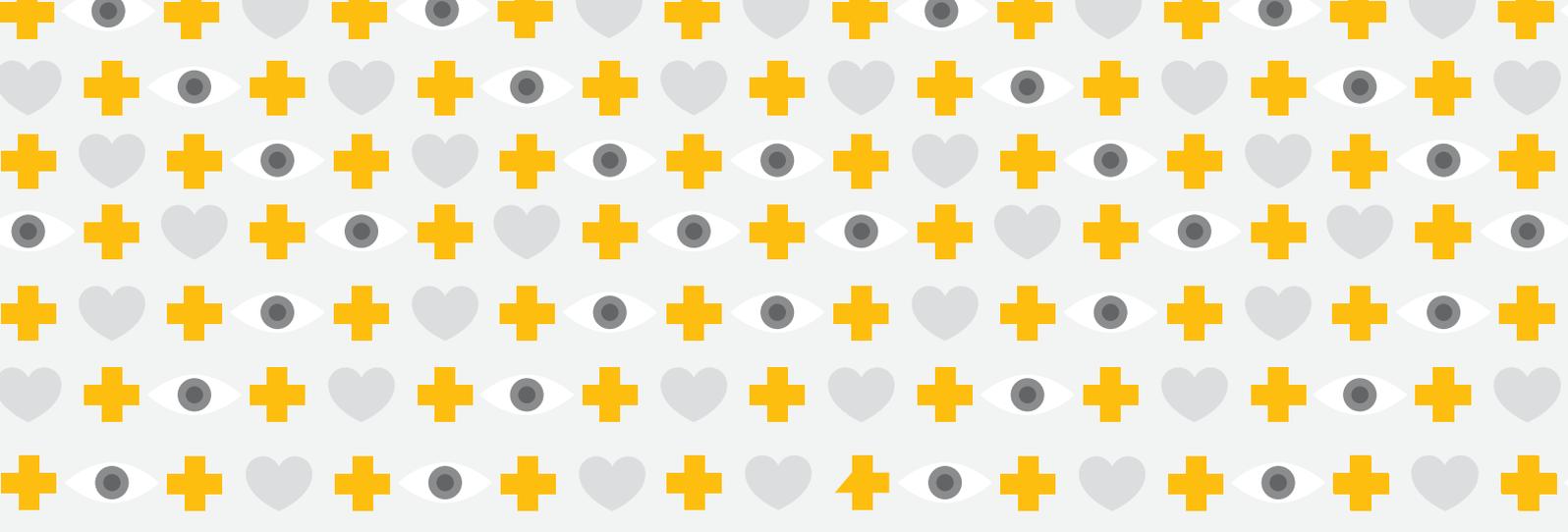


Transforming health insurance in India via a digitally enabled Ayushman Bharat

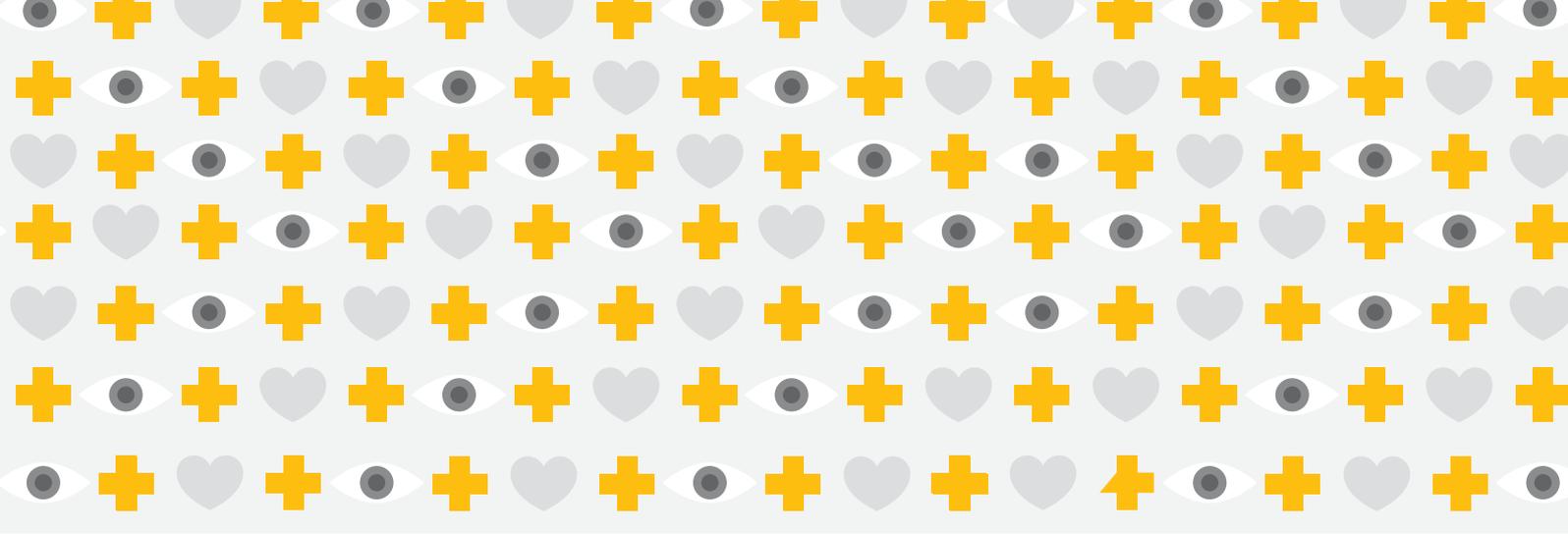
February 2020





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Message from PwC



Abhijit Majumdar
Partner and Technology Strategy Leader
PwC India

Ayushman Bharat is a bold initiative taken by the Government of India (GoI) to shift from a segmented, sectoral approach towards healthcare services to a need-based and comprehensive one. The scheme aims to holistically address all aspects of healthcare, including prevention of diseases, promotion of healthcare facilities and ambulatory care, at the primary, secondary and tertiary levels.

The approach adopts a continuum of healthcare, comprising the two interrelated components of health and wellness centres (HWCs) and the Pradhan Mantri Jan Arogya Yojana (PMJAY).

As a scheme, Ayushman Bharat is transformative because of its visionary approach in accepting its dependency on digital adoption, available healthcare facilities, balance of demand, financial viability, synergy with current medical structures, grievance redressal provisions and prevention of misuse and frauds. It mandates that all processes, including identification and verification of end consumers, empanelment of hospitals and settling of claims, be performed digitally, which brings increased transparency and real-time tracking to the system.

PwC conducted surveys with insurance and healthcare providers between September and November 2019 to understand the implications and challenges of this new scheme for stakeholders on the ground. Out of the surveyed insurance companies, three-fifth of the respondents did not have any active plans, schemes or products for people belonging to below poverty line (BPL), while another one-fourth did not cater to BPL beneficiaries and were in the process of including them. The insurance companies felt that the biggest challenge in the scheme was the coverage of diseases, followed by the resolution time of the claims and lack of information about settlement processes. On the other hand, many healthcare providers who are empanelled with several central and state government health insurance schemes already felt that the intended beneficiaries of the scheme comprised less than one-fourth of the overall patient count. Overall, the survey revealed a lack of clarity on the grievance redressal mechanism, the profitability of the scheme for insurance companies and providers, and the break-up of claim amount and package rates.

As teething issues surface, the GoI should continue focusing on the twin aspects of (a) leveraging technology as an enabler across the network of hospitals and (b) addressing areas which lack clarity, subsequently building transparency and confidence in healthcare providers and premium payers.

