NATHEALTH®
Healthcare Federation of India

Enabling an Accessible, Equitable, and Affordable health coverage for 1.4 Bn Indian citizens

March 2023

NATHEALTH®
Healthcare Federation of India

Contents

NATHEALTH acknowledges the research effort and consultation with all stakeholders including external experts PwC has provided for this paper.

NATHEALTH®
Healthcare Federation of India

Executive Summary

Executive Summary (1/2)

Indian healthcare is confronted with **several challenges** from a care delivery and financing perspective. This paper focuses on ascertaining ways to solve the problems of **insufficient infrastructure, inequitable health coverage and inadequate focus on outcomes.**

While PMJAY has enabled a mechanism to provide demand side accessibility for ~400 Mn people in the country, many in tier 2 and 3 cities, supply side accessibility remains a constraint. India has an **insufficient health infrastructure** with a **low bed density** ratio of ~1 bed/1000 population with **the** world average being 2.7 beds/1000 population (World Bank). This **highlights the need for PPP hospitals** in non-urban areas and a deep dive on the **reasons for a limited uptake by the PPP Viability Gap Funding (VGF) scheme** among private providers along with the key learnings and best practices around PPP structuring.

To address the issue of **inequitable health coverage**, 30% of the Indian population devoid of any financial protection for health, referred to as the Missing Middle, needs to be provided with health protection. The **lack of inclusion of OPD/primary care** in health insurance **contributes to high OOPE**. This section will explore an alternate option to extend the existing ABPMJAY scheme considering the significant financial implications by developing an affordable private health insurance product by leveraging on the existing ABPMJAY network.

Currently, healthcare provision is compensated by Fee For Service (FFS) and is incentivised based only on the quality accreditation, with an **inadequate focus on outcomes**. Under a **value-based payment model**, healthcare providers are compensated with efficient usage of services and reduced length of stay. This section aspires to **emphasise the importance and relevance of a value-based payment model of healthcare services** in the Indian context, the best practices across the globe and the recommendations on a possible reimbursement model.

The Government of India introduced a "**Scheme for Financial Support to PPPs in Infrastructure" (VGF Scheme)** with a view to support augmentation of the health infrastructure through a PPP mode in the country.

The scheme has seen no uptake by private providers. **Only 3 projects in Odisha have received an in-principle approval by the Empowerment Committee** and are yet to be awarded.

This could be **attributed to several challenges** ranging from the fundamental **design and construct** of the policy that lacks a customisation to the health sector, to the identified **location being not attractive** enough from a catchment and resourcing standpoint. The **complex bidding process**, lack of a clear **demand channeling mechanism** and **cashflow risks** owing to delayed payments also deter private providers from utilising this scheme.

Possible recommendations based on discussions with industry stakeholders and learnings derived from Indian and global case examples include the following-

- **Structured interactions** between the contributing stakeholders to create draft tender documents ahead of the RFP process will ease the complex bidding process and reduce longer approval times
- Role of **separate partner for design/construction of hospital** which is not the operator's competency
- Considering **opex over a period of 30 years is 25 times the initial capex, thus, a provision of the VGF support on the operating expenses** is required
- A **hub & spoke model** where the PPP should be limited to the hub location and government to facilitate acting as spokes (PHCs and district hospitals) by priority routing of sponsored patients from the catchment to the hub will ensure guaranteed volumes
- **Pricing** of services to be **aligned to the true cost of service delivery** with a flexibility to treat cash patients at a fee determined in consultation with the private provider will address the challenge of financial viability
- **Routing through TPAs for payment disbursements** will ensure timely payments

Executive Summary (2/2)

India witnessed a significant decline in **OOPE** to 48.2% in 2018-19 from 64.2% in 2013-14 owing to an increase in utilisation and reduction in cost of services in government health facilities. This **remains higher than the global average of 18%** and can be curtailed by inclusion of outpatient coverage in insurance products and **expanding health protection to the missing middle** (30% population).

Inclusion of **cashless OPD benefits** along with the standard insurance product or introducing the concept of **Health Savings Account (HSA)** could possibly be worked on from an OPD outlook.

For expansion of health protection to the missing middle, **the role of private insurers in designing an affordable & sustainable product for the missing middle** is a possible recommendation. The product characteristics will include developing a multivariant product to target different segments based on their affordability by **leveraging the existing ABPMJAY provider network, data and systems**.

The product development will require an **effective collaboration** between the policy makers, insurers and the providers to create awareness, affordability & accessibility. The government would be required to provide access of ABPMJAY's provider network, systems & infrastructure to the insurers to extend the benefit at affordable costs while creating greater consumer awareness for group enrolments to ensure mitigating the risk of adverse selection.

The **provider's alignment to the tariffs** for providing treatment will be an area of focus for validating the viability and scalability of the new developed product for the missing middle. **Exploring innovative distribution channels to enhance product reach** and a diverse risk pool will be instrumental in minimising the distribution costs and maximising the spread to the target population.

The **Traditional FFS model** of care provision is not the most efficient, provides incentives to caregivers based on a higher number of visits, procedures, tests and treatments. The barriers in FFS include insufficient revenue to cover high value services. **Increasing healthcare expenditure, excess healthcare costs attributed to inefficient services along with uncoordinated care** have set the stage for the **adoption of a value-based payment model** in India.

While India follows the FFS payment model along with incentivisation of providers based on quality accreditation for healthcare delivery today, efforts are in place by means of the ABPMJAY to **transition to Diagnosis Related Group (DRG) based payment models** and outcome-based incentives in the future.

Essential building blocks for a DRG-based system include a **patient classification system** that groups patients based on diagnosis, severity and demographic data, **price setting** based on true cost of service delivery and **cost weights** basis severity & clinical outcomes, **alignment of specific quality indicators/outcomes to link payments** with and establishing a costing tool. Globally, countries have taken 10-15 years to transition to DRG from FFS. With technology as a key enabler, India presents an opportunity to leapfrog DRG implementation.

Transition to the DRG-based reimbursement will be phased over time. **Foreseeable challenges include the unavailability of consistent patient data and limited data exchange** in the current ecosystem.

A **collaborative environment** of stakeholders from the government, providers and payers will be pivotal in achieving the transition to this new payment reform.

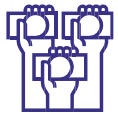
Revised PPP VGF scheme, a self-contributory affordable insurance product and transition to a DRG-based payment model will enable accessible, equitable and affordable health coverage for 1.4 Bn citizens.

NATHEALTH®
Healthcare Federation of India

02 Context Setting

Indian healthcare is confronted with a multitude of challenges from a financing and care delivery perspective

01



Inadequate funding & resources

- India's public health expenditure as a percentage of GDP is 2.1%, significantly lower than the world average of 9-10%

Public expenditure on health has risen from 1.2% in 2018 to 2.1% in 2023 and govt. has already announced plans to take it to 2.5% by 2025

02

Shortage of hospital beds

- Inadequate physical infrastructure with lack of proper equipment & facilities
- Bed density of **1 bed/ 1000 population vis a vis the world average of 2.7 beds/1000 population**
- 70-80% of hospital beds are concentrated in urban areas

03

High OOPE & Missing Middle

- Lack of inclusion of OPD/primary care contributes to high OOPE
- OOPE as a percentage of overall health expenses in India is **48.2%,** high in comparison to the **global average of 18%**
- At least **30% of the Indian population- the missing middle - are devoid of any financial protection for health**

04

Lack of value-based care

- Currently, healthcare provision is **incentivised based only on quality accreditation**
- Traditional Fee for Service model of care provision is not the most efficient and provides incentives to caregivers based on a higher number of visits, procedures, tests which may not be in line with patient health and wellness

These 3 are critical elements to be addressed to expand healthcare coverage for all

05

Shortage of human resources

- Doctor-to-patient ratio is abysmally low, 0.7 doctors/ 1,000 people while WHO average is 2.5 doctors per 1,000 people

Govt. is setting up 157 new medical colleges and 50 nursing institutions. Number of MBBS students graduating each year is expected to increase to 1 lakh very soon

06

Limited adoption of digital systems

- India has inadequate focus on technology and digital for healthcare delivery. This is a hindrance in achieving establishment of continuum of care, timely payments, robust fraud detection and enhanced trust & accountability

In recent years, there have been multiple initiatives on this front such as ABDM, eSanjeevani, and National Health Stack

Source- Secondary research, World Bank, NSS 75th round, NHRR, Health Insurance for India's Missing Middle- NITI Aayog, WHO

Building blocks of Indian healthcare: a reality check

Context

Insufficient infrastructure	*Inequitable health coverage*	*Inadequate focus on outcomes*
• India has a bed density of 1 bed/1000 population, compared to the world average of 2.7 beds/1000 population • 70-80% hospital beds are concentrated in urban areas	• At least 30% of the Indian population- the missing middle- are devoid of any financial protection for health, even for IP services • Lack of inclusion of OPD/primary care for most health insurance companies also contributes to high OOPE	• Currently, healthcare provision is largely Fee For Service and is incentivised based only on the quality accreditation and volume of services • Traditional Fee For Service model of care provision is not the most efficient payment model

What the paper will help answer

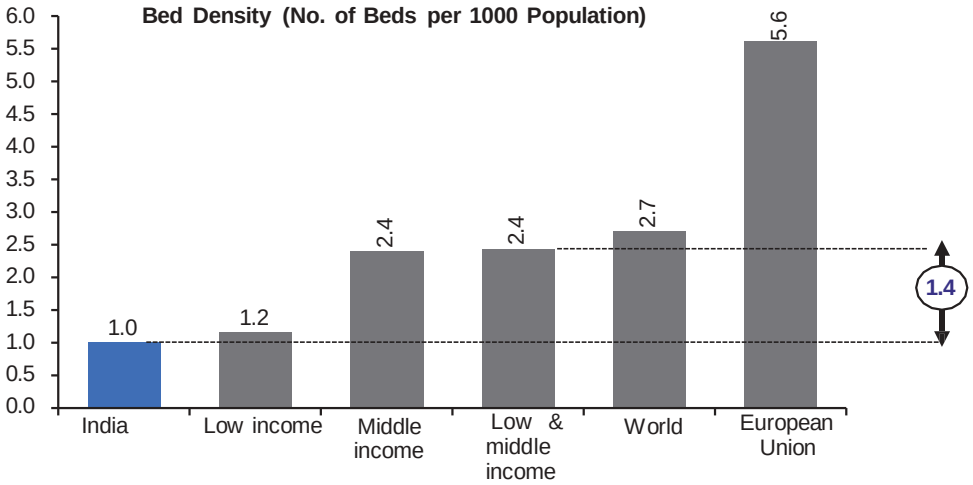
NATHEALTH®
Healthcare Federation of India

