fraud Units
SDGs	Sustainable Development Goals
SEC	State Empanelment Committees
SECC2011	Socio-Economic Caste Census, 2011
SFM	Support Function Management.
SGNO	State Grievance Nodal Officer
SHA	State Health Agencies
SSS	Social Security Scheme
TMS	Transaction Management System
UCS	Universal Coverage Scheme
UEMBI	Urban Employment-Based Medical Insurance
UHC	Universal Health Coverage
UNO	United Nations Organisation
URBMI	Urban Resident Basic Medical Insurance
UTs	Union Territories
VLEs	Village Level Entrepreneurs

Chapter- I

Introduction

1.1 Overview of Healthcare Policies in India

1.1.1 Healthcare policies in India have evolved over the years to address the country's healthcare challenges and provide access to affordable and quality healthcare services for its vast and diverse population. The National Health Policy (1983) aimed to provide "health for all" by the year 2000. The 1980s marked a shift towards a more comprehensive and integrated healthcare approach. It emphasised the development of primary healthcare services, the provision of essential drugs, and the integration of traditional medicine into the healthcare system.

1.1.2 Post economic liberalisation in 1990s, private healthcare providers expanded rapidly, leading to concerns about equity and quality. The government introduced health insurance schemes like the Central Government Health Scheme (CGHS) and Employees' State Insurance Scheme (ESIS) to provide coverage to specific groups. In 1996, the Rashtriya Swasthya Bima Yojana (RSBY) was launched to provide health insurance coverage to below-poverty-line families. National Health Policy (2002) recognised the importance of the private sector in healthcare and sought to encourage public-private partnerships. It also aimed to increase public spending on healthcare.

1.1.3 The National Rural Health Mission (NRHM), launched in 2005 aimed to improve healthcare delivery in rural areas by strengthening primary healthcare infrastructure, training healthcare workers, and providing free essential drugs. The National Urban Health Mission (NUHM), launched in 2013 envisages meeting the healthcare needs of the urban population with a focus on the urban poor, by making available to them essential primary healthcare services and reducing their out-of-pocket expenses for treatment. The two Missions were later subsumed under National Health Mission (NHM). The salient components of NHM includes Health System Strengthening, Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages the achievement of universal access to equitable, affordable & quality healthcare services that are accountable which is the broad objective of Universal Health Coverage (UHC) under Sustainable Development Goals (SDG) of United Nations Organisation (UNO).

1.1.4 The new National Health Policy was unveiled in 2017 with a focus on increasing government spending on healthcare, strengthening primary healthcare, reducing out-of-pocket healthcare expenditures, improving access to quality healthcare services, and achieving universal health coverage (UHC), with a focus on poor and vulnerable populations.

1.1.5 UHC in India is a significant policy goal, and to achieve this goal, the Government has embarked on a series of initiatives, the cornerstone of which is Ayushman Bharat launched in 2018. Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (PMJAY), one of the components of the Scheme, is aimed at achieving UHC in India by providing health insurance

coverage to eligible families for secondary and tertiary medical treatment in empanelled private and public hospitals. With Ayushman Bharat- Health and Wellness Centres: HWCs (since renamed as Ayushman Arogya Mandirs), another component of the Scheme, the government aims to strengthen healthcare infrastructure across the country, with a focus on setting up more HWCs (Ayushman Arogya Mandirs) and upgrading existing facilities. These efforts were intended to enhance the availability of primary healthcare services. The present study of the Committee is to evaluate the following which may play a crucial role in achieving the scheme's overarching goal of providing accessible and affordable healthcare to all citizens of India:

- Accountability among government agencies and healthcare providers responsible for delivering services under PMJAY;
- Health insurance component of the scheme; and
- Evolve new approaches to enhance the efficiency and effectiveness of the scheme.

1.2 Healthcare Access and Affordability in India

1.2.1 There exists a positive correlation between economic growth and improved health indicators. Significant disparities in terms of access and affordability to healthcare exist across the country. The quality of public healthcare facilities, including Primary Health Centres, Community Health Centres, district hospitals, and tertiary care hospitals, varies widely. Rural areas face significant challenges in terms of shortages of healthcare providers, infrastructure, and medical supplies. Urban areas have relatively better infrastructure and services compared to rural areas, but they are often concentrated in metropolitan cities, leading to overcrowding and long waiting times. The private healthcare sector in India offers a wide range of services, from primary healthcare to high-end specialised treatments, but it can be very expensive and inaccessible to a large portion of the population.

1.2.2 A significant proportion of the Indian population faces challenges in accessing affordable healthcare, leading to financial strain and even catastrophic out-of-pocket expenses. Lack of health insurance coverage is a significant factor contributing to affordability issues. While government-sponsored insurance schemes exist, coverage is often limited, and many people remain uninsured. There is a need for more healthcare infrastructure, an increase in the healthcare workforce, and reforms to reduce out-of-pocket expenses. India's healthcare access and affordability landscape is complex and marked by disparities. While the country has made progress in recent years with government initiatives, significant challenges remain in ensuring that quality healthcare is accessible and affordable to all its citizens, particularly those in underserved rural areas.

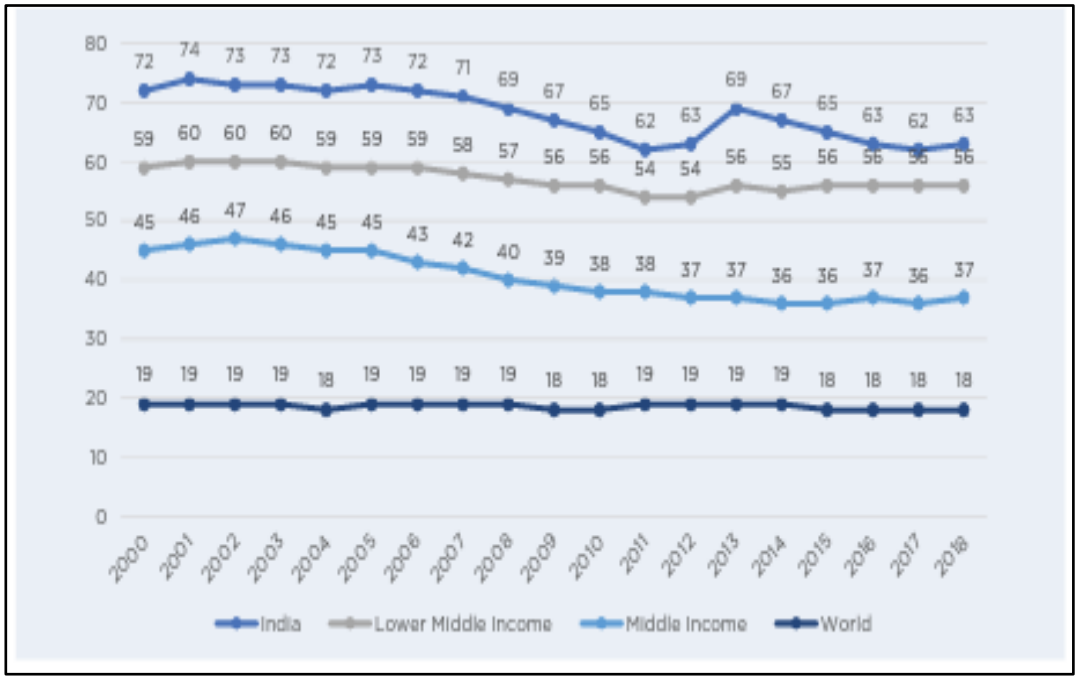
1.2.3 Health makes a vital contribution to economic progress, given that healthier populations live longer, are more productive, and have higher savings rates. For capital to be translated into positive healthcare outcomes, healthcare should be given priority in the budget. The Committee noted that in keeping with the objective of the National Health Policy 2017, Central and State Governments' budgeted expenditure on the health sector reached 2.1 per cent of GDP in FY 2022-23 (BE) and 2.2 per cent in FY 2021-22 (RE), against 1.6 per cent in FY 2020-21. The Economic Survey 2022-23 highlighted that the share of government health

expenditure in total health expenditure has increased from 28.6 per cent in FY 2013-14 to 40.6 per cent in FY 2018-19. The Survey also shows the hike in the share of spending on health in the total expenditure on social services, which has increased from 21 per cent in FY 2018-19 to 26 per cent in FY 2022-23 (BE).

1.2.4 NITI Aayog, in its 2021 report on "Health Insurance for India's Missing Middle", mentioned that India's health sector is characterised by low Government expenditure on health, high out-of-pocket expenditure (OOPE), and low financial protection for adverse health events. Persistently low Government spending on health has constrained the capacity and quality of healthcare services offered in the public system. Overburdened public hospitals often divert individuals to seek treatment in the costlier private sector. Almost 60% of all hospitalisations and 70% of out-patient services are delivered by the private sector (NSSO's 75th Round Survey on Social Consumption of Health, 2017-18).

1.2.5 The private sector is characterised by high OOPE, leading to low financial protection. Relatively low health insurance coverage and costlier provision of health services in the private sector drive India's high out-of-pocket expenditure (OOPE). Despite the decline in the past few years, India's OOPE as a per cent of current health spending is 63%, significantly above the average for lower-middle income countries and amongst the highest in the world. High OOPE poses a financial risk to individuals. They are vulnerable to impoverishment from expensive trips to the hospital and other health facilities. The impoverishing impact of health expenditure is similar in both rural and urban areas. Further, the incidence of catastrophic health spending – health expenditure exceeding a particular threshold share of consumption expenditure – has increased.

OOPE as a percentage of current health expenditure, India, and select country aggregates, 2000-2018:



Source: World Bank Open Data

1.2.6 The Committee believes that the Government's health expenditure needs to be increased reasonably from the present 2.1 percent of GDP on the lines of the objectives of the National Health Policy 2017. Apart from increased public health expenditure, the efficient utilisation of available funds should also be emphasised to improve the quality and access of healthcare infrastructure. The active collaboration with private stakeholders may also help in strengthening the infrastructure significantly.

1.2.7 The Committee is of the view that health insurance is a mechanism of pooling the high level of OOPE in India to provide greater financial protection against health shocks and improve efficiency in the organisation and delivery of healthcare for better health outcomes. Increased health insurance coverage will reduce catastrophic and impoverishing health expenditures by imposing a ceiling on the maximum health expenditure incurred by an individual or household. The publicly funded health insurance schemes are envisaged as keystone to advance Universal Health Coverage.

1.3 Universal Health Coverage

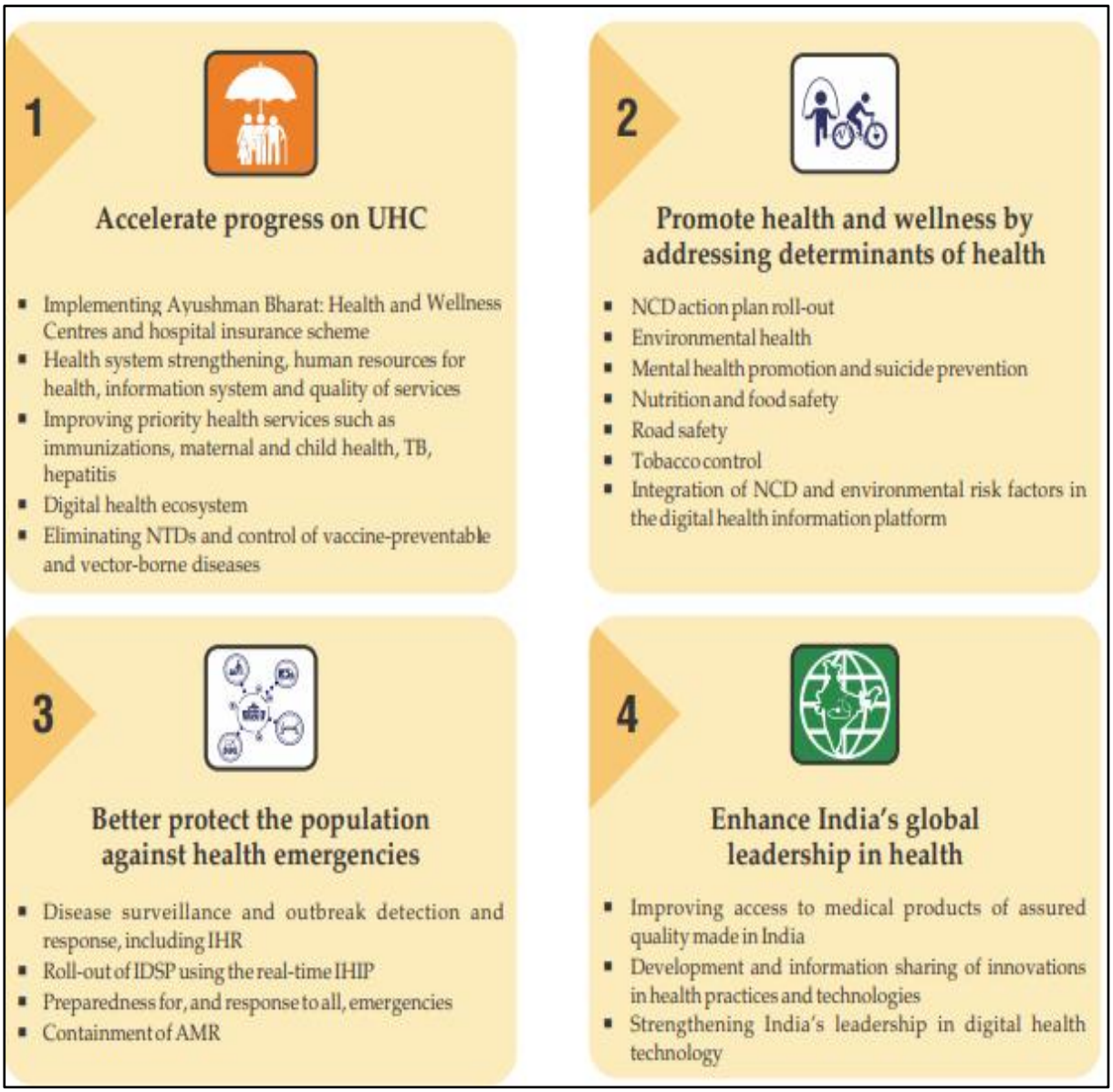
1.3.1 Universal Health Coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course. UHC is firmly based on the WHO Constitution 1948, which declares health a fundamental human right and commits to ensuring the highest attainable level of health for all.

1.3.2 Achieving UHC is one of the targets adopted by Sustainable Development Goals (SDGs) in 2015. The SDG target 3.8 specifically aims to achieve UHC, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality, and affordable essential medicines and vaccines for all by 2030. Advances towards this target are tracked through indicators on the coverage of essential health services (SDG 3.8.1) and catastrophic health spending (SDG 3.8.2), which is defined as the proportion of a country's population with large household expenditures on health relative to their total household expenditure.

1.3.3 At the United Nations General Assembly High-Level Meeting on UHC in 2019, countries reaffirmed that health is a precondition for and an outcome and indicator of the social, economic, and environmental dimensions of sustainable development. WHO's Thirteenth General Programme of Work aims to have 1 billion more people benefit from UHC by 2025 while also contributing to the targets of 1 billion more people better protected from health emergencies and 1 billion more people enjoying better health and well-being.

1.3.4 As a foundation for UHC, WHO recommends reorienting health systems towards Primary Health Care (PHC). In countries with fragile health systems, WHO focuses on technical assistance to build national institutions and service delivery to fill critical gaps in emergencies. In more robust health system settings, WHO drives public health impact towards health coverage for all through policy dialogue for the systems of the future and

strategic support to improve performance. The WHO India Country Cooperation Strategy 2019–2023 highlighted the four strategic priorities for cooperation with India, and to accelerate progress on UHC is the priority:



1.4 Healthcare and Health Insurance Schemes in Other Countries

1.4.1 Healthcare and health insurance schemes vary widely from country to country. The design and effectiveness of these systems can vary widely based on each country's economic, political, and cultural factors. Each country/region has adopted a different model to increase health insurance coverage. Some have increased insurance coverage through the expansion of government-subsidised schemes, while others have focused on developing robust voluntary coverage programs. NITI Aayog's 'Health Insurance for India's Missing Middle' report 2021 reviews the experience of three developing countries/regions - Thailand, China, and Latin America, to develop a deeper understanding of what has worked internationally.

Thailand

1.4.2 Thailand has three major health insurance schemes – government subsidised and compulsory contributory – which cumulatively cover its large population. The Civil Servant Medical Benefit Scheme (CSMBS) covers civil servants (all public sector employees), their spouses, and immediate relatives. The Social Security Scheme (SSS) covers formal sector employees in the private sector. The largest of the three schemes is the Universal Coverage Scheme (UCS); it covers those excluded by CSMBS or SSS. The UCS covers almost 48 million people, or approximately 75% of Thailand's population. Most of the rural population and the urban informal sector fall under this scheme. The screening of eligible candidates for UCS is done using a national electronic database with a citizen's ID base.

