Confederation of Indian Industry

Ayushman Bharat – National Health Protection Mission

Providing Universal Health Coverage to 500 million people

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Contents

Executive summary

Healthcare in India is largely underpenetrated, with government expenditure at around 1.25% of the GDP and an underperforming public healthcare ecosystem. It is extremely worrying that nearly 55–60 million Indians are pushed into poverty every year because they are unfortunately compelled to shell out half of their annual household expenditure to meet medical needs, especially for hospitalisation. Even after 70 years of independence, there is no real health insurance scheme for 80% of the Indian population.

One of the major policy initiatives of the government has been the announcement of the Ayushman Bharat – National Health Protection Mission (AB-NHPM) for the vulnerable section of the Indian population which, if implemented effectively, will help the nation move closer to the Sustainable Development Goal of 'Universal Health Coverage'.

It is expected that the scheme will have a far-reaching impact on the entire Indian healthcare and insurance landscape. The scheme envisages the adoption of standard treatment guidelines and defined package rates for surgical procedures, and the widespread use of IT and data analytics to monitor scheme implementation and manage fraudulent claims. All these measures taken together will help in regulating the hitherto unregulated hospital and healthcare sector and in making the health insurance sector a sustainable one. The scheme will help in generating large volumes of data which may be used later for designing better and targeted health programmes. This will assist in effective medical management; in studying the impact of including or excluding specific diseases, populations or coverages; and in optimising cost and improving efficiencies.

The scheme will also help in enriching the database of hospitals registered with the Registry of Hospitals in Network of Insurance (ROHINI) System and the human capital captured under the National Health Resource Repository (NHRR) project. This can later be used innovatively for improvement of access to and quality of healthcare services in the country. The scheme will have a multiplier impact on the healthcare and allied sectors like pharmaceutical, diagnostics and medical devices and the overall Indian economy by way of employment generation.

The execution of the scheme, however, will be a big challenge since it would involve identifying and focusing on the right critical success factors, allocating the optimum budgetary support, incentivising all stakeholders appropriately (e.g. insurance companies, third-party administrators, healthcare providers) and acting speedily to cover all the beneficiaries.

In the long run, AB-NHPM should envision strengthening of primary care, inclusion of out-patient treatment and a public healthcare delivery system, and expanding the scope of coverage to the entire population in order to make the government's transition from provider to payer a successful one and achieve Universal Health Coverage in the true sense.

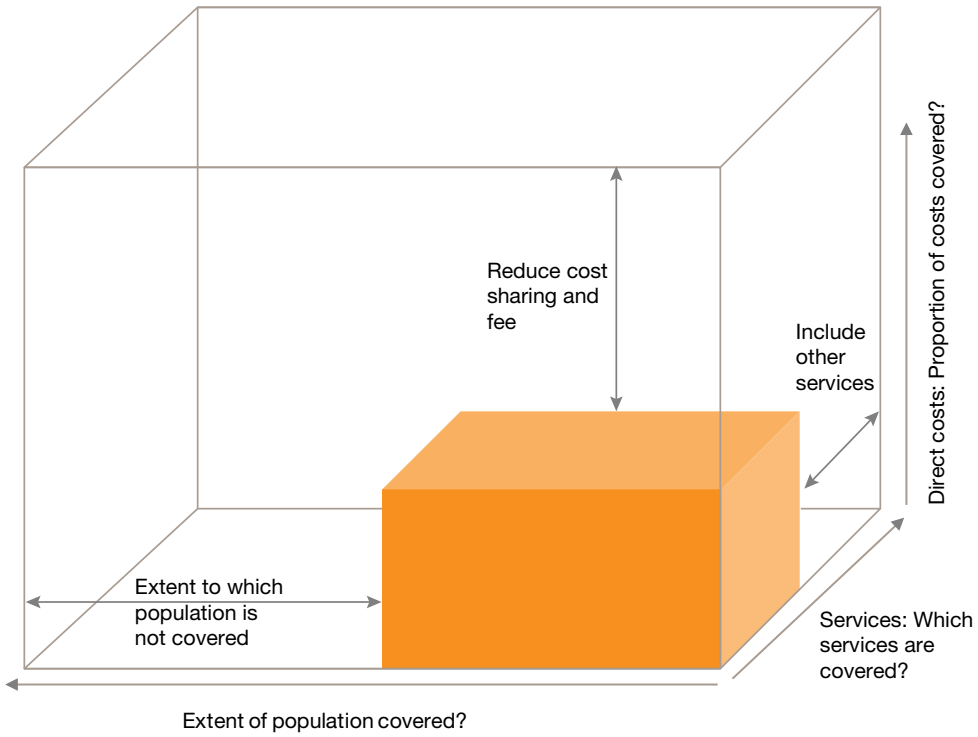
Section 1

UHC and past learnings

The coverage cube: Three dimensions of Universal Health Coverage (UHC)

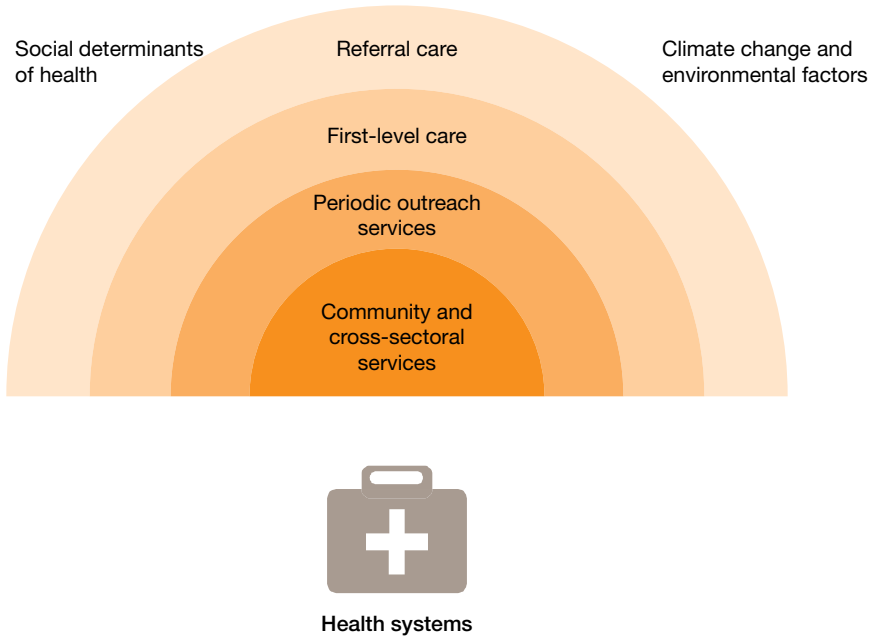
UHC is a dynamic process that should be responsive to constantly changing demographic, epidemiological and technological trends. The changing nature of health systems has significant implications for UHC monitoring.

