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Current Debate

Pradhan Mantri Jan Arogya Yojana – A socio-economic perspective

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1. Introduction

One of the main concerns of health policy in India is to reduce the burden of high out of pocket expenditure on health. According to the latest National Health Accounts (NHA) Report, 63.2% of current health expenditure is financed by household out of pocket expenditure (OoPE).[1] The share of OoPE in total expenditure on health in India is amongst the highest in the world, with the world average being 18.6% and that for low income countries is 41%.[2] Health care expenses can be catastrophic, pushing people into indebtedness and poverty. Almost 25% households in India face catastrophic health expenditure (defined as proportion of households that had out-of-pocket payments for health care equalling or exceeding 10% of the household expenditure)[3] and one estimate suggests that 55 million persons fell into poverty in India in 2011–12 due to the burden of OoPE on health.[4] The Government of India launched the Pradhan Mantri Jan Arogya Yojana (PMJAY), a government sponsored health insurance (GSHI) programme in 2018 to address this problem. The PMJAY along with the scheme for setting up of health and wellness centres constitute the Ayushman Bharat.

The PMJAY aims to provide an insurance cover of up to Rs. 5 lakh per year per household to around 10 crore households (~40% of the population) for meeting expenses towards secondary and tertiary care hospitalisation. According to official records, as of March 9th 2020, over 12.36 crore e-cards have been issued, over 90 lakh hospital admissions have taken place and almost 20000 hospitals have been empaneled under the scheme. While the scale of the programme is impressive, there are a number of concerns on whether such an insurance-based approach is indeed the most desirable in the Indian context. Although it is too soon to evaluate the impact of the PMJAY, some important insights can be drawn from the experience of other GSHI schemes that have been implemented in different states in the country as well as the Rashtriya Swasthya Bima Yojana (RSBY).

The RSBY was initiated in 2008 with the aim to provide insurance coverage to unorganized sector workers. Under the RSBY eligible families had a cover of Rs. 35,000 per year to access inpatient services in accredited government or private hospitals. The other schemes include the Rajiv Arogyasri scheme in Andhra Pradesh (this has later been split into two schemes when the state was divided into Andhra and Telangana), the Chief Minister's Comprehensive Health Insurance Scheme in Tamil Nadu and the Vajpayee Arogyasri in Karnataka each of which provide a targeted population in the state with a hospitalization cover of around Rs. 2 lakh per year.

Based on the available research on these schemes, this paper looks at some of the issues in relation to the effectiveness of schemes such as the PMJAY in addressing the health concerns in India. There are questions raised on how effective GSHIs can be in actually reducing OoPE on health. GSHIs also need to be assessed on what their impact can be on public expenditure on other aspects of healthcare such as primary health and preventive measures and overall costs to the economy. Anxieties have also been expressed on whether the PMJAY is a way to divert funds to the private sector away from strengthening public sector health care provision, which in the current context of a largely unregulated private sector can result in further inequities in access and utilization of health care.

2. Evaluating the effectiveness of PMJAY

2.1. Impact on OoPE

Studies show that the expenditure on outpatient care, medicines and diagnostics constitute a significantly higher proportion and is more impoverishing than OoPE on inpatient care.[5–8] Of the

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total current health expenditure in India 35.3% is on inpatient curative care services, the rest being on prescribed medicines (26.8%), outpatient curative care (17.1%), preventive care (6.8%), etc.[1] PMJAY only covers hospitalization expenses and up to 3 days of pre-hospitalization and 15 days post. Therefore, the majority of out of pocket health expenses does not fall under the purview of the PMJAY or similar state health insurance schemes. Strengthening access to universal and free primary care services including free medicines, therefore remains an important policy objective.

Even in relation to burden of OoPE due to inpatient care, how useful the PMJAY will be is suspect. Most evaluation of the RSBY show that this scheme did not manage to significantly reduce OoPE.[9,10] Surprisingly, even the state GSHIs mentioned above which include a larger proportion of the population as well as provide a much higher cover than RSBY, have not had a significant impact on reducing OoPE.[11] For example. a recent paper using NSS data finds no significant difference between the OoPE on inpatient care between those who were covered under the GSHI scheme and those who weren't, in three Southern states. This result held true for both public as well as private hospitals.[12]

2.2. Implications on public finance

Not only is the burden of OoPE on health disproportionately high, India ranks amongst the lowest when it comes to public spending on health as a proportion of GDP. Government health expenditure as a percentage of GDP in India is 1.2%[1] compared to the global average of 7.44% and the average of low- and middle-income countries of 2.74%.[2] The National Health Policy 2017 targeted increasing the health budget to 2.5% by 2025, which would require a 25% increase on a yearly basis by the central government. However, such a rise has not been seen in the last three years with the spending on health remaining around 1% of GDP.