1.4.3 The scheme offers a comprehensive set of services, including inpatient and outpatient care and medicines in the National List of Essential Medicines (NLEM). It also lays emphasis on health promotion and disease prevention. However, the scheme relies on annual government budget allocation and runs the risk of lower budgets during "lean years" of economic downturn with fiscal constraints.

China

1.4.4 There are three main health insurance schemes in China, namely Urban Employment-Based Medical Insurance (UEMBI), Urban Resident Basic Medical Insurance (URBMI), and the New Rural Cooperative Medical Scheme (NRCMS). They cumulatively cover nearly the entire population of the country. In addition to these, there are private medical insurance schemes that act as top-ups for those wanting additional benefits beyond those offered by the above schemes.

1.4.5 The UEMBI is a compulsory contributory scheme for the urban formally employed population and their families. It covers nearly 20% of China's population. The URBMI is a government-run voluntary scheme for urban residents who are not formally employed. It covers around 23% of China's population, including the unemployed, students, elderly people without previous employment, etc. URBMI covers inpatient and outpatient services along with critical illnesses. The scheme is financed by individual contributions and government subsidies shared between the central and lower-level governments. The NRCMS is a voluntary, partially subsidised scheme, like the URBMI, for rural areas. It provides health insurance coverage to rural households. In 2016, URBMI and NRCMS were merged into the Urban and Rural Resident Basic Medical Insurance (URRBMI) since they were broadly similar.

1.4.6 The need to increase the scale of financing available for URRBMI and to establish a sustainable financing mechanism has been felt to address the rapidly rising demands for healthcare.

Latin America

1.4.7 Several Latin American countries have expanded health insurance coverage to those outside the organised sector to move towards UHC. Bolivia, Colombia, Costa Rica,

Dominican Republic, Mexico, Peru, and Uruguay have introduced health insurance schemes covering additional groups beyond the poor. They have done this through partially subsidised, contributory health insurance schemes for the non-poor, predominantly engaged in the informal sector. Additionally, there are also schemes to cover vulnerable groups, including the disabled, pregnant women, the elderly and indigenous people. Aside from Bolivia and Uruguay, other above-mentioned Latin American countries classify their population based on income to determine eligibility. The households are targeted either through direct targeting, involving the use of surveys to determine eligibility, or through indirect targeting, which identifies and includes beneficiaries of other social assistance programs.

1.4.8 However, there are several challenges in the Latin American models. For example, there is adverse selection in Chile. Younger, healthier, and high-income people opt out of the public health insurance scheme, reducing cross-subsidisation. Peru and the Dominican Republic suffer from high exclusion errors in their targeting and unequal coverage. Since they do not have an integrated risk pool enabling cross-subsidisation, the fully subsidised have access to smaller benefit packages relative to contributory members. Further, there are high exclusion errors, i.e., eligible people are excluded from the scheme due to targeting and identification problems. Other Latin American countries, with multiple health insurance schemes for different socio-economic groups, also suffer from high premiums and inequality in access to healthcare due to fragmented risk pools.

United States

1.4.9 United States has about 17 percent of GDP investment in healthcare, which is the largest in the world. Affordable Health Care Act (ACA), popularly known as 'Obamacare', was implemented in 2014. Through a host of comprehensive healthcare reforms, the Obamacare covered about fifty percent uncovered population by 2016. The Employer mandate in Obamacare requires large employers to provide health insurance to employees or face penalties. This provision was, however, eliminated in 2019. Preventive Services such as vaccinations and screening are covered without cost sharing which promote early detection and disease control. The law also focuses on improving healthcare cost through organizations like Accountable Care organisation and provides for bundled payments for certain healthcare packages. Obamacare emphasises health information technology to enhance coordination among health care providers and improve patients' outcomes. The implementation of Obamacare has led to significant reduction in the uninsured and improved access to essential healthcare services for millions of Americans. It aims for widespread coverage, affordability, and quality care. Specific health schemes like Medicare, Medicaid have been subsumed in Obamacare. As of 2021, 91.7 percent population is covered through public and private health insurance.

1.4.10 The Committee notes that the experiences of Thailand, China, and Latin American countries demonstrate the difficulty of increasing health coverage in the informal/unorganised sector. Thailand made good progress in UHC by fully subsidising the informal sector, while China has partially subsidised that segment. However, China's experience also indicates the possibility of sustained coverage through a

contributory and voluntary scheme. Further, the examples from Latin America highlight that adverse selection and inadequate risk-pooling is a pressing challenge for voluntary contributory schemes targeted towards the informal sector. The adverse selection due to opting out of high-income people reduces cross-subsidisation, leading to high premiums and inequality in access to healthcare.

1.4.11 The Committee is of the view that the Government may consider some of the provisions of the Affordable Care Act of United States for inclusion in Ayushman Bharat. By including some sections of the persons falling in APL category, the provisions for 'employer mandate' to provide health insurance to the employee and his family, subsuming of specific schemes for children and senior citizens, tax incentives and disincentives to corporate regarding healthcare are some of the measures worth including in the Ayushman Bharat Scheme and PMJAY.

1.5 Purpose of Report on Implementation of the Ayushman Bharat Scheme

1.5.1 Ayushman Bharat is a health scheme of the Government of India launched on the 23rd September 2018 to achieve UHC as recommended in the National Health Policy 2017 and the SDGs. The scheme has been rolled out in rural and urban areas, based on the deprivation and occupational criteria of the Socio-Economic Caste Census, 2011 (SECC 2011) respectively, for over 10.74 crore families, with further expansion of beneficiary base to 12 crore families based on National Food Security Act (NFSA) data. The aim of the scheme is to reduce the out-of-pocket expenditure of poor and vulnerable populations and expand the coverage of essential health services by implementing its two interrelated components, PMJAY and HWCs (Ayushman Arogya Mandir).

1.5.2 Despite the gains made in recent years, public health spending has kept pace neither with the country's economic growth nor with that of most other countries in the WHO South-East Asia Region, resulting in many people being left behind. India's health sector is characterised by a low rate of public investment and an overburdened public healthcare system. This results in diverting individuals to seek treatment in the private sector, with varying quality of healthcare and rising rates of out-of-pocket health expenditures. While progress has been made, significant disparities in healthcare access and outcomes still exist, and the government continues to work on expanding and improving healthcare services for all citizens. Furthermore, the COVID-19 pandemic highlighted the need for a stronger and more resilient healthcare system. The pandemic has disrupted essential health services around the world and threatened already-achieved health outcomes. The Committee feels that if UHC is to become a reality by 2030, growth in the provision and coverage of essential health services must greatly accelerate.

1.5.3 The increasing cost of quality healthcare combined with greater need and demand for health with increasing incomes, higher life expectancy, and epidemiological transition towards non-communicable diseases have made health coverage imperative. Expansion of health insurance coverage is a vital mechanism to safeguard individuals against catastrophic and unpredictable health expenditures and to achieve UHC. Health insurance can also improve the efficiency and quality of healthcare provision. Insurers with pooled funds have

more bargaining power and information against providers as compared to individual customers.

1.5.4 Apropos of the above, studying the implementation of the Ayushman Bharat Scheme is important for analysing and assessing the effectiveness of the program in achieving its goals of improving access to healthcare, reducing financial burden, and addressing health disparities. It is necessary to identify areas where the quality of healthcare services can be improved, which might involve assessing the infrastructure of healthcare facilities, the training of healthcare professionals, or the availability of essential medicines and medical equipment. It may help in understanding the financial implications of the program and the ways to make it more sustainable.

1.6 The Process Followed

1.6.1 The Committee held deliberations with the representatives of the Ministry of Health & Family Welfare and the National Health Authority on the 13th June 2023 for holistic examination of the subject "Implementation of Ayushman Bharat". The Committee had also undertaken study visits to Chennai, Thiruvananthapuram and Bengaluru from the 23rd May to 26th May 2023, and to Mumbai and Goa from the 10th July to 11th July 2023 to assess the ground realities related to the scheme in the country and implementation problems thereof. During the study visits, the Committee as well interacted with the insurance companies and the PSUs to examine the aspects related to the role of insurance companies in the implementation of the scheme and the utilisation of the Corporate Social Responsibility funds respectively.

1.6.2. The Committee also examined the study notes and the replies to its questions obtained from the Ministry of Health and Family Welfare, and other stakeholders. The Committee, besides consulting reputed journals like the Lancet, also perused the following documents and information to acquaint itself with in-depth knowledge on the subject: -

i. National Health Policy 2017
ii. The contents on the website of the WHO regarding Universal Health Coverage and the Sustainable Development Goals
iii. The WHO India Country Cooperation Strategy 2019-2023
iv. Report of the Comptroller and Auditor General of India on Performance Audit of Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana
v. Report of the NITI Aayog on the Health Insurance for India's Missing Middle
vi. Annual Report 2021-2022 of the National Health Authority and the information available on their website
vii. Economic Survey-2022
viii. Union Budget 2023-24

1.6.3 The draft copy of this Report was considered by the Committee at its meeting held on the 11th December, 2023. The suggestions and amendments were included, and the Report was finalized.

Chapter- 2

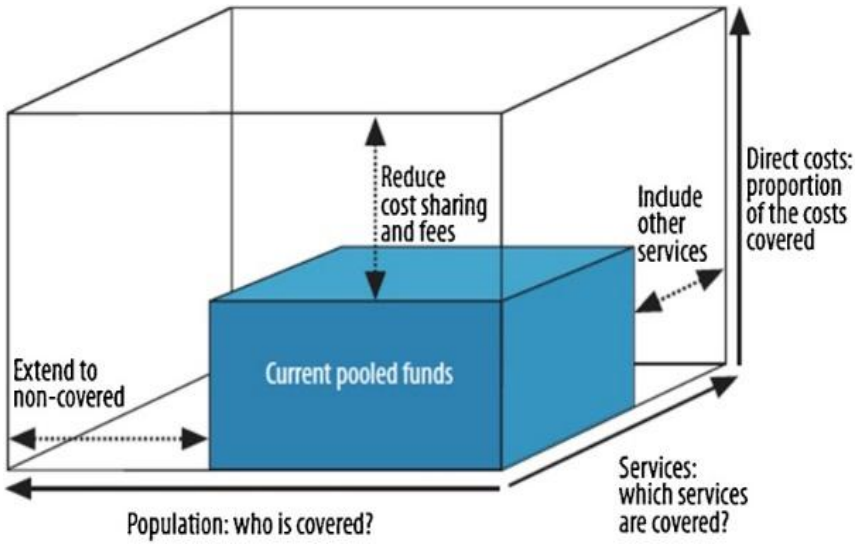
Ayushman Bharat Scheme

2.1 Rationale and Components for Ayushman Bharat

2.1.1 The National Health Policy 2017 envisages the goal of attaining the highest possible level of health and well-being through a preventive and promotive healthcare orientation and universal access to good quality healthcare services without anyone having to face financial hardships. Consequently, Ayushman Bharat Scheme was launched in 2018 with the objective to provide promotive, preventive, curative, palliative and rehabilitative aspects of Universal Health Coverage through two inter-related components *viz.(*i) Pradhan Mantri Jan Arogya Yojana (PMJAY) for providing financial protection for accessing hospitalisation care at the secondary and tertiary levels, and (ii) Health & Wellness Centers (Ayushman Arogya Mandir) with an aim to transform the existing primary health infrastructures into Health & Wellness Centers to deliver comprehensive primary healthcare services. Ayushman Bharat has been designed to meet Sustainable Development Goals (SDGs) and its underlining commitment, which is to "leave no one behind." It is an attempt to move from a sectoral and segmented approach to health service delivery to a comprehensive equity and need-based health care service.

2.1.2 In the year 2021, two more components, Ayushman Bharat Digital Mission (ABDM) and Ayushman Bharat Health Infrastructure Mission (ABHIM), were added under the ambit of Ayushman Bharat. ABDM (erstwhile National Digital Health Mission) was launched to realise the vision of the National Health Policy 2017 to provide quality healthcare by leveraging technology. ABDM intends to develop the backbone necessary to support the integrated digital health infrastructure of the country. ABHIM was launched to fill critical gaps in health infrastructure, surveillance, and health research with an aim to strengthen the public health infrastructure.

2.1.3 The three dimensions of Universal Health Coverage represented through the Universal Health Care Cube are – population coverage, package of services provided (disease coverage)



and level of financial protection. The aim of the Committee in this study is to see whether the efforts undertaken by the Government to move on all these three dimensions incrementally through Ayushman Bharat are in right direction to achieve Universal Health Coverage in the country.

2.2 Pradhan Mantri Jan Arogya Yojana (PMJAY)

2.2.1 As stated earlier, the focus of the Committee in this report is to scrutinise and evaluate the Pradhan Mantri Jan Arogya Yojana (PMJAY) within the broader framework of Ayushman Bharat. It will delve into a range of features and issues pertaining to PMJAY. PMJAY was launched on the 23rdSeptember, 2018, in Ranchi, Jharkhand. It is the largest publicly funded health assurance scheme in the world, which aims to provide a health cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalisation across public and private empanelled healthcare providers. The salient features of PMJAY are as follows:

i) 33 States/UTs are currently implementing PMJAY barring Delhi, Odisha, and West Bengal.

ii) PMJAY provides cashless access to health care services for the beneficiary at the point of service, that is, the hospital.

iii) PMJAY envisions to help mitigate catastrophic expenditure on medical treatment, which pushes nearly six crore Indians into poverty each year.

iv) It covers up to 3 days of pre-hospitalisation and 15 days of post-hospitalisation expenses, including diagnostics, medicines, and follow-up consultation.

v) There is no restriction on the family size, age, or gender. The RSBY had a family cap of five members. However, PMJAY has been designed in such a way that there is no cap on family size or age of members.

vi) All pre–existing conditions are covered from day one. This means that any eligible person suffering from any medical condition before being covered by PMJAY will now be able to get treatment for all those medical conditions as well under this scheme right from the day they are enrolled.

vii) Benefits of the scheme are portable across the country wide.A beneficiary can visit any empanelled public or private hospital in India to avail cashless treatment.

viii) Health Benefits Package 2022 includes 1121 packages and 1949 procedures across 27 specialties.

ix) Many of the States and UTs have further expanded the beneficiary base to approximately 15.5 crore families at their own cost.

x) The health cover of Rs. 5 lakhs is on a family floater basis, which means that it can be used by one or all members of the family.

Institutional Mechanism

2.2.2 The implementation of PMJAY is being administered through a three-tier mechanism at the National, State and District levels. The National Health Authority (NHA) has been constituted as the apex body tasked with the implementation of PMJAY. NHA is governed by a Governing Board, which is chaired by the Hon'ble Union Minister of Health and Family Welfare. A full-time CEO in the rank of Secretary, appointed by the Government of India, oversees the NHA under the guidance of the Governing Board.

2.2.3 For effective implementation of PMJAY, State Governments have set up State Health Agencies (SHA) or designated the function to an existing agency, trust, or any other society. The SHA is the nodal agency responsible for the implementation of PMJAY in the State, headed by a Chief Executive Officer. The SHA can onboard additional staff or Implementation Support Agencies (ISA) to aid in the implementation of the scheme. The CEO of SHA is appointed by the State Government and is ex-officio member-secretary of the Governing Council of the SHA.

2.2.4 In addition to the State-level entity, a District Implementation Unit (DIU) has also been established to support the implementation in every district included under the scheme. This team will be in addition to the team deployed by the insurance company/ISA. The DIU will coordinate with the implementing agency (ISA/insurer) and the empanelled hospitals to ensure effective implementation and send review reports periodically. The DIU must work closely and coordinate with the District Chief Medical Officer and his/her team.

2.3 Coverage of beneficiaries under PMJAY

2.3.1 The Scheme has been rolled out in rural and urban areas, based on the deprivation and occupational criteria of the Socio-Economic Caste Census, 2011 (SECC-2011), respectively, for over 10.74 crore poor and vulnerable families. PMJAY subsumed the then-existing Rashtriya Swasthya Bima Yojana (RSBY), which had been launched in 2008. The families that were covered in the RSBY but were not present in the SECC-2011 database are also covered under the scheme. The SECC database involves ranking the households based on their socio-economic status. It uses exclusion and inclusion criteria and accordingly decides on the automatically included and automatically excluded households. Rural households that are included (not excluded) are then ranked based on their status of seven deprivation criteria. Urban households are categorised based on occupation categories. In line with the approach of the Government to use the SECC database for social welfare schemes, PMJAY also identifies targeted beneficiary families through this data.

