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ABSTRACT

Arguably the most ambitious health insurance programme in the world today, the Pradhan Mantri Jan Arogya Yojana (PMJAY) gives India the chance to transform its healthcare infrastructure. Launched in September 2018 and foreshadowing the general elections of 2019, PMJAY is equal-parts political and economic. It aims to address the healthcare needs of India's poorest 100 million households and has the potential to deliver what its predecessors over the past several decades have failed to do. The path to success, however, is strewn with five hurdles: high health insurance premiums; heavy healthcare costs; absorption of technology to bring stakeholders together; addressing Centre-State jurisdictional issues; and ensuring that the politics of nomenclature does not get in the way of outcomes. This paper discusses these hurdles and concludes that if PMJAY succeeds, India's largest health insurance scheme would also become its most effective healthcare initiative.

INTRODUCTION

In August 2018, during his speech marking India's 72nd Independence Day, Prime Minister Narendra Modi announced the rollout of the health insurance scheme, Pradhan Mantri Jan Arogya Yojana (PMJAY) beginning 25 September 2018. PMJAY, the insurance arm of the Modi government's larger initiative, the Ayushman Bharat, marks a step forward for India towards financing the delivery of healthcare for the poor.[1] First introduced in Finance Minister Arun Jaitley's 2018 Union Budget[2] as National Health Protection Scheme, PMJAY has since changed not only in nomenclature but also its design. The objectives, however, remain the same: to provide a health cover of INR 500,000 for secondary and tertiary care to 100 million[3] poor and vulnerable households or 500 million individual beneficiaries. This is part of the government's larger agenda of achieving universal health coverage (UHC) by improving access and affordability of quality secondary and tertiary care services, through a combination of public hospitals and private care providers.[4] As of end-August, 29 states and union territories have signed up with the Ministry of Health and Family Welfare for the scheme.[5]

Entitlements under PMJAY include financing of pre- and post-hospitalisation expenses and a defined transport allowance per hospitalisation.[6] It will subsume two ongoing centrally sponsored schemes, the Rashtriya Swasthya Bima Yojana[7] (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS),[8] as well as many other state-government funded health insurance programmes. The coverage is portable across the country and beneficiaries are entitled to secondary and tertiary healthcare from any empanelled public or private hospital in India through cashless insurance. The financing mechanism is through either insurance, or trust, or a mix of both. The government terms it as the world's largest government-funded healthcare programme.[9] In fact,

it is the second largest, after China's integrated urban and rural residents' basic medical insurance system that covers more than a billion enrolees.[10] The financing breakdown of PMJAY between the Centre and the States will be 60:40 for most states, with a 90:10 ratio for eight north-eastern and three Himalayan states.[11] (See Table 1.)

Table 1: Centre-State Financing Breakdown of PMJAY

Central-State Premium Split Ratio	Break-up of installment 1 (on or before the commencement of the policy cover period)	Break-up of installment 2 (after completion of 2nd quarter of the policy cover period)	Break-up of installment 3 (after completion of 10 months of the policy cover period)
For 8 North-East and 3 Himalayan States: 90:10	Centre: 45% State: 45%	Centre: 45% State: 45%	Centre: 10% State: 10%
For other States: 60:40	Centre: 45% State: 45%	Centre: 45% State: 45%	Centre: 10% State: 10%
For Union Territories with legislature: 60:40	Centre: 45% State: 45%	Centre: 45% State: 45%	Centre: 10% State: 10%
For Union Territories Without legislature: 100:0	Centre: 45%	Centre: 45%	Centre: 10%

Source: https://pmrssm.gov.in

For PMJAY to be successful, in terms of delivering healthcare entitlements at low cost, it needs to convert five hurdles into enablers. First, health insurance premiums: to use the law of large numbers[13] to sharply cut down premiums. Second, healthcare costs: to use economies of scale and, again, the law of large numbers to push the healthcare sector to reduce prices, and make a return on volumes rather than on margins. The initial gains to people and existing healthcare providers need to be used to attract private investment and/or social entrepreneurs into the healthcare sector. This means using government-mandated high-quality

but low-priced outcomes on one side, but easing capital and administrative efficiencies, on the other. Third, linked intrinsically to the first and second enablers: to utilise technology to map beneficiaries, track insurers and healthcare providers, and embed deliverable accountability into the structure of the scheme. The case of the Goods and Services Tax Network (GSTN) is a successful model that can be adapted and replicated. Fourth, given that most of the health sector initiatives are centrally led, it is time to initiate debate on expanding the concurrent list beyond population control, prevention of spread of infectious diseases, and regulation of food and drugs. Finally, fifth: to keep four letters — M.O.D.I. — out of the nomenclature of the mission so it does not get in the way of execution in the States, each of which will want its own political signature on the scheme. This will become more relevant in the run-up to the general elections in 2019.