Message from ASSOCHAM



S Pradhan
Chairman, Insurance Council
Eastern Region, ASSOCHAM



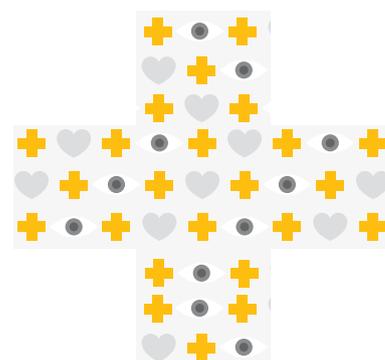
Perminder Jeet Kaur
Director,
East and North East, ASSOCHAM

Accessible healthcare is the need of the hour. The allocation of additional funds in Union Budget 2020–21 towards the health sector is a significant step towards improving the state of healthcare in India. The expansion of the Ayushman Bharat scheme would help fulfil existing gaps in secondary and tertiary healthcare, especially for the economically weaker sections of the society, as the scheme has played a huge role in increasing awareness and acceptance of health insurance amongst all sections of the society.

The dynamics of the health insurance industry are changing. For protection from new-age diseases, it is important that there are innovative insurance policies that are available to end users at the time of need and do not come with numerous terms and conditions.

The health insurance market in India is diverse and has potential for huge growth. There is need for greater awareness among people, especially on the support mechanism that is being provided by governmental and non-governmental agencies across the country.

Innovative solutions are essential for meeting the healthcare requirements of people from diverse social, cultural and economic backgrounds. This calls for greater partnership among the stakeholders of the sector – insurance companies, hospitals, healthcare providers, rural support centres, third-party administrators (TPAs), marketing agencies, web aggregators, social influencers, non-governmental organisations (NGOs) and others.



Introduction

The global health insurance industry is in a state of rapid transition owing to multiple factors such as an increased focus on healthcare by governments across countries and increased awareness about chronic diseases and prevention methods. It is expected that the health insurance market will generate a revenue of USD 2.2 trillion by 2024 globally, at a compound annual growth rate (CAGR) of 4.3% during the forecast period.¹ The Asia Pacific (APAC) region is expected to grow the fastest, at a CAGR of 5.7% between 2019–2024.

The Indian healthcare industry is also a part of this transition and is witnessing an increased push, especially from the government. In an attempt to improve the healthcare provisions for its citizens, the government has launched a number of welfare schemes and policies. With a majority of the rural population still not having access to quality healthcare, the government is focusing towards increasing penetration in rural areas.