2.3.2 Out of the total seven deprivation criteria for rural areas, PMJAY covers all such families who fall into at least one of the six deprivation criteria (D1 to D5 and D7) ***(Annexure-I)*** and automatic inclusion of D6 (Destitute/ living on alms, manual scavenger households, primitive tribal group, legally released bonded labour) deprivation criteria. For urban areas, there are various occupational categories ***(Annexure-I)*** of workers including Rag-picker, Beggar, Domestic Worker, and Street Vendor who are eligible for the scheme.

2.3.3 The Committee was informed that there were some limitations with the SECC database, like non-traceability (only five crore individuals of 1.8 crore families were verified), inappropriate inclusion & exclusion of people and difficulty in identifying beneficiaries on the ground with certainty. Further, many States were already implementing their own health insurance schemes with a set of beneficiaries already identified. There were large variations across States in terms of eligibility criteria and databases. To solve all these problems, the Union Cabinet provided flexibility to States/UTs to use existing non-SECC digitised databases against unidentified SECC beneficiary families to ensure that all families eligible as per the SECC data are covered and not denied benefits. In January 2022, due to the decennial population increase, the beneficiary base to be covered under the scheme has been increased to 12 crore families.

2.3.4 The Committee noted that in its Report No. 11 of 2023 on the Performance Audit of PMJAY, the Comptroller and Auditor General of India (CAG) stated that the SECC database of 2011 used as eligibility criteria for the scheme was more than seven years old at the time of inception of the scheme. Because of economic development and employment opportunities, many households may have become ineligible for inclusion, while others may have become eligible for the SECC under the existing criteria. Analysis of Beneficiary Identification System (BIS) data revealed several inconsistencies in the SECC database, like different names and dates of birth of beneficiaries in two different columns, invalid or blank entries in the fields for name, year of birth and gender of beneficiary. In its report, the CAG also highlighted several errors, like unrealistic size of family against unique ID and delay in rejection of cases in the BIS database. ***(Table 1 and 2 of the said Report)***

2.3.5 The report of CAG highlights the possibility of the presence of ineligible beneficiaries in the BIS database. It also indicates a lack of validation controls in the beneficiary registration process, resulting in the presence of duplicate beneficiaries in the system. Moreover, delayed action in the finalisation of approval of eligible beneficiaries and weeding out of the ineligible beneficiaries resulted in delayed/denied benefits to potential beneficiaries and ineligible persons availing benefits of the scheme and excess payment of premiums to the insurance companies. Further, it also delays re-application by a potential beneficiary in case rejection was due to lack of documents.

2.3.6 The Committee, in the above context, was apprised that several beneficiaries were facing problems in addition and inclusion of family members above or less than the prescribed 6 family members. The ministry stated that the criteria of 6 family members is with reference to one mobile number only and there was no cap on family size in PMJAY. The Committee, therefore, recommends that the difficulties being faced by the beneficiaries having family size less than or more than 6 members may be addressed promptly by updating the application software.

2.3.7 The Committee observes that the accurate identification and registration of the eligible beneficiaries under PMJAY is a major challenge. It is difficult to reach the poorest and the most vulnerable population of the country due to low literacy and awareness. This is true for most Lower and Middle-Income Countries (LMIC), and

India is not an exception. It is essential to ensure that the benefits reach the target section of population.

2.3.8 The Committee believes that the Ministry and NHA, along with implementing States/UTs, need to undertake a country-wide drive to scrutinise and validate the BIS database. Validation checks should be in place to increase the accuracy and reliability of the data. The inconsistencies in the database may be removed at the earliest. The appropriate mechanism may be devised to ensure weeding out of ineligible beneficiaries and identification of eligible beneficiaries in a planned, coordinated and time-bound manner. States/UTs need to be impressed upon to map their own database with the SECC database to avoid duplication. The process for approval or rejection of ineligible beneficiaries and registration of eligible beneficiaries needs to be made simple and less time-consuming to avoid delay beyond the prescribed time.

2.3.9 The Committee recommends that the NHA needs to develop an IT-based solution to educate and create awareness that a family is eligible for the scheme, and ways to rapidly identify the family if any member comes to an empanelled hospital for treatment.

2.3.10 The Committee believes that the Information, Education and Communication (IEC) programs are significant to understanding the various target audiences for PMJAY, like their attitudes and perceptions towards the scheme, and to educate the target audience about the scheme driving changes in their attitudes and behaviour. The programs are necessary to maximise the reach, impact, and awareness of the scheme amongst targeted beneficiaries. NHA needs to set up designated IEC cells, make special efforts in a planned manner and sensitise the entitled beneficiaries to generate awareness about the scheme. NHA should coordinate with SHAs and NGOs to design a comprehensive IEC plan and undertake IEC campaigns in a planned manner. Such IEC efforts should be recorded, reviewed, and monitored regularly.

2.3.11 The Committee notes that the flexibility has been given to the States/UTs to choose the remaining beneficiaries from any digital database that the State/UT has if the broad nature of these new people matches with the beneficiary nature of PMJAY. The Committee is of the view that under that dispensation, States/UTs may be asked to include senior citizens, particularly those residing in old age homes or any other place by revising the Deprivation Criteria, as beneficiaries of the scheme. Many senior citizens residing in places like shelter homes and old age homes do not fall under the Below Poverty Line and face financial problems while availing treatments. Their inclusion in the scheme would help them access affordable and quality treatment.

2.4 Implementation Process- PMJAY

2.4.1 Various States are using different models for implementing their own health insurance/assurance schemes. Since States are at different levels of preparedness and have

varying capacities to manage such schemes, PMJAY provides the States with the flexibility to choose their implementation model. They can implement PMJAY through three modes - trust, insurance, or mixed/hybrid.

A. Trust Mode

Under this model of implementation, the scheme is directly implemented by the State Health Agency (SHA) without the intermediation of the insurance company. The payment to the healthcare providers is made directly by the SHA. The SHA engages the services of an Implementation Support Agency (ISA) for claim management and related activities. As there is no insurance company in the picture, apart from day-to-day management and administration of the scheme, the SHA also carries out specialised tasks such as hospital empanelment, beneficiary identification, claims management and audits and other related tasks. 23 States/UTs have adopted this model of implementation.

B. Insurance Mode

In the insurance model of implementation, the SHA competitively selects an insurance company through a tendering process to manage the scheme in the State/UT. Based on market-determined premiums, SHA pays a premium to the insurance company per eligible family for the policy period, and the insurance company, in turn, does the claims settlement and payments to the service provider. The financial risk for implementing the scheme is also borne by the insurance company in this model. However, to ensure that the insurance company does not make an unreasonable profit, the scheme provides for a mechanism where insurance companies can only get a limited percentage of the premium for their profit and administrative costs. After adjusting a defined percentage for expenses of management (including all costs, excluding only service tax and any cess, if applicable) and after settling all claims, if there is a surplus, then 100 per cent of leftover surplus should be refunded by the insurer to the SHA within 30 days. 7 States/UTs have adopted this model of implementation.

C. Mixed/Hybrid Mode

Under this model of implementation, the SHA engages both the trust and insurance models in various capacities with the aim of being more economically efficient, providing flexibility and allowing convergence with the State scheme. Initial cover of a certain amount is provided by the insurance company, and the rest of the cover, up to Rs. 5 lakh is provided under trust mode. 3 States/UTs have adopted this model of implementation.

2.4.2 The Committee has been informed that initially, the States/UTs preferred the insurance mode of scheme implementation as these States had limited or no experience in health financing schemes. However, over the years of scheme implementation, the number of States/UTs implementing the scheme under trust mode has risen from 17 to 23 States,

whereas the number of States who have adopted insurance mode has fallen from 11 to 7 States/UTs. This trend hints at the wider adoption of the trust mode over other modes of scheme implementation.

2.4.3 With respect to the implementation challenges in the trust, insurance and mixed/hybrid model, the Committee has been informed that:

i) In trust mode, the financial outgo is not one-time, while in Insurance mode, the premium amount is paid to the Insurance companies in one go. Hence, the financial management is easier in the trust mode.

ii) In trust mode, revision of packages or any policy decision/amendment can be made during the policy period. However, in Insurance mode, implementation of such decisions can only be done after completion of the policy period.

iii) In Insurance mode, at the start of the policy year, claims are settled in a time-bound manner. However, to cap the loss ratio, the Insurance companies tend to raise unnecessary queries or reject claims towards the end of the policy period.

iv) For States/UTs with limited funds, claim settlement can be ensured timely in Insurance mode.

2.4.4 The Committee observes that there is a trend amongst the States to prefer the trust model and is of the view that the States opt for this model owing to their experience of working with the insurance companies. The Committee, therefore, recommends the Government to explore provisions to modify and improve the modalities related to the insurance mode to make it simpler, transparent, and attractive to the States. This will provide more options for the States to implement the scheme according to their regional demography and needs. The outgo of funds is immediate in insurance mode. The Committee suggests that the Government should push for payment of premium of insurance in instalments, preferably monthly/quarterly instalments.

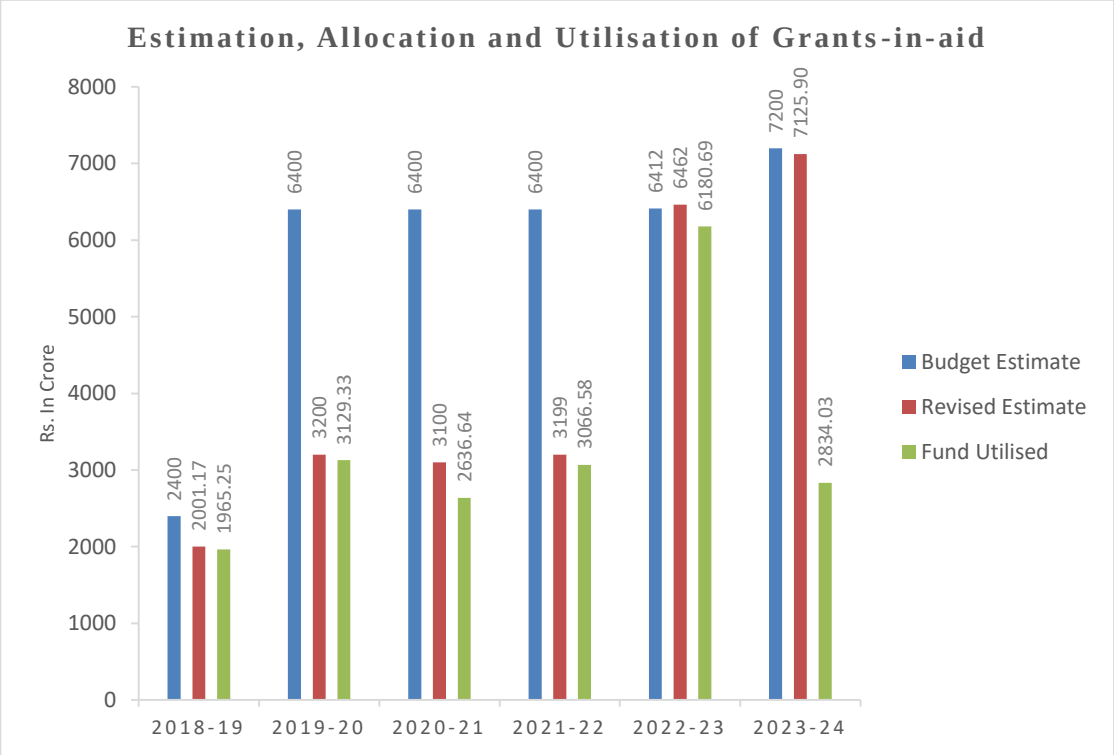
2.4.5 The Committee further believes that the Government should evaluate the performance of insurance companies. The Government should explore a robust monitoring mechanism to keep a check on any unjustified profit-making and any unethical linkage between the insurance companies and hospitals. Necessary mechanisms should be in place to ensure that the insurance companies are working as per the objectives and norms of the scheme.

Financing Mechanism

2.4.6 PMJAY is a centrally sponsored scheme, and the costs are shared between the Central and State Governments. The Government of India decides a national ceiling amount per family that is used to determine the maximum limit of the central share of the contribution. The actual premium discovered through the open tendering process, or the maximum ceiling

of the estimated premium decided by the Government of India for the implementation of PMJAY, whichever is less, would be shared between the Central Government and States/UTs in the ratio as per the extant directives issued by Ministry of Finance. In addition, administrative cost for implementing the scheme at the State level is also provided under the scheme and shared between the Centre and State in the same sharing pattern.

2.4.7 The existing sharing pattern is in the ratio of 60:40 for all States and Union Territories with legislature, except the North-Eastern States, two Himalayan States (Himachal Pradesh and Uttarakhand) and one Union Territory of Jammu and Kashmir, where the sharing ratio is 90:10. For Union Territories without legislature, the Central Government may contribute up to 100% on a case-to-case basis. The Central and State Governments/UT must open a separate designated escrow account through which the payment of premium, i.e., States/UTs and Central Government's share of the premium, is released. The estimation, allocation, and utilisation of Grant-in-aid under PMJAY are given as below:



Source: Annual Report 2022-23 of NHA (Fund Utilisation for 2023-24 is till 31.08.23)

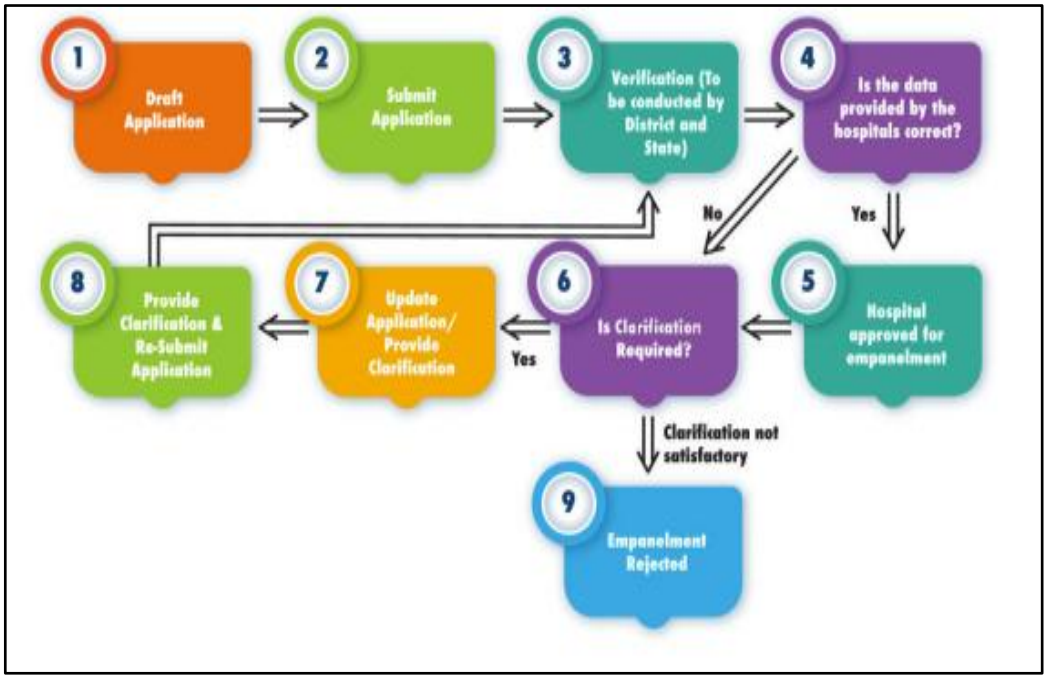
2.4.8 The Committee notes that the fund released by the Central Government during the last five years, from 2018-19 to 2022-23, towards PMJAY is around Rs. 17,000 crores, of which Rs. 6,180 crores were released in the last financial year. Also, except for the last financial year, the fund utilisation was much less as compared to the budget estimation. The Government should take steps to ensure higher and more efficient utilisation of funds allocated in the budget. The Committee would further like to state

that the budget of Rs. 6,000-7,000 crores allocated as the share of the Central Government is much less for 33 States/UTs. The Committee suggests that the budget allocation for the scheme should be increased as the PMJAY is the keystone scheme of the Government in achieving the UHC. For this purpose, other old/peripheral schemes of the Government in the healthcare sector may be subsumed or integrated with PMJAY so that the unutilised funds, resources, and manpower involved in those schemes may be utilised for the efficient implementation of PMJAY.

