ENGAGEMENT OF THE PRIVATE SECTOR IN THE PRADHAN MANTRI JAN AROGYA YOJANA: EXAMINING THE PROMISE OF A WATERSHED MOMENT FOR UNIVERSAL HEALTH COVERAGE

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Abstract:
The aim of Universal Health Coverage (UHC) has been reiterated in multiple Indian policy documents in the past. Many states as well as central governments have also espoused this goal through government-funded health insurance schemes. The recently launched Pradhan Mantri Jan Arogya Yojana (PMJAY) is yet another insurance scheme of the federal government to provide secondary and tertiary care services to poor and vulnerable sections to achieve UHC. By design, the insurance model of financing health care opens a window to engage with private healthcare providers. However, as past experiences suggest, engaging the private sector in pursuit of public health goals has not been an optimally effective strategy, either in India or globally. This can be explained ideologically through critiques of strategic purchasing as well as pragmatically through the gaps in the implementation of the previous schemes due to the weak stewardship role of the government. This paper compares the design of PMJAY with earlier public insurance schemes and suggests the scope for improvement in the new scheme to successfully achieve the goal of UHC.

Keywords: Universal Health Coverage, strategic purchasing, private sector, RSBY, PMJAY,

The concept of Universal Health Coverage (UHC) originated at the World Health Assembly in 2005, prompting frequent use of the phrase

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in public health discourse in general, and health services in particular. The World Health Organization (WHO) defines UHC as, 'a state of health system performance, when all people receive quality health services they need without suffering financial hardship' (WHO, 2010). Thus, equitable access to health care is one of the core outcomes of UHC. With the partial success of the Millennium Development Goals (MDGs) to achieve equity, the discussion on UHC has regained its relevance and prominence in the discourse of Sustainable Development Goals (Rodney and Hill, 2014).

UHC, in the Indian context, has been notionally represented in all major policy documents on health, starting from Bhore Committee (1946) to the Draft National Health Policy (2017), along with finding a mention in the Constitution (Reddy and Mathur, 2018). The Bhore Committee had proposed a government-funded three-tier healthcare system that integrated both preventive and curative services at all levels. Though the current public healthcare system is based on a similar structure and idea, sustained budgetary constraints have led to this system being inefficient as well as inequitable (Gupta and Chowdhury, 2014). This has encouraged the development of more effective models by the private sector, both formal and informal, consequently ensuring that they find their places in the health care delivery mechanism. The predominance of the private sector is one of the reasons for escalated out- of- pocket (OOP) expenditure for healthcare and further increased inequities (Reddy and Mathur, 2018; Katyal et al., 2015).

In other developing and developed countries, studies reveal that a key area in which inequity may arise within UHC is through disparities in the quality of care being offered and access to specialized clinical services (Rodney and Hill, 2014). Data collected on healthcare in India, for outpatient and inpatient procedures, shows that there is an increasing dependence on the private sector for curative services, which is adversely affecting the economically weaker sections residing in rural areas (Baru et al., 2010). Despite compelling evidence on the failure of such schemes to drive UHC, at the national and global level in India, government-funded health insurance has been the preferred approach by the state[6] and central[7] governments to address inequities in secondary and tertiary care.

[6] 19 government funded insurance schemes have been launched across different states. The states are Himachal Pradesh, Punjab, Rajasthan, Madhya Pradesh, Uttarakhand, Arunachal Pradesh, Assam, Tripura, Jharkhand, West Bengal, Odisha, Gujarat Goa, Kerala, Telangana, Andhra Pradesh and Tamil Nadu. See PWC,n.d.