As per the India Brand Equity Foundation (IBEF), the Indian life insurance industry is expected to grow at a rate of 12–15% for the next 3–5 years.² The health insurance sector in India is classified into three types, out of which two hold majority of the market share – group health insurance (48%), individual health insurance (41%) and government-sponsored health insurance (11%).³

With growing digitalisation, health insurance schemes and policies have become even more viable. This shift in regulations via policies and welfare schemes is giving a new direction to healthcare providers and insurance companies. Companies today need to ensure that they are not only able to meet the evolving needs of their customers, but also comply with the regulatory mandates from the government and keep up with the technological advancements to maintain their edge in the competitive landscape, while generating value in a cost-efficient manner.

The Government of India's (GoI) health insurance schemes aim to ensure that high quality healthcare services are accessible to all citizens, especially families belonging to economically weaker sections of the society. One such key health insurance scheme is Ayushman Bharat, which was launched in September 2018. It aims to improve India's healthcare facilities and insure 10.74 crore identified families by provisioning INR 5 lakh for each family in a year, with no cap on the number of members in a family. The scheme offers cashless hospitalisation and is available across a network of public and private hospitals.

With the introduction of this scheme, the current health insurance models are bound to be disrupted as healthcare and insurance ecosystems brace themselves for this change. This paper focuses on the health insurance coverage under the Ayushman Bharat scheme, also known as the Pradhan Mantri Jan Arogya Yojana (PMJAY). Furthermore, it highlights the challenges that the scheme has to overcome and the role that technology can play in enabling its successful adoption. These recommendations are based on surveys conducted by PwC between September and November 2019, which involved more than 35 key stakeholders (healthcare providers and insurance companies).

1. <https://www.globenewswire.com/news-release/2019/03/13/1752277/0/en/Healthcare-Insurance-Market-Size-to-Reach-2-2-Trillion-by-2024-P-S-Intelligence.html>

2. <https://www.ibef.org/industry/insurance-sector-india.aspx>

3. https://www.irdai.gov.in/ADMINCMS/cms/Uploadedfiles/english_hindi_annual%20report%202018%20webcopy.pdf

Envisioned benefits of the Ayushman Bharat scheme

This scheme was launched by the Government of India (GoI) to benefit the weaker sections of society. 'Accessible healthcare for all' is the vision driving the scheme as the intended beneficiaries of this scheme may not have the means

or the knowledge to proactively avail the benefits provided by the government. The five key elements of this scheme demonstrate how it strives to be transformational for the intended beneficiaries.



Benefits

Ease of treatment

- Cashless mandate reduces the financial pressure on the beneficiaries
- Ensures that the beneficiaries have to bear minimal inconvenience or struggle in reimbursing their claims

Ecosystem development

- Development of the healthcare ecosystem by generation of employment opportunities
- Digitisation of the entire process opens avenues for various system integrations to provide a seamless customer experience to improve process tracking and optimisation of cost and potentially reducing fraud in the long run

Coverage

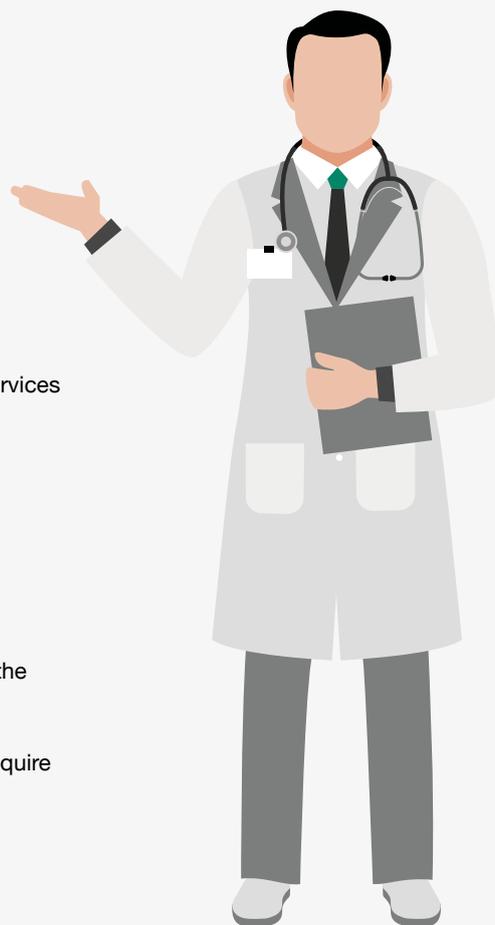
- Aims that 40% of our current population get access to healthcare services
- Helps avoid financially backward families falling in debt traps due to treatment costs
- Flexibility of eligibility criteria in terms of size and member age for such families

Portability

- Accessibility of the health services will be significantly increased by the portability through the empanelled hospitals
- Increases options of healthcare providers
- Increases ease of services from any location that the beneficiaries require
- Could ensure a truly one-healthcare ecosystem

Quality of services

- Scope for greater level of service standardisation by the hospitals as the purchasing power of the beneficiary improves
- Potential to introduce consistency in the quality of services also calls for similar turnaround time and process



Source: PMJAY, PwC analysis

Considerations for the scheme

Implementing one of the largest health insurance schemes in the world is an uphill task. Given the scale of Ayushman Bharat, the road to its implementation involves several considerations, many of which are already being addressed. These can be summed up into eight broad categories:



01 Available facilities

- Efficient on ground implementation requires adequate healthcare capacity to cater to the beneficiary needs
- Availability of basic staff and facilities to cover this surge in formal healthcare commitment – directly covered within the scheme itself
- The scheme’s ability to cater to the needs of specialised healthcare requires the support of existing ecosystem of providers in terms of leveraging current infrastructure through empanelment
- Currently there are more than 21,000 empanelled providers, public and private both and the participation number is increasing with each passing day

02 Financial viability

- Success of the scheme hinges on the balance between being sustainable and financially viable for all the stakeholders involved – ensuring that the interests of the service providers are also fulfilled, through aspects such as coverage amount and the model by which it is calculated
- Currently, the scheme has empanelment of public and private healthcare providers, which is a positive indicator for the scheme, but in the long term, including premier hospital chains into this scheme will have to be carefully planned so as to make the arrangement mutually beneficial through incentives or returns
- The scheme needs to find a way to reward hospitals by the quality of their services and facilities available via the coverage amounts offered to ensure the level of motivation to continuously improve their services
- Ensuring consistency in treatment amount has to take into account varying costs across geographies
- Just like any other scheme, there is that tight rope between the long-term financial sustainability of the scheme in the and the benefit to the stakeholders involved, which the government needs to balance

Source: PMJAY, PwC analysis

03 Balance of demand

- If required, mutually agreed dynamic rates (incentives for quality) for the hospitals can be assigned – they will have to be objectively updated as per the current standards, which is a humongous task
- Moreover, such dynamic rates would also need to consider the grievance cases in penalising the respective hospital's care rates
- Fortunately, this would be applicable at a much later stage of the scheme, once there is saturation of the empanelled providers against the demand
- While scaling up, the scheme will have to consider outpatient care options
- Among providers at nearly the same distance from the consumer, there may be preferences of premium private hospitals, which may skew the balance of demand

05 Beneficiary identification

- The need for a standard and acceptable way of registering and verifying patient identities across the empanelled hospitals has been considered
- The process needed consistency among care centres, including the ones that have poor internet connectivity, which has been considered
- The scheme has shown understanding that the identification proofs, automated verifications and assurance of service to all listed beneficiaries, all go hand in hand to avoid beneficiary inconvenience
- This is a major area where the government has taken advantage of their forward looking approach by leveraging technology to cater to these considerations

07 Grievance redressal and governance

- Considering the beneficiaries of the scheme, a robust mechanism to manage the grievance of each case is essential – to cater to the emergencies and the criticality of the medical cases, timely resolutions of these queries and defined timelines for response to admission, payment and other grievance resolutions have been assured by the government, which is also the payer in this case
- In addition to the preventive measures, governance is equally important to ensure a fraud-free ecosystem for this scheme.
- In the long term, it is a task for the scheme to continue to strive to be an inclusive scheme through inclusion of formal feedback from the hospital, beneficiaries, other stakeholders for use in future iterations of the scheme

04 Synergy with the current structure

- How the new scheme synergises with the existing initiatives – almost all the states have already been using such schemes and the transition to this central scheme has been ensured
- Furthermore, it is also important that the benefits under the central scheme are at par with, or better than the ones at the state level – this was another criteria that the government has taken into consideration while drafting the benefits of this scheme
- Moreover, it is equally important that this transition also ensures consumer awareness about the scheme, as it is already attempted

06 Technology adoption

- A connected ecosystem calls for digitisation of records in a format accepted across all platforms for different health insurance ecosystem stakeholders (hospitals, insurance companies, third-party administrators [TPAs] and the government)
- These standards need to be defined as a policy and enforced in way to ensure data is collected digitally and updated as per standard methodologies and formats
- Especially due to potential sync with different national databases, such as citizen identity verification, data security is a key consideration
- Considering the cashless mandate of the scheme, consistent digitisation of the stakeholder systems is key for the government to ensure all claims are tracked and governed
- Additionally, ensuring that these hospitals have the right set of tools to enforce is critical to maintain this standard
- Conducting technology and data audits (in future) to ensure that providers and insurers are complying with the policy has made it necessary for the government to access the same set of digital tools to monitor such data, as well as to analyse it proactively

08 Prevention of misuse and frauds

- Schemes of such magnitude would always have the challenge in ensuring that the right beneficiary is provided quality treatment for the right ailment at the right hospital
- It would also require preventing unscrupulous elements by trying to gain any monetary advantage through misuse, abuse or fraud, thereby increasing the funds required towards scheme implementation
- This can be simplified through technology-enabled parameters inbuilt in claims engine for real-time monitoring of claims using big data analytics
- The flagged cases can then be audited based on both concurrent and retrospective clinical and financial parameters – this may also require steps to incentivise honesty and penalise wrongdoings

Source: PMJAY, PwC analysis

Changing insurance business models

Current health insurance business models

Health insurance is based on the concept of an agreement between the customer and the health insurer wherein the customer agrees to pay a periodic premium to the insurer (such as insurance companies) in return for coverage of whole or partial medical expenses. The benefit to the customer is that he/she is assured of payment for medical expenditure valuing up to a proportion of the premium paid, depending on the risk underwritten in the agreement. The insurers generate revenue from the collective premiums paid by all customers, while incurring costs on operational expenses and claims paid against these policies.