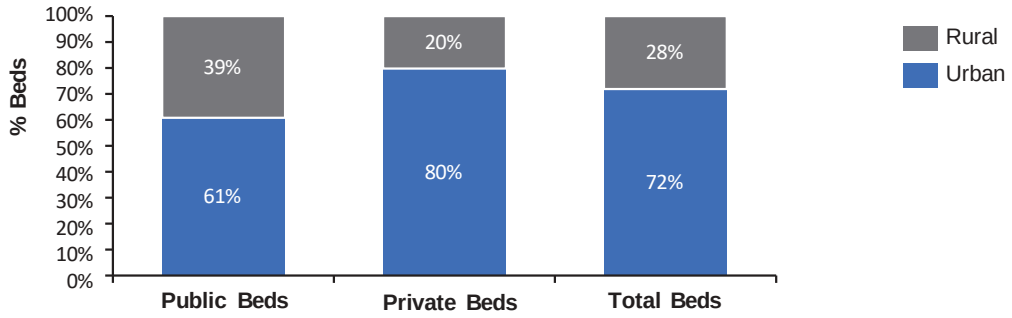
HOSPITAL

03 PPPs in healthcare for infrastructure creation

India has a low bed density as compared to ROW; Ayushman Bharat Health Infrastructure Mission (ABHIM) to play a key role in strengthening the public health infrastructure to fill the critical gaps

In spite of the significant decline in OOPE to 48.2% in 2018-19 from 64.2% in 2013-14, making healthcare accessible to the masses has been a challenge that the country is still confronted with





- Existing hospital beds and hospitalisation services have a high level of concentration in urban areas, which in turn impact the accessibility and affordability of hospitalisation services
- States of Odisha, Chhattisgarh, J&K, Bihar, Jharkhand and most of the northeastern states have a bed density of <0.7 beds/1000 population

Pan India Health Infrastructure Scheme for world class facilities making each district self reliant

- Creation & improvement of long-term public healthcare infrastructure with a financial outlay of INR 64,180 crore over 5 years
- Government has borrowed INR 13,879 crores to strengthen health infrastructure from **international agencies such as Asian Development Bank (ADB), Japan International Cooperation Agency (JICA)** and the World Bank **to augment PM-ABHIM**

The need for PPPs is further underlined given an enhanced impetus from the government and the efficiencies that the private provider will contribute

Source- Secondary research, World Bank, NSS 75th round, NHRR

Central government has VGF scheme in place to create hospital infrastructure in PPP mode; revamped scheme offers capital grant of up to 80%, from the earlier 60%

Evolution of VGF scheme

2010
VGF scheme extended to healthcare

Progress so far

2013-2014
Only 3 PPP projects in Odisha received an in-principle agreement; all 3 yet to be awarded

2020
Revamping of the VGF scheme

Salient features of the scheme

	Sub scheme 1	Sub scheme 2
Applicability	• PPP projects proposed by State Governments, Central Ministries and Statutory Authorities • Project to be awarded on a Design, Build, Finance, Operate and Transfer (DBFOT) basis • Open and competitive bidding process to be followed	
Eligibility	The project should be self-sustainable (100% operational cost recovery) in terms of operational expenditure	The project should be sustainable with VGF support of 50% O&M costs (provided for the first five years)
Financial Support	**Capital grant:** • Central government: lowest capital grant quoted subject to maximum 30% of total project cost • State government: additional grant up to a maximum of 30% of total project cost	**Capital grant:** Central & state government: Maximum 40% each of Total Project Cost **Operational grant:** • Central & state government: Maximum 50% of the NPV of the O&M costs for the first five years after COD (partial funded) • O&M cost included for the calculation of NPV is limited to the salary and consumables costs only
Private partner selection criteria	**Lowest VGF required by private partner for the project** • In case of projects under sub-scheme 1: Lowest capital grant • In case of projects under sub-scheme 2: Lowest sum of capital grant and NPV of operational grant for first five years from COD	

Source- Retrieved from https://pib.gov.in/PressReleasePage.aspx?PRID=1671910 , https://rb.gy/flbbzc

Despite revisions in the VGF scheme, the policy has seen a limited uptake driven by the following reasons (1/2)

Policy element	Description	Challenge w.r.t health sector
Design & construct of the policy 	• **Lacks customisation** - elements of the scheme seem to be more attuned to the infrastructure (power/road) projects and lack specific intricacies of the health sector • **Longer approval time** - The current scheme involves a multitude of stakeholders, which increases the overall timeline of the approval process - As an example, approval of all the project documents from the Empowered Committee before submission to Central Government adds to the back and forth involved in the process - Role of separate partner for design/construction of hospital which is not the operator's competency, adds to the timeline	• The **focus is on upfront costs** only - lacks focus on operating expenses which is a significant proportion. For a ~100-200 bedded facility, the **opex over a period of 30 years is 25 times the initial capex. Thus, a VGF scheme focused on capex is not optimal for a healthcare project** • Capping tariffs is a practice adopted from power/road PPPs where tariffs are simpler to calculate, forecast and fix in advance in the contracts, unlike in the health sector
Location & sizing 	• Government's vision of enhancing healthcare access in the **remotest locations in absence of proactive discussions with industry stakeholders** • Project viability depends on the feasibility of ensuring patient volumes, availability of medical professionals aligned to the cost-of-service delivery	• 3 PPP projects that received an in-principle approval (2013-14) were in remote locations- Balangir, Gajapati & Rayagada district. Odisha saw limited private participation. They remain unawarded to date.

Source- Secondary research, Primary interviews

Despite revisions in the VGF scheme, the policy has seen a limited uptake driven by the following reasons (2/2)

Policy Element	Description	Challenge w.r.t health sector
Financial Viability 	• **Volumes-** **Routing** of government sponsored patients to utilise the reserved beds if bidding variable is linked to percentage of reserved beds • **Pricing-** **Capped tariff rates & higher reservation for sponsored patients:** - No provision for inflation-adjusted price revision - Inflexibility to treat cash/unsponsored patients • **Cashflow risks owing to delayed payments** from sponsoring schemes	• **Lack of linkages** in the referral systems through health & wellness centres, PHCs and district hospitals do not assure volume guarantee • Both **capped tariffs and higher reservation**, if predefined, makes the project unattractive for private provider • Since a significant proportion of patients flow from the state and central government health schemes with no assured volumes and capped prices, the **risk of delayed payments** makes the entire proposition unappealing for the private provider • Cashflow risk owing to delayed payments
Monitoring & evaluation systems 	• **Stringent KPIs fixed** without provider involvement • **Manpower requirements-** Predefined manpower requirements without consultation with private partner	• **PPP contract of the Odisha government had predefined KPIs** related to manpower and bed allocation without provider alignment made it unattractive for private participation • **High manpower requirements** without giving flexibility to the operator in a situation where the demand scenario is uncertain, limits attractiveness from the private sector as it increases opex

Source- Secondary research, Primary interviews

What has worked in Healthcare PPPs in India?

However, there have been PPPs where some of these challenges have been addressed (1/2)
Case study 1: Super specialty Hospital in Katra, Jammu

***Public sector entity**: Shri Mata Vaishno Devi Shrine Board (established under the Jammu and Kashmir state government)*

***Private sector partner**: Narayana Health*

Background	Development (Build, Refurbish, Operate and Transfer) of a 230-bed super specialty tertiary care hospital covering over 20 different clinical specialties with a special focus on Cardiac Sciences and Oncology

As per tender document

BROT Model (Build, Refurbish, Operate & Transfer)

Model

Constructing and handing over the hospital building with assets

Public Partner

Operation and maintenance of the hospital to provide super specialty services including replacement of equipment in future

Private Partner

20 years

Duration

Key Learnings

Financial Viability

- **Pricing**: The Opex viability gap funding for the initial 5-6 years to cover the operating losses gave significant assurance on project viability to the provider
- **Cashflow**: Monthly payout of the opex viability gap funding allowed for working capital management for the provider

"Receivables were paid during the first 5-6 years on a monthly basis."

Source- Retrieved from https://www.maavaishnodevi.org/RFP_SMVDIME_Hospital_PPP_23.09.2013.pdf , Primary interviews

However, there have been PPPs where some of these challenges have been addressed (2/2)
Case study 2: PETCT PPPs in Chennai

***Public sector entity**: Tamil Nadu Medical Services*

***Private sector entity**: Anderson Diagnostics*

Background	Govt. of TN wanted to provide PET-CT and SPECT scan facilities to poor at affordable cost at various Govt. medical Institutions through Public Private Partnership (PPP) mode

Model

Build, Own & Operate (BOO)

Public Partner

Responsible for providing & maintaining physical structure/space

Private Partner

- Responsible for providing services with proper equipment, skilled manpower and consultants
- Estimated investment - INR 8.5 crores (per centre)

Duration

10 years

Financial bid criteria	• Bidder who offers the highest single common and uniform percentage of reduction on the scan charges will be considered for award of contract
Role of private partner	• Scan charges to be considered for revision after 5 years by standing committee • To pay 10% of their monthly collection to Hospital Maintenance Fund (HMF) of the hospital for utilisation of space, electricity & water

Key Learnings

Monitoring & Evaluation Systems

- Simplified KPIs such as maintaining equipment uptime of 95%, arranging scans at nearby similar facility at own risk & cost during equipment downtime beyond 48 hours and reporting of patient grievance redressal are acceptable and addressable

Financial Viability

- **Cashflow** - Timely payments routing through TPA with a turnaround of 7 days (payment was never delayed beyond 30-45 days)
- **Volumes-** 10% revenue share with government assures a check on the leakages and case diversion
- **Pricing -**Price per scan (bidding parameter) was reasonable, aligned to costs and in sync with market prices
  - ✓ Allowed to directly collect the charges from the non-sponsored patient at the agreed rate
  - ✓ There is also a provision for price revision at the end of 5 years

Source- Retrieved from http://www.tnmsc.com/tnmsc/linkfiles/tender_documents/tender190145.pdf , Primary interviews

Govt of UP has taken a step towards creating sustainable model by attempting to address challenges associated with construct of the policy and financial viability

