Report on evolution of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
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"It is essential to ensure that we free the poor of India from the clutches of poverty due to which they cannot afford healthcare".

~ Prime Minister Narendra Modi, Independence Day Speech, August 2018

Background and Introduction

Ayushman Bharat and the Pradhan Mantri Jan Arogya Yojana (PM-JAY), is transforming healthcare access in India. Two years into its operations, the scheme has become the country's flagship public health insurance scheme. By September 2020, the number of hospital admissions channelled through the PM-JAY had touched over 1.6 crores across India. Given the scale of operations in a country like India, with all its complexities and challenges, it is now well-established and recognised that sharing knowledge regarding the early ideation, concept development, design and evolution of PM-JAY could be of use globally. While there is a considerable body of knowledge available in the public domain as related to Ayushman Bharat/PM-JAY, there are perceived gaps in documentation of the early phases of the scheme's development before its launch. This report has been developed, acknowledging the importance of unpacking which building blocks led to the roll-out of this scheme.

On India's Independence Day in 2018, the country's Prime Minister Narendra Modi announced his intention to launch Ayushman Bharat, or the then National Health Protection Scheme, on September 25 the same year. Developed over a couple of years as a ground-breaking flagship scheme, Ayushman Bharat would become the answer to India's long-standing, intractable challenge -- that of providing good quality and affordable healthcare to the country's vulnerable and under-privileged. Millions of Indians live in fear of falling ill, and anyway, carry with them the burden of chronic and long-term health problems. The launch of this new initiative was planned for September 25, a date that commemorates the birth anniversary of Pandit Deen Dayal Upadhyaya, a well-known Indian politician and thinker who was very active on the Indian political scene between the 1940s and the 1960s. Ayushman Bharat was designed to reach 10 crore Indian families or 50 crore Indians and provide a health insurance cover of Rs 5 lakh per family per year for secondary and tertiary care hospitalisation. Ayushman Bharat was designed as one of India's most path-breaking interventions to strengthen the Indian public health system with preventive, promotive and curative services made easily available and affordable at the primary, secondary and tertiary levels of the public healthcare system.

In exactly two years from its launch, in September 2020, the Ayushman Bharat health insurance scheme, specifically known as the Pradhan Mantri Jan Arogya Yojana, had provided completely cashless, free treatment to 1.26 crore beneficiaries, and nearly half of these beneficiaries have been women and girls. In May 2020, PM-JAY had already reached one crore beneficiaries and had since seen many more milestones. There are more than 23,300 hospitals across India that are empanelled under the scheme, and PM-JAY is today operational in 32 states and Union Territories. At this juncture, it becomes important to look back and review critically the origin of the idea, the early activities that were initiated, and all efforts that were made towards the evolution of PM-JAY as the
country knows it today – as the largest publicly funded (fully government-funded) health insurance scheme in the world that has been life-changing for millions of Indians. Today, April 30, is observed as Ayushman Bharat Day, seen as a day of national importance since it is schemes such as PM-JAY that can take India towards achieving the vision of Universal Health Coverage (UHC), a commitment to leave no one behind – articulated in the National Health Policy of 2017 and the Sustainable Development Goals (SDGs). SDG target 3.8 is aligned with the vision of the PM-JAY, which is to "ensure financial protection against catastrophic health expenditure and access to affordable and quality healthcare for all".

These and several other policy instruments and articulations, both national and global, have helped India address the complex and severe disease burdens of illness and other health conditions that its people suffer from, both in terms of morbidity and mortality.

**India's health scenario: Challenges and assurances**

Health has always been a key driver of poverty and financial exclusion for Indians, and ill-health has always been a big reason millions of Indian families and individuals are pushed deeper and deeper into poverty and debilitating indebtedness. Despite significant progress and improvements in the health of India's people over the years, there is still a significant burden of disease and debilitation. There is a vast and growing burden of disease from Non-Communicable Diseases (NCDs), which today are the cause of over 60% of deaths in the country. Maternal and child health, under-nutrition, mental health issues and infectious diseases are also critical.

