Health Care Equity: An Analysis of Ayushman Bharat: A National Health Protection Scheme in India

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Abstract: *Purpose: The aim of the study is to assess how Ayushman Bharat's introduction aims to realize the vision of healthcare coverage for the socially and economically disadvantaged and assess the program based on the assistance it provides to individuals.*

Design/methodology/approach: The study aims to analyze Ayushman Bharat's Health and Wellness Centers (HWC) and Pradhan Mantri Jan Arogya Yojana (PM-JAY) programs in light of their difficulties, drawbacks, and effects on different states. As a result, the study adopts a case study methodology

Findings: Ayushman Bharat (AB-HWCs and ABPMJAY) can accomplish its core goals of providing comprehensive coverage to the vulnerable population and lowering catastrophic healthcare costs, according to a closer examination of the implementation of the initiatives and performance over the past year. The current state of public health services, the imbalanced healthcare infrastructure in metropolitan areas, the limited involvement of the private sector, and the ability of the initiative to quickly adapt to new and developing restrictions, however, may limit the reach and results of the initiative.

Originality: Since health risks are among the biggest threats to poor people's capacity to support themselves, achieving health equity is essential to the battle against poverty. By analyzing an innovative healthcare funding model to enable health equity from a developing country, India, the study brings value.

Key Words: *Health Care Equity, Health Security, Ayushman Bharat, Quality Medical Care.*

Introduction

The security of one's health is crucial to development, and the well-being of the poor is particularly critical for the fight against poverty. Health security is viewed as a crucial component of general human development and the fight against poverty because health risk is one of the most significant risks

to poor people's ability to support themselves (Innes et al., 2022; Osterholm, 2017; Bordier et al., 2020; Jutting, 2004). Governments all across the world have been concerned with ensuring the health and welfare of their citizens. The cost of medical care for impoverished households increases when they encounter a health shock because, according to a World Health Organization (WHO) assessment, the government spends less than 40% on primary healthcare. Such unforeseen medical costs result in serious financial difficulties and long-term poverty (Xia & Yuan, 2022; Damme et al., 2004; Annear et al. 2006).

Additionally, households frequently forgo treatment or choose low-quality care due to a lack of funds (Yang et al., 2020; Das et al., 2008), further impedes economic growth. Governments from all across the world are attempting to solve this problem in several ways. To address the issues, the majority of them have implemented micro health insurances (Hinjoy et al., 2020; Bordier et al., 2020; Escobar & Panopolou, 2003; Knaul & Frenk, 2005; Obermann, 2006; Liu & Rao, 2006; Wagstaff et al., 2003). Current research indicates that health insurance programs boost the quantity and quality of care sought while assisting households with their financial difficulties. However, there is little research on the unintentional impact of such insurance plans on health outcomes, and it is unevenly distributed between different insurance kinds, particularly in low-income nations. Not many studies in the literature take novel models and their effects into account. Therefore, this study aims to find and evaluate creative healthcare financing strategies from India. The study will also highlight unmet requirements, particularly affordability-related ones, and emphasize the necessity of stakeholder cooperation to enhance patient access and financial security. There is much potential for shared knowledge among policy makers and pertinent players to address issues in the healthcare sector.

Indian Background

India is a large nation with a sizable populace. Unquestionably, the Indian people need a sound healthcare system that is accessible and inexpensive. One of the biggest obstacles preventing India from reaching its potential is the state of general health at the moment. The journey towards a healthier country has only been partially completed, despite notable improvements in health indicators like life expectancy, infant mortality rate (IMR), and maternal mortality rate (MMR) as a result of increased access to healthcare services

nationwide, extensive health campaigns, sanitation drives, an increase in the number of government and private hospitals, improved immunization, growing literacy, and other health indicators. The Indian government has undertaken several measures to improve people's health.