[7] Rashtriya Swasthya Bima Yojana was RSBY was launched by the Ministry of Labour and Employment, Government of India in April 2008 to provide health insurance coverage for Below Poverty Line (BPL) families to protect them from financial liabilities arising out of health shocks that involve hospitalization. See https://www.india.gov.in/spotlight/rashtriya-swasthya-bima-yojana

In September 2018, another such government-funded insurance scheme, the Pradhan Mantri Jan Arogya Yojana (PMJAY) was launched by the central government. The new scheme claims to have addressed the lacunae in the erstwhile insurance schemes and hence, can be considered to be better equipped to achieve the vision of UHC, although the design of this scheme has been criticized as well, especially with regards to the insurance mode of financing and the insufficient budget allocation (Jan Swasthya Abhiyan, 2018). This commentary examines the measures adopted in PMJAY to facilitate the participation of the private sector in delivering healthcare to all sections of the society, taking from the conceptual as well as the practical bottlenecks experienced in other government schemes that involved private sector institutions through strategic purchasing mechanism to achieve UHC. The scope of the analysis of PMJAY is confined to the design of the scheme only as the scheme was recently launched and data on implementation is yet to be made available.

STRATEGIC PURCHASING OF HEALTHCARE SERVICES FOR UHC: A CONCEPTUAL UNDERSTANDING

The idea of strategic purchasing for health care is rooted in the Quasi Market Model (QMM), a product of the New Public Management (NPM) reforms introduced in the neo-liberal era. The World Health Organization (WHO) defines strategic purchasing as an active approach to financing healthcare in which transfer of funds, fully or in parts, is linked to the performance of the provider and is in accordance with the health needs of the population that they serve (WHO, 2017). Similarly, as a government-funded insurance scheme, PMJAY can be considered to be promoting strategic purchasing as the government pays for the insurance premiums which are used for purchasing healthcare services from a variety of private, public and voluntary providers. An argument in favour of strategic purchasing from the private sector is that 'money follows the patient', a process which might improve responsiveness, make private services available for the poor and enhance effective regulation of the private sector providers (Lagomarsino et al., 2012; McKee, Edwards and Atun, 2006).

Underlying the justification in strategic purchasing, the mandate of QMM was to change the form of the public sector organization to a 'quasi-firm'[8] (Ferlie, 1992). To aid that, existing public hospitals and health care

[8] As a quasi-firm the organizations like hospitals and schools are under pressure to attract business in order to maximise revenue. They also need to market their services to consumers or their proxies; they may be pressurised to reduce cost and raise quality; they may even determine their own competitive strategy in response to local market conditions. Like firms they may also collude with other providers or seek to find ways of reducing purchaser pressure on them. See Ferlie 1992

institutions are assigned an autonomous status to enable easy decision making and also in generating their resources. This created a split between the purchaser and the providers of health services. In this model, funding is not allocated solely through planning; instead, the allotment is done through competitive bidding, by both public and private providers, geared towards controlling the cost and maximizing profit (*Ibid*). Based on Britain's experience of strategic purchasing in the National Health Services (NHS)[9], Simonet argued that the internal competition neither ensured a patient-centric approach nor did it reduce the prescription cost; rather, it provoked private physicians to adopt cost-saving measures like reducing staff (Simonet, 2013). Other criticisms included aspects like increased administrative cost because of the complexity of this model and those private providers could skim resources from the public facility (Lagomarsino et al., 2012).

Owing to the fragmentation between the purchaser and provider, a third institution to ensure the accountability of services is warranted. However, guided by the neo-liberal doctrines of less government involvement, there is little scope for any such institution in QMM. Instead, in the name of choice, it rests the onus of accountability on the patients and their families, who are considered to be 'consumers'. It is also explicit that the public funding infused in private institutions raises ethical concerns regarding equity of access by excluding those who are unable to bear the rising cost (Kapilashrami and Baru 2019). This perspective can be categorized as 'ideological' as it is germane to the criticism of neo-liberal approaches to UHC.

Box 1: Two types of governance reforms proposed by HLEG

Managerial – All India and state level Public Health System Cadres and state level Health System Management Cadre.

Institutional – National Health Regulatory and Development Authority (NHRDA) with three key units for (i) legal, financial and regulatory norms, (ii) accreditation of both public and private sectors and (iii) evaluation of performance of both the sectors.

