Assessing the Implementation of India’s New Health Reform Program, Ayushman Bharat, in Two Southern States: Kerala and Tamil Nadu

Kalyani Pillai

College of William & Mary

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Assessing the Implementation of India's New Health Reform Program, Ayushman Bharat, in Two Southern States: Kerala and Tamil Nadu

A thesis submitted in partial fulfillment of the requirement for the degree of Bachelor of Science in Kinesiology & Health Sciences from The College of William and Mary

by

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Assessing the Implementation of India’s New Health Reform Program, Ayushman Bharat, in Two Southern States: Kerala and Tamil Nadu

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College of William & Mary
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Implementation of India’s Health Reform Program

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List of Abbreviations

AB-PMJAY Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana
AIADMK All India Anna Dravida Munnetra Kazhagam
APL Above Poverty Line
BJP Bharatiya Janata Party
BPL Below Poverty Line
CDR Crude Death Rate
CGHS Central Government Health Scheme
CHC Community Health Center
CHIS Comprehensive Health Insurance Scheme
CMCHIS Chief Minister’s Comprehensive Health Insurance Scheme
DMK Dravida Munnetra Kazhagam
DNB Diplomate of National Board
DNO Districts Nodal Officer
FHC Family Health Center
GDP Gross Domestic Product
HDI Human Development Index
HWC Health and Wellness Center
IMR Infant Mortality Rate
INR Indian Rupees
KASP Karunya Arogya Suraksha Paddhati
KBF Karunya Benevolent Fund
KKT Kalaignar Kappeetu Thittam
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>LG</td>
<td>Local Government</td>
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<tr>
<td>LSG</td>
<td>Local State Government</td>
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<tr>
<td>MD</td>
<td>Doctor of Medicine</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Rat</td>
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<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<tr>
<td>MoU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>NABH</td>
<td>National Accreditation Board for Hospitals &amp; Healthcare Providers</td>
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<td>NCD</td>
<td>Non-Communicable Diseases</td>
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<tr>
<td>NHA</td>
<td>National Health Authority</td>
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<td>NITI</td>
<td>National Institute for Transforming India</td>
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<td>NSSO</td>
<td>National Sample Survey Organization</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Co-operation and Development</td>
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<tr>
<td>OOP</td>
<td>Out-Of-Pocket</td>
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<tr>
<td>OOPE</td>
<td>Out-Of-Pocket Expenditure</td>
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<tr>
<td>PHC</td>
<td>Primary Health Center</td>
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<td>PMJAY</td>
<td>Pradhan Mantri Jan Arogya Yojana</td>
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<tr>
<td>RSBY</td>
<td>Rashtriya Swasthya Bima Yojana</td>
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<tr>
<td>SC</td>
<td>Scheduled Castes</td>
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<tr>
<td>SECC</td>
<td>Socio-Economic Caste Census</td>
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<tr>
<td>SES</td>
<td>Socio-Economic Status</td>
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<tr>
<td>SHA</td>
<td>State Health Agency</td>
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<td>ST</td>
<td>Scheduled Tribes</td>
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<td>TNHSP</td>
<td>Tamil Nadu Health Systems Project</td>
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<td>Acronym</td>
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<tr>
<td>TNMSC</td>
<td>Tamil Nadu Medical Services Corporation</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nation’s International Children Emergency Fund</td>
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<tr>
<td>USD</td>
<td>United States Dollar</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Implementation of India’s Health Reform Program

Overview

India is the most populous country in South Asia, having the largest rural population in the world. According to data published by the World Bank in 2019, roughly 22% of the population (273 million individuals) live in poverty. The country also has an exceedingly low percentage of its GDP spent on health care at 1.28%. The purpose of this research is to evaluate the implementation of a health reform program instituted by the government of India to improve financial access to healthcare for the population living in poverty. Each chapter’s content is explained as follows. Chapter 1 explains the historical development of India’s health care system while detailing the roles of the public and private sector. It highlights the challenges the system faces and introduces previous health care policies that the Government of India has had. Chapter 2 introduces the Ayushman Bharat Initiative, India’s new health insurance reform scheme which includes two sections: Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) and Health and Wellness Centers (HWCs). The various aspects of the program including background, eligibility criteria, coverage, implementation methods and financing are provided. Chapter 3 is an introduction to Kerala, the southern-most state of India. This section describes the state’s health indicators, health care performance, past health care initiatives and financing of its health care system. The chapter then moves on to detailing Kerala’s implementation of AB-PMJAY and the adaptations the state chose to make in rolling out the program. In Chapter 4, Tamil Nadu is introduced through a historical background while explaining the state’s prior health care policies, effectiveness of its health care delivery systems and state implementation of AB-PMJAY. Chapter 5 moves on to the methods providing information on patient recruitment and data collection followed by tables that illustrate the socio-economic and health indicators of both states. The purpose of the study was to investigate the implementation process of Ayushman
Bharat, specifically the AB-PMJAY portion of the program, and its effectiveness in the two southern states of India: Kerala and Tamil Nadu through the opinions of health care professionals working in the two respective states. These two states were chosen because of having similar demographics, success in rolling out prior state health care programs and an overall progressiveness in health care delivery and indicators compared to many other Indian states. While AB-PMJAY is expected to have discernable positive effects in states that are not as advanced as Kerala and Tamil Nadu, this research study attempts to understand the implementation in such progressive states as a way to explore problems that implementation will encounter in less developed states in India where the program will serve to improve India’s health indicators by providing health access to millions of people in poverty. To gain better understanding of the scheme’s implementation and roll out, the viewpoints of individuals working in the health care field who engaged with AB-PMJAY on a day-to-day basis were gathered using qualitative semi-structured interviews. The conceptual framework for this research project is that the World Health Organization is encouraging governments to implement Universal Health Coverage (UHC) and this is the first step of the Government of India’s effort in moving towards universal health coverage and the implementation strategies the country is undertaking to attain that goal. Within this framework, the study examines the accessibility, availability, and affordability of health care to the people of India by researching the roll out of AB-PMJAY in Kerala and Tamil Nadu. The results of the study highlighted the opinions of the participants, including personal experiences with the program, advantages and disadvantages of the individual state implementations of AB-PMJAY. The discussion provides an analysis of all the findings while a final conclusion presents an overall summary of AB-PMJAY implementation successes and drawbacks in Kerala and Tamil Nadu. The conclusion ends with
areas for the government to focus on for improvement of the program to have the desired effect of improving health indicators in India and moving the country forward in its development trajectory. Improvement in health indicators lead to advancement in economic output as more of the population can contribute economically. For India to move towards becoming a high-income country, it is critical for the country to improve its health indicators. Ayushman Bharat is the first step towards that goal and therefore the program’s successful roll out is vital to the country’s future.
Chapter 1

Introduction

Background

India has the second largest population in the world with roughly 1.4 billion individuals. Amongst that population, roughly 300 million individuals are living in poverty (Jagasia & Jagasia, 2019). Although it consists of 5% of the world’s population, India’s spending on health care is one of the lowest worldwide, at less than 1% of the world’s total health expenditure. Often, the overall health care system has been criticized as being flawed and exhibiting inconsistencies in access, quality and infrastructure (Angell et al., 2019; Forgia & Nagpal, 2012).

The health care system in India includes both private and public systems. Public systems are financed by taxes, while private systems are predominantly through out-of-pocket expenditures (OOPE), where patients have to pay and are not covered by any insurance. These health care costs are impossible to afford for the individuals living below the poverty line. The National Health Profile 2019 provided by the Ministry of Health & Welfare and the Government of India, published that India spends only 1.28% of its gross domestic product (GDP) on health expenditure. This is lower than even the average health expenditure across the Organization for Economic Co-operation and Development (OECD) which is at around 8.8% and significantly lower than the average health expenditure among high-income countries which is roughly 11.5% of GDP (Irene Papanicola et al., 2018; OECD Health Statistics, 2019). The low government expenditure on health care resulted in an increase in OOPE, making these payments a burden on the financial system. From 2005 to 2015, OOPE in India roughly comprised 69% of the total health care expenditures, while in comparison, the OOPE of the US national health care expenditures was only around 10-20% (World Health Organization, 2017). These high OOPE in
India have negative implications, such as pushing households further into poverty annually (Hooda, 2017).

Another challenge the health care system in India faces is the correlation between the demography of the country and the infrastructure of the health care systems. According to the World Bank, roughly 66% of India’s population lives in rural areas, which poses the problem of high inaccessibility to hospitals, clinics and proper care for these individuals, in comparison to those living in urban areas. According to the National Health Profile of 2018 provided by the Government of India, the data shows that in 2017, 84% of the 23,582 government hospitals in India were in rural areas. Although such a high percentage of government hospitals were in these rural locations, these hospitals only held 39% of government beds. In 2012, the McKinsley report on India’s health care stated that “the urban rich access health care at a rate that is double that of the rural poor and 50 percent more than the national average” (Mckinsley, 2012).

Attempts to improve access for those living in rural areas have been burdened with this issue such as the lack of trained physicians and other medical staff, scarcity of medical equipment and unsanitary conditions. For example, as per the World Health Organization (WHO), the doctor to population ratio recommended is 1:1,000, whereas in India the ratio is 1:1,674. These urban-rural health disparities continue to be an ongoing issue India needs to improve. Over the years, India has implemented various policies to attempt improving overall health care coverage. In 2008, the central government of India established the National Rural Health Mission in order to improve access for health care for the rural population through various means such as increasing public health standards and increasing the number of medical professionals. This mission was later joined by the National Urban Health Mission to institute the National Health Mission, established in 2014 (Angell et al., 2019). The goal of the enhancements to the mission was to
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improve hospital infrastructure. Results from these enhancements became visible in 2005 when one hospital bed was available for every 2,366 persons and within 10 years, one bed was available for every 1,883 persons (Patel et al., 2015). However, eventually more of these hospital beds were given to urban rather than rural areas, further increasing the urban-rural health disparities. In 2008, the Rashtriya Swasthya Bima Yojana (RSBY) was introduced as a government sponsored health insurance program that provided ₹30,000 Indian rupees (INR) (roughly $400 USD) for individuals living below poverty line (BPL). Certain issues that arose with this program included the lack of government supervision over the enrollment into the program, leading to families not under the poverty line being enrolled by contracted insurance companies (Ghosh, 2017). This ultimately led to truly impoverished families being prevented from receiving the RSBY coverage that was promised. The program also failed in reducing the financial hardships caused by OOPE and eventually, certain state governments in India chose not to implement the program.

In order to improve health access for the poor, the central government introduced the Ayushman Bharat Initiative in 2018. The purpose of this research is to study the early implementation of the scheme in two of India’s states with the highest health outcomes while examining how its formulation and roll-out is trying to avoid the pitfalls of previous national health initiatives as the government tries to reduce health inequities in India in association with state governments.
Chapter 2

Ayushman Bharat Initiative

On September 23rd, 2018, the Prime Minister of India, Narendra Modi, launched the Ayushman Bharat Initiative, a nationwide health reform scheme. The initiative has two parts: Pradhan Mantri Jan Arogya Yojana (PMJAY) and the establishment of Health and Wellness Centers (HWCs). The Pradhan Mantri Jan Arogya Yojana section, colloquially termed, “Modicare” or AB-PMJAY, focuses on implementing a public funded insurance program that provides an estimate of ₹500,000 INR (roughly $6,630 USD) per family annually without any OOPE for beneficiaries. The scheme allocates the established amount to an extent of roughly 100 million families, consisting of 500 million individuals, or 40% of India’s population (Angell et al., 2019). The program, which is costing the government roughly 1.54 billion USD annually (Presse, 2018), focuses on assisting poor families with financial coverage for their hospital expenses with a focus on secondary and tertiary care. With the money that the families are allotted, they can choose to receive health care at either an empaneled private or public hospital that is under the Modicare scheme. Although the PMJAY initiative was initially based on the foundation of the RSBY program mentioned earlier, the new health scheme soon took over the RSBY initiative, since it was able to provide more services to a wider range of individuals living BPL. The second part of Ayushman Bharat, the Health and Wellness Centers (HWCs), is the section of the initiative with the hopes of being able to increase the access to primary care in rural and urban areas, as opposed to secondary and tertiary care in AB-PMJAY. The HWCs will focus on providing primary health care services including diagnostic services, free medicines, treatments for non-communicable diseases (NCDs) and maternal and child health services. Roughly 150,000 HWCs are to be established by converting subcenters and local primary health
centers (PHCs) that serve 3,000 to 5,000 individuals to HWCs that would provide accessibility, universality and lessen the financial burden for those living in rural populations (Brundtland, 2018; Chatterjee, 2018).

The Press Information Bureau under the Ministry of Health and Family Welfare (MoHFW) lists several benefits of the PMJAY scheme that are been implemented in order to increase health care protection to its deprived citizens. Through administering the ₹500,000 INR (roughly $6,630 USD) to over 100,000 families while also providing cashless and paperless access to services for the patients at their point of service, the PMJAY scheme is hoping to decrease the extreme OOPE for hospitalizations. By implementing the PMJAY scheme, “Modicare” is planning to minimize having individuals fall into poverty due to excessive health care costs and to allow low income families to have access to quality health services available at private hospitals, without the immense pressure of monetary hardships. PMJAY is an ambitious government financed health protection scheme that is a further step towards India’s plan of attaining universal health coverage (UHC). The data posted by the Press Information Bureau of the Government of India states that through the 71st Round of National Sample Survey Organization (NSSO), 85.9% of rural households and 82% of urban households have no access to health care insurance, while more than 17% of the Indian population spent a minimum of 10% of their household budgets on health care services. With these extensive expenditures pushing families further into debt, the statistics showed 24% rural households and 18% of the population in urban areas have had to complete their health care payments through borrowing of money and other means.

To begin the process of beneficiary identification, the state ensures availability of requisite hardware, software and allied infrastructure that is crucial for identification and the AB-PMJAY
e-card printing. This software will be provided free by the Ministry of Health and Family Welfare and National Health Authority (MoHFW/NHA) to states. Afterwards, at each contact point, a quantity of printed booklets will be sent and distributed to the beneficiaries alongside either PMJAY e-cards after verification. The booklets provide information about the scheme’s benefits, policy period, network hospitals in the district under the scheme with their contact information, key contact individuals in the district, toll-free number of PMJAY call center and details of Districts Nodal Officer (DNO), if available for further information. The State Health Agency (SHA) will then identify and set up teams that have the capability to handle hardware and software support and troubleshooting dilemmas, provided by the MoHFW or NHA. Once the state takes the responsibility to complete all of the above, the next steps moves on to the preparation of the PMJAY scheme’s target data. In order to target the families that PMJAY is intended towards, an eligibility criterion has been set. The overall health care scheme is focusing on poor, rural families and identified occupational category of urban workers’ families. In order to do this, the government uses the Socio-Economic Caste Census (SECC) 2011 data for rural and urban areas, as well as the active families that were under the RSBY program. To ensure that individuals in these circumstances, in particular women, children and the elderly (as defined by the program) are not excluded from the scheme, the Ayushman Bharat health protection scheme regulates it so that there is no cap on the family size, age, nor restrictions on pre-existing conditions. The health initiative is labelled as an “entitlement-based scheme,” with entitlement being based on deprivation criteria from the SECC 2011 data. For families living in rural areas, the criteria include: families with only one room with kuccha walls and kuccha roof, predominantly made of grass/bamboo, polythene, or mud, families with no adult member between the age of 16 to 59, households that are female headed with no adult male member
between age 16 to 59, families with no able bodied adult member and disabled member
(including those suffering from disabilities in seeing, hearing, speech, movement, mental
retardation, mental illness, multiple disability, or other disability), Scheduled Castes (SC) and
Scheduled Tribe (ST) households, landless households whose major part of income is from
manual casual labor. Additionally, any of the following are also included automatically into the
scheme: households with destitute, without shelter, living on alms, manual scavenger families,
primitive tribal groups or legally released bonded labor (Department of Rural Development et
al., 2011; National Health Agency, 2018). For urban areas, there are eleven defined occupational
categories that are entitled under PMJAY. These include: rag picker, beggar, domestic worker,
street vendor/cobbler/hawker/other service provider working on streets, construction
worker/plumber/mason/laborer/painter/welder/security guard/coolie and another head-load
worker, sweeper/sanitation worker/ Mali (gardeners or florists), 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, washer-man/chowkidar (watchman) (Department of Rural Development et al., 2011;
National Health Agency, 2018). The SECC 2011 also lists 14 parameters of exclusion from the
program including: motorized 2/3/4 wheeler/fishing boat, mechanized 3-4 wheeler agricultural
equipment, Kisan credit card with credit limit of over ₹50,000 INR (roughly $660 USD),
household member government employee, households with non-agricultural enterprises
registered with government, any member of household earning more than ₹10,000 (roughly $132
USD) per month, paying income or professional tax, 3 or more rooms with pucca walls and roof,
owns a refrigerator, owns landline phone, owns more than 2.5 acres of irrigated land with 1
irrigation equipment, 5 acres or more of irrigated land for two or more crop season, owning at least 7.5 acres of land or more with at least one irrigation equipment (Department of Rural Development et al., 2011).

The next step in the process is to inform beneficiaries what to bring for identification. In order to establish identity to receive the health benefits under PMJAY, there is a process that requires beneficiaries to bring their Aadhaar card (identity card), or any valid government ID decided by the state, such as an election ID card, ration card, government certified list of members or RSBY card. Additionally, individuals must provide contact information, details regarding family status (joint/nuclear family structure), income certificate (annual income) and a caste certificate for those belonging to reserved categories (National Health Authority, n.d.; “PMJAY Ayushman Bharat Yojana Beneficiary List & Hospital List,” 2020). The next step focuses on beneficiary identification contact points, predominantly looking at infrastructure and locations. The scheme states that any resident must be able to find out if they are under the scheme with ease. For this, beneficiaries are given letters with QR codes (bar codes), which are scanned at contact points and in order to verify eligibility for the scheme, a demographic authentication for identification process also occurs (Government of Himachal Pradesh, n.d.).

Under the PMJAY initiative, if the beneficiaries need to be hospitalized, members of the family need not pay anything out-of-pocket (OOP) nor pay premium for hospitalization expenses. However, in order to access that care and reap these benefits, beneficiaries must go to empaneled government/public hospitals or private facilities. Furthermore, all of the public hospitals in states that are implementing PMJAY, will be considered as enrolled under the scheme. At each hospital, there will be a ‘Ayushman Mitra help desk,’ where a staff will examine the beneficiary’s documents to verify eligibility and enlistment under the scheme. PMJAY’s
covering of health expenses are predominantly for all secondary and most of tertiary care procedures. For example, the Times of India reported that the health ministry included 1,354 packages in the scheme, for which treatment for coronary bypass, knee replacements and stenting, among a few other procedures would be provided at 15-20% decreased rates compared to the Central Government Health Scheme (CGHS), which was a program started by the Indian Ministry of Health and Family Welfare in 1954 providing comprehensive health care facilities for central government employees and their dependents that resided in cities that were CGHS ensured (Kurian & Chikermane, 2018). These statistics were finalized by the chief executive of AB-PMJAY, Dr. Indu Bhushan, after analyzing prior programs such as CGHS and RSBY, mentioning that “reducing the prices of treatment packages will enable beneficiaries to opt for a greater number of procedures under the cover, if required.” The basic risk cover of the scheme includes expenses such as hospital registration, nursing and boarding charges within the general ward along with consultation fees, surgical equipment, procedure charges and costs of implants, medicines, diagnostic test and food for patients. The benefits also include pre- and post-hospitalization expenses and follow-up care (Dey, 2018). In the situation where multiple scenarios are necessary, the highest package rate will be waived and paid for the first treatment and a 50% waiver and a 25% waiver for the second and third treatment, respectively (Dey, 2018). Following that, the remaining will be paid for by the policy holder. AB-PMJAY does not provide coverage for conditions that does not require hospitalization can be treated as outpatient (OP) care, dental treatment that is cosmetic/corrective, assisted reproductive techniques, infertility related procedures, vaccinations or immunizations, cosmetic procedures, circumcisions for children less that 2 years of age, individual diagnostics and patients who are in a persistent vegetative state (National Health Authority, 2020).
Another aspect of the scheme is the incentives that are being provided for private hospitals in order to ensure an increase of quality hospitals in districts that are lacking proper access to care. For example, if a hospital is certified by the National Accreditation Board for Hospitals & Healthcare Providers (NABH) as an entry-level, it would receive 10% more as an incentive, while those certified at a more advanced level would receive 15% more. Additionally, hospitals that offer MD and Diplomate of National Board (DNB) members or hospitals being set up in backward districts would get an additional 10% (PTI, 2018). To support the PMJAY scheme, the government set out guidelines including incentives for private investments in hospitals within Tier 2 and Tier 3 cities (Government of India et al., 2019). These incentives include allotment of land on lease or through bidding, facilitating several permissions and clearances through a special window with timelines, providing timely payments for services, viability gap funding up to 40% of the total cost of the project and gap funding up to 50% of tax on capital cost. In order to receive these incentives, the private sector would have to “build, design, finance, manage, operate and maintain quality standards,” while taking financial risks and providing the health services at the PMJAY rates as opposed to the private hospital rates (Government of India et al., 2019). The Health and Welfare Ministry created three hospital models, Doctor Owner (30-50 beds), Doctor Manager Partnership- Multispecialty (100 beds) and Multispecialty (100 beds or more) as a guideline to be followed under the scheme (Government of India et al., 2019). A statement from the Ministry of Health and Family Welfare said that the objective of these broad guidelines is to improve the amount of quality health care services that are currently available in underserved populations to ensure that there is maximum utilization of the benefits that are available under the PMJAY scheme and for these individuals to access these services at affordable prices (Pilla, 2019).
implement PMJAY from three different options (National Health Authority & Government of India, n.d.). The three different implementation models include: assurance/trust model, insurance model or mixed model (National Health Authority & Government of India, n.d.). Since each state will have varying levels of capacity to administer such a large scheme, the central government provides them with the flexibility of choosing one of the models. The National Health Agency has published that the assurance/trust model is the most common implementation model that most states choose to adopt. For this model, the PMJAY scheme is directly implemented by the State Health Agency (SHA) without any involvement from the insurance companies. Here, the Government takes responsibility of the financial risk of establishing the program and the SHA will directly reimburse health care providers. Since there is no insurance company involvement in this model, the SHA, along with general management duties must also handle specialized tasks such as beneficiary identification, claims management, and audits (National Health Authority & Government of India, n.d.). For states using the insurance model, through a competition, the SHA chooses an insurance company through a tendering process (National Health Authority & Government of India, n.d.). Once the winning insurance company is selected, they will be in charge of managing PMJAY within that state. The SHA pays the market determined premium to the insurance company per eligible family during the duration of the policy period. From there, the insurance company then completes the claim settlements and payments to the service provider (National Health Authority & Government of India, n.d.). In the insurance model, the financial risk for implementing PMJAY is covered by the insurance company. To make sure that the insurance company does not make unfair profits, PMJAY provides a checking mechanism in which insurance companies are only able to receive a limited percentage amount from the premium for their own profit and administrative costs (National
Health Authority & Government of India, n.d.). After settling all claims and management costs, if there is a surplus, the entire leftover amount must be refunded by the insurer to the SHA in the span of 30 days. For states that choose to use the mixed model, the SHA utilizes both the assurance/trust model and the insurance model in a variety of manners with the goal of creating more efficiency while being economically beneficial. This model also offers more flexibility and allows states to converge their State schemes with the PMJAY scheme. Often times, more developed states that already have existing schemes that cover a large group of beneficiaries will choose to use this model (National Health Authority & Government of India, n.d.).
Chapter 3

Introduction to Kerala

Kerala, the southern-most state of India, is bordered by the states Karnataka to the North, Tamil Nadu to the East and the Arabian Sea in the West. With a population of 34.8 million individuals and consisting of 14 districts, Kerala is listed as comprising 1.18% of India’s land (Kerala Forest Department, n.d.). Prior to colonization, the predominant health care practices were Ayurveda and Siddha, both relying on homeopathic, natural treatments. After India gained independence on August 15, 1947, Kerala became a state in 1956. Since then, Kerala has managed to prioritize health as a primary concern. For example, in the 1970s, Kerala put in motion an immunization program for infants and pregnant woman almost a decade prior to when India’s central government established it for the whole country. By the 70s, the term “Kerala model” was conceived by researchers for its equitable development, while gaining worldwide acclaim for achievements in the health field in the face of a low per capita income (Madore et al., 2018).

Compared to many other Indian states, Kerala has maintained a reputation as being one of the best in health care performance. For example, in a health care report by the World Bank and the National Institute for Transforming India (NITI) Aayog, Kerala was listed as having the highest overall performance on the composite Health Index (Government of India et al., 2019). The Health Index is dependent on Health Outcomes (70%), Governance and Information (12%) and Key Inputs and Processes (18%). Kerala’s highest score of 76.55 is a drastic difference from the lowest performing state, Uttar Pradesh with a score of 28.14 (NITI Aayog et al., 2019). In 2011, Kerala had the highest Human Development Index (HDI) of all Indian states in the following categories: lower infant mortality rate (IMR) of 12 per 1,000 live births vs. 40 per
1,000 live births for India, lower maternal mortality rate (MMR) of 66 per 100,000 live births vs. 178 per 100,000 live births for India, higher literacy among males at 96% vs. 82% in India and females at 92% vs. 65% in India (Primary Health Care Performance Initiative, 2015). Often reputed as an outlier with significantly better health outcomes, Kerala’s success can be accredited to various factors. Kerala’s state government has accentuated the importance of primary health care and public health, decentralized governance, infrastructure of health systems, community participation and a focus on bettering health care systems to reduce health disparities among social groups. Furthermore, the state created a health care system with an infrastructure that would establish access for basic services at the community level and expand PHC coverage. Over the years, one method of expanding infrastructure that Kerala has developed is its increase in physicians, medical facilities and hospital beds (Primary Health Care Performance Initiative, 2015). For instance, from 1960 to 2010, the number of physicians increased from 1,200 to 36,000 while during the same period, the number of primary health care facilities increased from 369 to 1,356. With increasing the number of these primary health care facilities, cost of patient care decreased and there was a decreased pressure on the secondary and tertiary health care facilities. However, in the early 1980s, several of the public health centers in Kerala began reporting discrepancies in access to medicines, medical equipment and a lack of overall sanitation in the hospitals (Primary Health Care Performance Initiative, 2015). Furthermore, the facilities began to get overly crowded with long waiting times and poor service. After recognizing the scarce resources and prevailing issues in the public health facilities, in 1982, the National Health Policy began supporting nationwide policies that promoted privatized health care facilities (Primary Health Care Performance Initiative, 2015). Rapidly, the private sector began expanding. During the span of the next 15 years, while public government institutions
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increased their inpatient and ambulatory care, further development was seen in the private health sectors (Primary Health Care Performance Initiative, 2015). As these private health care systems began growing, more demand simultaneously grew for access to care to these facilities and higher quality health interventions and advancements. However, the drawback to the private health sector was the significant expenses, that were primarily paid out-of-pocket. These expenses were often unaffordable for the poor, having to spend up to 40% of their income on OOPE for accessing care (Primary Health Care Performance Initiative, 2015). After seeing a lack of trust in the public health care system, the state government issued the People’s Campaign for Decentralized Planning movement in 1996. The reform focused on the state government decentralizing a certain amount of power to Local Governments (LGs) that would create local services that were catered for the needs of the community. Kerala also was the only state that decentralized fiscal responsibilities by giving LGs 35 to 40% of the state’s budget (Primary Health Care Performance Initiative, 2015). With the new budgetary allocations, the goals of the LGs were to create new PHC buildings, purchase new medical equipment while improving the overall access and care to health services irrespective of caste, gender or socio-economic status (SES) levels. The public health system is predominantly comprised of sub-centers, primary health centers, secondary health centers that include community health care centers (CHCs) and taluks (sub-district hospitals), tertiary health centers that include district hospitals and medical colleges (Madore et al., 2018).

Kerala’s financing of health care system includes a combination from local, state, national and private sources (Madore et al., 2018). For example, in 2014, the national government covered 5.8% of the health budget, seeing the administering of national programs, 79.7% came from the state government, with the focus being on areas such as infrastructure,
supplies and health facilities while the local state governments contributed 14.5% of the budget (Madore et al., 2018). From 2014 to 2015, the total health expenditure in Kerala was the highest for Indian states, being USD $125 per capita. However, within the total health expenditure, 73.9% was from OOPEs and included specialty and private care (Madore et al., 2018). The high expenses proved to make it increasingly difficult for poor patients who wanted to get treated at private facilities compared to public hospitals. However, even with the high costs, many individuals still chose to receive their medical care at private hospitals by using a higher proportion of their income on health. This proved to be an issue and was evidenced in 2014, when data showed that more than 20% of individuals living in Kerala experienced calamitous health expenditures, which was the highest reported in all of India. By 2014, 60.5% did not have any health insurance, 34.6% were covered by a government sponsored health insurance scheme and roughly 90% of eligible households that were below the poverty line were enrolled in the national health scheme (Madore et al., 2018).