*Fig. 1: Disease burden in India is characterised by relatively high proportions of NCDs*¹

Over several decades in an independent India, multiple efforts in the health policy and programme arena have been to develop a solid system that can offer protection from such crushing costs for health care. However, this has never been easy in a massive, democratically-governed country with

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¹National Health Authority presentations
extensive plurality and diversity. Addressing Health for All through insurance and financial protection to reduce and minimise Out of Pocket (OOP) Expenditure (62% health expenditure is OOP) on health services has always been complicated, layered and characterised by multiple nuances. For instance, 70% of treatment is sought from and taking place in the private sector. Despite all this, there have been several efforts in the past and more recent times; these efforts are closely linked with an urgent need to provide Universal Health Coverage in compliance with international and national covenants and policy commitments. These policy instruments have enabled India to articulate critical programmatic interventions to address diverse issues related to health, health services, and systems.

The commitment of the National Health Policy of 2017 was: "The attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence."

Primary Health Care and Financial Protection
-Pillars of Universal Health Coverage

Over the years, India has seen several publicly-funded health insurance schemes, both national and state-specific initiatives. When PM-JAY was in the ideation and design stage itself, 22 states were already implementing various health insurance schemes with various names. The real challenge for the designers of PM-JAY was as to how they would devise a national scheme that could address all the gaps that existed, acknowledge what was already being done across Indian states and come up with a scheme that would take India's population to the next level in terms of health, wellness and financial protection.

Ayushman Bharat and PM-JAY
The health scenario led to the idea that making high-quality healthcare accessible to the most deprived sections of India's population was imperative. Leadership involved in the early ideation knew that this idea was not new to India but the approach. The country learned from past experiences and was ready to apply evidence and learnings from the past to create a new scheme. It

2National Health Authority presentations
was decided that a scheme would be designed by using evidence to define policy, an agile institution to implement the scheme and the wide use of innovation to drive healthcare initiatives. “The proposed NHPS will replace the existing schemes of the Government of India, namely the ‘Rashtriya Swasthya Bima Yojana (RSBY)’ and the Senior Citizens Health Insurance Scheme (SCHIS) and supersede the earlier proposed National Health Protection Scheme by increasing the insurance cover from earlier proposed Rs 1 lakh to Rs 5 lakh and targeting more beneficiary families” – this was explained by former Health Secretary, Ministry of Health and Family Welfare, Ms Preeti Sudan. The NHPS eventually came to be known as PM-JAY. NHPS was more like a placeholder name till the formal announcement was made.

Ayushman Bharat – PM-JAY sought to take a health systems approach for health care delivery:
- MoHFW envisages a holistic health systems approach for health care delivery
- Under Ayushman Bharat, comprehensive primary care is proposed to be delivered by Health and Wellness Centres primarily through public providers
- For secondary and tertiary care, they will be provided by National Health Protection Scheme (NHPS) delivered through both public and private health care providers

The purpose of this publication has been to record/document the evolution of PM-JAY/ Ayushman Bharat for global, regional and national stakeholders. How did the scheme come into existence, from the intention to policy formulation to the transition from existing health insurance schemes to PM-JAY – what were the developments? Right from the early idea to create an effective health insurance scheme for India's most needy until the scheme's launch, there are multiple learnings through the experiences of its ideation, design, and early roll-out that can be very useful globally.
The documentation process followed a specific methodology, and the key steps are detailed here:

- **Desk review**
  Early documents, presentations, working group notes, resources available on the website of the NHA, media reports and other documents available with the NHA were reviewed to collate information that was already available. However, most resources and knowledge products created under the initiative of the PM-JAY and the NHA did not focus on the early phase of the scheme, including ideation and evolution into a pan-Indian programme launched countrywide in September 2018.

- **In-depth interviews with key stakeholders (Purposive sample)**
  A purposive method was used to identify the universe of respondents to be interviewed for this documentation. Intensive discussions and meetings with NHA leadership resulted in the development of this respondent list. Owing to COVID-19, there were several challenges faced – one in procuring confirmations from all potential respondents, since many of them are part of the country's health system leadership and completely immersed in the COVID-19 response; and the second challenge was in having to hold all interviews only over the telephone.

- **The collation and synthesis of knowledge and information gathered, and documentation of the narrative that is the evolution of the PM-JAY**
A question looming significant for the Indian government back in 2014 and 2015: How could the country's governance and leadership create the world's best health insurance programme on an efficient and technologically robust ecosystem? The ultimate goal was clear: India needed a strong and effective mechanism to become a significant catalyst for Universal Health Coverage and achieve health for all across the country. Right from the start, this entire initiative was rolled out under the direct leadership of PM Modi between 2016 and 2018.

