national health authority
सत्यमेव जयते

PM-JAY AND INDIA'S ASPIRATIONAL DISTRICTS

PM-JAY POLICY BRIEF 3

Authors:
Owen Smith, Di Dong, and Sheena Chhabra | September 2019

Background

India's Transformation of Aspirational Districts Program, launched in 2018, aims to expedite socioeconomic progress in approximately 115 priority districts nationwide. The goal is to support these lagging areas to implement core schemes across six priority sectors, through coordinated action that unites the districts, states, and the center in a common purpose.[1] The focus districts are concentrated in eastern India, with 19 districts in Jharkhand (out of 24 total), 13 in Bihar, and 10 in both Chhattisgarh and Odisha (see Figure 1). There are also 16 states that have only 1 or 2 such districts.

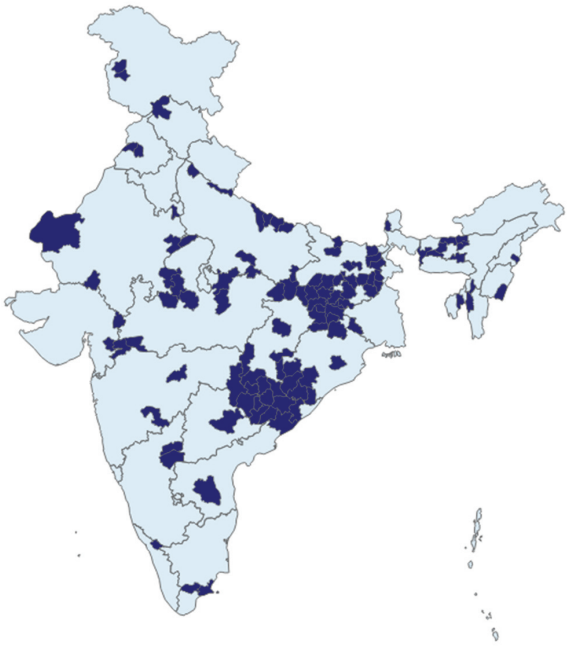
PM-JAY is being implemented across more than 30 states and union territories. State-wise comparisons of PM-JAY indicators are commonplace, since states have primary responsibility for implementation and because there is enormous variation across states in all aspects of scheme performance. But districts also have an important role in scheme implementation, and there are significant differences within states too. Understanding these emerging patterns at the district level can provide useful insights for PM-JAY going forward.

This policy brief offers a preliminary look at how PM-JAY implementation is faring in the Aspirational districts. It compares basic scheme indicators in these areas with progress in "non-Aspirational districts". The analysis covers less than one full year of claims data, including the launch phase when beneficiary identification and hospital empanelment were at a nascent stage in greenfield states, and therefore findings should be considered as preliminary. The brief begins with some benchmarking of Aspirational districts across all participating states, and then takes a closer look at ten states where data allows for additional analysis.

Highlights

- India's 115 "Aspirational districts" are the focus of a multi-sectoral effort across three tiers of government to boost socioeconomic progress in the country's most lagging districts.
- During the first year of implementation, PM-JAY indicators in Aspirational districts show significant room for improvement compared to their peers. They have empanelled fewer hospitals, made less progress on beneficiary verification, and recorded lower claims volumes and value.
- A more focused effort at the central, state, and district levels to strengthen PM-JAY implementation in Aspirational districts could help close these gaps.

Figure 1: Distribution of Aspirational Districts



Box 1: METHODOLOGY

Time period: PM-JAY claims data analysis covers the period from scheme launch to August 8th. Empanelment data is as of August 2019.

Data sources: PM-JAY's Transaction Management System (TMS) claims database and Hospital Empanelment Module (HEM). Not all states are presently integrated (e.g., Andhra Pradesh, Rajasthan). Hospital district information could be identified for about 90% of claims records, but patient home district information was available for less than one-third of claims. Other data sources are as noted.

Definition of PM-JAY population: All families with 5 lakh coverage. This includes those covered by PM-JAY (co-financed by Govt. of India and States) and all additional "extension" families fully funded by states under their own expanded coverage initiatives. Scheme utilization is normalized on a "per lakh beneficiary" basis.