In 2005, the World Health Assembly proposed that overall strong government stewardship can facilitate collaboration between public and private providers as well as health-financing organizations to

[9] National Health System (NHS) in Britain where the District Health Authorities (DHA) was granted a fixed budget to purchase care from hospitals and other community-level care providers which instilled competition among the providers. See Simonet (2013)

operationalize the idea of UHC as a more pragmatic approach to support the strategic purchasing approach (WHO, 2005). Armstrong (1997) contended that the capacity of stewardship enables the State to consolidate market-oriented reforms into an ethically driven policy-making framework. The same was suggested in the World Health Report, 2010. Although it opposed the provisioning of health services financed through public insurance, the High-Level Expert Group (HLEG) on Universal Health Coverage (UHC) by the Planning Commission of India supported the role of State *as guarantor and enabler and not necessarily the only provider (Planning Commission, 2011).*

According to HLEG, to achieve UHC, the government should provide a package of essential healthcare services; involving the private sector through strategic purchasing for secondary and tertiary care. Such a recommendation is antithetical to the notion of universalization of health care; it prioritizes medical care with the support of the private providers (Qadeer, 2013). The Group further suggested reforms in institutional and managerial structures to enhance the State's capacity as an effective purchaser of health care services but did not delve deeper into the structures of these bodies (Box1) (Thakur 2011). However, recollecting the NHS experience, it should be well understood that regulations cannot be guaranteed by such independent supervisory organizations, considering that they are run by former public sector functionaries who have the same *lingua franca* and *modus operandi* (Simonet, 2013).

EXPERIENCE OF PRIVATE SECTOR ENGAGEMENT IN INDIA SO FAR: QUESTIONING PMJAY'S DESIGN

The Pradhan Mantri Jan Arogya Yojana, also known as Pradhan Mantri Rashtriya Swasthya Suraksha Mission (PMRSSM), was launched in September 2018. The scheme aims to cover healthcare costs of up to Rs. 5 lakh for 10 crore households identified from the Socio-Economic and Caste Census (SECC) (GOI, 2018). Under this scheme, 'no- cost' secondary and tertiary health care will be provided through an active and accountable network of public and private providers. The inherent assumption is that a well-measured strategic purchasing of services in health care deficit areas, from private care providers, especially the not-for-profit providers, will not only increase the availability of services but also strengthen the public health care system.[10]

[10] Provider Network Under PM- RSSM: Empanelment and allied process retrieved from https://www.pmjay.gov.in/sites/default/files/2018-07/HBP.pdf

Several schemes launched by the Government of India and the state governments have engaged private players for delivery of healthcare. The most relevant scheme for comparison at this point is the Rashtriya Swasthya Bima Yojana (RSBY). RSBY, like PMJAY, is also a government-funded insurance scheme for promoting inpatient care through private health care providers. After the launch of PMJAY though, it has been subsumed under the new scheme. The PMJAY guidelines have acknowledged the shortcomings of the RSBY, especially for engaging private providers. It is, therefore, necessary to revisit the design of PMJAY based on the lacunae identified, both in the role of State as a purchaser as well as a regulator and in the role of the private sector as a provider, as highlighted in studies of public-funded health insurance schemes.

The fundamental problem with the empaneled private providers, especially in secondary and tertiary care, stems from the fact that the providers are generally located in bigger cities and towns. The lack of private hospitals in rural, tribal and remote areas has been reported by several authors (Nandi et al., 2013; Basu, 2010). PMJAY has introduced higher package rates for hospitals in these hard-to-reach areas as well as having provided viability gap funding for establishing new facilities. How far these measures promote investment by the private sector for healthcare in remote blocks needs to be separately examined once the block-wise data on the private sector is made public.