In addition to introducing the essential vaccines, National Rural Health Mission (NRHM) has developed many programs to enhance infrastructural facilities, equipment availability, pharmaceutical availability, and human resource strength. This mission focuses on reducing infant mortality, improving maternal health, increasing immunization rates, raising dietary standards, and raising hygiene awareness. The initiatives' outcomes were quite positive, and many health indicators rose in the rural area. Additionally, India's first National Health Policy (NHP) was created in 1983 by Ministry of Health and Family Welfare (MOHFW) to ensure that all social and geographic groups had more equitable access to health care. This was done by strengthening the health system and increasing primary health sector spending. Even though Indian healthcare has changed over the past three decades, it is now at a very crucial point in achieving the three A's of healthcare: affordability, accessibility, and availability. Additionally, because of the high cost of complicated life-saving therapies, secondary and tertiary health care prices have remained high and out of reach for many sections of society (Bhattacharjee & Mohanty, 2022). The challenges faced by the health system in India are: disparity in health status across India, the high demand for healthcare services, low health spending, high out-of-pocket spending, a disease profile that is highly volatile, unimpressive health indicators, poorly maintained medical equipment, a labour shortage, and inadequate health infrastructure (Small et al., 2017; Health and Family Welfare Statistics in India 2019-20; Niti Aayog, 2019).

The government has continually addressed major issues deteriorating the healthcare system through its policies and structures. The existence of an efficient healthcare coverage system for a long time is one of the common elements across the high-performing States, claims the research (Niti Aayog, 2019). For instance, all-inclusive health insurance program of Kerala was introduced in 2008, and Andhra Pradesh's health insurance program (Aarogyasri) debuted in 2007. According to the Insurance Regulatory and Development Authority of India, 2018 report, 75% of the Indian population is covered by government-sponsored health insurance programs, covering

48.2% of the country's population. This demonstrates the government's resolve to increase access to healthcare, particularly in light of its goal of achieving universal health coverage (UHC) by 2030.

The Indian government has also launched several programmes to help economically weaker citizens access quality medical care. The introduction of Ayushman Bharat (2018), which covers all the primary, secondary, and tertiary care verticals of healthcare service delivery, is one such initiative to attain UHC. The program intends to increase the affordability, accessibility, and quality of care for the underprivileged and vulnerable population, as well as to guarantee ongoing care for all Indians.

Health and Wellness Centres (HWC) and Pradhan Mantri Jan Arogya Yojana are two aspects of Ayushman Bharat (PM-JAY). These HWCs are updated versions of older programs like Primary Health Centres and Sub Centres. While the Pradhan Mantri Jan Arogya Yojana (PMJAY) focuses on delivering secondary and tertiary care services to the impoverished sector of society, health and wellness centres (HWCs) strive to deliver a wide variety of services close to the community.

The PM-JAY is a health insurance program for the underprivileged that provides cashless and paperless access to services at impanelled hospitals. The Central and State Governments each contribute a portion of the cash for the program. Except for the North-Eastern, Himalayan, and Union Territories with the legislature, the central share to State share ratio for all States is 60:40. The ratio is 90:10 for the North-Eastern States and the Himalayan States. The centre pays the entire premium in the case of Union Territories without legislatures.

These two health programs—HWC and PM-JAY—are part of Ayushman Bharat, which aims to create a new India by the year 2022 and assure increased productivity, well-being, reduce pay loss and financial hardship, create jobs, and strengthen the healthcare industry. After the program is implemented, the Indian healthcare system will take a giant step closer to UHC. To realize the vision of UHC, periodic evaluation and remedial action are crucial. Therefore, the study's goal is to assess how Ayushman Bharat's introduction aims to realise the vision of healthcare coverage for the socially and economically disadvantaged and assess the program based on the assistance it provides to individuals.

Methodology

The study aims to analyze Ayushman Bharat's Health and Wellness Centers (HWC) and Pradhan Mantri Jan Arogya Yojana (PM-JAY) programs in light of their difficulties, drawbacks, and effects on different states. As a result, the study uses a case study methodology to analyse the scheme.

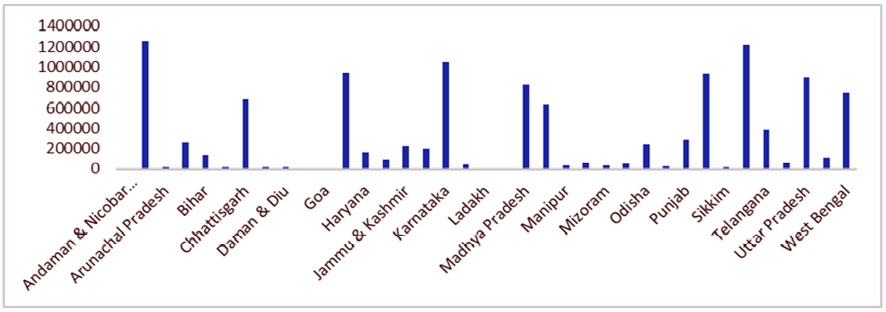
The Analysis of the Scheme: Ayushman Bharat

A lot has been accomplished, according to the study of the schemes. However, more work remains to be done in order to make both programs more cohesive, remove obstacles to seamless functioning, and eventually raise the quality of healthcare.