Health insurance models in India have slight variations based on the stakeholders and regulatory conditions. A health insurance policy may be bought by a person for him/herself, by a family member on behalf of the beneficiary or by a corporate entity owning responsibility for the health of its staff, at subsidised rates. Alternatively, it may be purchased by a government authority as part of a wider scheme in the interest of ensuring the beneficiary's health.

Several other global business models are fairly new or niche and cater to a specific customer base owing to the level of comfort and options provided to their customers. Some such models are:

- On-demand health insurance: A customer can seek insurance against specific diseases or for specific services as and when needed and accordingly the premiums would be decided over time.
- Direct primary care: The healthcare provider uses a subscription-based model and provides insurance services directly to the customers/patients.
- Digital enablement: Digital applications or platforms are used by customers to browse through different health plans, compare products as per their own requirements, calculate the approximate premiums, compare different companies and reach out to the health insurance companies to avail their specific plans.



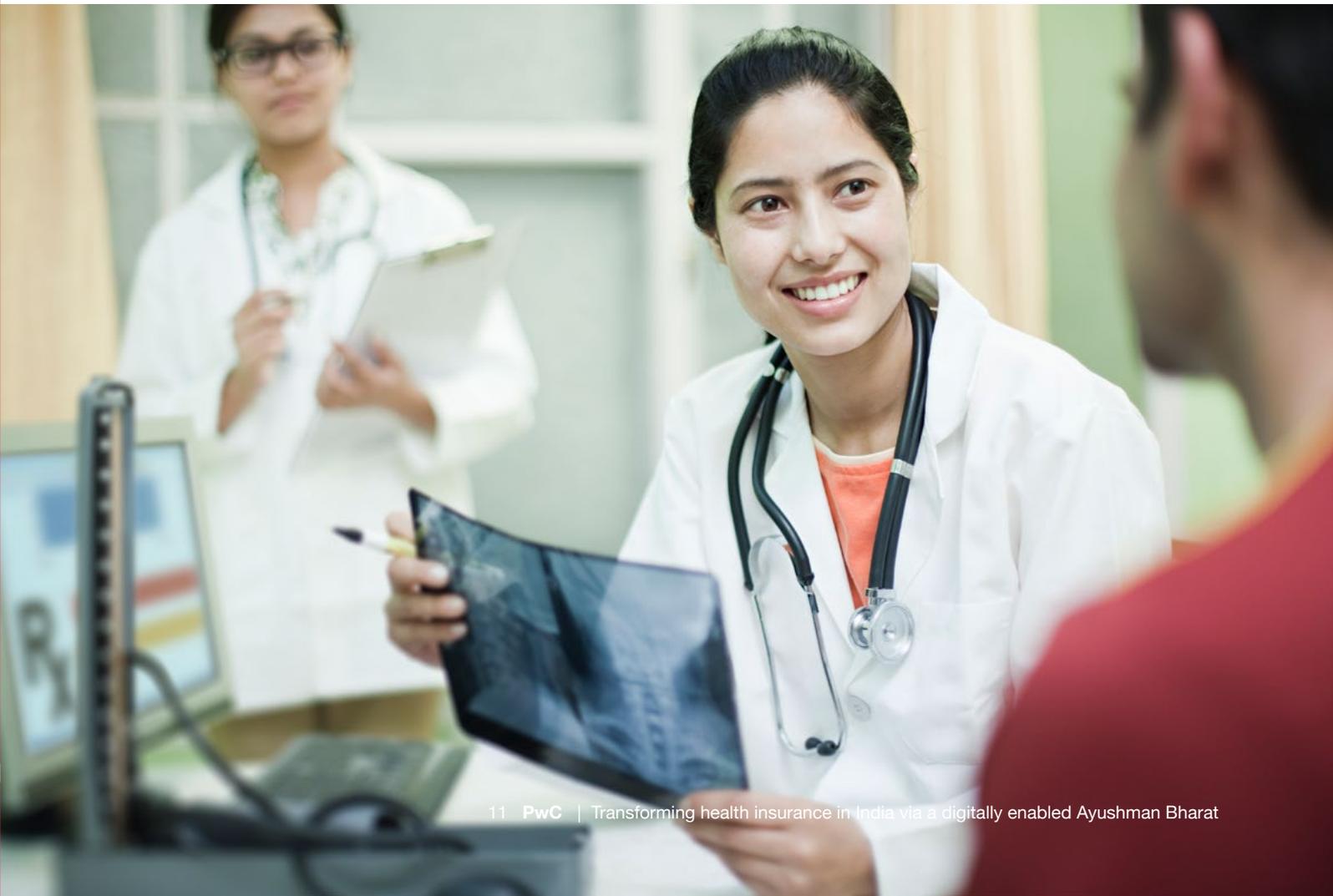
Disruption in health insurance reach through Ayushman Bharat

The Ayushman Bharat scheme builds upon its predecessor, the Rashtriya Swasthya Bima Yojana (RSBY), as it aims to provide healthcare and health insurance coverage to nearly 40% of the country's population through a visionary model. Its uniqueness lies in the fact that it provides for cashless hospitalisation and flexibility to the customers in terms of geographical coverage. The beneficiaries covered under this scheme consist of people belonging to economically weaker sections of the society and do not need to pay premiums for the coverage. Each beneficiary is given an identification card which is used to confirm the beneficiary's identity and eligibility across a wide range of empanelled healthcare providers.