TRANSFORMING HURDLES TO ENABLERS

1. Insurance Premiums

Under the law of large numbers, particularly for a country with a young demographic like India, the risks to an insurer should reduce with the increase in the number of people insured. As a result, the premiums directly related to that risk (whether life and health or fire and calamities) ought to fall. For example, if there are two people in the policy ecosystem and one of them needs secondary care, the risk on the system becomes steep as the other person will need to share as much as 50 percent of the financial risk. If the number in the system rises to 10, the same risk gets shared among 10, and one of them need care, the burden on each individual is one-tenth. India being the world's second most populous nation, its insurance premiums cannot be benchmarked against any other country but China. When Indian insurers price their premiums based on so-called "global" benchmarks, they are creaming off the law of large numbers to their benefit.

In a scheme like PMJAY, the impact of the law of large numbers on insurance pricing models needs to be magnified. That is, *ceteris paribus*, health insurance premiums must fall. To illustrate, if a corporation takes a group insurance cover for 1,000 employees and their dependents (for a total of 5,000), the cost of such a cover would be more than what is offered to governments that cover millions of citizens. In the case of PMJAY, policymakers aiming for efficient outcomes must marry this law of large numbers with the large populations across different states. Ideally, an individual policy would be priced higher than a company group cover which, in turn, will be costlier than a mass government scheme such as PMJAY.

The National Sample Survey (2014) found that 86 percent of rural population and 82 percent of urban population were not covered under any scheme of health expenditure support.[14] Most of them were covered under government-funded insurance schemes like RSBY, offering low protection at INR 30,000 per annum per family. PMJAY has the potential to increase the proportion of Indian population covered under health insurance by at least 200 percent.[15] With a cover of INR 500,000 per annum per family, this scheme can be a game-changer.

The direction that the government has taken so far appears to be efficient. In June 2018, it was reported that despite immense pressure from a lobby of private healthcare providers, PMJAY package rates will be pegged 15-20 percent cheaper than the Central Government Health Scheme (CGHS).[16] The Association of Healthcare Providers India (AHPI) has also been trying to put pressure on government to pull up PMJAY rates. Yet, prominent AHPI members such as Apollo Hospitals are already operating in Tamil Nadu on even lower rates.[17] For its part, the Indian Medical Association (IMA) is seeking higher package rates, and demanding that PMJAY eliminate the layer of insurance companies and allow their members to reimburse claims directly.[18] With this call, IMA would like to use the "trust" model under PMJAY and maximise

returns. It is making such a demand possibly because insurance companies are agents in the health insurance model and monitor misbehaviour by hospitals, while a government-run trust with weak capacity to monitor hospitals[19] would be beneficial to the hospital industry.[20]

The RSBY experience raises certain red flags that could serve as lessons for the implementation of PMJAY. For the 278 districts in 15 states covering 36,332,075 families for which data is available, the average premium paid is INR 379. However, there are stark inter-state differences (see Table 2) that can be explained partly by claims ratios. In-depth analyses are required to better understand and learn from the weaknesses of RSBY and enable PMJAY to deliver outcomes. However, the scheme data from RSBY are kept confidential by the agencies responsible for its implementation – the Ministry of Labour and Employment initially and in later years, the Ministry of Health and Family Welfare – and therefore inaccessible to researchers.[21] A seamless transition from the existing RSBY to PMJAY needs to be informed by the analysis of RSBY scheme data over the last decade, especially in the matter of premiums and reimbursements across private as well as public facilities. The government must adopt greater transparency and allow independent evaluations of the RSBY scheme.[22]

Table 2: Premiums for RSBY across states*

State	Premiums	Districts	Families enrolled
Mizoram	799	8	194,886
Kerala	738	14	2,060,802
Manipur	499	6	70,925
Gujarat	433	26	2,691,497
Chhattisgarh	432	27	4,146,227
Meghalaya	432	11	256,138
Uttarakhand	335	13	285,229

State	Premiums	Districts	Families enrolled
Odisha	321	30	4,462,959
Assam	320	23	1,421,104
Himachal Pradesh	275	12	480,588
West Bengal	254	21	6,290,046
Tripura	229	8	481,331
Nagaland	225	11	255,314
Bihar	217	38	7,028,409
Karnataka	182	30	6,206,620