2.5 Empanelment of Hospitals and Management

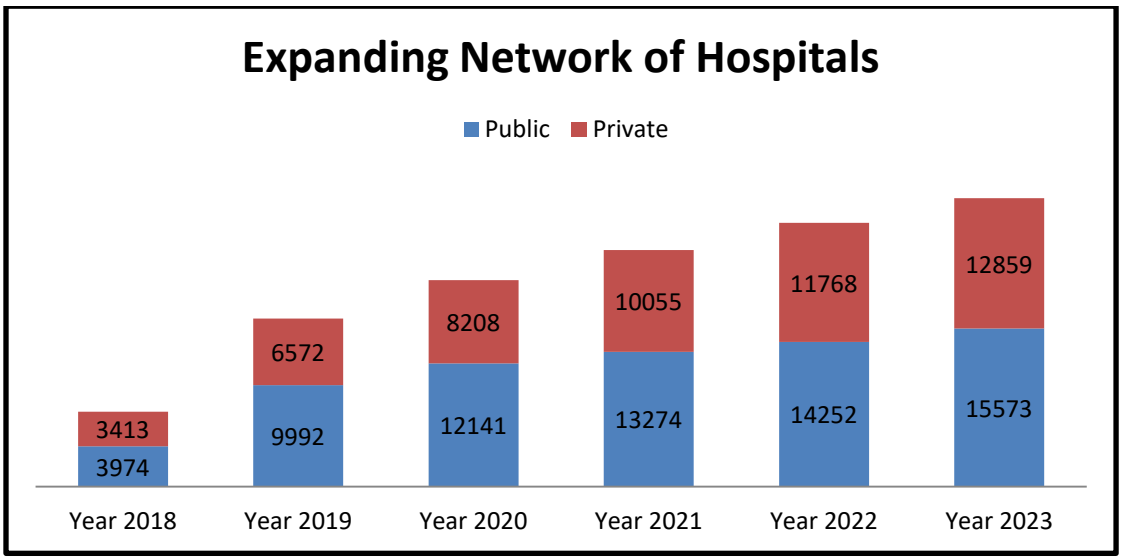
2.5.1 Preventive and quality health care are the core components of achieving Universal health coverage. PMJAY covers medical and hospitalisation expenses for secondary and tertiary care procedures with an aim to bring low-cost quality treatment as well as to provide essential drugs and diagnostic services at affordable prices to the beneficiaries. State Health Authorities, through State Empanelment Committees (SEC), are empowered to empanel private and public health service providers in their respective State/UTs. The States are free to decide the mode of verification of empanelment applications, conducting the physical verification either through the District Empanelment Committee (DEC) or using the selected insurance company (Insurance Mode) under the broad guidelines for hospital empanelment.

2.5.2 All public facilities with the capability of providing inpatient services (Community Health Centre level and above) are deemed empanelled under PMJAY. Private Hospitals may apply online through the Hospital Empanelment Management (HEM) portal for empanelment. The process of empanelment of Private Hospitals is defined in the Flow Chart below:



2.5.3 According to Hospital Empanelment and Management (HEM) guidelines, the criteria for empanelment have been divided into two broad categories viz. General and Specialty. The Empanelled Health Care Providers (EHCPs) empanelled under PMJAY for providing general care should meet the minimum requirements of General Criteria. Under the Specialty Criteria, Hospitals would be empanelled separately for certain tertiary care packages authorised for one or more specialities (viz. Cardiology, Oncology, Neurosurgery, etc.) and the Hospitals are required to meet the advanced criteria to provide those facilities as speciality packages, over and above the general criteria.

2.5.4 The network of empanelled hospitals across the States/UTs under PMJAY has expanded from 7,387 (3413 private and 3974 public) in 2018 to 28,432 (12,859 private and 15,573 public) as on the 12th June 2023.



2.5.5 The Committee notes that there are deficiencies like medical equipment being out of order and lack of basic infrastructure such as IPD beds, Operation Theatres, ICU care with ventilator support systems, blood banks, pharmacy, round-the-clock ambulance services, etc. Some EHCPs do not conform to the prescribed safety measures like fire, bio-waste management, etc. In Manipur, Tripura, and Uttarakhand, it has been reported[1] that 163 EHCPs were empanelled without conduct of physical verification. This risks the empanelment of EHCPs, which do not fulfil the minimum criteria of empanelment.

2.5.6 As of November 2022, the availability of EHCPs per one lakh beneficiaries ranged from 1.8 EHCPs in Bihar to 26.6 EHCPs in Goa. The availability ratio was highest in the Union Territory of Lakshadweep, i.e., 90.8 EHCPs per lakh beneficiaries. The availability of EHCPs is very low in the States/UTs of Assam (3.4), Dadra Nagar Haveli-Daman Diu (3.6), Maharashtra (3), Rajasthan (3.8) and Uttar Pradesh (5). The CAG report also stated that some of the EHCPs had not applied for empanelment of some of the specialities available to them and denied such services to PMJAY beneficiaries. Further, healthcare facilities in some districts of States lack speciality services, forcing PMJAY beneficiaries to travel to another district/State to avail of the treatment[1].

[1] *Report of CAG on Performance Audit of Ayushman Bharat-PMJAY; No 11 of 2023*

2.5.7 The Committee recommends that NHA and SHAs should ensure that the EHCPs follow all the norms and safety measures. The physical verification process should be followed earnestly to ensure that only those hospitals are empanelled that fulfil the requisite criteria. The Ministry should ensure that the periodic social audits of EHCPs, involving beneficiaries, are carried out effectively in coordination with NHA and SHAs so that malpractices may get detected and action may be initiated against the errant EHCPs. Consequently, this will also ensure that benchmarks for discharging social responsibilities are adhered to by EHCPs. There is also a strong need to invest in public hospitals to improve and upgrade the quality of the existing health facilities. The Committee believes that these steps would help in building an effective and accountable network of health service providers as per quality standards.

2.5.8 The Committee also noticed that the availability of EHCPs is not uniform across the country, and it is very low in some of the States. The Ministry, in coordination with State authorities, should make concerted efforts to encourage more private hospitals to get empanelled under the scheme in all the districts, particularly in regions with low density of EHCPs, and to eradicate disparities in the availability of EHCPs per lakh beneficiaries across various regions of the country. The IEC activities may be utilised robustly in efforts to empanel more hospitals. This would make affordable and quality treatment accessible to poor and vulnerable populations uniformly across the country, particularly in rural and remote areas, removing any regional disparity.

2.5.9 The Committee observes that failure to provide all available specialities by EHCPs reduces the availability of such services to beneficiaries. The Ministry, in coordination with NHA and SHAs, should ensure that all the specialities available in EHCPs are empanelled under PMJAY. Missing specialities should be empanelled in a time-bound manner. There is also a strong need to upgrade the speciality services available in EHCPs in all districts across the country as the lack of speciality services compels the beneficiaries to move off places, which causes hardship and a great amount of inconvenience, besides adding to the OOPE.

2.5.10 The Committee has been informed that the average available bed size is roughly 48 beds per EHCP. This indicates that most of the hospitals/institutions empanelled under PMJAY are of small scale, and many of the bigger hospitals/institutions are not empanelled under the scheme. The Ministry informed that most of these hospitals are in Tier-2 and Tier-3 towns and fewer in Tier-1 or metropolitan cities, and they are in a constant process of engagement with all bigger hospital chains to persuade them to join PMJAY. The Government should examine why larger hospitals are not joining the scheme and make efforts to empanel them. The Committee also recommends that the health facilities falling under the following categories be mandatorily empanelled:

i. **health facilities availing tax benefits;**

ii. **those receiving land grants/ concessions from the Centre/ State Governments for their establishment;**

iii. facilities affiliated with medical colleges; and

iv. any other category deemed fit by the Government.

2.5.11 The Committee came to know of the instances of delay in approval of empanelment of hospitals. In some cases, the delays beyond the stipulated period of 30 days ranged from 1 day to 44 months. The Committee is of the view that the Government should review the procedures in this regard and take necessary steps to reduce the pendency in such approvals after carrying out all effective checks.

2.6 Convergence of PMJAY with Schemes of States

2.6.1 At the time of implementation of PMJAY, it was observed that many States/UTs were simultaneously implementing their own health insurance/assurance schemes for various target populations. The benefit cover of these schemes is mostly available within the State boundaries except for some smaller States that have empanelled a few hospitals outside the State boundaries. Very few States had converged their schemes with the erstwhile RSBY scheme due to the lack of flexibility in the design of the RSBY. Even though these schemes were targeting the poor and vulnerable, there were large variations across States in terms of eligibility criteria and databases. Few States were using the food subsidy database, while some others had created a separate database for their welfare schemes.

2.6.2 The primary objectives for launching PMJAY were to ensure comprehensive coverage for catastrophic illnesses, reduce catastrophic out-of-pocket expenditure, improve access to hospitalisation care, and reduce unmet needs in secondary and tertiary healthcare. PMJAY is providing national portability of healthcare and has also established national standards for a health assurance system. It intends to converge various health insurance schemes across the States to check duplicity and ensure that eligible beneficiaries get covered. The Committee has been informed that, as a result, 24 States have converged their health assurance schemes with PMJAY, and efforts are being made to converge leftover State schemes. The convergence of the State specific schemes has helped bring uniformity in ensuring common cover amount, pan-India healthcare provider network ensuring healthcare services to eligible beneficiaries across the country, common Health Benefit Packages (HBP) with standardised rates across the country, common implementation structure for SHA and DIU across the country, centralised database at IT platform of NHA ensuring seamless exchange of information, and de-duplicated beneficiary database.

2.6.3 In the spirit of cooperative federalism and keeping in mind variations across the States, a lot of flexibility has been built in the PMJAY design. Therefore, PMJAY provides a lot of flexibility to States in terms of the following parameters:

i) Mode of implementation – States can choose the implementation model and can implement the scheme through Trust, Insurance or Mixed model.

ii) Usage of beneficiary data – PMJAY uses SECC data for targeting the beneficiaries; however, States have been provided flexibility to decide on the dataset for this

purpose if they are covering more beneficiaries than SECC-defined numbers. However, the State will need to ensure that all beneficiaries eligible as per SECC data are also covered.

iii) Co-branding – States can co-brand their existing health insurance/assurance schemes with PMJAY as per the co-branding guidelines of the scheme.

iv) Expansion of cover to more people – States can cover a greater number of families than those defined as per SECC data. For these additional families, the full cost will need to be borne by the States.

v) Increasing benefit cover to higher value – If the State want, they can even expand the benefit cover beyond Rs. 5 lakhs per family per year. However, in this case, the cost of additional cover will need to be completely borne by the State.

vi) Revision in package numbers and pricing – Keeping in view the different disease profiles and cost of service variations across the States, flexibility has been provided to the States to expand the number of packages, and within a limit, the State can also revise the package prices.

vii) Reservation of packages for public hospitals – To ensure that such services that can be provided well by Government health facilities are not misused by private providers, NHA has defined a set of conditions that are reserved for only public health care facilities. States can revise the list of such conditions that are reserved for public hospitals.

viii) IT Systems – Before the launch of PMJAY, some of the States were implementing their own health insurance schemes and were using their own IT systems. PMJAY provides flexibility so that States can continue using their own IT system and share data with NHA on a real-time basis in the specified format.

2.6.4 The Committee observes that the PMJAY scheme is running either after merging or in parallel with the State Government schemes. There are concerns that at the time of implementation, PMJAY, which is the major funding agency, may get the back seat in comparison to State schemes. The Government is taking steps like co-branding of Ayushman Bharat cards, kiosks, etc. The Committee believes that the Central Government should make efforts in right earnest for the convergence of State schemes with Ayushman Bharat and to give prominence to PMJAY.

2.7 Monitoring, Fraud Control and Grievance Redressal

2.7.1. NHA is monitoring PMJAY through the functional domains, namely, Beneficiary Management System (BMS), Transaction Management System (TMS), Provider Management System (PMS) and Support Function Management. This system aims to provide access to real-time information regarding various aspects of the scheme and helps foster a culture of data-based decision-making. NHA has also developed Grievance Redressal Guidelines and has established a Central Grievance Redressal Management System (CGRMS) to ensure that

disputes and grievances of PMJAY beneficiaries and other stakeholders are resolved in a transparent and time-bound manner.

2.7.2 Grievance Redressal under PMJAY has a three-tier system at the District, State and National levels. At each level, there is a dedicated nodal officer, viz. District Grievance Nodal Officer (DGNO), State Grievance Nodal Officer (SGNO) and National Grievance Nodal Officer (NGNO). One can lodge a grievance on the portal https://cgrms.pmjay.gov.in/ or through the national call centre 14555 or through mail, letter, fax, etc. The nodal officers are responsible for resolving grievances as per the defined turn-around time. Complainants can track the status of their grievance using the Unique Grievance Number, which is generated at the time of registration. The Committee has been informed that as of 28thAugust 2023, 98% of the total registered grievances have been resolved.

2.7.3 For a programme of the complexity and magnitude of PMJAY, it is essential to put in place a strong anti-fraud mechanism to maintain financial integrity as well as safeguard the health and well-being of the scheme's beneficiaries. Accordingly, NHA has set up a National Anti-Fraud Unit (NAFU), which works in close coordination with State Anti-Fraud Units (SAFUs) to instrumentalise anti-fraud and abuse control activities at the ground level. The Committee has been informed that NHA is also using artificial intelligence and machine learning technologies to detect suspicious transactions and potential frauds in PMJAY. NAFU, along with SAFU, also conducts surprise joint medical audits. As of 5th August 2023, the SHAs have taken appropriate actions against a total of 1.6 lakh claims as per guidelines of NHA. Further, 210 hospitals have been de-empanelled, and 188 hospitals have been suspended due to their involvement in malpractices.

2.7.4 The Committee appreciates the fact that during the study of this subject, about 98 percent of the total grievances registered were resolved and the implementation of PMJAY is being continuously monitored and evaluated at NHA. The Committee endorses the need for a robust data collection and analysis system for a mega scheme. Further, fraudulent practices, such as overbilling and unnecessary procedures, can strain the program's finances and undermine its goals. Preventing and detecting fraud is a significant concern. In view of these facts, the Committee is of the opinion that technology is crucial for monitoring and fraud prevention, as all the processes and data are in electronic form. To enhance the evaluation and analysis of available data in PMJAY, the Committee recommends establishing a dedicated and skilled IT research team, to develop and monitor the technical aspects of IT applications for effective dissemination of information and data analysis. Additionally, regular upgrades and improvements to PMJAY portals and modules are essential. Capacity-building programs in IT and data processing should be organised for officials and stakeholders, including hospital staff, at various levels.

2.7.5 The Committee believes that the instances of fraud activities should be recorded and shared with all SHAs. Artificial intelligence and machine learning technologies should be used intensively in data scrutiny, analysis, and monitoring. Further, instead of taking only reactive actions to the malpractices, the Government must set up

mechanisms through scrutiny of electronic data and field inspection to anticipate and take proactive actions to prevent fraudulent practices.

2.7.6 The Committee feels that obtaining feedback, satisfaction level and suggestions from the patients/beneficiaries plays an inevitable role and provides important indicators to ensure that the EHCPs are providing quality healthcare services. This also helps in evaluating and monitoring the performance and role of other intermediaries/stakeholders like insurance companies, Implementation Support Agencies (ISA), Arogya Mitras, NHA & SHAs officials, etc.

2.7.7 The Committee has observed that some of the EHCPs, after performing treatment/surgery, say that they are empanelled, but the surgery performed is not covered under the PMJAY. The Committee believes that to prevent such instances, the Government must publish a list of empanelled healthcare providers with the procedures for which they are empanelled. Such a list must be made accessible to the illiterate people, tribal population and people living in remote areas through Arogya Mitras, ASHA workers, Community Service Centres, etc. Further, the Government must ensure that all hospitals place a board with a list of all empanelled procedures available in that hospital at the reception area and the kiosks installed there.

Chapter- 3

Way Forward

3.1 Best Practices in Providing UHC

3.1.1 There are instances of best practices across the country, as reported by the NHA on its website. Such practices inspire the states to learn from the current best practices being showcased as well as be motivated to adopt and try new systems and practices to improve scheme efficiency and effectiveness. Some of the best practices that should be implemented across the country are delineated below:

Sikkim- BIS camp at the level of Gram Panchayat Unit

State Health Agency, Sikkim, had organised a BIS camp at Mangshilla Gram Panchayat Unit. The Zilla Panchayat provided logistical arrangements for the campsite, and the ward panchayats checked the list of eligible beneficiary families in that area from the SECC database that was shared. The Mangshila Nari Samaj, the active Civil Body Society in the area, conducted IEC activities along with the ASHA workers. The Common Services Centres and Village Level Entrepreneurs (VLEs) were approached for the camp. Nearly 90% of the beneficiaries of Mangshila Tibuk GPU were covered. It is now being replicated across all districts of the state to saturate beneficiary coverage.

Dadra & Nagar Haveli and Daman & Diu- Expanding PMJAY to non-SECC families to achieve UHC.