Three options have been made available to the state governments to implement the scheme – the trust model, the insurance model and combination of two wherein a fixed amount is administered through insurance and any amount beyond that is administered through trust. Under the trust model, the premiums are put into a trust which is managed by the state government. The state government also manages the health scheme in this case along with the claim settlement, independently as a payer. This model increases

the administrative work towards claim adjudications. The insurance model involves the payment of premiums by the state government to the insurance companies that administer the claim settlements and associated operations. This model leverages the experience of these companies in handling cases and their preparedness against possible frauds. Different states have chosen either the first or the second option (a combination of both of these models) for implementing the scheme, giving the government the opportunity to test and assess which model works best.

Compared to existing business models, these schemes are disruptive as they have broadened their reach and scale. Building upon the changes introduced by the RSBY, with the mode of payment being mandated as cashless, the Ayushman Bharat scheme brings ease in the process, in terms of technological capability and implementation by both healthcare providers and the insurance companies. Furthermore, the coverage amount under the scheme is standardised, ensuring reduced complexity of the insurance process.



Insights from providers and payers

Based on two surveys conducted by PwC between September and November 2019 (one conducted to understand the perspective of hospitals and another to understand the perspective of insurance companies) insights from the health insurance ecosystem were gathered.

Survey of insurance companies

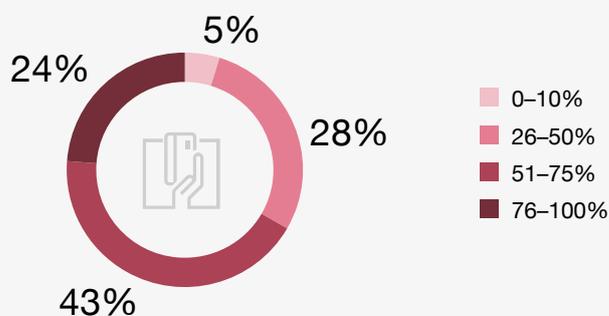
This survey took inputs from senior stakeholders of over 20 key insurance companies, all of whom cater to both urban and rural customers. Out of these surveyed companies, 62% of the respondents did not have any active plans, schemes or products for people belonging to below poverty line (BPL).

Another 24% did not cater to BPL beneficiaries but were in the process of including them, 10% included such beneficiaries as part of existing state-owned policies/schemes, while the remaining 5% were already partnered with the Ayushman Bharat scheme.

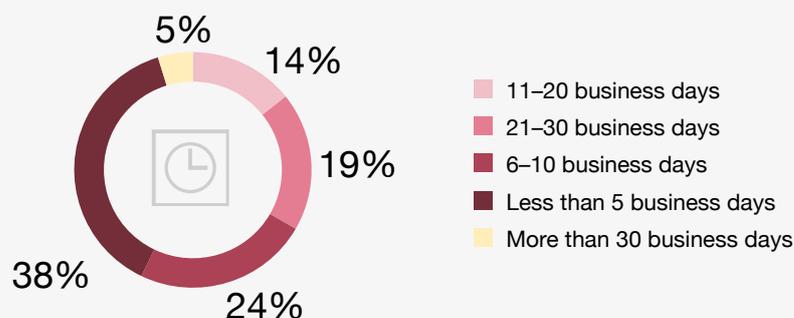
Industry insights

- 76% of the insurance companies are using digital applications to store customer data.