**Phase 1: Early ideation and actions**

One of the driving forces for the birthing of the PM-JAY was the policy and programmatic environment at the time. Essentially the first decade of the 21st Century was when the entire health leadership and bureaucracy, led by top leadership, was engaged in trying to articulate a position and a way forward for the country that would provide health for all, in every sense of the word. The Rashtriya Swasthya Bima Yojana (RSBY), the predecessor to PM-JAY, was launched in 2008 and was anchored within the Union Ministry of Labour. This scheme did reasonably well, reached almost 26-27 states and was globally recognised. Providing a cover of Rs 30000/- per family per year, RSBY had its limitations. Also, rising Out of Pocket expenditures on health among the poorest and marginalised was a growing concern for the Government of India. Like any massive programme or scheme, RSBY had hurdles and challenges. For instance, even after being functional for seven years, RSBY was reaching only 57% of its targeted benefits. Another intensely felt need was the gap in people's awareness and knowledge, and this was clearly because the information education communication (IEC) efforts had either been weak or ineffective.

A series of policy decisions and discussions led to developing a whole body of new ideas and immediate actions. There was a concern building up that RSBY had not evolved, and after the new government took charge in 2014, RSBY was shifted from the Ministry of Labour to the Ministry of Health and Family Welfare (MoHFW) in 2015 as a result of a decision taken by PM Modi directly. The same year, specific policy actions resulted in a 2015 Union Cabinet note that articulated the need to initiate a new insurance scheme. It was equally important to acknowledge that the new scheme would have to be completely public-health focused and beneficiary driven. The experience also pointed to the need for stronger checks and balances and systems to prevent malpractice or fraud (a common global experience with insurance claims related to healthcare). In 2016, the Ministry of Health and Family Welfare put together a small task force to initiate India's new health insurance scheme. After a few years of intensive effort in terms of early ideation and conceptualisation, with the Union Budget of 2018, the government approved a Rs 5 lakh insurance cover scheme followed by the Cabinet Note approval in March 2018, and thus the broader contours became clear. The Union Cabinet, chaired by PM Modi, approved what was first called Ayushman Bharat National Health Protection Scheme, later to be renamed PM-JAY, and expected to subsume the ongoing centrally sponsored schemes – the RSBY and SCHIS.

A collaborative effort between the NITI Aayog and MoHFW, through the work of a small and dedicated expert group, led to the PM-JAY's initiation, and it is these efforts that also managed to shift the insurance cover from Rs 1 lakh to Rs 2 lakh and then finally to Rs 5 lakh. The Ministry of Finance and the Prime Minister's Office were also closely involved.
The government's priority and intent to provide a continuum of care to its population was becoming quite clear. As a result, critical objectives of the PM-JAY began to get clarified and solidified early on:

- To reduce catastrophic out-of-pocket health expenditure
- To improve access to quality healthcare, and,
- To meet the unmet need of the population for hospitalisation care

**Consultative discourse**

An evident strength of the new scheme being conceptualised and readied lay in the consultative approach taken before developing even the earliest blueprint. This was critical because of the federal nature of governance and administration in India, with health being administered at the national and state levels. Various states have, over the years, made multiple efforts to provide public health insurance cover, and any new scheme would require all decision-makers and implementers to concur with future action. Initially, two to three regional meetings were hosted, and then senior officials and key experts working on designing the scheme undertook state-level visits. Experiences were collated and imbibed to come up with the early concepts.

A landmark consultation at the national level, bringing together several states, was held in February 2018\(^1\). During this workshop – attended by central and state government officials, personnel from multilateral organisations and technical bodies, and representatives from academia, among others – those significant streams of activity were identified and brainstormed on and decisions taken regarding the next steps. The workshop's participants focused on processes, information technology, fraud detection and grievance redressal mechanisms, awareness and continuum of care. The workshop's goal was to collectively develop a clear roadmap and implementation timelines for the PM-JAY (then called the NHPS).

A general design for the scheme emerged through more extensive consultations like the one described above, deep dives within smaller groups and expert meetings and efforts involving preparing several background papers, conceptual frameworks, presentations, and shared thinking.