The government has partnered (Table 1) with various private and public organizations to ensure high-quality and prompt healthcare services. The scheme's current architecture calls for partnerships between the public and private sectors. By limiting long-term commitments and utilizing ultra-lean care delivery models, this cooperation shows how to keep future expenditures under control.

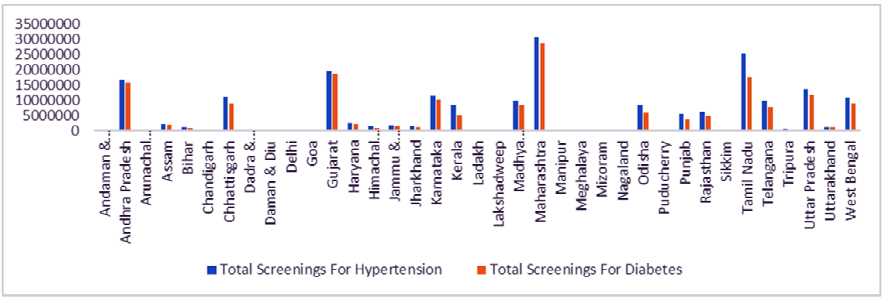
Ayushman Bharat's primary goals include improving the nation's overall healthcare system; as a result, attention must also be paid to more significant operational issues like providing high-quality, uniformed care, promoting quality accreditation, putting an emphasis on learning and capacity development, utilizing analytics and technology, and incorporating lessons learned from around the world. By concentrating on these overarching operational aspects, not only will the scheme be implemented more successfully, but the healthcare market will also be shaped, new market entrants will be encouraged, the regulatory framework will be reviewed, and new investment opportunities from cross-sectoral partners will be developed. The most wellness sessions, including yoga, were held in Andhra Pradesh (1258991), followed by Tamil Nadu (1221367), and the least were held in Delhi (21). Similarly, Maharashtra has completed the most tests for both diabetes and hypertension (30688913 and 28701082, respectively), followed by Gujarat (18700451) for diabetes and Tamil Nadu (25474873) for both conditions (figure 2). Maharashtra has completed the most oral, breast, and cervical cancer screenings (24912796, 10747620, and 8065033, respectively), followed by Gujarat (15973743, 7300448 and 6796232, respectively) (figure 3). Around 16 countries or partnership organisations are involved in the Ayushman Bharat Scheme (Table 1).

Figure 1: Number of Wellness Sessions Including Yoga Conducted



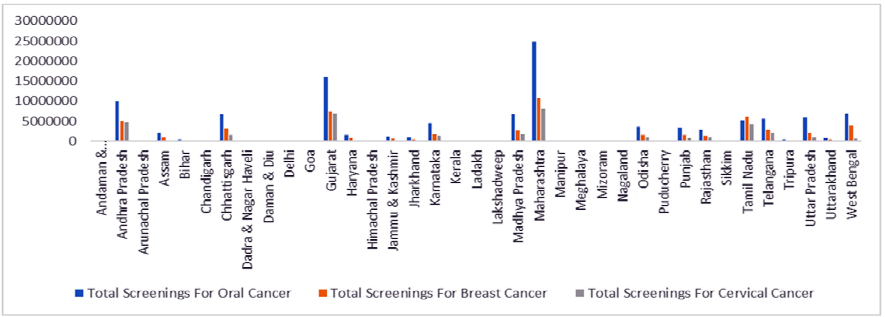
Source: https://main.mohfw.gov.in/documents/reports