Despite the overall high performance that Kerala exhibited in health, the state still displayed certain issues. Even though mortality rates are low, morbidity rates in those who suffer from chronic and NCDs, are relatively high in Kerala in comparison with other Indian states ("RSBY-Rashtriya Swasthya Bima Yojna – National Health Mission," n.d.). As previously mentioned, as the public sector became too densely populated and unable to meet the health needs of individuals, the private sector became increasingly used, leading to the high reliance on the private health care systems, even by those in the lower SES class. In 2008, Kerala participated in the RSBY program announced by the Prime Minister in alliance with its Comprehensive Health Insurance Scheme (CHIS), ultimately called the RSBY- Comprehensive Health Insurance Scheme (RSBY-CHIS). The idea of the CHIS was to include a modification to
the premium by expanding the benefits of the RSBY program to above-poverty-line households (Philip, Kannan, & Sarma, 2016). The coverage here was for the absolute poor, working poor and their family (up to 5 individuals) and families with similar conditions who are enrolled in the Scheme (Akshaya Center, n.d.). The program covered the head of the household, the spouse and three dependents, such as children or parents of the household head. For eligibility purposes, use of identification or the Aadhar card would be necessary. The scheme provided coverage of ₹30,000 INR (roughly $400 USD) per family annually for hospitalizations or medical/surgical procedures (Akshaya Center, n.d.). The RSBY-CHIS program was launched by the Left Democratic Front government (LDF) and ultimately had 4.09 million families covered by the scheme and ensuring its benefits (Krishnakumar, 2019). In 2011, another additional program, CHIS Plus, was also implemented (Jayashree, 2018). This scheme provided an additional ₹70,000 INR (roughly $930 USD) to individuals suffering from fatal conditions of the heart, kidney and cancer (Comprehensive Health Insurance Agency of Kerala, n.d.). Each patient is eligible for grants as high as ₹2 lakhs INR (roughly $2,652 USD).

In 2012, Kerala began another health initiative called the Karunya Benevolent Fund (KBF) which provided financial assistance to the poor population who were suffering from acute illnesses such as kidney disease, heart disease, hemophilia, cancer and provide palliative care for patients who are bed-ridden (Government of Kerala, n.d.). All BPL families and above-poverty line (APL) families who have an annual income of below ₹3 lakhs (roughly $3,980 USD) are eligible for the scheme (Karikkan & Gangadharan, 2018). The income for the program is generated and raised through a government lottery called the Karunya Lottery and is exclusively used for this initiative.
In 2016, Rajeev Sadanandan was appointed to be in charge of the RSBY program for the state and wanted to focus on revamping the public health sector and tackling the challenges regarding NCDs. The Chief Minister of Kerala’s direction was to ensue this issue by improving tertiary care, but due to the high expenses of conducting that effort, Sadanandan proposed for the health department to manage this issue by including primary and secondary care, as well (Madore et al., 2018). In February 2017, Mission Aardram was established as an initiative that would increase quality and capacity of government health facilities to increase utilization. In doing so, the motive is to decrease OOPE by forcing the private sector to reduce its prices in order to remain competitive. Through the program, the goal is to make the public sector more admirable by enhancing patient services and access to health care strengthening health care delivery by improving the infrastructure and quality of taluk and subdistrict hospitals (“Aardram Launched,” 2017).

On November 1st, 2018, Kerala signed a Memorandum of Understanding (MoU) with the National Health Authority for the implementation of the AB-PMJAY program. However, instead of fully implementing the national health scheme as is, Kerala decided to not call their program ‘Ayushman Bharat,’ and adopt the initiative with modifications. In a report to Frontline under The Hindu newspaper, a minister in Kerala stated, “we were clear that we were not going to blindly implement Ayushman Bharat and undermine our public health system…we said we will not call our scheme ‘Ayushman Bharat’…nor will it be the same scheme (Krishnakumar, 2019).” The main reason for Kerala’s rejection to implement the AB-PMJAY scheme with no modifications is the reduced coverage of insured individuals and concerns of running the scheme offered at the premium of ₹1,100 INR (roughly $15 USD) by the central government (Krishnakumar, 2019). Under the central government’s proposal with the PMJAY scheme, the
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Proposal was to deliver ₹5 lakhs INR (roughly $6,630 USD) to roughly 18.5 lakh families (around 1.85 million) in Kerala. However, under the already established RSBY-CHIS program, Kerala had been covering roughly 40.9 lakh families (around 4 million families) who were enrolled and receiving benefits (Krishnakumar, 2019). Kerala did not want to implement the PMJAY program and restrict the scheme to insuring only 1.85 million families, when their program was already covering a significantly larger number of 4 million families. Furthermore, the idea was that if Kerala implemented the PMJAY in its original state, the State would have to manage the funds of the additional families that were covered under the RSBY-CHIS program, as those families would not have been insured under the PMJAY scheme. Another crucial issue was that Kerala accounted for more than 40% of the nationwide claims under the RSBY initiative (Krishnakumar, 2019). Since such a large portion of the total RSBY premium came from Kerala, the central government wanted Kerala to join the initiative, so they would not lose any of the money that came as a package of PMJAY. However, the issue Kerala’s Finance Minister saw with the structure and implementation of PMJAY in Kerala was that ultimately, the State would have had to carry 80% of the expenses (Krishnakumar, 2019). He stated that, “the financial burden would have been on the State, while the entire credit would go to the Center.”

Due to all these complications, Kerala was apprehensive about joining the AB-PMJAY initiative. However, after further coercion from the central government, the State decided to figure out a way to implement the health scheme in their own way that would make the program bigger and more beneficial for its people.

By the end of March 2019, Kerala decided on a new comprehensive health insurance scheme, Karunya Arogya Suraksha Paddhati (KASP) and in conjunction with the PMJAY program, the overall initiative was called KASP-PMJAY. The initiative will focus on providing
financial protection to 40 lakh (roughly 4 million) households in Kerala, while covering the majority of secondary and tertiary health services in empaneled public and private hospitals, including the treatment of cancer or cardiac disease ("KASP-PMJAY Scheme on the Cards," 2018). The scheme includes several of the previous initiatives under its umbrella, including RSBY-CHIS, CHIS Plus and KBF. While the AB-PMJAY program only included a benefit package of 1,345 health packages in 23 medical specialties, the number of health packages in the KASP-PMJAY program included 1,824 health packages ("Reliance to Run State’s Health Insurance Scheme," 2019). In order to finalize the comprehensive list of benefit packages and budgetary allowances for KASP-PMJAY, the government created a committee as a part of the rollout. Under the direction of D. Narayana, the Director of Gulati Institute of Finance and Taxation, the committee was the merger of all the prior health schemes combined with the AB-PMJAY program in order to provide better health care package for Kerala and the State would not have to bear significant additional finances ("Reliance to Run State’s Health Insurance Scheme," 2019). For the health scheme to run properly, the committee established that the necessary premium would have to be between ₹2,000 and ₹2,400 INR (roughly between $27 and $32 USD) annually per family. Several insurance companies such as New India Assurance, National Insurance, United India Assurance and Reliance General Insurance all participated in the tender invited for launching KASP-PMJAY ("Reliance to Implement Karunya Scheme," 2019). Ultimately, Reliance General Insurance was chosen to be the insurance provider for the implementation of the program after offering the lowest premium prices of ₹1,671 INR (roughly $23 USD) for providing the coverage of ₹5 lakhs INR (roughly $6,630 USD) per household ("Reliance to Implement Karunya Scheme," 2019). Speaking on the benefit of combining Kerala’s previous health schemes, Rajeev Sadanandan mentioned that previous health schemes
have been fragmented in the sense that they all had various risk pools and implementation mechanisms and not all of them were targeted towards just the poor (Krishnakumar, 2019). However, after being joined together for the KASP-PMJAY scheme, the target will have a stronger focus towards achieving a common risk pool and implementation mechanisms, ultimately creating a greater impact on the poor population in Kerala. By establishing this new health initiative, the goal should be to significantly lower OOPE and provide a foundation towards reaching UHC.
Chapter 4

Introduction to Tamil Nadu

Tamil Nadu is a southeastern state in India that is bordered by Kerala, Andhra Pradesh, Karnataka and bounded by the Indian Ocean. The state is comprised of 33 districts with the Chennai district representing the highest population, as per the 2011 Census. In accordance with the Tamil Nadu State Budget Analysis 2019-20, Tamil Nadu has designated a total health expenditure of 5.1%, which is slightly lower than the average allocation of other states of India in 2018-19. Despite this, Tamil Nadu has managed to maintain the status of being one of the better performing states within India. This has been possible due to the implemented health care policies and government expenditure on health that have led to the increase and improvement of primary health care services, particularly in rural areas for the disadvantaged populations (Kanmony, 2017). For example, the Health and Family Welfare Department published that 45% of the state’s annual budget is allocated for primary health care (Kanmony, 2017). Tamil Nadu has also established an increased level of autonomy for agencies within the public sector. In the public sector, full autonomy has been established to allow various health initiatives and vaccine or immunization campaigns to function smoothly and to provide any necessary support. One example of this is where jurisdiction is given to district officers who work to create solutions to issues that result in maternal deaths. If these solutions prove to be successful, they are duplicated in other districts in order to reduce the overall MMR. This system of a district level public health management body only occurs in Tamil Nadu and is a part of why the state has an effective public health system (Kanmony, 2017). For example, Tamil Nadu is the only state that has a specific public health infrastructure at the district level and was the first state to implement the Public Health Act in 1939 (Parthasarathi & Sinha, 2016). The Tamil Nadu Public Health Act
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headlined the administrative and legal responsibilities for various governments and agencies operating as a public health system. Additionally, it established powers of regulation and inspection, standards of food hygiene and water quality and provided legislation regarding response plans to public health threats (Swaniti Initiative, n.d.). Another benefit of Tamil Nadu is the effectiveness of the way the state uses the resources they obtain from the central government, particularly in comparison with other Indian states (Kanmony, 2017). During the 1980s to 1990s, the Tamil Nadu government implemented four actions that would significantly improve health for their citizens (Kanmony, 2017). For the first action, Tamil Nadu administered the Multi-Purpose Workers scheme swiftly in comparison to other states. This scheme focused on providing women with 18 months of basic primary health care training by opening roughly 60 schools as training facilities (Kanmony, 2017). Next, India’s central government created a program to expand and grow the number of PHC centers and sub-centers in rural areas. Tamil Nadu took a proactive stance on this initiative and built their facilities at a faster rate than other states. During this period, the idea of a 24-hour PHC was established in 1997 and by 1999, around 250 PHCs began performing 24x7 services (Kanmony, 2017). By 2012, 1,612 PHCs had joined into the scheme. One example of how the PHC performed these round-the-clock services was by enlisting three staff nurses during a post to ensure that all of the PHCs were able to provide delivery care services for 24-hours every day of the week (Kanmony, 2017). As the third action, the scope of the universal immunization program across India was increased in conjunction with the United Nation’s International Children Emergency Fund (UNICEF) since 1986. This had a significant effect for Tamil Nadu, as the state was ranked first in the number of children vaccinated among all other Indian states. This was evident as only 6% of rural and 1.7% of urban children living in Tamil Nadu had received no vaccinations (Kanmony, 2017). Finally,
post 1990, Tamil Nadu began giving importance to procuring drugs. The Tamil Nadu Medical Services Corporation (TNMSC) was established as a building block to obtaining drugs with the state allocating 15% of its’ health budget for drugs (Kanmony, 2017). The TNMSC also promoted the proper use of generic drugs at an affordable cost by employing quality control mechanisms to achieve reliable supply for many government health facilities, which was of great use to PHC and resulted in patient satisfaction (Parthasarathi & Sinha, 2016). In 2003, the Government of Tamil Nadu developed a health policy that addressed health challenges, methods to better management of health systems, to increase the effectiveness of health care services provided by the public sector while managing ways to battle NCDs and accidents (Parthasarathi & Sinha, 2016). Over the next 20 years, the health policy concentrated on improving the general population’s health status, with a focus on disadvantaged and tribal populations. To support and reinforce the health policy of 2003, the Tamil Nadu Health Systems Project (TNHSP) was put in action by the Health and Family Welfare Department. Later in 2005, the World Bank approved the TNHSP and the program continues to run efficiently in Tamil Nadu (Parthasarathi & Sinha, 2016).

While Tamil Nadu began giving importance to furthering the public sector through their primary health care services since the late 1980s, simultaneous efforts to expand the private sector started during the 1990s (Parthasarathi & Sinha, 2016). These efforts included the creation of public-private partnerships in health education campaigns, the contracting of diagnostic facilities and financial support from various corporate bodies that ultimately contributed to increasing Tamil Nadu’s health indicators (Parthasarathi & Sinha, 2016). Alongside the improvements in both the public and private sector, Tamil Nadu has also seen growth in its industrialization resulting in growth of the economy. Ranked third among all the states in per
capita income levels, Tamil Nadu has also seen advancements in its gender equality, literacy rate and lower fertility rate that all played a role in the public health developments that the state witnessed (Parthasarathi & Sinha, 2016). Health indicators in Tamil Nadu such as IMR, MMR and crude death rate (CDR) are higher in comparison with the national average and other Indian states that were used for comparison, except for Kerala (Kanmony, 2017). Although the Tamil Nadu health model has been lauded as one of the better health care delivery systems, there have been identifiable drawbacks. For example, the private sector has often been identified as increasing the “rich-poor gap” in regards to health care access, there are enduring levels of malnutrition, anemia and there is a constant demand for more public health services from the people of Tamil Nadu (Parthasarathi & Sinha, 2016). An additional ongoing issue is the use of out-of-pocket payments as a primary source of finance for health in Tamil Nadu, with 68% being identified as the amount of OOP health financing coming out of Tamil Nadu’s total health expenditure (TNHSP et al., 2019). However, Tamil Nadu still seems to prevail amongst other states in its health model due to certain differences that makes the state more productive in comparison to others. These differences include the separation of medical officers into differing public health and medical tracks, requirement of individuals working in the public health track to obtain a public health qualification, having those individuals working in the public health track focus on management of health services while having those in the medical track work in hospital care and placing an increased jurisdiction on the medical officer-in-charge of rural health facilities for providing services to patients (Parthasarathi & Sinha, 2016).

While Tamil Nadu has been able to improve its health services, there are still many parts of the society that live in more disadvantaged populations that cannot afford quality health care. One method of handling this situation is to provide free health care in government hospitals.
However, the drawback of this approach is that certain treatments and facilities are not available at these district/government hospitals. Due to this, many individuals who need further health care services will go to facilities with advanced health care options which can lead to large crowds and waitlists for procedures and surgeries (Chief Minister’s Comprehensive Health Insurance Scheme, n.d.). In order to combat some of these obstacles, on July 23rd of 2009, the Government of Tamil Nadu implemented the Kalaignar Kappeetu Thittam (KKT) or the Chief Minister Kalaignar Insurance Scheme for Life Saving Treatments that was led under the Tamil sub-nationalist Dravida Munnetra Kazhagam (DMK) party (Shroff et al., 2015). This scheme was meant to assist the poorest citizens of the low-income strata who could not afford expensive treatments and procedures. Additionally, it was a method for receiving free treatment in authorized government and private hospitals for serious illnesses (Chief Minister’s Comprehensive Health Insurance Scheme, n.d.). To provide access to treatment for these identified life-threatening conditions, a network of public and private hospitals were built for patients, with a focus on the poor and low-income groups, unorganized sector workers who are in need of financial assistance (La Forgia, 2012). The insurance scheme covered roughly 13.4 million families or 36 million individuals (Forgia & Nagpal, 2012). The eligibility requirement included those who were BPL, families that had an annual income of less than ₹72,000 INR (roughly $955 USD) or families of members of 26 welfare boards (unorganized sector) (Forgia & Nagpal, 2012; Selvavinayagam & Vijayakumar, 2012). For the enrollment process to begin, camps in various villages were set up with 1,000 teams through the insurance company throughout the state. During this process, the target population were identified through documents such as a ration card or income certificate. Once all the verification and data processing were completed, the beneficiaries were given a smartcard and enrolled under the
program successfully (Selvavinayagam & Vijayakumar, 2012). Each family insured under the Kalaignar scheme would be insured for an amount of ₹1 lakh INR (roughly $1,326 USD) for 4 years with an annual premium of ₹469 INR (roughly $6 USD) per family that was paid in full by the Government of Tamil Nadu. By the government decree, there was a list of diseases that would be covered under the insurance scheme and in authorized hospitals alongside procedures and their package rates that were available for informational purposes on their website (Selvavinayagam & Vijayakumar, 2012). Within the first year of the Kalaignar scheme, 153,410 patients benefitted and ₹415 crore INR (roughly $55,032,859 USD) claims were submitted (Selvavinayagam & Vijayakumar, 2012). The ability for those living in disadvantaged situations and populations to visit a private health care facility was often seen as a laurel of the program. The scheme was successfully rolled out and the government’s initiative to increase the health status of those in low SES made a positive impact on the citizens of Tamil Nadu.

As the Kalaignar Insurance Scheme expired on July 5th, 2011 and a new government party took over with a new Chief Minister in place, the program was rebranded as the Chief Minister’s Comprehensive Health Insurance Scheme (CMCHIS) (Thakur, 2016). Run under the All India Anna Dravida Munnetra Kazhagam (AIADMK), a centralist regional political party that opposed the DMK, the new health insurance was established with certain changes made to the scheme. With United India Insurance Company being chosen as the insurance provider for the implementation process, benefits of the insurance program were increased so that each family would now receive a coverage of ₹1 lakh INR (roughly $1,326 USD) every year for a total value of ₹4 lakhs INR (roughly $5,304 USD) for 4 years compared to the ₹1 lakh INR (roughly $1,326 USD) for 4 years ("Chief Minister’s Comprehensive Health Insurance Scheme Launched", 2016). Additionally, for certain listed procedures or diseases, the amount provided
could rise to ₹1.5 lakhs INR (roughly $2,000 USD). Following these listed guidelines, complete
cashless transactions were guaranteed under the CMCHIS. The health insurance scheme
provided treatment for 1,016 procedures, 23 diagnostic procedures and 113 follow-up procedures
("Chief Minister’s Comprehensive Health Insurance Scheme Launched," 2016; “Health
Coverage,” 2018). The program would additionally cover treatment for newborns, while
including medical management as opposed to the singular and immediate use of surgical
interventions with omitting discussion of alternative plans ("Chief Minister’s Comprehensive
Health Insurance Scheme Launched," 2016). Treatments for heart attacks, open heart surgeries
and angioplasties would also be covered under the insurance scheme. In addition, one-year post-
hospitalization follow-up care for a listed number of pre-identified conditions would be provided
for under the scheme (TNHSP et al., 2019). Furthermore, all investigations completed in
conjunction with the treatment that was authorized by a government hospital would be paid for
under the scheme, even if at the end of the investigation, surgery was deemed to be unnecessary.
In the occurrence of a hospital admission, investigations and additional charges billed for five
days would be reimbursed to the hospital/facility. This process was a vital difference from the
previous insurance scheme, as only investigations directly correlated to surgery would be
covered under the program and all other investigations would have to be paid OOP (“Jayalalithaa
Announces New Medical Insurance Scheme,” 2011). To prevent criticism that private hospitals
were being endorsed at the loss of government hospitals, the CMCHIS generated the policy that
government hospitals would be paid the same package rates as those in private hospitals.
Moreover, certain treatments would only be available at government or district hospitals.
Although new ID cards were to be issued, the CMCHIS would use the already existing database
for beneficiaries, leading individuals who were already enrolled under the previous health
insurance to reap benefits from the new CMCHIS without any further issues ("Jayalalithaa Announces New Medical Insurance Scheme," 2011). Over the years, improvements to the scheme has been occurring. The total sum insured under CMCHIS for certain listed procedures increased from ₹1.5 lakhs INR (roughly $2,000 USD) to ₹2 lakhs INR (roughly $2,652 USD) annually and an additional 312 new procedures have been added to the existing 1,016. The coverage of the scheme also extended to include orphaned children and migrant workers who lived in Tamil Nadu for more than six months ("Health Coverage," 2018; TNHSP et al., 2019).

On September 11th, 2018, a Memorandum of Understanding (MoU) was signed between the National Health Agency, Government of India and the Health and Family Welfare Department, Government of India to implement the Pradhan Mantri Jan Aarogya Yojana (PMJAY) scheme in association with CMCHIS. The state insurance scheme was to be dovetailed under the National Health Protection Scheme to become one mega insurance scheme PMJAY-CMCHIS. With the association of PMJAY along with CMCHIS, 77 lakh (roughly 7 million) families living in poverty and vulnerable situations would receive benefits. The coverage of the insurance scheme would be an increased value of ₹5 lakhs INR (roughly $6,630 USD) per family annually and could primarily be used for secondary and tertiary care hospitalization ("TN Signs MoU to Implement Ayushman Bharat Scheme," 2018). While PMJAY covered roughly 77 lakh (roughly 7 million) families, CMCHIS was already providing benefits to an estimated 1.57 crore (15.7 million) families (Press Trust of India, 2018). Since most families living in low SES and disadvantaged populations were already beneficiaries of CMCHIS, the Tamil Nadu government acted to determine that those 15.7 million families who were under the previous scheme would be covered the same amount of ₹5 lakhs INR (roughly $6,630 USD) as those ensured under PMJAY-CMCHIS to maintain uniformity (Press Trust of India, 2018). Therefore,
all CMCHIS beneficiaries irrespective of being enrolled in the PMJAY-CMCHIS would be provided with the upgraded coverage amount. If any beneficiaries were not previously covered under CMCHIS, they would now be ensured under PMJAY-CMCHIS.

Although the state seems to be following AB-PMJAY in a manner of full implementation of the program, one minor change that was established was Tamil Nadu’s decision to only cover 1,027 procedures opposed to the 1,300 provided in the private sectors ("CM, PM Plans Merged in Tamil Nadu, Health Cover Now up to Rs 5 Lakh," 2018). The Tamil Nadu government defended their decision by explaining their requirement of reserving certain basic procedures such as hysterectomies and appendectomies to government hospitals/public sector at a free cost. Additionally, 500 procedures that are not available under the PMJAY scheme would be offered under CMCHIS, such as cochlear implantations, liver transplant, heart and lung transplant. For these cases, up to ₹25 lakhs INR (roughly $33,152 USD) would be covered by CMCHIS under the corpus fund. In this process, once government hospitals create a profit margin from certain procedures, 27% from that is given back to the corpus fund and any additional cost above the insurance coverage is paid for from this fund (CM, PM Plans Merged in Tamil Nadu, Health Cover Now up to Rs 5 Lakh, 2018). An additional benefit of implementing PMJAY in Tamil Nadu is the policy that cardholders can undergo treatment anywhere in India under the scheme and will be guaranteed the same benefits that they would in their respective state. Under PMJAY-CMCHIS, Tamil Nadu will pay a premium of ₹699 INR (roughly $9.27 USD) and the central government will cover 60% of the cost for all of the eligible beneficiaries, which include the 7 million families ("CM, PM Plans Merged in Tamil Nadu, Health Cover Now up to Rs 5 Lakh," 2018). Apart from minor modifications to the insurance scheme, the state has chosen to
fully implement AB-PMJAY and is sound in its decision to administer the program in conjunction with their already successful insurance scheme.
Chapter 5

Geographical Maps and Data Tables

Geographical Maps

Figure A: Map of India

Note. Figure A from (“State of India Map - Nations Online Project,” n.d.)
Figure B: Map of South India

Note. Figure B from “(South India Travel Map,” 2014)
**Figure C:** Map of Kerala

Note. Figure C from ("Kerala Map,” n.d.)
Figure D: Map of Tamil Nadu

Note. Figure D from (“Tamil Nadu Map: State, District Information and Facts,” 2020)
**Data Tables**

**Table 1:**

*Socio-Economic Indicators:*

<table>
<thead>
<tr>
<th>State</th>
<th>Total Population (in millions)</th>
<th>Poor (in millions)</th>
<th>% of Rural Population</th>
<th>% of Urban Population</th>
<th>Annual Growth Rate of Real GSDP (%)</th>
<th>GSDP (Gross State Domestic Product) Per Capita</th>
<th>% of Individuals with Aadhar Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerala</td>
<td>33(^A)</td>
<td>3(^B)</td>
<td>52.3(^C)</td>
<td>47.7(^D)</td>
<td>7.2(^E)</td>
<td>$12,537.78(^F)</td>
<td>92(^K)</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>72(^L)</td>
<td>9(^M)</td>
<td>51.6(^N)</td>
<td>48.4(^O)</td>
<td>8.6(^P)</td>
<td>$24,711.98(^Q)</td>
<td>71(^V)</td>
</tr>
</tbody>
</table>


**Table 2:**

*Percentage of Total Population in Rural Areas Using Public Health Sector:*

<table>
<thead>
<tr>
<th>State</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerala</td>
<td>72(^A)</td>
<td>63(^B)</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>74(^C)</td>
<td>53(^D)</td>
</tr>
</tbody>
</table>

Table 3:

**Health Indicators:**

<table>
<thead>
<tr>
<th>State</th>
<th>Maternal Mortality Ratio (Per 100,000 Live Births)</th>
<th>Infant Mortality Ratio (Per 100,000 Live Births)</th>
<th>Water and Sanitation (% of Households Drinking Water on Premises)</th>
<th>Life Expectancy for Males (years)</th>
<th>Life Expectancy for Females (years)</th>
<th>Medically Treated Tuberculosis per 100,000</th>
<th>Adult HIV Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerala</td>
<td>61&lt;sup&gt;A&lt;/sup&gt;</td>
<td>12&lt;sup&gt;B&lt;/sup&gt;</td>
<td>76%&lt;sup&gt;C&lt;/sup&gt;</td>
<td>73.8&lt;sup&gt;D&lt;/sup&gt;</td>
<td>78.7&lt;sup&gt;E&lt;/sup&gt;</td>
<td>369&lt;sup&gt;F&lt;/sup&gt;</td>
<td>0.08%&lt;sup&gt;G&lt;/sup&gt;</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>79&lt;sup&gt;H&lt;/sup&gt;</td>
<td>21&lt;sup&gt;I&lt;/sup&gt;</td>
<td>47%&lt;sup&gt;J&lt;/sup&gt;</td>
<td>68.9&lt;sup&gt;K&lt;/sup&gt;</td>
<td>73.5&lt;sup&gt;L&lt;/sup&gt;</td>
<td>348&lt;sup&gt;M&lt;/sup&gt;</td>
<td>0.22%&lt;sup&gt;N&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Chapter 6

Methods

If AB-PMJAY can further improve health outcomes in Kerala and Tamil Nadu which are Indian states with relatively better health outcomes, then its impact in states with the poorest health outcomes in India would be significant. The insurance scheme is likely to have a more discernible impact in states with a higher percentage of individuals living below the poverty line in comparison to Kerala and Tamil Nadu. While understanding that AB-PMJAY would have a greater effect on such states that are lower ranked in health performance, we chose to study Kerala and Tamil Nadu to examine whether a positive impact would uphold in these two states that have already established themselves as the higher performing states of India for healthcare. Additionally, both these states have prior insurance programs that have been running successfully preceding AB-PMJAY. When comparing health indicators, number of people living BPL, and overall health performance, these two states have managed to retain a reputation as progressive states in regard to healthcare. They have comparable backgrounds, demographics and successful levels of developments while having differences in their health systems. Therefore, Kerala and Tamil Nadu were selected to review the early roll out of AB-PMJAY through the views of health professionals working in the two states. In order to gather viewpoints of individuals who deal with the health reform program on a real-life basis, healthcare professionals, physicians, and individuals working with the scheme in the two states were interviewed to understand their opinions on the implementation and rollout of the program.
Patient Recruitment

A Human Subject Protocol proposal was submitted to the Institutional Review Board (IRB) of the College of William and Mary. Following approval, early processes of participant recruitment began. The initial stages of the recruitment process took place in the United States by phone and email. Several attempts were made by phone and email to reach different categories of health care professionals in Kerala and Tamil Nadu through the phone and emails. Twenty-one individuals were recruited; 10 were from Kerala and 11 were located in Tamil Nadu. The professions of participants included physicians working in Government Hospitals or Private Hospitals, Medical Superintendents, Public Relations Officers in Public and Private hospitals, Director of a Prominent Cancer Center, Public Health & Preventative Medicine Officer, Vice Chancellor of a Prominent Government Medical University with the addition of 1 participant in the Bio-Medical field and 1 minister/political figure who played a key role in the implementation of AB-PMJAY. Amongst these participants, 15 were male and 6 were female.