District list: India had 640 districts in 2011 when the Socio Economic & Caste Census (SECC) was conducted, upon which PM-JAY eligibility is based. Today there are over 720 districts. Evolving district boundaries and populations posed a challenge to calculating "per capita" and "per beneficiary" estimates, and approximately 5% of districts were excluded from the analysis for this reason.

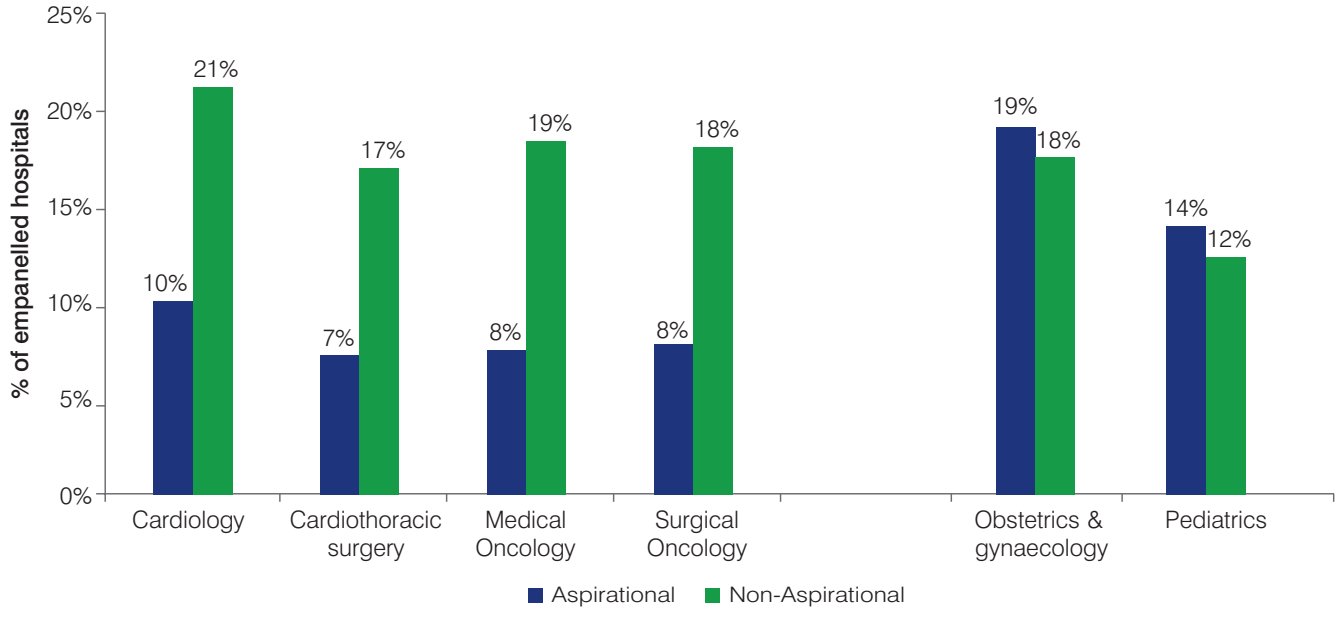
Findings and Implications

How is PM-JAY faring across India's Aspirational districts?

During the early phase of implementation, key indicators of PM-JAY performance include beneficiary registration, hospital empanelment, and the number and value of claims processed. District-level data is not yet readily available for certain indicators and states, including the distribution of eligible "extension" populations (see Box 1). Nevertheless, available data already point to some important early patterns with respect to PM-JAY in Aspirational districts.

Across India, about 44 percent of empanelled hospitals in Aspirational districts are private, compared with 49% in non-Aspirational districts. This relatively small difference masks large state-wise variation. About 9 states have no private hospitals empanelled in any Aspirational districts. Larger differences are apparent in key specialties, as shown in Figure 2. For key tertiary care services, the share of hospitals empanelled to provide services in Aspirational districts is less than half the share in other districts. For secondary care, the differences are relatively small. Empanelled hospitals in Aspirational districts are also smaller (an average of 20 beds compared to 30 elsewhere) and less likely to be accredited

Figure 2: Hospitals in Aspirational districts are less specialized



(1.2% of hospitals are accredited in Aspirational districts, compared to 3.8% in other districts). These patterns are the natural but unfortunate outcome of lower historical investments in lagging and predominantly rural regions.