In this context of tight budgets for health, increasing budgets for PMJAY would come at the cost of some other aspects of healthcare. The government allocated Rs. 6400 crore for the scheme in Budget 2020, compared to Rs. 3200 crore for 2019–20 (Revised Estimate) and Rs. 1998 crore for 2018–19 (Actual Expenditure). In contrast, the allocations for the National Health Mission, through which much of the health systems strengthening especially at the primary level is supposed to take place, declined slightly from Rs. 33,789 crore in 2019–20 (Revised Estimates) to Rs. 33,399 crore in 2020–21 (Budget Estimates).[13]

An analysis of budgets in Andhra Pradesh showed that a quarter of the health budget in the state was on the GSHI and this led to a slowdown of expenditure on primary and secondary health services. This study argues that not only is there a diversion of funds away from lower levels of care but this could have longer term cost implications as reduced access to primary and secondary care may increase hospitalizations which are more expensive.[14]

Escalating costs and shifting of resources away from primary care services could have very serious implications of the PMJAY. With expanding coverage and greater utilization of the scheme, costs are bound to increase further. Moreover, the industry has been complaining that the package costs under PMJAY are too low[a]; an indication that future costs would be higher. Further, with most of the care sought under PMJAY being in the private sector, these funds would not in any way contribute towards strengthening the public health system. About 50% of the empaneled hospitals are in the private sector.

2.3. Absence of regulatory framework

Cherry-picking of more profitable procedures by the for-profit private sector can be a serious moral hazard outcome of insurance schemes such as the PMJAY. A study of the Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY) in Maharashtra found that private hospitals chose high-paying surgeries and expensive procedures covered under the insurance scheme, leaving the less profitable ones for the public hospitals.[14] There have also been reports of private hospitals in states such as Andhra Pradesh, Chhattisgarh and Bihar conducting unwarranted hysterectomy surgeries to gain from insurance.[b] Data show that even for those enrolled in GSHI schemes, it is found that expenditure in private hospitals for hospitalization is much higher than in public hospitals.[12] Further, the availability of private hospitals is also very skewed across the country with most of them being present around state capitals and big cities, that too more in the better off states. The assumption that access to affordable care in the private sector through insurance coverage would make up for the gaps in the public system is therefore untenable for the vulnerable populations living in the most far-off places.[15]

All of this calls for a strengthened regulatory framework for the private sector as well as better quality of care being available in the public health system. It is well documented that regulatory mechanisms for the private sector in healthcare in India are scanty.[16] The processes and agencies of registration across states vary significantly and it is not even possible to get a comprehensive list of private providers across the country. The private sector itself is also very heterogenous comprising of a large number of small unincorporated establishments as well as corporate hospital chains linked to multinational corporations. Under an insurance-based regime it would become even more important to build a system of regulation. The National Health Authority that has been set up to monitor the implementation of the PMJAY may emerge to play such a role.

2.4. Under-resourced public health system

Basic economic theory shows that there are a number of market failures associated with health care provision such as externalities and public goods especially in preventive care, because of which healthcare provision cannot be left to markets alone. Asymmetric information related market failures such as adverse selection and moral hazard persist in the case of health insurance markets. While regulation of the private sector is one way of addressing these market failures, for equity as well as efficiency reasons it is also important for there to be present a strong and effective government financed and run health care system. As seen above, one of the concerns of the shift of policy attention to insurance-based schemes such as the PMJAY is that it takes away funds and resources from the public sector. The public health system in India is in dire straits and needs much more investment to be able to function effectively.

According to the rural health statistics released by the health ministry, on March 31, 2019 less than 10% of the sub-centres and Primary Health Centres (PHC) are functioning as per Indian Public Health Standards (IPHS) norms. About 19% of the sub-centres do not even have regular water supply and 26% are without electricity. Only 40% PHCs operate on a 24 × 7 basis. There are huge vacancies in human resources at all levels, with the shortages increasing at

[a] See https://www.business-standard.com/article/news-ani/reviewing-package-rates-for-ab-pmjay-essential-for-quality-healthcare-mtai-119062101093_1.html for example.

[b] For instance see https://www.thehindu.com/opinion/columns/Pushed-into-hysterectomies/article14416695.ece and https://thewire.in/health/national-health-insurance-scheme-chhattisgarh-damage-good.

the level of specialists. For example, of the 3334 sanctioned positions for obstetricians and gynaecologists in community health centres, 2135 are lying vacant.[17] It can only be imagined what kind of care the health system is able to provide with such poor infrastructure and non-availability of human resources. The reasons for the same and the reforms that need to be undertaken to address these problems need to be discussed and acted upon on an urgent basis.

3. Conclusion

India faces a double burden of disease with around 28% of mortality in the country still being attributed to communicable diseases.[18] These require efforts towards improved hygiene, sanitation and clean drinking water along with improving access to primary health care including improving coverage of the immunization programme. Malnutrition is an underlying cause of death for a large number of deaths, especially among infants and children. On the other hand, the burden of non-communicable diseases (NCDs) is also increasing, also requiring stepping up on preventive measures such as improving diets and lifestyle, screening and so on. Such a context calls for a strong public health system that is able to respond to these contrasting demands in an integrated manner. Lopsided focus in policy on insurance-based schemes such as the PMJAY which only address hospitalization expenses are both inadequate and ineffective in responding to the situation. Hopefully, there will be greater attention paid to the other aspect of the Ayushman Bharat, the Health and Wellness Centres (HWCs), expanding and strengthening which would be a more appropriate response to the current needs of the health system.

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Declaration of Competing Interest

The author does not have any conflicts of interest to declare

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