UHC goes much beyond health insurance for 100% of the population



Adapted from Tracking Universal Health Coverage: First Global Monitoring Report: WHO and World Bank

UHC extends beyond curative care and has direct implications on health outcomes



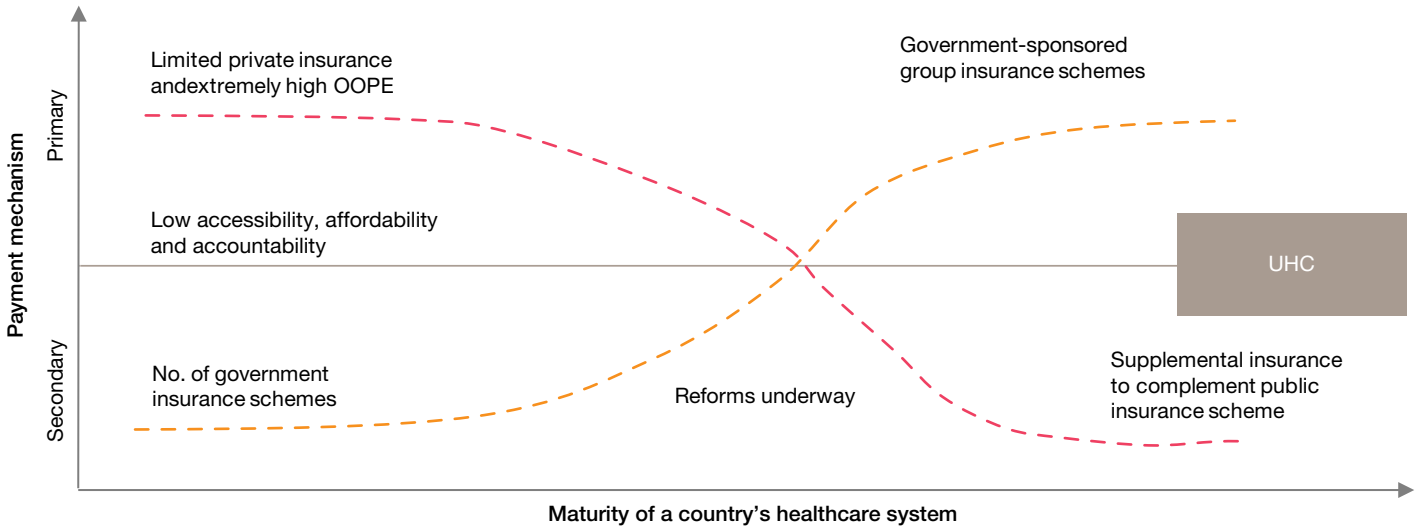
Source: PwC research and WHO report on 'Together on the road to universal health coverage: A call to action'

Investments in UHC and its projected impact

No. of healthy life years gained:	535 million
Average life expectancy gained by 2030:	5 years
Unintended pregnancies averted due to use of modern contraceptive methods:	400 million (2016–2030)
Child deaths averted (0–4 years):	41 million (2016–2030)
Non-communicable disease (deaths averted):	20 million (2016–2030)
HIV/AIDS infections averted:	21 million (2016–2030)
Additional people with access to clean water in 2030 (above 2015 baseline):	226 million
Additional number of people accessing treatment for depression:	94 million

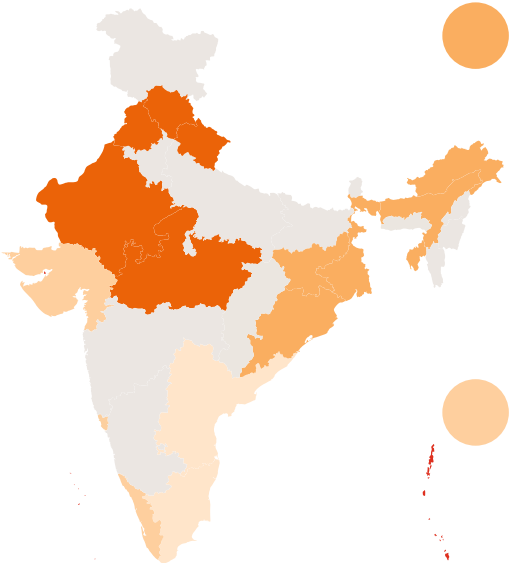
WHO modelled projections for 67 low- and middle-income countries (2016–2030)

Government-sponsored insurance schemes are critical for UHC



Adopted from M. Kimball et al. (2013), ILO

While multiple government-sponsored insurance schemes exist in India….



Himachal Pradesh	Mukhya Mantri State Health Care Scheme
Punjab	Punjab Government Employees and Pensioners Health Insurance Scheme
Rajasthan	Bhamashah Swasthya Bima Yojana, State Insurance and Provident Fund Department, Rajasthan Chief Minister's Relief Fund
Madhya Pradesh	MP Swasthya Suraksha Yojana
Uttarakhand	Mukhyamantri Swasthya BIma Yojana and U-Health Card

Arunachal Pradesh	Arunachal Pradesh Chief Minister Universal Health Insurance Scheme (APCMUHIS)
Assam	Atal Amrit Abhyan, Assam Aarogya Nidhi, Sneha Sparsha
Tripura	Tripura Health Assurance Scheme for Poor
Jharkhand	CM's Health Insurance Scheme, Sarva Swasthya Mission
West Bengal	West Bengal Scheme, Swasthya Sathi, Mabhoi Scheme
Odisha	Biju Krushak Kalyan Yojana

Gujarat	Mukhyamantri Amrutum and Vatsalya Yojana, Chiranjeevi Yojana
Goa	Chief Minister's Comprehensive Health Insurance Scheme
Kerala	Comprehensive Health Insurance scheme

