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
2. Omits clinically appropriate indications as part of claims authorization system
3. Allows for funding of less cost-effective interventions
   - E.g. proton beam therapy, mandates minimum inpatient stay for possible day-cases, pacemakers
4. Creates incentives for volume/overuse through paying for technologies and interventions through FFS
   - MRI, hearing aids, radiotherapy etc.
5. 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  - Does not take advantage of Aadhar - outdated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:

1 Set goals & criteria

2 Operationalize general criteria & define methods for appraisal

CONTEXT
- Donors
- Health System
- Markets
- Political institutions
- Regime
- Rights
- Technology
- Wealth

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