Next, PMJAY has set out a technology-intensive criterion for the empanelment of private players, in the name of patient safety and appropriate care. The experience of Aryogsri in Andhra Pradesh, another government-funded insurance scheme for Below Poverty Line (BPL) households, shows that such criteria almost inevitably lead to the selection of corporate hospitals. One of the biggest criticisms of Arogyasri has been that the corporate healthcare industry has effectively extracted the State's allocation of healthcare resources (Prasad 2015). This is also a potential threat for PMJAY, especially in backward areas, where secondary and tertiary level public institutions may not be able to meet these standards and are hence rendered ineligible.

Many studies on RSBY in multiple states like Maharashtra, Kerala, Gujarat, Chhattisgarh and Andhra Pradesh, highlighted a similar problem regarding private players for the nature and cost of care (Wagle and Shah, 2017; Rathi, 2011; Jisha 2015; Patel et al., 2013; Dasgupta et al., 2013; Nandi et al., 2016; Prasad, 2015; Roy, 2018). Some that occur in common include overcharging, unnecessary surgical procedures, and selectively providing services for conditions with higher package rates. There were also cases of denying healthcare to poorer patients or those with medical complications,

as discovered in the case of most private hospitals in Delhi that were given land at a subsidized rate under the condition that they would provide free outpatient and inpatient care to 25% and 10% of the poor patients, respectively (Qadeer and Reddy 2006; Shukla, 2018).

Box 2: *Recommendations of HLEG*

Ensure that at least 75% of outpatient care and 50% of in-patient services are offered to citizens under the national health package (NHP); for which they would be reimbursed at standard rates as per levels of services offered, and their activities would be appropriately regulated and monitored to ensure that services guaranteed under the NHP are delivered cashless with equity and quality

Provide only the cashless services related to the NHP and not provide any other services which would require private insurance coverage or out of pocket payment.

Reddy et al (2011) have ascribed these imperfections emanating from market-oriented mechanisms to weak stewardship by the State. The State therefore, needs to design a safety net for the poor before engaging the private players, e.g. a fixed percentage of services, and very importantly, design mechanisms to monitor and enforce this implementation (Saith and Mehrotra, not dated). Similar options for effective strategic purchasing were also recommended by HLEG (Box 2).

Aiming to engage the private sector in a manner that can increase coverage and decrease costs, the PMJAY has constituted somewhat elaborate governance structures at the district, state and national levels. Currently, the national level 'Agency' has been given the status of an 'Authority' to ensure that the restructured body has "full autonomy, accountability and mandate to implement PMJAY through an efficient, effective and transparent decision-making process" (The Wire, 2019). While this could reflect, on the one hand, the government's intention to strengthen the regulatory function, on the other hand, it gives them the power to decide on what means to employ to increase strategic purchasing from the private sector (PWC, not dated).

According to PMJAY guidelines[11] all major decisions are to be taken at the national level, delegating the task of implementing the scheme to district

[11] Guidelines for processes for empanelment of hospitals (seehttps://www.pmjay.gov.in/sites/default/files/201807/GuidelinesonProcessesforEmpanelmentofHospitals_0.pdf) and Grievance Redressal Guideline (see https://www.pmjay.gov.in/sites/default/files/2018-07/GuidelineforGrievanceRedressal_0.pdf)

and state machinery, which may not have adequate capacity. Recalling what went amiss with RSBY, the district and state-level authorities did not interact with the private players regularly and devised no functional grievance redressal mechanism (Dasgupta *et al.*, 2013, Shukla et al 2011; Rathi 2011; Desai 2009). The experiences were similar in other schemes that propagated private sector engagement (Venkat Raman and Bjorkman 2009). Besides, the same district-level committee is being given the task of 'empanelling as many private institutions', screening their eligibility for the scheme and monitoring their performance. These responsibilities may potentially lead to conflict in understanding the role of these institutions.

Given the State's failure to reinforce the Clinical Establishment Act[12], it is less likely that the institutional structures created under PMJAY will be able to do it. Thus, an alternative yet efficacious approach to regulate the private sector is to strengthen the public sector. Like RSBY, PMJAY also enrolls the public sector for the scheme. This strategy has not worked in favour of the public sector, as suggested by the RSBY experience. More direct measures are required to make the public sector robust and able (Das Gupta and Muraleedharan, 2014).