Salient features of the draft policy	**Mode B** Greenfield development of minimum 50 bed hospital: GoUP land + incentives	**Mode C** Greenfield development of min.50 bed hospital: Private land + GoUP incentives	**Mode D** Greenfield development min. 200 bed hospital: Private land + GoUP incentives
Role of private partner	Construct, operate & maintain, transfer the hospital (at least 50 beds) including HMIS as per ABDM	Procure land, construct, operate & maintain, the hospital (at least 50 beds) including HMIS as per ABDM	Procure land, construct, operate & maintain, the hospital (at least 200 beds) including HMIS as per ABDM
Contract duration	50 years	50 years	10 years
Capital grant & Interest subsidy	40% of total project cost, 5% towards interest subsidy for construction for 5 years	NA	NA

A few of the challenges addressed in the new draft UP government's scheme	
Design & construct of the policy	Incorporation of Opex VGF determined through bidding- minimum opex grant sought
Financial Viability- Pricing	**For IPD services:** Uninsured patients- • Government to reimburse basis PMJAY rates (Mode B & C) • Private partner allowed to treat basis market rates (Mode D) **For OPD services,** Government to reimburse • Consultation fees basis CGHS rates • Diagnostics charges basis 2 times of the agreed monthly OPD fees for actual patient volume (up to a capped volume only)

Mode A- Central Govt. PPP VGF Scheme

Source- Department of Health, Govt of Uttar Pradesh

Models prevalent globally

Globally PPPs have been successful due to balanced risk & rewards, broad stakeholder engagement, contract structure and flexible model

PPP model type	Infrastructure- based model	Discrete clinical services model	Integrated PPP model
Features of common PPP models	To build or refurbish public healthcare infrastructure	To add or expand service delivery capacity	To provide a comprehensive package of infrastructure and service delivery
Examples	• British PFI model	• Sawai Man Singh (SMS) Medical College Hospital in Jaipur • Romania- Outpatient dialysis services with IFC • Anderson Diagnostics, Tamil Nadu, India	• La Ribera Hospital, Valencia, Spain • Jandaloop Health Campus, Perth, Australia • Queen Mamohato Memorial Hospital, Maseru, Africa • Hospital Alberto Leopoldo Barton Thompson, Peru
Stakeholder role			
CAPEX and OPEX	Private	Private	Private
Demand Channeling	Public	Public	Varies
 **Critical element for success** 	**Design & construct of the policy:** • Government repays the construction cost and the annual maintenance contract in form of an amortised annual payment over the life of the contract **Financial Viability:** • Government owns the responsibility of patient volume making the model attractive for the private provider	**Design & construct of the policy:** • An 'asset-light' format- reducing cost and complexity • Contract duration in line with the life of equipment (less than 10 years) • For long term contracts, medical device manufacturer partners with provider to bid on project **Financial Viability:** • Guaranteed patient volumes makes the model attractive for the private provider	**Design & construct of the policy:** Given the significantly different competencies involved, two sets of partners are involved • One partner to finance and design/construct the hospital in the short run • Other partner to manage and deliver healthcare services over the length of the contract

Source- Retrieved from https://globalhealthsciences.ucsf.edu/sites/globalhealthsciences.ucsf.edu/files/ppp-report-series-business-model.pdf , Secondary research

Recommendations

Addressing a multitude of critical success factors would make hospital partnerships more viable and enable enhanced involvement from the private sector (1/3)

Contract Structure & Broad Stakeholder Engagement

Policy Element	Recommendations
Design & construct of the policy 	**Simplification of policy construct & design** to create the acceptable framework and shorten approval times • A phase of structured interactions with the public & private partner and the transaction advisors will help in drafting tender documents ahead of the RFP before the final bids are called • Given the significantly different competencies involved in building and operating a hospital, the **role of infrastructure companies** could be evaluated for setting up the hospital **(a separate PPP) and the private partner to be involved in operationalising the hospital**. **VGF support on both capital & operating expenses** • Design/construct the project in a way that the **hospital becomes self-sustaining** in 5 years • Private hospitals work on an asset light model with minimum investment on infrastructure. Hence, a **predefined component of opex VGF (bidding parameter) will make the project more attractive for the private sector**

Learnings from aviation sector- UDAN scheme

Government compensates the airline's operating losses in the form of opex VGF to boost regional air connectivity. The bid evaluation parameter was set as the lowest VGF per seat with provision to adjust basis inflation, every financial quarter

Implications on the health sector

Bidding parameter- **Minimum VGF required per operating bed based on the scale of operations**

Provision of inflation adjustment of VGF sought to cover up the increase in prices of drugs, consumables, salaries and utilities

VGF ask could go down based on the percentage of beds reserved for sponsored patients and the flexibility to cater to cash patients

Source- Retrieved from https://www.civilaviation.gov.in/sites/default/files/UDAN-Manual.pdf, Secondary research, Primary interviews

Recommendations

Addressing a multitude of critical success factors would make hospital partnerships more viable and enable enhanced involvement from the private sector (2/3)

Contract Structure & Broad Stakeholder Engagement

Policy Element	Recommendations
Location & sizing 	Creation of hub & spoke models:- - PPP location identification shouldn't be done in silos just to fill in the infrastructure gaps, rather there should be **a systematic location assessment** based on population, accessibility, attractiveness for medical manpower and, where there is a larger supply-demand gap, to create "hubs" - Government should take the onus of **strengthening the infrastructure and service offerings at PHCs/district hospitals to act as spokes** and facilitate running the hub/referral centre. Private providers are constrained to hire and retain medical professionals in the remotest location, considering the expectations of high-end work and no guaranteed patient volumes

Balanced Risk & Rewards and Flexible

Policy Element	Recommendations
Financial Viability 	**Volumes** • Narrow networking- Priority routing of sponsored patients from the catchment to the identified hub will ensure guaranteed volumes **Pricing** • **Higher flexibility to the private partner for determining reimbursement rates** based on **true cost of service delivery** (based on the tariffs of the government health schemes) and periodic inflation-adjusted tariff revision **Timely payments** • Evaluation of **routing payments through insurance companies/TPAs** by the state schemes to ensure timeliness of payments • **Evaluating alternate payment methods like an advance payment** to the private partner based on an estimated number of patients (like the Alzira model where the government funds healthcare services by paying the provider a capitation charge derived from the public health budget) and later adjusts against submitted bills

Source- Secondary research, Primary interviews

Recommendations

Addressing a multitude of critical success factors would make hospital partnerships more viable and enable enhanced involvement from the private sector (3/3)

Balanced Risk & Rewards and Flexible Model

Policy Element	Recommendations
Monitoring & Evaluation Systems	• **Predefined KPIs** should be limited to national building code, pollution, fire and clinical establishment act and clinical parameters like morbidity rate, mortality rate, Hospital Acquired Infection (HAI) rate, hospital readmission rates • **KPIs related to manpower requirements** limits attractiveness from the private sector as it is difficult to foresee demand pertaining to specific specialty • **Refusal of patients** due to unavailability of services which are part of scope of service delivery (excluding the non-availability of bed scenario) could be included as a predefined KPI • Penalty on non-adherence to non-critical KPIs shouldn't be so stringent that there is likely risk of losing out on entire performance guarantee in 1-2 years

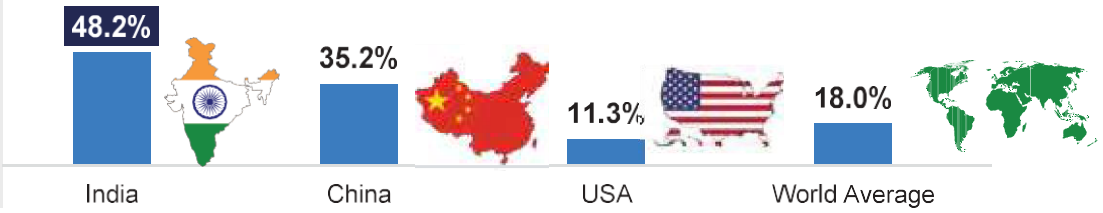
Source- Secondary research, Primary interviews

04 Leveraging the AB-PMJAY network to cover the missing middle

India has high OOPE due to lack of OPD coverage for most and no IPD coverage for the missing middle (30% population)

"High OOPE on health is impoverishing some 55 Mn Indians, annually, with over 17% households incurring catastrophic levels of health expenditures every year" -WHO (2022)

- Out-of-pocket expenditure (OOPE) as a percentage of overall health expenses in India is higher compared to the global average (2019) despite a significant decline in OOPE to 48.2% in 2018-19 from 64.2% in 2013-14



High OOPE is driven by:

01 Outpatient coverage not included in the current health plans

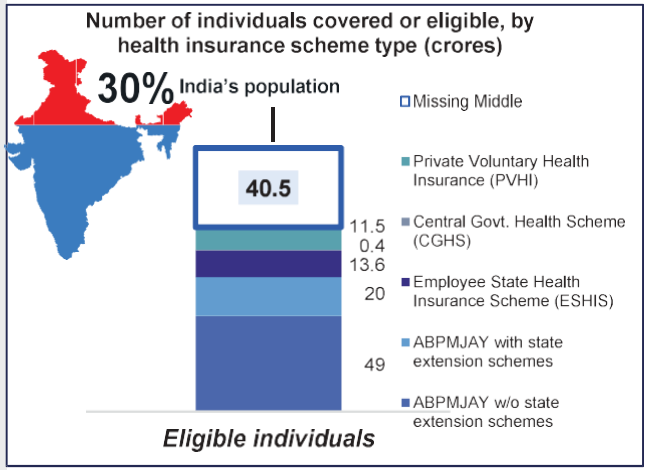
- OOPE on out-patient care **accounts for a larger share** of catastrophic health expenditure compared to in-patient care
- **Rising healthcare costs, increasing incidence of diseases and the global pandemic** have spurred the need for OPD coverage

Over two-thirds of total OOPE are on out-patient care, and most OPD - over 70% - is sought in the private sector"

- NSSO's 75th Round Survey on social consumption of health

02 Lack of health protection for the Missing Middle population

- Most existing health insurance schemes cover the organized sector belonging to well-off income deciles and the deprived BPL families. While CGHS, ESHIS and PVHI cover the former, ABPMJAY covers the latter
- Apart from a few policies in some states, there are no public or private schemes designed explicitly for the above-poverty-line (APL) yet deprived class of population and the once working in the unorganized sector- **'missing middle' population** (30% population)



Source- Retrieved from https://www.niti.gov.in/sites/default/files/2021-10/HealthInsurance-forIndiasMissingMiddle_28-10-2021.pdf , World Bank Data, Secondary research

How have other countries curtailed outpatient expenses?