**The design: Key pillars**

Interestingly, in a highly simplified articulation, the PM-JAY was beginning to take shape along four critical pillars of action. Each of these four pillars were soon to emerge as key areas of focus with fairly far-reaching global implications. The evolution and early design of the organisation and the scheme is founded on these four pillars:

- **Scheme design**: The design of the scheme, including identifying beneficiaries, packages of insurance, payment structures, guidelines and several other technical and operational aspects of the scheme.
- **Structures/Organisation**: The development of institutional mechanisms to provide full operational support and efficiency in implementing the new scheme.
- **Information technology systems**: How the information technology structure evolved.
- **The on boarding of the states**: How states joined in on a federal structure and adopted the PM-JAY, including sharing their own experiences with public health insurance schemes at state-level.

**Pillar 1: The scheme and its design**

A core driver for the design and development of PM-JAY as a new scheme (despite several other public health insurance schemes have been active at various points across India, centrally and in the

\(^1\)Ayushman Bharat, National Level Consultation of Working Groups on Proposed National Health Protection Scheme, 15-16 February, 2018. (Ministry of Health & Family Welfare & National Health Mission) HA Presentations
states) was the fact that earlier schemes had worked independently of the more extensive health care system in the country. This had resulted in increased fragmentation of risk pools. Also, they did not have any linkages with primary health care. This meant a need to take a two-pronged approach. The first was to address preventive and promotive health by upgrading the existing sub-centres and Primary Health Centres to Health and Wellness Centres. The second approach translated into PM-JAY – a demand-led health care reform system to meet the eligible beneficiary family's immediate and urgent hospitalisation needs in a cashless manner, thereby insulating the family from catastrophic financial shock. This core objective of the scheme essentially shaped actions for the actual design of the scheme.

The proposed scheme had the following components:

### Target population
- More than 10 crore poor and vulnerable families
- Families figuring in SEC database (both urban and rural) will be automatically entitled for benefits under the scheme based on deprivation and occupational criterion
- **No family size and age limit**

### Benefit package
- A cover of **Rs 5 lakh per family** per year
- Medical and surgical conditions with minimal exclusions
- Cover pre and post hospitalisation expenses
- All pre-existing conditions shall be covered from day one
- Defined transport allowance provided at the time of discharge

### Institutional structure
- National Health Agency to be set up at National Level
- States/UTs to set up/identify State Health Agencies
- Inter-Ministerial group named as National Governing Council to be set up under leadership of Secretary Health with representatives from line Ministries, NITI Ayog and State Governments. Similar governance structure at the state level

### Implementation model
- State/UTs can decide to implement the scheme through an insurance company or directly through the trust/Society

### Proposed scheme: Salient features

#### Financing of the scheme
- Funds shared between Central and State governments
- Premium to be shared between Centre and State in the ratio of
- 60:40 in all States and UTs with own legislature
- 90:10 in North Eastern States and 3 Himalayan States
- 100% Central contribution in UTs without legislature

#### Validation of beneficiaries
- All identified beneficiary families to get benefits under NHPS
- Aadhaar to be primary mode of identification of beneficiaries. However, no person will be denied benefit in the absence of Aadhaar and alternate method of identification will be prescribed in consultation with State Government

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*Ayushman Bharat: India's Pledge for a Healthier Tomorrow; NHA
*Presentation shared by former Secretary, Ministry of Health and Family Welfare, Ms Preeti Sudan, in July 2020*
The first policy call to be taken was on beneficiaries – the most critical aspect of the scheme. Who needed the scheme the most, who needed this support the most – there were various options for identifying the beneficiaries, and this was a difficult choice and decision to make for several reasons. During the early decision-making, it was decided that the Socio-Economic Caste Census (SECC) database would be most appropriate. It allowed for the availability of income-based criteria for selection and was also available in digitised formats. There was a lot of discourse on the use of SECC data, and a decision was taken to conduct detailed field checks. On April 30, 2018, all Gram Sabhas of the country were involved in a massive consultative process to identify beneficiaries using the SECC database.

### Proposed scheme: Salient features

#### Health care providers
- Public hospitals will be deemed empanelled
- Private Health care facilities will be empaneled based on defined criteria (including specialty specific criteria)
- States will be responsible for empanelment
- Defined procedures to be reserved for public hospitals

#### Package rate based payment
- Hospitals to be on a fixed package rate based payment
- Packages and their will be fixed by Government in advance
- No additional money to be charged by hospitals
- States will have flexibility to modify these rates

### Who would benefit?

The first policy call to be taken was on beneficiaries – the most critical aspect of the scheme. Who needed the scheme the most, who needed this support the most – there were various options for identifying the beneficiaries, and this was a difficult choice and decision to make for several reasons. During the early decision-making, it was decided that the Socio-Economic Caste Census (SECC) database would be most appropriate. It allowed for the availability of income-based criteria for selection and was also available in digitised formats. There was a lot of discourse on the use of SECC data, and a decision was taken to conduct detailed field checks. On April 30, 2018, all Gram Sabhas of the country were involved in a massive consultative process to identify beneficiaries using the SECC database.

