national health authority

Pradhan Mantri Jan Arogya Yojana
Ayushman Bharat
PM-JAY

EMPOWERING GOVERNMENT HOSPITALS: The Potential of Insurance

PM-JAY POLICY BRIEF 6

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May 2020

Background

PM-JAY and its aligned state schemes have empanelled over 10,000 government hospitals and about an equal number of private hospitals nationwide. The role of private hospitals has captured much of the attention around PM-JAY. This could be due to several factors – because their participation represents a significant departure from the traditional government health system, because their strong views about the (in)adequacy of package rates has attracted headlines, because they are the locus of concern about fraud and abuse, or simply because of long-standing ideological debates about public and private roles in the health sector.

There has been comparatively less focus on the role of government hospitals. But PM-JAY and state health insurance schemes represent an extraordinary opportunity for strengthening the performance of government hospitals across India. Insurance reimbursement implies both a new provider payment model for government hospitals – case-based payments instead of input-based financing – and a shift towards greater autonomy in hospital management. It is notable that in both respects this brings India's hospitals closer in line with the norm in advanced health systems (e.g., OECD countries). It is also notable that no advanced health system relies predominantly on for-profit private hospitals: instead, publicly owned or (in a few countries) non-profit hospitals predominate. Far more than just a cost recovery mechanism, insurance schemes can become a key building block for hospital payment and management reform across India's government health system.

This policy brief summarizes the findings of an in-depth study aimed at documenting operational evidence on how government hospitals have mobilized, managed,

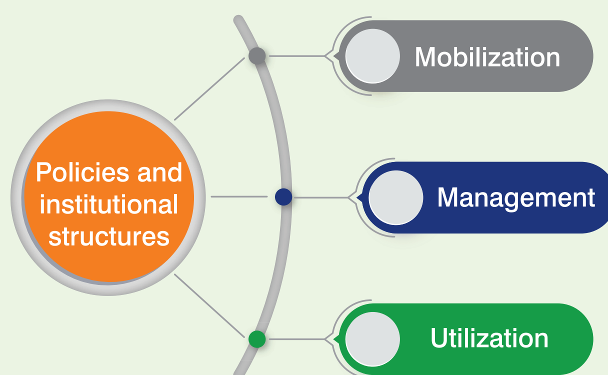
Highlights

- Government-Sponsored Health Insurance Schemes (GSHIS) offer an extraordinary opportunity to strengthen government hospitals across India through additional investment, financing and management reforms.
- An in-depth case study examined the policies and implementation experience with respect to resource mobilization, management, and utilization by government hospitals under four state insurance schemes prior to the launch of PM-JAY in September 2018.
- All four states issued guidelines on how insurance revenues should be allocated within government hospitals and whether a portion of these flows will be retained by the state for other purposes. But there are gaps in state leadership and capacity-building efforts to support hospitals.
- Although small compared to supply-side budgets, insurance revenues account for a large share of flexible funding at the hospital level. High claims rejection rates in some states indicate a lost opportunity.
- Hospital-level institutional structures for fund management differ across states. Hospital practices related to HR recruitment, purchasing of medicines and consumables, and financial management using insurance revenues can be strengthened.
- Facility-level voices report positively on the opportunities to improve care offered by insurance receipts, citing a long list of improvements to infrastructure and patient benefits. But in some states, fund utilization rates and reporting practices reveal performance gaps.
- Going forward, there is an opportunity for national and state governments to leverage the momentum of PM-JAY to ensure a wider transformational shift not only in how secondary and tertiary care is financed but also in how it is managed at the hospital level.

Box 1: METHODOLOGY

The study adopted a case-study approach to document the experience of government hospitals and states with government-sponsored health insurance schemes. A research instrument was developed to guide key informant interviews and secondary data collection (e.g., budget and scheme expense details). Key questions were grouped under three themes: resource mobilization, resource management and resource utilization. Policies and institutional structures were also analyzed as key cross-cutting determinants that underlie the three themes. The study framework is shown in Figure 1.