Inclusion of cashless out-patient benefits as a part of health coverage will help curtail out-of-pocket expenditure

An integrated product including cashless OPD benefits can lower overall costs and improve health outcomes

Advantages of a combined product

- Development of **a coordinated or integrated care model** by aligning providers to ensure seamless transition of patients
- **Improved efficiency with reduced redundancies** (e.g., repeated tests) and greater use of primary care, which helps screen and manage chronic conditions early
- An out-patient product will also demonstrate additional value to customers as **a higher incidence of catastrophic payments for outpatient care** is reported

Many countries have **successfully implemented coverage of outpatient benefits** as part of their health protection plans and have achieved significant benefits*

- **Health Savings Account (HSA) in US, Singapore, South Africa**
- **Universal Coverage Scheme (UCS) in Thailand**
- **Statutory Health Insurance (SHI), Germany**

Health Savings Account (HSA)

A voluntary tax-advantaged account to help people save for medical expenses that are not reimbursed by high-deductible health plans

Pool of money for **use towards discretionary OPD expenditure** (for diagnostics, consultations & OTC medications with a prescription)

Financing
Individual contributions and/or payroll deductions

Advantages

- Flexibility of use- absence of any limits/sub-limits
- Portability
- Long term savings
- Tax benefits – earnings in the account grow tax free

Growing need of HSA

- Lack of outpatient coverage in health insurance plans
- High deductibles/copayment in inpatient hospitalisation
- Growing medical inflation owing to advancement in treatment methods

Learnings from global experience

- **Controls healthcare expenditure-** Managing day-to-day benefits by the consumers through a dedicated savings account keeps the healthcare expenditure under control
- **Alternate fund to manage health emergencies**- HSA paired with a health insurance plan ensures the health saving account funds are not exhausted in case of a health emergency
- **Drivers for adoption-** Payroll deductions/ tax benefits play a vital role in driving adoption of pre-financed healthcare schemes for individuals

* Non-exhaustive

Source- Secondary research

How have other countries curtailed outpatient expenses?

Thailand & Germany have extended OPD benefits to the entire population through varied financing mechanisms and provider payment models

Universal Coverage Scheme (UCS)

UCS provides a **comprehensive benefits package** with a focus on primary care

Financing mechanism

- **Per capita budget allocation** estimated based on the average utilisation rate of outpatient visits and inpatient admission multiplied with the unit cost respectively

Provider payments

- Prospective
- Age-adjusted capitation payment for outpatients and prevention and health promotion services according to the population in the catchment area

Learnings

- Primary care acts as a **gatekeeper** for seeking higher levels of care. It has been successful in cost containment and reduction in complicated cases
- Decreased **total health expenditure** from 34% (2000) to 11% (2018) (World Bank, 2021)
- The capitation (inclusive of outpatients and inpatients) has proven **more effective in cost containment than the fee-for service model**, with a decent quality of care (World Bank Group, 2019)

Statutory Health Insurance (SHI)

Health insurance is mandatory in Germany, **SHI covers 88% and PHI covers 10% of population**

Financing mechanism

- Contributions are **pooled in a central fund** in form of **income-related contributions** equally shared between employer and employees (7% each)
- **Shortage of funds is managed by charging additional premium and excess funds are distributed in form of bonuses or additional services**

Provider payments

- **Fee for Service (FFS) for GPs & specialists**, basis negotiated fee schedules
- **Fixed annual bonus for GPs** for patients enrolled in a disease management program

Learnings

- **Thrust towards preventive care programs** have significantly contained costs even in absence of a gatekeeping mechanism between OP & IP services
- **Uniform premiums across age groups** facilitate cross subsidisation between young and older population
- **FFS** being the only provider payment model has its own limitations such as lack of incentives for quality and incentives for volume

While outpatient coverage is a critical element in the journey towards UHC, but given that 30% population still lacks a standard health insurance product even for IPD, the paper will focus on identifying solutions to cater to this missing middle w.r.t. hospital admissions

Source- Retrieved from https://eurohealthobservatory.who.int/countries/germany#:~:text=The%20statutory%20health%20insurance%20(SHI,provided%20by%2041%20insurance%20companies. , https://extranet.who.int/kobe_centre/sites/default/files/pdf/2_8_Case%20study_Thailand.pdf , Secondary research

How have other countries attained UHC?

Thailand with limited fiscal resources was successful in implementing an integrated delivery system offering comprehensive coverage to its entire population financed through general taxation

Thailand (Subsidised Scheme)

	Civil Servant Medical Benefit Scheme (CSMBS)	Social Security Scheme (SSS)	Universal Coverage Scheme (UCS)
Population Coverage	4 Mn (6%)	12 Mn (19%)	48 Mn (75%)
Beneficiaries	Civil servants, their spouses and immediate relatives	Employees in the private and public sector	Those not covered by CSMBS or SSS
Financing	General tax, through annual budget bill	Tripartite, 4.5% payroll (1.5% each from employee, employer & government)	General tax, through annual budget bill

Universal Coverage Scheme (UCS)

Coverage

100% of overall population

Benefits

Comprehensive OPD & IPD services including medicines concerning the National List of Essential Medicines (NLEM)

Care provision

Public primary network of health centres, accredited private facilities and district hospitals

Provider payment

Outpatient : Age-adjusted capitation,
Inpatient: DRG with global budget

Challenge

Financial implications on government due to-

- Discrepancies in benefit packages & payment mechanisms across the three health insurance schemes
- Relies on annual government budget allocation and runs the risk of lower budgets during "lean years" of economic downturn

Key Learnings

- Focus on wellness (health promotion and disease prevention) and illness (inclusion of outpatient care which acts as gatekeeper) had significantly helped in better utilisation of health care services
- Delivery of quality and affordable care poses a large long-term financial burden, with an increasing aging population and no policy on standardisation of care
- The government has ensured UHC covering 100% population through a multitude of schemes

Source- Retrieved from https://extranet.who.int/kobe_centre/sites/default/files/pdf/2_8_Case%20study_Thailand.pdf , Secondary research

How have other countries attained UHC?

China implemented a hospital-centered fragmented delivery system financed through government subsidies (both local & central) and voluntary contributions

China (Voluntary contribution & partially subsidised)

*Urban Rural Resident Basic Medical Insurance**

	Urban Employment-based Medical Insurance	Urban Resident Basic Medical Insurance	New Cooperative Scheme For Rural Residents
Population Coverage	20% population	80% population	
Beneficiaries	Urban residents with formal jobs	Urban residents without formal jobs (children, students, elderly, and the young unemployed)	Rural residents
Financing	Mandatory	Voluntary contribution (accounts for ~20% of total cost) and government subsidies shared between central and local governments (accounts for about ~80% of total cost)	

Urban Resident Basic Medical Insurance

Coverage

100% of overall population

Benefits

Inpatient and outpatient services for catastrophic illness

Care provision

Public primary network of health centres and public hospitals for inpatient care

Public and private facilities together for outpatient care

Provider payment

Fee for service is the dominant, Case-based Relative Values (follow similar principles as DRGs) is gaining prominence

Challenge

- **Nonscalability of the scheme** - High dependency on the local government for the subsidies to cover up the costs, while voluntary contributions are structured as flat contribution
- Non-uniformity within schemes - Multiple different risk-pools and sub-schemes within the umbrella of schemes linked to voluntary contribution

Key Learnings

- The hospital-centered and fragmented delivery system in China (unlike the primary-healthcare-based system in Thailand) and the dominant Fee for Service payment model may lead to significant financial burden
- Multiple non-uniform schemes with deductibles, copayments, and reimbursement ceilings is leading to higher OOPE in China (twice the global average)

Source- Retrieved from https://www.commonwealthfund.org/international-health-policy-center/countries/china,Secondary research

*Consolidation underway

What could be done to attain UHC in Indian context?

A low-cost private health insurance product could be explored considering the financial implications of expanding the existing PMJAY coverage on the government for covering the missing middle

Expanding the existing ABPMJAY coverage to the missing middle

- Extension of PM-JAY health to cover **the missing middle.** While this will have fiscal implications on the government, it can evaluate covering the missing middle. This will have its own set of challenges

  Challenges as learned from global experience-

  - Rising healthcare costs
  - Need for provision of comprehensive benefits
  - Supply side constraints

Reliance on only government will have its own constraints and financial implications. Also, since this will be a policy decision for the government to evaluate, the focus of the paper will be on evaluating the role of a private insurer in designing an affordable product for the missing middle

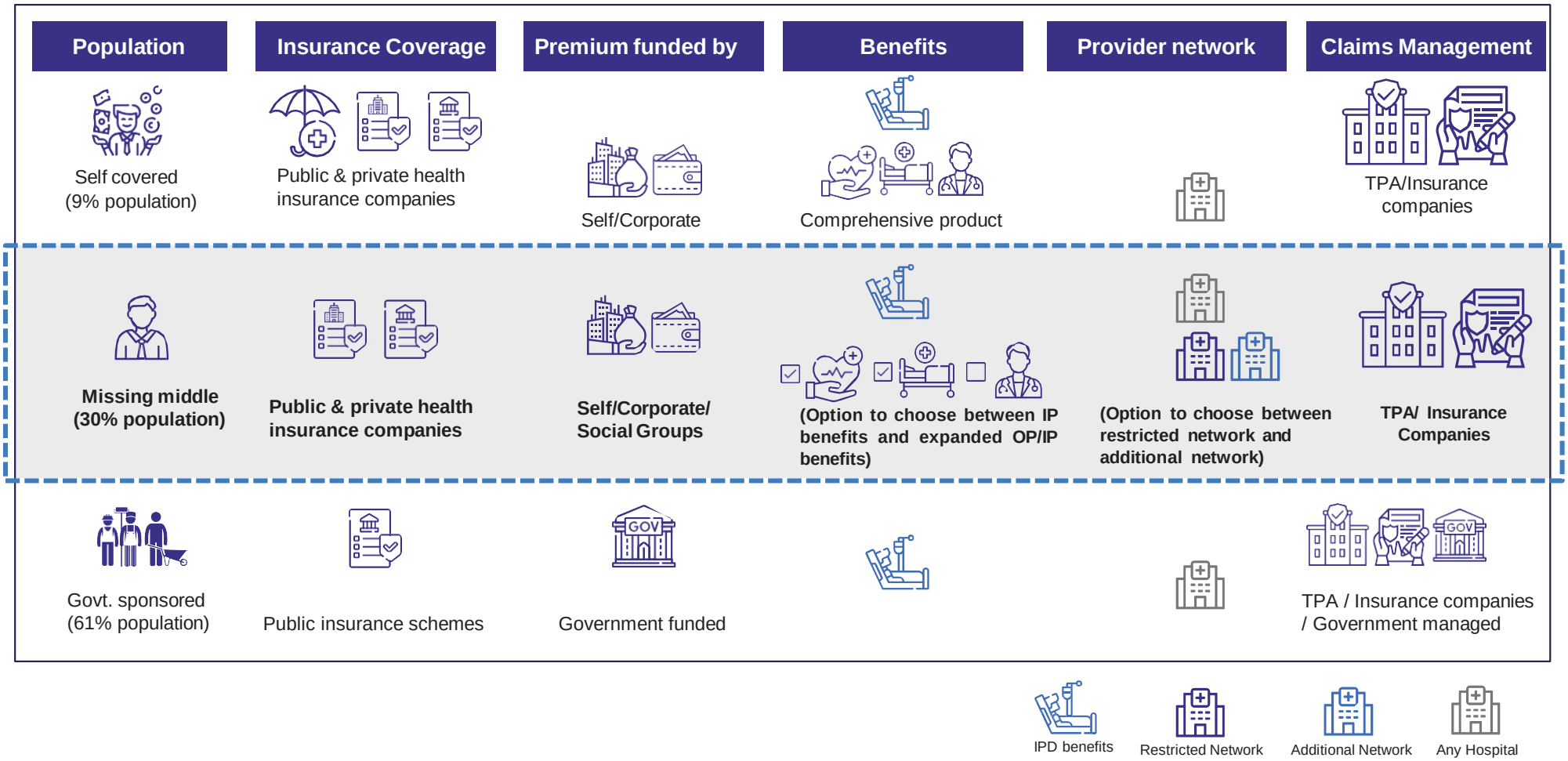
Evaluating the role of private health insurers in designing a self contributory product which is appealing, accessible, and affordable