** In descending order of average premiums charged*

Source: State-wise scheme status of Rashtriya Swasthya Bima Yojna, Ministry of Labour and Employment

A thorough evaluation of RSBY will also answer the question of whether the bidding processes have been arbitrary. As Table 3 shows, the variations in premiums are not only between states, but inter-district as well. PMJAY ought to extract the anomalies in RSBY implementation and fix them. Although states seem to be preferring trusts as implementation model for PMJAY — with 18 states adopting it — RSBY data could provide insights into the health-seeking behaviour of low-income families at the district level, which can help in the calculation of costs.[23]

Table 3: Number of premiums in various states

State	Districts	Number of premiums
Assam	23	2
Bihar	38	25
Chhattisgarh	27	1
Gujarat	26	7
Himachal Pradesh	12	1
Karnataka	30	3
Kerala	14	1
Manipur	6	2

State	Districts	Number of premiums
Meghalaya	11	1
Mizoram	8	1
Nagaland	11	1
Odisha	30	5
Tripura	8	1
Uttarakhand	13	1
West Bengal	21	17

Source: State-wise scheme status of Rashtriya Swasthya Bima Yojna, Ministry of Labour and Employment

2. Healthcare Costs

According to the latest health round of the National Sample Survey 2014, nearly half of the hospitalisation needs of rural households were for conditions like infections (25 percent), injuries (12 percent), and gastro-intestinal problems (11 percent).[24] Cardio-vascular diseases (eight percent) came next, and followed by psychiatric and neurological, genito-urinary, and obstetric and neonatal (six percent each). Most of these conditions can be addressed at the primary level, if identified early enough and managed well; this is what health and wellness centres are trying to achieve. In terms of a breakdown of hospitals by ownership, private hospitals dominate India's healthcare. In the last three NSS rounds (1995-96, 2004 and 2014), the proportions of rural households who sought health care from private institutions were 56 percent, 58 percent, and 58 percent; the figures were 57, 62, and 68 percent for urban households.[25] The choice of private institutions among rural families was highest in Maharashtra at 81 percent, followed by Andhra Pradesh (78 percent) and Gujarat (77 percent). Public hospitals were preferred most in Assam at 89 percent, followed by Odisha (81 percent) and West Bengal (77 percent).[26]

Further, the cost of hospitalisation outside insurance schemes also needs greater scrutiny. The average medical expenditure per

hospitalisation for rural households in a public hospital stood at INR 5,636 (INR 6,473 for males and INR 4,843 for females). The figure was nearly four times higher for a private hospital at INR 21,726.[27] Among states, hospitalisation costs at INR 8,520 are the lowest in Assam and the highest in Punjab (INR 29,779). While it may be argued that this could be a function of demand and supply equilibrium, when the costs in one state are 3.5 times larger than in another, there is a resource imbalance or an externality that needs to be corrected through policy incentives.

PMJAY needs to use initial gains to people and healthcare providers to attract private investment and/or social entrepreneurs into the healthcare sector. This means, ensuring a strong regulatory framework in terms of pricing while providing flexibility and opportunities for professional private capital to enter the market and make a profit. As discussed earlier, in the context of the large numbers in India, such profit will have to be based on *volumes* rather than *margins*. While the pricing for specific surgeries can be laid down—as in the case of RSBY—outcomes also need to be tracked, and a system of performance-based incentives created. This can be done by bringing to the negotiating table, healthcare providers, insurers, and governments. The idea of drafting a "package rate"[28] that includes all costs associated with the treatment (to be defined by the government in advance) is a step in the right direction — but one that needs careful thought such that while the pricing is kept under check there are enough incentives for investments.

More than the obstacles of monetary capital or land, the bigger hurdle is the shortage of human capital. Studies have found that rampant absenteeism among rural doctors is one of the factors impacting the country's health services. Reasons for absenteeism[29] include the lack of social facilities like schools for children, irregular

supply of electricity and potable water, and poor sanitation and hygiene in villages and health facilities. There is also the concern for the safety of women especially in some remote rural areas. Government staff also tend to be complacent, as they are assured of regular, lifetime employment. It has not helped that, as one study says, there is a "complete lack of monitoring by the state health hierarchy".[30]

The general belief is that state governments are not doing enough to provide adequate number of doctors, nurses and allied professionals. This, however, is not the case across the board. In an October 2017 lecture,[31] Comptroller and Auditor General of India and former Finance Secretary Rajiv Mehrishi gave the example of the Dholpur district of Rajasthan. Here, healthcare professionals on the ground are only a fraction of the number sanctioned by the state government, which in turn is a fraction of the number actually required. Out of the 81 doctors required, 62 percent were sanctioned, of which 42 percent were hired. In other words, only 26 percent of the required number of doctors in Dholpur were delivering healthcare on the ground. Among them, while the percentage was higher for medical officers (18 out of 27 or 67 percent on the ground), it was zero for the higher-skilled paediatricians, anaesthetists and dental surgeons. Only 30 percent of the required nursing and paramedic staff were functioning.