Figure 2: Statewise Screening for Hypertension and Diabetes



Source: https://main.mohfw.gov.in/documents/reports

Figure 3: Number of Screenings for Different Types of Cancer



Source: https://main.mohfw.gov.in/documents/reports

Table 1: Partnership Organizations/Countries in Ayushman Bharat

S/N	Partnership organizations/ Countries in Ayushman Bharat
1	German Agency for International Cooperation (GIZ)
2	The World Bank,
3	World Health Organisation,
4	Bill and Melinda Gates Foundation,
5	Clinton Health
6	Access Initiative
7	National Skill Development
8	Corporation, ICICI Foundation for Inclusive Growth
9	Asian Development Bank, Akshaya Patra Foundation
10	Bharti Foundation
11	Novartis Social Business
12	NATHEALTH
13	WISH Foundation
14	Health Systems Transformational Program - Public Health Foundation of India
15	Insurance Institute of India, Department of Health Research - National Cancer Grid
16	Quality Council of India, International Innovation Corps -University of Chicago

Beneficiary identification, hospital network development, health benefits package introduction, development of standard treatment guidelines (STGs), awareness and empowerment programs, capacity building initiatives, provision for fraud prevention, detection, and control, engagement of service providers, hospital operations management, continuous monitoring and evaluation, response to Covid-19, and convergence of scheme are the major initiatives introduced under this scheme (Table 2). Table 2 lists the best practices followed for each endeavour. Aapke Dwar Ayushman, 625 STGs, working with State Health Agencies (SHA), quality certifications, quality dashboards, and other instances are a few examples.

Table 2: Key Initiatives and Best Practices Under Ayushman Bharat

Key Initiatives	Best Practices
Beneficiary Identification	➢ Mission mode campaign "Aapke Dwar Ayushman". ➢ MoUs with leading service providers such as CSC e-Governance Services Ltd. and UTIITSL Ltd. to ensure free issuance of cards to (SECC 2011) beneficiaries ➢ Collaboration with State Health Agencies to establish a grassroots network of Health Care Workers (HCWs) and Front-Line Workers (FLWs) to mobilize beneficiaries. ➢ Convergence with Panchayati Raj institutions by enlisting them to mobilize beneficiaries.
Creation of Hospital Network	➢ Supply of health care services- pre-selected, well equipped, and well-prepared hospitals ➢ Distribution - optimal accessibility ➢ Quality standards and criteria for selection ▪ General criteria – For hospitals that provide non specialised general medical and surgical care with or without intensive care unit (ICU) and emergency services. ▪ Unique Criteria (for clinical specialties) – A specific set of criteria has been identified for each specialty. ▪ Monthly Quality Audit Checklist ▪ AB-PMJAY Quality Certification ▪ AB-PMJAY Quality dashboard ➢ Empanelment of hospitals under Central government ministries ➢ Direct empanelment for private hospitals ➢ Revision of empanelment policy
Health Benefit Packages	➢ Treatment packages containing various procedures (cross-specialty, add-on, stand-alone, follow-up, stratifications, etc.), expanding access to various treatments, and a scientific integration of implants and high-end consumables within the packages., ➢ Reimbursement based on specified package rates

Standard Treatment Guidelines (STGs)	➢ A total of 625 Standard Treatment Guidelines (STGs) ➢ Pre-authorising Panel Doctor (PPD) and Claims Panel Doctor (CPD) ➢ Third-party administrators (TPAs), insurance companies, SHAs
Beneficiary Awareness and Empowerment	➢ Various modes of communication such as leaflets, booklets, hoardings, TV, radio spots, interpersonal communication, etc., ➢ Arogya Manthan to celebrate the launch day of the AB-PMJAY scheme ➢ Diwali Campaign - #Gift of Health ➢ Launch of Ayushman Bharat - PMJAY Sehat ➢ Social media campaign on Ayushman CAPF initiative ➢ Collaboration with State Bank of India (SBI) - AB-PMJAY ATM screensaver was deployed at more than 38,000 ATM sites across the country ➢ AB-PMJAY digital banner advertisement has been deployed on SBI's YONO app ➢ Kumbh Mela-activities like hot-air balloons, pole kiosks, press campaigns, electronic media campaigns, newspaper advertisements ➢ Arogya Dhara 2.0 ➢ Adhikar Patra to make them aware of the rights ➢ Abhinandan Patra and a feedback form - thank you note ➢ Ayushman Mitra-helping eligible people to get their Ayushman ➢ Cards created ➢ 'Arogya Samvad' Newsletter to communicate the progress and updates
Capacity Building	➢ Setting up sustainable institutional structures, ➢ Building and strengthening the human resource and institutional capacity ➢ Sustaining knowledge and skill through knowledge management and the use of appropriate tools.