Figure 1: Study Framework



A purposive sample of insurance schemes in four states was selected: Chhattisgarh, Kerala, Meghalaya, and Tamil Nadu. The scheme names and administering agencies are shown in Table 1. All schemes were launched between 2008 and 2013 and therefore had many years of implementation experience. The sampled states provide a good mix of population size, income levels, government health spending levels and insurance schemes with varying population coverage and provider mix. All states relied on insurance companies instead of state trusts to reimburse claims under their basic coverage programs. Table 2 provides an overview of the states and the schemes selected for the documentation.

Table 1: Sampled states and insurance schemes

States	Insurance schemes studied	Scheme administering agencies
Chhattisgarh	Rashtriya Swasthya Bima Yojana (RSBY) and Mukhyamantri Swasthya Bima Yojana (MSBY)	State Nodal Agency (SNA-CG)
Kerala	Rashtriya Swasthya Bima Yojana (RSBY) and Comprehensive Health Insurance Scheme (CHIS)	Comprehensive Health Insurance Agency of Kerala (CHIAK)
Meghalaya	Megha Health Insurance Scheme (MHIS)	State Nodal Agency (SNA-MHIS)
Tamil Nadu	Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS)	Tamil Nadu Health Systems Project (TNHSP)

Table 2: Schemes at a glance

Indicator	Chhattisgarh	Meghalaya	Kerala	Tamil Nadu
State population	2.57 crores	28 lakhs	3.56 crores	6.92 crores
Families covered (2018)	56 lakhs	4.4 lakhs	41 lakhs	1.57 crore
Coverage rate (% of total families)	100%	49%	Not available	80%
Annual limit (INR) per family prior to PM-JAY merger	50,000 for RSBY & above 50,000 for selected procedures under MSBY	2,80,000	30,000 for RSBY & up to 70,000 under CHIS	1,00,000
Number of empanelled hospitals	1197	172	581	881
Number of empanelled government hospitals	609	156	281	224
Government hospitals as a % of total empanelled hospitals	51%	91%	48%	25%
Scheme expenditure as a % of state health budget	9% (2017-18)	10% (2019-20)	Not available	13% (2017-18)

and utilized insurance revenues under state insurance schemes that preceded the launch of PM-JAY.[1] Key features of the overall policy and institutional environment were also analyzed. The four focus states are Chhattisgarh, Kerala, Meghalaya, and Tamil Nadu. The objective is to inform future policies and guidelines at the national and state level on the mobilization and use of insurance revenues by government hospitals.

Key Findings and Policy Implications

Policies and Institutional Structures – Clear guidance in some areas, but room for improvement

All four states have issued policy documents related to insurance funds for government hospitals. These focus on the revenue-sharing model between the state and government hospitals, areas where funds can be utilized, spending categories and allocation limits for each category (e.g., staff incentives, drugs and consumables, infrastructure). The allowable shares and number of categories differ across states, with some more prescriptive than others. There is a possible trade-off between "light-touch" guidelines that provide significant flexibility to facilities and insufficient guidance that leads to excess caution and inaction. For example, some hospital decision-makers indicated that they were risk-averse, allowing insurance receipts to accumulate in their bank accounts out of concern that any spending decisions will be questioned in the absence of clear instructions from the state. Table 3 shows the key allocation shares under the state schemes as stipulated by the relevant policy documents.

A key policy choice is whether scheme administering agencies should retain a share of the insurance revenues earned by government hospitals to allocate for other purposes. At the time of research, Chhattisgarh and Tamil Nadu had opted to do so, while Kerala and Meghalaya allowed the full claims amount to be paid to government hospitals. Chhattisgarh retained 40 percent of the approved claims for a Hospital Development Fund for centralized funding of hospital investment, irrespective of claims volumes achieved by an empaneled government hospital under the scheme. This creates a potentially equalizing force in resource allocation across the government hospital network, since funding does not strictly follow patient footfalls. Tamil Nadu retained 28 percent for a state corpus, which is primarily used for reimbursing expenses for high-end tertiary procedures (e.g., transplants, cochlear implants) whose cost would typically exceed the annual household coverage limit.

Retaining a portion of revenues earned by government hospitals implies differential pricing for public and private hospitals for the same treatment packages. This may be justified on the grounds that government hospitals already receive significant supply-side financing, they may not have the absorptive capacity to manage substantial additional resources at the facility level, or for system-wide equity considerations. Of course, it also implies a dilution of the positive incentive effects of demand-side financing for government hospitals.