These patterns are mirrored on the demand side. There have been zero private hospital admissions in Aspirational districts in ten states (see Figure 3). Private hospitals account for a larger share of admissions in non-Aspirational districts in all states except Maharashtra and Uttarakhand. The average claim size is significantly smaller in Aspirational districts in all states except Jharkhand (Figure 4). The share of surgical packages is similar, but tertiary care is far less common in Aspirational districts. Women account for a larger share of admissions in Aspirational districts (54% vs. 47%), possibly due to OB/GYN services prevailing at the secondary level.

Figure 3: Fewer private hospital admissions in Aspirational districts

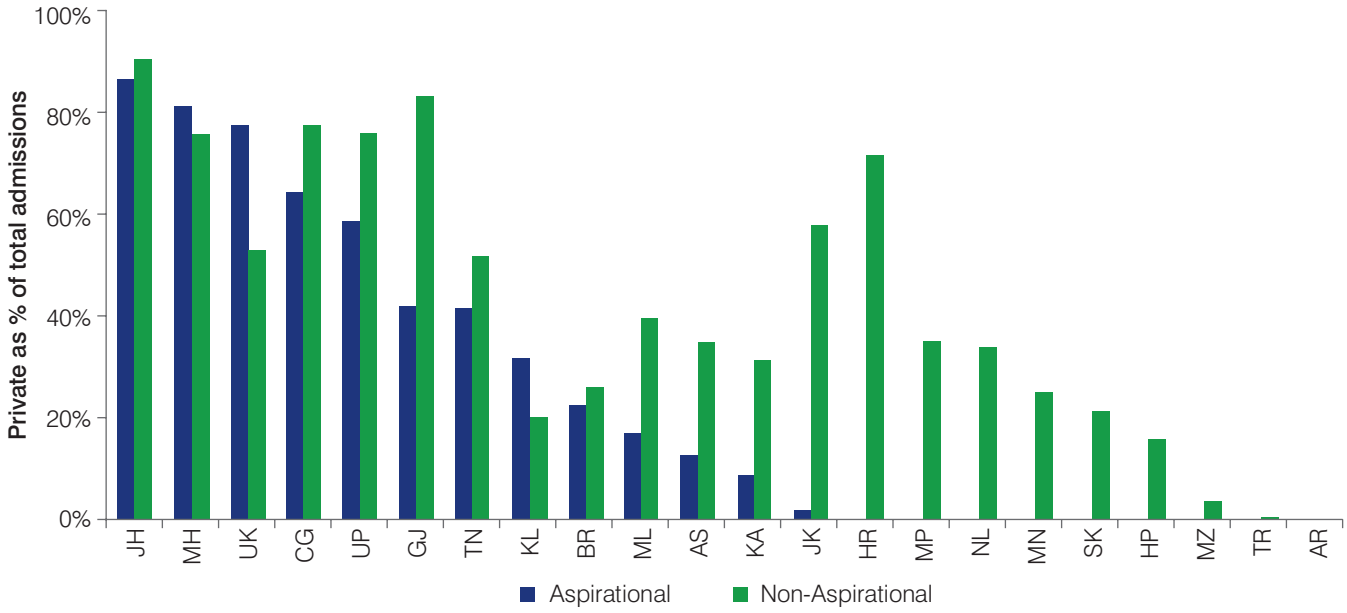
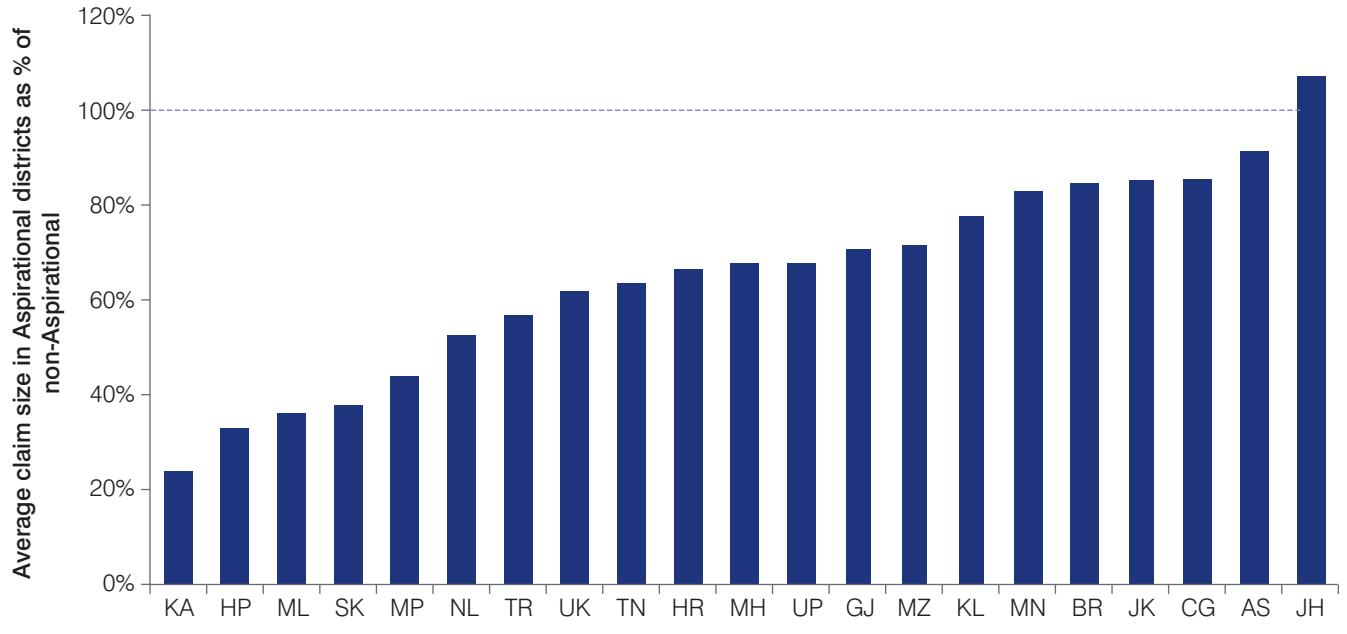
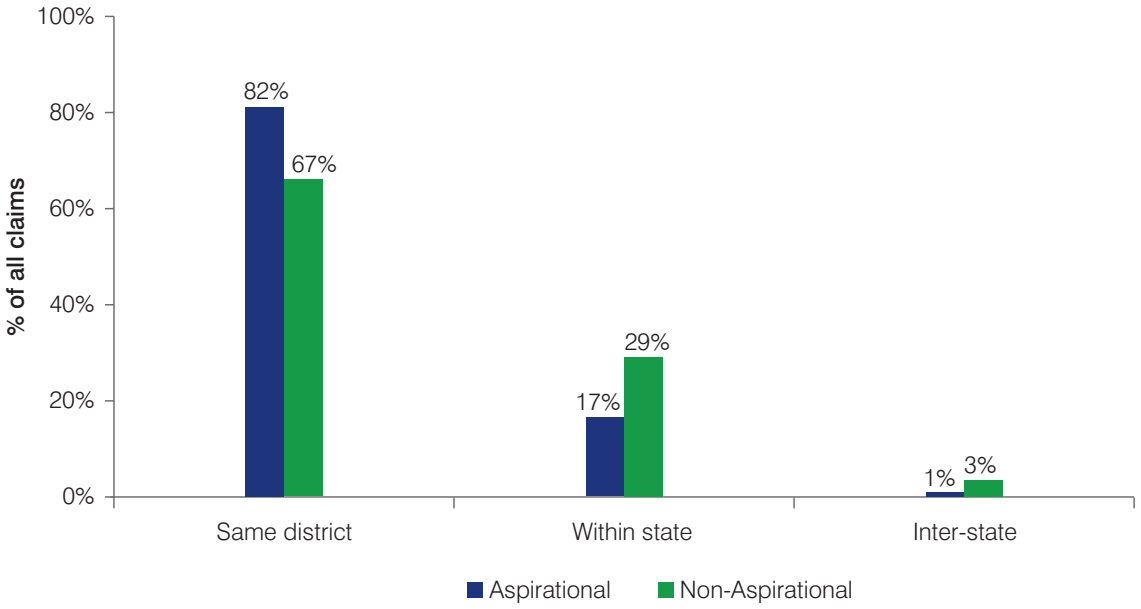