Data Collection

For each interview, participants were initially given a written informed consent form and were explained that their identities would remain anonymous and were able to remove themselves from the study at any given time, if desired. To explore the opinions of how healthcare professionals in the two respective states felt about the implementation of AB-PMJAY, qualitative semi-structured interviews were utilized. To obtain appropriate information, two respective interview guides were developed with seven open-ended questions for each state that allowed participants to explain their experiences. The questionnaire for Kerala included exploratory questions that asked opinions on (1) current health care systems of the state, (2) awareness of the AB-PMJAY program and the state’s adoption of the policy, (3) questions
regarding state’s past health care systems and influence of AB-PMJAY, (4) impacts of deviating from AB-PMJAY and implementing a varied version of the policy, (5) drawbacks to the AB-PMJAY scheme (6) benefits of the state program vs AB-PMJAY, (7) impact of AB-PMJAY on health outcomes. The questionnaire for Tamil Nadu included open-ended questions that looked into (1) current health care systems of the state, (2) awareness of the AB-PMJAY program and the state’s adoption of the policy, (3) improvements to the health care of the poor and disadvantaged population of Tamil Nadu by implementing the PMJAY scheme, (4) advantages of implementing AB-PMJAY, (5) looking at difference in benefits for AB-PMJAY in comparison to previous health care initiatives, (6) drawbacks to the PMJAY scheme, (7) impact of AB-PMJAY on health outcomes. To follow-up on responses, probing questions were asked to help further discussion. The interview guides for Kerala and Tamil Nadu can be found under Appendix A and Appendix B, respectively. All of the interviews were held face-to-face in Kerala and Tamil Nadu while ranging from 30 minutes to 1.5 hours. They were conducted from July 7th, 2019 to July 23rd, 2019 in both states. The interviews were given in English and Malayalam (native language of Kerala) in Kerala and only in English in Tamil Nadu. After receiving permission from the participants to tape the interviews, the interviews were recorded and later transcribed.
Chapter 7

Results

Following the interviews conducted in both Kerala and Tamil Nadu the taped interviews were transcribed. The transcripts for Kerala can be found under Appendix C. The transcripts for Tamil Nadu can be found under Appendix D.

Kerala

Analyzing responses for the first question on opinions regarding the current health care system in Kerala, there was a consensus amongst all participants that the system in the state is running smoothly in both the public and private sectors. While many individuals applauded the services of the state’s PHCs, FHCs and Taluk hospitals, certain interviews revealed differences between government hospitals and private hospitals. The predominant issues for government hospitals were related to the immense amount of overcrowding, shortage of staff and manpower, and lack of high-end equipment for testing. Private hospitals were seen as advanced establishments, providing quality care with highly qualified doctors and high-technological medical equipment. However, certain interviewees discussed how the prices for receiving treatment at private hospitals are exuberant and unrealistic for families living below poverty line (BPL). Regarding quality of care, both government and private hospitals were seen as providing high caliber services. The overall sentiment from all interviews displayed opinions that Kerala’s health care system is distinctly advanced and is one of the most developed in India.

When looking at the AB-PMJAY scheme implementation in Kerala, all of the interviewees were aware of the health insurance reform program to a degree, showing that awareness amongst health care professionals in the state is decent. The primary reason Kerala has chosen to implement AB-PMJAY in a modified manner is the larger coverage of
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beneficiaries. Under KASP-PMJAY, which is the Kerala implementation of AB-PMJAY, more individuals under BPL are being covered in comparison to AB-PMJAY. Certain interviewees expressed opinions that additionally, Kerala may have wanted to modify the program for political reasons. State government officials want it to be clear that the Kerala’s health care model without AB-PMJAY has been running smoothly, solely without the additional help of the central government’s program. A few interviewees explained why they do not believe PMJAY should be implemented because the state is not benefitting from the scheme due to Kerala spending more money on providing health care benefits to its citizens through the KASP program, in comparison to the funding the central government is providing the state with. The argument that Kerala has to undertake a higher percentage of the expense than the central government in implementing PMJAY was a major concern for select participants. At the same time, those opposed to implementing PMJAY in the state explained how they felt coerced into having to implement the program in Kerala, as it would have been a political risk to reject a national government health scheme.

When asked whether Kerala’s past health care initiatives has influenced the state’s decision to implement the PMJAY in their own manner, many participants said yes. Since Kerala has successfully been able to implement and roll-out programs such as the Karunya Benevolent Fund and RSBY-CHIS, which have benefitted many families living BPL in the past, the state had confidence in its own prior programs in making the decision to choose implementing the PMJAY scheme with certain modifications. The majority of participants explained that there was a positive impact for beneficiaries in deviating from implementing the PMJAY scheme as the original model and instead modifying it to KASP-PMJAY. While AB-PMJAY would only cover 20.54 lakh (roughly 2 million) families, the KASP-PMJAY program extends coverage to an
additional 19.4 lakh (roughly 1.9 million) families who were already enrolled under the RSBY/CHIS scheme that was put in place prior to KASP.

This discussion point led into the next question, which delved into any potential drawbacks within the PMJAY scheme. One of the issues a few participants saw was how due to the KASP program covering the additional 19.4 lakh families and not AB-PMJAY, Kerala has to fully cover that extra cost without any support from the central government while also having to pay a higher premium. Due to this, the state has growing concerns since they must find additional funds to provide coverage for the extra families they are covering. In Transcription 7 included in Appendix C, the participant mentions that 80-85% of the burden of the insurance scheme is being placed on the state. This led to the criticism that if a larger percentage of the burden of insurance scheme is being put on Kerala, then it should not be labelled as a centrally sponsored program. Another potential drawback to the program was the difference in coverage between inpatient (IP) and OP services. IP services include everything that is done after a patient is admitted into the hospital, while OP services are everything that occurs before admission, including investigations, testing and other laboratory expenses. Under PMJAY, no OP services are covered, while all IP services are. Therefore, any investigations, medical testing, laboratory works completed as an OP will not be covered and must be paid by the patient out-of-pocket. Often times, these investigations that occur as an OP can become expensive and is difficult for those living BPL to pay out of pocket. Another recurring major drawback of the PMJAY scheme that many participants highlighted was the lack of private hospital participation. Participants who were working in private hospitals listed various issues as to why they were reluctant to join into the central government scheme, the main reason being the low package rates that were formulated and established. Particularly for large corporate private hospitals, where costs of
treatment are already high, the main criticism was that the treatment/procedure package rates that were produced by the central government are too low, making it both unacceptable and unrealistic for them to implement it. In Transcription 3 seen in Appendix C, a medical superintendent of a leading corporate private hospital described their dilemma. Amidst facing pressure to join KASP-PMJAY, the hospital seemed highly unwilling to join due to abysmally low package rates. The example given was that a procedure might cost ₹25,000 INR (roughly $330 USD) at their hospital, but under the KASP-PMJAY program, the price could be as low as ₹12,000 INR (roughly $160 USD). While admitting that this is beneficial for the PMJAY cardholders, the private hospitals are not in favor in establishing it, since they will have to face hefty financial losses. Many participants expressed how major private hospitals face an issue in being able to break even. These reputable institutions provide a certain quality of care that stems from having qualified professionals, more manpower, not prescribing generic drugs and having the latest medical technological equipment, which can all equate to the costs of treatments and procedures available in private hospitals very expensive. The underlying sentiment amongst participants was that when having to account for all these expenses and then having a large influx of patients that are cardholders come into these private hospital to undergo services, it is unlikely that these hospitals can make a profit and at the very least, break even. In Transcription 10 found in Appendix C, an example was given by the interviewee whom, after completing a cost-effective study, describes the massive deficit their hospital, a Cancer Centre, will be facing once they implement KASP-PMJAY. The participant mentions how the minimum amount for a breast cancer surgery at their hospital is ₹35,000 INR (roughly $461 USD). The package rate listed under PMJAY and what the hospital will receive from the government is ₹14,000 INR (roughly $184 USD). So, the hospital is forced to absorb a loss of ₹21,000 INR (roughly $277
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USD). The participant discussed how package rates also can include hospital stays for 4-5 days and that rate will cover everything, so the admitted patient will not have to pay anything OOP for the entire duration. This means that the private hospital cannot charge any extra costs during that time. The study participant expressed that the hospital would be losing a significant amount of money from a patient staying in the hospital for that long since they cannot charge their normal rates and must adhere to the regulated packages of PMJAY. The interviewee mentioned that additional issues that lead to further financial losses are claim rejections and basic technical difficulties. The example regarding technical difficulties given was how at a certain hospital there was a large influx of PMJAY cardholder patients who were admitted over a period of time. Roughly half of these patients were successfully registered as cardholders onto the computer system, while the other half of the patients failed to be registered as PMJAY beneficiaries onto the system due to technical difficulties. As a result, the costs for the patients that were admitted but unregistered because of the technical issues had to absorbed by the hospital, resulting loss of money to the hospital. Regarding the claims issue, if any claims are rejected by the insurance company, the hospital must then bear that loss as well. This would add further financial strain on the hospital. During the interview, the participant also brought up concerns regarding the criteria being developed by the individuals in formulating and regulating these package rates. The participant expressed skepticism whether or not enough consultation is being done with private hospitals to establish more realistic package rates for procedures/treatments. Interviewees expressed their concerns that as more eligible beneficiaries come to the hospital and have procedures done under these low package rates, the hospitals will not be able to incur the losses nor be able to break even. As the hospitals fall into a financially unsound situation because of the deficits, the result could potentially be that these corporate private establishments are not able to
provide the quality care that they normally would. Due to the financial constraints, many major corporate hospitals are not choosing to become an empaneled PMJAY hospital. Therefore, beneficiaries under the program only have a limited number of empaneled private hospitals that they can go and receive treatment from. The participant from Transcription 4 within Appendix C mentioned a conversation they had with a private hospital regarding the KASP-PMJAY scheme that introduced a potential social drawback for PMJAY in Kerala. The interviewee explained that administrative and health professionals at that medical establishment revealed the mindset that they did not want to be a part of the program because the population of enrolled members, predominantly the poor and disadvantaged, would begin infiltrating their hospital by coming in large numbers to receive treatment and services. Since the hospital wanted to maintain a certain image of being of a superior quality and catering to individuals of a higher social strata, the facility was not fond of becoming an empaneled hospital. While that is not a direct drawback of the program itself, it does highlight certain potential stigmas that may possibly influence the mindset that private corporate hospitals have in joining the scheme. Although the majority of private corporate hospitals expressed hesitation in joining the KASP-PMJAY scheme until package rates are modified, a number of private trust hospitals and non-corporate middle-tiered private hospitals expressed interest in joining the program. Several of these hospitals have the infrastructure and resources of a corporate private hospital. However, they are lacking in bringing in a sufficient number of patients resulting in potential financial instability. For these types of private hospitals, PMJAY is almost used as a publicity method to rally more patients in. By becoming an empaneled PMJAY hospital, the establishment is able to expand their pool of patients to include the poor and disadvantaged communities, who might come in larger numbers in search of private hospital services. At that point the hospital gets the advantage of an increase
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in the number of patients, the government’s money and a name of being a PMJAY empaneled facility.

Although several drawbacks were highlighted throughout the interviews, many participants did also see multiple advantages and benefits to implementing PMJAY. Particularly for the poor and disadvantaged population, one of the main advantages was the large amount of money (5 lakhs) that each eligible family is awarded per year. In Transcription 1 shown in Appendix C, the participant mentioned how a listed procedure that would have normally cost ₹40,000 INR (roughly $530 USD) at a private hospital would now cost ₹12,000 INR (roughly $160 USD) under PMJAY. The participant from Transcription 5 in Appendix C explained how the experience of seeing firsthand how much of an impact the PMJAY scheme benefits can have on an individual living in poverty and facing difficult circumstances, exemplified the importance of the program. For the population living BPL, out-of-pocket expenditures are catastrophic and often propel the individuals further into poverty. In Transcription 3 in Appendix C, the participant discussed their point of view of how in Kerala, health-seeking behaviors are very high. The interviewee brought up that even for the population living in poverty, people want to ensure that their health is sustained. If they feel that their health is undermined, they will often do whatever they can to get the care they need, even if that means falling into debt. For this situation, a reform program like PMJAY will help decrease catastrophic health expenditure (CHE). Additionally, many enrolled beneficiaries are being able to reap the benefits easily by displaying their Aadhaar card or the mobile number attached to their registration, if they have gone through the enrollment program accurately. For enrolled KASP-PMJAY members, another benefit is the ability to go to empaneled private hospitals that provide high quality care to undergo treatments and procedures that they normally would not have been able to receive
because of the high treatment costs at private hospitals. In Transcription 2 in Appendix C, the study participant brings up a positive characteristic of the PMJAY scheme that includes pre-existing conditions. The example that was brought up by the interviewee was if a patient under BPL is diabetic and the hospital says that since they are diabetic, their illness will not be covered. At that point, the patient would have to pay for the treatment out-of-pocket, which can be unrealistic for many individuals who are living in poverty. However, under the PMJAY program, that concern is not pertinent, since the pre-existing condition would be covered. One advantage that was agreed upon almost unilaterally amongst all the interviews in Kerala was how the government hospitals and the public sector are benefitting from the PMJAY scheme. Since government hospitals also provide high quality care, many patients often choose to use the services there. For example, in Transcription 2 in Appendix C, the study participant explains how a coronary angiogram is worth ₹500 INR (roughly $7 USD) at a government hospital. Under the PMJAY set package rates, the government hospital may now receive ₹2,500 INR (roughly $33 USD) for that same procedure, leading the hospital to gaining a profit. The participant in Transcription 5 within Appendix C also detailed experiences on how BPL individuals who are enrolled in the scheme are covered in every way once being admitted and becoming an IP. For example, under KASP-PMJAY, a circumstance might occur where a government hospital does not have certain procedure that is required for the necessary care for the patient, such as a urine culture laboratory testing facility. The government hospital will then get the testing outsourced and send the patient to a private hospital with a slip and their Aadhaar card/proof of enrollment, where the private hospital can provide the required services. Once the patient can show that facility that they are an enrolled PMJAY beneficiary, they will not be charged any costs OOP at all. Therefore, the advantage is the surety that if a patient enrolled
under PMJAY comes to a hospital and is admitted IP for care, even if they have to go to other facilities to complete something that the initial hospital does not provide, they will not have to pay any costs OOP and everything will be covered under the scheme. The interviewee provided a specific example where a pregnancy delivery, including the procedure, laboratory and extra costs such as medications would roughly result to ₹4,000 INR (roughly $53 USD). Based on the pre-determined package rate listed by PMJAY for a delivery, the government hospital is paid ₹12,000 INR (roughly $160 USD) by the government via the insurance provider for Kerala, Reliance. Since the hospital was able to successfully complete the procedure with only ₹4,000 INR (roughly $53 USD), the government hospital then received a profit of ₹8,000 INR (roughly $107 USD).

When asked the final question whether implementing PMJAY would affect health outcomes in Kerala, there was no definitive position. However, the majority of participants expressed the view that more enrolled individuals, particularly those amongst the poor and disadvantaged communities, would now be able to receive more treatments and procedures using the PMJAY benefits that they would not be able to afford under normal circumstances. In turn, this could potentially help improve health outcomes. Interviewees also stated that the KASP-PMJAY program is still new and requires time to grow, that implementation drawbacks need to be worked through first and then additional studies looking at correlation between the health insurance scheme and health outcomes can be done to see if there is any effect. Overall in Kerala, the majority of participants interviewed who were working in the health care field, either in health care management or on the medical side, did foresee benefits from PMJAY, particularly for families living under BPL whom the scheme is catered for. However, there was mixed response that Kerala is already too advanced as a state in health care to see any significant
benefits from the program. There was also a theme amongst many of the interviewees that stated opinions that PMJAY might have more of a visible positive impact in states that are not as far ahead advanced in its health care, such as Bihar. While most participants from the Kerala portion of the study found KASP-PMJAY to be useful, there were criticisms and a concordance amongst some that the state would run smoothly under its own health care initiatives without the presence of PMJAY.

_Tamil Nadu_

Following the interviews conducted in Tamil Nadu, the overall opinions regarding the current health care system in the state were that it is a well-developed system that involves both the public and private health care facilities. Several participants mentioned that there are more than sufficient numbers of private hospitals, both small and large located throughout the state. The government hospitals are also run well, providing quality care. However, a problem that was identified in these establishments were the ratio of physicians to patients. The hospitals often have a scarcity of doctors and staff and suffer from immense overcrowding. Particularly in rural areas of the state, there is a need for more doctors, funding and infrastructure/facilities. Despite the shortage, the quality and experience of the medical professionals in Tamil Nadu were lauded. Participants also mentioned how performance wise, Tamil Nadu remains ahead of many other states and often trails right behind Kerala, providing a very similar level of health care services. The interviewee in Transcription 12 within Appendix D mentioned that medical costs are not as high in Tamil Nadu in comparison to certain cities such as Bombay and Delhi. When it came to Tamil Nadu’s catering of health services to the poor and rich, there were varying opinions. Certain participants felt that treatment in the state caters to both the poor and rich whereas others felt that there was a deficit in the system which does not cater to the lower income section, acting
more as a cost-prohibitive system. However, the general consensus regarding the overall system was that Tamil Nadu is advanced in terms of health and is a state that stresses the importance of providing quality health care.

Participants were then asked about whether they have been exposed to the AB-PMJAY scheme and if so, whether Tamil Nadu chose to roll out a full implementation of the program or one with modifications. All of the participants were cognizant of the health reform program and were able to discuss their opinions in varying levels, showing that there is awareness of the program in the state amongst health care related professionals. The interviewees were all in unanimity that it was a full implementation of PMJAY in Tamil Nadu. There were no major modifications done to the roll out of the program in the state, except that Tamil Nadu’s previous health care initiative, the Chief Minister’s Comprehensive Health Insurance Scheme (CMCHIS) was merged with the new PMJAY scheme. The only minor modification that was made was that CMCHIS was previously providing its beneficiaries with 1 lakh per family annually (roughly $1,321 USD) and up to 2 lakhs (roughly $2,643 USD) for specified procedures. After merging with PMJAY, the total coverage amount became 5 lakhs (roughly $6,608 USD) per family annually. The scheme is now called PMJAY-CMCHIS.

After discussing the roll out of the program in Tamil Nadu, participants shared their opinions regarding seeing any improvements to the health care of the poor and disadvantaged populations in Tamil Nadu by implementing PMJAY-CMCHIS. The primary viewpoint from the majority of participants was that there would be improvements to the scheme’s catered population, those living BPL, since they are receiving treatment and health care from high quality institutions for free. For families who are living under impoverished conditions, most interviewees expressed that PMJAY-CMCHIS would be an important and appreciated program
for beneficiaries, as it would assist providing the most marginalized population of the state access to receive a certain standard of health care. For example, the study participant in Transcription 11 within Appendix D mentioned how for an individual living BPL, it is extremely beneficial to have the opportunity to undergo a surgery like a cardiac bypass without having to pay any costs OOP. One participant raised the point that PMJAY allows for portability, where beneficiaries can travel to other states within India to obtain treatment without any difficulty in receiving services. The interviewee in Transcription 14 under Appendix D brought up how if an enrolled beneficiary lived in Bihar, the individual would have the ability to come to Tamil Nadu, get a bypass surgery done and then return back to Bihar without having to pay OOP under PMJAY. The participant in Transcription 13 seen in Appendix D also mentioned how the scheme is comprehensive and altruistic, involving mental health, pregnant woman, rural/urban components and could potentially reduce mortality rates. However, along with a few other participants, there were questions raised regarding the longevity of the scheme due to doubts on how long funding from the government will last, how many participatory hospitals there will be, apprehensions from private hospitals becoming empaneled and how well hospitals realistically implement PMJAY-CMCHIS.

Participants were then asked what they felt were the major improvements and/or advantages in implementing PMJAY. Some of the common agreements amongst participants for the major advantages was the 5 lakhs amount of coverage that each family was provided with per year. By providing individuals living BPL with these benefits, the study participant in Transcription 12 under Appendix D stated how this was a way to bring more people under the health care net. Particularly for enrolled individuals who are living in the rural areas of Tamil Nadu, by being covered under PMJAY-CMCHIS, these beneficiaries will be given the quality
care that they would not be able to afford under normal circumstances. In Transcription 14 of Appendix D, the interviewee pointed out another advantage for the poor and disadvantaged that they are also receiving treatment for critical illness such as cancer and heart attacks—medical conditions that could cost a lot OOP expenses without the benefits provided by PMJAY-CMCHIS. Several participants agreed that the scheme runs well in the public sector. The participant in Transcription 15 in Appendix D explained that many government hospitals are generating extra money through PMJAY-CMCHIS. In turn, the profit that has come into the government hospitals due to PMJAY has allowed these facilities to utilize that money to work on upgrading medical equipment and infrastructure. Additionally, participants mentioned how in Tamil Nadu, certain private hospitals are wanting to become an empaneled hospital so that they can attract more patients, which in turn could result to generating more money for the hospital. One participant’s interview, listed as Transcription 11 in Appendix D, brought awareness of how often there is a lack of checks and balances within the health system of India. Through PMJAY, there has started to be a semblance of creating an accountability system as the scheme involves certain measures that are used to decrease corruption, ensure there is no misuse of the system and avoid unnecessary procedures. The interviewee detailed their experience with this by explaining how hospitals must receive permission from the central government to confirm if a patient can be under the insurance. Within the span of 24 hours, the government provides an update and three hours from that point, the hospital must move forward with the procedure/treatment. If a surgery is being performed, a photograph is taken with the patient and surgeon during the span of the procedure that must be uploaded online. To ensure there is no fraud, the central government requires extra measures to be taken such as including a barcode of the device stent that must be scanned so there is a record of everything that is being used during a patient’s stay. Another
example provided by the participant who is the Chief Cardiologist at a PMJAY empaneled private trust hospital is if a patient comes in requiring surgery. The participant would take the patient in for an angiogram and then complete a form, upload the image onto a database and then wait for approval from the government. If and once the approval is sent back, the patient can then be admitted as IP and is eligible for all the benefits under PMJAY-CMCHIS, meaning they will not have to pay any amount OOP all the way until their discharge. If the approval is not sent back, then the patient is not admitted and remains as OP. Since they are only outpatient and PMJAY does not cover any OP services, patients will have to pay OOP for the services that are required. Additionally, once a patient is discharged, they can receive a phone call from a PMJAY employee who enquires the satisfaction of the patient’s services that were provided at the hospital. The patient can convey any tribulations they may have faced while admitted and an official will then be sent to investigate the issue. Having these measures set in place allows the government to establish a degree of liability on the hospitals providing care.

The next question led to participants discussing how in terms of the number of people and the amount of benefits that the targeted population will be receiving, if they think the PMJAY initiative has more coverage compared to prior health care initiatives. The responses from all of the participants were synonymous, with interviewees explaining how past health care initiatives included the Kalaignar scheme and CMCHIS for individuals identified as living BPL. The Kalaignar program provided 1 lakh (roughly $1,324 USD) to families per year, while including a provision of up to 1.5 lakhs (roughly $1,987 USD) on specified procedures. The succeeding health initiative was CMCHIS, which also provided 1 lakh (roughly $1,324 USD) to families annually, however with an increased provision of up to 2 lakhs (roughly $2,649 USD) on specified procedures instead. With the current PMJAY-CMCHIS scheme, the coverage
amount has significantly increased, providing beneficiary families with 5 lakhs (roughly $6,624 USD) annually. This increase in coverage amount provides families that do not have the means to undergo treatments and procedures in their normal circumstances, the ability to receive health care services of higher caliber.

From this, participants were asked what they thought were drawbacks to the PMJAY scheme. A few participants mentioned the issue of the lack of coverage for outpatient services, since only inpatient services were covered. In Transcription 11 seen in Appendix D, the participant mentioned the issues that can occur if a patient who is admitted as IP has a complication. The hospital faces a disadvantage because they will have to use additional resources and treatments apart from what was initially prescribed and what the central government provided funding for, meaning the hospital will face losses. Additionally, if an enrolled beneficiary gets into an accident, their health care services will not be covered until they are admitted into the hospital. Until that point, they will have to pay everything out-of-pocket.

Participants also expressed concerns regarding potential misuse with the PMJAY scheme, including patients attempting to change their pre-existing conditions with the help of a corrupt doctor to receive benefits, since pre-existing conditions are included under PMJAY. Additionally, worries regarding Aadhaar cards being misused and dealt under the tables were conveyed. One participant, in Transcription 16 within Appendix D, suggested how instead of the government simply providing funding to insurance companies to be given to hospitals, additional funding should be provided to district hospitals, PHCs, FHCs, taluk hospitals and government hospitals to provide more high-end equipment in these facilities that lack the advanced technology. The participant explained how for these facilities that are serving such large numbers of individuals on a daily basis, acquiring high-technological medical equipment would be
extremely useful for providing improved quality services. A few interviewees highlighted issues with the eligibility criteria regarding PMJAY. In Transcription 18 within Appendix D, the participant included criticisms discussing how the eligibility criteria is based on the SECC 2011, which is now relatively outdated and how updates are vital since the population of BPL individuals has grown over the years. If the criteria are not updated, there could potentially be people who are not covered under the scheme since they do not fit the 2011 criteria requirements. Other interviewees expressed concerns that there are criteria listed that is not necessarily enough to establish an individual as being ineligible or unfit, instead should be instituting better methods to validate criteria. In Transcription 13 under Appendix D, the participant argues the validity behind the 14 exclusion criteria that is established by the SECC. If any individual meets any of these criteria, then they are automatically excluded from being eligible for PMJAY. One example emphasized by the interviewee is the eligibility criteria that is listed in the SECC 2011 that having a motorized 2/3/4 wheeler/fishing boat means you are automatically ineligible for enrolling in PMJAY. The participant questions why that criteria are enough for someone to lose their eligibility by raising the point that simply because an individual has a motorized 2/3/4 wheeler/fishing boat does not equate to that individual being able to afford costly treatments or procedures. Participants also voiced opinions regarding the decision-making process for PMJAY saying that a committee needs to be established at the grassroot level. In Transcription 12 of Appendix D, the participant explains that individuals who are at the frontlines and are firsthand involved with PMJAY must be given ample leeway to make decisions regarding coverage predicaments. Additionally, interviewees mentioned that these individuals working at the field level should be the ones that are redirecting discussions and troubleshooting concerns with officials higher up working on the policy aspect to then facilitate
conversation on what implementation issues should be worked on. Since these grassroot level workers are the ones who are directly seeing what aspects of the program are operative and inoperative, they would potentially have a more conclusive idea on how best to move forward. Other concerns included raising awareness of PMJAY in rural areas and amongst the BPL population, so beneficiaries know more about the benefits they are being offered under the scheme since that is lacking currently. A final drawback to PMJAY was the lack of private hospitals signing on to be a part of the health reform program. Majority of participants, those who worked at private and public hospitals, expressed that there are cost structure issues and how the package rates provided by the central government are abysmally low. Since the rates are unrealistic for many corporate private hospitals, they are not inclined to become an empaneled hospital. Most of the interviewees said that package rates need to be revisited and made more reasonable along with private hospitals needing to receive more funding from the government to ensure that they are able to break even. Participants expressed their opinion that once that process happens, there is a possibility that more private hospitals choose to implement PMJAY. Although there were many drawbacks that were listed by the participants, many of them concurrently mentioned that most of the disadvantages are implementation issues that affect the hospitals and not as much the beneficiaries.

The final question that was brought up to the participants were how they thought implementing PMJAY-CMCHIS would affect health outcomes in Tamil Nadu. Most of the participants did not have a clear-cut answer, but there was a general consensus among most that health outcomes could potentially improve as health care delivery enhances, leading to a healthier population. A few participants mentioned that Tamil Nadu might be too advanced to see significant results of change from PMJAY in comparison to select states in Northern India.
that might not be as evolved in the health sector. However, other participants disagreed with that view and explained their stance that even though Tamil Nadu is comparatively progressive, no state is too advanced to implement programs such as PMJAY that has the ability to provide such extensive benefits to the poor and disadvantaged population. One interviewee discussed how in general, PMJAY has been met with a positive reception in Tamil Nadu for the most part. The participant mentioned how that reception stance could potentially have been affected by the politics of Tamil Nadu, which is currently a coalition party with the central government. Overall, there was a common theme amongst all participants in the Tamil Nadu group that identified how PMJAY is a relatively new and huge scheme that is bound to face implementation issues. One of the participants stated that “a plan is only as good as you implement it.” The sentiment was followed by the interviewee explaining that before there can be any differences seen in health outcomes, the program’s implementation needs to improve. Once these concerns can be ironed out and rectified, this health reform scheme will be an achievement that will be immensely beneficial to the targeted population.
Chapter 8

Discussion

Subsequent to analyses of interviews conducted in Kerala and Tamil Nadu, the varying opinions by study participants exemplifies how there is mixed response regarding the effectiveness of the Ayushman Bharat-PMJAY scheme, particularly in the implementation. In both Kerala and Tamil Nadu, there was mutual agreement that the benefits provided from PMJAY were extremely beneficial for the targeted population, those living below poverty line. The primary advantages were the large sum of money, 5 lakhs (roughly $6,642 USD), given to each enrolled family annually and how by implementing this scheme, it would bring more of the population living BPL under the overarching health care net. Particularly for the beneficiaries living in rural communities who would normally not be able to afford quality treatment are now being given the chance to receive high-end care from all hospitals in the public sector and empaneled hospitals within the private sector without having to pay OOP. Expensive procedures and treatments for critical illnesses including cancer and cardiovascular conditions are now offered to these beneficiaries for free resulting in a decrease in the amount of catastrophic health expenditures. Many study participants expressed how they firsthand witnessed the impact KASP-PMJAY and PMJAY-CMCHIS had for beneficiaries in their respective states. For PMJAY enrolled individuals living in poverty who do not have the financial support to undergo a costly procedure such as a breast cancer surgery or a cardiac bypass, this scheme provides the means necessary to receiving care which is monumental for these families. Another major advantage of the implementation of PMJAY in Kerala and Tamil Nadu has been the success of how the system is being run in government/district hospitals and medical colleges. Many participants articulated how these hospitals within the public sector are benefitting from PMJAY, even
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profiting financially. Since the rates of treatments and procedures of public hospitals are lower compared to the package rates provided by the central government, the funding that these facilities receive from the government are resulting in the hospitals being able to make a net profit. In turn, the government hospitals are able to utilize that money to their advantage by upgrading their medical equipment, working on improving infrastructure and hiring more health professionals to help combat the issue of staff shortage leading to overcrowding. The main advantage of PMJAY’s roll out working well in government hospitals is that it is consequently strengthening the health care services of the public sector. One improvement that could potentially help furthermore, is if there can be additional funding provided from the government to the public hospitals so they can acquire more high-technological equipment and laboratory facilities. Although the profit margins from the PMJAY scheme are currently helping government hospitals upgrade their equipment to a small degree, many of them lack certain facilities which require them to outsource patients to larger establishments that do have them. By providing more funding to these public hospitals, it will help increase the services that these institutions are able to administer exclusively on their own. While these benefits provided by the scheme should be commended, several implementation issues remain that need to be addressed.