The Administration added two more categories in PMJAY under the head of non-SECC families to provide UHC to the residents of the UT of DNH & DD, and they have achieved 100% coverage. These additional categories are resident families whose annual income is below Rs. 1.5 lakh (premium paid by UT Administration), all resident families whose annual income is above Rs. 1.5 lakh (premium paid by the individual) and Building and Other Construction Workers (premium paid by labour welfare board).

Chandigarh- BIS Camps and door-to-door verification of beneficiaries

Chandigarh, being an urban city with a high migratory population, it had become difficult to verify the beneficiaries of the scheme. Out of 71,278 target families, only 23,687 could be traced, and thus, verification of genuine beneficiaries was necessary. To ensure this, all PMJAY cards registered in a month were scrutinised by cross-checking documents, telephonic verification, and verification from hospital records, if needed. A special focus was on non-KYC patients/cards, and door-to-door field verification of some sectors was also performed. This ensured that 99% of the cards were genuine, as verification was done afresh.

Uttar Pradesh-Usage of Community Radio services

To increase awareness of the scheme at the grassroots level, an Integrated Communication strategy with the community radio was developed. The Centre for Advance Research (CFAR) was roped in to organise a community radio media workshop for this purpose. CFAR, through its media coverage, captures beneficiary success stories and publishes positive news updates related to PMJAY in UP. Community radio has played a vital role in mobilising beneficiaries to enrolment stations.

Kerala- Installation of Kiosks as a one-stop solution for all PMJAY-related information and issues

The State IEC team has conceptualised and installed kiosks at Empanelled Health Care Providers (EHCPs) as the one-step solution that serves as a knowledge point for the scheme. Monitoring and evaluation are carried out with the support of the District Implementation Unit (DIU) to perceive the impact generated through this innovation. It was found that the kiosk has significantly impacted the branding of the PMJAY scheme, easy identification of beneficiaries and easy process flows of admissions in installed healthcare institutions. It has also increased patient flow to the healthcare institutions. Besides, District EHCP Connect is an initiative of SHA Kerala to connect with EHCPs through District Project Coordinators (DPCs) for information sharing, mutual bonding, doubt clearance, and advanced training. These initiatives have helped in reducing claim rejections due to failure in adherence to scheme guidelines. This has led to an overall improvement in scheme utilisation by the EHCPs.

Jammu & Kashmir- Publication of success stories through wall calendars

Word of mouth plays an essential role in successful behaviour change. For this purpose, SHA J&K printed the success stories and testimonials of PMJAY beneficiaries on yearly calendars and distributed them to beneficiaries to encourage others to avail of benefits under the PMJAY scheme. The success stories and testimonials are captured by visiting beneficiaries who have taken treatment under the scheme and getting their consent to publish their story. These calendars were distributed among masses through Public and Private Empanelled hospitals during the current year.

Karnataka- Online referral system for beneficiaries from Primary Health Institutions to Empanelled Hospitals to ensure a continuum of care.

Beneficiaries usually visit Primary Health Institutes (PHI) as their first level of treatment. In case the beneficiary needs to take further treatment that may not be available at the PHI level, a referral is provided for taking treatments under any of the other empanelled hospitals. SHA Karnataka has migrated this manual referral system into an online referral system. Through this, every PHI's and empanelled hospital's capabilities and specialities are mapped to the online referral system. The system

searches for the availability of specialities in the PHIs of the respective district. If there is no availability, the system provides a list of hospitals in ascending order of proximity for beneficiaries. This strong referral system has ensured that patients utilise the government hospital facilities, thereby aiding in the capacity and capability building of the government PHIs.

Maharashtra- Clinical protocols developed to prevent misuse of packages and procedures under the scheme.

SHA Maharashtra has developed clinical protocols by using principles of evidence-based medicine to help treating specialists arrive at appropriate treatment decisions that prevent misuse of procedures and packages under the PMJAY scheme. The clinical protocols include a simple set of questions developed by the experts of specialities from the Private and Public sectors to be answered by treating physicians while raising pre-authorizations. This practice prevented the misuse of packages while raising pre-authorisations.

Uttarakhand- Daily Quick Audit System (DQAS) to improve efficiency and reduce fraud of claims.

The SHA introduced the Daily Quick Audit System (DQAS) in September 2019 to check irregularities in claims approved for payment by the Implementation Support Agency (ISA). A Universal Committee was constituted to conduct a Daily Quick Audit of all approved claims. The committee is chaired by the Chairman SHA, with Directors of all divisions and the State coordinator of ISA as members. Capacity building of all committee members and daily audits improved the quality and time of claim processing, resulting in faster claims to the hospitals. Further, this practice aided in detecting frauds by virtue of which 13 hospitals have been de-empanelled, and there has been recovery and savings of more than Rs.1 crore.

Nagaland- Daily audit of Ayushman Cards at the time of pre-authorisation

In Nagaland, to solve the problem of utilisation of the scheme by ineligible beneficiaries, the SHA decided to conduct a daily audit of Ayushman cards against which pre-authorisation has been registered. Daily record-keeping and monthly reporting are being done to ensure effective implementation. This exercise identified 10 Beneficiary Identification System (BIS) operators who were involved in issuing fraudulent Ayushman cards to ineligible beneficiaries. From September 2020 to January 2022, SHA has audited more than 7,429 pre-authorisation cases, of which 99 pre-authorisation cases have been cancelled due to ineligible cards amounting to over Rs. 12 lakhs.

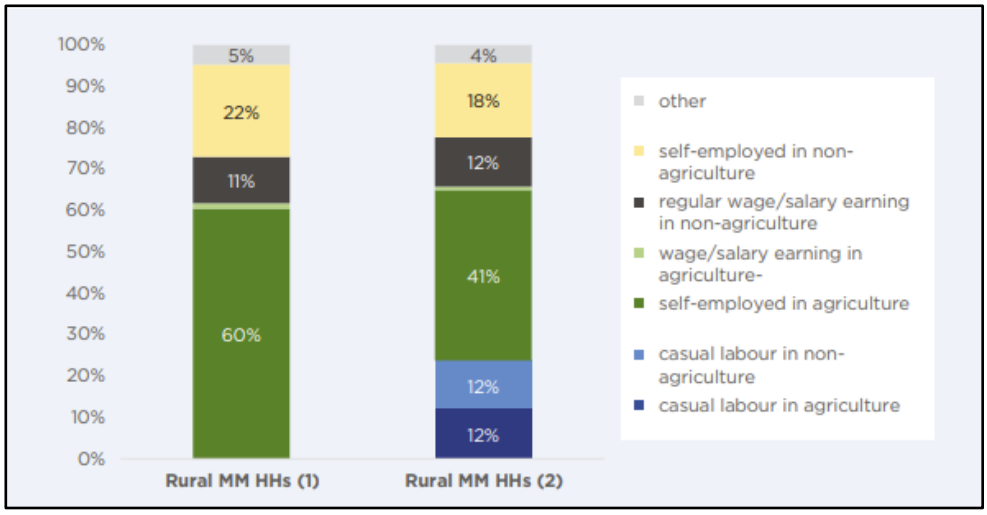
3.1.2 The Ministry, in coordination with NHA and SHAs, should accelerate and intensify the IEC activities. The camps at village and block levels should be organised in a planned manner to increase awareness about the scheme and to fast-pace the registration of eligible beneficiaries. Civil societies, NGOs and local-level officials need

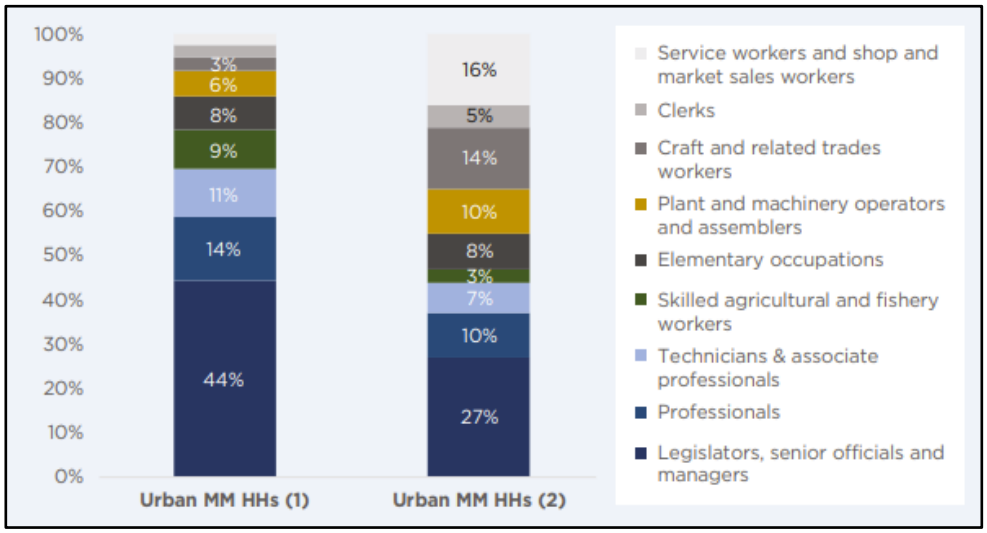
to be involved in making these camps successful. The ration shops may also be roped in to increase awareness among the local masses, which could play a significant role in saturating beneficiary coverage across all the districts. Further, the verification of genuine beneficiaries is necessary to prevent the leakage of funds. The practice followed in Chandigarh should be implemented across the country, particularly in urban areas where the proportion of the migratory population is high, to ensure the genuineness of beneficiaries. A dedicated cell should be formed in every district for cross-checking of documents, telephonic verification, and door-to-door field verifications with a special focus on non-KYC beneficiaries. The success stories and testimonials of PMJAY beneficiaries should be given wide publicity through Community Radio, wall calendars and kiosks installed at EHCPs. Kerala's model of kiosks as a one-step solution should be encouraged.

3.1.3 In order to achieve 100% coverage of targeted beneficiaries under the PMJAY scheme, the states with a smaller number of identified and eligible beneficiaries should include additional categories in the scheme. Further, as per the report of NITI Aayog titled "Health Insurance for India's Missing Middle", at least 30% of the population (about 40 crore individuals) are devoid of any financial protection for health.

Insurance Scheme	Individuals Eligible or Covered (cr.)	Percentage of Population Eligible	Families Eligible or Covered (cr.)
Government Subsidized Schemes	69	51%	15.3
AB-PMJAY (w/o State Extension Schemes)	49	36%	10.9
AB-PMJAY State Extension Schemes	20	15%	4.4
Social Health Insurance Schemes	14	10%	3.6
Employees' State Insurance Scheme (ESIS)	13.6	10%	3.5
Central Government Health Scheme	0.4	0.3%	0.13
Private Voluntary Health Insurance (PVHI)	11.5	9%	2.6
Total Eligible or Covered (assuming no overlap)	**94.5**	70%	**21.5**
Total Population / Families	**135**		**30**
Uncovered Population / Families	**40.5**	**30%**	**8.5**

3.1.4 The PMJAY scheme and State Government extension schemes provide comprehensive hospitalisation cover to the bottom 50% of the population, and around 20% of the population is covered through social health insurance and private voluntary health insurance. The uncovered population spread across all expenditure quintiles in both urban and rural areas. This category predominantly constitutes the self-employed (agriculture and non-agriculture) informal sector in rural areas and a broad array of informal, semi-formal and formal occupations in urban areas.





3.1.5 The report of NITI Aayog highlighted the issue of low financial protection for health in the missing middle segment of the population. There are some States where the target set to cover the population under the PMJAY scheme has not been met through identifying beneficiaries as per the SECC database and other digital databases available with the States. The Committee, in view of the findings of the NITI Aayog, is of the view that such States should include new categories for 100% targeted coverage under the scheme. This will also address the issue highlighted by NITI Aayog. Further, the expansion of health insurance /assurance coverage is a necessary step to achieve UHC. Hence, the outreach and base of beneficiaries to be covered under the PMJAY scheme should be gradually increased till UHC is achieved.

3.1.6 The Committee appreciates the fact that Ayushman Bharat scheme, since its implementation has covered a large section of population at a fair speed, about 40 crore Ayushman Cards have been targeted at the end of current financial year. The Committee has however, observed that there is wide variation in the per capita amount spent on health care per annum among the States ranging from Rs. 556/- (Bihar) to Rs. 9450/- (Arunachal Pradesh), according to a study[2]. To achieve UHC, the Committee

[2] *www.thelancet.com,Vol13, June,2023*

recommends the Government to impress upon the States/UTs with low investment in health care, to enhance it reasonably to achieve the targets of UHC.

3.1.7 The Committee observes that the initiative of District EHCP Connect in Kerala helps in information sharing and capacity building of EHCPs in dealing with the treatment of beneficiaries and improves adherence to scheme guidelines. The online referral system adopted in Karnataka made the search for available specialist treatment in the proximity to the residence easy and aided in the optimal utilisation of available resources. The practice of following clinical protocols developed by using principles of evidence-based medicine checks the misuse of packages while raising pre-authorisations. The Committee is of the opinion that these good practices should be implemented across the country as these initiatives would lead to an overall improvement in scheme utilisation.

3.1.8 The Committee observes that the daily audit system by the dedicated audit team, as adopted by the states of Uttarakhand and Nagaland, aided in detecting fraudulent practices, improved quality and time of claim processing, and effective implementation of the scheme. The Committee also appreciates the IT-enabled beneficiary feedback and redressal system developed in Punjab. The sharing of experiences and feedback by beneficiaries after obtaining the treatment services helps in monitoring the quality of services and checks for illegal activities. The Committee is of the opinion that a robust daily audit system and the IT-enabled automated feedback and redressal system should be established at the district level in all the States/UTs.

3.2 Challenges and potential areas of improvement under PMJAY

3.2.1 The Committee, during study, observed *inter alia*, the following challenges in implementation of AB-PMJAY: -

(i) Limited Coverage: PMJAY aims to provide health coverage to economically vulnerable sections of society, the scheme's coverage remains limited. Several health services, such as outpatient care, preventive healthcare, and non-hospitalisation expenses, are not covered under PMJAY. This limitation restricts the comprehensive access to healthcare for the beneficiaries.

(ii) Disparities in Implementation: Despite efforts to ensure uniform implementation across the country, disparities in the execution of PMJAY persist between states and regions. Some states have faced challenges in the effective deployment of funds and resources, leading to uneven access to quality healthcare for beneficiaries. This inconsistency in implementation has hindered the scheme's ability to reach its full potential.

(iii) Infrastructure and Resource Constraints: Inadequate healthcare infrastructure and human resources in certain regions have posed significant challenges to the successful implementation of PMJAY. The lack of well-equipped hospitals, skilled medical

personnel, and essential medical equipment has affected the quality of healthcare services provided under the scheme. This issue has resulted in long waiting times and substandard treatment for many beneficiaries.

(iv) **Information Dissemination and Awareness:** Despite efforts to create awareness about PMJAY, there have been challenges in effectively disseminating information about the scheme, especially in rural and remote areas. Limited awareness among the target population has resulted in a low rate of enrolment and utilisation of the scheme. This lack of awareness has hindered the scheme's potential to reach and benefit its intended beneficiaries.

(v) **Fraud and Misuse:** PMJAY has encountered instances of fraud and misuse, including false claims, identity theft, and improper billing practices by some healthcare providers. Such fraudulent activities have led to financial losses for the government and compromised the quality of healthcare services provided to the beneficiaries. Addressing these issues requires a robust monitoring and oversight mechanism to ensure transparency and accountability in the implementation of the scheme.

(vi) **Administrative Challenges:** Complex administrative procedures and bureaucratic hurdles have posed challenges in the smooth functioning of the Scheme. Delays in the approval process, cumbersome documentation requirements, and procedural bottlenecks have hindered the timely delivery of healthcare services to the beneficiaries. Streamlining administrative processes and reducing red tape could help improve the overall efficiency of the scheme.

(vii) **Quality of Care:** While the Scheme aims to provide affordable healthcare, ensuring the quality of healthcare services remains a challenge. Inadequate monitoring mechanisms and quality control measures have resulted in varying standards of care across different healthcare facilities. Ensuring uniform quality standards and regular monitoring of healthcare providers are essential to enhance the overall effectiveness of the Scheme.

3.2.2 The Committee is of the considered view that to achieve Universal Health Coverage, untapped sections of community, regions and sections of the people must be covered under the scheme to increase the covered population axis. Providing preventive health and making the health benefit packages attractive would result in decrease in disease burden axis thereby reducing the implementation cost, the third axis of the Cube. Addressing these shortcomings requires a comprehensive approach, including strengthening healthcare infrastructure, improving administrative efficiency, enhancing awareness, and implementing robust monitoring mechanisms to ensure transparency and accountability.