Figure 4: Average claim size is smaller in Aspirational districts



It is also noteworthy that populations residing in Aspirational districts exhibit less mobility in terms of seeking care outside their home district than populations in non-Aspirational districts. Figure 5 shows that a much larger share of patients from non-Aspirational districts travelled to different districts within their home state or to different states altogether.

Figure 5: Less portability by residents of Aspirational districts

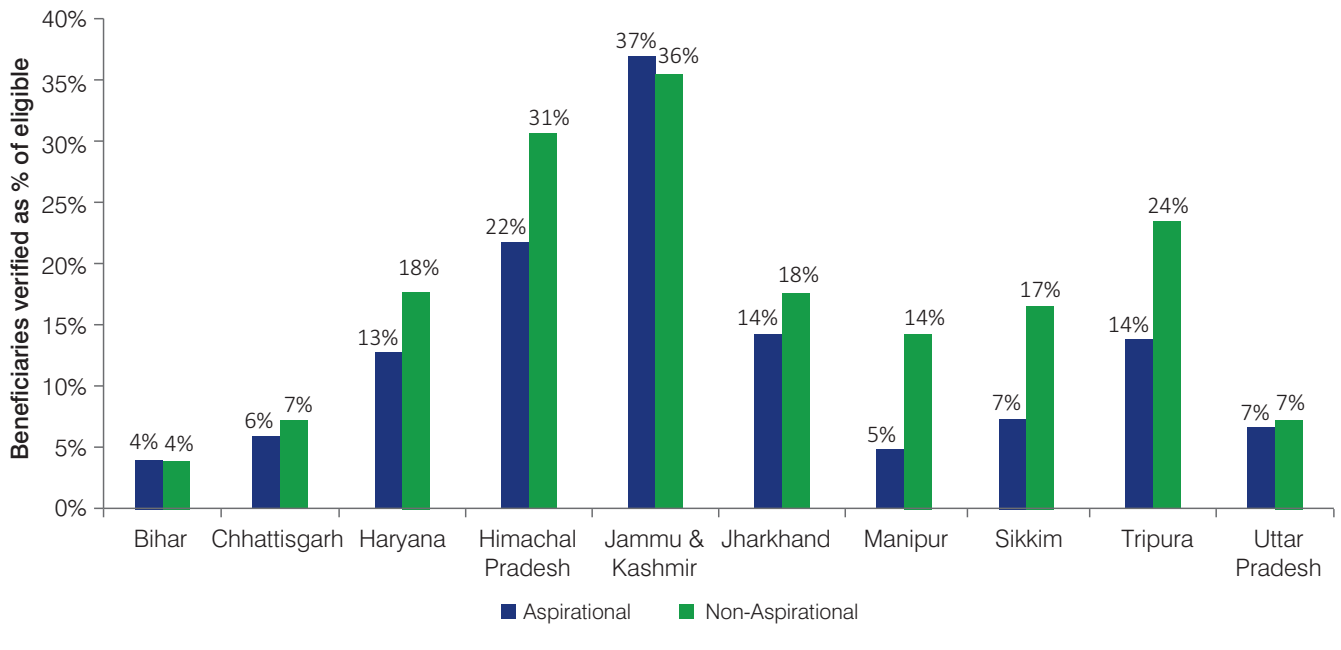


A deeper dive in 10 states

In states with complete district-level eligibility numbers, including extension populations (see Box 1), a more granular analysis of key PM-JAY indicators is possible. This section looks at 10 such states. Figure 6 shows that beneficiary verification rates – the share of eligible populations who have been registered for PM-JAY – are higher in non-Aspirational districts than Aspirational districts in all but one state. This may reflect some combination of lower beneficiary awareness in Aspirational districts and weaker operationalization of beneficiary identification systems in these areas. Beneficiaries should be able to register at public and empanelled private hospitals, at over 2 lakh common service centers nationally, by phone or online. But implementation on the ground may fall short. This is a key process which is in principle amenable to rapidly scaled-up efforts to make faster progress.

