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A HEALTH SCHEME SANS CLOUT

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A 15th Finance Commission report estimated that total costs for AB-PMJAY in 2019, taking then levels of hospitalisation rates and expenditure and assuming full coverage, would range between 28,000 crore and 74,000 crore, | Photo Credit: luchschen

Mainstreaming transformative technologies in the healthcare ecosystem and boosting innovation in delivery are a major focus under the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) — with the three intentions of containing costs, improving care quality, and bridging existing gaps in service provision. A 15th Finance Commission report estimated that total costs for AB-PMJAY in 2019, taking then levels of hospitalisation rates and expenditure and assuming full coverage, would range between 28,000 crore and 74,000 crore, with projections for 2023 being more than double this range. Certainly, the unremitting sluggishness of India's public health spending and the massive funding requirements of AB-PMJAY warrant innovative solutions so that the lofty commitments can be met.

With this in view, the National Health Authority, the implementing body of AB-PMJAY, set up an "innovation unit" last year to promote indigenous cost-effective technologies. However, the current discourse on innovation in healthcare seems to be missing out on two fronts: first, the very nature of the proposed innovations; and, second, the piecemeal adoption being envisaged.

While healthcare technology start-ups showcase an impressive range of solutions, not all of them can promise substantial system-level impact in terms of aspects like cost control. Second, a discourse on innovation revolving around items like telemedicine and drone technology disregards other simpler, fundamental, but highly impactful items, like operational processes and business models.

Multiple sporadic but successful precedents of such healthcare innovations already exist in India. These include, for example, thorough standardisation of hospital procedures. These are founded on evidence-based protocols that also permit other cost-saving innovations such as task-shifting, high-volume procedures, and reduction in complications. Standardisation of cataract surgeries in Aravind Eye Hospital is an example.

Reducing costs through robust procurement systems for supplies; cost minimising-substitutions like using generic medicines; and work-profile alteration of existing human resources are other possible avenues of bringing innovation without adversely affecting quality. For example, in the case of certain services, quality of care can be maintained by using physician assistants rather than doctors. These are not only pertinent to AB-PMJAY but would also be instrumental in achieving cost control. Further, the reimbursement mode (package rates) for healthcare providers under AB-PMJAY can allow for pushing such innovations through strategic design of payment components and the accompanying incentive-disincentive structures. The question arising then is: what stands in the way of mainstreaming such basic yet impactful innovations?

While creating a smooth interface between healthcare technology start-ups and hospitals can aid in easy diffusion of solutions, it won't guarantee a widespread uptake. In the absence of substantial and streamlined incentives for providers, adoption of innovations would largely be erratic, piecemeal, and incomplete. Large-scale adoption will thus require sufficient demand generation. AB-PMJAY, however, remains restricted in this capability, especially with regard to such things as business-model innovations.

A foremost reason for this is that AB-PMJAY, despite having an apparently formidable beneficiary base, still has a small share in the overall scenario of inpatient care provision. This is due to low empanelment of hospitals; a general reluctance of private providers towards dispensing AB-PMJAY benefits; and limited contribution of AB-PMJAY to the overall business of hospitals.

Not being a major payer of private inpatient care reduces its leverage with the hospital system. While talks of expanding the beneficiary base under AB-PMJAY to approach universalisation have been afloat, budgetary allocation trends render it a pious hope. Government health insurance schemes have traditionally been characterised by limited coverage of targeted population and low utilisation rates and claims ratios, owing to such factors as low awareness and bureaucratic barriers. Further, the perennially sluggish and ineffectual healthcare regulatory framework in India is likely to pose another impediment.

This doesn't mean that cost-effective healthcare innovations cannot be pushed via AB-PMJAY. However, the kind of innovations and their consequence, and the extent and depth of their incorporation, will largely depend on the clout of AB-PMJAY in healthcare provision. This highlights how AB-PMJAY still has a long way to go in terms of becoming the central player in Indian healthcare.

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