3.2.3 The Committee, in order that the PMJAY becomes more effective to achieve UHC, places following observations and recommendations with scope of improvement on record:

i) Quality of Healthcare Services and health infrastructure:

a. Maintaining the quality of healthcare services across a vast network of public and private providers is challenging. Variability in the quality of care can affect patient outcomes. The Committee has observed that most of the Government hospitals are not up to the standard in cleanliness, infrastructure, and the treatment of the patients. These hospitals are not patient friendly. The Government must take steps to make Government hospitals patient-friendly, ensure quality cleanliness and upgrade the basic infrastructure. The Ministry, through the Health Secretaries across the States, should have a periodic report on cleanliness and infrastructure in those hospitals. Government hospitals may be rated like private hospitals under NABH.

b. The Committee has been informed of the complaints regarding delays in settling claims and payments. This may be because schemes like PMJAY deal in volume. The Government should address the issue by ensuring that the turn-around time of claim settlement and claim rejection ratio is reduced significantly. This may be done by implementing various provisions like the use of IT-based modules, regular interaction among SHAs, EHCPs, ISAs, insurance companies and other stakeholders, and capacity building of stakeholders involved in claim processing. These steps would increase the proportion of timely payments, which is the major concern of most hospitals and would attract major private hospitals for empanelment under PMJAY.

c. The Committee would also like to highlight that there are regional disparities in healthcare infrastructure and services between different states and regions, which lead to unequal access and outcomes. Moreover, most of the healthcare infrastructure is concentrated in cities and urban areas. It is also seen that the public healthcare facilities available in rural areas are flawed due to the shortage of well-equipped and staffed infrastructure, which limits the accessibility to care. The Committee believes that the Government should take steps to strengthen the healthcare infrastructure in rural and underserved areas to ensure accessibility to quality healthcare services.

d. The Committee would like to place an emphasis in applying behavioural science insights to increase the uptake of the PMJAY Scheme. Keeping in view some of the recent behavioural studies, the Committee suggests that PMJAY messaging to the targeted population can be revised by including the following behavioural insights:

- **Simplification: PMJAY messaging to contain short and simplified text with clear behavioural instruction to register with the Scheme.**

- **Social norms: People simulate behaviour when they see that others are also doing it. PMJAY messaging can be designed in such a way that carries a strong message that others are doing it. Moreover, behavioural studies indicate that people are risk-seeking over losses but risk-averse over gains. Gain-framed PMJAY messaging will prove to be effective.**

ii) Capacity and Workforce:

a) Ensuring an adequate and skilled healthcare workforce to meet the increased demand for services is a challenge. In view of this fact, the Committee is of the opinion that the Government must fill the vacancies at various levels in NHA, SHAs, DIUs and other implementing agencies at the earliest. Apart from that, the Ministry must also engage with State Governments to ensure that the medical professional workforce, including the paramedical staff, is adequate in all healthcare institutions. A periodic report may be called from Health Secretaries in the States about vacancies at various levels in healthcare institutions of the respective State.

b) The Committee believes that capacity building of people involved in the implementation of PMJAY must be upgraded through training and mid-career programs. The Government should focus on providing training related to technical skills, IT systems, accounting, data analysis, optimal use of artificial intelligence, etc. This would help in the efficient and intensive usage of the new technologies in the implementation and monitoring of the PMJAY scheme. This would also play a major role in improving the indicators highlighting the achievements, acceptance, coverage, and impact of the scheme.

iii) Importance to Medical Ethics:

The Committee is of the opinion that maintaining medical ethics and avoiding unnecessary procedures, tests, and over-prescription is a concern, as it can lead to rising costs and potential harm to patients. The Government should give impetus to value education and ethics in medical curriculum and training workshops to sensitise the staff involved in the implementation of the scheme that maintaining small ethical standards would bring significant results.

iv) Technology and Data Security:

a) The Committee has been informed that the personal details and medical history of the beneficiaries under PMJAY are maintained by the NHA through various modules of their IT platform. The beneficiaries may visit multiple doctors. The digital record would help the doctor to see the medical history of the beneficiary with his/her consent. The NHA has also maintained a standardised

registry containing the list of all the hospitals, which is called the Healthcare Facility Registry, a list of all the healthcare professionals, doctors, nurses, a list of all labs, a list of all the drugs, etc. These initiatives are significant to make the PMJAY scheme cashless, paperless, portable, transparent, etc. However, the Committee would also like to highlight that safeguarding patient data and ensuring the security of health information systems are vital to prevent data breaches and misuse. The Government must ensure robust IT infrastructure with quality encryption and safeguards.

b) The Committee also believes that the Government should give impetus to trust-building campaigns as some of the beneficiaries may hesitate to join the scheme of misleading information regarding breaches of their personal and medical data security. The Committee has also been informed that some of the healthcare professionals have also raised data security concerns and are hesitating to register at the NHA registry. The Government must address these concerns through continuous interaction and trust-building initiatives.

v) Indirect Cost and Expenditure Beyond the Cover of Rs. 5 lakhs

a) The Committee has seen that, while interacting with the beneficiaries of Ayushman Bharat, even if the beneficiaries are insured, they must bear the high indirect cost that might go beyond their ability to pay. To address the catastrophic financial burden on poor patients and to achieve the objective of PMJAY, the Government needs to cover this indirect financial loss for a poor patient for whom this cost is not negligible.

b) The Committee, while interacting with both private and government hospitals, has noted that some of the complex and high-end surgeries or chronic treatment cost more than the sum of Rs. 5 lakhs covered under the PMJAY. Also, some of the costly procedures and surgeries are not covered under the scheme. To address such issues, some of the hospitals have set an example by successfully attracting Corporate Social Responsibility (CSR) funds and private investment to create funds to bear the expenditure of beneficiaries for the cost of treatment over and above the insured sum of Rs. 5 lakhs. The Government need to implement such practices across the country to make PMJAY more and more effective and beneficial for the poor sections of the society. Further, in many cases, the amount of Rs. 5 lakhs may not be utilised by every patient/family. Only in cases of serious diseases and other surgeries, this amount is utilised. Apart from Rashtriya Arogya Nidhi, the Government should consider the creation of some special purpose vehicle or arrangement to cater to fill the gap in such special cases in a more structured manner.

c) The Committee would also like to suggest that the Government must encourage more Public-Private Partnerships (PPP) and take steps to attract more funds through CSR. The NHA management team should assist the Government hospitals in attracting more CSR funds from private companies and PSUs. The

Government should also make strategies to bring more funds to less industrialised States through CSR and PPP mechanisms. These initiatives would also assist in addressing the lack of healthcare facilities in rural and remote areas and filling the gaps due to regional disparities.

d) The Committee is of the view that the cost of medicines, particularly in cases of diseases like cancer where long-term treatment is required, is also a matter of concern. The Government should consider providing medicines free of cost to all the beneficiaries across the States through the PMJAY scheme.

vi) Need to expand the treatment procedures covered under PMJAY

The Committee has come to know that some costly procedures and serious diseases are not included in the PMJAY. Further, the OPD expenses are not covered by the scheme and are considered only in the case of inpatients. The Committee recommends that the coverage of procedures and surgeries under PMJAY needs to be increased. Further, the Committee suggests that the rates under the health benefit packages (HBP) of PMJAY must be revised frequently and kept updated *vis-à-vis* the present market rates.

vii) Inclusion of Above Poverty Line (APL) middle-class people in the PMJAY

The Committee is of the view that there are many lower middle-class people who fall in the APL category, and they are just above the BPL and the inclusion criteria for the PMJAY. Such people are in dire need of this scheme. The report of NITI Aayog titled "Health Insurance for India's Missing Middle" also suggests that even after the implementation of the PMJAY, at least 30% of the population (over 40 crore individuals) still lack any form of financial protection for health. Adverse health events can lead to financial hardship and even push them into poverty. They are characterised by informal employment with unstable incomes and a lack of social security benefits. The Committee believes that the Government should consider expanding the base of beneficiaries to be covered under the PMJAY by including more categories in eligibility criteria. This is also in line with the eventual objective of the Government to attain the SDG goal of the UHC.

viii) Guidelines and Mechanism to Govern Employment and Conduct of Arogya Mitras

The Committee has been informed that the Central Government has not issued any standard guidelines to employ Arogya Mitras under the PMJAY. There are different arrangements to employ them and to pay them any honorarium across the States. In some States, they are retired or serving employees of the same hospital for which additional payment is made to them for their services. They help the patients in their registration and provide guidance during the treatment. The Committee recommends that the Central Government

should issue guidelines and minimum qualifications to be complied with by the States while employing Arogya Mitras. The Government should devise a mechanism to monitor the conduct and ethical behaviour of Arogya Mitras.

3.2.4 The Committee feels that addressing these challenges and concerns is essential to ensure the success and sustainability of PMJAY in providing healthcare access to millions of vulnerable individuals in the country. Regular assessments and adjustments are needed to overcome these issues and make the program more effective.

RECOMMENDATONS/OBSERVATIONS- AT A GLANCE

Healthcare Access and Affordability in India

The Committee believes that the Government's health expenditure needs to be increased reasonably from the present 2.1 percent of GDP on the lines of the objectives of the National Health Policy 2017. Apart from increased public health expenditure, the efficient utilisation of available funds should also be emphasised to improve the quality and access of healthcare infrastructure. The active collaboration with private stakeholders may also help in strengthening the infrastructure significantly.

(Para 1.2.6)

The Committee is of the view that health insurance is a mechanism of pooling the high level of OOPE in India to provide greater financial protection against health shocks and improve efficiency in the organisation and delivery of healthcare for better health outcomes. Increased health insurance coverage will reduce catastrophic and impoverishing health expenditures by imposing a ceiling on the maximum health expenditure incurred by an individual or household. The publicly funded health insurance schemes are envisaged as keystone to advance Universal Health Coverage.

(Para 1.2.7)

Healthcare and Health Insurance Schemes in Other Countries

The Committee notes that the experiences of Thailand, China, and Latin American countries demonstrate the difficulty of increasing health coverage in the informal/unorganised sector. Thailand made good progress in UHC by fully subsidising the informal sector, while China has partially subsidized that segment. However, China's experience also indicates the possibility of sustained coverage through a contributory and voluntary scheme. Further, the examples from Latin America highlight that adverse selection and inadequate risk-pooling is a pressing challenge for voluntary contributory schemes targeted towards the informal sector. The adverse selection due to opting out of high-income people reduces cross-subsidisation, leading to high premiums and inequality in access to healthcare.

(Para 1.4.10)

The Committee is of the view that the Government may consider some of the provisions of the Affordable Care Act of United States for inclusion in Ayushman Bharat. By including some sections of the persons falling in APL category, the provisions for 'employer mandate' to provide health insurance to the employee and his family, subsuming of specific schemes for children and senior citizens, tax incentives and disincentives to corporate regarding healthcare are some of the measures worth including in the Ayushman Bharat Scheme and PMJAY.

(Para 1.4.11)

Ayushman Bharat Scheme

Coverage of beneficiaries under PMJAY

The Committee, in the above context, was apprised that several beneficiaries were facing problems in addition and inclusion of family members above or less than the prescribed 6 family members. The ministry stated that the criteria of 6 family members is with reference to one mobile number only and there was no cap on family size in PMJAY. The Committee therefore recommends that the difficulties being faced by the beneficiaries having family size less than or more than 6 members may be addressed promptly by updating the application software.

(Para 2.3.6)

The Committee observes that the accurate identification and registration of the eligible beneficiaries under PMJAY is a major challenge. It is difficult to reach the poorest and the most vulnerable population of the country due to low literacy and awareness. This is true for most Lower and Middle-Income Countries (LMIC), and India is not an exception. It is essential to ensure that the benefits reach the target section of population.

(Para 2.3.7)

The Committee believes that the Ministry and NHA, along with implementing States/UTs, need to undertake a country-wide drive to scrutinise and validate the BIS database. Validation checks should be in place to increase the accuracy and reliability of the data. The inconsistencies in the database may be removed at the earliest. The appropriate mechanism may be devised to ensure weeding out of ineligible beneficiaries and identification of eligible beneficiaries in a planned, coordinated and time-bound manner. States/UTs need to be impressed upon to map their own database with the SECC database to avoid duplication. The process for approval or rejection of ineligible beneficiaries and registration of eligible beneficiaries needs to be made simple and less time-consuming to avoid delay beyond the prescribed time.

(Para 2.3.8)

The Committee recommends that the NHA needs to develop an IT-based solution to educate and create awareness that a family is eligible for the scheme, and ways to rapidly identify the family if any member comes to an empanelled hospital for treatment.

(Para 2.3.9)

The Committee believes that the Information, Education and Communication (IEC) programs are significant to understanding the various target audiences for PMJAY, like their attitudes and perceptions towards the scheme, and to educate the target audience about the scheme driving changes in their attitudes and behaviour. The programs are necessary to maximise the reach, impact, and awareness of the scheme amongst targeted beneficiaries. NHA needs to set up designated IEC cells, make special efforts in a planned manner and sensitise the entitled beneficiaries to generate awareness about the scheme. NHA should coordinate with SHAs and NGOs to design a comprehensive IEC plan and undertake IEC campaigns in a planned manner. Such IEC efforts should be recorded, reviewed, and monitored regularly.

(Para 2.3.10)

The Committee notes that the flexibility has been given to the States/UTs to choose the remaining beneficiaries from any digital database that the State/UT has if the broad nature of these new people matches with the beneficiary nature of PMJAY. The Committee is of the view that under that dispensation, States/UTs may be asked to include senior citizens, particularly those residing in old age homes or any other place by revising the Deprivation Criteria, as beneficiaries of the scheme. Many senior citizens residing in places like shelter homes and old age homes do not fall under the Below Poverty Line and face financial problems while availing treatments. Their inclusion in the scheme would help them access affordable and quality treatment.

(Para 2.3.11)

Implementation Process- PMJAY

The Committee observes that there is a trend amongst the States to prefer the trust model and is of the view that the States opt for this model owing to their experience of working with the insurance companies. The Committee, therefore, recommends the Government to explore provisions to modify and improve the modalities related to the insurance mode to make it simpler, transparent, and attractive to the States. This will provide more options for the States to implement the scheme according to their regional demography and needs. The outgo of funds is immediate in insurance mode. The Committee suggests that the Government should push for payment of premium of insurance in instalments, preferably monthly/quarterly instalments.

(Para 2.4.4)

The Committee further believes that the Government should evaluate the performance of insurance companies. The Government should explore a robust monitoring mechanism to keep a check on any unjustified profit-making and any unethical linkage between the insurance companies and hospitals. Necessary mechanisms should be in place to ensure that the insurance companies are working as per the objectives and norms of the scheme.

(Para 2.4.5)

Financing Mechanism

The Committee notes that the fund released by the Central Government during the last five years, from 2018-19 to 2022-23, towards PMJAY is around Rs. 17,000 crores, of which Rs. 6,180 crores were released in the last financial year. Also, except for the last financial year, the fund utilization was much less as compared to the budget estimation. The Government should take steps to ensure higher and more efficient utilization of funds allocated in the budget. The Committee would further like to state that the budget of Rs. 6,000-7,000 crores allocated as the share of the Central Government is much less for 33 States/UTs. The Committee suggests that the budget allocation for the scheme should be increased as the PMJAY is the keystone scheme of the Government in achieving the UHC. For this purpose, other old/peripheral schemes of the Government in the healthcare sector may be subsumed or integrated with PMJAY so that the unutilized funds, resources, and manpower involved in those schemes may be utilized for the efficient implementation of PMJAY.

(Para 2.4.8)

Empanelment of Hospitals and Management

The Committee recommends that NHA and SHAs should ensure that the EHCPs follow all the norms and safety measures. The physical verification process should be followed earnestly to ensure that only those hospitals are empanelled that fulfil the requisite criteria. The Ministry should ensure that the periodic social audits of EHCPs, involving beneficiaries, are carried out effectively in coordination with NHA and SHAs so that malpractices may get detected and action may be initiated against the errant EHCPs. Consequently, this will also ensure that benchmarks for discharging social responsibilities are adhered to by EHCPs. There is also a strong need to invest in public hospitals to improve and upgrade the quality of the existing health facilities. The Committee believes that these steps would help in building an effective and accountable network of health service providers as per quality standards.

(Para 2.5.7)

The Committee also noticed that the availability of EHCPs is not uniform across the country, and it is very low in some of the States. The Ministry, in coordination with State authorities, should make concerted efforts to encourage more private hospitals to get empanelled under the scheme in all the districts, particularly in regions with low density of EHCPs, and to eradicate disparities in the availability of EHCPs per lakh beneficiaries across various regions of the country. The IEC activities may be utilised robustly in efforts to empanel more hospitals. This would make affordable and quality treatment accessible to poor and vulnerable populations uniformly across the country, particularly in rural and remote areas, removing any regional disparity.