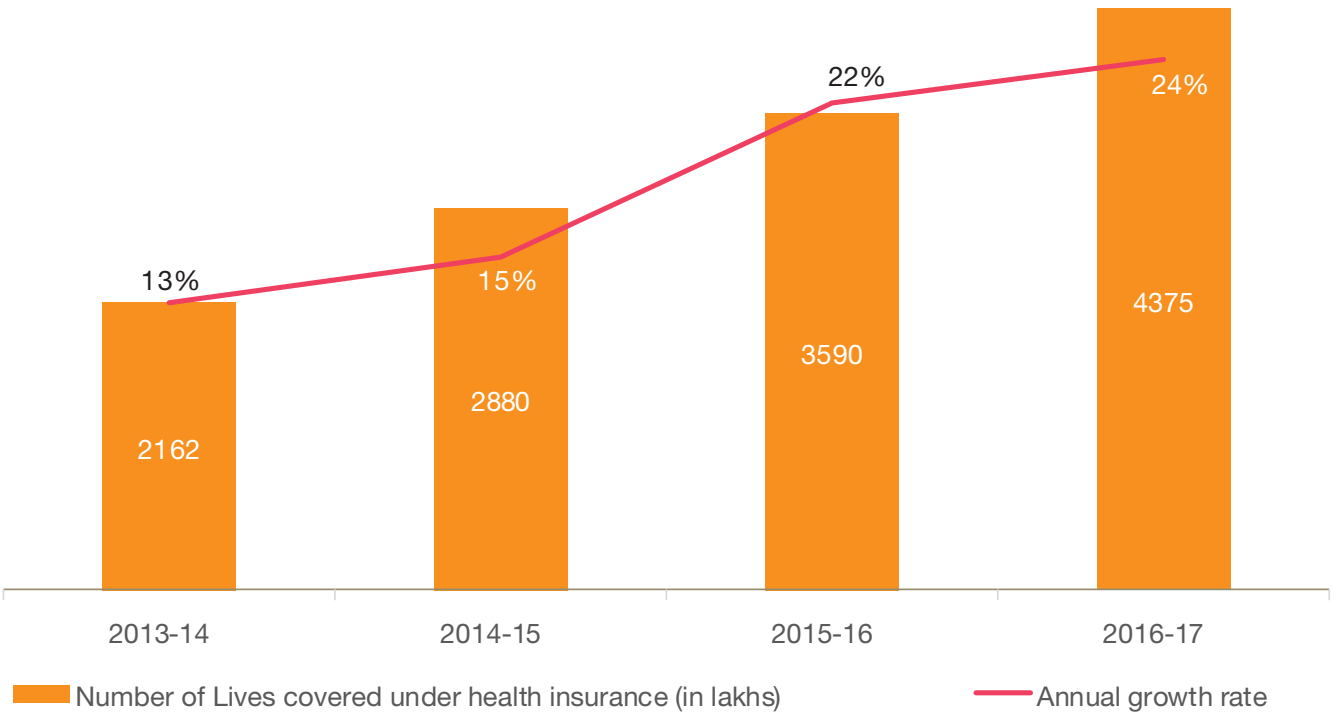
Telangana	Arogyashree (co-branded with RSBY)
Andhra Pradesh	Arogya Raksha Health Scheme, Dr. NTR Vaidya Seva Scheme
Tamil Nadu	Chief Minister's Comprehensive Health Insurance Scheme

… the overall penetration is still relatively low

Number of policies issued: 13 million	Average amount per claim: 25,000 INR	Claim settlement: 40% cashless, 47% reimbursement and 13% via both cashless and reimbursement
Lives covered ~450 million	Number of claims: 110 million	

Despite the increase in annual growth, more than 80% of the population still does not have any significant health insurance coverage.

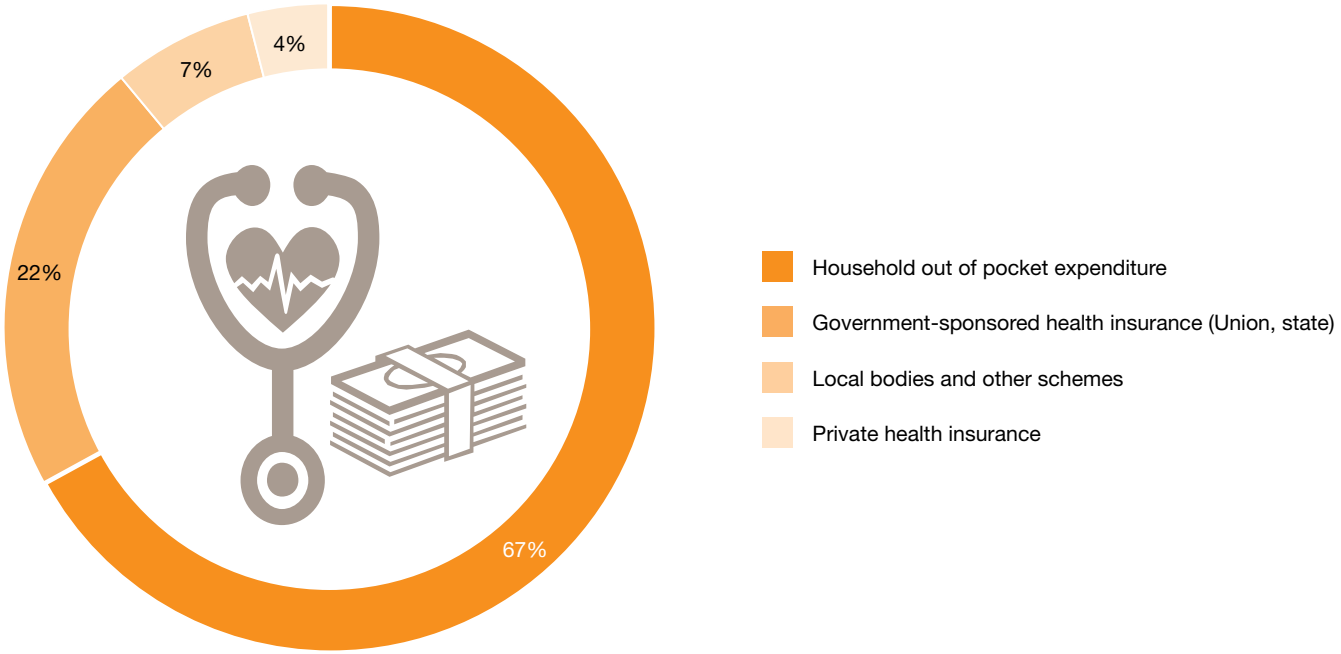
Health insurance in India



Source: IRDA annual reports

More than two-thirds of healthcare spend is out-of-pocket expenditure

Healthcare financing schemes for India



More than 2/3rd of expenditure on healthcare is out of pocket

Private health insurance accounts for <5% of total healthcare financing

Health insurance covers mostly in-patient treatment

It is imperative for any UHC scheme to cover OPD/ medicines/diagnostics

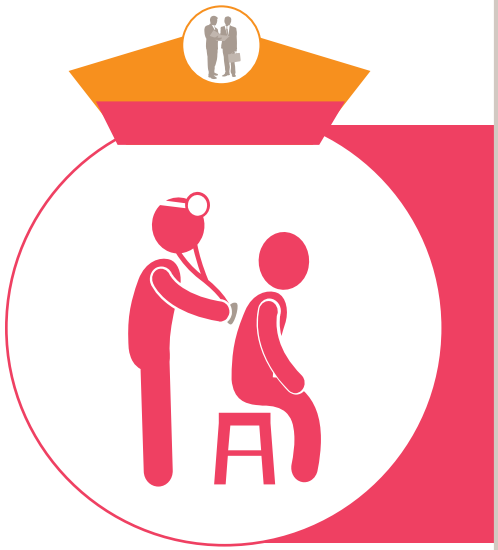
Source : National Health Accounts (2014-15)