- **Leveraging the existing ABPMJAY infrastructure** in terms of provider network, data systems and treatment guidelines
- Multi-variant product (standard IPD with restricted provider network, comprehensive OPD/IPD benefits with expanded provider network) allowing buyers to choose basis affordability
- **Leveraging on larger distribution network** such as use of government assets like post offices to enhance the reach

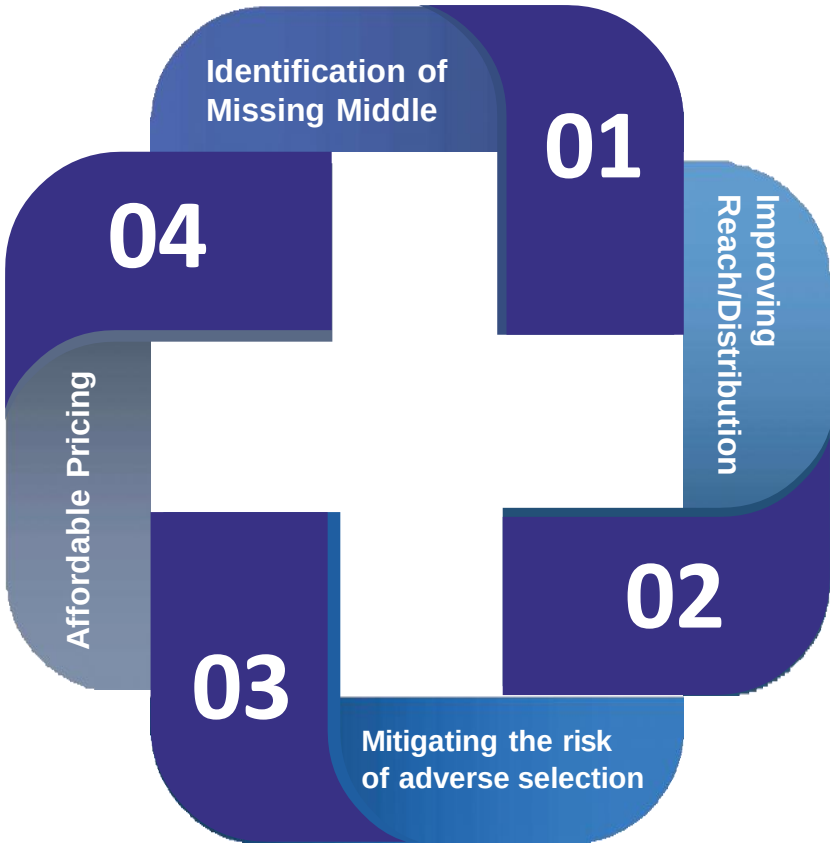
Source- Primary interviews

What could be done to attain UHC in Indian context?

Introduction of an affordable product to support the healthcare needs of the missing middle will enable India to progress in achieving universal health coverage



Critical success factors for moving towards UHC



01 Identification of Missing Middle

- Identification of this segment remains a significant hurdle
- Targeting the missing middle segment will require a different outreach strategy which distinctly focuses on this population, and their sub-segments, such as use of government databases such as National Food Security Act (NFSA)

02 Improving reach/distribution

- Defining and designing an **economical, custom-made distribution strategy** which distinctly **focuses on the missing middle** will be critical to ensure maximum outreach to the population
- Role of **alternate and innovative distribution channels** like Point of Salesperson (PoSP), digital platforms could be explored to maximise the reach

03 Mitigating the risk of adverse selection

- Essential for creation of a **large and diversified enrolment base**
- **Group enrolment (such as social groups) and increasing household participation** by making the population aware and the product affordable **can help mitigate the risk of** adverse selection

04 Affordable pricing

- The cost of health insurance i.e., the **premium, needs to be aligned with the affordability** of the missing middle
- The reimbursement rates/schedule of charges need to be jointly agreed with the provider network to make it a win-win proposition
- **Reduction in distribution costs** of insurers will contribute to make the premiums attractive for the missing middle

Source- Secondary research, Primary interviews

What could be done to attain UHC in Indian context?

Designing an affordable and sustainable insurance product for the missing middle will require an effective collaboration between the policy makers, insurers and the providers

Mapping stakeholder role to 3A's

Stakeholder	Role	Affordability	Accessibility	Awareness
Government	Allowing access of PMJAY's provider network, systems & infrastructure to insurer to extend the benefit at low costs	☑	☑	
	Greater consumer awareness for group enrolments to build large and diversified risk pools to keep the premium low		☑	☑
	Leveraging on larger distribution network to enhance the reach at lower costs	☑	☑	☑
Insurer	Leverage on data analytics and value-based contracts to maximise efficiency in terms of protection and cost	☑	☑	
	Multi-variant policy allowing buyers to choose basis affordability	☑	☑	☑
	Innovative distribution channels to enhance the reach and have diverse risk pool	☑	☑	
Provider	Alignment on appropriate schedule of charges	☑	☑	
	Acting as awareness facilitator for higher uptake			☑
	Assisting in implementing measures to avoid adverse selection	☑		

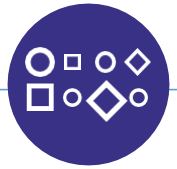
Source- Primary interviews

Role of government

Government → Insurer → Provider

Allowing access of PMJAY's provider network, systems & infrastructure to insurer to extend the benefit at low costs

- Access to current PMJAY data (such as incidence rate and claims outgo) will help in determining the pricing of the new product
- Access to PMJAY's hospital provider network database, benefit packages, tariff creation methodology and workings for the creation of products with similar benefits
- Allowing to utilise e-Sanjeevani tool that can act as a gatekeeper to have primary care based integrated model



Greater consumer awareness for group enrolments to build large and diversified risk pools to keep the premium low

- Government should build consumer awareness through Information, Education, and Communication (IEC) campaigns
- Additional channels, including Government health facilities, Anganwadi centres, and ASHA workers can also be leveraged to build consumer awareness

Leveraging on larger distribution network to enhance the reach at lower costs

- Databases such as NFSA, PM-KISAN, Co-Win and Pradhan Mantri Suraksha Bima Yojana could be leveraged to enhance the reach at reduced costs
- Use of government assets like post offices, and regional rural banks as distribution channels

Source- Primary interviews

Role of insurer

Leverage on data analytics and value-based contracts to maximise efficiency in terms of protection and cost

- Access to historical claims data can help insurers deploy advanced analytics to reimagine risk evaluation and enhance efficiency
- Selective contracting arrangement with the providers and provision of an incentive for patients to utilise the provider network

Multi-variant policy allowing buyers to choose basis affordability

- Evaluate introduction of restricted provider network-based pricing (e.g., narrow network at lower price points and expanded network at higher price points, like zone-based pricing)
- A multi-variant product could be introduced - basic benefit at lower price points and expanded comprehensive benefits at higher price points

Innovative distribution channels to enhance the reach and have diverse risk pool

- Point of Salesperson (PoSP) – a local connect of the neighborhood grocery store or mobile store could be extensively leveraged
- Informal and formal groups including associations, unions, societies, MSMEs and self-help groups (e.g., taxi driver associations, providers on aggregators such as Urban Company) could be targeted to reduce the cost of identification and outreach
- Evaluate more group insurance (social groups such as farmer's union, cooperative societies) to reduce risk of adverse selection

Source- Primary interviews

Role of provider

Government → Insurer → **Provider**

Alignment on appropriate schedule of charges

- Alignment on suitable tariffs for the new product for the missing middle by providing consultation/feedback on the suggested rates and sharing of costing data (if need be) as a rationale to arrive at the acceptable rates

Awareness facilitators for higher uptake

- Collaborate with the insurer in creating awareness of the new insurance product by means of various marketing channels