(Para 2.5.8)

The Committee observes that failure to provide all available specialities by EHCPs reduces the availability of such services to beneficiaries. The Ministry, in coordination with NHA and SHAs, should ensure that all the specialities available in EHCPs are empanelled under PMJAY. Missing specialities should be empanelled in a time-bound manner. There is also a strong need to upgrade the speciality services available in EHCPs in all districts across the country as the lack of speciality services compels the beneficiaries to move off places, which causes hardship and a great amount of inconvenience, besides adding to the OOPE.

(Para 2.5.9)

The Committee has been informed that the average available bed size is roughly 48 beds per EHCP. This indicates that most of the hospitals/institutions empanelled under PMJAY are of small scale, and many of the bigger hospitals/institutions are not empanelled under the scheme. The Ministry informed that most of these hospitals are in Tier-2 and Tier-3 towns and fewer in Tier-1 or metropolitan cities, and they are in a constant process of engagement with all bigger hospital chains to persuade them to join PMJAY. The Government should examine why larger hospitals are not joining the scheme and make efforts to empanel them. The Committee also recommends that the health facilities falling under the following categories be mandatorily empanelled:

i. **health facilities availing tax benefits;**

ii. **those receiving land grants/ concessions from the Centre/ State Governments for their establishment;**

iii. **facilities affiliated with medical colleges; and**

iv. **any other category deemed fit by the Government.**

(Para 2.5.10)

The Committee came to know of the instances of delay in approval of empanelment of hospitals. In some cases, the delays beyond the stipulated period of 30 days ranged from 1 day to 44 months. The Committee is of the view that the Government should review the procedures in this regard and take necessary steps to reduce the pendency in such approvals after carrying out all effective checks.

(Para 2.5.11)

Convergence of PMJAY with Schemes of States

The Committee observes that the PMJAY scheme is running either after merging or in parallel with the State Government schemes. There are concerns that at the time of implementation, PMJAY, which is the major funding agency, may get the back seat in comparison to State schemes. The Government is taking steps like co-branding of

Ayushman Bharat cards, kiosks, etc. The Committee believes that the Central Government should make efforts in right earnest for the convergence of State schemes with Ayushman Bharat and to give prominence to PMJAY.

(Para 2.6.4)

Monitoring, Fraud Control and Grievance Redressal

The Committee appreciates the fact that during the study of this subject, about 98 percent of the total grievances registered were resolved and the implementation of PMJAY is being continuously monitored and evaluated at NHA. The Committee endorses the need for a robust data collection and analysis system for a mega scheme. Further, fraudulent practices, such as overbilling and unnecessary procedures, can strain the program's finances and undermine its goals. Preventing and detecting fraud is a significant concern. In view of these facts, the Committee is of the opinion that technology is crucial for monitoring and fraud prevention, as all the processes and data are in electronic form. To enhance the evaluation and analysis of available data in PMJAY, the Committee recommends establishing a dedicated and skilled IT research team, to develop and monitor the technical aspects of IT applications for effective dissemination of information and data analysis. Additionally, regular upgrades and improvements to PMJAY portals and modules are essential. Capacity-building programs in IT and data processing should be organised for officials and stakeholders, including hospital staff, at various levels.

(Para 2.7.4)

The Committee believes that the instances of fraud activities should be recorded and shared with all SHAs. Artificial intelligence and machine learning technologies should be used intensively in data scrutiny, analysis, and monitoring. Further, instead of taking only reactive actions to the malpractices, the Government must set up mechanisms through scrutiny of electronic data and field inspection to anticipate and take proactive actions to prevent fraudulent practices.

(Para 2.7.5)

The Committee feels that obtaining feedback, satisfaction level and suggestions from the patients/beneficiaries plays an inevitable role and provides important indicators to ensure that the EHCPs are providing quality healthcare services. This also helps in evaluating and monitoring the performance and role of other intermediaries/stakeholders like insurance companies, Implementation Support Agencies (ISA), Arogya Mitras, NHA & SHAs officials, etc.

(Para 2.7.6)

The Committee has observed that some of the EHCPs, after performing treatment/surgery, say that they are empanelled, but the surgery performed is not covered under the PMJAY. The Committee believes that to prevent such instances, the Government must publish a list of empanelled healthcare providers with the procedures for which they are empanelled. Such a list must be made accessible to the illiterate people, tribal population and people living in remote areas through Arogya Mitras, ASHA workers, Community Service Centers, etc. Further, the Government must ensure that all hospitals place a board with a list of all empanelled procedures available in that hospital at the reception area and the kiosks installed there.

(Para 2.7.7)

Best Practices in Providing UHC

The Ministry, in coordination with NHA and SHAs, should accelerate and intensify the IEC activities. The camps at village and block levels should be organised in a planned manner to increase awareness about the scheme and to fast-pace the registration of eligible beneficiaries. Civil societies, NGOs and local-level officials need to be involved in making these camps successful. The ration shops may also be roped in to increase awareness among the local masses, which could play a significant role in saturating beneficiary coverage across all the districts. Further, the verification of genuine beneficiaries is necessary to prevent the leakage of funds. The practice followed in Chandigarh should be implemented across the country, particularly in urban areas where the proportion of the migratory population is high, to ensure the genuineness of beneficiaries. A dedicated cell should be formed in every district for cross-checking of documents, telephonic verification, and door-to-door field verifications with a special focus on non-KYC beneficiaries. The success stories and testimonials of PMJAY beneficiaries should be given wide publicity through Community Radio, wall calendars and kiosks installed at EHCPs. Kerala's model of kiosks as a one-step solution should be encouraged.

(Para 3.1.2)

The report of NITI Aayog highlighted the issue of low financial protection for health in the missing middle segment of the population. There are some States where the target set to cover the population under the PMJAY scheme has not been met through identifying beneficiaries as per the SECC database and other digital databases available with the States. The Committee, in view of the findings of the NITI Aayog, is of the view that such States should include new categories for 100% targeted coverage under the scheme. This will also address the issue highlighted by NITI Aayog. Further, the expansion of health insurance /assurance coverage is a necessary step to achieve UHC. Hence, the outreach and base of beneficiaries to be covered under the PMJAY scheme should be gradually increased till UHC is achieved.

(Para 3.1.5)

The Committee appreciates the fact that Ayushman Bharat scheme, since its implementation has covered a large section of population at a fair speed, about 40 crore Ayushman Cards have been targeted at the end of current financial year. The Committee has however, observed that there is wide variation in the per capita amount spent on health care per annum among the States ranging from Rs. 556/- (Bihar) to Rs. 9450/- (Arunachal Pradesh), according to a study[2]. To achieve UHC, the Committee recommends the Government to impress upon the States/UTs with low investment in health care, to enhance it reasonably to achieve the targets of UHC.

(Para 3.1.6)

The Committee observes that the initiative of District EHCP Connect in Kerala helps in information sharing and capacity building of EHCPs in dealing with the treatment of beneficiaries and improves adherence to scheme guidelines. The online referral system adopted in Karnataka made the search for available specialist treatment in the proximity to the residence easy and aided in the optimal utilisation of available resources. The practice of following clinical protocols developed by using principles of evidence-based medicine checks the misuse of packages while raising pre-authorisations. The Committee is of the opinion that these good practices should be implemented across the country as these initiatives would lead to an overall improvement in scheme utilisation.

(Para 3.1.7)

The Committee observes that the daily audit system by the dedicated audit team, as adopted by the states of Uttarakhand and Nagaland, aided in detecting fraudulent practices, improved quality and time of claim processing, and effective implementation of the scheme. The Committee also appreciates the IT-enabled beneficiary feedback and redressal system developed in Punjab. The sharing of experiences and feedback by beneficiaries after obtaining the treatment services helps in monitoring the quality of services and checks for illegal activities. The Committee is of the opinion that a robust daily audit system and the IT-enabled automated feedback and redressal system should be established at the district level in all the States/UTs.

(Para 3.1.8)

Challenges and potential areas of improvement under PMJAY

The Committee is of the considered view that to achieve Universal Health Coverage, untapped sections of community, regions and sections of the people must be covered under the scheme to increase the covered population axis. Providing preventive health and making the health benefit packages attractive would result in decrease in disease burden axis thereby reducing the implementation cost, the third axis of the Cube. Addressing these shortcomings requires a comprehensive approach, including

strengthening healthcare infrastructure, improving administrative efficiency, enhancing awareness, and implementing robust monitoring mechanisms to ensure transparency and accountability.

(Para 3.2.2)

The Committee, in order that the PMJAY becomes more effective to achieve UHC, places following observations and recommendations with scope of improvement on record:

i) Quality of Healthcare Services and health infrastructure:

a) Maintaining the quality of healthcare services across a vast network of public and private providers is challenging. Variability in the quality of care can affect patient outcomes. The Committee has observed that most of the Government hospitals are not up to the standard in cleanliness, infrastructure, and the treatment of the patients. These hospitals are not patient friendly. The Government must take steps to make Government hospitals patient-friendly, ensure quality cleanliness and upgrade the basic infrastructure. The Ministry, through the Health Secretaries across the States, should have a periodic report on cleanliness and infrastructure in those hospitals. Government hospitals may be rated like private hospitals under NABH.

b) The Committee has been informed of the complaints regarding delays in settling claims and payments. This may be because schemes like PMJAY deal in volume. The Government should address the issue by ensuring that the turn-around time of claim settlement and claim rejection ratio is reduced significantly. This may be done by implementing various provisions like the use of IT-based modules, regular interaction among SHAs, EHCPs, ISAs, insurance companies and other stakeholders, and capacity building of stakeholders involved in claim processing. These steps would increase the proportion of timely payments, which is the major concern of most hospitals and would attract major private hospitals for empanelment under PMJAY.

c) The Committee would also like to highlight that there are regional disparities in healthcare infrastructure and services between different states and regions, which lead to unequal access and outcomes. Moreover, most of the healthcare infrastructure is concentrated in cities and urban areas. It is also seen that the public healthcare facilities available in rural areas are flawed due to the shortage of well-equipped and staffed infrastructure, which limits the accessibility to care. The Committee believes that the Government should take steps to strengthen the healthcare infrastructure in rural and underserved areas to ensure accessibility to quality healthcare services.

d) The Committee would like to place an emphasis in applying behavioural science insights to increase the uptake of the PMJAY Scheme. Keeping in view some of the recent behavioural studies, the Committee suggests that PMJAY messaging to the targeted population can be revised by including the following behavioural insights:

- **Simplification: PMJAY messaging to contain short and simplified text with clear behavioural instruction to register with the Scheme.**
- **Social norms: People simulate behaviour when they see that others are also doing it. PMJAY messaging can be designed in such a way that carries a strong message that others are doing it. Moreover, behavioural studies indicate that people are risk-seeking over losses but risk-averse over gains. Gain-framed PMJAY messaging will prove to be effective.**

ii) Capacity and Workforce:

a) Ensuring an adequate and skilled healthcare workforce to meet the increased demand for services is a challenge. In view of this fact, the Committee is of the opinion that the Government must fill the vacancies at various levels in NHA, SHAs, DIUs and other implementing agencies at the earliest. Apart from that, the Ministry must also engage with State Governments to ensure that the medical professional workforce, including the paramedical staff, is adequate in all healthcare institutions. A periodic report may be called from Health Secretaries in the States about vacancies at various levels in healthcare institutions of the respective State.

b) The Committee believes that capacity building of people involved in the implementation of PMJAY must be upgraded through training and mid-career programs. The Government should focus on providing training related to technical skills, IT systems, accounting, data analysis, optimal use of artificial intelligence, etc. This would help in the efficient and intensive usage of the new technologies in the implementation and monitoring of the PMJAY scheme. This would also play a major role in improving the indicators highlighting the achievements, acceptance, coverage, and impact of the scheme.

iii) Importance to Medical Ethics:

The Committee is of the opinion that maintaining medical ethics and avoiding unnecessary procedures, tests, and over-prescription is a concern, as it can lead to rising costs and potential harm to patients. The Government should give impetus to value education and ethics in medical curriculum and training workshops to sensitise the staff involved in the implementation of the scheme that maintaining small ethical standards would bring significant results.

iv) Technology and Data Security:

a) The Committee has been informed that the personal details and medical history of the beneficiaries under PMJAY are maintained by the NHA through various modules of their IT platform. The beneficiaries may visit multiple doctors. The digital record would help the doctor to see the medical history of the beneficiary with his/her consent. The NHA has also maintained a standardised registry containing the list of all the hospitals, which is called the Healthcare Facility Registry, a list of all the healthcare professionals, doctors, nurses, a list of all labs, a list of all the drugs, etc. These initiatives are significant to make the

PMJAY scheme cashless, paperless, portable, transparent, etc. However, the Committee would also like to highlight that safeguarding patient data and ensuring the security of health information systems are vital to prevent data breaches and misuse. The Government must ensure robust IT infrastructure with quality encryption and safeguards.

b) The Committee also believes that the Government should give impetus to trust-building campaigns as some of the beneficiaries may hesitate to join the scheme of misleading information regarding breaches of their personal and medical data security. The Committee has also been informed that some of the healthcare professionals have also raised data security concerns and are hesitating to register at the NHA registry. The Government must address these concerns through continuous interaction and trust-building initiatives.

v) Indirect Cost and Expenditure Beyond the Cover of Rs. 5 lakhs

a) The Committee has seen that, while interacting with the beneficiaries of Ayushman Bharat, even if the beneficiaries are insured, they must bear the high indirect cost that might go beyond their ability to pay. To address the catastrophic financial burden on poor patients and to achieve the objective of PMJAY, the Government needs to cover this indirect financial loss for a poor patient for whom this cost is not negligible.

b) The Committee, while interacting with both private and government hospitals, has noted that some of the complex and high-end surgeries or chronic treatment cost more than the sum of Rs. 5 lakhs covered under the PMJAY. Also, some of the costly procedures and surgeries are not covered under the scheme. To address such issues, some of the hospitals have set an example by successfully attracting Corporate Social Responsibility (CSR) funds and private investment to create funds to bear the expenditure of beneficiaries for the cost of treatment over and above the insured sum of Rs. 5 lakhs. The Government need to implement such practices across the country to make PMJAY more and more effective and beneficial for the poor sections of the society. Further, in many cases, the amount of Rs. 5 lakhs may not be utilised by every patient/family. Only in cases of serious diseases and other surgeries, this amount is utilised. Apart from Rashtriya Arogya Nidhi, the Government should consider the creation of some special purpose vehicle or arrangement to cater to fill the gap in such special cases in a more structured manner.

c) The Committee would also like to suggest that the Government must encourage more Public-Private Partnerships (PPP) and take steps to attract more funds through CSR. The NHA management team should assist the Government hospitals in attracting more CSR funds from private companies and PSUs. The Government should also make strategies to bring more funds to less industrialised States through CSR and PPP mechanisms. These initiatives would also assist in addressing the lack of healthcare facilities in rural and remote areas and filling the gaps due to regional disparities.

d) The Committee is of the view that the cost of medicines, particularly in cases of diseases like cancer where long-term treatment is required, is also a matter of concern. The Government should consider providing medicines free of cost to all the beneficiaries across the States through the PMJAY scheme.

vi) Need to expand the treatment procedures covered under PMJAY

The Committee has come to know that some costly procedures and serious diseases are not included in the PMJAY. Further, the OPD expenses are not covered by the scheme and are considered only in the case of inpatients. The Committee recommends that the coverage of procedures and surgeries under PMJAY needs to be increased. Further, the Committee suggests that the rates under the health benefit packages (HBP) of PMJAY must be revised frequently and kept updated *vis-à-vis* the present market rates.

vii) Inclusion of Above Poverty Line (APL) middle-class people in the PMJAY

The Committee is of the view that there are many lower middle-class people who fall in the APL category, and they are just above the BPL and the inclusion criteria for the PMJAY. Such people are in dire need of this scheme. The report of NITI Aayog titled "Health Insurance for India's Missing Middle" also suggests that even after the implementation of the PMJAY, at least 30% of the population (over 40 crore individuals) still lack any form of financial protection for health. Adverse health events can lead to financial hardship and even push them into poverty. They are characterised by informal employment with unstable incomes and a lack of social security benefits. The Committee believes that the Government should consider expanding the base of beneficiaries to be covered under the PMJAY by including more categories in eligibility criteria. This is also in line with the eventual objective of the Government to attain the SDG goal of the UHC.

viii) Guidelines and Mechanism to Govern Employment and Conduct of Arogya Mitras

The Committee has been informed that the Central Government has not issued any standard guidelines to employ Arogya Mitras under the PMJAY. There are different arrangements to employ them and to pay them any honorarium across the States. In some States, they are retired or serving employees of the same hospital for which additional payment is made to them for their services. They help the patients in their registration and provide guidance during the treatment. The Committee recommends that the Central Government should issue guidelines and minimum qualifications to be complied with by the States while employing Arogya Mitras. The Government should devise a mechanism to monitor the conduct and ethical behaviour of Arogya Mitras.

