Webinar on Governance for Strategic Purchasing
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Governance Aspects in Strategic Purchasing

Perspectives from health insurance programmes in India

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Presentation outline

- Key questions covered in the webinar
- Between the state & the market – Features of the Indian health system
- Health financing reform experience in India – The key milestones
- Governance learnings from RSBY
- Implementing strategic purchasing under PMJAY – mechanisms, processes, agents
- Aligning purchasing with UHC aspirations – ensuring coverage with quality
- The road ahead – new questions, new opportunities

Key questions for the webinar

- What specific governance aspects, including political and institutional drivers, are critical in the implementation & expansion of different strategic purchasing instruments of government-sponsored health insurance programmes in India?

- How could strategic purchasing in the health sector in India be a key policy lever to influence quality of care, particularly in the private sector?

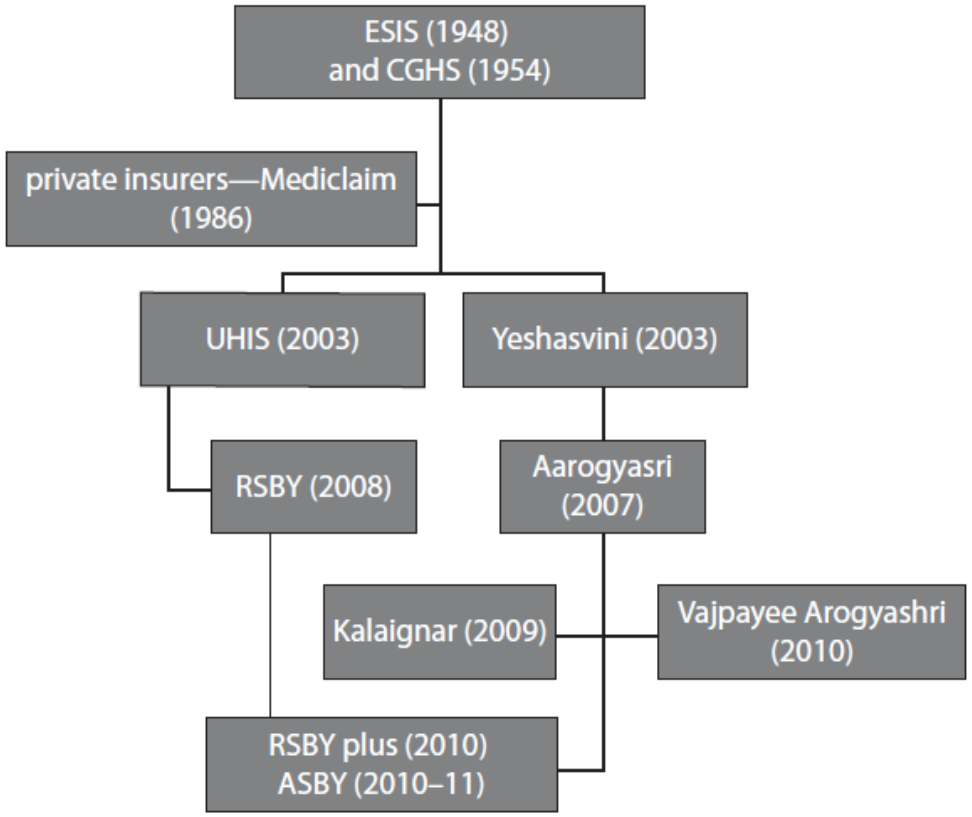
Key features of the Indian Health System

Some Structural Issues

- Predominance of informal livelihoods – less than a fifth of the workforce in salaried, formal jobs negates possibility of (mandatory) contributory Social HI schemes
- Service provision highly fragmented; coexistence of a vast three-tiered public sector, and a highly diverse private sector; Service mix heavily skewed for pvt sector for both OPD & inpatient care (72% & 79% for OPD; 58% & 68% for IPD, urban & rural areas)
- Services mostly “free” in public sector, but of poor quality and inadequate availability commensurate to demand. Studies show that people spend a lot out of pocket even in public hospitals
- Weak regulation of private sector; highly diverse costs of treatment to patients – weak standardisation of prices and treatment quality; Poor gatekeeping role for health system – rampant bypassing of referral chains

Key milestones in financing reforms:

Evolution of government-sponsored health insurance for secondary & tertiary-level care



Source: La Forgia, G & Nagpal, S, Government-sponsored health insurance schemes in India: Are you covered? The World Bank, pg 29

- Public sector 'Mediclaim' by 4 nationalized insurance cos. with annual caps
- Pre-RSBY marked by irregular Illness Assistance/Sickness Relief Funds. UHIS first national attempt (2003), Yeshasvini among certain beneficiary groups
- Private insurance & cashless coverage insignificant before 2000, emergence of TPAs

Which aspects of health system governance are relevant for financing reforms in India?