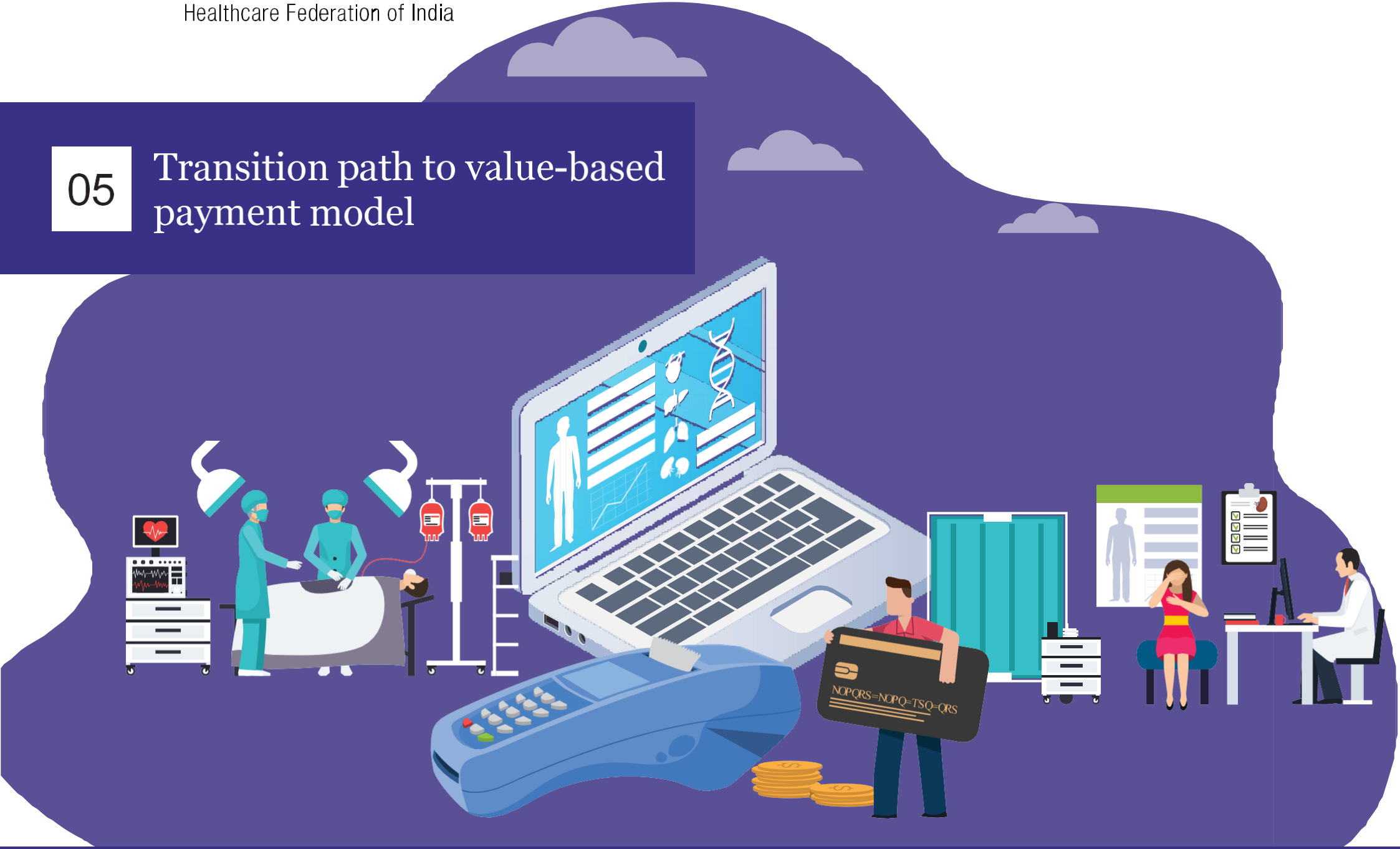
Assisting in implementing measures to avoid adverse selection

- Supporting the insurer ecosystem in testing eligibility of potential insurance buyers through medical history assessment and diagnostic screenings to avoid adverse selection and price the high-risked individuals accordingly

Source- Primary interviews

NATHEALTH®
Healthcare Federation of India

05 Transition path to value-based payment model

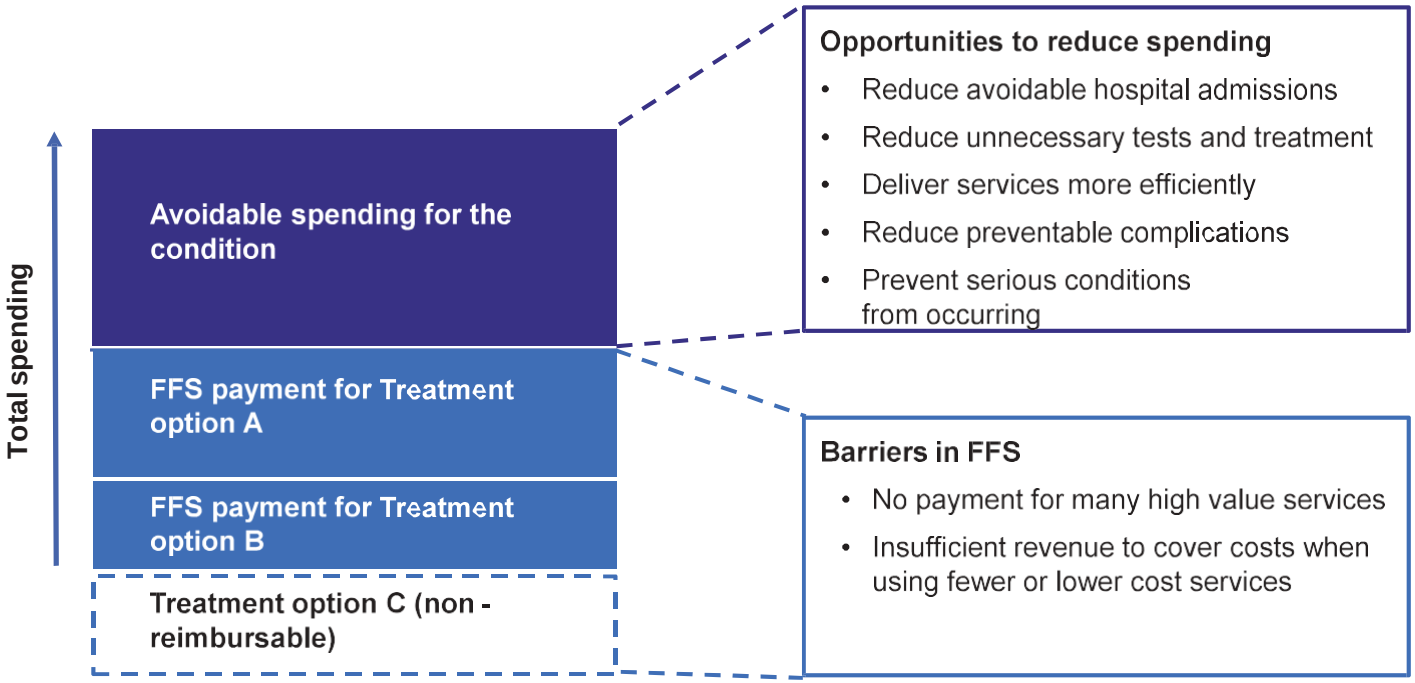


Value-based reimbursement is a payment system that compensates healthcare providers with the efficient usage of services and reduced length-of-stay

Need for value- based care

- **Increasing healthcare expenditure, excess healthcare costs** attributed to unnecessary and **inefficient services** along with **uncoordinated care**
- All these factors, **coupled with increased patient expectations,** have set the stage for the adoption of value-based healthcare, where the **payment for care is tied to** promoting the implementation of clinical pathways

FFS spending to treat patients with a specific condition



> **Payers that implemented value-based payment models reduced healthcare costs by an average of 5.6 percent, improved provider collaboration, and created more impactful member engagement"**
>
> - State of Value-Based Care in 2018 Report

Globally, multiple reimbursement models are in use and their application varies according to the type of care being provided…

Payment Model	Description	Settings
 Fee for Service (FFS)	• A **fixed payment for each unit of service provided** to treat a disease condition	• Fixed payment for each unit of service without regard to outcomes. It is typically paid retrospectively by billing for each individual service or patient contact • Example- US, India, Japan, Korea, France
 Diagnosis Related Groups (DRGs)	• Patients under case-based method are **grouped based on different criteria** such as diagnosis, procedures needed for treatment. Hospitals are paid a fixed rate per category per admission (or case treated)	• Payment for **hospital inpatient cases** in several countries • Example- Netherlands, Sweden, Germany, Taiwan
 Capitation	• A **fixed payment for a defined population over a defined period** (generally 1 year) is made prospectively to providers for providing a given set of services	• Mode of payment for General Practitioners (GPs) in several countries • Example- Spain, US
 Global Budget	• **Prospective lump-sum payment** covering a range of services independent of actual volume provided	• Payment for public hospitals in several countries • Example- Sweden, UK
 Pay-for-Performance (P4P)	• Payment model that **rewards providers for achieving pre-defined targets for quality indicators or efficacy parameters** to increase the quality or efficacy of care.	• Typically combined with FFS or DRG as bundled payment

Source- Better ways to pay for health care- OECD report

… with most countries adopting DRG based value-based reimbursement models for inpatient settings

Payment models followed in various countries

Country	Public hospitals	Private non-profit hospitals	Private-for profit hospitals
Australia	DRG	FFS	FFS
England	DRG	FFS	FFS
France	DRG, P4P	DRG, P4P	DRG, P4P
Germany	DRG	DRG	DRG
Malaysia	Global budget	FFS	FFS
Republic of Korea	FFS	FFS	FFS
Thailand (UCS)	DRG, Global budget	DRG, Global budget	DRG, Global budget

Source- Price setting and price regulation in health care- Lessons for advancing Universal Health Coverage, WHO

Provider payments in India have traditionally been paid as Fee-for-Service with emphasis on quality certifications; a recent focus on being value based is in a pilot phase with ABPMJAY's DRG based reimbursements