Percentage of cashless claim transactions

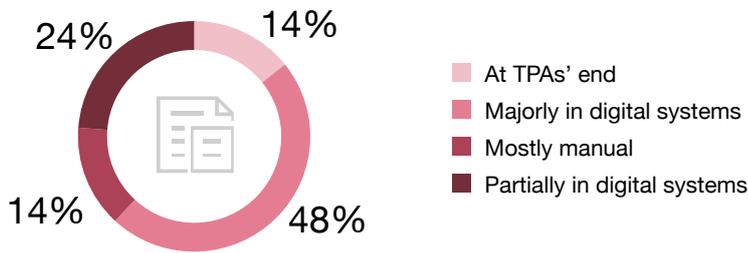


Average turnaround time for settling a standard insurance claim



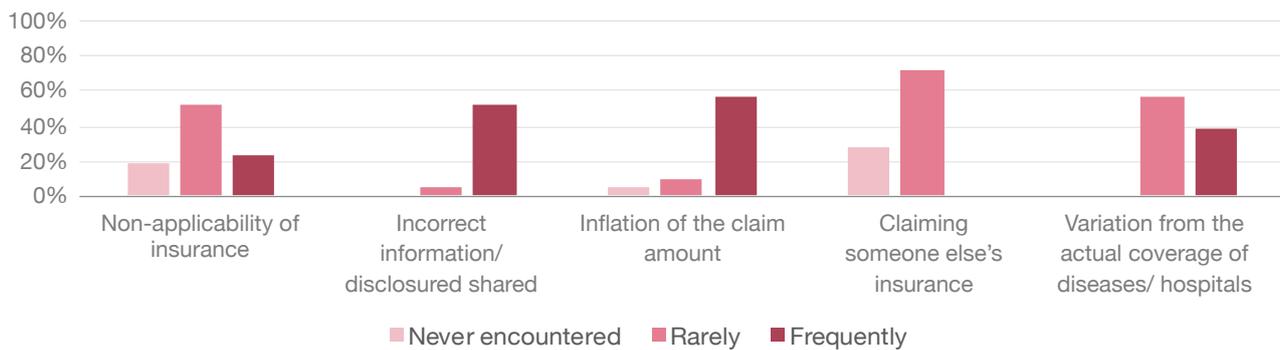
Source: PwC survey on health insurance companies (September to November 2019)

Method of maintaining customer history/verification/background check records



- 50% of the respondents felt that they have a secure mechanism for data storage and exchange requirements for Ayushman Bharat while another 30% were already in the process of developing the infrastructure/architecture to support necessary requirements.
- Fraud cases for all insurance companies surveyed constituted for less than one-fourth of their total cases encountered. Out of this, 86% of the surveyed companies encountered roughly only up to 5% fraud cases.

Frequency of different fraud case types

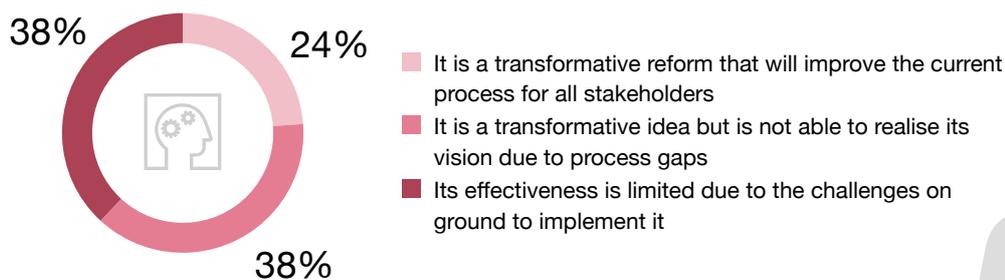


Source: PwC survey on health insurance companies (September to November 2019)

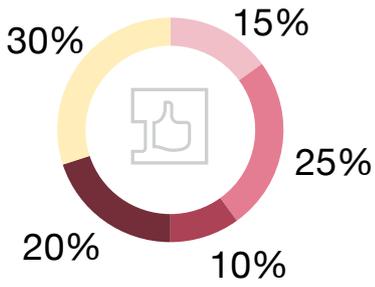
Perception of Ayushman Bharat

- Insurance companies felt that the biggest challenge in the scheme was the coverage of diseases (31%), followed by the resolution time of the claims and lack of available information (20% each).

Perception of Ayushman Bharat Scheme



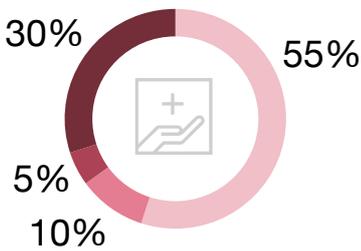
Perceived preparedness to implement the Ayushman Bharat scheme



- No, the requirements and role are not yet clear to us
- No, we do not feel the scheme is in line with our company's offerings
- No, we feel the roadmap has not yet been defined clearly
- Yes, we feel prepared to cater to the requirements of the scheme's beneficiaries
- Yes, we have planned to incorporate the scheme into our current portfolio soon



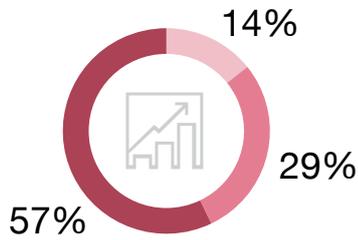
Perceived advantages of Ayushman Bharat scheme over the previous comparable schemes offered by the government for the poor



- Increased customer base due to inclusion of BPL customers
- No benefits seen/no visible difference compared to other schemes
- Previous schemes/alternates available were better
- Visibility among the common people



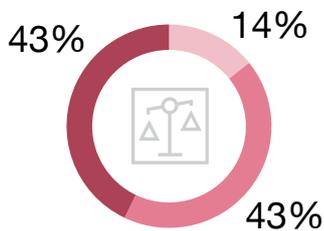
Realised/expected profitability through this scheme



- It has very little profitability for us
- It is an increase in overall market size and is definitely beneficial with additional profit for us as well
- It is hard to say at this point due to lack of visibility on its financial feasibility for us



Comparison of insurance coverage and rates of Ayushman Bharat scheme with that of other similar schemes