(Para 3.2.3)

MINUTES

XII
TWELFTH MEETING

The Committee met at 03.00 PM on Tuesday, the 13th June, 2023 in Committee Room 'A', Parliament House Annexe, New Delhi.

PRESENT

CHAIRMAN

1. **Shri Bhubaneswar Kalita - Chairman**

MEMBERS

RAJYA SABHA

2. Shri Anil Agrawal
3. Shri Sanjeev Arora
4. Dr. L. Hanumanthaiah
5. Shri Imran Pratapgarhi

LOK SABHA

6. Shri K. Navas Kani
7. Dr. Lorho S. Pfoze
8. Dr. DNV Senthilkumar S.
9. Dr. Jadon Chandra Sen
10. Dr. Krishna Pal Singh Yadav

SECRETARIAT

1.	Shri Sumant Narain	Joint Secretary
2.	Shri Shashi Bhushan	Director
3.	Smt. Gunjan Parashar	Deputy Director

WITNESSES

Representatives of the Ministry of Health and Family Welfare, and National Health Authority

1. Shri Rajesh Bhushan, Secretary, MoHFW
2. Shri S. Gopalakrishnan, Special Secretary, MoHFW & CEO, NHA
3. Shri Lav Agarwal, Additional Secretary, MoHFW
4. Shri Vishal Chauhan, Joint Secretary, MoHFW
5. Dr. Pankaj Arora, Director, NHA
6. Shri Rohit Deo Jha, Joint Director, NHA

2. At the outset, the Chairman welcomed the Members of the Committee and apprised them that for holistic examination of the subject "Implementation of Ayushman Bharat" and in view of the importance to know the ground realities related to the subject across the country and implementation problems thereof, the Committee had recently undertaken a study visit to Chennai, Thiruvananthapuram and Bengaluru. The study visit was beneficial in examination of implementation of the scheme at ground level. He proposed that if Members are agreed to, a two days study visit to the States of Maharashtra and Goa on 10th and 11th July, 2023 may be

undertaken to hear the views of Shipping Corporation of India and different Port Trusts for their contributions in strengthening Ayushman Bharat through their CSR initiatives.

3. The Chairman informed the Members that the Committee has also taken up another subject *i.e.* "Quality of Medical Education in India" for detailed examination. During the proposed visit, the Committee would also like to interact with some banks to assess their role in facilitating quality medical education in India as a lender for aspiring medical students and main-banker for establishment, up-gradation and strengthening of medical institutions. The Committee, then authorized the Chairman to finalize the proposed study visit programme and approach the Hon'ble Chairman, Rajya Sabha for seeking necessary approval. Thereafter, the Chairman stated that the Committee would be hearing Shri Rajesh Bhushan, Secretary, Ministry of Health & Family Welfare, Shri Gopalakrishnan, CEO, National Health Authority along with other officials of Ministry of Health & Family Welfare to acquaint with their views on implementation of Ayushman Bharat.

4. Later, the Chairman welcomed the witnesses and then asked them to apprise the Committee of their views on the present status of implementation of Ayushman Bharat Scheme and how far the scheme has achieved its objective since inception including its functioning, problems identified and corrective measures taken thereon, new initiatives taken to strengthen it, public-private partnerships, public awareness programs, feedback from beneficiaries of the scheme and other stakeholders, integration with state-specific insurance schemes, collaboration with PSUs for direct contribution in Ayushman Bharat.

5. The Secretary, Ministry of Health & Family Welfare gave a brief description on the subject and then the CEO, National Health Authority made a detailed presentation on the subject, who *inter-alia* highlighted the following key points:

(i) Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) launched on 23rd September, 2018 is the largest publicly funded health assurance scheme in the world;
(ii) 33 States/UTs are currently implementing the scheme barring Delhi, Odisha and West Bengal;
(iii) The scheme provides health cover of Rs. 5 Lakh per family per year for secondary and tertiary care which has no cap on family size, age and gender;
(iv) Health benefit package under the scheme includes 1121 packages and 1949 procedures across 27 specialities in the year 2022;
(v) Approx. 23.61 crore Ayushman Bharat Cards have been issued;
(vi) As on 12th June, 2023, a total of 28,432 hospitals are empanelled under the scheme out of which 12,859 hospitals are private;
(vii) Out of the 5.19 crore hospital admissions, 48% are female patients;
(viii) The implementation of AB-PMJAY is being administered through a three-tier mechanism at National, State and District levels;
(ix) AB-PMJAY is implemented through three modes- trust, insurance and mixed;
(x) High end procedures such as bone marrow transplant and cochlear implant surgery have been introduced in Health Benefit Package 2022;

(xi) NHA established a Central Grievance Redressal Management System (CGRMS) portal and any complaint received are immediately assigned to respective State Grievance Nodal Officer designated at each SHA for necessary action;

(xii) National Anti-Fraud Unit (NAFU) has been created at NHA for overall monitoring and implementation of anti-fraud framework supported by State Anti-Fraud Unit;

(xiii) NHA is using Artificial Intelligence and Machine Learning to detect fraud proactively;

(xiv) Under Anti-fraud initiatives, 5.7 Lakh Ayushman Cards have been disabled, 210 hospitals have been de-empanelled and 214 hospitals have been suspended;

(xv) In view of the limitations of SECC database such as non-traceability, inappropriate inclusion & exclusion and difficulty to identify beneficiary on ground with certainty, the Union Cabinet in Jan 2022 provided flexibility to States/UTs to use existing non-SECC digitized database against unidentified SECC beneficiary families and this has helped in increasing the beneficiary base to 12 crore families.

(xvi) Ayushman Bharat Digital Mission (ABDM) was launched in September 2021 with aim to build an integrated digital health infrastructure in the country;

(xvii) More than 40 crore 14-digit Ayushman Bharat Health Account (ABHA) have been created that facilitate sharing of health data with appropriate consent;

(xviii) More than 1.9 lakh healthcare professionals have been registered on Healthcare Professionals Registry (HPR) which is a comprehensive repository of all healthcare professionals; and

(xix) More than 2 lakh health facilities have been registered on Health Facility Registry (HFR) which is a comprehensive repository of health facilities of the nation across different systems of medicine.

6. After the presentation, the Members of the Committee made some suggestions and raised certain queries which are as under:-

(i) Some states have their health insurance scheme and Ayushman Bharat is implemented in integrated mode with those state schemes which leads to less prominence to Ayushman Bharat.

(ii) For high end costly surgeries the beneficiaries have to shell out money beyond the sum of Rs. 5 lakhs and asked the Ministry to think ways to fill those gaps such as through CSR funds from third party, to create funds for the said purpose, etc.

(iii) The Committee also enquired about any policy of the Ministry to deal with the situation where beneficiaries have to bear indirect expenditure like loss of wages, transportation, etc.

(iv) The Committee desired to know the number of beds covered under the scheme.

(v) The Committee was also keen to know why big hospitals/institutions are not getting empanelled under the scheme and also suggested that the government may insist to reserve certain percentage of beds in such hospitals for empanelment under the scheme.

(vi) The Committee pointed out that as far as trust, hybrid and insurance models are concerned the most of states are going with Trust model.

(vii) The Committee suggested that for individual health insurance the Ministry should push for monthly payment of premium which would lessen the burden of one-time payment of huge premium.

(viii) The Committee pointed out that many high end procedures and also OPD expenses are not covered under Ayushman Bharat Scheme.

(ix) The Committee desired to know whether the insurance companies involved in the scheme have been evaluated by the Government for their performance and unjustified profit making.

(x) The Committee suggested that the standard of facilities in Government hospitals should be upgraded and also the Government should consider providing free medicine to all patients.

(xi) The Committee desired to know about number of anti-fraud investigations initiated in the country and what are the reasons for suspension of hospitals in large numbers in Madhya Pradesh recently.

(xii) The Committee suggested that all procedures of empanelled hospitals covered under Ayushman Bharat should be prominently displayed at some suitable place near the reception of the hospital, as some hospitals after treatment told beneficiaries that the surgery done was not covered under the scheme.

(xiii) The Committee suggested that the benefits of the scheme should also be extended to above poverty line families and specifically senior citizens residing in old age homes.

(xiv) The Committee enquired about the recruitment process of Ayushman Mitras and whether their services are monitored and assessed.

7. The Secretary, Ministry of Health & Family Welfare along with CEO, National Health Authority, then replied to some of the queries of the Committee and inter-alia highlighted the following points: -

(i) Most states run their own health insurance schemes along with the Ayushman Bharat. In order to ensure due prominence to the Ayushman Bharat, the Ministry has given directions to issue co-branded cards with photographs of both, Prime Minister and Chief Minister affixed on them. Further, Hospitals have been directed to establish a co-branded 'May I help you' Kiosk in their reception area.

(ii) The revision of Package rates of Ayushman Bharat is under review for the 6^{th} time. The reason behind certain big hospitals not showing interest in empanelment under Ayushman Bharat may be delay in settlement of claims, hence the Ministry is focussing on timely payment of the claims and persuading such hospitals to join the scheme.

(iii) Under the scheme more than 13 lakh beds are being offered in various empanelled hospitals and health centres.

(iv) For registration under Ayushman Bharat Digital Mission (ABDM), some doctors and health professionals are showing initial hesitancy that they may be monitored by external agencies using the data on ABDM. The Ministry is in dialogue with various health professional bodies to persuade doctors to get registered with ABDM in large numbers.

(v) The Ministry informed that there is complete flexibility for the states to choose any mode *i.e.* trust, insurance and hybrid. However, regular reviews with the states are being done and the states may switch from one mode to another mode.

(vi)The Ministry acknowledged the suggestion of the Committee regarding payment of premium in instalments and assured to explore it with insurance companies.

(vii) Rashtriya Arogya Nidhi (RAN) fund has been created under the Ayushman Bharat scheme for providing certain financial assistance in case of surgical interventions costing more than Rs. 5 lakhs. Ministry also acknowledged the suggestion of the Committee to involve CSR funds directly in Ayushman Bharat to meet the gaps in high end surgeries.

(viii) On the point of covering senior citizens belonging to above poverty line also under the scheme, the Ministry apprised the Committee that all the states have been given flexibility to fill the shortfall in number of beneficiaries under Ayushman Bharat in their states, after considering the SECC data, from any digital database of the State as long as the broad nature of these new people is similar to the beneficiary nature of AB-PMJAY and this may also include the senior citizens.

(ix) With respect to Sickel Cell Anaemia, the Secretary apprised that screening for the disease will be done in the whole country and treatment will be provided under Ayushman Bharat scheme. The patients will also be provided pre-marriage counselling.

(x) The Ayushman Mitras, in some states, are the retired hospital employees and in some states outsourced. However, no regulating guidelines have been issued by the government. The point of the Committee is well taken that mechanism will be evolved to monitor the conduct of the Ayushman Mitras.

8. The Chairman then asked the witnesses to submit a written response to the queries raised by the Members to the Secretariat within 15 days.

9. A verbatim record of proceedings of the meeting was kept.

10. The meeting then adjourned at 4:41 p.m.

III
THIRD MEETING

The Committee met at 3.30 p.m. on Monday, the 11th December, 2023 in Committee Room-4, Parliament House Annexe Extension Building, New Delhi.

MEMBERS PRESENT

1. Shri Bhubaneswar Kalita - Chairman

RAJYA SABHA

2. Dr. Anil Agrawal
3. Shri Sanjeev Arora
4. Dr. L. Hanumanthaiah
5. Shri B. Parthasaradhi Reddy
6. Shri S. Selvaganabathy
7. Dr. Santanu Sen
8. Shri A. D. Singh

LOK SABHA

9. Shrimati Mangal Suresh Angadi
10. Shri Maddila Gurumoorthy
11. Ms. Ramya Haridas
12. Shri K. Navas Kani
13. Dr. Sanghmitra Maurya
14. Shrimati Pratima Mondal
15. Dr. Lorho S. Pfoze
16. Adv. Adoor Prakash
17. Dr. Rajdeep Roy
18. Dr. DNV Senthilkumar S.
19. Shri Anurag Sharma
20. Dr. Mahesh Sharma
21. Dr. Krishna Pal Singh Yadav

SECRETARIAT

1. Shri Sumant Narain - Joint Secretary
2. Shri Shashi Bhushan - Director
3. Dr Saket Kumar - Deputy Secretary
4. Smt. Noyaline Vinitha F.C. - Joint Director

2. At the outset, the Chairman welcomed the Members of the Committee and informed them about the agenda for the day, *i.e.* to consider and adopt ******Draft 151st Report of the Committee on the subject "Implementation of Ayushman Bharat"; *******.

3. The Committee then considered the draft **** 151st ******Reports of the Committee. The Committee discussed that Government should consider mandatory empanelment of some big hospitals under the Ayushman Bharat Scheme to cater to the critical care needs that are

not available in small hospitals. Thereafter, it was decied to incorporate in the 151st report of the committee that, Hospitals availing tax exemptions, land concessions, and those affiliated with medical colleges could be considered for mandatory empanelment under Ayushman Bharat Scheme. After a brief discussion, the Committee adopted the ****** 151st Reports. ******The Committee also authorised the Chairman to carry out any typographical/factual errors in the ****** 151st Reports, if necessary.

4. The Committee decided that the ***** 151st Reports may be presented to the Rajya Sabha and simultaneously laid on the Table of the Lok Sabha in the ensuing Session.

5. ******

6. *******

7. The meeting adjourned at 4:30 p.m.

**pertains to other matter*

ANNEXURE, TABLES
and
LIST OF SOURCES

Annexure I

DEPRIVATION CRITERIA FOR RURAL AND URBAN AREAS

As per Socio-Economic and Caste Census (SECC) database, the deprivation criteria D1 to D5 and D7 for rural areas are:

- D1- Only one room with kucha walls and kucha roof
- D2- No adult member between ages 16 to 59
- D3- Households with no adult male member between ages 16 to 59
- D4- Disabled member and no able-bodied adult member
- D5- SC/ST households
- D7- Landless households deriving a major part of their income from manual casual labour.

For urban areas, the following 11 occupational categories of workers are eligible for the scheme:

- Ragpicker
- Beggar
- Domestic worker
- Street vendor/ Cobbler/hawker / other service provider working on streets.
- Construction worker/ Plumber/ Mason/ Labour/ Painter/ Welder/ Security guard/ Coolie and other head-load worker
- Sweeper/ Sanitation worker/ Mali
- Home-based worker/ Artisan/ Handicrafts worker/ Tailor
- Transport worker/ Driver/ Conductor/ Helper to drivers and conductors/ Cart puller/ Rickshaw puller
- Shop worker/ Assistant/ Peon in small establishment/ Helper/Delivery Assistant / Attendant/ Waiter
- Electrician/ Mechanic/ Assembler/ Repair worker
- Washerman/ Chowkidar

Tables 1 and 2

Report (No. 11 of 2023) of the Comptroller and Auditor General of India on Performance Audit of Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana

Cases of Family Size against one PMJAY ID

Table 1

Range of members in a household	11 to 50	50 to 100	100 to 200	200 to 201
Actual number of cases	43180	12	04	01

Cases of Delay in Processing of Rejection of Cases

Table 2

State/UT	**Rejected cases**	**Maximum delay (in days)**
Assam	1640	32
Chandigarh	632	70
Himachal Pradesh	5287	199
Jammu & Kashmir	497358	404
Kerala	1149	223
Madhya Pradesh	198555	NA
Manipur	90	18
Punjab	254	32
Uttar Pradesh	34066	334

Sources:

1. National Health Policy, 2017; Government of India.
2. Background material of the Ministry of Health and Family Welfare.
3. Union Budget (2023-2024), Ministry of Finance.
4. Economic Survey, 2022, Ministry of Finance.
5. Annual Report 2021-2022, National Health Authority.
6. Universal Health coverage (UHC) and Sustainable Development Goals, World Health Organisation.
7. *Health Insurance for India's Missing Middle*, Kumar Anurag and Sarwal Rakesh, Niti Aayog, October 2021.
8. *Report of the Comptroller and Auditor General of India on Performance Audit of Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana*, Union Government (Civil), National Health Authority, Ministry of Health and Family Welfare, Report No. 11 of 2023 (Performance Audit).
9. *Shrink the universal health coverage cube*, Masamine Jimba and Maya Sophia Fujimura, The Lancet, Volume 392, Issue 10164, P2551, December 15, 2018.
10. *Estimating funds required for UHC within Indian States*, Nachiket Mor and Sudheer Kumar Shukla, The Lancet Regional Health – Southeast Asia 2023;13: 100165, Volume 13, 100165, June 2023