Significant gaps in current health insurance schemes

	Scenario	Gaps
Insurance schemes	Mostly tax funded and non-contributory	Non-incentivised nature of insurance scheme
Quantum of insurance cover	Largely provides a coverage of <1 lakh INR	Coverage is insufficient in comparison to total cost incurred annually on treatment
Population coverage	A majority of these schemes are targeted at below poverty population	Minimal inclusion of above poverty population in government schemes
Number of schemes	Multiple state government health insurance schemes	Fragmented and each offering a different benefit package
Spectrum	Usually covers only-in-patient expenses and don't cover wellness and rehabilitative care	Mostly excludes OPD, diagnostic and pharmaceutical expenses
Pricing of packages	Highly skewed	No standardised package
Treatment protocols	Subjective medical decisions	No defined clinical protocols
Market penetration	Broadly confined in tier 1 and 2 cities	Limited penetration to tier 3 and 4 cities

Source: PwC research

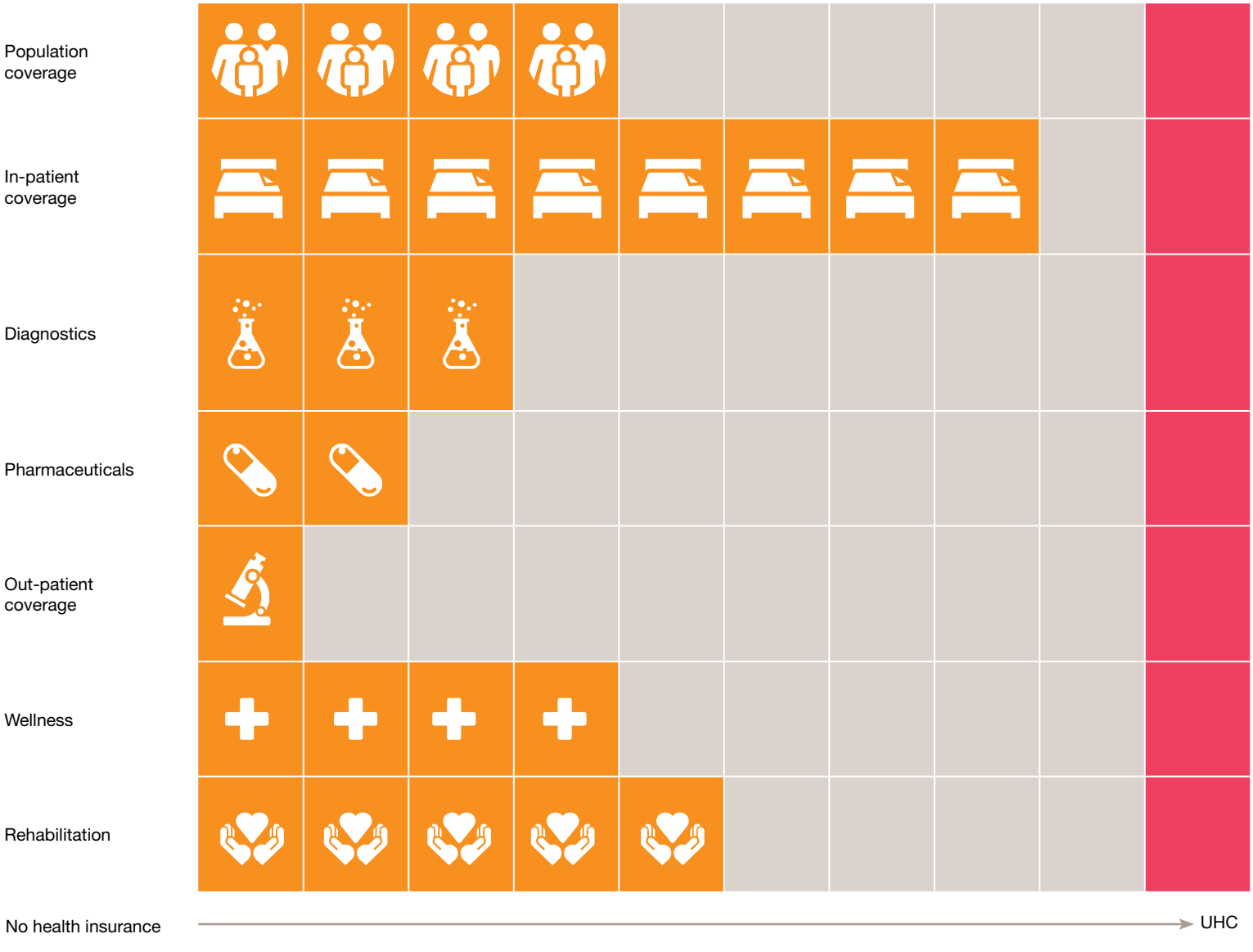
AB-NHPM is now poised to become the world's largest sponsored health insurance scheme



- *Budgetary announcement*
- *100 million family beneficiaries*
- *500,000 INR cover per family*
- *Families identified as per Socio-Economic Caste Census 2011*
- *Funded 60:40 by Centre and state*
- *To be merged with other state schemes*
- *To be implemented through an insurance company or directly through a trust/society or a mixed model*
- *Driven by strategic purchasing fromprivate sector*

Over 500 million Indians to be covered in AB-NHPM

AB-NHPM is a step towards UHC on different parameters



Source: PwC research

Section 2

Putting in the building blocks

A well-designed UHC scheme can result in positive outcomes

Sources of funding	Insurance mechanisms	Payer–provider relationship	Health priorities and outcomes
Analyse the fiscal space	**Design and implement the UHC scheme**	Fortify payment mechanisms	Widening of population coverage, OPD, drugs and diagnostics; progress towards preventive and rehabilitative care
Identify additional sources of funding	**Define:** Target population and service coverage	Introduce disease coding and EMR	Monitor the health outcomes
	Consider: Public vs private, contributory vs non-contributory, mandatory vs non-mandatory nature of scheme	Reduce fraud	
		Introduce standard treatment protocols	
▲ Healthcare financing		▲ Strategic purchasing	▲ Care provision

National Health Protection Scheme

AB-NHPM promises to bring about a tectonic shift in the healthcare ecosystem

Standardised treatment guidelines (STGs)

Mandate adoption of STGs for standardised treatment and billing.