	➢ SHA capacity gap analysis ➢ Promotion of Cascade Model of Training through Training of Trainers
	➢ Joint Certification Programme (Claim Adjudication, Medical Audit, and Field Investigation) with I.I.I supported by World Bank for the stakeholders involved in the claim processes of AB-PMJAY ➢ "BODHI" for internal skilling of National Health Authority (NHA) divisions
Fraud Prevention, Detection, and Control	➢ Zero tolerance approach toward any fraud, ➢ An anti-fraud framework based on Prevention, Detection, and Deterrence. ➢ Advanced Analytics and Forensics ➢ Joint Medical Audits ➢ Use of Advanced Data Analytics Leveraging Machine Learning/Artificial Intelligence ➢ Advisories and Manuals ➢ Monitoring Tool RADAR (Risk Assessment, Detection, and Analytical Reporting ➢ Action against errant entities
Service Provider Engagement	➢ A robust real-time Management Information System (MIS). ➢ IMPACT Portal - a comprehensive portal displaying information related to infrastructure and human resources availability at State and District levels along with various operational dashboards ➢ Twenty-three separate need-based dashboards ➢ Improved Claim Settlement Turnaround Time ➢ Claim Adjudication Audit (CAA) ➢ Auto-Adjudication POC ➢ New IT enhancements (New query and rejection template) ➢ Empanelment of agency for Providing Human Resources ➢ Insurance pilot for covering Missing Middle/Non-Poor Population ➢ Automation of the payment process

Hospital Operations	➢ Electronic engagement, regular video conferences webinars, field visits, and direct calling
Monitoring and Evaluation	➢ Real-time dashboards to continuously keep track of coverage, benefits and financial protection aspects of the scheme ➢ Regular policy briefs based on utilization and data triangulation with state specific disease patterns
Beneficiary Empowerment	➢ Call Centre Operations AB-PMJAY Helpline ➢ Grievance redressal ➢ Quality audit of closed grievances
COVID-19 Response	➢ Free of cost access to private facilities for the scheme beneficiaries ➢ New packages for Covid -19 for the scheme beneficiaries. ➢ Direct Lab Empanelment for the scheme beneficiaries. ➢ Hospital Empanelment Module (HEM) Lite to overcome the delay due to lockdown. ➢ Call Centre support
Scheme Convergence	➢ Converge Ayushman Bharat with various national schemes to allow various ministries ➢ Reduced cost and standardized quality service ➢ Optimized & de-duplicated beneficiary

The subsequent sessions analyse the pillars separately to get a broader understanding of the challenges and the consequences within each pillar.

Health and Wellness Centres (HWCs)

HWCS, Ayushman Bharat's initial pillar, aims to provide Comprehensive Primary Healthcare (CPHC). As of March 31, 2022, the Government of

India had created 117440 HWCs under this project, surpassing the goal of 110000 HWCs by that date (annual report MOHFW, 2022). There are 34485 HSS with GEO coordinators as of May 31, 2022. (Annual report MOHFW, 2022). The Ayushman Bharat report (2022) states that Community Health Centres (CHCs) are working to address the unmet need for non-communicable and chronic diseases. The freedom to prioritize the gradual rollout of service packages depending on the local epidemiological environment and resources has been granted to States and Union Territories (UT). The CHCs require qualified personnel, medications and supplies, well-maintained medical equipment, and most importantly, public trust in order to deliver the enhanced services.