In most states, fewer hospitals are empanelled in Aspirational districts per lakh eligible beneficiaries when compared to non-Aspirational districts. Figure 7 illustrates. In some states this gap is relatively small, in others it is much larger. This is also true of bed availability. It is important to note that in some states,

Figure 6: Beneficiary verification rates are lower in Aspirational districts



such as Haryana, there is only one Aspirational district, whereas in Jharkhand the majority of districts are denoted Aspirational. As noted above, fewer empanelled hospitals in Aspirational districts partly reflects lower historical investments in these areas. The population residing in these districts can travel to other parts of the state or country, but as Figure 5 showed, they are less likely to do so. PM-JAY guidelines recommend the payment of 10% higher package prices to hospitals in Aspirational districts to encourage supply availability in these areas, but implementation of this recommendation has been inconsistent thus far.

On the demand side, both the number of claims and the total value of claims are lower in Aspirational districts across all states except Jharkhand. This demand gap is generally much larger than the supply gap shown in Figure 7 on empanelment. These indicators of PM-JAY utilization are among the most important metrics of scheme performance, and thus represent a key signal of shortcomings in lagging districts. Going forward, close monitoring of these patterns and identifying approaches to close the gap will be critical.

Figure 7: Fewer hospitals are empanelled in Aspirational districts

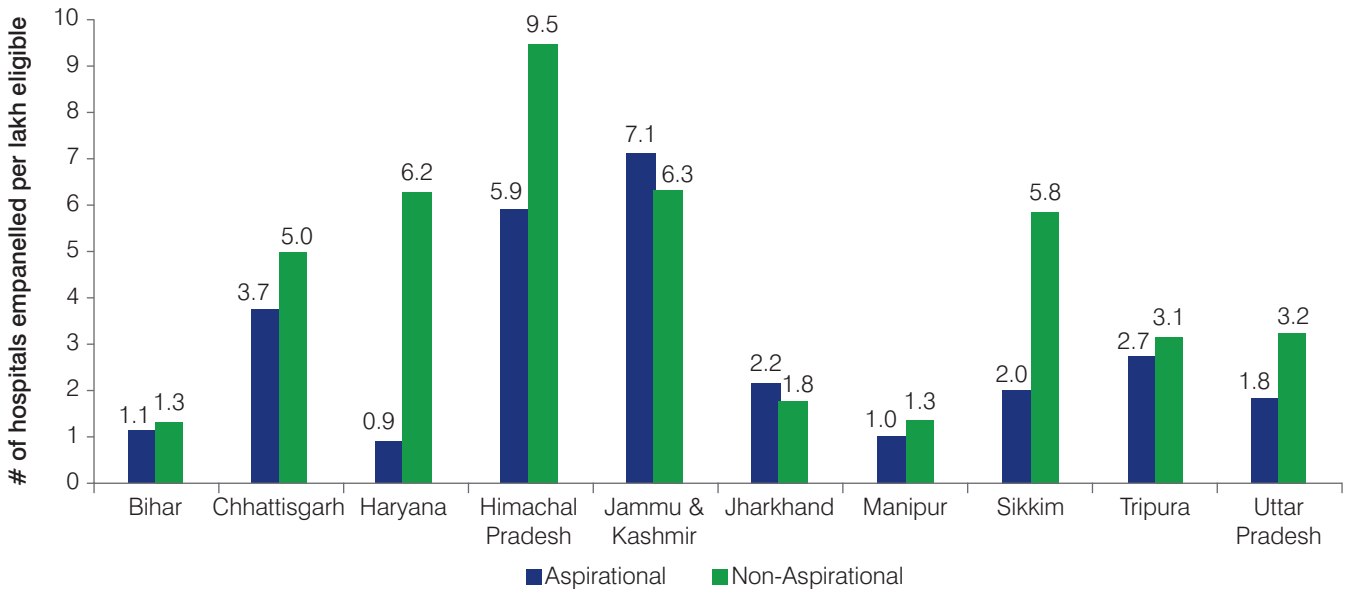


Figure 8: Lower claims volume in Aspirational districts

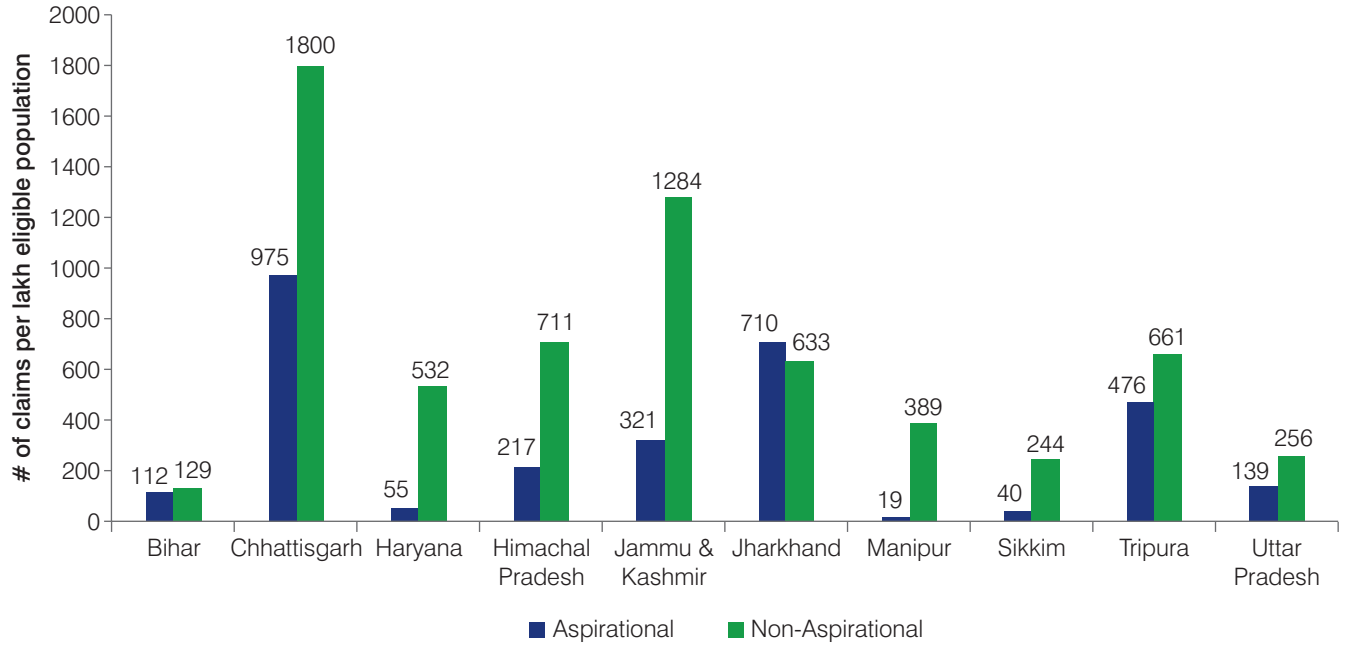
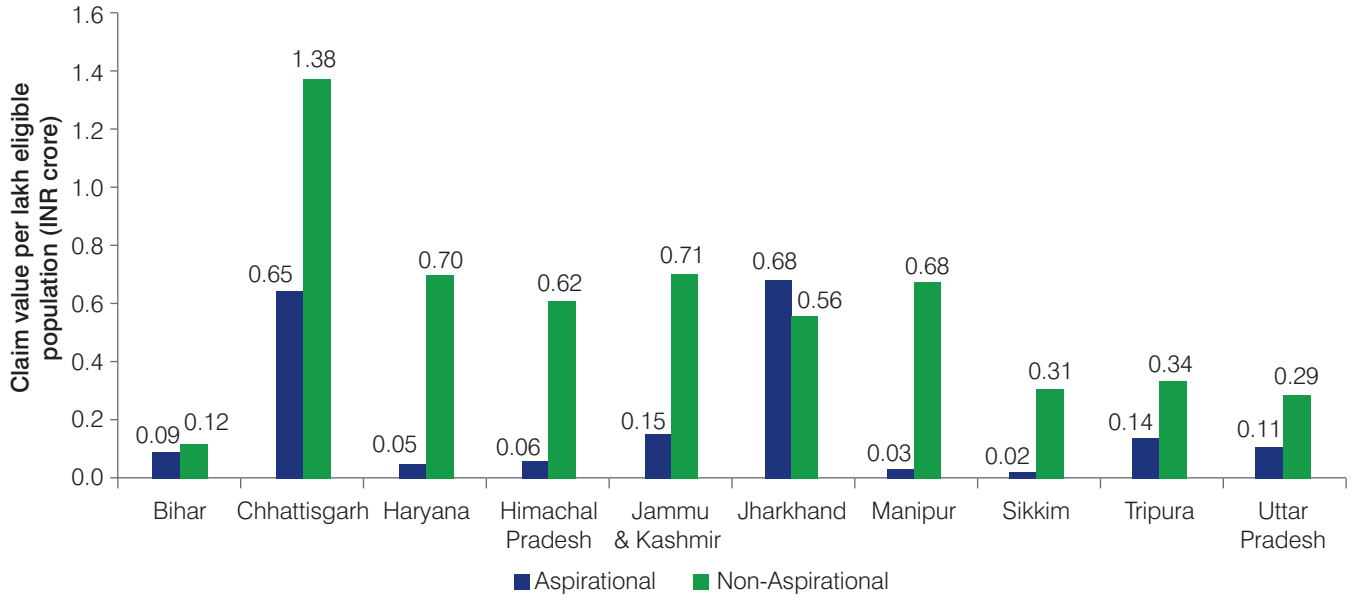