- Federal administrative structure and constitutional provisions outlining division of legislation & policy-implementation for health sector (financing) reforms between national and provincial governments, including sharing financial responsibilities for national health programmes
  - Health is a State subject which means State Governments have main decision making power
- Involvement of local (district, municipality, village-level) governments in decentralised policy implementation – issues of capacities and accountability
- Organisational aspects of Indian bureaucracy – hierarchies, decision-making processes, frequent transfers, transparency and accountability
- High heterogeneity among both purchasers & providers - implications on enforcing contractual provisions, auditing performance; Aligning incentives across different agents

Influence of political will & agency (positive); interference & rent-seeking (negative)

Early experiences of purchasing health care services in India

India's first attempt for nationwide GHIS

The Rashtriya Swasthya Bima Yojana (RSBY)

- Targeted insurance scheme for hospitalised illnesses, launched in April, 2008 for families officially identified as Below Poverty Line (300mn +), informal sector workers eligible; 5 members/family covered
- Select package of service available in selected (empanelled) hospitals ONLY for hospitalised procedures and few day-care subject to annual cap of INR 30,000 (~$500)/family
- Mostly 'passive' purchasing from public and private hospitals; reimbursed on a fee-for-service basis based on a schedule of charges/rates for procedures fixed in advance.
- Weak local capacity and poor governance mechanisms responsible for highly-varied performance across states under RSBY
- Varied governance capacities across states. Misuse of system in few States.

Purchasing services from private sector hospitals in secondary & tertiary care by state-specific GHIS

RAJEEV/YSR AAROGYASHRI (ANDHRA/TELENGANA)

- Launched in 2007; 85% population coverage – primarily oriented towards specialised tertiary care services incl critical illnesses – initially managed through insurance later through a Trust without intermediation by Insurance Cos.
- Most (1000+) procedures covered through ~400 pub/pvt hospitals
- About 80 m beneficiaries, but accounts for nearly a quarter of the state govts health expenditure

VAJPAYEE AAROGYASHRI (KARNATAKA)

- Launched in 2010
- Eligibility limited to hh included in the official poverty (BPL) list; non-poor covered on co-payment (30-50% of Basic Package Rate)
- Sum assured Rs 150,000 (USD 2,500) on a family floater basis per year. Additional buffer of Rs.50,000/- (USD 833) per year for the entire family on a case to case basis.
- Standard schedule of package-rates; strong MIS, screening to select partnering 'network' hospitals

Implementing purchasing under GHISs in India

Key lessons learnt on governance aspects

- Performance of the scheme in states is also dependent on the design of governance arrangements in the health system
- Strong institutions with clear mandates & political support at the state level – incl the public health service delivery system – are critical for successful implementation of the scheme
- In RSBY, at the national level a dedicated institution was not set up for this purpose which was a challenge
- Clear and unambiguous guidelines are important for effective implementation
- A strong IT platform is key to success

Strategic purchasing under new health financing policy paradigm in India

Key features of *Pradhan Mantri Jana Aarogya Yojana* (PMJAY)

- Aims to provide insurance coverage for hospital care up to Rs. 500,000 (USD 7,143) per family per year, to ~500 mn of poorest and most vulnerable populations in the country