Additionally, public health requires a lengthy procedure for authorising new roles, hiring new employees, and onboarding them. This calls for a streamlined, time-bound plan to fill both open and new positions (Ayushman Bharat Report 2022; KPMG Report 2020). Even though the government is looking at partnerships to do this, carrying out major and minor repairs to put the plan into action would be a mammoth effort given the diverse topography and existing State of healthcare infrastructure among States. The primary healthcare system before implementing Ayushman Bharat-Health and Wellness Centres is compared and analysed in Table 3, along with the suggested plan and actual results. The following list includes some of the main difficulties. Even though money was set aside, the pace of implementation and the launch of service packages differ depending on the State/UT and are not consistent across the country. There is a considerable gap in the timely availability of sufficient drugs and supplies up to the final mile, which has a significant impact on the effectiveness and outcomes of HWCs. To promote transformation, there is a need for comprehensive skill development of the supply chain management (SCM) workforce, implementation of the SCMIT system, and reengineering SCM procedures in public health. It is also challenging to supply a significant number of HWCs with modern diagnostic equipment due to the disparate geographic conditions and health conditions in the various states. Not all State governments have specified the protocols as of yet just makes the problem worse.

Table 3: Comparison of primary healthcare systems before and after the implementation of Ayushman Bharat-Health and Wellness Centres

Before Ayushman Bharat	After Ayushman Bharat	Realty after Ayushman Bharat
Selective primary health care	Comprehensive primary health care	A budget was set aside to offer complete treatment. SHC, Primary healthcare centre (PHC), and UPHC each received funding for the facility upgrade. However, State/UTs have a significant influence on the speed of implementation and the rollout of service packages. Based on the resources and the local epidemiological environment, the implementation is done in phases.
Focused on men and women of reproductive age group-RCH oriented	Life cycle approach	Life cycle approach
Low drug availability at outlying centres results in high out-of-pocket costs.	Most peripheral centres now have more readily available medications, which has reduced out-of-pocket costs.	There are now more medications available at the outlying centres. To supply high-quality CPHC consistently throughout all States, a unified list for HWCs must be established, along with standardization of the national

Before Ayushman Bharat	After Ayushman Bharat	Realty after Ayushman Bharat
		and State level essential medicine lists. The success and results of HWCs will depend on how readily available medications are.
Limited follow-up at the community level	Medicines and diagnoses are available at HWCs, making it easy to follow up at the community level.	Severe delays in the timely delivery of sufficient medications and supplies up until the last mile. The SCM personnel must be heavily skilled up, the SCMIT system must be adopted, and SCM practices in public health must be reengineered in order to foster transformation. Considering the varied geographies and health conditions throughout the states, it is difficult to distribute new equipment to significant number of HWCs. At this time, not all state governments have specified the protocols.
The lack of staff in public health facilities is one of the critical causes of the underutilization of the extensive	HWCs provide comprehensive healthcare, lowering the financial burden on patients and the cost of transportation.	The public health system needs a qualified healthcare workforce as soon as possible to regain public confidence. Delivering quality services requires a substantial last-mile crew that must be trained.

Before Ayushman Bharat	After Ayushman Bharat	Realty after Ayushman Bharat
network of SHCs and PHCs (KPMG report, 2019).		
Limited Human Resources at Sub centres	A community health officer to lead the team and integrate the healthcare process.	Staff nurse positions are filled to a 60 percent level. In contrast to the requirement of at least two doctors, 60% of PHCs only have one physician. Most critically, 5% of PHCs do not have a single doctor on staff.
Limited focus on chronic disease prevention.	The risk factors for chronic illnesses and other ailments are a focus of HWCs.	
Because Sub Health Centres (SHC) and PHCs were unable to handle healthcare at the primary level, secondary level institutions were overloaded.	A robust HWC network would efficiently manage the patients at the primary level, lowering the secondary level overcrowding.	The ability to find qualified candidates to fill the position, the difficulty of training a large number of MHLP/CHOs, and the system's adoption of a new cadre
There was no access to telehealth at peripheral centres	enhanced network and referral connections via teleplatforms. Tele-pathology and tele-	Getting HWCs to embrace these solutions and connect to the network is challenging. The adoption of the e-Aushadhi/ SCM IT system is progressing

Before Ayushman Bharat	After Ayushman Bharat	Realty after Ayushman Bharat
	radiology adoption could make it possible for HWCs to offer more services.	in different ways across the States. The utilisation of the e-Aushadhi/SCM IT system is ineffective because of connectivity in remote places, a skilled workforce, and the maturity of the current SCM IT system.
Manual records lead to overburdened staff and data errors	A robust IT platform, standardized digital health records	Widespread capacity building is required for information and communication technology (ICT) literacy and training of a large number of workforces across new ICT systems/ modules. Both the new and existing staff need hand-holding exercises.
Focus on the wellness component was limited	Wellness activities (including yoga) are mainstreamed	It is in progress