The most prominent drawback of the PMJAY program implementation that was seen in Kerala and Tamil Nadu is the lack of private hospital participation. From all the interviews in both states, evidence was clear that many hospitals in the private sector, primarily corporate private hospitals, were unwilling to enroll under the health insurance scheme because of the abysmally low package rates that were formulated by the central government. The majority of private corporate hospitals emphasized concerns that their institutions would fall into financially difficult situations if they were to implement the PMJAY package rates for procedures and
treatments. Since there is such a significant disparity between the package rates of the private hospitals and those developed by the central government, the fundamental problem these establishments had was the fear of not being able to break-even. Certain interviews highlighted the deficit the private corporate hospitals would face if they were to become a PMJAY empaneled hospital. Due to this, a large number of these facilities are apprehensive and unlikely to take up this scheme, which is a major drawback for the program, since beneficiaries being able to seek treatment at reputable private hospitals without paying OOP is one of the cardinal highlights of PMJAY itself. In order to address this issue, the central government needs to revisit the package rates. To create treatment and procedure package rates that are more reasonable, so that private hospitals become increasingly willing to implement the PMJAY scheme, the central government needs to work with leading officials who are working firsthand at the private institutions to get an idea of the range of rational package rates. By doing so, they can work together to formulate package quotas that are acceptable to both the central government and private institutions. While this drawback is predominantly one that affects the hospitals and not the enrolled members, it is a significant concern that needs to be addressed immediately. If the central government is willing to provide higher reimbursement rates, both the private and the public sector will benefit. An indirect advantage will be that government hospitals can utilize the extra resources to improve their facilities while more private hospitals may be willing to join the scheme, even if the government rate is not at par with their costs. It is worth mentioning that while several private corporate hospitals are reluctant to implement PMJAY, there are non-corporate trust hospitals in both Kerala and Tamil Nadu that have shown interest in becoming PMJAY empaneled facilities. A chief reason for these hospitals to roll out the scheme is due to the fact that while they have the infrastructure of a private hospital, they lack patients and suffer
from financial uncertainty. With the publicity that PMJAY brings, more PMJAY enrolled
beneficiaries are likely to go to these hospitals in search of receiving quality care at a private
hospital. This then benefits these hospitals as they get an influx of patients coming in from poor
and disadvantaged communities while receiving funding from the government. In order to better
the roll out process, there needs to be more overall discussion between the PMJAY policy
drafters at the central government level and individuals who are working with the program at the
field level. Often times, officials higher up who work on policies are not able to see the
implementation issues that occur at the grassroot level. By facilitating conversation between
these two groups, PMJAY policy making officials can get a better concept of what the day-to-
day implementation complications are, allowing them then to be ironed out and improvements
made to the scheme.

When it comes to handling misuse of the AB-PMJAY scheme, certain measures have
been put in place by the central government such as having to upload required photographs and
forms for treatments and scanning barcodes so there is a record of what is being used for every
procedure. While these measures do help establish a sense of accountability for the doctors and
hospitals providing treatment, there are still areas in which exploitation of the scheme can occur.
For example, only inpatient services and not outpatient services are covered under PMJAY.
Corruption within the system can occur if a doctor orders a patient to undergo unnecessary
investigative tests that occur as an OP, where the patient will fully have to pay OOP for all the
services. Furthermore, pre-existing conditions are covered under PMJAY. Misuse of the scheme
can also take place if a patient were to change the status of their pre-existing conditions under
unethical manners with the assistance of a physician who is practicing fraudulent behavior.
While designing measures to counteract this abuse may prove to be difficult, it will strengthen
the program if they can be successfully prevented. Another obstacle that a few participants discussed was the dilemma regarding claim rejections. A handful of hospitals, primarily private, have complained that several claim rejections have resulted in their institution having to bear the financial loss which results in the hospital losing money. The concurrent process of having to then counteract and try to work out these rejected claims has been known to be an arduous procedure. By cultivating systems that can help to establish an easier process to resolve rejected claims could be an improvement made upon PMJAY. One possible solution to counter this issue could be to process claims ahead of time so that any rejection occurs before the procedure. Once approval is given to move forward with the procedure, payment must be made, and the claim cannot be rejected.

The established eligibility criteria for PMJAY has been a point of apprehension for many participants in the study. Currently, the eligibility criteria to be enrolled under the scheme comes from the SECC 2011. The main criticism is that the criteria from 2011 is now outdated and since then, the number of individuals living BPL has increased. As a result, there is a possibility that there are individuals who have been excluded from being enrolled under PMJAY because they do not fit the eligibility criteria that was established in 2011. The central government needs to update the SECC 2011 criteria and apply improved methods to validate criteria, so no BPL families are potentially prevented from becoming enrolled in the scheme. Additionally, revisiting the grounds regarding the exclusion criteria of PMJAY could prove to be beneficial. While the interviews in Kerala and Tamil Nadu exhibited that there was decent awareness of PMJAY amongst health care workers in both states, there needs to be more awareness brought to the attention amongst the BPL and rural communities. The populations this scheme is targeting may not be aware of the full extent of the benefits they are receiving from PMJAY. Therefore,
propagating more publicity and information of the program in these communities could help raise more attention to what PMJAY is and what are the benefits it provides for these individuals.

When looking at the differences in opinions of the PMJAY roll out in Kerala compared to Tamil Nadu, there was a contrast amongst some participants in regard to reception of the program. While both states listed the advantages of the program, there seemed to be a higher level of reluctance towards implementing PMJAY in Kerala than Tamil Nadu. Kerala’s primary reasons for disinclination for administering the scheme was since the state is having to provide more funds in comparison to the central government since it is covering a larger number of families under its KASP program. This led to the belief that PMJAY should not be labelled as a centrally sponsored scheme, if the state is having to bear a larger portion of the funding. Arguments by certain Kerala officials express their opinion that the central government is attempting to take credit for implementation of the scheme in the state, while simultaneously placing an unfair financial burden on Kerala by denying them funds. While there is substance in Kerala’s hesitation of having to spend more money on providing health care than what the central government is funding the state with, there are also concerns if a portion of Kerala’s dubious reception of implementing PMJAY is due to political reasons.

AB-PMJAY is a central government program, which is currently run under Prime Minister Modi, who belongs to the right-leaning Bharatiya Janata Party (BJP). Kerala’s leading political party is currently the left-leaning Communist Party of India (Marxist) whose ideologies commonly oppose that of the BJP. The opinions raised in the interviews mentioned that since many of Kerala’s officials who are in charge of rolling-out AB-PMJAY in Kerala are of CPI (Marxist) allegiance, they may not want to give credit to the central government, which is being
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led under the BJP party. In comparison to Kerala’s reception of PMJAY, Tamil Nadu seemed more willing to implement the program in the state without much deliberation. However, similar to Kerala, participants raised concerns that the positive reception to the program could be based on political alliance. The current ruling party of the state is All India Anna Dravida Munnetra Kazhagam (AIADMK). While the political position of the party falls under centrism, the alliance of AIADMK is with the National Democratic Alliance, which is a right-wing political alliance led by the BJP. Since Prime Minister Modi, who is in charge of rolling out the program, is a member of BJP, there is a possibility that Tamil Nadu might be more receptive to a program sponsored by the central government, in comparison to a non-central government ruled state like Kerala.

There is no doubt that Kerala and Tamil Nadu are both very advanced states that have been able to successfully provide quality care with its prior health initiatives prior to PMJAY. Although these states might not require the implementation of PMJAY to provide the same level of care it has been providing for all these years, it would be incorrect to say that these states would not benefit from this scheme. Irrespective of how advanced either state is, there are always families that are living BPL and in rural communities who could benefit from what PMJAY is offering. The amount and the coverage that the scheme provides to its beneficiary families is a large feat that can potentially help move the country towards attaining universal health coverage (UHC). Additionally, the program can begin closing the gaps on inequality and health disparities between urban and rural populations.

Some participants raised concerns regarding the cost management and longevity of PMJAY. They had apprehensions about sustainability of the scheme. India spends only 1.28% of its GDP on its health expenditure. This is a low amount of GDP spent on health care as opposed
to other middle-income countries and consequently India comparatively tends to have some of the lowest health indicators. PMJAY is an extensive and ambitious program to substantially increase financial investment in health in order to improve the health outcomes of the country. However, the question arises as to how long the central government will be committed to running the scheme effectively long enough for it to show results in health indicators.

While there may be more significantly evident advantages as a result of PMJAY implementation in states that have lower health statuses such as Bihar, Madhya Pradesh and Uttar Pradesh, both Kerala and Tamil Nadu can also reap benefits from the scheme to a degree once implementation issues have been remedied.
Chapter 9

Conclusion

The Ayushman Bharat initiative is a nationwide health reform scheme that was launched in 2018. The initiative has two sections: Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) and Health and Wellness Centers (HWCs). The PMJAY portion of Ayushman Bharat focuses on implementing a public funded insurance program that provides ₹5 lakhs INR (roughly $6,630 USD) per family annually without any OOPE for beneficiaries. The scheme extends its coverage to roughly 100 million families, consisting of 500 million individuals, or 40% of India’s population (Angell et al., 2019). The health reform program that costs the government an estimate of 1.54 billion US dollars annually, focuses on assisting families living in poor and disadvantaged conditions by providing financial coverage for their hospital expenses with a focus on secondary and tertiary care (Presse, 2018). With the money that enrolled PMJAY beneficiaries are allotted, they can choose to receive health care at either a public hospital or PMJAY empaneled private hospital.

The insurance scheme goal is to decrease the extreme out-of-pocket expenditures for hospitalizations through providing cashless and paperless access to services for the patients at their point of service (Government of India et al., 2019). By attempting to minimize having BPL families fall further into poverty due to catastrophic health expenditures, the program benefits strive to allow low income families access to quality health services available at private hospitals, without having to face pressure from monetary hardships. PMJAY is an ambitious central government sponsored health protection scheme that is pushing India towards having UHC. Reports have shown that AB-PMJAY has the capability to make significant impacts for
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health care delivery in Indian states that have low health index ratings such as Madhya Pradesh and Uttar Pradesh.

The purpose of this study was to examine whether PMJAY would have a similar impact in two states that have already established themselves as the higher performing states of India for healthcare. Kerala and Tamil Nadu have consistently held a reputation of being amongst the most advanced states in overall health performance in India. According to the 2019 NITI Aayog Health Index report published in collaboration with the Ministry of Health & Family Welfare and the World Bank, both Kerala and Tamil Nadu are amongst the top ten states for best overall performance, with Kerala ranking number one. These two southern states of India have comparable demographics, health indicators and similar levels of success in implementation of prior state-run health care initiatives leading Kerala and Tamil Nadu to be chosen to review the roll out of AB-PMJAY through the views of health professionals employed in the two states. To assemble opinions of individuals who deal with the health reform program on a real-life basis, healthcare professionals, physicians, and individuals working or familiar with the scheme in the two states were interviewed to understand their views on the implementation and rollout of the program. A total of twenty-one participants were interviewed, with 10 individuals from Kerala and 11 individuals from Tamil Nadu. Participants were interviewed to gain information about their personal experiences and perspectives with KASP-PMJAY and PMJAY-CMCHIS in Kerala and Tamil Nadu, respectively.

Following evaluation of the interviews conducted in both states, a range of opinions were gathered, illustrating that there was a mixed reaction amongst the two states on how efficacious the PMJAY scheme is in Kerala and Tamil Nadu. In both states, the primary advantages highlighted were the generous coverage amount of ₹5 lakhs (roughly $6,630 USD) per year
provided to each beneficiary family, how enrolled PMJAY individuals who are BPL and living in disadvantaged conditions are given accessibility to receive quality care, treatments and undergo surgeries that they would not be able to afford under normal conditions for free without any OOPE and how these individuals are being brought under the overall health care net. Additionally, there was mutual agreement in both states that PMJAY was predominantly running smoothly in the public sector, which includes government hospital, district hospitals, medical colleges. Many of these establishments were able to even generate a profit which could then be used to upgrade their facilities and overall, PMJAY was seen as playing a role in potentially strengthening the public sector. While these benefits were commended, multiple implementation concerns were identified.

The prominent drawbacks of the scheme noticed by participants included minimal private hospital participation due to unacceptably low package rates formulated by the central government, lack of understanding of the day-to-day implementation issues of PMJAY, potential misuse of the system, outdated eligibility criteria and general lack of awareness of the scheme amongst rural and poor populations. Additionally, there were concerns raised about the cost management and sustainability of the program due to the high expenses AB-PMJAY requires for successful implementation. Possible solutions to ameliorate the program could be adjusting and reformulating the package rates so private hospitals are more willing to enroll, facilitating discussion between individuals at the grassroot level who see daily implementation concerns and the PMJAY policy drafters, establishing new ways to combat fraud and corruption, updating the eligibility criteria for beneficiaries and creating awareness/publicity campaigns in the rural and disadvantaged communities.
When comparing differences in opinions of PMJAY implementation in Kerala versus Tamil Nadu, Kerala seemed to have increased skepticism regarding the benefit of the scheme as opposed to Tamil Nadu. This perception was seen through the differing implementation method of PMJAY in each state, with Kerala choosing to rollout the program with its own modification, whereas Tamil Nadu decided on a full implementation without modifications. The main reason for Kerala’s minimal enthusiasm of PMJAY has to do with the state having to spend more money than the central government is funding Kerala with, since the state is covering an increased number of families under its modified program which utilizes Kerala’s past health care initiative, Karunya Arogya Suraksha Paddhati (KASP). However, certain opinions raised questions whether the reception of the program’s implementation also had to do with underlying political factors.

Overall, both Kerala and Tamil Nadu are recognized as being two of the most advanced states within India. While both states have the capability to provide quality health care without implementation of PMJAY, the extensive financial coverage that the scheme offers is highly advantageous to the BPL population the program caters to. Although the impact that PMJAY can have on improving state health care performances might not be as distinguishable in Kerala and Tamil Nadu compared to states such as Bihar and Rajasthan, there are still considerable benefits that BPL beneficiaries in both states can reap. While Ayushman Bharat- PMJAY has significant potential to reduce inequalities in accessing health care, decrease impoverishing health expenditures and enhance the quality of health care provided, the program must initially focus on amending its implementation pitfalls.

Studying the more advanced states of Kerala and Tamil Nadu is critical for understanding the roll out issues of the program. However, the most important evaluations in the future will be
how PMJAY is implemented in poorer Indian states where its impact, if successfully executed, will be more significant. With fewer issues such as overwhelming poverty levels and a lack of health infrastructures seen in other states, Kerala and Tamil Nadu serve as important lenses from which to study Ayushman Bharat, India’s ambitious nationwide health reform scheme. It is possible with minor adjustments to the program, that it could lead to India improving its health indicators and economic output by reducing destitution based on out-of-pocket expenditure on healthcare.
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Appendix A

Kerala Interview Guide

1. What is your opinion on the current health care system in Kerala? Could you explain?

2. Are you aware of the new AB-PMJAY scheme? If so, why did Kerala choose to adapt that program instead of the full implementation of the program, as it is?

3. Do you think Kerala’s past health care initiatives has influenced the state’s decision not to fully implement the PMJAY’s program as it is?

4. What is the impact of deviating from the PMJAY scheme and implementing a varied version of it?

5. Do you think there are any drawbacks to the PMJAY scheme?

6. What are the advantages of the PMJAY scheme? Do you think the PMJAY scheme is beneficial for the targeted population (the poor and the disadvantaged) in Kerala?

7. How do you think implementing this initiative will affect health outcomes in Kerala?
Appendix B

Tamil Nadu Interview Guide

1. What is your opinion on the current health care system in Tamil Nadu? Could you explain?

2. Are you aware of the new AB-PMJAY scheme? If so, did Tamil Nadu choose to adopt the full implementation of the program or did they modify it in their own way?

3. Do you think that there will be any improvements to the health care of the poor and disadvantaged population of Tamil Nadu by adopting the PMJAY scheme?

4. What are the major improvements/advantages to implementing the PMJAY initiative?

5. In terms of the number of people and the amount of benefits that the targeted population will be receiving, do you think the PMJAY initiative has more coverage compared to prior health care initiatives?

6. Do you think there are any drawbacks to the PMJAY scheme?

7. How do you think implementing this initiative will affect health outcomes in Tamil Nadu?
Appendix C

Kerala Transcriptions

Transcription 1

State: Kerala
Profession Title: Doctor at a Private Hospital

I: Hello. How are you?

P: Good. So, what do you want to ask me today?

I: Basically, I would like to ask you some questions about the PMJAY scheme. I am currently working on an Honors Thesis program where I am looking at the rollout of the new PMJAY program in both Kerala and Tamil Nadu. So, I’m travelling to both states to interview individuals who work with the program and get their opinions on the implementation of the scheme.

P: Okay, you have something prepared?

I: Yes, I have a few questions ready if that is okay. But to start off, I just wanted to ask do you consent to be a part of this research? If it is okay, would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if everything is okay for you. Everything will be anonymous.

P: Let me see. Okay, where do I sign?

I: Right here.

P: Okay. Yeah, ready.

I: Okay, thank you. The first question I wanted to ask was what is your opinion on the current health care system in Kerala and if you could elaborate a bit on that?

P: Kerala has a decent health care system currently that combines many prior health care initiatives. Compared to other states, the health system and the outcomes that arise from it are among the better end of the spectrum.

I: Okay. Are you aware of the new AB-PMJAY scheme? If so, why did Kerala choose to adapt that program instead of the full implementation of the program, as it is?

P: Kerala has a program that they feel is working for its citizens, so they did not want to simply just implement the central government’s scheme. Instead they wanted to have a combination of Kerala’s prior programs and find a way to incorporate the Centre’s program along with it. Kerala’s version also covers greater beneficiaries.
I: So, do you think Kerala’s past health care initiatives has influenced the state’s decision not to fully implement the PMJAY’s program as it is?

P: Yes, Kerala feels that the state’s past initiatives have done well, so they should continue to keep those programs instead of just implementing the PMJAY’s program alone.

I: Okay. What is the impact of deviating from the PMJAY scheme and implementing a varied version of it?

P: I don’t think there is any negative impact from deviating from the scheme. The varied version is just covering more people which is a good thing.

I: Do you think there are any drawbacks to the PMJAY scheme?

P: The government hospitals are more the ones that are benefitting because the private hospitals are not joining due to the abysmal low prices that the government is assigning for treatment/procedure package rates. They need to work with private hospitals and come up with more reasonable rates or else private hospitals are not going to be able to break even with these rates that are provided.

I: What are the advantages of the PMJAY scheme? Do you think the PMJAY scheme is beneficial for the targeted population (the poor and the disadvantaged) in Kerala?

P: It is extremely beneficial for that population due to the financial reasons and benefits they are getting. To put it in perspective, if a surgery for instance without the PMJAY program would be around 35,000-40,000, under the PMJAY scheme it might be listed as around 12,000.

I: How do you think implementing this initiative will affect health outcomes in Kerala?

P: More individuals, particularly amongst the poor population, will be able to receive procedures and treatments that they usually would not be able to afford. So, since they will now be able to receive these treatments, health outcomes might become better.

I: Okay, thank you so much for your time.

P: Okay, sure.
Hello. How are you doing?

Good good.

So, basically today I wanted to talk to you about PMJAY. I am working on an Honors Thesis program where I am looking at the rollout of the new PMJAY program in both Kerala and Tamil Nadu.

Okay, yeah. I can talk to you a bit about it based on what I know.

So, to start off I just wanted to ask do you consent to be a part of this research? Would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable. Everything will be anonymous. No names will be used in the paper.

Let me take a look at it. Okay, I can sign.

Thank you so much. Okay, so basically, I wanted to start out by asking what is your opinion on the current health care system in Kerala? Could you explain?

So, the current healthcare system consists of many health policies, lot of it is a populist approach (such as NCD programs, blindness control programs). There are also things like the health technology assessment – NICE program. Programs need to look at cost utility, ethical, societal benefits but often times many programs don’t look at these points. I was working with WHO prior to my current posting and coming to India I have seen that often politics pushes healthcare which is not good.

Oh wow, that’s so interesting.

Yeah, I think it is hard to compare Kerala’s healthcare systems with the other states because it is smaller, it has higher education rates and they have had PHC for a long time. They also have had a structured and systematic approach early on…when you compare this to places like UP or MP, where officials need to establish PHC in places that have a lot of rural population, it is significantly harder than establishing them in Kerala where there is not too much of a rural population but rather more of an semi-urban population. The implementation is a lot easier in Kerala due to this, because adopting programs and building PHC is states with higher rural populations in India is very challenging. So, in that sense, Kerala has an advantage.

Hmm
P: See, there is also an advantage, because it has a mixed population of Hindu, Christians and Muslims. Lots of money comes in from other places when a lot of these populations go to work in places such as the Gulf. Education, demographics, geography, and money coming in from other places makes this state slightly different and more apt to implement policies. Unfortunately, the government has been changing every 5 years, so often there is no static policy or stability. One government follows one thing and the second government will do the opposite. That is the tragic part of implementing policies in Kerala. However, the health care in Kerala in general has been pretty good overall.

I: Okay. So, the next question I had was- are you aware of the new AB-PMJAY scheme? If so, why did Kerala choose to adapt that program instead of the full implementation of the program, as it is?

P: The main reason that they chose to adapt their own program instead of the full implementation is mainly because of the rift between the central government and the state government. The central government has also given every state flexibility in what they want to do, so the states implement the program based on their judgement. Kerala does not want to fully implement the program primarily because of politics and they want to show that they have something better, but I do not necessarily believe that to be true. They have the Karunya scheme, but that is not run by the Department of Health- but by the Department of Finance. If you look at states that are run by parties that are non-central government ruled, then they are not implementing the program or are implementing the program in their own way. The policy is such a huge and nicely drafted one that each state, at some point or other, will have to implement it. Kerala has agreed to implement 2 lakh benefit. Up till 2 lakhs they will pass on benefits to the patients and that would be in most of the public hospitals. Things are still going to evolve as this is such a huge initiative and the intent is great.

I: Yeah.

P: See, 70% of health care is run by the public sector and the private sector does not find it sustainable or reasonable to participate in this. That is true within Kerala also. There are very few private institutions that have signed for PMJAY. It is UHC policy and that is good, it is difficult to implement this is non-central government states as they don’t want to show that this is a good policy because of politics. So, many of these states will implement a scaled-down version of the scheme.

I: Hmm I see, so do you think Kerala’s past health care initiatives has influenced the state’s decision not to fully implement the PMJAY’s program as it is?

P: To a degree…overall, health care definitely has catastrophic costs for the poor, so Indian society has found policies like RSBY very beneficial. Many people saw these health initiatives as a winning tool. Each state began to implement their own versions of the scheme as it was a winning tool for elections and such. PMJAY is a mother of all insurance scheme. It will take time, but I think soon enough all states will implement it as
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It is very powerful and will provide more benefits than what individual state health initiatives can provide on their own.

I: Okay, so in your opinion what is the impact of deviating from the PMJAY scheme and implementing a varied version of it?

P: Mmm…I would say there is a negative impact in that the society will not really benefit. I don’t know whether the government is concerned whether it benefits or doesn’t, but the society can take the benefit because 2.3% of the country’s population goes BPL because of extreme health care expenditures. This won’t happen now, because the government is paying for it. It is universal health care in its nature. Right now, it is this policy is still too new that it is hard to tell if there is a negative impact from deviating from the scheme. Modicare is the only way to move towards UHC as if such a large population is going to be insured under this, you have to make sure it is very cost effective and is a sustainable model. Ultimately, out of 2 people, one person will be under this scheme. So, if I have a procedure like a bypass for 1.2 lakhs, they are only going to pay me around 45,000-50,000 rupees. Now, I can choose not to see those patients or choose that I need to be more inclusive and provide it at the cost that is more lenient. When this scheme gets larger and more people become insured under it, eventually private hospitals will also have to join it, in my opinion. But in comparison to Ayushman Bharat, KASP is having a larger reach.

I: Do you think there are any drawbacks to the PMJAY scheme?

P: Kerala can never lead to privatization; it is always more leaning towards government oriented. Kerala has a communistic attitude which is not forward looking and that is why it will be difficult for them to understand that other initiatives, such as this one, that could be more progressive. It will take time, that the program is so well crafted. Kerala has signed it but is doing it in their own way. They are mainly working with government hospitals as many private hospitals are not really taking up this program a lot. However, I don’t think this vision has any role in this because the program is for public and private. But the public is benefitted more because salaries are paid by taxes, so they can provide free healthcare.

I: Hmm, yeah.

P: Ayushman Bharat is very beneficial for the public sector. Let me tell you. At a government hospital, say if a C-section is performed, they would do it free. If the patient is ensured under PMJAY then the government is going to pay the medical college or the hospital. The government hospital previously wasn’t getting any money or just a minimum charge of 50-100 rupees, now they would get 2,000 rupees for the C-section. For the private sector, where C-section cost is between 10,000 and 1.2 lakh, you are now going to get 2,000 rupees if the patient comes in insured under PMJAY. That is why private hospitals are not signing on to this deal, because it is not practical to sustain their establishment.
I: Okay.

P: The hospital I am working at right now is not under this program. The answer why we are not is simple— it is not sustainable and that is the main reason for not enrolling in the program. Despite being charitable, if our C-section is 10,000 and the government is going to give me 2,000, how long can I keep doing the procedures for that low of a price? For our hospital, per unit we are required to have 5 doctors. Just under me, I run 2 units meaning I have 10 doctors under me that I need to pay. So, if I need to pay them, my nurses, my anesthesiologists— it is just not sustainable at these low prices. It is highly unrealistic for private hospitals to join PMJAY because of this. There is a private hospital association where they have joined and represented to the government to make the prices of these procedures more realistic so that the private hospitals can join as well. The central government in a very dubious manner have just said they are looking into it, but I don’t know. Right now, the statement is they are looking into it and might revise it, but we don’t know. Realistically, I don’t see private hospitals like ours enrolling in this program because it is just not sustainable, and we will not be able to break even. Being a part of PMJAY will in a way kill the hospital and its business. I think this issue is a disadvantage of the program itself because by keeping prices this low, most private hospitals are not going to be a part of this. Private hospitals are also a big part of the health care system, and if they cannot be a part of it, this is not going to really be an all-inclusive system.

I: So, you’re saying this is a disadvantage of the program itself?

P: Yes, I think it is. But look… in totality the program is 100% going to be beneficial. The way this is designed, they put an IT system together. They have a robust hospital information system so everyone who is insured is part of the registry within the scheme. They have electronic medical systems and records for the hospitals that are enrolling, so issues such as forgery will not happen. Plus, with the packages given to the public sector, the population living in poverty will really benefit from this scheme. And see, a lot of schemes do not cover pre-existing conditions, but PMJAY is and that is huge. If you are a diabetic and then they say since you are diabetic, your illness will not be covered then you lose out on the benefits. However, here that is not happening.

I: Oh wow, okay. So, what are the advantages of the PMJAY scheme? Do you think the PMJAY scheme is beneficial for the targeted population (the poor and the disadvantaged) in Kerala?

P: I want to mention PMJAY versus KASP, KASP is also very limited, they only have it for 3-4 private hospitals, the rest are all for public hospitals. Anyway, as of now, I think it is very beneficial to the government hospitals. A coronary angiogram right now might be at 500 rupees, now they get 2,500 rupees. So, it is an advantage to them. And then of course to the targeted population, yes.