The lack of human capital may be explained in three ways. First, the greater the level of knowledge and specialisation among healthcare professionals, the fewer the number on ground. Second, even among the non-specialists, the opportunities in home areas are preferred. Why would a nurse choose to travel all the way to a small district hospital if he/she can get a better paying job in a town or a city closer to home? Third, intangibles such as schooling opportunities for children add to the pull of staying in cities and avoiding a rural posting. Indeed, India needs to rethink its system of incentives and design it better to draw

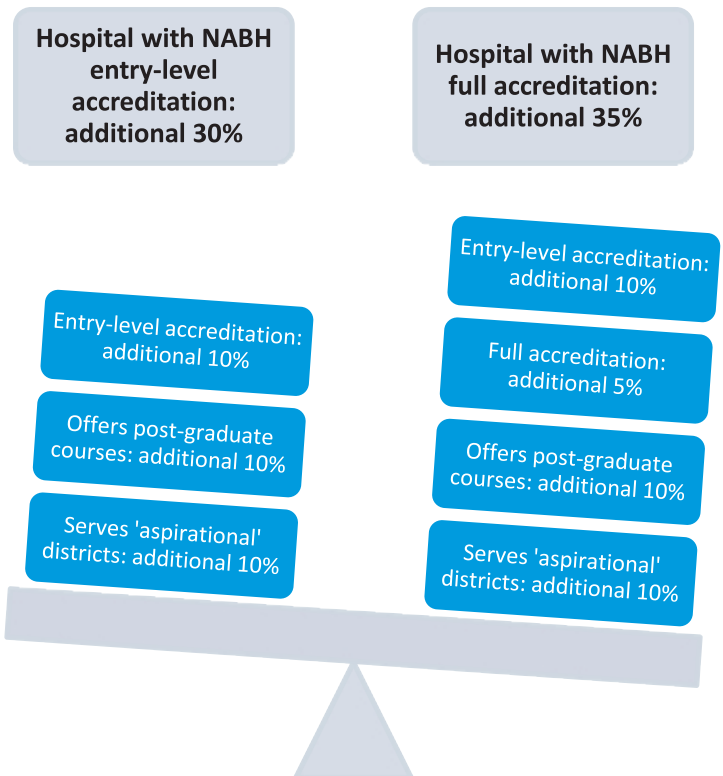
human capital to the more remote and rural parts of the country. To begin with, there is a need for better infrastructure in these areas. Health professionals need to be incentivised to serve in rural areas. Among the policy measures that can be taken in this regard are bringing these professionals on a faster promotion track, or funding their further education tied to their service and performance.

A linked issue is that of high out-of-pocket spending by households. This may be a natural outcome of the "free-for-all" in the lightly-regulated healthcare sector. PMJAY intends to augment the purchasing power of 100 million of India's poor households with a INR 500,000 coverage. The mission opens up the possibility of bringing some *de facto* price regulation into the health sector through the "package rate" system. As the scheme expands and PMJAY becomes available for paying non-poor households at the same rate (discussed below), charging high margins will become unfeasible for even higher-end hospitals. As rural households would gain more purchasing power with PMJAY's coverage, the possibility of no-frills, high-quality private hospitals in rural areas could be on the horizon. There is a need for the government to study entry barriers for small- and medium-size hospitals in rural and semi-urban areas and put in multi-sector initiatives to overcome the bottlenecks that are identified.

The government is deliberately using the rollout of PMJAY to push for regulation in the healthcare sector, as well as to incentivise hospitals to expand to rural areas.[32] In addition to capping the PMJAY package rates 15-20 percent lower than those under CGHS, the government is keeping the option of upward revisions of rates for hospitals through a performance-linked payment system, also designed to improve quality and patient safety, based on meeting milestones.[33] (See Figure 1) In addition to the 30-35 percent that hospitals can claim by fulfilling certain criteria, states have the flexibility to increase rates by up to 10

percent or reduce them to suit local market conditions. Finally, states may retain their existing package rates, even if they are higher than the prescribed 10 percent flexibility slab.[34]

Figure 1: Incentives for Hospitals in the Scheme



Source: Government of India, Ayushman Bharat National Health Protection Mission Guidelines, Ministry of Health and Family Welfare, https://www.abnhpm.gov.in/download-documents Accessed on 5 September 2018

3. Technology

Irrespective of whether a trust, insurance or a mixed model is being used, it is crucial to create an information technology ecosystem that will facilitate free and robust flows of data through the structure. This is important given the enormity of taxpayers' money involved in the mission and the potential for malpractice at the levels of delivery,

charges, settlement, and claims. Unfortunately, in the case of previous experiments in health insurance, the lack of information has been the missing link between financial outflows and entitlement outcomes.