Standardised package rates

The scheme identifies approximately 1,350 treatment/surgical procedures for which package rates will be fixed.

Updating ROHINI

It will benefit the health insurance sector in the management of claim costs through reduction in fraudulent claims.

Enrichment of National Health Resource Repository (NHRR)

Generation of repositories on hospitals, providers and other human resources for health.

IT integration and data generation

Will create data for improved operational, financial and medical management effectiveness via IT-enabled systems.

Employment generation

The scheme will have a multiplier effect on the Indian economy through employment generation and promoting the healthcare industry in tier 3 and 4 cities.

Standardised treatment guidelines (STGs) and package rates

Standardisation

Quality of care
Improved quality of services received by patient

Health outcomes
Increase in evidence-based medicine treatments, leading to improved health outcomes

Consistency of care
Improved consistency of care

Package rates

Claims management
Uniformity of surgical expenses, thereby enabling efficient management of claims

Uniformity
Helps in curbing tendency to overcharge

Price optimisation
Helps in standardising prices of treatment across the country for similar type of institutions

Enrichment of ROHINI system and NHRR creation

Registry of Hospitals in Network of Insurance (ROHINI) is a registry of unique hospitals in the health insurer and third-party administrator (TPA) network in India. It acts as an authentic data repository of hospitals which may be utilised for geography-specific trend analysis and curbing leakages arising due to fake hospital information.

NHRR is country's first ever healthcare establishment census to collect data of all public and private healthcare establishments. The project aims to strengthen evidence-based decision making and develop a platform for citizen- and provider-centric services by creating a repository of India's healthcare resources.

Enriching the ROHINI system through large-scale empanelment and registration of hospitals

…by removing inefficiencies like non-reporting, under-reporting and delays in transmission of public health data.

Improved user experience by enabling choice of best suited provider

This will help in leveraging private sector health infrastructure in service delivery.

Better fraud management at provider level due to generation of unique IDs for each hospital and improving claim efficiencies

It will also address the issue of unavailability of private sector health resource data, health infrastructure, equipment and other important data points.

Data creation and employment generation

Improving disease profile
Improvement of national health and disease prevention, prognosis of National urban health mission (NUHM) and National rural health mission (NRHM)

Process efficiencies
Bringing in operating efficiencies and improving financial performance and future cost predictions and budgeting

Capability building
Identifying utilisation patterns and their distribution or variation amongst different states and of healthcare resources accordingly

Fraud management
Predicting, preventing, detecting and managing frauds

Services	Transportation	Data management	Hospitality	Operations and general admin.	Quality accreditation	Human resource management
Industries	Pharma and diagnostics	Insurance	TPAs	Hospitals	Medical devices and supplies	Infrastructure

This will positively impact the current healthcare ecosystem

Hospitals

- Push for package rates
- Focus on quality
- Focus on accreditation
- Focus on operational improvements to reduce costs

Pharmaceuticals and diagnostics

- Focus on low-cost, good-quality drugs and on centralised procurement
- Focus on supply side shortages

Insurance

- To build capacities for effective claims management, actuarial capacities, clinical audit capacity and hospital scrutiny
- Negotiate package rates, improve system automation

Digital and IT service providers

- Develop IT architecture to link patient data, hospital data and insurance companies with Socio-Economic Caste Census (SECC) and Aadhaar data
- Digitisation trends will further help in reduction of costs, etc.

Government

- Identify additional sources of financing
- Build in system automation for monitoring and grievance redressal
- Regulators to ensure fair competition

Section 3

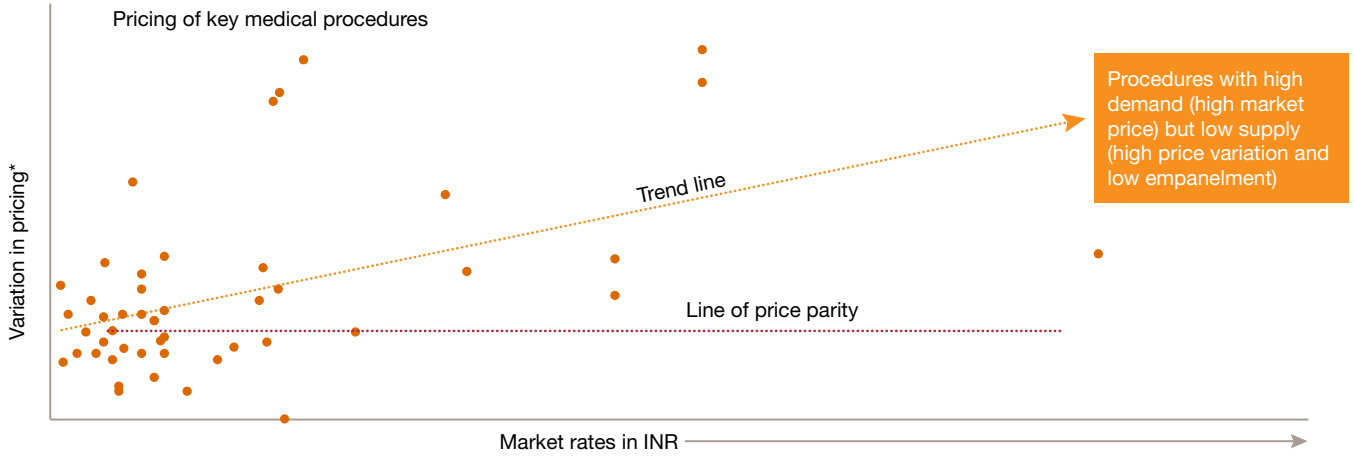
Imperatives for success

Right implementation

Key parameters	Immediate term	Medium term	Long term
Institutional structures	• Identifying and setting of State Health Agency (SHA) and District Implementation Units (DIUs) • Building contracts with insurance companies/implementation support agency	• Operations support in stabilising and issue resolution • Scale up implementation across states	• Capacity building of officers at regular intervals • Strengthening of SHAs and institutional structures
Identification and verification of beneficiaries	• Updating Socio-Economic Caste Census (SECC) list • Creating multiple service location • Develop unique list of beneficiaries	• Linkage for approval to insurance company • Issuance of e-card	Monitor training of all stakeholders involved in beneficiary identification
Hospital empanelment	• Setting of State and District Empanelment Committee • Online empanelment of hospitals via PMRSSM interface (registration and application, tracking, follow-up, etc.) • Signing of contracts	• Appointment of nodal officer for administrative and medical purposes • Hospital transactions for treatment procedures	• Hospital quality strengthening (nudging towards entry-level National Accreditation Board of Hospitals [NABH] or higher) • Evolve hospital rating system for further usage
Information technology	Deployment of requisite hardware, software, allied infrastructure and IT team across states	• Assess Information Technology (IT) team for readiness • Track readiness of state's IT platform for scheme and it's integration with central software	• Monitor deployment of IT hardware, software and allied infrastructure at empanelled hospitals • Monitor and reporting of deployment of kiosks • Develop standard operating procedures (SOPs)
IEC and capacity building	• SOPs need to be defined for all key processes • Development of Information, Education and Communications (IEC) strategy and guidelines • Develop and devise training methodologies	Strengthening of SOPs and guidance documents and implementation of IEC campaign	• Ongoing capacity building and Institutional strengthening • Incorporation of DRGs, disease coding and electronic medical reports (EMRs)

Identification of critical success factors, their seamless execution and evolution over the course of implementation will be the pillar for effective implementation.

