India's publicly financed insurance scheme – scope for revision

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> "Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), the flagship scheme of Central government has been a catalyst working towards removing unequal gender coverage in healthcare insurance. Currently women comprise up to 49.6% of the total enrolled AB PM-JAY beneficiaries."
> – All India Radio News, tweet posted on 9 Mar 2022[1]

Prinja and colleagues[2] assessed the impact of India's publicly financed health insurance scheme on public sector district hospitals in Dec 2022 issue of the Journal. Therein they calculate State- and speciality-wise percent share of Pradhan Mantri Jan Arogya Yojana (PMJAY) claims (number and value) at district hospitals across the country along with net financial gain at district hospitals in cost efficient scenario.[2] The authors—which also included the Executive Director of National Health Authority—investigated funds transferred to government run hospitals under claims made by the staff and the difference it had with its actual expenditure. The authors found that as the former amount was higher, the health care service providers got monetary benefits which they might utilise under various heads to upgrade their infrastructure. We are indebted to the administrators for the massive exercise of collecting huge data and analysing it so that we could make some sense by having a bird's eye view of the currently running scheme.

Nevertheless, there are few points of contradiction towards which I want to draw their attention. Nowadays the Indian government is opening one Medical College per district and for that purpose is upgrading several district hospitals to teaching Institutions.[3] And after establishment of a Medical College, it is necessary to get approval of its regulatory body, the National Medical Commission. When one visits the website of the Commission, it shows minimum standard requirements of teaching and non-teaching staff, medical equipments, infrastructure, land requirement etc.[4] But the study by Prinja and colleagues[2] avoids this point. During the study period, as the conversion from district hospitals to Medical Colleges had been going on, readers would like to know whether few or many hospitals under the observation underwent the transition and what were the cost implications. How much funds were spent to create and upgrade the facilities and whether that process resulted in increased footfall, the article lacks the information? And whether subsequently it recouped the cost by managing more/complicated cases, should be underscored.

Many a times primary and secondary care hospitals refer patients to get them higher level care due to various considerations. The study by Lahariya and colleagues[5] highlighted that many a times the transfers do not have clear reasons. Although most people in India live in villages, most of the physicians live in cities.[6] Sometimes lack, or shortage of manpower is a reason for such shifting to higher-level centres. Readers would also like to know whether the investigators encountered such cases or not; and if yes, what were its cost implications.

During COVID-19 pandemic, different States provided different level of care to COVID-19 patients.[7] Although the authors collected the data for this insurance-scheme before COVID-19 pandemic, now is the time to take into consideration this factor too. What we can learn from such success stories where COVID-19 patients were admitted under the scheme, may become a teaching exercise for the future. When the government allowed patients of the infectious disease to avail admission facility under the insurance scheme,[8] why did some States fare poorly, we should inquire into.

Under the study limitations, the authors mentioned that due to lack of electronic health records, the average length of stay was estimated by discussion with experts in the field. Nonetheless, in this era of hospital-based care when patients are managed in tertiary care Institutions, there could be possibility of medical errors,[9] sometimes resulting in prolongation in hospital stay. Therefore, although making an average of such calculus may provide an accurate picture, collecting data from a small number of patients, or experts, may provide an off-the-mark scenario. At the opposite end of the spectrum when a physician makes last ditch attempt to save a patient when a specialist is not available nearby and undue delay in transport for referral may cost her life, such cases should be evaluated on a different scale.[10]

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HG conceptualised and wrote the paper.

Declaration of interests
None.

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