I: Hmm, yeah. Okay, so do you think implementing this initiative will affect health outcomes in Kerala?
P: 100%, because right now like in NHS he first has to go to a gatekeeper like a GP and then if they think the patient needs more care, he refers them to a referral hospital. In India, if I fall ill, I need to analyze myself whether I am bad, so there is not really a gatekeeper. Instead, I go directly to the hospital and then when I get discharged, I go back home. Then, I again see if I need to go back to a doctor or if I am okay, so there is a problem of handover of patients. Patients sometimes will get confused, go back to the hospital because they are not sure if they are okay and then that trip again will cost them more money. So, other systems like in the US or UK, there is a handover program, so hospitals are not overcrowded, there is a gatekeeper to monitor. Within Indian system, those who cannot afford all these visits usually are getting a better deal. Also, many public hospitals in Kerala are decent and at that you get good treatment and then the hospital also benefits because they get paid, it’s a win-win situation.

I: Oh wow, okay.

P: But see, there has been a criticism that by incentivizing more private hospitals to be a part of the program, they are removing the focus from trying to clean up public hospitals. While yes, unfortunately that is there, how much can the government do? Government GDP spending on healthcare is so low that it is negligible. Government doesn’t really have a lot of resources to put in more manpower and structures in place at these public hospitals, whereas private hospitals see all this as a business and put in the money to make sure everything is more advanced. To make this program more successful and all-inclusive, somewhere PMJAY is going to have to figure out how to increase private hospital privatization which can happen through incentivization, revision of cost prices and etc.

I: Hmm yeah, makes sense. So overall?

P: Overall, this scheme going to be extremely beneficial because the poor is going to be able to afford treatments and all the medical colleges and private hospitals. Plus, the pre-existing condition is a great clause, in my opinion.

I: Okay, yeah that’s all the questions that I had. Thank you so much, I know I took up a lot of time.

P: Sure, no problem…okay…all the best.
Transcription 3

State: Kerala
Profession Title: Medical Superintendent at a Leading Private Hospital

I: Good morning. How are you doing?
P: Good morning, I’m doing well.

I: So, today I wanted to talk about the new scheme Ayushman Bharat-PMJAY. I am working on an Honors Thesis program where I am looking at the rollout of the new PMJAY program in both Kerala and Tamil Nadu.

P: Sure, do you have some questions?

I: Yes, I do. I just wanted to ask- do you consent to be a part of this research? Would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable. Everything will be anonymous, no names used at all.

P: Sure, let me take a look. Okay, here you go.

I: Thank you very much. To start off, I wanted to begin by asking what is your opinion on the current health care system in Kerala?

P: The government portion of the system runs well with a tier system. It includes PHC and FHC, taluk hospitals and government/district and hospitals and medical colleges. There are a lot of preventive and curative services given free of cost. There is also a National Health Mission. Kerala is considered as the most developed state in the country, so based on the developmental health indexes, the funding will be less in comparison to states that are more under-developed such as UP. Those states will receive more funding from NHM. Public sector is definitely a huge network, but it does run well. For the private sector, many people make up this system as well. Most people do go to the private sector (around 70%). One reason that people do choose this is because of the availability of doctors in times of need because quality wise things are pretty good in government hospitals as well. There is also a specialist shortage in public hospitals and in private hospitals, if you have a need that you want to see a specific doctor, a patient will definitely be able to see them, but in a government hospital it might not be available. Also, in a government hospital there can be problems of staff shortage. There is also sometimes a mental aspect in that if people are giving birth, they would rather have it in a very clean, quiet space that private hospitals can provide. However, in government hospitals now, things like overcrowding, lack of privacy and sanitary conditions are slowly starting to begin to change because of programs like RSBY. It is also harder on government hospitals, because for us at a private hospital, the most patients I see in day- I cap it at around 30. But for a government hospital, they might see around 150+ patients per day.
I: Okay, so are you aware of the new AB-PMJAY scheme? Could you explain why Kerala choose to adapt the program instead of the full implementation of the program, as it is?

P: Yes, I am. It is because KASP-PMJAY is covering more people than just PMJAY, so the state’s varied version of the scheme covers more families.

I: Hmm, okay. So, do you think Kerala’s past health care initiatives has influenced the state’s decision not to fully implement the PMJAY’s program as it is?

P: Yes, they have had successful previous health initiatives so I think that might have influenced them.

I: What do you think is the impact of deviating from the PMJAY scheme and implementing a varied version of it?

P: KASP-PMJAY is covering more people than just PMJAY, so that is the difference and the impact. More individuals under the BPL are being covered under the KASP program. KASP is providing 2 lakhs at the base line and an additional 3 lakhs with certain provisions.

I: Okay. Do you think there are any drawbacks to the PMJAY scheme?

P: Yes, I do. Let me explain. The Government of India has fixed package rates for treatments/procedures. For example, a certain procedure at a private hospital might be 25,000 rupees. However, the new listed price is 12,000. Do you think a private hospital would accept those charges? No, they are very reluctant. Only 80 private hospitals across the state have accepted to be a part of PMJAY because of this. Our hospital is facing a lot of pressure to be a part of the scheme, but if we bring it and even if we provide the general ward with these benefits, our hospital needs to maintain a certain quality. This will be beneficial in government hospitals, but for private hospitals I don’t know how this will work. In Kerala, they made some changes in the package rates by putting the state share combined with the PMJAY. However, even after Kerala made the adaptations, still the rates that comes under KASP-PMJAY is not really acceptable for most of the major private hospitals. Some of the private hospitals where they did enroll under the program was where they were not really getting a lot of patients and this was a good idea to bring more patients in so the hospital can survive. But even then, most of even the smaller private hospitals also have not shown much interest in being a part of PMJAY. The Indian Medical Association in Kerala is not really for the implementation of PMJAY because it will create a loss of money for most of the private hospitals. Main reason private hospitals cannot do this scheme is because of package rates. They are not against the program, but prices are too low. A package rate can be for a hospital stay for 4-5 days that covers everything, the private hospital cannot charge anything more than that rate. So, we are losing a lot of money from that patient staying that many days and we have to deal with those low prices. It just isn’t realistic. Also, because we are a large private hospital, we have gotten many representatives coming to push us into being a part of the
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PMJAY program because if we agree to it, then many other big private hospitals would do it as well. However, we need to conduct more studies and spend more time looking into it before we can agree to anything to be a part of the PMJAY scheme. We cannot take forward an institution without some kind of a profit, we have tried to look at these package rates and no matter what we are just not able to find ways to break even. We have done cost-effective studies, but it is not possible because we need to maintain our quality. We are for the scheme, but the prices need to be reasonable. They need to work on that first and if those are acceptable, then we would definitely be a part of PMJAY. Another option we had was if we could be selective with the scheme. For example, only our cardiology program was able to find a way that they could work with the package rates provided through PMJAY. So, if there was a way that just that department could use the PMJAY scheme benefits, maybe that would be one way to start getting private hospitals to be a part of the initiative. Because other departments like Radiology, we are using some of the latest high-technology equipment, which is extremely expensive but also why we are able to provide such high-quality care. Additional to that, we have to select highly qualified staff who know how to handle these machines, which is an additional cost. We have that reputation of providing that care, so when the government says do that same care at the low rates that we are telling you- it is just not possible. Also, another problem is that say we were a part of PMJAY, there can be problems because we are such a large hospital and once patients know we are under the scheme we will get a large influx of patients coming in. If we get overcrowded and we don’t have enough beds for patients, there can be problems that arise. So, there are disadvantages to this program. The government also needs to be more efficient in paying back employees/hospitals on time. There are also so many formalities that come with being a part of this scheme, such as lots more paperwork, that will require more manpower. In turn, we are going to have to pay all those people- so there are so many indirect additional costs that are coming into this. That with the low-price rates is just not reasonable to work with. For the government hospitals, the government are providing all the equipment and things, so these public hospitals don’t face the financial back draw that we do. Also, in the case of medicine, the scheme wants to use generic drugs as much as possible. We can start to prescribe them, but who is going to ensure the quality of the drug? There are definitely many problems with this program as delve more into the depths of the intricacies.

I: What are the advantages of the PMJAY scheme? Do you think the PMJAY scheme is beneficial for the targeted population (the poor and the disadvantaged) in Kerala?

P: Definitely, this is extremely helpful for the poor. Overall it is beneficial and is a good policy. However, I have really looked into the minute details and there are a lot of problems that can arise with this scheme that need lots of time to be ironed out. Also, health-seeking behaviors in Kerala and India in general are very high. People are very concerned with their health and going to get help from medical facilities and doctors. The OOPE are catastrophic amongst the poor population, however even if they have to sell their own house, people won’t budge on getting the health care they need. So, for a situation like this, the PMJAY program is definitely going to be beneficial. I would say the scheme is more beneficial in government hospitals than in private. If the Central
government can find ways to rectify the prices and be more reasonable with them, then the program will be even better.

I: How do you think implementing this initiative will affect health outcomes in Kerala?

P: Could potentially help health outcomes, but there are many implementation drawbacks that need to be worked on first. The minute details of this scheme need to be worked on first, because the more you get into it, the more issues start arising.

I: Okay, thank you so much for all your time.
Transcription 4

State: Kerala
Profession Title: Project Manager at a District Hospital

I: Hello. How are you doing?

P: I’m good. Can you explain a little bit about what you will be asking me?

I: Yes definitely. So pretty much today I wanted to ask you some questions about the PMJAY scheme. I am currently working on an Honors Thesis program where I am looking at the rollout of the new PMJAY program in both Kerala and Tamil Nadu. So, I’m travelling to both places to interview individuals who work with the program and get their opinions.

P: Okay okay…I see. Yeah sure.

I: Yeah. Sorry, so to start off I just wanted to ask do you consent to be a part of this research. If it is okay, would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable. Also, everything will be anonymous.

P: Okay, I’ll look at it…. Okay, I can sign.

I: Great, thank you so much. Okay, so the first question I wanted to ask was what is your opinion on the current health care system in Kerala? Could you explain?

P: Regarding the current health care system in Kerala, it is pretty good. There is a large amount of India’s population that lives in poverty. Particularly for them, these public hospitals and PHCs with the three-tiered system works really well and is beneficial. The three-tiered system is focusing on primary, secondary and tertiary care. However, often this system does not work very efficiently. For example, in my opinion, if I were to get sick, I would most likely go to the medical college. I feel that there are higher level trained professionals there and so I don’t really want to waste my time going to these Public Health Centers where there are so many people and you can see people laying on the floor because there are not enough cots and beds for patients. That is a problem I often see at these public hospitals and PHCs. For example, say a normal doctor at a private hospital or higher-level medical college were to see 25 patients per day, these public hospitals and PHCs that are more available for sick, poor patients would have doctors that are seeing roughly 70-75 patients per day. However, there are positives to these PHCs and public hospitals too. These doctors see so many patients that they have a good knowledge of cases that come into the hospital and they are pretty good at giving accurate care. Maybe not so much for specialist care, but for primary/general care- I would say the healthcare system provided in the government hospitals are pretty efficient. One thing is that the government wants the government hospitals to use generic drugs as a prescription. However, in reality, many times the doctors here feel they cannot
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guarantee the quality of these generic drugs, so they may end up prescribing a branded drug. But everything in the government hospitals are free, surgeries are not too expensive – so overall healthcare provided is pretty good. In regard to overcrowding- when you look at private vs. public, 100% you will see significantly higher numbers of crowds at the public hospitals which can lead to some issues.

I: Hmm, okay. So, obviously you are aware of the new AB-PMJAY scheme. I was wondering, why did Kerala choose to adapt that program instead of the full implementation of the program, as it is?

P: In my opinion, I think it has to do with political reasons. But also, between the PMJAY scheme and KASP, there are differences in package rates for procedures and treatments. Kerala also wanted to do an adapted program because there are some specific state additions that they wanted to include. The national government has given states the flexibility on how they want to implement PMJAY. As you may know, PMJAY has the three models: trust model, insurance model and mixed model. Government does direct pay for the trust model, there is usually a cap on government funds and then there is insurance model. Here in Kerala, we have chosen to use the insurance model and our insurance provider we selected is Reliance.

I: So, in your opinion, do you think Kerala’s past health care initiatives has influenced the state’s decision not to fully implement the PMJAY’s program as it is?

P: Yes, past health care initiatives been good for disadvantaged families. Also, programs like the Karunya Benevolent Fund and many of Kerala’s health programs have worked well and benefitted many. But I also think there are political reasons to why Kerala chose to implement it with its own modifications.

I: Hmm, would you say that there is an impact of deviating from the PMJAY scheme and implementing a varied version of it or not?

P: I wouldn’t say there is a big impact from deviating from the PMJAY scheme because through Kerala’s varied implementation more people are getting covered under the program. So, more people are benefitting. Also, the more people that are a part of the program, the less the premium will cost. There are no negative implications from implementing the varied version, only positives.

I: Okay, so in your opinion do you think there are any drawbacks to the PMJAY scheme?

P: Umm… so one thing I see is when discussing PMJAY and private hospitals there are certain things to look at. 1- The salary for employees working in private hospitals are higher. 2- For private hospitals, say they have a number of beds in their general ward and those get filled in by patients who are PMJAY enrolled. These patients stay in the ward for more than a week. Usually the private hospital would get a good chunk of money from each patient for this, but through PMJAY the prices have been slashed significantly. Once the patient is discharged, there is a 15-day gap where we wait for the insurance
companies to pay us back, sometimes there are problems with claims getting rejected and issues can arise. Often times because of a multitude of reasons, primarily the fact that price of running a private hospital is so high and the packages prices provided by PMJAY are significantly lower, these private hospitals are not able to break even. Also, a lot of these private hospitals hold a reputation that they do not want to lose because of the risks involved with taking on PMJAY. So, many of them are not wanting to be a part of it...because it is a loss for them.

I: Yeah.

P: Uh…I’ll also add something. I went to go talk to a private hospital a few days ago. I’m not going to say the name of this hospital, but it is a reputable one.

I: Of course, sure…no problem.

P: Anyway, the people at the hospital said that “look the type of people that come into our hospital are on the more richer side…we don’t want to include these kinds of programs and have more poor people start coming into our hospital…” So, see…if these kinds of mindsets are going to set in…I don’t know…I don’t think it’s a good way to think about things. They basically were saying they didn’t want people from that poor population to start coming in and infiltrating their hospital. So, they said they are not interested in that.

I: Hmm…this was a private hospital that said that?

P: Yeah…these kinds of views are not a good way to look at it in my opinion.

I: So just to clarify, they think that by implementing this program at their hospital- poor people will start coming into their hospital in larger numbers and they don’t think that will look good for them, right?

P: Yeah exactly, that’s what they think. This was just that hospital, I’m not saying every private hospital is like that, but that it is also a scenario that can happen. To go back to what you asked initially- if I were to say major disadvantage to this program- first I have to say that I think this is a brilliant program. Now, structurally…see there is a middleman here who is the insurance provider. So, things also depend on how they decide to handle claim acceptances and rejections and things like that. I don’t know maybe we have to look at states that have not taken up the insurance model and see if there are disadvantages or advantages to that or something…

I: Sure. Okay, so the next question I had was, what are the advantages of the PMJAY scheme? Do you think the PMJAY scheme is beneficial for the targeted population (the poor and the disadvantaged) in Kerala?

P: Yes, I do think it is very beneficial to them. Also, I want to add in that the awareness in Kerala to this program is increasing. Especially, I think compared to other states like Bihar or other states that may not be as developed in health, Kerala definitely has
awareness. Oh…also, so Kerala is running as an enrollment program whereas a lot of other states are entitlement based. So, for the enrollment, you have to remember and register, but for the entitlement- it is given to everyone who fits the qualifications. So, I think the entitlement is easier for the overall people, because for the enrollment you need to make sure you know about it. But because the awareness is high amongst the people mostly everyone knows that on a specific day they need to go and get their Aadhaar identification card and everything.

I: How do you think implementing this initiative will affect health outcomes in Kerala?

P: I’m not sure, but I think it will make them better. This program has just started, it’s so new. It is going to take time, but we have that prior experience with RSBY. This is just a huge, advanced version of that.

I: Yeah, so just to kind of summarize, what is your overall opinion about KASP-PMJAY?

P: I think it is a huge program and that it is honestly brilliant. There are some problems here and there than need to be fixed, but it is so new, I think it will take time to iron out things…but yeah good, I think it will be very helpful.

I: Okay, thank you so much for your time, I know it’s been a while.

P: No problem, this is a good program to talk about. Okay, yeah take care.
Transcription 5

State: Kerala  
Profession Title: Public Relations Officer at a District Hospital

I: Hi, how are you? Thank you so much for your time.

P: Hi, yeah, I’m good. Sure, no problem.

I: Basically, I wanted to ask you some questions about the PMJAY scheme. I am currently working on an Honors Thesis program where I am looking at the rollout of the new PMJAY program in both Kerala and Tamil Nadu. So, I’m going to both states to talk to healthcare professionals and individuals who work with the program to get some of their opinions on the implementation process.

P: Okay, sure. Yeah so what do you want to ask me?

I: Okay, before we start the interview, I just wanted to ask do you consent to be a part of this research? If it is okay, would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable. Also, everything will be anonymous.

P: Yeah it is okay. I can sign.

I: Thank you so much. So, the first question is what is your opinion on the current healthcare system in Kerala?

P: Okay, my general opinion of the current healthcare system in Kerala is that it runs pretty smoothly. Back then, there was the RSBY program that we had in place, Rashtriya Swasthya Bhima Yojana. This was a pretty good program. Starting recently is when the Prime Minister put in place this new PMJAY program. And in general, Kerala has a pretty efficient system. There are of course some drawbacks, but still runs well in totality.

I: Okay, so since you are aware of the PMJAY program, I wanted to ask why Kerala choose to adapt that program instead of the full implementation of the program, as it is?

P: Okay, this PMJAY program, here in Kerala is known as KASP, Karunya Arogya Suraksha Paddhati. There is not really that much of a big difference between the two. Main difference between this KASP and PMJAY is that this Ayushman Bharat is something that is going on all across India. For Ayushman Bharat, the Central government is paying 60% and the State government is paying the remaining 40%. So,
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this is covering a large number of beneficiaries- I don’t know exactly but I think that PMJAY is covering somewhere around 18 lakh people here. However, apart from these beneficiaries for the other under this KASP, for an additional 22 lakh beneficiary families, Kerala is also giving an additional money. And for this, the entire amount of money being given for the families is coming entirely from the State government. So basically, main difference is, compared to just PMJAY alone through this KASP-PMJAY program, more families and people are getting covered and receiving benefits. And for these additional families getting covered from KASP, the state government is paying 100% for it. The amount these families are receiving are the same from PMJAY and KASP, but KASP is just covering a greater number of families. So, this reason is why Kerala chose to modify the PMJAY program to make it their own.

I: Do you think Kerala’s past health care initiatives has influenced the state’s decision not to fully implement the PMJAY’s program as it is?

P: So, this KASP includes the Karunya Benevolent Fund and that got merged into this. So, if patients were previously under this KBF program, they can go to the Karunya offices and then if they are identified as being BPL based on the qualifications- then that whatever amount the doctor says is eligible gets sent to this Aadhaar hospital and they transfer those funds to here. Under this new KASP program, if one person from a beneficiary family comes to our kiosk, they tell us their identification number they get when they register for their Aadhaar card. They don’t even need to tell us the card or bring it in, they can even give us their mobile number and then we can register them and then the way the treatment in our hospital works is that if that patient is admitted, then we do all the necessary things we can that we have the facility for in our hospital free of charge. Now, say the patient needs something that we do not have facility for in our hospital- could be a MRI, CT scan, ECG, lab tests…anything of the sort…So, if we cannot do it at our district hospital, then we will get it outsourced to another larger hospital that has the facilities that we have a working agreement with. This is free of charge to the patient. For example, so at our hospital last year some patients needed urine culture lab testing. That is something we do not have the facilities for in our government hospital here. So, we had to send it out to a private hospital. So, we send the patient with a form/slip that says they have this Aadhaar card to the facility that we have an agreement with, so the testing can be completed. Once the patient shows them this slip that says they are a KASP-PMJAY beneficiary, the private hospital facility lab people will not charge them, and the patient will get the service free of charge. Then, if this occurs for a lot of patients where they have to go to private hospitals for certain testing because government hospitals do not have all the necessary facilities for certain testing procedures, then at the end of every month, these private hospitals will send us, the government hospital, a bill with the attached slips and bring it to us. Basically, what I’m trying to explain is that if a patient enrolled in this KASP-PMJAY scheme comes to us, then no matter what, even if they have to go outside of our hospital for treatment because we may not be able to provide it for them, they will not have to pay anything out of their pockets.

I: Wow, okay. So, do you think there is any sort of impact for Kerala for deviating from the PMJAY scheme and implementing a varied version of it?
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P: No, I don’t think there is any negative impact. Kerala’s varied version is just covering a larger span of people, like I had mentioned. So, I don’t think there is really any major impact from deviating from the Central governments scheme and implementing a varied version of it.

I: Okay. Do you think there are any drawbacks to the PMJAY scheme?

P: One of the main drawbacks is that this PMJAY program is being used in government hospitals, but it is not happening in private hospitals. When a patient registered under KASP-PMJAY comes into our hospital for a C-section, at our hospital we get 12,000 rupees as sanctioned by the government as the listed package rate. So, our hospital gets this listed amount and we do everything necessary for the patient. Everything that is done to the patient in the time they are admitted as in-patient...everything is covered, and the patient will not have to pay anything out of pocket. However, anything performed out-patient is not covered. Any of those tests, they will have to pay out-of-pocket. But, the entire period from the time the patient is admitted to the discharge plus also including medication for 5 days post-discharge, everything is fully covered for 12,000 rupees. Now, if you compare this to how much this whole C-section stay would cost at a private hospital...from what I know there are private hospitals out there that take anywhere from 50,000 rupees to 1.5 lakh for a delivery. So, say for example a patient who doesn’t have an Aadhaar card walks into a private hospital for a delivery, that hospital is getting 50,000 rupees. If a patient with an Aadhaar card goes to the private hospital for a delivery, the private hospital can only charge 12,000 rupees because that is the government established rate. So then, that private hospital faces a 38,000 rupees loss because of this. Due to this, the private hospitals are not likely to be a part of this because they don’t want to have to endure financial losses such as this. Now, when it comes to the government hospital with this same situation. At a government hospital, no matter how much we do labs and include the actual delivery procedure, the most the delivery charge comes out to is around 4,000 rupees. So, the government hospital is paid 12,000 from the government via the insurance provider because as I mentioned that is the set rate. However, since the hospital was able to complete the entire procedure with only 4,000 rupees- the government hospital is then getting a profit of 8,000 rupees. So, this is extremely beneficial for the government public hospitals. So, that is where the difference comes in. For the private hospital, they had a large loss of money whereas the public hospital was able to make a profit. For the private hospitals the main problem is, the charges they have set for procedures and treatments is drastically higher than the set charges that have been established for procedures and treatments for Aadhaar card holders. So, for them this is not something they can be a part of. Also, one thing you should know these claim procedures are very important. If an insurance company rejects a claim because they suspect any sort of malpractice going on... once they reject that claim, the hospital has to bear that loss. These issues don’t usually happen in government hospitals, but more in private. But also, I don’t know if this whole issue is a huge drawback for the program because even if you cannot go to a private hospital, you can still get good treatment at a government hospital. The only issues in government hospitals is the overcrowding and lack of staff, but you can still get good treatment.
overcrowding also happens because at government hospitals a doctor might have to see 125 patients per day. When that happens, crowds start building up. But at a private hospital, a doctor may say I can only see a maximum of 90 patients today and that is the limit, so there will be less people there and not many crowds.

I: Oh wow.

P: Also, more and more people are starting to go more to government hospitals. Private hospitals are still somewhat expensive for families even with the card because not many big private hospitals have taken up this PMJAY scheme, so it’s not really useful in that sense. In our district, only one hospital has become PMJAY empaneled. On the other side for families with the Aadhaar card, at a government hospital they barely have to get charged anything, so it is really good.

I: Interesting. What are the advantages of the PMJAY scheme? Do you think the PMJAY scheme is beneficial for the targeted population (the poor and the disadvantaged) in Kerala?

P: Absolutely no doubt. I think it is very beneficial for the poor population and is extremely useful for the very disadvantaged individuals. Working in this government hospital for a while, I can tell you personally I have seen poor individuals come with nothing, because they don’t even have food to eat. For them, a program like this is something that is such a blessing for them and means more to them than to an individual who is well off. So, yes, it is extremely beneficial for that population living BPL.

I: My last question is how do you think implementing this initiative will affect health outcomes in Kerala?

P: I think it will help outcomes become more of the poor population will be able to get the treatments and procedures they need because now they can afford it. Previously, there was no way they could afford any treatments at a private hospital due to the high charges, but now with this card at least they are being given a chance. This program is really wonderful. Everyone has to work properly and without any corrupt motives and then this program will work smoothly as it continues to roll out.

I: Okay, that’s everything I have. Thank you so much for explaining everything in so much detail, I really appreciate it.

P: No problem, hope this helped.

I: Absolutely, thank you again.
I: Hi, how are you? Thank you so much for your time.

P: Hello, I’m fine. Sure.

I: So, I wanted to ask you some questions about the PMJAY scheme. I am currently working on an Honors Thesis program where I am looking at the rollout of the new PMJAY program in both Kerala and Tamil Nadu. I am going to both states to talk to healthcare professionals and who work with the scheme to see what their opinions are regarding the implementation process. Before we start the interview, I just wanted to ask do you consent to be a part of this research? If it is okay, would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable. Also, everything will be anonymous.

P: Okay. Sure, I can tell you what I know. Sorry only thing is, I’m in a bit of a rush because I have to head out to see a patient, but I can quickly answer your questions.

I: I’m so sorry, okay thank you so much. The first question is what is your opinion on the current health care system in Kerala?

P: I would say that the overall healthcare is very beneficial. Kerala is a state that is very advanced compared to many others. You can see that in its economic standing, literacy levels and other statistics similar to that.

I: Okay, so are you aware of the new AB-PMJAY scheme? If so, why did Kerala choose to adapt that program instead of the full implementation of the program, as it is?

P: Yes, I think Kerala chose to adapt the program to KASP-PMJAY because they are covering a larger number of people in comparison to just AB-PMJAY.

I: Do you think Kerala’s past health care initiatives has influenced the state’s decision not to fully implement the PMJAY’s program as it is?

P: Kerala’s past health care initiatives have been pretty good. Programs like RSBY and KBF have done well and benefitted people, so maybe that is why Kerala decided to implement it in its own way.

I: What is the impact of deviating from the PMJAY scheme and implementing a varied version of it?
I would say the only impact really is that more people are getting covered. So, it’s a positive impact. I don’t think there have been any negative impacts from implementing it in Kerala’s own manner.

Do you think there are any drawbacks to the PMJAY scheme?

I think the fact that not many private hospitals are willing to implement the program is a major drawback. Government hospitals see a lot of beneficiaries daily, but I don’t think private hospitals are engaging with this scheme much because the rates decided by the government are too low for them to work with.

Okay, what are the advantages of the PMJAY scheme? Do you think the PMJAY scheme is beneficial for the targeted population (the poor and the disadvantaged) in Kerala?

Absolutely. Because I see a lot of patients that come into our hospital who are Aadhaar cardholders. A lot of people come to government hospitals and it can get quite overcrowded, because a lot of people come to government hospitals with this card and they can get good treatment and they don’t have to pay anything. Now, they can also get treatments or procedures done at private hospitals too with this card. So, I think it is very beneficial for that population living BPL.

Sorry, I have to head out in a minute. Do you have any more questions?

Just one last question. How do you think implementing this initiative will affect health outcomes in Kerala?

Hmm, I think the initiative could potentially help increase health outcomes.

Okay, thank you so much for your time.

No problem. All the best.
State: Kerala  
Profession Title: Minister Directly Working With KASP-PMJAY

I: Hello, how are you. Very nice to meet you. Thank you so much for your time.

P: Hi, please sit. So, what did you want to discuss?

I: So, primarily I wanted to ask you some questions about the PMJAY scheme. I am currently working on an Honors Thesis program where I am looking at the rollout of the new PMJAY program in both Kerala and Tamil Nadu. So, I’m going to both states to talk to healthcare professionals and individuals who work with the program to get some of their opinions on the implementation process. So, I wanted to get your opinions.

P: Okay sure.

I: Okay, before we start the interview, I just wanted to ask do you consent to be a part of this research? If it is okay, would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable. Also, everything will be anonymous.

P: Okay, yes, I can sign.

I: Thank you so much. So, my first question is what is your opinion on the current health care system in Kerala?

P: I would say the current health care system in Kerala is excellent on its own. The Kerala model is very advanced and one that many other states look up to. We are actively building upon the system even more so we can provide even better care. But Kerala on its own is very advanced and the services we provide are excellent.

I: Okay. Are you aware of the new AB-PMJAY scheme? If so, why did Kerala choose to adapt that program instead of the full implementation of the program, as it is?