#### Hospitalisation services
- Beneficiary to get treatment at empaneled hospital on the basis of Aadhaar based verification (as far as possible)
- Mechanism to provide treatment for persons without Aadhaar will be developed

#### Strengthening of public health facilities
- Public health care facilities to retain claim amount
- Use of claim amount to improve infrastructure/human resources and as incentives to staff

#### Prevention of fraud/misuse
- Robust safeguards with proper checks and balances to minimise unnecessary hospitalisation. Pre-authorisation will be mandatory for all tertiary care and select secondary care packages
- Medical/claim audit, data analysis standard treatment guidelines and electronic health records will be used
- Software will be designed in such a manner that suspected fraudulent practices will be flagged immediately

#### Use of information and communication technology
- Robust, modular, scalable and interoperable IT platform
- It will connect MoHFW/National Health Agency with State Health Agencies and beneficiaries to Public and health care providers.
A very exhaustive exercise was carried out to identify the targeted beneficiaries of the scheme. This Beneficiary Identification System also involved a massive collection drive.

**Targeted beneficiaries**:  
- The numbers in respect of each state are derived from Socio-Economic Caste Census (SECC) database.
- Rural Families
  - 7.56 crore families: Based on deprivation (families figuring in any one of the five deprivation criteria, D2, D3, D4, D5, D7) and
  - 6 lakh families: Automatically included
- Urban Families
  - 1.97 crore: Based on 10 occupational criteria
- 22 lakhs: Such many currently enrolled families under RSBY but not covered under the targeted families derived from SECC data are also proposed to be covered.
- Total: 9.91 crore families

The Figure 3 shows the process undertaken after collecting SECC-based beneficiary identification until the scheme was ready for beneficiaries to utilise.

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**Proposed brief process flow**

**Step 1**
Based on the numbers derived from SECC data by GoI, each State Government will prepare database of targeted families using SECC data  
**Potential issues:**  
- The quality of SECC data and variations between states  
- Mapping of SECC data with State’s own data sets

**Step 2**
State government will carry out Aadhaar seeding eligible beneficiaries  
**Potential issues:**  
- Process of Aadhaar seeding at the front end and its usage  
- Family ID (AHL TIN may be used) and individual Aadhaar me correction in the SECC data against the Aadhaar data

**Step 3**
The above activities will be preceded by intensive IEC campaign particularly among the targeted beneficiaries  
**Potential challenge:** How to inform beneficiary about their entitlements

**Step 4**
If the scheme is implemented through insurance mode then insurance company will be selected by the State government through an open tender process  
**Potential issues:**  
- Tendering process  
- Part cover through insurance and part through trust

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Fig. 3: Brief Process Flow for Beneficiary Management

**NHA Presentations**
The package
Decision-making around the package was one of the most critical components of the scheme and its design. Detailed research, analysis and discussions led to the development of the scope of the package for the beneficiary. Once this was done, pre-defined packages were procured rapidly, ensuring they were reasonable. There were several considerations to keep in mind. For instance, Tamil Nadu, Karnataka and Telangana were already covering tertiary care in their packages.

Pillar 2: Structures and organisation
This was a massive and ambitious national scheme that was unfolding in design. It was becoming evident to leadership that there would be a need for an independent organisation to implement the scheme. That is how the National Health Authority was created as a successor of the National Health Agency, functioning as a registered society since May 23, 2018. After the Indian Cabinet decided to go for full autonomy of the agency for optimal implementation of the scheme, the National Health Agency was reconstituted as the National Health Authority on January 2, 2019, via a Government of India Gazette notification. The NHA is an attached office of the MoHFW with full functional autonomy.10

The respective States has set up state Health Agencies (SHAs) in a society/trust to implement the scheme at the State level. SHAs have full operational autonomy over implementing the scheme in the state, including extending the coverage to non-SECC beneficiaries.