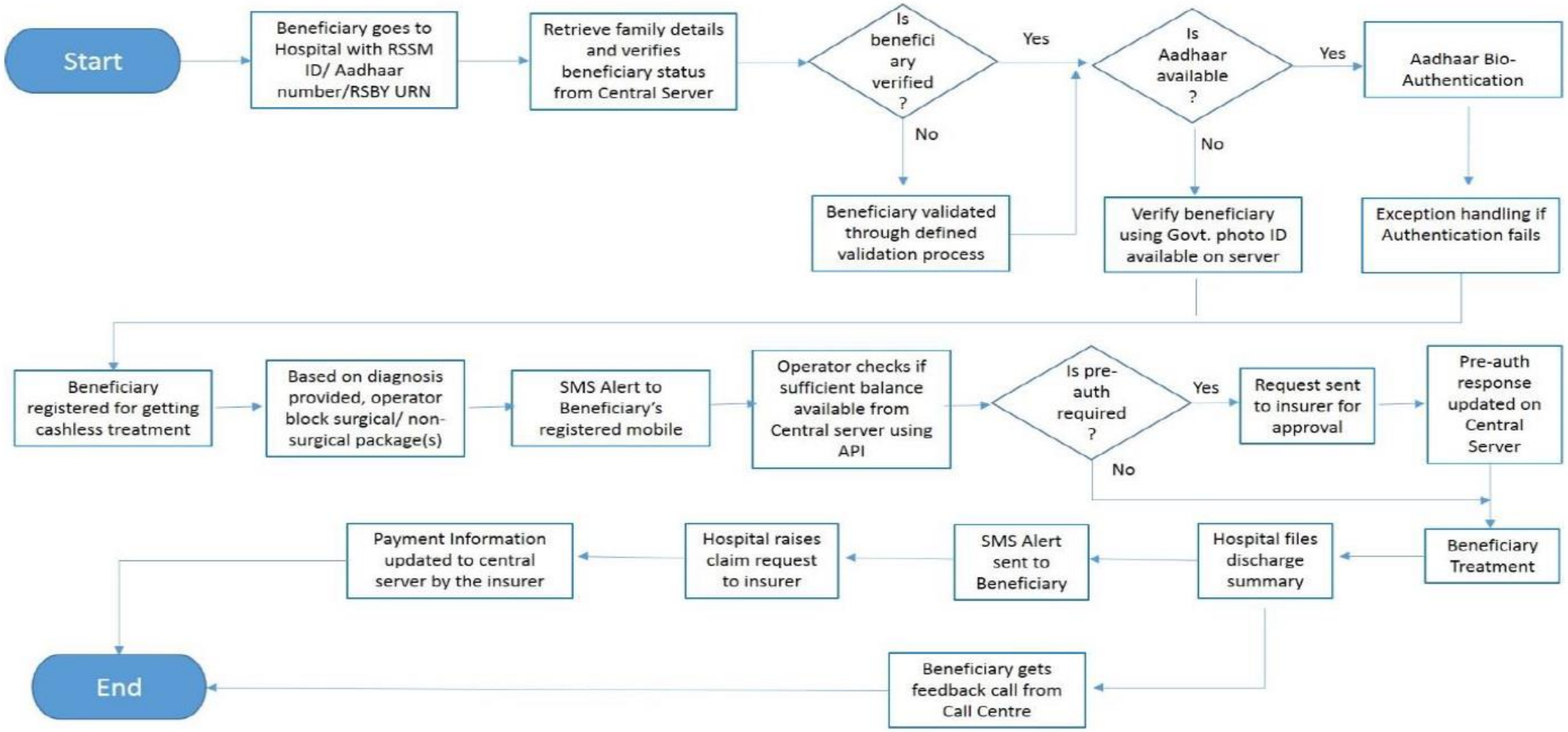
- Basic model similar to RSBY & other precursor state schemes – scheme operated through either a competitively-selected for-profit insurance company (Insurance Model) or semi-autonomous public agency (Trust Model) or some combination of these two (Mixed Model) as the single-purchaser at the State (provincial) level

- Publicly-funded through general tax-revenue; funding shared 60:40 between central and state governments

- Overall stewardship in policy design, defining benefits, developing clinical guidelines, IT platforms, operational standards, processing & analysing claims, coordination with other nodal agencies is through National Health Authority, a quasi-independent body under Ministry of Health and Family Welfare.

- Launched 23rd, Sept, 2018. Currently, in 32 states, 18097 hospitals empanelled, 4.5m beneficiaries utilised/admitted, 102m e-cards issues (as of 17/09/2019)

Process flow under PMJAY



Guidelines on processes for Hospital Transaction, National Health Authority
https://www.pmjay.gov.in/sites/default/files/2018-07/GuidelinesonProcessesforHospitalTransaction_0.pdf

The architecture of purchasing under PMJAY

Key processes & agents

- Structured processes for empanelment (or cancellations) of providers (hospitals) at the state-level overseen by Empanelment Advisory & Disciplinary Committee (EADC)
- Specific criteria for hospitals to be empanelled according to different specialties, based on online applications with supporting documentation
- Requirement of pre-authorization for certain category of individual claims – paid against schedule of charges for exhaustive list of procedures, after verification of discharge documents and associated evidence (imaging, clinical/radiological investigations etc) by State Nodal Agency
- Few treatment paid as a per inpatient day-care surgeries packages
- Either Insurance Companies (who carry financial risk also) or Implementation Support Agencies (ISA) who do not carry financial risk selected in states to support SHAs in claim processing and associated management
- Provision for additional package rate beyond the scheduled rates through quality certifications (entry level-10%, full accreditation-15%), aspirational/backward districts-10%, running PG/DNB courses-10%)