P: We don’t want in fact an insurance program in Kerala. We stand for publicly provided universal healthcare system. Kerala doesn’t need an insurance system because ideally, we stand for a publicly provided universal healthcare system. So, we invest in every health sector. There is also the private sector in Kerala. Because our tertiary sector has developed to meet the new lifestyle disease challenges. Because of the challenges in tertiary health care system, private sector remained in the system. Then in this context the government introduced the universal health care insurance program. Now, they cover only 18 lakh families in Kerala. That is totally inadequate. But nevertheless, we cannot say no to that because if we say that- the money we lose is only 100 crores or something, but the kind of political propaganda that will take place by doing that will not be
accepted. So, we try to make this insurance program and make it a more concrete situation in Kerala. That is, say we have to have much larger coverage than 18 lakh families and instead make it so that it covers roughly 42 lakh families, which is half the population in Kerala. We want to structure the fees and procedures in such a manner that the public health system would benefit from it. We are not going to subsidize for the private health system. So, unless they match relatively low service fees that are better for the private, the focus will be on the public health institutions. So, these are the two things. We have the larger coverage and we want to give additional pumping up of other services and Ayushman Bharat. So, that is why we have now designed this KASP program. This coverage is 42 lakhs, much larger than the 18 lakh the PMJAY is offering. We are going to prop it up by providing many more procedures and some diseases that are not covered by Ayushman Bharat. And also pay for investigations, etc. and not just in-patient. Often times, the investigations will be done before the patients are admitted as in-patient, so none of that gets covered under PMJAY and the patient will have to pay OOP. But we want that to be covered too under the Kerala version. So, these components will be the assurance model. Okay? The government will pay accredited hospitals additional money for this. And then there are families, households that are outside the 42 lakhs, who are eligible for the Karunya Benevolent Fund that we have in Kerala. So, say in those families whose annual income is up to 3 lakhs, they were assured of certain support up to 2 lakh rupees once in a lifetime. Not every year, but once in a lifetime. This is going to continue. So, under our Kerala modified version of PMJAY, it is a much larger scheme. Total cost of it will be something like eligibility in something like 700-800 crores and the central government gives 100 crores.

I: Do you think Kerala’s past health care initiatives has influenced the state’s decision not to fully implement the PMJAY’s program as it is?

P: We are not implementing Ayushman Bharat as it is, but only with our own terms. We are covering more people; Kerala has accounted for more than 40% of nationwide claims that were under the previous RSBY initiative. RSBY- CHIS was already covering 40.9 lakh families where as PMJAY was covering 1.85 lakh. If things are working well for us here, why wouldn’t we implement this program in our own manner.

I: What is the impact of deviating from the PMJAY scheme and implementing a varied version of it?

P: It is covering more people because we made it KASP rather than just PMJAY which would not have covered this many people. Our approach is very good. It covers a lot more. The central government has things like the Health & Wellness center and all. It’s all bogus. You put 1,000 crores for the entire India, we are not going to get any productive wellness centers. The only place any concept of good Wellness centers being implemented is in Kerala where we are transforming out PHCs to Family Health Centers which are staffed well now and provide care. There is only something like 1,000 PHCs in Kerala and now we have converted around 400 of them into Family Health Centers. We are also very rapidly expanding the tertiary sector, as well. Kerala is spending something
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like 5,000 crores in the tertiary facilities. We are also creating new facilities in the tertiary sector so we can meet the new challenges that occur.

I: Do you think there are any drawbacks to the PMJAY scheme?

P: See, universal health insurance doesn’t make sense if it is to be given by the state government. I don’t understand why the state government has to give such a large chunk of money…it doesn’t make sense. The central government can, they can invest in the health system directly instead of going through an insurance company giving the amount. We are forced to take this route because of the central government brought in insurance which we cannot politically reject. So, we are struggling to design the insurance in such a way to suit our public health system. To be blunt, a lot of all this is political reasons. If I am honest and being given the freedom, I will say I don’t want this PMJAY insurance program. The central government gives 60% of the insurance premium for 18 lakh totals. That will come to something like 80…90 crores. Round to 100, let’s say. But if your premium is much higher…like Kerala’s is, 1,600, the total premium the central government will accept it only 1,000. So, we have higher premium, then we are covering an additional 42 lakh people. So, 42 lakh- the 18 lakhs…that we are covering. Plus, now we have additional services that we are providing. So, Kerala state is spending 750-800 crores. And central government is providing us with 100 crores only. 80-85% of burden of insurance scheme is on Kerala…So, it doesn’t make sense at all. The only real reason that Kerala joined this is for purely political reasons. The central government wants to make a show that they can have this huge health system in India, and they want to push that responsibility onto some insurance company. Unless you have a good primary health care system, these insurance schemes don’t really mean anything.

I: What are the advantages of the PMJAY scheme? Do you think the PMJAY scheme is beneficial for the targeted population (the poor and the disadvantaged) in Kerala?

P: Kerala model is good enough on its own and I don’t think this PMJAY program is something we need at all. From all the things I have been explaining, I don’t think this PMJAY is a beneficial system. There are lots of problems with it. The problem with PMJAY is that the state is going to have to carry 80% of the expense so the entire financial burden is falling on the state, but the whole credit of everything is going to the central government.

I: Okay. How do you think implementing this initiative will affect health outcomes in Kerala?

P: One thing is that the public health system used to be weak. Therefore, for all these lifestyle disease problems- people were going to private hospitals where the charges were exuberant. We are expanding our presence the lifestyle disease sector. Now, the public health hospitals are able to meet the demands of treating these lifestyle diseases. In general, we are actively expanding and creating more facilities. And Kerala has been fixing the rate for treatments/procedures relatively low. So, if the private sector wants to come, they will have to work with that. So, it will bring down the cost of health care in
Kerala. That is what we are attempting to do. But meanwhile, there will be some hitches. Because now, the middle level hospitals which were previously a part of RSBY, are staying out of it and trying to bargain. We cannot really work with that. Sooner or later, they will have to come under it. Now, a lot of people are going to government hospitals in comparison to private hospitals because the public health system is getting better. We are not ousting the private sector; they are also good. But things need to be addressed about the high charges there. These big private hospitals are very reluctant to come in, because we were having this system for catastrophic diseases called Karunya. We accept whatever procedures the prescribe. So, they want that to continue. We said no. We have paid the insurance premium for 42 lakh people, now you cannot have a parallel assurance system. Honestly, I think later on all these big private hospitals that are saying no to joining the KASP-PMJAY scheme will come under it sooner or later. Otherwise, they are going to suffer. It will be a big burden on them, but nevertheless, it is going to be important to ultimately bring down the cost of health care in Kerala.

I: Okay, that’s all the questions I had. Thank you so much, once again, for your time.

P: Sure, all the best.
State: Kerala  
Profession Title: Public Relations Officer at a Government Medical College

I: Hello, how are you doing today?

P: Good. Yes, so what is the topic about?

I: So, pretty much I wanted to ask you a few questions about the new PMJAY scheme that has been implemented. I’m working on an Honors Thesis program where I am studying the rollout of the new PMJAY program in both Kerala and Tamil Nadu. I’m going to both states to interview healthcare professionals and individuals who work with the program to get their opinions on PMJAY’s implementation process.

P: Okay okay.

I: I just wanted to ask you- do you consent to be a part of this research? If you do, would you be willing to sign this consent form for my college? You can take a look at the document first to see if you are comfortable with everything. Everything will be anonymous in the paper.

P: Yeah, fine.

I: Okay, thank you. So, the first question I have is what is your opinion on the current health care system in Kerala?

P: I would say the current health care system is pretty good in Kerala.

I: Are you aware of the new AB-PMJAY scheme? If so, why did Kerala choose to adapt that program instead of the full implementation of the program, as it is?

P: So, they can cover more people. Government colleges, general hospitals, Lisie hospitals, Taluk hospitals- they are all in this PMJAY program. They are required to be under it. Hospitals with inpatient is where this program has benefits. For the outpatient, there are no real packages or benefits, so patients only benefit when they are admitted as inpatient. OP cover few items. CFC has started. Some taluk and district hospitals and medical colleges too have it.

I: Do you think Kerala’s past health care initiatives has influenced the state’s decision not to fully implement the PMJAY’s program as it is?

P: So, Comprehensive Health Insurance Agency was administering the old RSBY. Now it is converted to the scheme, CHIS. State government is implementing CHIS. Those who are covered under RSBY will get benefit through that program. Those who are in the BPL list will get coverage through the State’s KASP program.
I: What is the impact of deviating from the PMJAY scheme and implementing a varied version of it?

P: This scheme is very beneficial for the poor population. Last year itself there was coverage of Rs. 80,000 rupees but based on number of members in the family. But now it is 5 lakhs irrespective of the number of members in the family and more people are getting covered under KASP.

I: Do you think there are any drawbacks to the PMJAY scheme?

P: I don’t see any major drawbacks. Medical colleges are in the scheme and it is helping the people. Lab test, CT Scan, medicine, MRI are all free. Kerala is more government oriented, but accredited private hospitals can join the program if they wanted to. Also, empaneled private hospitals can join if they desire to join. Since the rates are low and they worry that they may have to incur losses, private hospitals are reluctant to join the program now. That might be a drawback. Also, if any claims get rejected, the hospital is the one that loses money. So, that also is a drawback.

I: What are the advantages of the PMJAY scheme? Do you think the PMJAY scheme is beneficial for the targeted population (the poor and the disadvantaged) in Kerala?

P: 90% of the patients coming in have cards. People can go to government hospitals or empaneled private hospitals and with the card, they can get the same treatment based on MOU with state government and the empaneled hospitals. In certain districts with lots of poor people, this program is very beneficial. But in districts where people can afford more, they will go to private hospital because they prefer that, but medical college will provide service with the card. In private hospitals and medical colleges, the hospital and empaneled doctors decide their rate for surgery, treatment etc. and their rate could be higher compared to government hospitals. That is why private hospitals say they cannot afford to be in the program. But private hospitals with MOU with the state government will do the service under the program with its established rate.

I: Okay. How do you think implementing this initiative will affect health outcomes in Kerala?

P: I think it will help them. This program is more successful in certain districts because of the poor population and fewer private hospitals in comparison to other districts. In places like Trivandrum, even though there are lots of card holders, many go to private hospitals because of the availability of several private hospitals. More people are making use of the program in Kerala compared to Tamil Nadu because of the poor population in Kerala. Tamil Nadu also has poor people but have more facilities in the metropolitan areas.

I: Okay, thank you so much for your time.

P: Yeah, sure.
Transcription 9

State: Kerala
Profession Title: General Practitioner at District Hospital

I: Hello, good morning.

P: Hi. So, this is regarding the PMJAY scheme? This is for what?

I: Yes, I primarily would like to talk to you about PMJAY. I am working on an Honors Thesis program where I am looking at the rollout of the new PMJAY program in both Kerala and Tamil Nadu.

P: Okay, yeah. I can talk to you a bit about it based on what I know.

I: So, to start off I just wanted to ask do you consent to be a part of this research? Would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable.

P: I need to look at the paper before I sign.

I: Sure, here you go. Oh, also this is all anonymous. No names will be used.

P: Fine, yeah okay.

I: Thank you so much. Okay, so basically, I wanted to start out by asking what is your opinion on the current health care system in Kerala? If you could explain more about that?

P: Kerala has the maximum health care facilities in India. We always speak about Kerala model Healthcare. I think you are aware of it, right. Our health indicators are better than national level. You take communicative disease, children mortality rate or even male to female sexual disease, they are all comparatively low in Kerala and other states always look up to Kerala as a model state when it comes to healthcare.

I: Hmm.

P: You know why our healthcare is good in Kerala, because we have a good grassroot level activity. To begin with, we have ASHA, Advocate Social Health Activist group, to help roughly a population of 1000 in our panchayat. Like that, there are 13 Ashas and one person from that community who is well known to everyone would be selected as the Asha worker. She would know what is happening in that community and will be able to help them to address their health matter to the nearest Primary care hospital where the 1st primary care doctor will be available for them. The whole panchayath will come under that primary care doctor who can oversee that panchayath community with the help of
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this lady. That is, the grassroot level set up and thus every panchayath will have at least one primary health center and bigger panchayaths will have more than one Primary care hospital which will all be taken care and fully supported by the government. Then besides Asha, there will be 3-4 sub centers who will be taking care of another 5000 population through the primary health center. These health centers will be managed by a Junior Health Inspector and a Junior Public Health Nurse. The inspector will take care of communicable & non-communicable diseases and the health nurse will take care of all perinatal/general care related need of patients. Five to six of these units would be managed or taken care by this medical team which will come under the wing of a medical community health center where one can get both preventive and emergency treatment care. This would be the 2nd level unit and unlike the Primary care, this will not be based just on a preventive aspect. Primary care is mainly concerned on Preventive aspect whereas the community center, the 2nd level will be dealing with both preventive and treatment aspect in its equal terms. If they can’t manage the treatment at the community level, then Taluk headquarter hospital will be the next choice which should preferably be in a Municipal area. Taluk will have all facilities and would function as a specialty hospital care and if it doesn’t work out, case would be referred to a District and then to the General hospital which are both super specialty hospitals, District hospital are managed by politicians whereas the general hospital would be managed by bureaucrats or by District collector directly. This is the health care system model controlled by the government. Now, these government medical system cater to only roughly 40% of the general population and that is when the significance of private hospitals comes to play when the 60% of the population would seek medical help from these private entities. They would focus on the treatment aspect of the larger percentage of population since the private sector hospitals are not interested in the preventive aspect. Their finances and health indicators are good and can pay their doctors, nurses, ICU’s and technicians etc. The treatment quality in these private hospitals are superior to none and people realizing that quality doesn’t come free wouldn’t mind paying to get treatments there. People come from all over the world for treatment at these super specialty private hospitals not looking for a cheaper, but for a quality treatment.

I: Okay.

P: Also, there are differences between government versus private regarding quality treatment and cleanliness and better facility. For example, you come to a Taluk hospital at midnight with appendicitis, only causality medical officer will be there, and surgeon had to be called in whereas in a private setting, there is a difference in providing the medical service. In a government Taluk setting, there is no cardiologist in the emergency whereas in a private setting there might be at least 4 cardiologists on site. Government mainly provides primary or secondary or casualty care and when it comes to specialty care and treatment. Roughly around 60-65% of Keralites seems to be going to Government hospitals. It is the private sector that is easily accessible with a higher fee with exception of few specialty government hospitals and institutions Kerala. These are at par government hospitals which can compete with private but is not in every one’s reach.
Are you aware of the new AB-PMJAY scheme? If so, why did Kerala choose to adapt that program instead of the full implementation of the program, as it is?

Kerala is far ahead in the health care system offering a quality care and maintaining a very successful health care system of its own and why should we implement the central government scheme and lower the healthcare quality. PMJAY program is advantageous to other Indian states, but not to Kerala as it is way ahead with high health care standards and thus will not be beneficial to Kerala. Why Kerala is not implementing the program as full is because they are not getting adequate money. Kerala is not implementing program because central didn’t provide adequate funding to the service provider to move ahead and then when Kerala tried to implement, central would reduce the funding saying that satisfactory tech implementation have not been completed. So, Kerala found it very impractical to fully adapt to this program. Hospitals had to collect the fees from the patients to stay functional and for those who couldn’t afford, had to go to the general medical college and be satisfied with the health care options there. So, that’s the answer to your second question.

Do you think Kerala’s past health care initiatives has influenced the state’s decision not to fully implement the PMJAY’s program as it is?

This PMJAY was initiated to improve the health status of the nation and to reduce the mortality rates. In 2007, government has developed an initiative called National Health Mission and it had passed its 1st & 2nd phase & 3rd phase is going on currently. What happens is that every government official will have his or her own delegation of power for financial management whereas the National Health Mission, which is a government agency doesn’t have that power, so all the finances to health services are routed through them. It is easier to utilize the central funding for states like Bihar with a health indicator rate of roughly 30% to move up the scale when Kerala’s health indicator is already set high with roughly 80%. Thus, Kerala had to develop its own health system without central government’s help as it had already established a higher health indicator. So, states like Kerala won’t benefit from this government plan unless central government change its plan to help states with high health indicators. At the same time, the private hospitals in Kerala cannot afford to offer low cost treatment and lose money as the central funding and premium is very low with financial restrictions that private hospitals cannot afford to accept that plan to treat the population that it is supposed to benefit from the scheme. The hospitals that tried to accept patients from the National PMJAY plan haven’t received any money from that scheme and thus that scheme never got popularized in Kerala.

What is the impact of deviating from the PMJAY scheme and implementing a varied version of it?

Very simple, in Kerala, we are far above that scheme and didn’t anticipate any major benefit to adapt the PMJAY scheme.

Do you think there are any drawbacks to the PMJAY scheme?
P: PMJAY program is not a disadvantaged program, it just wouldn’t work for Kerala as it is a small state with higher standards of health indicators. Kerala doesn’t need this program unlike the other bigger states of India. That is why Kerala adopted to something different of its own and it is working out very effectively. Kerala is more advanced in health care and have not had to face the same communicable diseases the other states had to manage to eradicate. This small state is very efficient in controlling and quarantining situations beyond control. People in states like Bihar are still going through nontraditional treatment methods because unlike Kerala, they don’t have enough doctors to cater to their needs.

I: In comparison to the PMJAY’s program, do you think the state’s current program is more beneficial for the targeted population (the poor and the disadvantaged) in Kerala?

P: Yes, obviously, they will benefit more.

I: How do you think implementing this initiative will affect health outcomes in Kerala?

P: I will give you two to three examples on that; India is the top list as a TB testing provider and responsible for 90% of the testing capability. Also, India being a largely populated country does not panic over measles or any Pandemic spreads, but rather would manage such outbreaks and handles it very effectively unlike the other parts of the world. See, Kerala is very advanced with 100% literacy rate and with many super specialty hospitals and doctors and with a population of superior healthcare awareness. For example, in Kerala, you can hardly see a case of protein energy malnutrition compared to other states. Health indicators and quality care are improving in Kerala and far ahead of other Indian states especially in the North. Tamil Nadu is trailing just behind Kerala. So, the PMJAY program would definitely work in other parts of India where doctors and facilities are lacking and are inhabited with a population with limited healthcare awareness.

I: Okay, thank you so much for all of this.

P: Yeah, welcome.
State: Kerala  
Profession Title: Health Official of a Prominent Cancer Center

I: Hello, thank you so much for your time.

P: Hi, sure. No problem. You want anything to drink?

I: No, thank you so much.

P: Okay. So, what did you want to discuss?

I: So basically, I wanted to ask you some questions about the PMJAY scheme. I am currently working on an Honors Thesis program where I am looking at the rollout of the new PMJAY program in both Kerala and Tamil Nadu. So, I’m going to both states to talk to healthcare professionals and individuals who work with the program to get some of their opinions on the implementation process.

P: Okay, this is for your university? Is this basically about KASP?

I: Yes, exactly. Pretty much about KASP.

P: Okay okay. Because we are having lots of meetings about it recently, since we are going to be implementing it here soon. We have agreed to it and everything. Okay.

I: Oh wow, I see okay. Um, before we start the interview, this is something for my college. I just wanted to ask do you consent to be a part of this research. If it is okay, would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable. Everything will be anonymous.

P: Let me look through the document. Okay, so names will not be printed, right?

I: No, no names will be printed.

P: Alright. Here you go.

I: Thank you so much. So, the first question is what is your opinion on the current health care system in Kerala?

P: The current health care system here is pretty good. In Kerala we have an advanced system put in place already. We rank the highest in many health indicators and the type of quality of health care we provide is extremely high.

K: Are you aware of the new AB-PMJAY scheme? If so, why did Kerala choose to adapt that program instead of the full implementation of the program, as it is?
P: So basically, KASP is covering more beneficiaries than PMJAY is. It also has to do with the 60% central government and 40% state government funding. When PMJAY looked into Kerala situation, they found that Kerala has double the people below BPL. That is what Ayushman Bharat found out. I don’t remember the exact number. But the central government cannot pay insurance for that many people. So, Kerala state took over that costs. That is Kerala’s responsibility alone and not the central governments. So, under KASP, Kerala is paying more premium. I think something regarding PMJAY covering 20.54 lakh families, but Kerala state is covering an additional 19.4 lakh families and they are paying full for that on their own. So, we worked with central government and we changed the name to KASP-PMJAY. Because basically it is reversed where it is like 60% to 70% Kerala and the remaining 40% central government. Pretty much PMJAY was modified in the Kerala manner because Kerala contribution is a lot more because our population here is almost double. So, we renamed it as KASP and are providing a wider coverage.

I: Do you think Kerala’s past health care initiatives has influenced the state’s decision not to fully implement the PMJAY’s program as it is?

P: In Kerala, there is Karunya Benevolent Fund that the government started earlier. That began with a lottery initiative to generate the initial funding to treat cancer, renal diseases etc. For non-cancer treatment, government used to provide fund to private hospitals. But what happened was, a week ago the Karunya fund was suddenly stopped. Reliance was the insurance company. 1,200 rupees/patient was the premium Reliance quoted. KBF’s money was being used as the premium for all the patients. All government hospitals and premium medical colleges came under the KASP scheme two months back. Hospitals under the Kerala government health services and all government medical colleges are all pretty much under the KASP-PMJAY program for the past two months or so. KASP is inviting private hospitals, but they haven’t joined yet. Also, the three autonomous cancer centers are still standing at the periphery. Autonomous means we generate our own income, but the state will also subsidize us. In government hospitals, general and Taluk hospitals, Kerala government looks after the salary and other expense to run our patient costs. So, even if KASP has a loss, the hospitals don’t have to pay, government will absorb the loss. For us, it is not like that. Treatment rates for KASP are created by the central government. It is not acceptable in cancer centers. The problem with implementing this is that the treatment rates that they have formulated. They have formulated these rates in Delhi without working with any major cancer centers or anything. These KASP-PMJAY package rates are just not acceptable. But the state has signed a MOU with the central government, so we are forced to join the scheme because we are a government hospital. But we are going to have a huge deficit of about 100 crores under this plan in a year with this KASP-PMJAY being implemented, with these package rates they have given us because they are abysmally low. It is going to be such a huge deficit. We have calculated this cost. The government has gone back and forth to debating whether or not they should support us. Finally, the government said they will support us with the huge deficit. We have not gotten any details about this, but they have said that they will. We are in this because Kerala signed the MOU, we are basically
Implementation of India’s Health Reform Program

forced to be a part of the PMJAY program because we have no option. There is another facility in Kerala that focuses on heart and brain diseases. They are the central government’s autonomous institute. Technically, even though they should be signing onto KASP-PMJAY, because they are not under the state government and the package rates are not acceptable for them, they did not sign on to be a part of the scheme because they were not forced to since they are not under Kerala government control. But as of what we have heard latest, the Kerala government has said that they will support us. The rates agreed upon by the Central government and company people are so desperately low that cancer centers like ours cannot recoup the costs of providing the medical services.

I: What is the impact of deviating from the PMJAY scheme and implementing a varied version of it?

P: Like I said, here Kerala is having to pay more like 60% state and 40% central government, because we are giving more coverage. Usually in other states, the ratio is split as 60% central and 40% state. Poor people who come under the KASP-PMJAY will not have to pay a thing, so it doesn’t really affect them. For them this is good.

I: Do you think there are any drawbacks to the PMJAY scheme?

P: The main thing is these package rates. The rates are so desperately low. The rates agreed upon between the central government and the companies are just unbelievably low. In places like Bihar and Jharkhand, places where patients might not be getting anything, this scheme is useful. But in places like Kerala, where we already have a standard quality of care being provided, I just don’t understand how these package rates are reasonable. One of the main things we see here is breast cancer and lung cancer. So, the rate that we have gotten from the insurance company for a breast cancer surgery is 14,000 rupees. We are a no profit motive facility. Our rate for the surgery is 35,000 rupees. This is the minimum amount for a breast cancer surgery. What we are getting back is only that 14,000. We are getting a loss of 24,000 rupees. Chemo with treatment for our rates is 40,000 rupees. Under KASP it is 20,000 rupees. Basically, double. Only the radiation therapy rates were acceptable and reasonable for us. For many cancers, for chemotherapy, KASP-PMJAY haven’t even listed any medications. For every cancer, we have looked at anticipated deficit which is 10.56 crore for just breast cancer. For lung, deficit would be around 13.15 crore because there are more patients affected. For lung cancer surgery if it is at an operable stage, KASP-PMJAY rates have given 60,000 rupees. For our hospital usually, the rate is 1 lakh. For lung cancer, chemo is necessary often. Our chemo rates are 74,000 rupees. KASP-PMJAY has listed their rates as 0. How would a cancer specialist come up with these rates? Who decided on these rates? They should have gotten top-tier cancer specialists and consulted with the leading cancer hospitals to come up with the package rates so it would have been more realistic and reasonable to work with. They have formulated these rates without doing any of that, which is such a huge drawback to this whole program. That’s why one of the most leading cancer centers in India has not joined the PMJAY program until these package rates have been modified to be more reasonable. The insurance is only for one year, so for next year a new package is being formulated. They are only potentially modifying these package rates because they are low and all
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across India, many private hospitals are not joining PMJAY for this reason. There is a
gap between reality and the prices they have provided for us. In places with populations
who get no treatment and have very poor health care systems, getting these packages
where the central government is paying for free with the state government is good. But
here, we are already providing a standard of care. We are having to cut down that
standard of care to work with these package rates. Also, all testing and investigation that
occurs as an outpatient will not be covered and will have to be paid OOP. Only once the
patient is admitted and is inpatient will the PMJAY benefits be valid. The thing is that,
when it comes to cancer for radiation and chemo, even if it is done on an outpatient basis,
insurance will pay. This is because chemo and radiation are usually done outpatient here,
they are not admitted. However, until the diagnosis is established, all investigations prior
to that are not covered at all. For cancer, these investigations usually rack up to a very
expensive amount, not like other diseases. For example, the investigation for a breast
cancer case would cost around 15,500 rupees for one patient just to diagnose them. Under
KASP-PMJAY, for the patient it would cost 0. So, this 15,500 amount… the hospital is
going to have to absorb it or the government needs to give it to us. The deficit that we
have calculated includes these investigations also. We don’t do any investigations that are
unnecessary. We are a government facility and we are facing these problems. So large
corporate hospitals that have even more expensive package rates than us-how in the
world are they going to work with the package rates provided by KASP-PMJAY? They
will not be able to, so they are not going to sign on to be a part of the scheme. Also, I was
in contact with a government medical college in Kerala recently. They mentioned how
they had 8,000 Aadhaar cardholder patients come. Only 4,000 could be registered into the
system. The remaining 4,000 they were not even able to enter them into the computer
system because there are certain criteria that you need-like a photo of certain
dimensions, certain documents. These were all inpatient patients. So, from the 8,000
patients that came to that medical college over 2 months as inpatients-only 4,000 were
entered as registered beneficiaries onto the system under the KASP-PMJAY scheme,
simply because of technical difficulties. That means the remaining 4,000 that are there in
the hospital sitting unregistered are having to be funded by the medical college
themselves. If those remaining 4,000 patients could also have been included and
registered properly, then yes, it would have been beneficial to the medical college. But
these technical difficulties are still occurring and causing losses. Additionally, from the
4,000 that were successfully registered into the system-only 50% of those bills were
cleared by the insurance company. The other 50% claims were rejected. So, the 100-crore
deficit that we have calculated for our hospital is not even including these rejection
claims. Suppose for example we raise the bill for 10,000 patients. If the bills for only
5,000 patients are cleared, the remaining 5,000 patients bills…who’s going to clear
those? Who is going to support those funds? The government has not mentioned any of
these problems. The process for working out these rejection claims is very difficult. So,
even those beginning level implementation problems are still there that they have not
ironed out. Also, because the premium was set so low is why the package rates are also
set that low. So, maybe if they set the premium a little higher and the package rates also
higher to be more reasonable-maybe then more private hospitals will also begin to join.
Right now, the fact that private hospitals are not joining is a big drawback. Overall, these
are all major drawbacks to the program itself.
I: Okay, do you think the state’s current program is beneficial for the targeted population (the poor and the disadvantaged) in Kerala?

P: Yes, for the poor this is good. We are a government hospital. Most of the patients that come here are cardholders who are poor. The standard of care we provide at this facility is on par with private. So, we have lots of people coming in with the KASP-PMJAY card. These patients don’t have to pay anything.

I: How do you think implementing this initiative will affect health outcomes in Kerala?

P: See, if the government can support us with these fund issues for hospitals- in terms of benefitting the poor population and the public- this is very beneficial for them. They are not having to pay for anything for good treatment and procedures. If we are not making the patients pay and the government is supporting us, the patient is really getting affected in any way by anything. If the government is not going to pay and is not going to support us, then what will happen is on one side yes…we are going to go broke. But also, the type of quality of care that we provide right now would decrease which would obviously affect the patients negatively. Like I mentioned, in places like Bihar and states where there may not be as many resources in Kerala and as high-quality care provided- I think this program is really good for the poor disadvantaged population. Kerala is too advanced to reap benefits from this program. So, I think honestly yes there are a lot of positives for the poor, disadvantaged community. But for the hospitals and institutions, there are a lot of problems with the program.

I: Okay, thank you so much for the time. This was really helpful.

P: Sure, good luck for this.

I: Thank you so much.
Appendix D

Tamil Nadu Transcriptions

Transcription 11

State: Tamil Nadu
Profession Title: Chief Cardiologist at a PMJAY Empaneled Leading Private Trust Hospital

I: Hello, how are you?