Pillar 3: The IT system
Using technology to strengthen India’s healthcare is an ongoing effort in public and private provider spaces. In this environment of growing digitisation, it is evident that a sophisticated and efficient IT system would be the backbone of PM-JAY, and it would also become one of the digital building blocks for the country in this new millennium. As a result, the IT system pillar within the design of the PM-JAY was built, very early on, as the largest division within the NHA. This system was to be

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10 https://pmjay.gov.in/about/nha (accessed on February 11, 2021)
designed to keep in mind that a solid platform is necessary to take quality healthcare to those who could least afford it, transform hospital systems, electronic records, clinical decision support systems, and monitor the entire flow of transactions between patient providers and patient, strategic payer. It was helpful to leverage the potential network available before this scheme, especially since India generally has robust IT systems. The IT developed for PM-JAY was not from a blank slate and utilised existing systems. Significant infrastructure build-up (especially the massive cloud structure) and massive capacity building exercises were key activities undertaken. The way the scheme had been designed, it was IT-led. Even today, there is distinct monitoring, evaluation and learning, data and evidence-based culture at NHA. This remains extremely helpful for an effort of this type. The IT was a design challenge, but at the same time, there was recognition that it was simply a means to achieve the goal and to ensure the plan could be rolled out. So, to deal with this, either a new IT system could be built from scratch or could work on the existing one. Telangana’s IT system was studied and then adopted (it is an open-source system). The Tata Consultancy Services (TCS) was engaged with the Telangana system, so NHA also began engaging with them and explaining PM-JAY requirements.

The National Informatics Centre (NIC), C-DAC, TCS, Telangana Government, Project Management Unit, and Price Waterhouse Coopers were the core collaborators on the PM-JAY IT design and roll-out.

Some of the critical requirements of the IT system would be:

1. Identified key principles/focal points for developing a robust NHPS IT system
   a) Consensus on how to determine unique id for enrolment
   b) Scalability of the IT system to the whole country
   c) Adoptability by states who have existing schemes
   d) Determine some basic minimum standards at the central level, which all states will be required to follow when designing/implementing their software
   e) Determining how to maintain a balance between developing a robust, comprehensive IT system and rolling it out on time
   f) Determine how to integrate existing state scheme and their variations with the central system
   g) Identify what GoI should own data and what should be owned by states
   h) A robust IT system should have 3 layers
      1. People layer: how to identify a person, how to assign a unique id to them etc.
      2. Business process layer: how to empanel a provider, what packages will be available etc.
      3. Money flow layer: how will payments be made etc.
There were challenges:

**Enrolment**

1. Beneficiary Selection - how should existing beneficiaries RSBY/State-sponsored insurance scheme be mapped with SECC
   - If the State-sponsored scheme is not included in the deprivation index of SECC – are they covered?
   - If yes, for them + RSBY beneficiaries: they will have to be enrolled
2. De-duplication
3. Enriching SECC data with NPR (address, mobile number, ration card number, date of birth. Aadhaar)
   a) Scenario one: State has already updated the data
   b) Scenario two: State has not updated the data. Here they can use Ujjwala/PMAY data
   c) Scenario three: many states are using some other data sources (not SECC)
4. New families/members created post-SECC 2011 but meet the deprivation criteria – would they be eligible? If yes, the enrolment module will have to account for that
5. A standard master for pan India to be maintained ay SECC id. And unique id smaller number of digits as beneficiary id
6. Enrolment can be done either at an enrolment drive or health facility – premium should be paid only for verified beneficiaries. Flexibility will be given to the state

**Hospital empanelment**

1. Unique pan India id for each hospital
2. Completely online
3. API to import data from state empanelment
4. Minimum standards to be defined in the core module with a state-specific module
5. Unique pan India package id
6. Process for issuing show causes and blacklisting
7. Empanelment should not be a part of the core module

**Hospital transaction**

1. Metadata and data standards to be followed
2. EHR standards should be followed, and preferably clinical data should be entered in digital format and not scanned copies
3. Minimum data set to be defined
4. Deployment at the state level with a defined set of data being synced in real-time with the central server
5. Hospital transactions should be ultimately online
6. Module to integrate with existing state-specific schemes
7. Provision for top-up payment by the state
8. The insurance company should also use the NHPS transaction module to make payments
9. A referral module should be included
10. The concept of gate keeping through public health facilities has its pros and cons and needs to be understood and planned accordingly in the IT module (except for emergency procedures)
**Data challenges**

1. SECC Data is household-level data, not individual data
2. If new districts, blocks or villages have been created post-2011, SECC data will not reflect that demographic change
3. SECC does not have an address – it focuses more on economic data rather than demographic data, which is used to locate families

Beyond this, the IT system also worked through a Beneficiary Identification System. With the PM-JAY, a beneficiary can show the authorisation letter on their mobile phone. Further, how would hospitals take this format was a consideration too. Then, there was a Transaction Management System need – every hospital used this to manage the chain.