Figure 9: Lower claims value in Aspirational districts



Summary

On most PM-JAY indicators, Aspirational districts are lagging behind their non-Aspirational peers. This includes beneficiary verification processes, hospital empanelment, and the number and value of claims per lakh beneficiaries. This is perhaps to be expected. Hospitalization rates in Aspirational districts were lower than non-Aspirational districts long before PM-JAY existed (as shown, for example, in National Sample Survey data from 2014), and these districts earned their label in the first place because there was significant room for improvement across many schemes and sectors.

Nevertheless, the evidence suggests that more can be done to strengthen scheme implementation in Aspirational districts. This can be done through efforts at the Center, state, and district levels. At the Center, a notable feature of the Aspirational District Program is the appointment of Prabhari officers from among senior civil servants posted to the Government of India, who serve as champions of individual districts and can help connect the periphery to the Center. As a new scheme, PM-JAY may require some awareness raising efforts among these officers with regard to key program features and challenges. At the state level, State Health Agencies (SHAs) are responsible for PM-JAY implementation and can extend additional resources and management oversight to help Aspirational districts. Lastly, district implementation units in the lagging districts can be energized to support PM-JAY implementation where it is needed most.

References

1. NITI Aayog. "Deep Dive: Insights from Champions of Change: The Aspirational Districts Dashboard". New Delhi. 2018.

Disclaimer

The findings, interpretations, and conclusions expressed in the policy brief are entirely those of the authors, and do not represent the views of any author's employer, official policy or position of any agency of the National Health Authority (NHA). The PM-JAY data used in the analysis should not be utilized/quoted without prior permission of NHA.

Acknowledgements

We acknowledge with gratitude the contribution and support provided by the Analytics team (Chirag Sidana, Lakshya Arora and Dhairya Thakker), Malti Jaswal, Henna Dhawan, Parul Naib, Aastha Arora, and Ajay Tandon for their timely inputs. Special thanks to CEO and Deputy CEO at NHA for their overall strategic guidance and facilitating the necessary approvals.

List of PM-JAY Policy Briefs Published so far

1. **Raising the Bar:** Analysis of PM-JAY High-Value Claims (July 2019).
2. **PM-JAY Across India's States:** Need and Utilization (September 2019).
3. **PM-JAY and India's Aspirational Districts** (September 2019).