P: Hello, fine fine. Yes, so what are we talking about today?

I: So, pretty much I wanted to ask you a few questions about the new PMJAY scheme that has been implemented. I’m working on an Honors Thesis program where I am studying the rollout of the new PMJAY program in both Kerala and Tamil Nadu. I’m going to both states to interview healthcare professionals and individuals who work with the program to get their opinions on PMJAY’s implementation process. This is my first interview here in Tamil Nadu.

P: Okay, wonderful.

I: Oh, before we start, I just wanted to ask you- do you consent to be a part of this research? If you do, would you be willing to sign this consent form for my college? You can take a look at the document first to see if you are comfortable with everything. Everything will be anonymous in the paper.

P: Yes, no problem. It is okay for me.

I: Thank you so much. So, the first question I have is what is your opinion on the current health care system in Tamil Nadu?

P: So, Tamil Nadu is a pretty well-developed state in terms of both public and private health care. There are a lot of private hospitals, both small and large that are managed by doctors and entrepreneurs. The government hospitals here are also well-developed. They do have a lot of facilities, but often times they are overcrowded. Often, you’ll see almost 150 cases in the OP. Sometimes what can happen when it gets so overcrowded like that is that quality can potentially go down since the number of patients is too much and at the same the number of doctors and staff is so low at these government hospitals. See, let me tell you the main issue for health is the ratio of doctors and patients, which is just unreasonable. There is a lack of money and manpower in these government/district hospitals and that is a major issue for delivery of health care. There is also a lack of proper nurses. The ratio is not good. For example, I have seen it where it is 1 nurse and she has to deal fully with 15 patients alone. They cannot employ more nurses because the hospitals are not willing to pay more money. Overall, I see these problems. Also, too
much OOPE, too much competition, amount of GDP spent on health care is low so what can happen is quality of care also will become low.

I: Hmm, okay.

P: But, see there are problems. But I have to say the PHCs are very good. Especially, in Tamil Nadu, the delivery services for pregnant woman are really good. Maternal mortality rate has also come down because of good, clean services being available. There are even midwives that will go to some patients houses. However, manpower training is not enough, there needs to be more. When you look at the private hospitals in Tamil Nadu, it is also really good. There are quite a few hospitals which are equipped with MDs, surgeons, MBBS who often become freelancers. The private hospitals, even the small ones do things like deliveries, C-sections, gallbladder operations, urology procedures, orthopedics, fractures, knee replacements and more. People do tend to go to the private hospitals more. Often this is because they are scared that there is a lack of accountability at government hospitals, whereas there is more at a private hospital. Seem when you compare private versus public, the private hospitals need to please their patients more. Affordability, availability…this is all really important for people…quality people don’t care as much. Health care is going down because of this. Patients want immediate treatment and if they don’t get it, sometimes the whole family will come down to the hospital and make issues. All these things can happen.

I: Wow.

P: See, health care should not be profit motivated, it should be government/public sponsored. When it comes to private facilities, the care gets more diluted because there is more privatization going on. Government controlled private hospitals are okay. Also, see private hospital doctors have the ability to set the number of patients that they see per day. So, because they don’t have as much of an overcrowding issue the quality is good, but at the same time the costs are very high. Whereas for government, everything is free.

I: Okay, so are you aware of the new AB-PMJAY scheme? If so, did Tamil Nadu choose to adopt the full implementation of the program or did they modify it in their own way?

P: Yes, Tamil Nadu has chosen to adopt the full implementation of the program, they have not made any major modifications to it in any way. The CMCHIS program is just merged with the PMJAY schemes. And now through PMJAY, instead of 1 lakh, 5 lakhs are being given to each beneficiary family.

I: Do you think that there will be any improvements to the health care of the poor and disadvantaged population of Tamil Nadu by adopting the PMJAY scheme?

P: Absolutely. For the poor and disadvantage population here, this scheme is so beneficial. They are getting to undergo surgeries like a cardiac bypass without having to pay anything OOPE. For families that have nothing, this is such a gift.
Okay, so what are the major improvements/advantages to implementing the PMJAY initiative?

Okay, the benefits of PMJAY is that first- they are making sure unnecessary procedures are not being done. This also helps with corruption, not just helping out with the poor. Because in general, there is a lack of checks and balances in the Indian health system. See, after a patient leaves, they get a phone call where someone will ask the patient, how were your services at the hospital. The patient can tell them and then if there was any fraud or some issue financially or anything, an official will come to the doctor’s house to discuss what happened. The government should have an authority to overview of treatment. This will be very beneficial. This PMJAY is trying to make a centralized program, which is good. Also see, payment is not an issue. The hospitals have to get permission from central government if patient can be under insurance. The government has full control. Within 24 hours, they will let you know and then within 3 hours, you have to move forward. You have to take a photograph of the patients and surgeon during the procedure. There is a barcode of the device stent that needs to be scanned so the central government can see. So, cheating the system is not really that easy honestly. For example, you are the patient. You come in and say you need surgery. I take you angiogram and I fill out a form, upload the picture online and then wait for approval. If I get the approval back, then the patient becomes inpatient and they can use all the benefits and don’t have to pay anything OOP through discharge. However, if I don’t get approval back, then they stay outpatient and they will have to pay OOP for whatever they need done. That is how this works.

Okay, yeah. Makes sense.

I think this program will definitely grow, and it will be particularly useful for North Indian states. See, no matter how advance Tamil Nadu is, this PMJAY scheme will definitely be useful. 100% will be beneficial, health care needs to be more regulated. See, Tamil Nadu is very proud of this program here.

So, in terms of the number of people and the amount of benefits that the targeted population will be receiving, do you think the PMJAY initiative has more coverage compared to prior health care initiatives?

Well, CMC was providing 1 lakh for families and PMJAY is providing 5 lakhs, so yes. The prior health care initiatives included programs such as Kalaignar, which Karunanidhi started. It also started out with giving 1 lakh, around 8 years back. A lot of the cases were given to private hospitals, even small cases. Then came the CM Scheme, with Jayalalitha. The program was modified and said that a simple case that is done in the government hospitals can still be done there. 70% cases are still done in government. The major cases only are given to the private hospitals. So, this is strengthening the public hospitals by giving them more cases, it is increasing the money for them. So, see, the public hospitals are doing better with this scheme and PMJAY is strengthening the public sector.

Okay, interesting.
P: Also, let me tell you at our private hospital- we are PMJAY empaneled hospital. Almost 80% of people who come into that hospital are PMJAY cardholders. Per day, we have a minimum of 15 PMJAY cases. A minimum. In cardiology, we see so many PMJAY cases. Same in urology. We have a lot of private hospitals that have taken up PMJAY here. In Tamil Nadu there have been 3,000 cardiac bypass operations performed. Under the PMJAY scheme, all of them have been free. That is incredible. We are not facing problems of breaking even, because our patient turnover is good. By using this PMJAY scheme, we are getting more publicity and more and more patients are coming in…so financially, we are doing okay. In cardiology in Tamil Nadu, 95% cases happen in private hospitals and then 5% public. See, how I see it is- say you are a PMJAY beneficiary. You come, there is no profit for me. But, if we strike up a good relationship and then you bring many of your other friends you are also under the PMJAY scheme, then more people are coming to me. My reputation will go up and more people will come to me. See lot of people from not close by come to our hospital, because at our hospital we have made a good name for ourselves that we follow this PMJAY-CMCHIS program very well and that we have good care and there are no problems for beneficiaries. I can say for us, here, especially our Cardiology and Urology department, we want this PMJAY program and we are happy with it. But this is because we are a Trust private hospital. The big corporate private hospitals do not want to be a part of PMJAY. They want a profit in every case, and they are not going to get that through PMJAY, so very minimal corporate private hospitals have taken this scheme up. PMJAY has also been targeting the smaller, rural private hospitals. For them also, this scheme has been beneficial. But in general, in Tamil Nadu a lot of the trust private hospitals and middle level private hospitals that are not corporate are in favor and taking up the PMJAY scheme.

I: Do you think there are any drawbacks to the PMJAY scheme?

P: Yes. See OP- outpatient, nothing is covered for the patients. But IP- inpatient, it is covered. Say an admitted patient goes into complication. Doesn’t happen often, maybe 2%. The drawback is for the hospital because they are going to have to use resources and give treatment beyond what the patient was initially required to have and what was provided by the central government. But see here, these implementation issues are only hurting the hospitals. The patients don’t get affected in any way. Hmm…patients have to be in sharing room in the general ward, there is no single room. Also, the scheme does not cover routine procedures. These cannot be realistically covered by the government, so patient must pay of-pocket and honestly, that can be a lot of money. Also, for accidents, patients only start getting covered after they are admitted. So certain procedures and surgeries are covered. Surgeries like hysterectomy that are misused are not included in the program. But government hospitals can perform then with no pay. But private cannot perform or if they do, then they need OOP for the patients. Regarding potential misuse of the program, sometimes patients try to change the record of pre-existing conditions. They will find a doctor that writes what he wants them write. So, fraud can happen like that. See overall, India has great ideas. It’s just that when it comes to implementation is where things tend to fall flat.
I: How do you think implementing this initiative will affect health outcomes in Tamil Nadu?

P: I think it could make them better potentially. See, I’ll go a little off tangent but because you are doing this study looking at Kerala and Tamil Nadu, I can also mention something. This is just something I have noticed. There is a mentality in Kerala to oppose whatever the government is saying. They seem to think they are very advanced, and they may be, but a scheme like PMJAY will always be beneficial. I think there are also political reasons underlying here. Certain states that have different political affiliations may feel that we don’t want the Prime Minister and the central government to get the good name for all the hard work that we are doing. That mindset it not right, in my opinion. Highly politicalized, that is a problem…there are so many people who need it and cannot afford to even think about going to get some care at a private hospital without this help. Lots of cancer centers and radiotherapy facilities are taking up this PMJAY program because it is so good. The scheme is also really good for cardiac bypass surgery. There is a lot of awareness about this program in Tamil Nadu. See, only government schemes like this can make a good difference. Records are being seen so there is less misuse, a doctor’s work is being monitored so less corruption and there is a lot of help given to the poor with the large sum of money that is being provided for them and they can choose to get the treatment at the public or private hospital. So, you know I think this is an excellent program. Of course, some drawbacks but in Tamil Nadu we have been pretty receptive to the scheme. PMJAY is being utilized well here and it is being appreciated.

I: Great, thank you so much. I really appreciate all the time you took helping me out.

P: Yes, no problem. It is a good scheme, worth talking about. Good luck for this.

I: Thank you so much.
Transcription 12

State: Tamil Nadu
Profession Title: Information Technology and Biotechnology Specialist

I: Hello, how are you doing?

P: Hi, I’m doing well, thanks. How are you?

I: I’m doing good. So, I wanted to ask you some questions about the new PMJAY scheme that’s been implemented. I’m working on an Honors Thesis program where I am studying the rollout of the new PMJAY program in both Kerala and Tamil Nadu. So, I’m going to both states to interview healthcare professionals and individuals who work with the program to get their opinions on PMJAY’s implementation process.

P: Okay, that’s an interesting topic.

I: Yeah, I just wanted to ask before we start- do you consent to be a part of this research? If it is okay with you, would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable with everything. Everything will be anonymous.

P: Okay, sure. Let me take a look at it…yes, this is fine. Okay, here you are.

I: Okay, thank you so much. So, the first question I have is what is your opinion on the current health care system in Tamil Nadu?

P: First of all, I would say the healthcare system in Tamil Nadu is very advanced. Price performance wise, it is ahead of many states such as Maharashtra, Bangalore and other places. Here, the medical costs are not as high as other places such as Bombay, Delhi, Calcutta. You get more bang for your buck here. You’ve got some of the most advanced hospitals and equipment out there and a lot of the government hospitals are very good in Chennai specifically. It is really good. Sometimes, even private hospitals will refer patients to a government hospital if necessary, since the quality is so good now and doctors are good. Doctors also see a lot of divergent cases in government hospitals and PHCs, so doctors become very experienced in treating patients. What’s the status? You have excellent hospitals, excellent doctors. Today, medical tourism is supposed to be a booming industry here. You can find treatment that cater to the really poor and then to the really rich as well. If you ask me the status of health care today in Tamil Nadu- it includes a combination of insurance, a combination of government help, combination of private help…due to all this the health care delivery is a lot more effective than it was 10 years ago. Programs like PMJAY-CMCHIS augments it well. If it is implemented properly, it can do good. They need to give decision making process to the lower field level rather than saying you need to follow these set regulations or that’s that. A bureaucrat sitting in Delhi is not going to understand what is going on at the field level in
these hospitals and is not going to see the direct impact the individuals at these hospitals see. If the decision-making process is moved downwards to the field level, the impact of this program is going to be momentous according to me.

I: Okay, so are you aware of the new AB-PMJAY scheme? If so, did Tamil Nadu choose to adopt the full implementation of the program or did they modify it in their own way?

P: Yes, so as far as I know, Tamil Nadu has chosen to do a full implementation of the program and not really made any modifications to it.

I: Do you think that there will be any improvements to the health care of the poor and disadvantaged population of Tamil Nadu by adopting the PMJAY scheme?

P: Yes, it will. There will definitely be an improvement, there is no question about it. This program reaches out to the most marginalized population. The impact is going to be very profound, if you ask me.

I: Okay, what would you say are the major improvements/advantages to implementing the PMJAY initiative?

P: Primarily, I would say the major advantage is that it is bringing more people under the health care net. Particularly, those living in rural areas will now also fall under the healthcare net and will be provided care that they previously would not have been able to afford. This is what I believe. I think that as this program is implemented in the rural areas of Tamil Nadu, the attractiveness of practicing medicine in rural areas will increase. Currently, because there is no money everyone wants to migrate to the metropolitan urban areas, no one wants to practice in the villages and tribal areas. This gives an opportunity and incentive for people to go and practice in these regions. The incentive to be in the rural areas is not there. Doctors are in so much debt after all their years of education, to make some money most of them feel they need to work in urban areas in prestigious hospitals. A byproduct improvement could potentially be that as the scheme reaches out more and more into the rural areas, it will also attract more health professionals to that area to service them.

I: Okay. In terms of the number of people and the amount of benefits that the targeted population will be receiving, do you think the PMJAY initiative has more coverage compared to prior health care initiatives?

P: Yes, definitely. As I mentioned, it will bring a lot more people under the health care net who would normally not qualify for anything else and who would not have the means to get treatments and procedures done.

I: Do you think there are any drawbacks to the PMJAY scheme?

P: I would say the issues are that the decision making is very rigid, and rule based rather than being need/situation based. The only way it can be more successful is that they need
to be a little bit more flexible on the medical cap that they are putting per person and essentially, the decision making has got to be brought down to the field level and need to give people working at the front lines the leeway to make decisions. In other words, don’t say that these are the only rules with which you have to make a decision. Empower those at the grassroot level the chance to make decisions because they may have a better idea of what is going on with the roll-out process because they are seeing it directly. This is not a disadvantage, but something I think potentially needs some work. I would also say they should link this scheme with other government benefits on the health care side that are available. Often times, people, particularly the BPL population, don’t know what kind of benefits are available to them through the government, so they need to increase awareness of these programs. The government should increase publicity for all the government programs that are available and then link them with PMJAY-CMCHIS, so together this becomes a very holistic approach.

I: How do you think implementing this initiative will affect health outcomes in Tamil Nadu?

P: I think they will increase with this program as health care delivery gets better. When health care quality improves, health care timing improves, health care reach improves, I think all these put together could potentially affect health outcomes and we will have a healthier population. I think you will really see differences in health outcomes with this PMJAY program when you see it implemented in states like Madhya Pradesh, Bihar and some of the more underdeveloped northern states. In comparison to these states, Tamil Nadu…Kerala and some other southern states are far better off. India’s population is so extensive, some may wonder how it is even possible to roll out a health scheme of this level. There are going to be implementation issues as this is still a new scheme, but if they can fix those issues and it can be done properly, this will be a great achievement.
Transcription 13

State: Tamil Nadu
Profession Title: Internal Medicine General Physician at Leading Private Hospital

I: Hello, how are you doing?

P: Hi, doing fine.

I: I just wanted to ask you a few questions about the new PMJAY scheme that has been implemented, if you have some time. I’m working on an Honors Thesis program where I am studying the rollout of the new PMJAY program in both Kerala and Tamil Nadu. I’m going to both states to interview healthcare professionals and individuals who work with the program to get their opinions on PMJAY’s implementation process.

P: Alright.

I: Before we begin, I just wanted to ask before we start-do you consent to be a part of this research? If you are okay with it, would you be willing to sign this consent form for my college? You can take a look at the document first to see if you are comfortable with everything. Everything will be anonymous in the paper.

P: I would like to take a look at it first. You said everything is going to be anonymous, right?

I: Yes, definitely. No names will be used at all and generic professional descriptions will be used.

P: Okay, here.

I: Thank you so much. So, the first question is what is your opinion on the current health care system in Tamil Nadu?

P: There is a huge deficit. The system does not cater to the lower section. Even among the upper…or the group of people who have lots of money, the system is quite cost prohibitive in terms of getting complete care. It is not driven towards primary, preventive health care. It is primarily remedial now. So, you go to the doctor when you are sick and sometimes it is already too late which rakes up the cost. So, there is no concept of annual health checks so that is a problem. There is a lack of public awareness and public awareness campaigns. Communicable diseases like TB have to be addressed a lot more strongly. The government has a lot going on and they are incentivizing it, but it is still not reaching the masses.

I: Okay. Are you aware of the new AB-PMJAY scheme? If so, did Tamil Nadu choose to adopt the full implementation of the program or did they modify it in their own way?
P: I am not positive, but I believe Tamil Nadu has chosen to adopt full implementation and that they are participating in the scheme.

I: Do you think that there will be any improvements to the health care of the poor and disadvantaged population of Tamil Nadu by adopting the PMJAY scheme?

P: The idea is very good and seems to be very comprehensive. It involves mental health, pregnant women, it has rural/urban components to it, it helps reduce mortality…there is a lot of stuff. But I think the problem I had looking at it was that they talk about the Health & Wellness Center. I’m not quite sure exactly what they have identified as the exact centers. I know talks were underway when they first announced it as to which would be the participatory hospitals…whether private corporate sector would participate and if so, how the remuneration will be. The program in general is very altruistic, it’s very lofty, it’s what we need- but I don’t see how they have worked out the payment because at the end of it, you cannot go broke. So they need to have a clear path about the participatory hospitals and if they want to work with the existing government hospitals which are completely state funded, the problem we see is that perhaps the doctors are not- maybe they are not remunerated well enough or it may not be on par with private practice, but not enough like the NHS, which is why the doctors resolve to private practice. They don’t have checks and balances in place to make sure they complete the obligatory duties in the government hospital before they go away and work in private hospitals.

I: What are the major improvements/advantages to implementing the PMJAY initiative?

P: Like I said, I think idea is good and can be beneficial. However, I don’t think the implementation process has been ironed out well and that needs to be worked on first.

I: Okay, in terms of the number of people and the amount of benefits that the targeted population will be receiving, do you think the PMJAY initiative has more coverage compared to prior health care initiatives?

P: The scheme is quite large, but I would need to do more research before I can answer this question.

I: Sure. Do you think there are any drawbacks to the PMJAY scheme?

P: I see a lot of implementation issues. Many private hospitals are not taking on the PMJAY scheme. They don’t have the cost structures planned out- the government needs to be clearer with us on working out the nitty gritty details of procedure costs and making them more reasonable prices. Even if we had a certain wing dedicated to these kinds of patients, then there needs to be more funding from the government for that. These prices that are provided from the government are just too low. I feel that there are also a lot of problems with the eligibility criteria. There are a lot of criteria included that it is not enough to deem one unfit or ineligible or eligible. I don’t see that working. There are not enough systems in place to build upon. They need to come up with better methods to
validate the criteria. They don’t have that, they never had it. Families having only one room with kuccha wall and kuccha roof. What if someone was able to scam their way into getting eligibility. There need to be stronger methods to validate the criteria. Because they don’t have the best criteria and it is not strong enough, I think there is alleyway for misuse to occur. Why would they exclude households having motorized 2,3 or 4 wheelers or fishing boat? Does that automatically mean that you have money? Does it mean they have enough to spend for a bypass surgery? I think many schemes start out rally well like this, but then they don’t figure out the payment side of all this well. Someone needs to foot the bill- I don’t know…I don’t really see that being sorted out well here.

I: How do you think implementing this initiative will affect health outcomes in Tamil Nadu?

P: Like all things, a plan is only as good as how you implement it. In order to implement it, you need to know your ground realities. They do not have enough systems in place. Only once they better this initiative will we see any sort of effect on health outcomes.

I: Okay, thank you very much.

P: You’re very welcome.
State: Tamil Nadu  
Profession Title: Geriatrician at a Leading Private Hospital

I: Hello, how are you?  
P: Hi, doing good. Thanks. So, topic is what?  
I: So, I wanted to ask you some questions about the new PMJAY scheme that’s been implemented. I’m working on an Honors Thesis program where I am studying the rollout of the new PMJAY program in both Kerala and Tamil Nadu. So, I’m going to both states to interview healthcare professionals and individuals who work with the program to get their opinions on PMJAY’s implementation process.  
P: Okay.  
I: Before we start- do you consent to be a part of this research? If it is okay with you, would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable with everything. Everything will be anonymous.  
P: Yeah, that’s okay.  
I: Okay, thank you so much. So, the first question I have is what is your opinion on the current health care system in Tamil Nadu?  
P: Private hospitals have to be proactive to get patients. I think the rates are very low. Bulk of the work under this scheme is happening in the government hospitals. What I understand in Tamil Nadu is a little bit like Kerala, may be not quite up to that standard. But in district hospitals good level of care. About 10-15 years back, the political establishment pushed the district hospitals especially with regards with maternal mortality and child mortality. For example, in Tiruvallur, the government is saying all deliveries has to be done at the district hospital to avoid unskilled nurses doing deliveries at homes. Also, when we are talking about this scheme, we are talking about the poor and the vulnerable. Because in Tamil Nadu the scheme started 10 years ago, everyone got trained and got skills. The implementation was not thought through well, but the will was there to implement it. The medical officers at district hospitals have the ethos of trying to do some work for the people of Tamil Nadu. It is where I have an issue with the Prime Minister’s scheme. In other states I doubt whether there is hardly any infrastructure to implement the scheme. So, it might happen that it could turn out to be detrimental to the public sector and might divert the money to the private sector. Maybe these people should have access to the private hospital, but that will be costly to the government and it might be taking the focus away from the public healthcare system.
I:  Are you aware of the new AB-PMJAY scheme? If so, did Tamil Nadu choose to adopt the full implementation of the program or did they modify it in their own way?

P:  I think the PMJAY program is quite rigid. Examples are you need identification, and some kind of data and need to submit claims. These are all new. Infrastructure is all dependent on individual states and no help from the Central government. But Tamil Nadu had similar kind of scheme, which started 10-15 years ago, and they already have the IT infrastructure. May be very little bit of modification is all they needed. Limit may be only two lakhs. Basically, took the prior scheme and made it bigger.

I:  Do you think that there will be any improvements to the health care of the poor and disadvantaged population of Tamil Nadu by adopting the PMJAY scheme?

P:  In comparison to prior health schemes?

I:  In a general sense, but also whichever way you would like to answer is fine.

P:  In Tamil Nadu it is different. I think I would like to see it just as an insurance policy. PMJAY is an insurance policy. It is difficult to compare it with the entire health infrastructure Tamil Nadu had put up over the decades. In Tamil Nadu, the government was teaching and training students in medical procedures and setting up infrastructure over the years whereas in states like Bihar this doesn’t exit. So, in Bihar you can compare, because before PMJAY there was no insurance, but now they have. So, if you are comparing PMJAY in Bihar with Tamil Nadu it is entirely different and comparing very different products. But the private hospitals could exploit high end procedures, and this might be happening even in Tamil Nadu, but there is infrastructure for high end procedures like bypass surgery in Bihar. Another good thing about PMJAY is you can migrate, so people from Bihar could migrate to Tamil Nadu to get high end procedures like bypass done and go back to Bihar. But to your question, comparing with insurance is fine, but PMJAY is just an insurance, but the health infrastructure is different in different states. Also, PMJAY is washing its hand off developing healthcare infrastructure in the deprived states. So, that is a drawback and unwanted side effect.

I:  Okay. So, what would you say are the major improvements/advantages to implementing the PMJAY initiative?

P:  On the whole the program is good because it helps patients below the poverty line as long as he has the card in the areas of critical illness like cancer, heart attack.

I:  Okay. In terms of the number of people and the amount of benefits that the targeted population will be receiving, do you think the PMJAY initiative has more coverage compared to prior health care initiatives?

P:  In terms of how much money it is offering, yes. But it is just building off of prior health care initiatives.
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I: Do you think there are any drawbacks to the PMJAY scheme?

P: The package rates is a big problem. They are not low. It is abysmally low. But there are some private hospitals that can take it up as a challenge. May be this will trigger of innovation for low cost devices and processes. This one along with economies of scale will help the private hospitals to cut the cost. It depends on the leadership these private institutions have. Many private hospitals have the problem of not enough patients to fully utilize capacity they have all the time, so they might see it as an opportunity to fill the capacity. The result is the person who is deprived of the service will get it now. Also, a disadvantage is that it could suppress public healthcare systems in states where it is developed. Also, I think the opportunity is being lost to address the health infrastructure in the country. Third one is long-term cost. Majority of the high-end procedures are being diverted to the private sector. So, there is loss of skill in the government sector.

I: How do you think implementing this initiative will affect health outcomes in Tamil Nadu?

P: I don’t think in Tamil Nadu there will be difference in health outcomes. This program is beneficial to the people outside Tamil Nadu. Inside Tamil Nadu it is already happening. Even without PMJAY, still health outcomes have been good in Tamil Nadu. In Tamil Nadu, I don’t think PMJAY is going to be big positive shift. But outside Tamil Nadu, where health infrastructure is not as good as Tamil Nadu, the health outcome could see improvements because of PMJAY initiative.

I: Okay, that’s it. Thank you so much for your time.

P: Okay, thanks. Yeah sure.
Transcription 15

State: Tamil Nadu
Profession Title: Chief Cardiothoracic Surgeon at a Private Trust Hospital

I: Good morning.

P: Good morning. Yes, what are the questions you wanted to ask regarding?

I: So, I wanted to ask you some questions about the new PMJAY scheme that’s been implemented. I’m working on an Honors Thesis program where I am studying the rollout of the new PMJAY program in both Kerala and Tamil Nadu. So, I’m going to both states to interview healthcare professionals and individuals who work with the program to get their opinions on PMJAY’s implementation process.

P: Okay.

I: Before we start- do you consent to be a part of this research? If it is okay with you, would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable with everything. All of it will be anonymous, so your name will not be included.

P: Yeah, that’s fine.

I: Thank you so much. So, the first question I have is what is your opinion on the current health care system in Tamil Nadu?

P: Current health care system is pretty good. Tamil Nadu is relatively advanced. As far as Tamil Nadu is concerned, Ayushman Bharat it is not being implemented in the name of Ayushman Bharat because before Ayushman Bharat was notified by the Prime Minister, the Tamil Nadu government had a fairly comprehensive insurance scheme. So, most of the rates and packages and procedures and are similar in the Chief Minister’s Comprehensive Package as well as the Ayushman Bharat. Because of that Ayushman Bharat has not taken very up much in Tamil Nadu. Under the Chief minister’s scheme, lots of good work is being done.

I: Are you aware of the new AB-PMJAY scheme? If so, did Tamil Nadu choose to adopt the full implementation of the program or did they modify it in their own way?

P: It is a full implementation of the program. CM scheme used to be 1 lakh, now it is 5 lakhs with PMJAY. What is happening in Kerala is that though the Ayushman Bharat is a national scheme, the political masters of the state have not totally signed off on the scheme, therefore the scheme is not fully implemented.

I: Okay. So, do you think that there will be any improvements to the health care of the poor and disadvantaged population of Tamil Nadu by adopting the PMJAY scheme?
P: Tamil Nadu government have a state insurance scheme. Kerala government also had a state insurance scheme. The packages in the Kerala scheme is abysmally low. Because of this many of the corporate world such as corporate hospitals such as this one reluctant to join the scheme. That is not the case in Tamil Nadu. In Tamil Nadu the packages are little better. More private hospitals are willing to be PMJAY empaneled hospitals. I think around 25 private hospitals in this area are under PMJAY. In Kerala the implementation of the Minimum Wages Act for paramedical work force etc. is extremely strict and lots of smaller hospitals are actually on the verge of shutdown. So, I can understand their anxiety in many private hospitals not wanting to be a part of the scheme. But in Tamil Nadu, labor is still little cheaper. So, in Tamil Nadu lots of corporate hospitals, including this one, have joined the Chief Minister’s scheme. And this is extremely beneficial for the disadvantaged population. In Tamil Nadu, even if we are pretty advanced in terms of health, we always feel there is always a need for healthcare. But I will say that Kerala and Tamil Nadu are far ahead of other states with respect to health statistics.

I: What are the major improvements/advantages to implementing the PMJAY initiative?