Discussion on HWCs

After comparing the primary healthcare systems in Kerala before and after the introduction of Ayushman Bharat-Health Centres, it can be concluded that regular maintenance of the physical infrastructure (following the upgrade) is necessary for the continuous delivery of services. In addition, consistent service delivery depends on routine maintenance of the physical infrastructure (after the update). Furthermore, the efficient running of wellness centres and

the purchase of telemedicine may be hampered by drawn-out and time-consuming public procurement and contracting processes. Implementing community-based outreach is more challenging in urban areas due to the diverse population makeup, varying health demands, and easy access to secondary level and private healthcare facilities. It will be essential to hire more last-mile workers, cooperate with both for-profit and non-profit partners, implement IEC successfully, and monitor various states to properly engage the community. In order to bring together the multiple healthcare programs from the MoHFW and non-healthcare programs from other ministries, an effective plan and implementation are required.

Analysis of Pradhan Mantri Jan Arogya Yojana (PMJAY)

Ayushman Bharat's second pillar, AB-PMJAY, was unveiled on September 23, 2018. The program aims to assist more than ten crore low-income and vulnerable families by covering secondary and tertiary hospitalization expenses up to INR 5 lakh per family per year (about 50 crore beneficiaries). Examples of centrally subsidized programs that have been incorporated under the AB-PMJAY are the Rashtriya Swasthya Bima Yojana (RSBY) and Senior Citizen Health Insurance Scheme (SCHIS).

The government spent 51.3% on primary care, 21.9% on secondary care, and 14% on tertiary care, according to the National Health Accounts for 2014–15. India's public health system lacks comprehensive healthcare services, especially secondary and tertiary care coverage. These treatments are widely available from private healthcare providers, resulting in high OOP expenses. By enhancing the public healthcare system and utilizing the high-quality services of private healthcare providers at various stages of care, the plan seeks to reduce catastrophic expenditures. After the program's launch, it was predicted that AB-PMJAY and other government-funded health policies would cover 17 crores (68%) of families. A thorough analysis of the plans reveals the difficulties or issues the plan encountered during implementation.

The Following are the main points:

- Beneficiary coverage differs between rural and urban areas because eligibility is based on deprivation categories in the former, while occupational considerations are taken into account in the latter.

- Due to the lack of availability or incomplete seeding of beneficiary details, there are certain challenges with the approval of beneficiaries with low confidence/profile matching scores.
- An in-depth study also reveals a lack of cooperation among those enrolled in the present state-owned health programs, which results in double counting or omission of beneficiaries.
- There are problems with the e-card generation process resulting from inadequate or absent training. The coverage appears to be adequate and is more than twice as high as other state-owned health programs. However, if the qualified family's assigned Rs. 5 lakhs of coverage are consumed, there is no provision for coverage.
- Although the centre supports the program, it is unclear exactly how the money will be distributed among the many categories.
- Moreover, many SHAs have been unable to allocate and use the money properly for the urgently required IEC due to the requirement that information education and communications (IEC) is paid for out of a particular fund. It is also not obvious what the maximum and minimum budget allotments are for each subheading.
- In total, 1,394 packages were created and covered by the program for launch purposes for up to one year. The updated health packages were created using the correct nomenclature. The duplicates have been eliminated.
- Packages under the plan, pre-authorization is not required for about 750 treatments. Pre-authorization has been outlined in many states, though, for all treatments. While in the case of brownfield states, they employed their current pre-authorization standards in order to qualify the packages for the programme.
- Additionally, there is no differentiation in price or grading for empanelled healthcare provider (EHCP)s based on their geographic location (tier 1 vs. tier 2 and 3), or the size of the hospital (big and small healthcare organizations) within the same territory.
- There are numerous issues with the pricing structure used for packages. The approved list's minimum and maximum usage requirements must always be adhered to. It is also required to calculate the package price

divided across the numerous items, including the medications, supplies, and implants. Another concern with regard to pricing is the need to standardise and define an approved list of drugs, equipment, and implants in terms of minimum and maximum usage for high volume and tertiary care procedures, approved generic/branded drugs, and the calibre of such drugs, equipment, and supplies used by EHCP throughout India.