Today the gap can be bridged with technology that will map beneficiaries, track insurers and healthcare providers, and embed accountability into the structure of the scheme. Here, governments (both at the Centre and the states) have proven experience through the GSTN (Goods and Services Tax Network), a pillar of the GST launched in July 2017.[35] Every invoice for every transaction is recorded digitally and can be tracked, monitored and followed through. The chances of tax leakage are minimal. In order to claim input tax credits, companies need to be on the GSTN. The system has raised the cost of indirect taxes evasion, and is nudging evaders towards becoming part of the legitimate economy.

Through a special purpose vehicle—in which the Central and State governments own 24.5 percent each; HDFC, HDFC Bank, ICICI Bank and NSE Strategic Investment Co hold 10 percent each; and LIC Housing Finance holds 11 percent—the GSTN provides a shared IT infrastructure and services to governments (Central and States) as well as taxpayers. For taxpayers, the GSTN facilitates the filing and payments of returns. For governments, the portal hosts the IT systems of all tax departments of the Centre and the States. Technically, this will reduce transaction costs of doing business, and cut transaction time. All an entrepreneur needs to do is upload invoice information, match input tax credit claims, upload returns, pay taxes, and sign off with a digital signature. Placing every invoice online holds up barriers to subjectivity by officials.

The trails of transactions, tracked by GSTN, will be able to reach any rupee evaded and capture every evasion on indirect as well as direct taxes.[36] On the direct tax evasion side, the digital trail of indirect taxes

evaded can now reach into the pockets of individuals through their PAN (permanent account number) and/or Aadhaar and its linkages to the banking sector. Beginning with large evasions, the trickle-down effect of this digitally linked trail could help plug evasion on the direct taxes side—that is, evasion that is created in the system of indirect taxes, and expresses itself through direct spending of individuals.

While adapting this model, an important idea that needs to be implanted into this technology SPV is one of medical protocols. That is, the entire process from entry in the emergency room to diagnosis and tests, to line of treatment to discharge, needs to be mapped through systems that follow global best practices. While these practices can be disease-specific, they need to give doctors and paramedics the flexibility to fix the problem through a system of authority, all done through the technological platform. Integrating the existing primary-level care infrastructure, including the health and wellness centres that are being rolled out with the PMJAY ecosystem and the primary care unit acting as a technology enabled gatekeeper to the insurance scheme, will improve efficiency. The draft Digital Information Security in Healthcare Act (DISHA) which aims to protect the storage, use and transmission of a patient's health data, once ready, should enable the health sector to navigate the ethical minefield of electronic health records.[37]

To illustrate, a surgery in New York, for example, needs the following detailed protocols: scheduling, consent, pre-procedure verification, marking the procedural site, and "time out" before starting the procedure.[38] Importing such a system and implanting it into the PMJAY infrastructure would help deliver medical precision to patient care. It will also ensure that an unnecessary ultrasound or CT scan is not forced on patients, and that outpatient care is not being converted arbitrarily into inpatient care by hospitals, as noticed in RSBY.[39] All these should be

tracked by the technology platform right down to the level of hospital, insurer, doctor and patient. Integrating such protocols within a system offering data protection, patient autonomy and privacy will help the government use the money efficiently, prevent fraud by hospitals, doctors and insurers, and ensure that the resultant lower cost of treatments translates into even lower premiums.

The intellectual property, process and experience of such an infrastructure are already in place, and what it needs is modification to adapt it to the healthcare sector. The special purpose vehicle could be modelled in the way of GSTN. Instead of taxes, the network could track claims; instead of invoices it could follow procedures; instead of entrepreneur behaviour, it could analyse doctor practices; and instead of transactions, it could follow protocols. As the implementation of PMJAY will expectedly vary across states, a flexible template can be offered by the National Health Agency (NHA), working with the National Electronic Health Authority of India (NeHA) which will ensure a bare minimum set of data points that will help track the initiative at multiple levels. According to their respective data requirements, individual states should be able to build on the base module. The strategy and approach paper on a proposed National Health Stack can be the base document for a national debate involving all stakeholders on the issue.[40]

This can be done at the level of hospitals, doctors, insurers, households and individuals. At the back-end, trends emerging from 100 million or so households need to be captured by Big Data to ensure that: 1) the entitlements reach the beneficiaries; 2) the out-of-pocket expenditure of poor households—which constitutes most of the health expenditure and eats into their savings—is reduced; 3) the beneficiaries get satisfactory healthcare; 4) middlemen have no place in the system; 5) collusion to harvest unfair benefits is preempted; and 6) a data protection mechanism is put firmly in place.

