Center for Global Development

Reflections
25-26 February 2019

PMJAY:
huge accomplishment in a short period of time

- Structure
- Empanelment
- Claims
- Payments
- Information systems
- Communication with states

Observations on PMJAY list and pricing 1

- General categories concentrate claims, not serving to convey priorities
- Omits clinically appropriate indications as part of claims authorization system
- Allows for funding of less cost-effective interventions
  - E.g. proton beam therapy, mandates minimum inpatient stay for possible day-cases, pacemakers
- Creates incentives for volume/overuse through paying for technologies and interventions through FFS
  - MRI, hearing aids, radiotherapy etc.
- Process for deciding future adjustments, inclusions and exclusions unclear
  - Inflation, cost and risk adjustment arrangements
  - How to include or disinvest, consider new technologies, etc.

Observations on PMJAY list and pricing 2

- Package cost of provision does not link to upstream premium financing (5 lakh) nor to downstream provider payment
  - Costs vary by geography, access barriers, patient mix, economies of scale, etc.
  - No costing methodology or adjustment, how states should proceed when providers won't participate
- Link to PHC under development
  - Seek opportunities to create incentives as part of PMJAY (eg use outpatient clinics, secondary NCD prevention)
- SHA as a strategic partner on implementation and adaptation (positive feedback)
- PMJAY relationship with vertical programmes (eg TB) and state level schemes; missed opportunity to realise economies of scope and scale and exert purchasing power

Other issues raised

- Beneficiary ID:
  - Does not take advantage of Aadhar - outdated
  - Does not recognize dynamism in labor market income and related entry/exit into poverty
  - Orphans, old age homes excluded from tenders
- Operational costs (50 Rs per family):
  - Base level allocation in program management insufficient, needs to be revisited
- Procurement of devices and pharmaceuticals:
  - Opportunities to develop framework agreements at NHA, use auction methods, etc.
  - NZ example: PHARMAC, volume guarantee, etc.
  - China example: volume guarantee, quality regulation, quality prescribing enforcement, cash fronted by center and paid back by state

Near-term actions for consideration

- Data analytics to understand priorities for list, pricing and payment adjustments with attention to incentives icl for data collection
- Establish a permanent unit charged with benefits and premium adjustment
- Develop proposal to adjust package groupings and shape to create incentives for application of c/e standard treatment guidelines for high priority disease burden areas
  - See Chile AUGE example
  - Role for STGs/QS to inform/moderate FFS payment structure
  - Later consider move to DRG
- Develop draft guidelines for a process for future benefits plan inclusions and costing, defining relative roles and responsibilities amongst agencies and levels of government
  - Pilot with a new technology

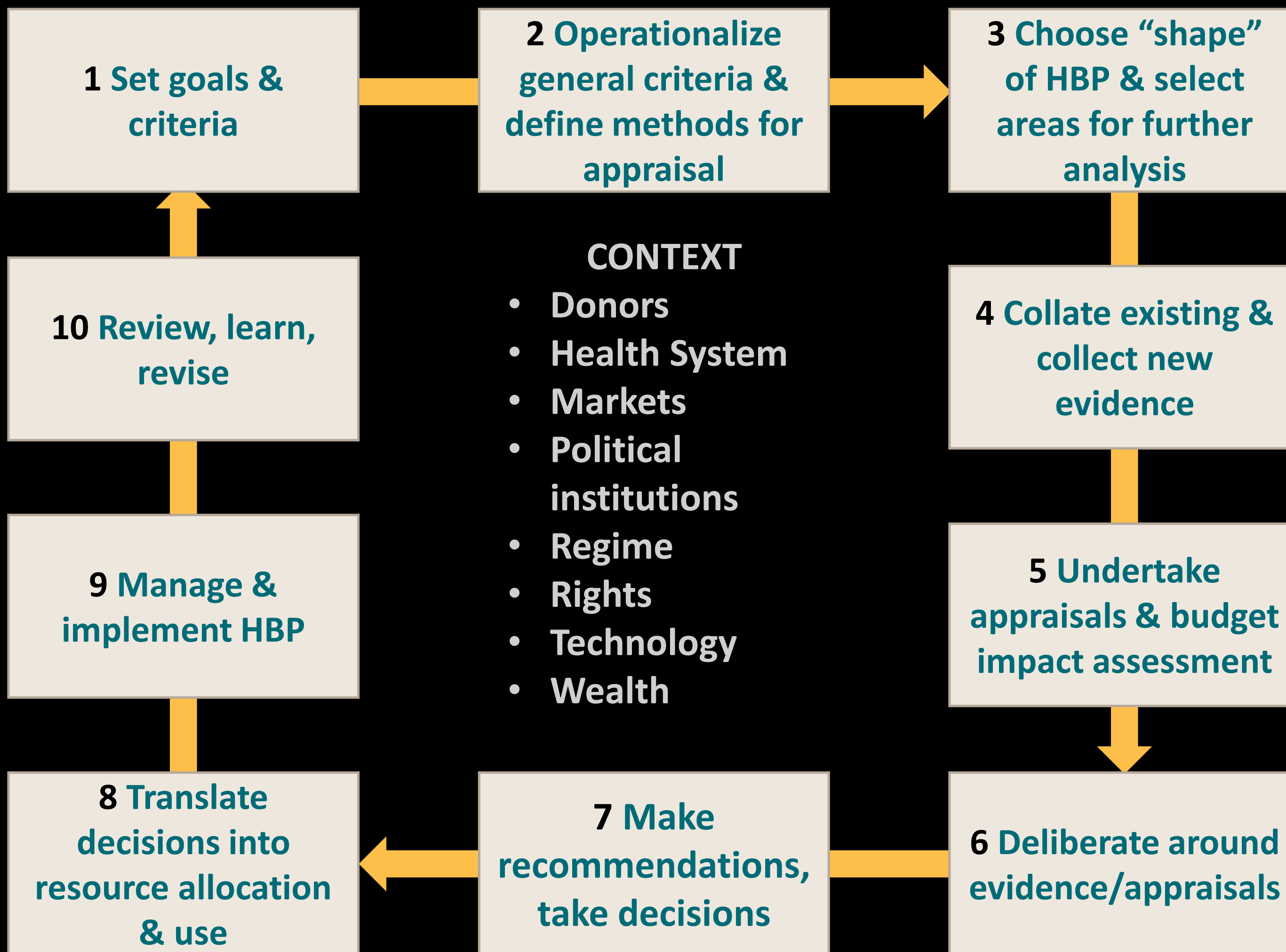
Longer-term issues

- Shift to DRGs
- Connection to PHC and prevention

Resources

Full text of book What's In, What's Out: Designing Benefits for UHC at link:

https://www.cgdev.org/publication/whats-in-whats-out-designing-benefits-universal-health-coverage


1 Set goals & criteria
2 Operationalize general criteria & define methods for appraisal
3 Choose "shape" of HBP & select areas for further analysis
4 Collate existing & collect new evidence
5 Undertake appraisals & budget impact assessment
6 Deliberate around evidence/appraisals
7 Make recommendations, take decisions
8 Translate decisions into resource allocation & use
9 Manage & implement HBP
10 Review, learn, revise
CONTEXT
Donors
Health System
Markets
Political institutions
Regime
Rights
Technology
Wealth