The study revealed gaps in leadership for effective governance at the state level. Policy guidelines could be strengthened by putting more focus on key strategic issues such as how to improve resource mobilization. In most states there have been limited capacity-building efforts such as training to reduce claims rejection rates, increase fund utilization, or support expenditure planning and management. State health agencies could also be more proactive in producing "public goods" such as generic job descriptions for administrative staff hired under the scheme, expenditure reporting modalities, and other inputs. In all states, there is limited oversight by the scheme administering agencies on the use of insurance receipts by government hospitals. Policies also lack measures to achieve a more integrated approach to governance and administration of insurance schemes within the overall functioning of the Health Department. Coordination between scheme administering agencies and the rest of the government health system could be enhanced.

Resource Mobilization – Successes and shortcomings

The contribution of government hospitals to overall treatment volumes under government insurance schemes varies widely across India's states. During both the later years of RSBY and the early years of PM-JAY, for example, government hospitals

Table 3: Overview of policies related to insurance claims revenues

Details	Chhattisgarh	Kerala	Meghalaya	Tamil Nadu
Year policy was issued	**2010-11**	**2008**	**2012**	**2012**
Share of eligible claims retained by the state	**40%**	**-**	**-**	**28%**
Share transferred to facilities	**60%**	**100%**	**100%**	**72%**
Staff incentives	25%	15%	30%	15%
Medicines and consumable	35%	-	-	40%
Hospital upgradation	-	-	-	17%
Other hospital expenses	-	85%	70%	-

accounted for less than one-quarter of total claims in some states but over three-quarters of the total in other states. These patterns can reflect various state-specific characteristics, and there is no "optimal" level, but states with low claim volumes at government hospitals are forgoing a significant opportunity for resource mobilization (including Government of India co-financing) to strengthen their public hospital networks. A better understanding of this issue can help shape the health financing policy agenda.

The case studies revealed that both supply-side and demand-side incentives make GSHIS a potentially powerful resource mobilization tool for government hospitals. Provider incentives linked to insurance revenues include staff incentives, greater management autonomy, and the opportunity to enhance quality of care and overall infrastructure. There are also incentives for beneficiaries to use their insurance card. They can avail of a dedicated counter and staff for handling all hospital admission and discharge formalities, assured access to medicines, consumables, and implants if required, laboratory and radiology investigations, and under some schemes air-conditioned wards, post-discharge medicines and a nominal amount for transportation costs.

At the same time, there are certain disincentives to mobilize revenues noted across all states. These include increased administrative burden of claims management and documentation, and in some places a fear of audit queries related to how funds are ultimately spent. Also, responses across states reveal that there can be some reluctance among beneficiaries to use their insurance cards in government hospitals under the premise that services at these facilities are supposed to be free and they would therefore prefer to retain their balance for use at private facilities. These considerations are summarized in Table 4.

The share of total claims volumes and value generated by government hospitals varies widely across the four states. For example, public providers accounted for 15 percent of the total claims volume in Chhattisgarh, but 68 percent in Kerala. Among government hospitals, the role of medical colleges also varies significantly. The overwhelming majority (84 percent) of government hospital claims in Tamil Nadu are from medical colleges, compared to only 4 percent in Meghalaya. Table 5 has further details.

It is difficult to compare the value of insurance receipts at the hospital level with the supply-side budgets

Table 4: Pros and cons of insurance revenues for government hospitals

	Incentives	Disincentives
Hospitals	• Financial incentives for staff • Funds for facility upgradation • Predictable and flexible funds • Autonomy in fund management	• Additional burden of claims management • Fear of audit queries once funds are spent
Beneficiaries	• Assured diagnostics, medicines, and consumables • No out-of-pocket expenses • Separate admission counter • Transport allowance (some states) • Separate air-conditioned wards for the insured (some states)	• Possible reluctance among beneficiaries to use insurance cards in government hospitals; services are expected to be free, and beneficiaries may want to save coverage balance for private hospitals