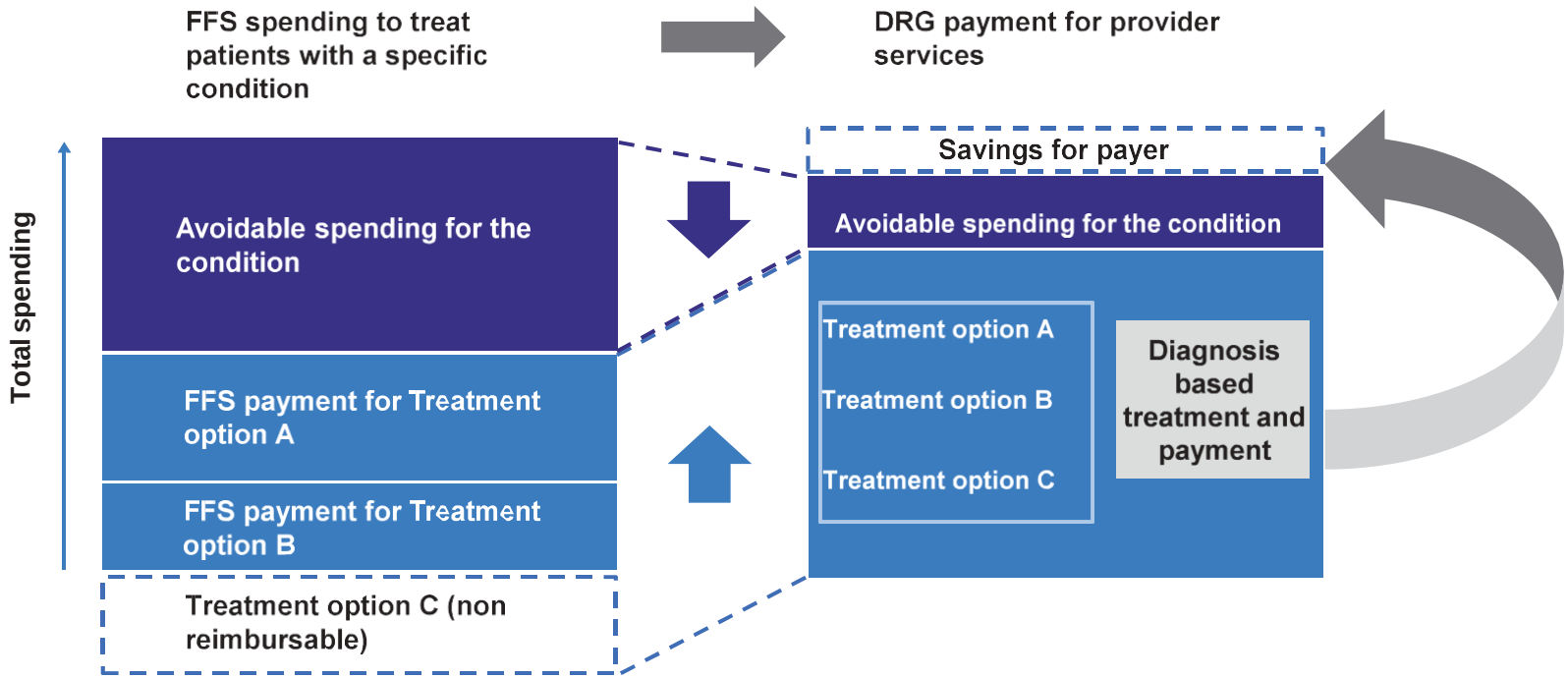
	Today	Proposed: Increasing focus on value-based reimbursements
Payment model	**Fee For Service** • **Traditional** healthcare model - fees are paid for every service provided • Case based payments- providers are **paid a fixed rate for a bundled set of services** provided against a defined package (inpatient services) • Provides incentives to providers based on a higher number of visits, procedures which may not be in line with patient health outcomes	**Diagnosis Related Group (DRG) based** [#] • Providers should be paid based on the case mix complexity; resource demands & the cost incurred by the hospital • Groups patients based on distinct clinical characteristics , i.e., degree of severity, comorbidities, and complications and enhances the value by paying providers based on the nature & severity of the case
Other incentives	**Quality accreditation based** • Providers are reimbursed differentially based on their quality accreditation status (NABH vs Non-NABH) across different payers • PM-JAY Quality Certification Program provides additional financial incentives (5 -15%) based on the certification of the empaneled health care providers	Quality accreditation based [#] • Additional financial incentives (2.5 -7.5%) based on the certification of the empaneled health care providers
	• Incentives based on provider's geographical location & level of care • Provision of incentives for hospitals based on location (Tier I/II/III) and the level of care provided (secondary/tertiary care) for surgical and medical packages	Outcome based incentives (7.5 %) [#] Financial incentives (1.5% each) on the 5 components- • Beneficiary satisfaction rate • Readmission rate • Extent of out-of-pocket (OOP) expenditure • Confirmed grievances • Improvement in health-related quality of life
	Base rate + **Accreditation based incentives** (100% weightage)	**Base rate * cost weights** + **Accreditation based incentives** (50% weightage) + **Outcome based incentives** (50% weightage)

Source- NHA report on Provider payment and Price Setting under PMJAY, Secondary research, Primary interviews

,

[#] *PMJAY's way-forward plan as mentioned in the recently released NHA report – Data collection pilot in progress*

Value-based reimbursements have shown a decline in healthcare expenditures and improved care quality



Early results of DRG pilot testing in Germany show a 35% reduction in medical costs and 30% shorter length of stay"

- Medical payment series: the rise of the DRG payment model

Globally, different countries adopted different approaches for the transition to DRG system

Critical components for transitioning to DRGs

Selection of grouper

- Countries can either develop its own grouper or adopt an existing one
- If adopting a grouper, the similarity to the standardised classifications of diseases and procedure codes currently in use in that country is to be considered

Determining cost weights

- Globally, multiple approaches have been adopted to calculate cost weights- determining how much is paid for one DRG versus another, using existing charge (or tariff) data, undertaking specialised costing studies, or borrowing cost weights from other countries

Fee for service

DRG

USA

- U.S. Medicare program was the **first & longest program (~15 years)** in the world to implement DRGs as a payment method and therefore needed to develop its own DRG grouper (HCFA-DRG). This grouper was later adopted by several other countries
- Used costing studies to calculate the cost weights

Russian Federation

- Developed its own grouper (R-DRG), using the primary classifications
- Used costing studies to calculate the cost weights

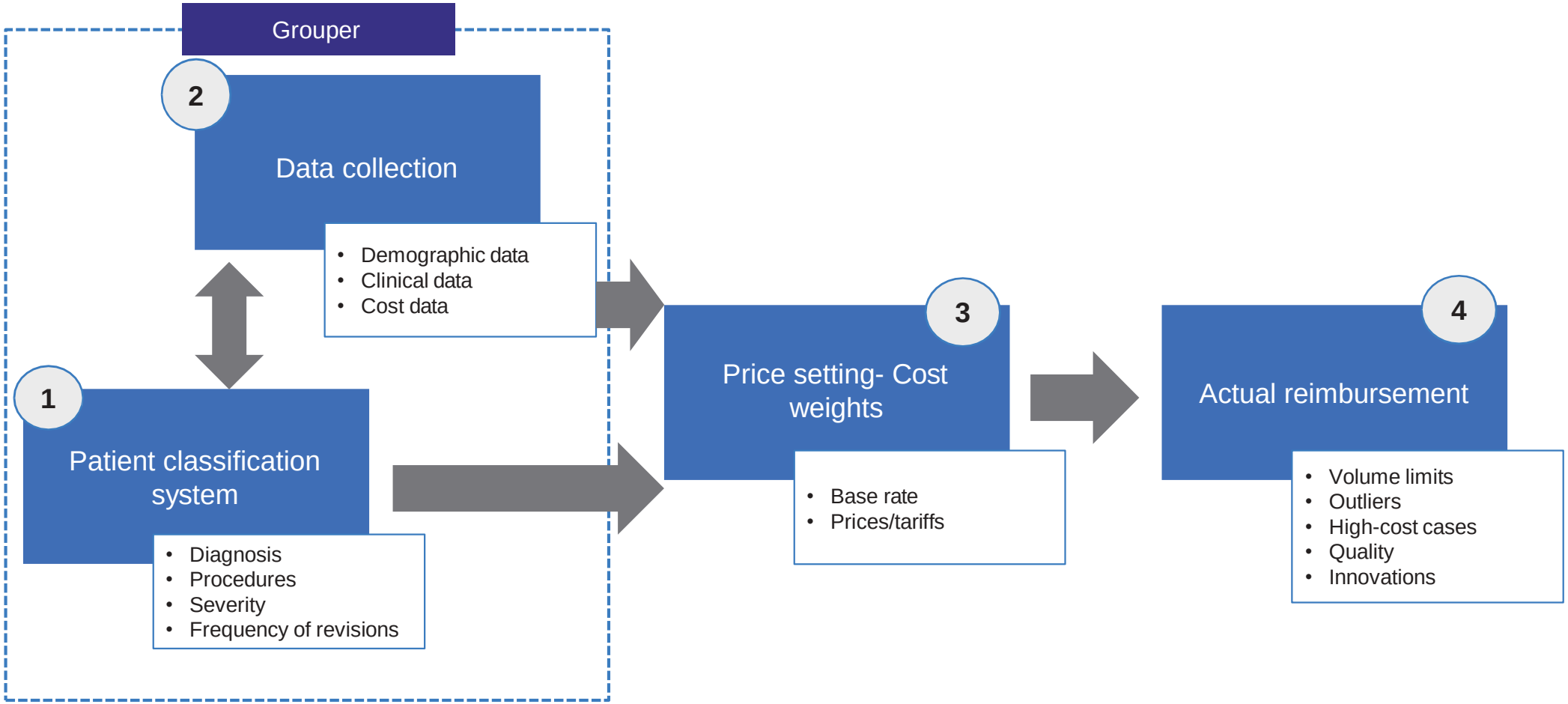
Estonia

- Most **recent and shortest transition (~10 years)**
- Adopted the readily available grouper (NordDRG)
- Used existing hospital charges or health insurance reimbursements to calculate the cost weights

With technology as key enabler, India has an opportunity to leapfrog implementation of DRG

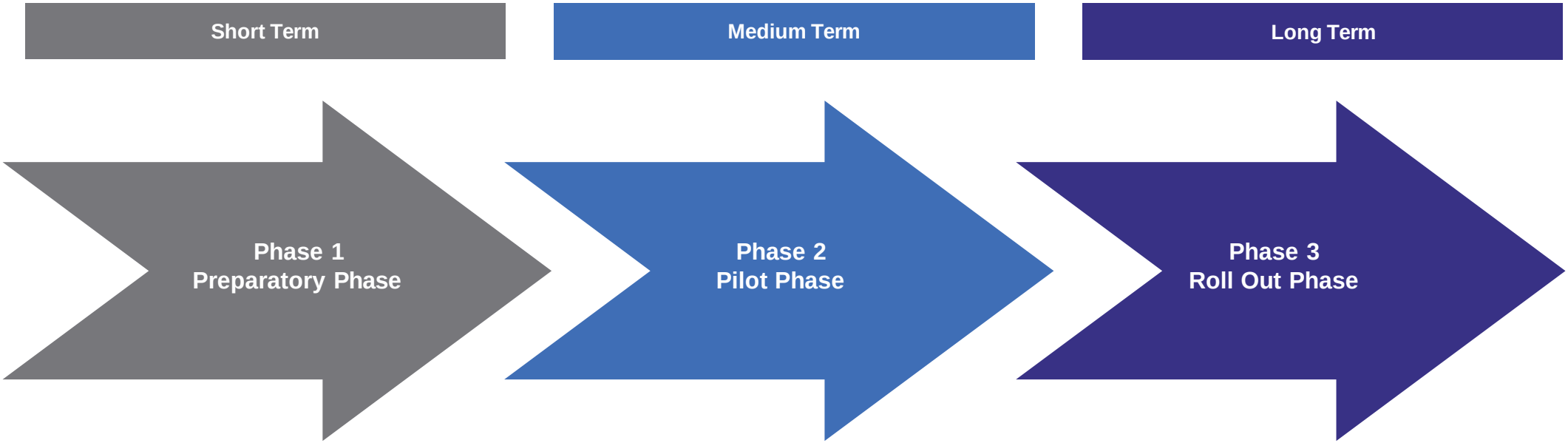
Source- Retrieved from https://elibrary.worldbank.org/doi/abs/10.1596/978-1-4648-1521-8 , Secondary research