It is important to note that state-level autonomy was built into the system – states could choose and implement the scheme using any software of their choice, as long as they used the national guidelines. The IT effort to roll out and implement the PM-JAY has been an unprecedented and colossal exercise, and since its initiation, India is now able to benefit from the National Digital Health Blueprint, which came into being through a cloud-based, fully scalable IT mechanism.

Preventing fraud and malpractice was a big part of the early design by creating and rolling out the systems that would monitor this. The World Bank's efforts in bringing forward global practices related to the management, prevention and mitigation of fraud were a key contribution to the learning that led to the system being designed and put in place.

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**Best practice lessons relevant to global systems and experiences:** The IT system that supports the implementation of the PM-JAY is its backbone, including end-to-end information security, the privacy of personally identifiable data for beneficiaries, portability, grievance management and anti-fraud measures. ‘This system, created in record time in the early stages of the scheme, was paramount to operationalizing the scheme and ensuring its coverage and service expansion in a relatively short period of time.’

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**Pillar 4: The states: onboarding and design**

India's administrative system in its governance can be seen as a strength in designing a scheme like the PM-JAY. The federal structure allows for stringent nationally-set guidelines and frameworks and leaves enough room for flexibility, choice and freedom to operate and administer at the state level.

Key leadership from the MoHFW, Niti Aayog and NHA later began deep discussions with all state governments and key stakeholders. There were several states with similar schemes already in existence, so, needless to say, there were apprehensions at the state level in quickly accepting a brand new scheme. But one of the strengths of the early dialogue and discourse around the PM-JAY was that it was grounded in mutual respect and a spirit of collaboration and collective management and administration. For instance, if a state already had a successful scheme with a very similar package as that which was to be offered under PM-JAY, there was an option to go with that. In fact, even with the roll-out of the PM-JAY, it came to be known by different names in different states. The option was there to co-brand the scheme along with PM-JAY. Flexibility and the option for co-branding were great catalysts in removing early apprehensions regarding PM-JAY. It was also positioned as an additional option that a state could pick.

As part of the early design in its components related to state-level action, states were seen as either greenfield states (those that had no government health insurance scheme before being approached...
for adopting PM-JAY) or brownfield states (those that either had their state-specific scheme or had adopted and implemented RSBY).

Another option given to states was to choose between the trust, insurance or mixed model under the new scheme.

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**Best practice lessons relevant to global systems and experiences:** A highly consultative approach was adopted right from the start of the design, and this proved to be highly effective for the future success of the scheme. With India’s federal structure and health being a subject of governance that is on the concurrent list, states and state governments have a huge and significant role to play and a stake in the roll-out of any such scheme that will affect the way health is managed in the state. Leadership in the early stages of the scheme and its evolution showed a strong focus on gathering state-level knowledge and evidence of what has worked in the past, ongoing schemes, and how they could be dove-tailed into the new scheme among other aspects. This not only helps with strengthening the design of the scheme but also ensured smooth roll-out later.

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**Phase 2: Setting-up the national health authority**

For such a massive and ambitious scheme, the need for dedicated institutional frameworks and structures was evident right from the start. There was also a clear idea that a very nimble and innovative organisation would be the only kind of institution that could take on such a monumental task. Despite that, the beginnings were humble, and it was a small team that initiated all the early thinking, conceptualising and work.

Following the first Union Cabinet approval in March 2018, the National Health Agency was set up as a society, under the Societies Registration Act of 1860, in May 2018. About eight months later, the Union Cabinet also approved the restructuring of the existing National Health Agency as the National Health Authority, which implied an enhanced legal status for the organisation. This further meant that the restructured NHA would have full autonomy and accountability to drive its mandate of implementing the PM-JAY through an efficient, effective and transparent decision-making process.

In a matter of six months, it was all put together and launched. Working against a compressed time frame helped the NHA leadership that the PMO held review meetings once every two weeks, which was very helpful in identifying gaps, locating solutions, trouble-shooting and implementing the scheme. Shifting from an ‘agency’ to an ‘authority was also a key decision.