4. Federalism

Specific responsibilities of different layers of government in the federal framework towards different aspects of health and healthcare are listed under the Seventh Schedule of the Indian Constitution, divided between Union List, State List and the Concurrent List.[41] For the most part, health-related issues in India are included under the state list. Through amendments, however, the Centre has been given joint responsibility in areas such as population control, prevention of spread of infectious diseases, and regulation of food and drugs, through their inclusion in the concurrent list.[42] However, port quarantine, including quarantine hospitals as well as seamen's and marine hospitals are part of the union list.[43] Table 4 gives a detailed look at the constitutional division within healthcare.

Table 4: Constitutional Division within Healthcare

Category	Item	Provisions
Union List	Item 28	Port quarantine, including hospitals connected therewith; seamen's and marine hospitals.
Concurrent List	Item 19	Drugs and poisons
Concurrent List	Item 20-A	Population control and family planning
Concurrent List	Item 25	Education, including technical education, medical education and universities
Concurrent List	Item 26	Legal, medical and other professions
Concurrent List	Item 29	Prevention of the extension from one state to another of infectious or contagious diseases or pests affecting men, animals or plants
Concurrent List	Item 30	Vital statistics including registration of births and deaths.
State List	Item 6	Public health and sanitation, hospitals and dispensaries

Source: Government of India, Ministry of Law and Justice, The Constitution of India, http://legislative.gov.in/sites/default/files/coi-4March2016.pdf , Accessed on 22 March 2018

While this spread between three lists is unambiguous, health is generally regarded as a 'State subject' under the Constitution, and therefore, the responsibility of state governments. States were given jurisdiction over public health and sanitation; hospitals and dispensaries through insertion of Item 6 in the State list. However, the 42nd Amendment of the Constitution in 1976 made two significant changes: it added "population control and family planning" and "medical education" as Item 20-A and Item 25, respectively, on the Concurrent List.[44] Despite states contributing a major proportion of finances in health, central initiatives have come up through the inclusion of health-related issues in the concurrent list, particularly through the inclusion of population control. Over the past decade, however, the focus of centrally-led initiatives has expanded beyond this narrow objective and now covers a wider spectrum of healthcare issues (see Table 5).

Table 5: 13 centrally-driven major healthcare initiatives in the last 10 years

Years	Schemes
2008	RSBY
2008	Pradhan Mantri Bhartiya Jan Aushadhi Yojana
2009	National (Draft) Health Bill
2010	The Clinical Establishments (Registration and Regulation) Act
2016	The Electronic Health Records Standards
2016	The National Treatment Guidelines for Antimicrobial Use in Infectious Diseases
2017	The Medical Device Rules
2017	The National Medical Commission (NMC) Bill
2017	The Public Health (Prevention, Control and Management of Epidemics, Bio-terrorism and Disasters) Bill
2017	Draft National Action Plan for Containment of Antimicrobial Resistance
2018	Draft Digital Information Security in Health Care Act (DISHA)
2018	Pradhan Mantri Jan Arogya Yojana
2018	Health and Wellness Centres

As an aside, education being shifted to the concurrent list along with 'medical education' and 'population control and family planning' as part of the 42nd Amendment has led to education becoming a justiciable right across the country through the Right to Education Act of 2009. It is not clear how such a law could have been passed if education was still a state subject. While the reassignment of education from the State List to the Concurrent List was a relatively small part of the sweeping scope of the 42nd Amendment, and problematic in some respects, it has not still been reversed as it has ratified a pre-existing reality.[45] The case of health could be similar.

The National Health Policy 2017 had made a logical case for regulation of healthcare, and explicitly supported "the need for moving in the direction of a rights-based approach". However, the previous decade's experience of centrally-led initiatives like the Clinical Establishment Act within an ecosystem which has assigned healthcare as a state subject suggests that health being in the concurrent list can perhaps ensure better success of centrally-led initiatives such as PMJAY. That central interventions are necessary in health due to lack of technical capacity at the state level points to the fact that broad policy guidance by the Centre in a more rigorous Centre-State interaction can be beneficial to the health sector.