Right pricing strategy



*Ratio of market price and NHPS price

Difference between market price and NHPS price is higher for costly procedures, thereby limiting the availability of these procedures. It is imperative to follow the right pricing strategy for the scheme to make maximum impact.

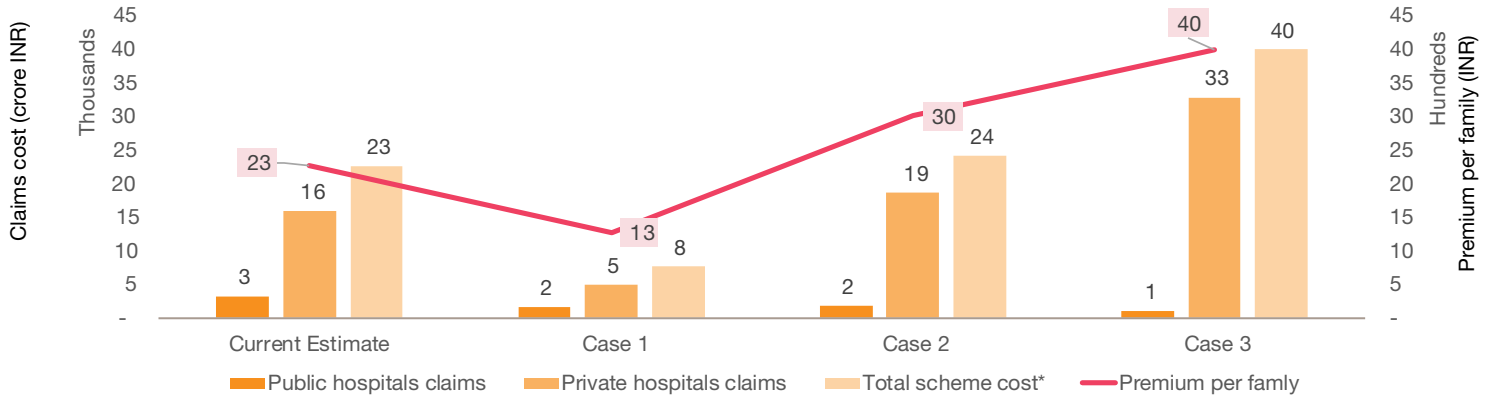
Difference between market price and NHPS price is higher for costly procedures and this might limit the availability of these procedures. Hence, it is imperative to follow the right pricing strategy for the scheme to make maximum impact.

Right costing considerations

	RSBY	AB-NHPM
1 Coverage	30,000 INR	500,000 INR (16–17 times that of RSBY)
2 Services covered	Limited	Cover high-end procedures
3 Premium	300–400 INR	?
4 Population covered	18 crore	50 crore

Premiums should be appropriately benchmarked to insurers so that they can be engaged constructively.

Right budgetary considerations



	Current estimate	Case 1	Case 2	Case 3
Coverage of target population	100%	60%	60%	100%
Increase in incidence rate due to coverage	30%	20%	70%	100%
Percentage of total hospitalisation in private hospitals	54%	60%	75%	90%
Reduction in private cost due to introduction of package rates	NA	50%	20%	20%
Total scheme cost (crore INR)	~23,000	~8000	~24,000	~40,000

Source: PwC simulation based on NSSO report

* Assuming 15% administrative expenses

Right pooling strategy

Multiple schemes lead to:

- **Duplication of beneficiaries across multiple schemes**
- **Inefficiencies in scheme management and roll-out**
- **Insurance frauds**
- **Poor beneficiary targeting**
- **Dual premium for same services**

Scheme	State	Population covered	Premium payment	Coverage limit
Sarva Swasthya Mission	Jharkhand	Entire population of Jharkhand • BPL (>25,000 INR),offered Health security by affordable pricing of standardised services	Family pays the premium: • 20 INR per family member and 170 INR as subsidy • Total premium: 190 INR	Public and private hospitals coverage: up to 30,000 INR Private hospitals coverage: up to 30,000 INR
Chief Minister's Comprehensive Health Insurance Scheme	Tamil Nadu	1. Families (residents of state) with income less than 72,000 INR per annum 2. Sri Lankan refugees 3. Orphans 4. Migrants on fulfilment of certain conditions	Government of Tamil Nadu pays the entire premium	Based on ailment/procedure: 1,00,000 INR or 2,00,000 INR per family per year and grants for follow-up treatment
Mukhyamantri Amrutum and Vatsalya Yojana	Gujarat	1. BPL (part of district BPL list) – for Amrutum 2. Families with income of 1.5 lakh INR and below – for Vatsalya	Government of Gujarat pays the entire premium	2 lakh INR/family for tertiary medical cover and 300 INR transportation charges

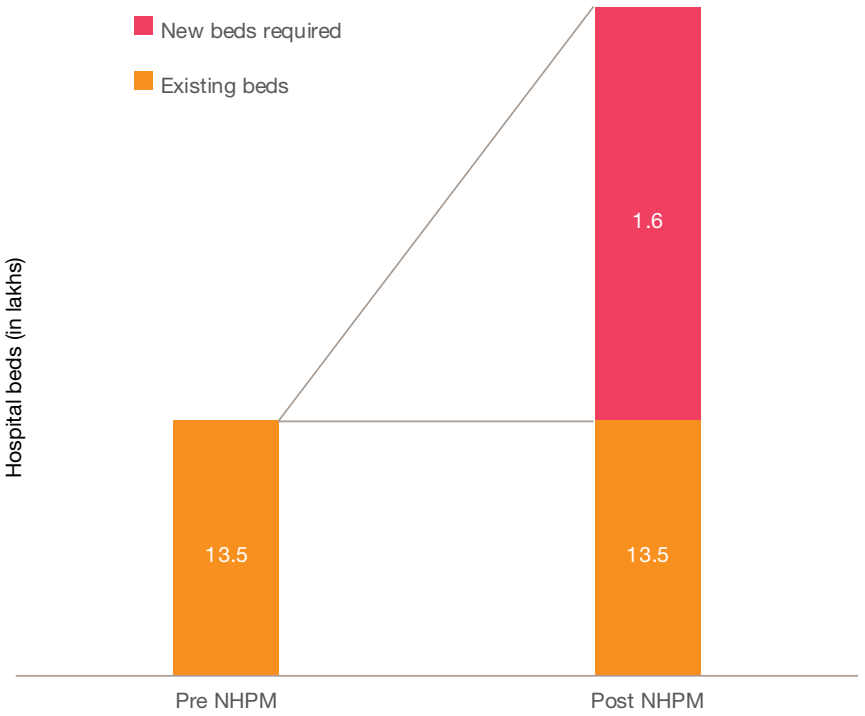
Existing schemes have seen a significant rise in financial costs due to systemic inefficiencies and fraudulent behavior across stockholders.