Key governance considerations in implementing PMJAY

STEERING: Oversight Functions

- Improving on the system of fee-for-service package rates to more efficient, cost-effective payment mechanisms; using HTA in purchasing decision mechanisms, strengthening some promising start
- Decentralised scheme oversight – local priorities reflected in purchasing behaviour. Lot of flexibility provided to States
- Not only strategic purchasing but strategic regulation - Harmonised efforts between national & state agencies to encourage, incubate and incentivise pvt providers aligned to wider health system goals
- Encouraging competition between providers in a results/performance-based framework; stimulate cost-reduction through operational improvements by providers

ROWING: Operational Functions

- Massive organisational demands in scheme management – critical need for technical capacities (managing claims, actuarial, clinical audit, hospital scrutiny) at all levels
- Presently, mostly concentrated in NHA, with capacities in most states & district mgmt units for this is being built
- Popularise effective use of IT systems across entire process cycles
- Matching fast turnaround for high-volume claim processing, quality checks and controls as demand grows
- Real time monitoring dashboards for various stakeholders

Approaches to use purchasing as policy lever to influence service quality & responsiveness

- Formulating comprehensive set of guidelines for hospitals under PM-JAY to satisfy different criteria to get graded quality certification (bronze, silver, gold) from NABH (Quality Council of India)
- Covers different aspects of quality - infrastructural inputs, clinical services, support services, patient care & health outcomes through 53 quality standard indicators and 182 standardised verification indicators
- Aims to significantly transform quality landscape especially for small/medium-scale health facilities in both pub/pvt sector where quality certification highly deficient/limited as per national national accreditation system for health facilities
- Incentives for health facilities with graduated progression into silver & gold standards to avail additional financial benefits (higher reimbursement rates, greater credibility and increase patient demand

Other available policy levers to influence quality of health services through PMJAY

- Developing comprehensive Standard Treatment Guidelines and Care Pathways
  - First-time opportunity to propagate evidence-based medicine across the unregulated pvt sector
  - Incentives for hospitals to follow for NABH accreditation * addnl financial benefits
  - Existing governance mechanisms esp quality audits weak to enforce wider adoption across highly diverse institutional capacity (both provider & purchaser level)
- Wider implementation through suitable medico-legal frameworks of Clinical Establishment Rules
- Wider implementation of combined IT & physical monitoring/surveillance systems against upcoding & other frauds and irregularites
  - Joint Committee reports involving insurance regulators & purchasing agency
  - Consultative process of recommendations to prevent fraudulent practices & perverse incentives
- Popularising and strengthening beneficiary feedback, grievance redress

Challenges and opportunities for expanding strategic purchasing for better health system outcomes in India

- ★ Promoting harmonised health service ecosystem towards a single-payer model, allowing for local needs, preferences and health care market
- ★ Expanding population & service coverage
- ★ Developing new, appropriate IT systems including implementing STGs, quality parameters etc.
- ★ Creating key linkage between primary care and PMJAY so as to develop continuum of care, effective gatekeeping and rationalise service demand
- ★ Encouraging & incentivising more performance-based metrics associated with outcomes in the purchasing & payment mechanisms

Combine STEERING & ROWING roles in governance for financing health services through purchasing functions to ensure equitable, universal coverage with quality

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comments & feedback

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Governance for strategic purchasing - webinar series

February 12, 2019 Governance for strategic purchasing: An analytical framework to guide a country assessment – Overview of the WHO framework

June 25, 2019 Governance for strategic purchasing: performance-based financing in a decentralised setting: Country focus Argentina

August 13, 2019 Strategic purchasing instruments to improve quality of health services: Country focus Indonesia

September 24, 2019 Strategic purchasing instruments to improve quality of health services: Country focus India

November 11, 2019 (8:30-9:30 EST) Séparation des fonctions entre agence(s) d'achat et prestataires (questions autour de la faisabilité politiques, autonomie,…) : exemple de la Tunisie (in French)

November 27, 2019 (7:30-8:30 EST) Implementation of a purchaser-provider split (questions of political feasibility, autonomy): Country focus Cambodia

TBC Health information systems and strategic purchasing: Country focus Colombia

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