Contextually, at the Drafting Committee meeting of the Indian Constitution, both B.R. Ambedkar and Jawaharlal Nehru supported shifting health from the State List to the Concurrent List. The amendment to that effect was jointly suggested by the Ministries of Health and Home Affairs, but was defeated despite support from top leaders, because of strong opposition from UP, Assam, Bombay and Bihar. In the initial listing, "health insurance" was to be part of the Concurrent list along with welfare of labour; conditions of labour; provident funds; employers' liability and workmen's compensation and old age pensions as part of Item 26.[46]

Researchers have long suggested that along with enhancing financial powers and resources to the states within the health sector, the political frictions between the Union and the States may be made more manageable if the subject is shifted to the Concurrent List.[47] Perhaps the time has come to revive this debate, given the number of centrally-led initiatives in the health sector. Now that 19 states are governed by the Bharatiya Janata Party (BJP) directly or through a coalition,[48] and the party is in power at the Centre as well, this is a political opportunity to streamline India's healthcare policymaking. The Centre is already discussing the issue of bringing water into the Concurrent List with all the states; [49] adding health to the agenda will offer efficiency gains to social sector policymaking in the country. In parallel, learning from China's experience, local governments – States, municipalities or *panchayats* – can be given the political responsibility of expanding coverage even to the non-poor households with clearly defined targets, thus creating a truly pan-India risk pool.[50]

5. Politics of Nomenclature

Four letters—M.O.D.I.—must be kept out of the nomenclature of PMJAY so it does not get in the way of execution in the States. After all, the states, whether contributing 10 percent or 40 percent to the scheme, will want their own political signature on it. Andhra Pradesh Chief Minister Chandrababu Naidu, for instance, is unlikely to bother sowing political gains for the prime minister, particularly after the public breakdown of their coalition.[51] To be fair, the government has not named the scheme "Modicare"; only the media has done so, presumably in an editorial effort at easy recall. Equally, Modi's ministerial colleagues must refrain from using similar nomenclatures.[52] The danger, however, might be that such semantics could prevent the success of the mission in the seven states where the BJP is not part of the governing coalition. On the other hand, if "Brand Modi" has become a selling point in the majority of the States where the BJP leads the coalitions, it might help set the national health agenda.

Over the last few months, health policy researchers as well as the public have had to keep up with the frequent changes in the nomenclature of the initiative. As Table 6 shows, the scheme has changed names at least five times since conceptualisation. To add to the confusion, the official guidelines still carry the name, Pradhan Mantri Rashtriya Swasthya Suraksha Mission (PMRSSM).[53] Finally, at the soft launch on 15 August 2018, the prime minister used the current name, Pradhan Mantri Jan Arogya Yojana (PMJAY).[54]

Table 6: The evolution of Pradhan Mantri Jan Arogya Yojana (PMJAY)

February 2018	National Health Protection Scheme
March 2018	National Health Protection Mission
June 2018	Pradhan Mantri Rashtriya Swasthya Suraksha Mission
July 2018	Ayushman Bharat – National Health Protection Mission
August 2018	Pradhan Mantri Jan Arogya Yojana

Yet, the problem with PMJAY being called "Modicare" or "NAMOcare" is not necessarily its correlation to the mission's success or failure in particular states. Rather, the problem is more moral. Its roots lie in Modi demolishing the Nehru-Gandhi monopoly on naming schemes during the run-up to the 2014 elections. An answer under Right to Information query on scheme names, for instance, showed that of the 58 Central schemes and institutions, 27 carried the names Nehru-Gandhi family[55] with only four carrying Mahatma Gandhi's name. Worse, for a political party that has done immeasurable and possibly permanent damage to the celebration of the Nehru-Gandhi prefix in every major scheme, road, university, hospital, or school, both at the Centre and in the States to use the same technique and replace "Nehru-Gandhi" with "Modi" shows not only a lack of imagination, but the ironic and Orwellian embrace of the opponent.

PMJAY needs the support of the States for its success. In an election year, pushing the Modi name, even in the 19 States where the BJP or coalition is in the majority,[56] will be exhausting for political parties, BJP's coalition partners and the electorate alike. State leaders in Punjab and West Bengal, for example, have alleged that the Centre wants states to carry the financial burden of PMJAY while it reaps the political benefit in the coming Lok Sabha polls.[57] Such bickering can cloud an otherwise potentially transformative scheme.