Right infrastructure

Hospital bed requirement

Population to be covered	50 crore
New population (no previous health insurance coverage)	33%
Hospital admission incidence rate	6%
Average length of stay (ALOS)	3 days
'New' hospital beds required*	1.6 lakh

* From new population which comes under coverage for the first time, and also from increased demand from previously covered population due to higher coverage

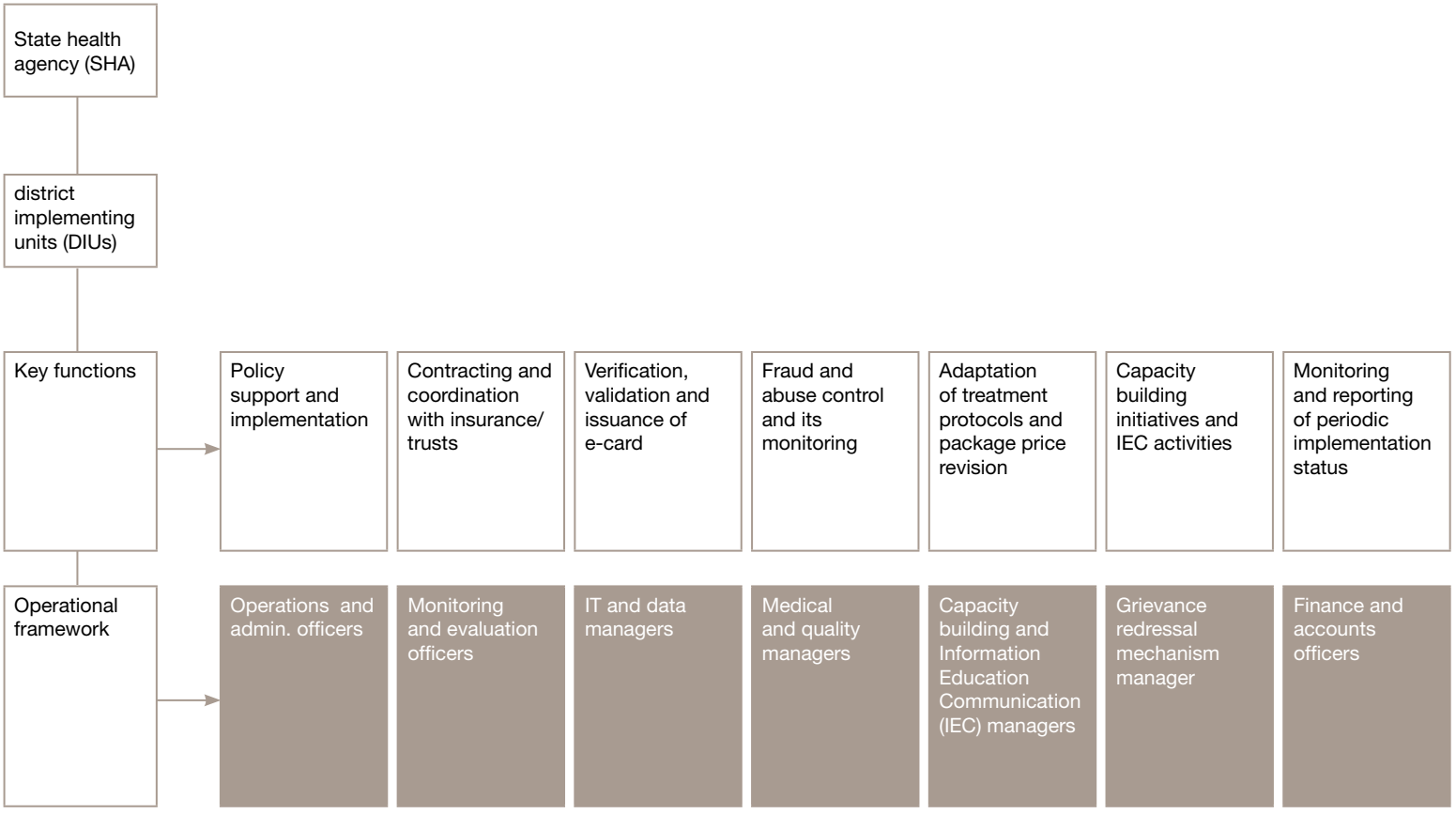


Demand for new beds to be met by:

- **Capital investments**
- **Changing status of non-functional beds to functional**
- **Public-private collaboration**
- **New business models**
- **Focus on preventive health care**

Right infrastructure strategy required to meet new bed capacity demand from AB-NHPM

Right institutional structures and frameworks



Appropriate institutional mechanisms would be needed for strategic implementation support and programme management.

Right leakage management

Foreseable fraud challenges in NHPS

- Enrolment of genuine/ghost beneficiaries
- Impersonation in connivance with cardholders and hospital, leading to fraudulent admissions
- Conversion of OPD patient into an IPD patient
- Showing medical management cases as day care procedures
- Deliberate blocking of higher priced package or multiple packages to claim higher amounts
- Treatment of diseases which a hospital is not equipped for
- Non-payment of transportation charges
- Hospitals/doctors not following standard protocols
- Doctors performing procedures needlessly
- Hospitals charging money even though it's a cashless scheme

Analytical activities

- Hospital analytics
- Doctor-level analytics – by specialisation
- Package-level analytics
- Disease profiling
- Fraud analytics based on diagnostics
- Analytics on consumption patterns of drugs, from a fraud and predictive standpoint
- For states where the insurance programme is self-managed, we can do a solvency analysis based on claim ratio
- Time to settle – one of the key KPIs; it should be analysed by insurer, because it is a major dampener for participating hospitals
- Deduplication algorithms to prevent duplicate enrolments

PMRSSM will create a need for various system analytics for risk mitigation in implementation/operations.