Table 5: Resource mobilization by government hospitals

State	Chhattisgarh	Kerala	Meghalaya	Tamil Nadu
Reference period	2012-2018	2008-2018	2013-2018	2012-2018
Volume of claims paid to government hospitals during reference period	8.47 lakhs	40.9 lakhs	1.25 lakhs	11.43 lakhs
Value of claims paid to government hospitals (INR crores)	305.4	1,809.9	57.8	1,738.8
Average claim size (INR)	3,608	4,422	4,614	15,207
Claims from medical colleges (by value) as a share of total government hospital claims	25%	Not available	4%	84%
Claims from government hospitals as a share of total claims pay-out under the scheme				
By value	15%	72%	38%	34%
By volume	23%	68%	50%	42%

(mostly in-kind transfers covering salaries, drugs, etc.) due to the structure of expenditure reporting. Using the Chhattisgarh state budget data, it was estimated that from 2015-16 to 2017-18, insurance receipts of all empanelled government hospitals were approximately 5 to 7 percent of the state government's supply-side, line-item revenue budget for those same facilities (or 3 to 4 percent if flows retained for the corpus fund are excluded). This estimation could not be readily done in the other states.

Although relatively small from a system-wide perspective, insurance claims typically constitute the largest, most predictable and most flexible pool of funds at a hospital's disposal. At several hospitals, stakeholders expressed the view that other resource streams do not accord as much flexibility to hospital managers, and that transfers through the state budget can be lumpy and unpredictable. In some cases, the reliability of insurance receipts was credited with enabling lower vendor prices because there would be fewer payment delays. Facility data confirm the importance of insurance revenues as a source of flexible funds. From a small sample of four hospitals across three states for which data could be obtained, insurance claims constituted about 40 to 50 percent of total receipts into hospital societies. The flexible funds made available under the National Health Mission were much smaller.

However, it is widely recognized that insurance receipts are not entirely "additional" to the regular supply-side funding channel. Several key informants at both the state and hospital levels noted that requests for additional resources during the annual budget cycle – for infrastructure, equipment, drugs, or other needs – are increasingly met with suggestions to use insurance receipts instead. Although concerns are sometimes voiced that insurance revenues imply paying hospitals twice – through both supply and demand-side financing – a more positive interpretation is that this is a more "incentive-compatible" approach to channel additional resources to government hospitals, and an essential first step towards a predominantly output-based financing model as is common in advanced health systems.

Government hospital insurance earnings are often diminished due to high claims rejection rates. This is a reflection of medical record maintenance and claims management capacity, and directly impacts resource mobilization efforts. Chhattisgarh and Meghalaya have claims rejection rates among government hospitals of 18% and 19%, respectively. This is almost three times higher than health insurance industry norms, and far higher than Tamil Nadu. Insurers may view government hospitals as an easier target for claims denial than private hospitals. Insufficient resources are not an adequate reason for frequent claims rejection, since the insurance receipts themselves can be invested by hospitals in strengthening these processes. There is a need for stronger state-led capacity-building efforts in this area to address the foregone opportunity of high claims rejection. Table 6 shows state-wise claims rejection rates.

Resource Management – Finding a balance between flexibility and state support

Hospital level institutional structures for fund management differ across states. In Chhattisgarh and Meghalaya funds are managed by the existing registered hospital societies (e.g., Rogi Kalyan Samiti), while empanelled government hospitals in Kerala and Tamil Nadu have set up specific insurance committees constituting only hospital staff. This is done not only to reduce external and political influences on management and expenditure decisions but also to increase operational efficiency. These committees have full autonomy to take scheme-related decisions including those related to management and expenditure of insurance claims receipts. Procurement guidelines across states reinforce this autonomy.

Practices at the facility level indicate high levels of provider autonomy in human resource management and the allocation of staff incentives. For example,

Table 6: Claims rejection rates

Claims Rejection Rate (CRR) by Value	Chhattisgarh	Meghalaya	Tamil Nadu
Time period	2012 to September 2018	May 2013 to September 2018	2012 to 2018
CRR for government hospitals	**18%**	**19%**	**1.4%**
CRR for government medical colleges	24%	28%	1.5%
CRR for other government hospitals	16%	18%	1.2%
CRR for private hospitals	**4%**	**2%**	**0.3%**
Absolute loss to government hospitals (INR crores)	**68.3**	**13.3**	**27.8**

scheme revenues were used for purposes such as hiring paramedical staff on a short-term basis, ASHA workers to serve as data entry operators on a per-diem, and insurance staff on a purely incentive-based pay model. However, there are no standardized practices related to human resources deployed under the insurance scheme and paid out of claim funds to provide support for hospital administrators. Tamil Nadu has provided some guidance on this topic. Recruitment practices vary from using an HR agency to hire people to seeking recruitment through informal channels. Flexible funds for hiring may allow hospitals to avoid inefficient and ineffective government recruitment processes. But light-touch state support to facilitate hiring could be helpful.