The values and motives of the private sector behind joining a government scheme are of critical relevance. Reich (2000) argues that private sector institutions providing healthcare services under publicly financed schemes should comprehend this as a social responsibility and also see it as their moral obligation to strive for excellence. The RSBY experiences showed that the aspect of the motivation of the private sector also varies greatly (Patel et al., 2013). This was also evident in other schemes like Chiranjeevi Yojana which promoted institutional deliveries; the private sector providers joined the scheme so that they could gain an official certificate under the Medical Termination of Pregnancy Act (Acharya and McNamee 2009). These diverging values of equity and universality in the case of the public sector in contrast to the self-interest and profit maximization of the private sector are often the reasons for the failure of the private sector participation in public services (Baru and Kapilashrami, 2019). The PMJAY has seemingly not made any explicit effort to address this aspect.

[12] The Clinical Establishments (Registration and Regulation) Act, 2010 has been enacted by the Central Government to provide for registration and regulation of all clinical establishments in the country with a view to prescribe the minimum standards of facilities and services provided by them. The Act has taken effect in the four States namely, Arunachal Pradesh, Himachal Pradesh, Mizoram, Sikkim, and all Union Territories except the NCT of Delhi. See http://clinicalestablishments.gov.in/cms/Home.aspx

DISCUSSION

There are many reasons why PMJAY may not be able to fulfill the stated objective of achieving UHC. Firstly, the amount allocated for PMJAY in the 2018-19 national budget is Rs. 2000 crores. With expenditure for healthcare up to Rs. 5 lakh per household covered under the scheme, it will be able to bear the healthcare cost of only 40,000 families this year. Thus the benefit will reach less than 10 households in each block[13] (approx.5500 blocks in India). Secondly, the scheme uses the Socio-Economic Caste Census (SECC) of 2011 to identify the eligible households. Thus it includes only those families who qualified in one of the seven markers of deprivation when the data was collected. There may be additional households that meet the deprivation criteria now but have no means to be included. There is no mention of any continuous enrollment process under the scheme. Thirdly, some states may not participate in the scheme. It includes those with existing state insurance schemes or with politically divergent positions from the central government about the objectives of the scheme[14]. Despite the provision of portability in the design of PMJAY, the benefits and experiences of seasonal migrants may vary across the country.

Notwithstanding these operational shortcomings, this paper argues that engagement of the private sector to deliver a substantial proportion of secondary and tertiary healthcare falls short in two key requirements– increasing coverage (in terms of numbers of providers in a given geographic area) and decreasing economic barriers (with respect to out of pocket expenditure). The evidence presented so far is best categorized into two perspectives: *ideological* and *pragmatic*.

The *ideological position* is rooted in the critique of neoliberal reforms which proposes strategic purchasing as a key driver to achieve UHC. At the core of this reform process is the doctrine that the State should withdraw its role as a service provider; instead it should perform the financing and stewardship functions and delegate service delivery to the private sector. There are two arguments against the strategic purchasing of healthcare from the private sector. First, the spatial distribution of the private sector is not uniform across and within the states. The private sectors are mostly located in areas where people have purchasing power, not in the backward

[13] Each block is approximately 100,000 to up to 250,000 population

[14] Four states have opted out of PMJAY – Delhi, Telangana, Odisha and West Bengal. The Central government is trying to convince them to join the scheme to ensure portability benefits. See https://www.livemint.com/politics/policy/modi-government-again-urges-four-states-to-join-ayushman-bharat-1559739658188.html

and remote blocks. Second, the fragmented model of healthcare interrupts the scope for forward and backward referral linkage between primary care, which is largely provided by the public sector, and the secondary and tertiary care being delivered by the private sector[15]. With currently no standards for referral and most people directly approaching the private sector for their illnesses, there may be an increase in the number and amount of claims, if hospitalized. In case no hospitalization is required, it will increase the out of pocket expenditure for outpatient care at the private hospital; which is already very high in India[16] but not covered under the scheme (Prinja et al, 2019).