P: It is good for the BPL population primarily. Hmm… just trying to connect Kerala and Tamil Nadu… See, in Kerala the implementation of the Minimum Wages Act for paramedical work force etc. is extremely strict and lots of smaller hospitals are actually on the verge of shutdown. So, I can understand their anxiety in many private hospitals not wanting to be a part of the scheme. But in Tamil Nadu, labor is still little cheaper. So, in Tamil Nadu lots of trust hospitals, including this one, have joined the Chief Minister’s scheme. And this is extremely beneficial for the disadvantaged population. In Tamil Nadu, even if we are pretty advanced in terms of health, we always feel there is always a need for healthcare. But I will say that Kerala and Tamil Nadu are far ahead of other states with respect to health statistics. Also, many private hospitals like us want to join the scheme. Yes, because the money is so much. Also, the private hospitals want to attract more people. Volume is an important factor. Because the volume is so huge in India, even cases with very small margin will cover fixed cost and generate some profit. This PMJAY scheme is also not pushing towards privatization or anything. Simpler PMJAY schemes are allowed to run only in government hospitals and will not be entertained in a private hospital. For example, for many government medical colleges, the extra money coming through the PMJAY program has allowed them to do lot more upgrading of equipment, infrastructure, building, etc.

I: In terms of the number of people and the amount of benefits that the targeted population will be receiving, do you think the PMJAY initiative has more coverage compared to prior health care initiatives?

P: Even though PMJAY is the scheme that is on paper, the Chief Minister’s scheme is what is being implemented in Tamil Nadu and in effect I will be talking about the Chief Minister’s scheme, even though they are not exactly the same thing. But for an end user it doesn’t matter whether the money comes from the PM’s scheme or CM’s scheme. The Chief Minister’s scheme is very similar to the Ayushman Bharat. The state scheme came
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much earlier than the Ayushman Bharat, so it is in people’s head. It is like Medicare or the VA, everybody knows. Ayushman Bharat is newer, so it will take some time to penetrate into the psyche of everybody. But there are slight variations between the two, but for all practical purposes, what is being implemented is the same.

I: Okay, do you think there are any drawbacks to the PMJAY scheme?

P: It is meant for people below poverty line. So, who decides it? Anyone who has the BPL ration card is eligible for the scheme. That card should only be given to people below poverty line. But corrupted people could give the card to ineligible people through payment under the table deals. Once a person gets the card, he cannot be denied service in a hospital. So, he could drive in a Mercedes car and show his card to get the medical service. So, there is an approximately 10% misuse of the scheme. The other drawback we cannot include everybody in the scheme. For example, suppose the patient needs a bypass surgery. A straightforward process, but for more risky ones the patient has to stay longer in the ICU and hospital spends and therefore need to bill more. But the package is the same for every bypass surgery, so the sicker people tend to lose.

I: Okay. How do you think implementing this initiative will affect health outcomes in Tamil Nadu?

P: This initiative in Tamil Nadu is very supportive and popular. I can speak only in relation to cardiology. Good awareness and lots of cardholders. About 50% of those who are coming to the cardiology. Overall, it is an extremely beneficial scheme. Particularly, for patients who cannot afford the high cost. The Tamil Nadu scheme from the very inception is very popular.

I: Also, I just was wondering for myself- routine care checkups are not covered under the scheme, right?

P: No, but if you have a heart attack and are treated in the ICU, it is covered.

I: Okay, thank you so much.

P: Yeah, sure.
State: Tamil Nadu
Profession Title: Medical Doctor at Leading Corporate Private Hospital

I: Hi, how are you?

P: Hello, I’m doing well. Thanks.

I: I wanted to ask you some questions about the new PMJAY scheme that’s been implemented, if that’s okay. I’m working on an Honors Thesis program where I am studying the rollout of the new PMJAY program in both Kerala and Tamil Nadu. So, I’m going to both states to interview healthcare professionals and individuals who work with the program to get their opinions on PMJAY’s implementation process.

P: Okay okay, sure.

I: Before we begin- do you consent to be a part of this research? If it is okay with you, would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable with everything. Everything will be anonymous.

P: That’s okay, yeah. Here.

I: Thank you so much. So, first question I have is what is your opinion on the current health care system in Tamil Nadu?

P: Good anyway. It is ranked third in the health care system. Need more doctors and fund. Need to equip the hospitals with needed infrastructure and facilities. Need qualified doctors. There is a lack of staff and qualified doctors.

I: Are you aware of the new AB-PMJAY scheme? If so, did Tamil Nadu choose to adopt the full implementation of the program or did they modify it in their own way?

P: If big corporate hospitals like ours fully implement it would be better. But up to two lakhs, it is currently being implemented in public hospitals under the Tamil Nadu Insurance scheme. From private hospital’s point of view, government is allotting less money. If they get the full price of the treatment, then private hospitals will accept it. This hospital is in the CM’s scheme only for bypass and CM scheme was already for about 10 years. With 5 lakhs insurance, patients cannot go to the private hospitals.

I: Okay. Do you think that there will be any improvements to the health care of the poor and disadvantaged population of Tamil Nadu by adopting the PMJAY scheme?

P: Potentially. Depends on how well the hospitals implement the program.
I: So, what would you say are the major improvements/advantages to implementing the PMJAY initiative?

P: Main advantage… I would say is the amount given to eligible families by the scheme. A lot of money is being allotted for the families.

I: In terms of the number of people and the amount of benefits that the targeted population will be receiving, do you think the PMJAY initiative has more coverage compared to prior health care initiatives?

P: Yes.

I: Do you think there are any drawbacks to the PMJAY scheme?

P: I think the government should allow the full price of the treatment, otherwise what is the benefit of it? In Tamil Nadu people are getting the treatment in public hospitals under this scheme, so government should equip this government public hospitals to benefit the poor people. National government should not just give money to the insurance companies but equip the hospitals. Need to focus on giving equip all the district hospitals, PHC, need to focus on that- need to build more public hospitals. Instead of just giving money, the government needs to also provide more equipment to these hospitals because that is what is going to be useful for many of the district hospitals, PHCs and taluk hospitals who don’t have many high-end equipment. The income criteria are also faulty. You see lots of people who are way below the poverty line and how could the government fully understand their health issues? Those things need to be worked on.

I: How do you think implementing this initiative will affect health outcomes in Tamil Nadu?

P: Maybe it will get better. It is hard to say. It depends on how well the hospitals can implement the program. Tamil Nadu is far ahead and more people in CM’s scheme. I think there is a good reception of this program in Tamil Nadu. In Kerala, I’m not sure- I think if some people don’t think this a great program it could have to do with. If you ask a BJP person, he will say it is a great program. But an independent person will say both the advantages and disadvantages. I think that both Kerala and Tamil Nadu have advanced schemes compared to other states. National government should give more money to the state governments so that they can take care of the poor people’s healthcare needs. I think this program is more beneficial to poor people in states like Bihar and Orissa. I don’t know if they have lots of public health facilities. It may just a building there, but not enough doctors or facilities. So, there this scheme would help a lot.

I: Okay, great. Thank you so much for your time.

P: Okay, sure. Yeah.
Transcription 17

State: Tamil Nadu  
Profession Title: General Physician at a Private Hospital

I: Hello. How are you?

P: Hello, good. Yes, so tell me. What is this interview about?

I: So pretty much, I wanted to ask you a few questions about the new PMJAY scheme that has been implemented. I’m working on an Honors Thesis program where I am studying the rollout of the new PMJAY program in both Kerala and Tamil Nadu. I’m going to both states to interview healthcare professionals and individuals who work with the program to get their opinions on PMJAY’s implementation process. This is my first interview here in Tamil Nadu.

P: Okay.

I: Um, if it is okay, I wanted to first ask- do you consent to be a part of this research? If you do, would you be willing to sign this consent form for my college? You can take a look at the document first to see if you are comfortable with everything. Everything will be anonymous in the paper.

P: Yeah, fine for me.

I: Okay, thank you so much. So, the first question I have is what is your opinion on the current health care system in Tamil Nadu?

P: I don’t think any structured program currently going on. I think the government introduced some health insurance schemes whereby deserving people can be given treatment in government hospitals for surgical procedures etc. These are all in the government hospitals.

I: Are you aware of the new AB-PMJAY scheme? If so, did Tamil Nadu choose to adopt the full implementation of the program or did they modify it in their own way?

P: I believe it is a full implementation.

I: Do you think that there will be any improvements to the health care of the poor and disadvantaged population of Tamil Nadu by adopting the PMJAY scheme?

P: I went through the whole program. It is an ambitious program. But I have my own doubts since it involves public as well as private hospitals. The private hospitals should be willing to take huge discounted rates. I doubt many of the private hospitals will be willing to do that.
I: Okay. So, what would you say are the major improvements/advantages to implementing the PMJAY initiative?

P: It is very advantageous to poor communities and also those living in rural areas who would not be able to afford good quality care usually.

I: Okay. In terms of the number of people and the amount of benefits that the targeted population will be receiving, do you think the PMJAY initiative has more coverage compared to prior health care initiatives?

P: Just the amount of money given to eligible families increased.

I: Do you think there are any drawbacks to the PMJAY scheme?

P: The private hospitals not being willing to be a part of PMJAY scheme is a disadvantage. Unless the government can somehow pay the difference to the private hospitals. For example, if I do a c-section in a private hospital, I need to have X number of rupees to cover my cost alone, leaving alone any profit. I want the government that X amount. But if I am going to get X minus something, then I will be putting money from my pocket. I don’t that will be realistic, and many private hospitals will not be part of that scheme. For example, my sister owns a nursing home in Karnataka and her nursing hospital is part of the scheme and doing reasonably well, meaning they are getting X plus sum amount and they are getting volumes. Now some other scheme they brought in and they are not getting that much volume, so they opted out of the scheme. If private hospitals join, volume will increase, but they should have some profit margin. Private hospital is not for charity work, they need profit too. Private hospitals have to pay for so many things like electricity, tax on building etc. Private hospitals are less likely to come under the program, inclusion criteria issues...this program comes with lots of expectations. For example, the patient may think that an ECG is necessary, and he is covered up to 5 lakhs under the program, but the doctor might think it is not necessary. The patient will think that it is due to me and I am not getting it. These sorts of issues will come.

I: Finally, how do you think implementing this initiative will affect health outcomes in Tamil Nadu?

P: Government hospitals, at least Chennai is well equipped, and all the treatment is free. I think what the Prime Minister is aiming is rural population. There it will be beneficial to the people. So rural areas won’t see much added benefit because they are getting free treatment already, but rural areas will benefit.

I: Okay, thank you so much for your time.

P: Okay good, yeah sure.
Transcription 18

State: Tamil Nadu
Profession Title: Head of Pediatric Cardiology & Thoracic Surgeon at a Public Health Centre

I: Hello, good morning. How are you doing today?

P: Good morning, doing well. So yes, I got your email about what you wanted to discuss. Can you explain a little more?

I: Yes, absolutely. Basically, I’m working on an Honors Thesis program where I am studying the rollout of the new PMJAY program in both Kerala and Tamil Nadu. I’m going to both states to interview healthcare professionals and individuals who work with the program to get their opinions on PMJAY’s implementation process. So, I just wanted to ask you a few questions about the new PMJAY scheme that has been implemented if that is okay?

P: Sure.

I: Also, before we start, I just wanted to ask before we start- do you consent to be a part of this research? If you are okay with it, would you be willing to sign this consent form for my college? You can take a look at the document first to see if you are comfortable with everything. Everything will be anonymous in the paper.

P: Sure, no problem…here you go.

P: See, I’ll tell you. In this PHC we had the CM scheme and I know how impactful these sorts of health schemes can have on people and the state. I think there can be good things done with Ayushman Bharat also. So, if you ask me some questions, I can respond to those.

I: Sure sure, definitely. So, the first question I have is what is your opinion on the current health care system in Tamil Nadu?

P: Health care system here is pretty good. I personally work on a lot of insurance schemes for children cardiothoracic surgical programs in this PHC. So, I know how much work it takes into rolling out programs and working out funding details. One average surgery here for me costs 1 lakh in my own project. My project demands that much because it requires the intricate surgery and then an extended weeklong post-op stay. This fund and what we get from the PMJAY-CMCHIS is really nice. The drawback is unless you have funds earlier, it is very difficult to meet the day-to-day expenses and keep our ends meet. But I do have to say that the PMJAY scheme has helped us.

I: Are you aware of the new AB-PMJAY scheme? If so, did Tamil Nadu choose to adopt the full implementation of the program or did they modify it in their own way?
Implementation of India’s Health Reform Program

P: Yes, a lot of people in Tamil Nadu do use this PMJAY-CM scheme. I think it is full implementation of the program. I don’t think Tamil Nadu has done any modifications.

I: Do you think that there will be any improvements to the health care of the poor and disadvantaged population of Tamil Nadu by adopting the PMJAY scheme?

P: Yes. So, the poor will be able to receive good care without having to pay anything out of pocket. Also, CM scheme used to provide 2 lakhs per family, but now with this PMJAY, each family gets 5 lakhs per year. Even if they don’t use the 5 lakhs right away, that extra fund is available to those beneficiaries. From what I have seen from our population, nearly 80% cannot afford a cardiac surgery. That is because, even the middle-income people, if you ask them to spend 3 lakhs for one surgery…imagine- how can they do that? They are going to have to take so many loans and everything. So, for the poor…you can imagine. So, this program can be beneficial for them- there are just some implementation issues that I feel are occurring. But it is important to say, as much as these problems are there- I will 100% say that it is beneficial for the poor and disadvantaged population.

I: What are the major improvements/advantages to implementing the PMJAY initiative?

P: The amount provided by the scheme is a major advantage. All these empaneled hospitals that have this program…particularly PHCs and government hospitals that already have a decent infrastructure also can benefit from being able to do more procedures for a potential benefit with the money they are getting from the government. Even smaller hospitals, if they have a basic infrastructure, they have benefitted from this scheme.

I: In terms of the number of people and the amount of benefits that the targeted population will be receiving, do you think the PMJAY initiative has more coverage compared to prior health care initiatives?

P: I wouldn’t say this initiative is better than prior health care initiatives, because it is instead building off of those schemes. But, yes like I had mentioned, I would say that the amount that is provided through this PMJAY-CMCHIS program is very big, so that is a really good thing for them.

I: Do you think there are any drawbacks to the PMJAY scheme?

P: See, I think in general often what happens is they implement big programs like this but then there are problems in following through. One thing, the eligibility criteria is based on SECC 2011 census. So far one problem I have seen is that I have had multiple poor families come in because they need surgeries. When they come in, I test and see if the eligibility is really there. I have seen multiple families that do not meet them. Which means, what was the yardstick they had when they first started implementing them. 2011 is a long time ago. The criteria need to be updated for the poor as the population has grown from that time and there maybe people out there who are not being covered because of this. Look, the idea is excellent, but there are some issues. Main question is
how are we to implement it to benefit these people who are in need? I think there needs to be more funding provided by the government. PM idea is good, but there are things that need to be worked out. Also, more at a fundamental level before the government works on schemes like this, they need to first help out hospitals too. In many hospitals, staffing is a huge problem. Many PHCs and government hospitals have so many people coming in, but there is a lack of staff - from technicians to nurses to doctors. First, that needs to be worked on and helped out with. In my opinion, they must have a committee to be brought to the grassroot level. Those who are really first-hand involved with this scheme must be the ones also working on it directly and instigating discussion on it. Then those individuals higher up will have a better idea on how to fix issues and how to move forward with things. This program can certainly benefit many. Policy making is one aspect, but executing it is another thing. And seeing the beneficiaries and talking to them directly is also another aspect of why they need to have more people at the field level. So, if a project like this starts, there should more of a holistic approach as well. It is not very organized. Practically speaking, only the policy is out there, but the structure will take a lot more time to get organized. Now, another issue in regard to the corporate private hospitals not choosing to be a part of the PMJAY scheme. I’ll tell you what, for the private hospitals this is not really a major issue for them. These hospitals have plenty of money, they are not really willing to help the poor unless they are directly approached. Here, the empanelment has become a status symbol. From the point of view of the hospital, the money they spend for this is just money. They already have an infrastructure and a target population which is not the poor. There is also a group on non-corporate private hospitals. These hospitals also have an infrastructure, but they lack patients. For them, this is a gold mine. They get the governments money and they get the publicity so more of these poor patients come in. It might not even be that high quality care that they are providing, but for these level hospitals this scheme might be helpful. For the corporate hospitals, if they end up accepting this scheme, I think it is more because they are doing it as a matter of a status symbol.

I: Sorry, you said the corporate hospitals?

P: Yes. Also, I think another issue is that although each family gets 5 lakhs, there is a cap restriction for each individual of around 1.25 lakhs. Certain procedures are not included, and it is not very clearly defined. So sometimes if clarity of procedure is not included in the list provided, then reimbursement issues occur. I think in general the main disadvantage is that implementation is haphazard. There are problems and it doesn’t seem like officials are entirely sure how to implement it smoothly.

I: Hmm, okay.

P: Also, one thing is awareness amongst populations like those living in tribal populations is very low. They often do not know what these program benefits are or anything. So, there needs to be more awareness amongst those populations.

I: Okay. So, how do you think implementing this initiative will affect health outcomes in Tamil Nadu?
P: Hmm…well I think if the scheme is more relaxed, then benefits are increased, then we would probably be able to study the health outcomes separately and see if they are improved. There needs to be more research done to see about the health outcomes. The results, mortality…morbidity…Tamil Nadu is already pretty doing well in those. See, in general I will say that Tamil Nadu is one of the more advanced states. However, I have to say that no matter how advanced it is- this scheme is still very beneficial, particularly for the population living BPL. Advancement cannot equal finance. You may be advanced, but if you don’t have money, you cannot have a good health system. The system will only cater for the rich and will become unfair. So, this is a good program that gives more of an equal chance for the population living in poverty. The amount of money each family gets per year for their health is very good and can be helpful for them. You know, overall, I think more people need to be brought into the program. This can be a great program and it can help the disadvantaged population a lot, but there are just procedural issues that are there.

I: Okay, thank you so much. It was wonderful to get your opinions.

P: Sure sure, good luck with your project.

I: Thank you so much.
State: Tamil Nadu
Profession Title: Public Health & Preventive Medicine Doctor at a Reputed Private Hospital

I: Hi, how are you? Thank you for your time.

P: Hi, sure.

I: So, I wanted to ask you some questions about the new PMJAY scheme that’s been implemented. I’m working on an Honors Thesis program where I am studying the rollout of the new PMJAY program in both Kerala and Tamil Nadu. So, I’m going to both states to interview healthcare professionals and individuals who work with the program to get their opinions on PMJAY’s implementation process.

P: Okay, I can tell you what I know from my experiences. That’s fine?

I: Sure definitely. I just wanted to ask before we start- do you consent to be a part of this research? If it is okay with you, would you be willing to sign this consent form for my college if you are? You can take a look at the document first to see if you are comfortable with everything. Everything will be anonymous.

P: Okay, sure. Can I take a look at it first?

I: Absolutely, take your time.

P: Okay, this is fine, just wanted to go through it.

I: Sure, thank you so much. So, the first question I have is what is your opinion on the current health care system in Tamil Nadu?

P: It is a good system that runs well. The PHCs are a good facility, they are a wonderful resource where they go to rural areas where they don’t have many facilities. They are also good for national program implementations. The disadvantage is that when it comes to rural communities, there are not many facilities/hospitals in those areas and also the doctors who have to go there need to travel from the city. Things have been changing from what it was before, though. It is a good system for primary care.

I: Okay. Are you aware of the new AB-PMJAY scheme? If so, did Tamil Nadu choose to adopt the full implementation of the program or did they modify it in their own way?

P: I am not sure whether Tamil Nadu modified it. If you look at the scheme itself, there is no doubt that this scheme is advantageous, and it is improving the healthcare of the people. I am very happy with the scheme, but the finance part I am not sure. But as a doctor, I would say it is a good scheme.
I: Do you think that there will be any improvements to the health care of the poor and disadvantaged population of Tamil Nadu by adopting the PMJAY scheme?

P: Yes, I think it there will be improvements because they are getting more resources to receive treatment and care from high quality institutions for free. We are currently not a part of the PMJAY-CMCHIS program, but I think soon enough we will end up joining under it.

I: Okay. So, what are the major improvements/advantages to implementing the PMJAY initiative?

P: I would say that right now young people don’t take any screening for diabetes, cancer etc. But it has changed because PMJAY will help people receive early diagnosis of this illness and improve in areas of mental health, prenatal care, pregnancy care, neonatal care, eye care, geriatric care etc. I think it is good in all these areas.

I: In terms of the number of people and the amount of benefits that the targeted population will be receiving, do you think the PMJAY initiative has more coverage compared to prior health care initiatives?

P: I cannot comment on this question, because I am coming from U.K. I was there for the last 15 years.

I: Okay, no problem. Do you think there are any drawbacks to the PMJAY scheme?

P: Though they are wonderful initiatives, there is no guarantee that it will always reach out to the needed people in the right amount. Always changes could happen to the scheme and delay the implementation. It has to be strict implementation guidance. You said you are looking at Tamil Nadu and Kerala by the way?

I: Yes.

P: See, Kerala is always proactive and advanced similar to Tamil Nadu, but this PMJAY program still contains initiatives that can always be implemented. In that respect, I would say no state, Kerala nor Tamil Nadu is too advanced to implement programs such as this one because still there are poor and rural people who are not aware of this program and it has to be made available to them.

I: Okay. How do you think implementing this initiative will affect health outcomes in Tamil Nadu?

P: Medically, PMJAY is a very beneficial program in Tamil Nadu, but I cannot comment on the financial aspect of it.

I: Okay, thank you so much.
Transcription 20

State: Tamil Nadu
Profession Title: Doctor at Leading Private Hospital

I: Hello, how are you doing? Thank you for giving me some time.


I: Basically, I wanted to ask you a few questions about the new PMJAY scheme that has been implemented. I’m working on an Honors Thesis program where I am studying the rollout of the new PMJAY program in both Kerala and Tamil Nadu. I’m going to both states to interview healthcare professionals and individuals who work with the program to get their opinions on PMJAY’s implementation process.

P: Okay, sure.

I: To start, I just wanted to ask you- do you consent to be a part of this research? If you do, would you be willing to sign this consent form for my college? You can take a look at the document first to see if you are comfortable with everything. Everything will be anonymous in the paper.

P: No problem.

I: Thank you so much. So, the first question I have is what is your opinion on the current health care system in Tamil Nadu?

P: We are very much on top of it even though there are still some grey areas, which needs to be checked.

I: Okay. Are you aware of the new AB-PMJAY scheme? If so, did Tamil Nadu choose to adopt the full implementation of the program or did they modify it in their own way?

P: Yes. But now it is implemented by the governmental public sector organizations. Probably it needs to be extended to the private sector also. Of course, there are issues with the private sector implementation for too many reasons. But soon the private sector has to fall in line and undertake such a huge project which is catering to about 100 crores.

I: Do you think that there will be any improvements to the health care of the poor and disadvantaged population of Tamil Nadu by adopting the PMJAY scheme?

P: Yes, it is advantageous to the poor and under privileged population of Tamil Nadu. All the government schemes are initiated with the intent to focus on the poor and under privileged. At the metro cities the government hospitals are all well-equipped. But that is not the case with lower-tier hospitals and district hospitals. The facilities available at primary care facilities are far from satisfactory. Problems that primary care facilities
cannot handle has to be referred to district hospital and sometimes even the district
hospitals are not 100% equipped to handle very complex cases and medical emergencies
and those patients needs to be transferred to the class-1 tier city government hospitals.
Times lost in referrals are very critical and can cause the patient’s life. So, the
government should introduce the new healthcare system to help the poor and the
disadvantaged.

I: Okay. So, what are the major improvements/advantages to implementing the PMJAY
initiative?

P: Even the educated people don’t know the value of health insurance scheme. They know
about car insurance, house or electronic device. But people are not educated enough
about health insurance. Only now people are beginning to understand the value of health
insurance. I think government should implement some rigid rules like U.S. doing in the
case driver’s license etc. Because of lack of rules, people are thinking why I should be
paying 50,000 rupees for health insurance etc. That attitude is slowly changing. Number
of people who have insurance in India is far from satisfactory. Only now government
employees are having health insurance. If the PMJAY is extended to private hospitals and
hospitals are empaneled to accept this scheme, India will be making tremendous progress
towards healthcare. So, there are no disadvantages, but only advantages. PMJAY covers
the entire family for a reasonable amount.

I: In terms of the number of people and the amount of benefits that the targeted population
will be receiving, do you think the PMJAY initiative has more coverage compared to
prior health care initiatives?

P: Yes, more money is being offered to families. It is very beneficial. A very big initiative.

I: Do you think there are any drawbacks to the PMJAY scheme?

P: I don’t. But there are some regional issues because of political issues. For example, when
the central government tries to implement something and state government is in tune with
the central government’s ideology, the state government may try to delay because of
political reasons and not because of other reasons. The only main potential drawback I
see is that private hospitals aren’t too keen on joining PMJAY because the private
insurance quote and the rates at the hospitals are so different. But even though private
hospitals are not initially interested, eventually they will come around.

I: How do you think implementing this initiative will affect health outcomes in Tamil
Nadu?

P: A lot. For example, some medical test or investigation could be very expensive. He is not
paying from his own pocket now because he is covered under PMJAY. No state is too
advanced or grown to an extremely high level. Every state still needs help, including
Tamil Nadu. There are still 25% of the people still not covered under any scheme. If this
scheme is extended to lots of illness, morbidities and surgeries, and remove some of the income and other restrictions, it will definitely improve the current healthcare system.

I: Okay, that’s all the questions I have. Thank you so much once again.
Transcription 21

State: Tamil Nadu
Profession Title: Leading Official at a Reputed Medical University

I: Hello, good afternoon. Thank you so much for giving me some time for this interview.

P: Hello, yes sure. Please sit. So, what is this regarding? I wanted some more detail.

I: Of course. So basically, I am working on an Honors Thesis program where I am studying the rollout of the new PMJAY program in both Kerala and Tamil Nadu. I’m going to both states to interview healthcare professionals and individuals who work with the program to get their opinions on PMJAY’s implementation process. So, I just wanted to ask you a few questions about the new PMJAY scheme that has been implemented if that is okay?

P: Okay.

I: Also, before we start, I just wanted to ask before we start- do you consent to be a part of this research? If you are okay with it, would you be willing to sign this consent form for my college? You can take a look at the document first to see if you are comfortable with everything. Everything will be anonymous in the paper.

P: Okay. Before I sign this, I want to make it clear that I am not speaking on behalf of the medical university. I would like that to be noted. This is purely my personal opinion.

I: Yes, absolutely I understand. Thank you.


I: So, the first question I have is what is your opinion on the current health care system in Tamil Nadu?

P: Fairly well covered. It is lacking in small areas like small primary healthcare places or areas. People are not aware, or they tend to consult to social media for information. That apart, the system is good. Almost 90% of the delivery of the service in Tamil Nadu institutionalized and average citizens get access to healthcare. Under the CM’s insurance scheme. Expenses and treatments are covered under the scheme.

I: Are you aware of the new AB-PMJAY scheme? If so, did Tamil Nadu choose to adopt the full implementation of the program or did they modify it in their own way?

P: Modification is very minimal like some overlap of the system. Almost full implementation.
I: Do you think that there will be any improvements to the health care of the poor and disadvantaged population of Tamil Nadu by adopting the PMJAY scheme?

P: Yes, I think so. PMJAY is better than prior initiatives in certain areas. It is a little expansive. It makes more people come into the program.

I: What are the major improvements/advantages to implementing the PMJAY initiative?

P: Coverage of more people. By implementing this scheme, there will be improvements for the poor and disadvantaged community in Tamil Nadu. Even in states that are advanced, there is still a need for schemes of this proportion for people in socio-economic disadvantages.

I: Okay. In terms of the number of people and the amount of benefits that the targeted population will be receiving, do you think the PMJAY initiative has more coverage compared to prior health care initiatives?

P: More money being provided per family. So, for the average, poor citizen who is enrolled in the scheme- it helps give them more access to better care. I won’t say one scheme is better than the other, PMJAY and CMCHIS complement each other which is why they were merged together.

I: Do you think there are any drawbacks to the PMJAY scheme?

P: Not covered under certain restrictions like kinds of diseases and treatments. They need to provide beneficiaries and hospitals more information to increase awareness about required documents. Also, restriction of the amount concerns. For various states, human factors and politicization can also be an issue in implementation. Politics can be a factor. When anything is new, there could be resistance to change. Also, the fact that private hospitals are not interested in the program because of the low package rate for them is a disadvantage of the scheme. Maybe with a little more discussion between the officials of PMJ and local officials, the rate situation can be fixed between the private hospitals and the government.

I: How do you think implementing this initiative will affect health outcomes in Tamil Nadu?

P: I think it will enhance the mortality rate. I think we can benefit from this program as much as Northern Indian states could.

I: Okay, that’s all I wanted to ask. Thank you so much for the time.

P: Sure, good luck with the research and safe travels back home.

I: Thank you so much.