Right scheme monitoring indicators

Identification and verification of beneficiaries

- Families eligible in SECC
- Beneficiaries identified via valid Government ID
- Household covered
- Families migrated
- Families found with no change
- Families that could not be contacted
- Families currently enrolled in RSBY
- Families enrolled in state health insurance schemes

Hospital empanelment

- Hospital registered but application submission pending
- Application submitted with documents verified and under scrutiny by DEC/SEC
- Application sent for field inspection
- Application approved and contract pending

Treatment availed

- Qualified staff missing
- OT notes and daily monitoring chart not available
- Proof of payment of transportation charges missing
- Help desk missing
- Patients presenting complaints that do not match with package blocked
- Treating doctor's details not shared
- Package blocked without patient being admitted

Pre-authorisation and claims processing

- Percentage of pre-authorisation raised
- Percentage of pre-authorisation approved Percentage of pre-authorisation declined
- Time to pay hospitals after submission of claims
- Percentage of pre-authorisation settled within TAT
- Percentage of re-imbursement claims reported
- Percentage of claims paid/rejected
- Percentage of claims paid within 30 days

Fraud

- Beneficiary fraud: Enrolment of in genuine/ghost beneficiaries
- Beneficiary fraud: Impersonation in connivance with cardholders and hospital, leading to fraudulent admissions
- Hospital fraud conversion of OPD patient into an IPD patient
- Hospital fraud: Showing medical management cases as day care procedures

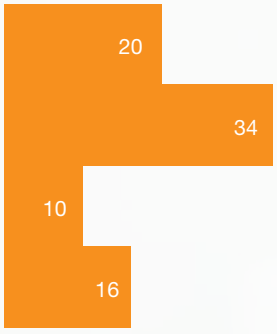
Complaints

- Qualified staff missing
- OT notes and daily monitoring chart not available
- Indoor case papers incomplete
- Proof of payment of transportation charges missing
- Help desk missing
- Patients presenting complaints that do not match with package blocked
- Treating doctor's details not shared
- Package clocked without patient being admitted

Right monitoring dashboards (illustrative)

Identification and verification of beneficiaries

- Percentage of families currently enrolled in RSBY
- Percentage of families eligible in SECC
- Percentage of households covered
- Percentage of families covered under state insurance schemes



Hospital empanelment

Percentage of hospitals empanelled

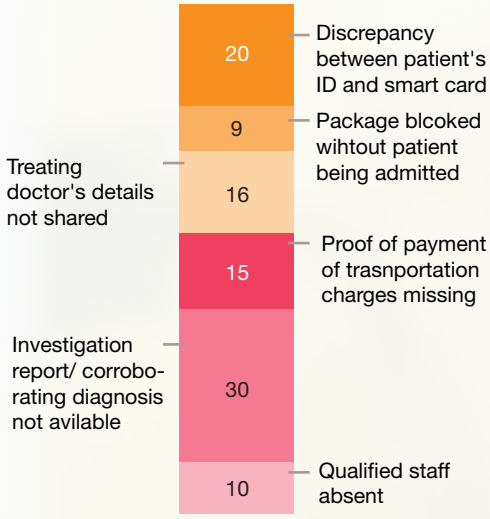
Percentage of verification of the empanelment application by the insurance company and approval by state

Percentage of applications rejected

Percentage of hospitals de-empanelled

Percentage of application submitted with documents verified and under scrutiny by DEC/SEC

Treatment availed



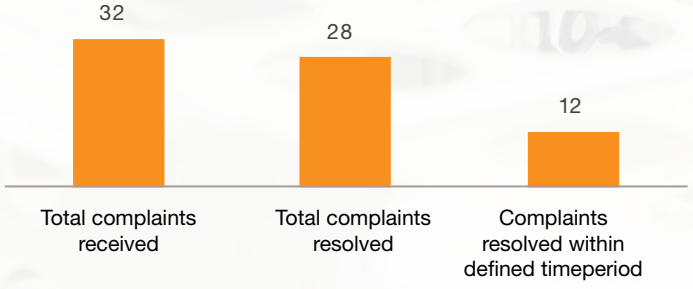
Claims

- Pre-authorisation of claims approved
- Claims rejected

Fraud

- Beneficiary fraud
- TPA fraud
- Hospital fraud
- Dignostics fraud
- Insurance fraud

Complaint



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The Confederation of Indian Industry (CII) works to create and sustain an environment conducive to the development of India, partnering industry, Government, and civil society, through advisory and consultative processes.

CII is a non-government, not-for-profit, industry-led and industry-managed organization, playing a proactive role in India's development process. Founded in 1895, India's premier business association has around 9000 members, from the private as well as public sectors, including SMEs and MNCs, and an indirect membership of over 300,000 enterprises from around 265 national and regional sectoral industry bodies.

CII charts change by working closely with Government on policy issues, interfacing with thought leaders, and enhancing efficiency, competitiveness and business opportunities for industry through a range of specialized services and strategic global linkages. It also provides a platform for consensus-building and networking on key issues.

Extending its agenda beyond business, CII assists industry to identify and execute corporate citizenship programmes. Partnerships with civil society organizations carry forward corporate initiatives for integrated and inclusive development across diverse domains including affirmative action, healthcare, education, livelihood, diversity management, skill development, empowerment of women, and water, to name a few.

As a developmental institution working towards India's overall growth with a special focus on India@75 in 2022, the CII theme for 2018-19, India RISE : Responsible. Inclusive. Sustainable. Entrepreneurial emphasizes Industry's role in partnering Government to accelerate India's growth and development. The focus will be on key enablers such as job creation; skill development; financing growth; promoting next gen manufacturing; sustainability; corporate social responsibility and governance and transparency.

With 65 offices, including 9 Centres of Excellence, in India, and 11 overseas offices in Australia, Bahrain, China, Egypt, France, Germany, Iran, Singapore, South Africa, UK, and USA, as well as institutional partnerships with 355 counterpart organizations in 126 countries, CII serves as a reference point for Indian industry and the international business community.

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PwC India's Healthcare team offers advisory services in the healthcare sector covering multiple domains such as strategy, business planning, market scan, commercial due diligence, feasibility study, operations improvement, cost reduction, health IT, digital and technology, internal audit and PPPs.

Healthcare Advisory has a dedicated team with diverse operational experience in setting up and managing hospitals, and in healthcare consulting. This enables the team to deliver granular strategy and market and operational insights of the highest quality. The team works with leading healthcare providers, medical technology companies, central and state governments, diagnostic players, insurance companies and private equity players on projects both in India and overseas.

Notes

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