The *pragmatic perspective*, on the other hand, accepts neoliberal reforms as a 'done deal' and hence strategic purchasing as inevitable. In doing so it advocates for a stronger stewardship role of the government. It argues that the private sector will deliver the services as per the conditions if there is effective regulation. Experiences of the different insurance schemes have documented serious reservations about the State's capacities to regulate the functioning of the private sector. The utilization of healthcare is marked by the asymmetry of information and supply-induced demand. Grounded in these realities, the private sector may, directly and indirectly, promote services with higher costs. The State has hardly been able to control this, so far. Its weak control over the existing private sector is also manifested in its inability to enforce the Clinical Establishment Act due to lobbying by medical professional associations in favour (implicitly) of the private sector. There is also candid support for the private sector by the country's political and bureaucratic elites (Baru 2018).

However, there is some hope that PMJAY may be able to revamp the regulatory institutions of the State through the proposed three-tier governance structure (National Health Authority, State Health Agency and District Empanelment Committee); provided it enhances the capacities of the personnel in these bodies and empowers them with enough authority. The scheme should begin by focusing on the district level, where most of the empanelment is done; hence regulation is critical. As per the scheme guidelines, the final decisions regarding punitive measures rest

[15] Primary level is the first point of care which acts as a gatekeeper for the secondary and tertiary care. If the linkages between these three layers are broken, the patient may directly reach the secondary and tertiary care facilities which may increase the caseload at those levels. This may be beneficial for the private sector initially, but as the caseload exceeds their institutional capacity, they will deny services to the poorer patients.

[16] 4.2 per cent of India's Gross Domestic Product (GDP) is spent on health care. Out of this, the government's share is only one-fifth, rest is being spent by the households. Majority of the health care expenditure is for out-patient care. See https://www.downtoearth.org.in/news/out-of-pocket-health-spending-has-risen-in-rural-india-study-35613

with the state and national levels. This is likely to undermine the control of district-level bodies over private institutions. An empowered District Empanelment Committee will not only empanel the appropriate private hospitals but will also enable effective implementation of strategies for reducing fraud and resolving grievance redressal. A thorough capacity-building and accountability strategies of these institutions are warranted. Moreover, there is a conflict of roles if the same public officials responsible for empanelment are also responsible for regulating private providers. This, therefore, needs to be factored in while these regulatory bodies are constituted at all levels.

The other way of regulating the private sector is to posit the public sector as a tough competitor; this entails strengthening public healthcare institutions (Das Gupta and Muraleedharan, 2014). The PMJAY, while promising to strengthen public institutions, only incentivizes the public hospitals in the same manner as the private ones. Based on the experience of RSBY, cited previously, it is amply clear that introducing market principles do not lead to an increase in revenue for the public sector. Instead in some cases, it reduces the range of services as well as the patient load (Dasgupta et al., 2013). With already a higher preference for the private sector[17] owing to better facilities, a big chunk of budgetary allocation for PMJAY is bound to go to those institutions instead of to the public facilities which are suffering from lack of adequate staff as well infrastructure. To make the public hospitals compete with private facilities for funds under the scheme, the government needs to continue budgetary allocations to upgrade public institutions so that they match the private sector and also ensure efficiency and accountability of expenditure (Jain et al, 2014).

The PMJAY shall surely enjoy the backing of the newly-elected national government as this is a flagship scheme of its previous regime (2014-19). Therefore, it is now the responsibility of the government to fill in some of these explicit gaps; particularly those that relate to the regulation of the private sector, along with the strengthening of the public sector. UHC is a global commitment, and the PMJAY is designed as a key instrument to achieve that. It may be hoped that addressing these gaps restores faith in the public systems, in its stewardship and financing roles and beyond.

[17] Between NSSO 60th (2004) and 71st round (2014), share of inpatient care from public facilities has decreased in both rural and urban areas in a majority of the states. See Jain et al, 2015

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