The procurement of medicines and consumables using insurance receipts at the facility level poses an important challenge. There are risks that hospitals will have less purchasing power and therefore incur higher unit prices, that local drug procurement may allow corruption to thrive, or that the quality of medicines will suffer. Government hospitals in Chhattisgarh, Kerala and Tamil Nadu purchase their supplies from the medical services corporations in these states and undertake local procurement of medicines and consumables only if the corporation is unable to supply the same and provides a no-objection certificate to the facilities to undertake local procurement. The effectiveness of these corporations varies across states. In Meghalaya there is more reliance on local purchasing, often by patients themselves, who are then reimbursed. There are obvious risks in this approach. Across states, approaches such as rate contracts are rarely used.

Financial management reporting practices related to insurance revenues could be strengthened. Hospital authorities receive funds directly from the insurance companies or state health agencies via designated special-purpose bank accounts. Standard accounting practices are followed, and books of accounts maintained, but there is ample scope for improvement. In all four states, government hospitals have separate bank accounts for management of insurance claim receipts. This does imply some additional administrative burden for hospitals. In most facilities no accounting software is used, leading to challenges and risks that are inherent in any manual accounting system.

Resource Utilization – Significant benefit for hospitals and patients, but accountability gaps too

Medicines and consumables, infrastructure upgradation and staff incentives were the top three spending categories for insurance receipts in both Meghalaya and Tamil Nadu, constituting more than 90 percent of total expenditure by government hospitals. Data was not available for Chhattisgarh and Kerala. The evidence suggests meaningful investments are being made to enhance quality of care. Key informants at hospitals were able to cite a long list of improvements in both medical and non-medical infrastructure and specific patient benefits (drugs, consumables, transport subsidies, etc.).

There is significant variation across states in fund utilization rates by government hospitals despite the flexibility and provider autonomy that characterizes this pool of resources. Since 2012-13, average utilization against receipts has ranged from 64 percent in Meghalaya to 95 percent in Tamil Nadu (Table 7). The scheme administering agency in Chhattisgarh does not maintain facility level expenditure records, and therefore cannot report on this indicator. Nor did Kerala. Aggregate utilization figures mask wide variation in fund absorption capacity at the facility level within states, highlighting the importance of local leadership. Facility level governance and administration is dependent on the individual leadership skills of the chairperson of the insurance committee or hospital society. As previously noted, a fear of audit queries has also reportedly discouraged fund utilization in certain hospitals and states.

Expenditure patterns from the state corpus in Chhattisgarh and Tamil Nadu are very different as per their design. Utilization levels of the state corpus funds in the two states are relatively low. Only 60 percent utilization of the corpus funds in the last three years in Chhattisgarh points towards a need for building capacity of government hospitals to identify needs and/or strengthen implementation of capital projects by the state. The potential of the corpus fund to serve as an equalizing force in the allocation of funds to the

Table 7: Income and expenditures by government hospitals out of insurance claim receipts

Expenditure categories	Meghalaya	Tamil Nadu
Reference period	**2013-2018**	**2012-2018**
Receipt (in INR crores)	49.9	1,389.1
Expenditure (in INR crores)	32.1	1,320.7
Overall utilization	**64%**	**95%**

state's hospitals is being diluted by low utilization. In Tamil Nadu, corpus fund utilization was better but still modest, at 79 percent.

Mechanisms for integrated reporting and a robust overview of hospital financing need to be developed. There is no systematic procedure for tracking the utilization of funds by hospitals, and expenditure reporting is weak. However, Tamil Nadu has recently set up a web-based portal for empanelled government hospitals to report expenditures against claims receipts. The SHAs in all states reported that oversight of expenditure incurred by the hospital societies falls outside their purview, as hospital societies are independent legal entities that do not come under their jurisdiction. There is a need to improve coordination between scheme administering agencies and Health Departments to ensure greater oversight and accountability and a more integrated overview of health financing in the state.