- Concern exists as well regarding private hospitals' participation. Even though the system has more than 7000 private providers impanelled, Tier-1 cities like Gurugram (17), Mumbai (29), and Bengaluru (28) only have a tiny number of private healthcare providers (KPMG, 2020).
- Effective quality, results, and practice monitoring is crucial, as are field quality, medical audits, and substantial analytics use.
- According to KPMG (2020), 6 States and UTs have selected a hybrid strategy, 9 States and UTs have chosen an insurance mode, and 17 States and UTs have chosen a trust technique. While West Bengal, Delhi, Telangana, and Odisha are States/UTs that currently run State-owned health programmes, all three States, with the exception of Delhi, have not yet signed up to participate in AB-PMJAY.
- As states struggle with the issue and the pay-out has not been launched properly, the NHA needs to establish and publicise suitable guidelines for incentive distribution across cadres.
- Implementing Support Agency (ISA) with an L-1 financial quotation without a lower baseline was chosen because the majority of greenfield states used the trust method of implementation of the scheme and lacked the institutional capacity to engage in rigorous selection, negotiation, and contracting processes.
- Because the majority of greenfield states adopted the trust mode of implementation of the scheme and lacked the institutional capacity to engage in rigorous selection, negotiation, and contracting processes, ISA with an L-1 financial quotation without a lower baseline was chosen.
- Many States have insufficient workforce capacity or a delay in recruiting the staff to administrate and implement these schemes, which has resulted in States' dependency on NHA. Because of these reasons, States consider insurance organizations a blessing in terms of institutional assistance.

- The beneficiary identification portal is easy to use and records the whole patient experience. States will eventually become the stewards of this platform. NHA is also utilising an open API approach to facilitate and give organised data to Sates for their internal uses. Ten states have used this thus far.
- In order to implement the fraud management platform/analytics in the future and enable real-time fraud detection, NHA is working to improve their accuracy.
- An enterprise IT suite is being developed to automate daily activities at NHA and SHA. Real-time interactive dashboards powered by data present a significant opportunity to improve monitoring and decision-making.
- One of the efforts to create an efficient monitoring mechanism and analyse usage trends is using the RADAR (Risk Assessment, Detection, and Analytical Reporting) dashboard.
- The higher portability for high-value claims reflects both the patients' preferences for seeking treatment at larger institutions in other regions as well as possible service shortfalls in several states.
- The analysis reveals a lack of institutional capacity at the SHA level to hire and deploy the necessary competent personnel for the programme to function effectively, particularly for greenfield states.
- IEC guidelines, templates, and procedures have not been fully implemented; thus, more funding and oversight will be needed to accomplish the desired goals.
- The institutional ability to design and carry out IEC has been constrained at the state level.
- Limited IEC activities have led to a lack of understanding of the program, the exploitation of beneficiaries, and the emergence of dishonest practices like charging for services. Lack of institutional ability at the SHA level to hire and deploy the necessary skilled personnel for the program to operate effectively, particularly in greenfield states.
- It is better to have experts from the industry or tie up with reputed agencies to train the staff concerning industry practices, detection of fraud, process monitoring mechanisms, and evaluation.

Conclusion

Ayushman Bharat (AB-HWCs and ABPMJAY) can accomplish its core goals of providing comprehensive coverage to the vulnerable population and lowering catastrophic healthcare costs, according to a closer examination of the initiative's implementation and performance over the past year. The current state of public health services, the imbalanced healthcare infrastructure in metropolitan areas, the limited involvement of the private sector, and the initiative's ability to quickly adapt to new and developing restrictions, however, may limit the initiative's reach and results.

In order to address today's healthcare concerns, crucial decisions must be taken about the four pillars of healthcare: availability, cost, accessibility, and acceptability. The subsequent enablement will concentrate on making quality care and providers available across geographies, at current prices, within reach of rural and semi-urban patients, and acceptable to all stakeholders. The government has enabled comprehensive health coverage to the sizeable vulnerable population.

The concept is a significant step toward the UHC, but its implementation is crucial. The following list of prospective areas to strengthen the present implementation for better results is based on the current structure and on-the-ground execution of Ayushman Bharat.

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