Essential building blocks of DRG systems



Source- Euro DRG, Berlin University of Technology

Transition to the DRG based reimbursement in India needs to be phased as it will allow flexibility and time for both the payer and the provider to understand, refine and adapt to the new system



Develop a cost-accounting system and calculate cost weights from a sample of voluntary participating hospitals
-Build capacities (IT, Human resources and Training) to enable DRG system design and implementation

Conduct a pilot in order to initiate the DRGs using multiple approaches (simultaneously or sequentially)- by geography, hospital type, partial DRGs (a set of conditions, cases, or clinical specialisations)

Scale up of the efforts to implement DRGs based on the learnings from the Pilot phase

Source- Secondary research, Primary interviews

Implementation of DRG would require the building blocks of public financing, resource availability, utilisation of technology and a collaborative ecosystem

Phase 1- Preparatory Phase

Setting up a core committee

- Establish a DRG unit for undertaking the implementation
- Conduct specialty-wise discussions to discuss the feasibility of adoption of groupers for identified specialties
- Identification of stakeholders required for implementation

Operationalisation & Integration of ICD

- Mapping of the provider and payor's master data with International Classification of Diseases (ICD)
- Capacity building of all the stakeholders involved would ensure compliance on use of ICD

Claims database analysis and defining value -based incentives

- Analysis of claims data to identify conditions to begin DRGs with – (utilisation review, readmissions, packages based on high volumes, high costs, great variations (outliers) in medical practice and abuse potential
- Determination of a methodology around collection, analysis and sharing of this quality data

Establishing a costing tool

- Collect and analyze patient specific cost information for packages where DRG payments are initiated
- Select pilot hospitals for the costing
- Use of cost and clinical data to generate first set of weights
- Integration of the outcome indicators to the payment system

Phase 2- Pilot Phase

- Initiate DRGs for selected pilot specialties/conditions/hospitals/states as defined above
- Invite participation with providers across the public and private sector
- Provide sensitisation and training for the selected hospitals
- Collect, review and analyze data to refine the process
- Report outcomes and recommendations
- Ramp up of technological adoption and system adoption
- Capacity building

Phase 3- Roll Out Phase

- Adjust/refine weights using objective methods/data/criteria, based on learnings from the pilot
- Incremental inclusion of specialties/conditions/hospitals/states
- Strengthen existing monitoring and audit processes to identify any improvements in quality and performance indicators of the providers
- Impact assessment by means of qualitative/quantitative studies
- Capacity building on experiences learned
- System integration with registries and sources of truth

Source- Retrieved from https://rb.gy/tot7wb , Secondary research, Primary interviews

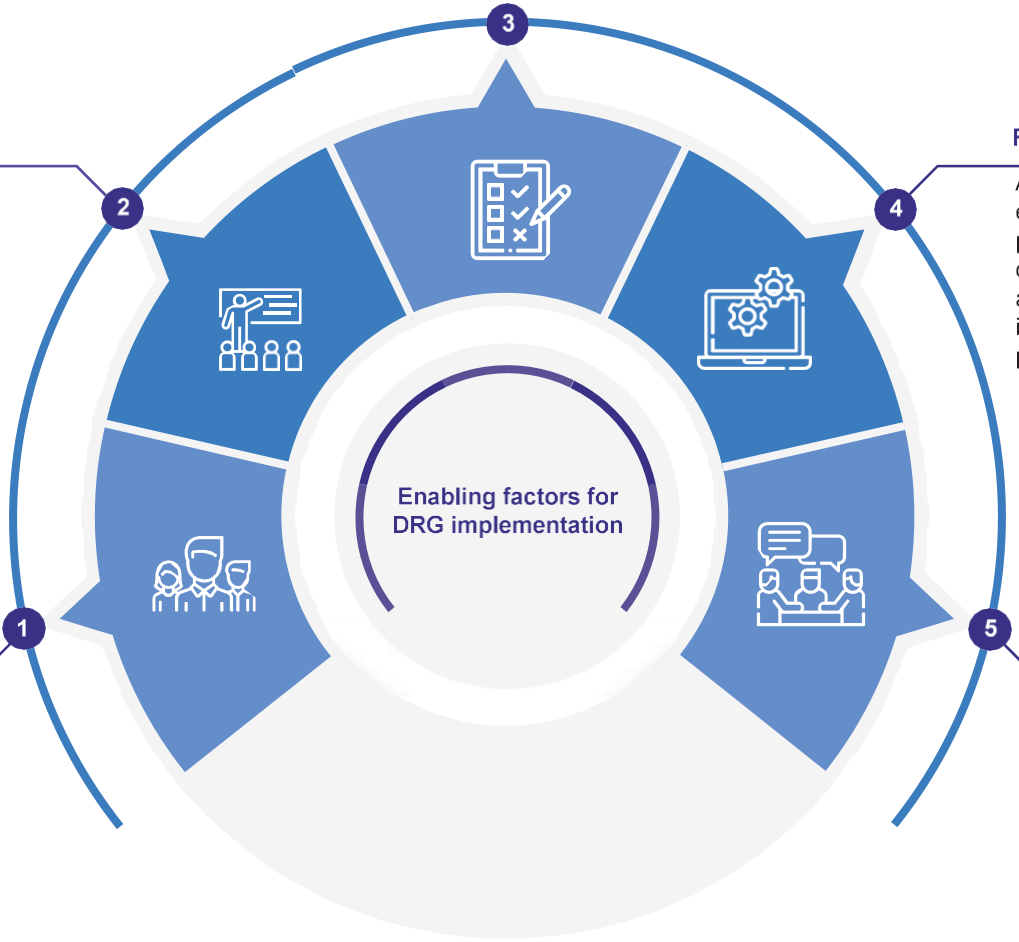
Role of the following enablers will be pivotal in achieving the transition to this new payment reform

Early Evaluation

Periodic impact evaluation studies after the implementation of the pilot will provide reassurance to stakeholders on the importance of continuing to implement and expand the DRG payment reform

Capacity Building

Training programs related to the **use of primary classifications, coding standards, coding quality, DRG system design, costing and tariff setting, reporting, and DRG-specific performance monitoring** will be helpful for government agencies, hospitals, and payers during the preparation for, and early implementation of DRG transition



Role of technology

Adoption of robust hospital IT systems will enable collection and exchange of consistent patient data across hospitals; will enable comparability based on patient's condition and treatment outcomes about where value is created or lost along the care delivery pathway

Institutionalization through units & teams

Early establishment of a DRG unit (or at least a designated team) to drive the transition to DRGs is crucial

Transparency & stakeholder involvement

Effective communication between policy makers, medical associations, payers and providers will ensure a smooth transition to the DRG system

Source- Retrieved from https://documents1.worldbank.org/curated/en/895741576646353914/pdf/Transition-to-Diagnosis-Related-Group-Payments-for-Health-Lessons-from-Case-Studies.pdf
Secondary research, Primary interviews

NATHEALTH®
Healthcare Federation of India

06 The Need for Action

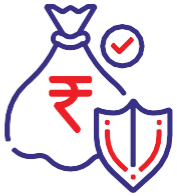
Building blocks of Indian healthcare: Need for action

Today

Insufficient infrastructure

01 ***How can we leverage PPPs for creating more hospital beds?***

Inequitable health coverage



02 ***What is the best way to serve the missing middle?***

Inadequate focus on outcomes

03 ***How can we move towards value-based care?***

Tomorrow

Updated VGF scheme which mitigates the challenges and enables enhanced involvement from the private sector in enabling creation of more hospital beds

Introducing a self-contributory insurance product, which is appealing, and affordable for the missing middle, with an **affordable premium,** by **leveraging on infrastructure and systems created for ABPMJAY**

Transitioning to a DRG-based payment model that compensates healthcare based on the **case mix complexity, resource demands & the cost incurred by the hospital**

NATHEALTH®
Healthcare Federation of India

Acknowledgements (Key contributors)

Core committee members

Sunil Thakur, Quadria Capital

Visalakshi C, Tata Capital Healthcare Fund

Mayank Bathwal, Aditya Birla Capital

Sanjiv Navangul, Bharat Serums and Vaccines

Anuradha Sriram, Aditya Birla Capital

Amitabh Jain, ICICI Lombard

Bhavna Singh, Bharat Serums and Vaccines

Parth Govil, Axis Bank

Gaurav Saboo, Axis Bank

Nitin Agrawal, Axis Bank

Siddhartha Bhattacharya, NATHEALTH

Anwesha Pandey, NATHEALTH

Vrinda Chaturvedi, NATHEALTH

Chirag Bomzon, NATHEALTH

PwC Healthcare Team

Arpita Mehta

Rahul Jalan

Ashish Rampuria

Rana Mehta

Experts whom we interviewed

Ajay Rao, DFC

Anjali Nambiar, Dvara Research

Dr. Cristian Baeza, Center for Healthy Development

Dr. Dhananjay, NHA

Dinesh Arora, ADB

Dr. Hari Prasad, Apollo Hospitals

Hasna Ashraf, Dvara Research

JC Langenbrunner, HSTP

Dr. K Madan Gopal, NITI Ayog

Karine Bachongy, IFC

Nachiket Mor, Banyan Academy of Leadership in Mental Health

Piyush Jain, Impact Guru

Pranav Mohan, ADB

Rajeev Sadanandan, HSTP

Dr. Srinivasaraman Govindarajan, Anderson Diagnostics

Sabahat Azim, Glocal

Sandhya J, Narayana Health

Saurabh Suneja, NIIF

Dr. Sreenivasan Narayana, Narayana Health

Sushmita Sahoo, IFC

NATHEALTH acknowledges the research effort and consultation with all stakeholders including external experts PwC has provided for this paper.

NATHEALTH®
Healthcare Federation of India

About NATHEALTH

NATHEALTH has been created with the vision to "Be the credible and unified voice in improving access and quality of healthcare". Leading healthcare service providers, medical technology providers (devices & equipment), diagnostic service providers, health insurance companies, health education institutions, healthcare publishers and other stakeholders have come together to build it as a common platform to power the next wave of progress in Indian healthcare. NATHEALTH is an inclusive institution that has representation of small & medium hospitals and nursing homes. It is committed to working on its mission to encourage innovation, help bridge the skill and capacity gap, help shape policy & regulations and enable the environment to fund long term growth. NATHEALTH aims to help build a better and healthier future for both rural and urban India.