Indeed, PMJAY has the potential to institute reforms to the country's healthcare and health insurance systems at a lower cost to the exchequer, if streamlined health information and monitoring systems can arrest the possibility of over-provisioning and cost-inflation. The idea to shift away from a decaying system of government-funded hospitals and people, towards a mix of private and government healthcare, governed by common principles and financed by low-cost health insurance—is a step in the right direction. That the government is resisting pressure from the private sector to increase rates means that it is also supporting the existing public sector to lay claim to some part of these funds, and use the reimbursements to improve quality and enhance infrastructure facilities in government hospitals.

The path to implementation, however, is going to be full of challenges. In a pre-election year, the PMJAY could be the National Democratic Alliance's social sector answer in the 2019 elections to what the United Progressive Alliance's Mahatma Gandhi National Rural Employment Guarantee Act was in the 2009 polls. Therefore, the political stakes are high. It is this alignment of political and citizen stakes through healthcare and health insurance that should ensure delivery. There will be difficulties, but this massive campaign is a necessary alternative to fix India's healthcare system. For this, it has to find flexibility to dovetail existing state insurance schemes, and to not cause worry among state-level leadership.

CONCLUSION

There is no doubt that the span of India's healthcare has delivered outcomes in the recent years. While it may be arguable whether these achievements are enough or are effective, what is indisputable is that India has taken huge strides in its healthcare delivery. Life expectancy at birth has jumped to 68 in 2015 from 41 in 1960, closing the gap between the world average of 72 versus 53 in 1960.[58] According to the World Health Organization, in 2000, India had 0.527 physicians for every 1,000 people, 1.169 midwifery personnel, and 0.037 dentistry personnel. By 2016, those numbers had shot up by 43 percent, 79 percent, and 302 percent, respectively.[59] Between 1994 and 2015, infant mortality rates have fallen to 37 per 1,000 live births from 74.[60] Maternal morality ratio, meanwhile, has dropped to 167 per 100,000 live births in 2011-13 from 212 in 2007-09.[61] Out-of-pocket expenses, however, have gone down only marginally to 62 percent from 68 percent, compared to the world average of 18 percent.[62] This makes India's direct out-of-pocket payments among the highest in the world.[63]

As a matter of adequate caution, it must be pointed out that healthcare infrastructure cannot and *should not* be seen in isolation. There are various conditions that influence health, including economic well-being on the part of households and the provision of safe drinking water and sanitary conditions on the part of the state—without which the rural landscape will "continue to be factories of disease", as the Joseph Bhore committee[64] noted in 1945. Further, it needs to be appreciated that insurance cover and the existing health infrastructure can only go so far; India needs to invest in new medical colleges and nursing institutions, as the National Health Policy 2017 has acknowledged.[65] At the same time, the health and wellness centres initiative—perhaps the least talked about component of Ayushman Bharat—marks the much delayed shift from selective primary health

care to comprehensive primary health care which will reduce the need for people to visit secondary and tertiary hospitals.

On the health insurance front, there are four schemes running at present: RSBY, Employment State Insurance Scheme,[66] Central Government Health Scheme,[67] and Aam Aadmi Bima Yojana.[68] PMJAY needs to take lessons from all these and focus on efficiency of administration and effectivity of outcomes. Otherwise, there is a danger of this idea becoming only a little more than a political band-aid, only to fall by the wayside to wait for another government to rework it. Ultimately, PMJAY should become the core vehicle to India's progress towards universal health coverage. It should expand to include non-poor households as well, using a voluntary approach offering a non-subsidised premium. As the premium will still be less than the market rate, most non-poor households will opt for it, if the implementation in initial years is smooth. As discussed earlier, giving local level governments the responsibility to expand coverage to eventually include the non-poor population in a phased manner could work as a counterbalance to the perceived centralisation tendency in any move to shift healthcare from the state list to the concurrent list.

Taken together, the lack of healthcare as well as access to health insurance needs rapid fixing. Both sectors need reform, weighed down as they are by misgovernance and poor regulation. When 86 percent of rural population and 82 percent of urban population are still not covered, PMJAY can be the tool to accelerate the process and reform both healthcare and health insurance—as the Jan Dhan Yojana has done for financial inclusion—and take India towards a single-risk pool where all government-supported insurance schemes are merged together. Communicating these entitlements is key. Both, coverage as well as communication, can be addressed using Aadhaar as a fulcrum of targeted healthcare and health insurance delivery. The five

hurdles—health insurance premiums, healthcare costs, technology, federalism, and politics—can thus become enablers and push the world's second largest government-funded healthcare programme towards becoming the most effective.

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