With little state oversight of expenditures of this additional revenue stream by government hospitals, the onus of effective utilization falls exclusively on facility-level leadership. In brief, there is a risk of autonomy without accountability, as public resources are shifted from a budgetary line-item route to output-based financing with weaker controls. In this context, greater risk mitigation may be required. There are islands of proactive leadership at the facility level, but these best practices have not been disseminated more broadly, nor translated into improved state-level guidelines that can strengthen scheme performance and help to maximize the gains at all facilities.

Despite these shortcomings, many facility-level voices reported that new business processes enabled by insurance revenues are having a large impact on the administration and management of government hospitals. From a medical college in Chennai to a CHC in rural Meghalaya, facility administrators reported positively on how they were able to improve their hospitals using insurance revenues. Some examples from across the states are given in Table 8. An example of facility leadership is presented in Box 2.

Table 8: Value addition: Selected resource utilization examples reported by hospitals

Categories	Few examples
Infrastructure upgradation (medical)	• New patient general wards • Specialist wards (e.g., burn units) • Intensive care units • Operational theatre infrastructure including laminar air flow system • New construction and upgradation of existing civil structures • Investments in medical equipment
Infrastructure upgradation (non-medical)	• Rain water harvesting, security system, public announcement system, training room with conference and projection facilities
Tangible patient benefits	• Better infrastructure, increased access to medicines and consumables, no out-of-pocket expenses for medical care, nominal allowance to cover costs for travel to facilities

Box 2: FACILITY LEADERSHIP CAN BE TRANSFORMATIVE: A CASE STUDY FROM MEGHALAYA

Bhoirymbong CHC in Ri Bhoi district in Meghalaya offers an interesting study of how local leadership can have a major impact on performance. Strong community efforts have helped to achieve high levels of population coverage in the surrounding area, resulting in high utilization rates and resource mobilization. Bhoirymbong CHC's hospital committee has proactively used the insurance revenues to provide air-conditioning in all patient wards, establish diagnostic and radiology services appropriate for a CHC, provide health counselling services, and set up a fully functional gym and playroom for the community. These benefits are accessed by all patients irrespective of insurance status. Moreover, the CHC took the initiative to transition from purchasing drugs on the local market to setting up an in-house drug inventory through wholesale procurement directly from the manufacturers resulting in substantial savings. They have also implemented innovative outreach campaigns at the village level to strengthen demand. This transformation is a result of facility initiative and leadership, without policy prescriptions from the state.

Summary

Insurance revenues offer enormous potential to improve service delivery at government hospitals by introducing fundamental changes in both financing and management. Over the long-term, a full transition from supply- to demand-side financing could be considered, as is the case in most advanced health systems. At present, however, the state case studies suggest important shortcomings in implementation of this new approach to government hospitals. States would benefit from guidance and knowledge-sharing on key policy options available in this sphere and their implications.

References

1. Government Hospitals and Insurance Revenues: Documenting Experiences in Chhattisgarh, Kerala, Meghalaya and Tamil Nadu. World Bank. February 2020.

Disclaimer

The findings, interpretations, and conclusions expressed in the policy brief are entirely those of the authors, and do not represent the views of any author's employer, official policy or position of any agency of the National Health Authority (NHA).

Acknowledgements

We would like to express our gratitude to Dr. Indu Bhushan, CEO, Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), National Health Authority (NHA) and Dr. Praveen Gedam, Additional CEO, AB PM-JAY, NHA for rich discussions that contributed to finalizing the underlying report. We deeply appreciate the warm welcome and extensive support provided by a large number of officials, managers and staff affiliated with the Mukhyamantri Swasthya Bima Yojana (Chhattisgarh), Comprehensive Health Insurance Scheme (Kerala), Megha Health Insurance Scheme (Meghalaya) and the Chief Minister's Comprehensive Health Insurance Scheme (Tamil Nadu). We would also like to acknowledge the support from Lakshmi Sripada in finalizing the brief.

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1. **Raising the Bar:** Analysis of PM-JAY High-Value Claims (July 2019).
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