**Phase 3: Roll-out and the first year milestone**

**Operational initiatives**

1. **Financial allocations and directions**

   Costing: This was initially carried out by MoHFW, with revisions and reviews by Niti Aayog. Costing studies done by the World Bank in Karnataka and Chattisgarh in 2014 was an essential resource and guidance. PM-JAY was designed for complete funding from the Government of India with cost-sharing between the central and state governments. The decision was to follow a 60:40 funding ratio between centre and state, except the North-Eastern states, the three Himalayan states (Jammu & Kashmir, Himachal Pradesh, Uttarakhand) and Union Territories with legislatures. In the exceptional states, the ratio would be 90:10, with the centre contributing...
90% of all funding for PM-JAY. In the Union Territories that do not have legislatures, funding from the centre could be up to 100% on a case-by-case basis.

2. **Procurement**

The scale and complexity of a scheme like PM-JAY implied the need for detailed and complex procurement methods.

3. **Logistics and operations**

During the early planning for the roll-out and implementation of PM-JAY, some of the critical operational elements were:

- Access for the beneficiary – as to whether there would be a card or not, seeding with the Aadhar card
- The matter of provider payments – with a bills reimbursement model
- Bringing hospitals on board – how would economies of scale be managed, and how could they be convinced to take on PM-JAY; what would be their procedure for empanelment:
  - Apply online for Empanelment under NHPS
  - For empanelment, sign MoU with Insurance Company (IC) and/or State Health Agency (SHA)
  - Provide staff for training on NHPS
  - Ensure availability of necessary hardware, software, internet and human resources for carrying out transactions under NHPS
  - Provide space for Ayushman Mitras (supportive volunteers)
  - When a beneficiary reaches the hospital as its first contact point, capture Aadhaar and other details for verification of the beneficiary
  - Provide cashless and paperless healthcare services to beneficiaries
  - Provide travel allowance upon discharge
  - Maintain and share claims data and documents with IC/SHA online
  - Seek pre-authorisation as required and follow standard treatment guidelines as and when implemented
  - Receive claim payment on a package basis

By December 2018, 500,000 (5 lakh) beneficiaries had availed treatment under the AB PM-JAY (within three months of the scheme’s launch. This number grew to 2 million (20 lakh) beneficiaries in April 2019 and 3.6 million (36 lakh) beneficiaries in July 2019. Within a year since its launch, AB PM-JAY had cleared begun showing impact:

- There were 32 states and Union Territories implementing the scheme
- The number of e-cards issued was 103 million (10.3 crores)
- Over 4.6 million (46 lakh) hospital treatments had been availed of, and Rs 74500 million (7450 crores) of value treatments had been provided to beneficiaries
- Over 18200 hospitals had been empanelled
- There were 380,000 (3.8 lakh) installations of the AB PM-JAY app
- The NHA Call Centre had answered 4.5 million (45 lakh) calls
Conclusions and the way forward

The effort put into the early phase between the original idea to launch a nationwide health insurance scheme that would change the game for India's millions who live without affordable, quality healthcare was a primary reason for the immediate success of PM-JAY. Many experiences had challenges and opportunities within that effort, so it was a journey with several stories to tell. The PM-JAY as a scheme was designed and rolled out based on the convergence between centre and state. This was a factor that contributed to the scheme's success in terms of state-level acceptability, uptake and utilisation over the last two years between 2018 and 2020.

It is well-understood and acknowledged that PM-JAY takes India forward in its journey towards UHC, but there is little doubt that much else needs to be done. But the path chosen to design and launch PM-JAY holds the promise of becoming a global benchmark. Even the creation of the NHA has been seen as in line with global standard practice, and this could be a major aspect of India's ongoing public health system reform and the drive for UHC. This is why this narrative is critical for key stakeholders throughout the world. Also, continued knowledge exchange and management between countries around the world can significantly contribute to the growth of this pan-Indian health insurance scheme. Establishing a global knowledge repository of health insurance experiences could be of great value.

With the last two years between 2018 and 2020, India has been presented with a massive window of opportunity to tangibly shift the goalpost in terms of healthcare service delivery in India and address the health burden millions of Indians carry each day.
The launch of the PM-JAY heralded a new vision and approach for health systems strengthening in India. This report sheds light on the early days of the roll-out of the initiative and experiences of stakeholders involved in its ideation and design.