- At par
- Better
- Lower



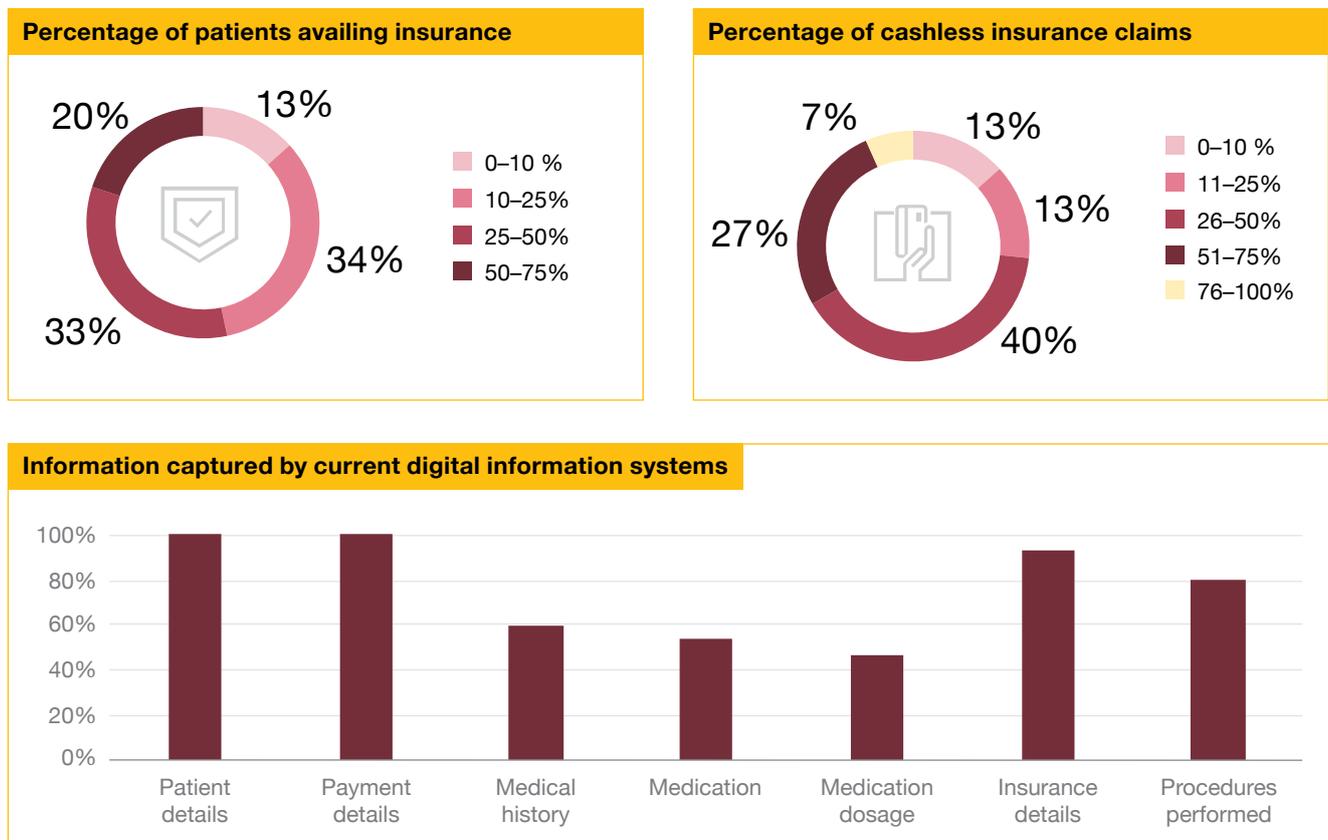
Source: PwC survey on health insurance companies (September to November 2019)

Survey of hospitals

This survey took inputs from senior stakeholders of over 15 hospitals across India, all of whom cater to both urban and rural customers. Out of the surveyed health insurance companies, more than half (53%) of the respondents represented hospitals with a capacity of more than 200 beds. The key insights gathered from this survey are:

- The intended beneficiaries of Ayushman Bharat were found to be less than one-fourth of the overall patient count in all the hospitals surveyed.
 - Further, for around 80% of the respondents, the beneficiary to total patient ratio was less than 10%.
- The surveyed hospitals are currently empanelled with several central and state government health insurance schemes, such as the Central Government Health Scheme (CGHS), the Ex-Servicemen Contributory Health Scheme (ECHS), the Delhi Government Employees Health Scheme (DGEHS), the Bhamashah Swasthya Bima Yojana (BSBY) and the Mukhyamantri Gambhir Bimari Yojana.

Insurance scenario for the surveyed providers

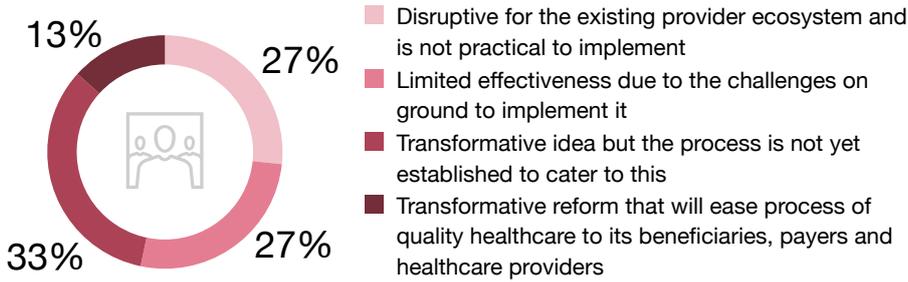


Source: PwC survey on hospitals (September to November 2019)

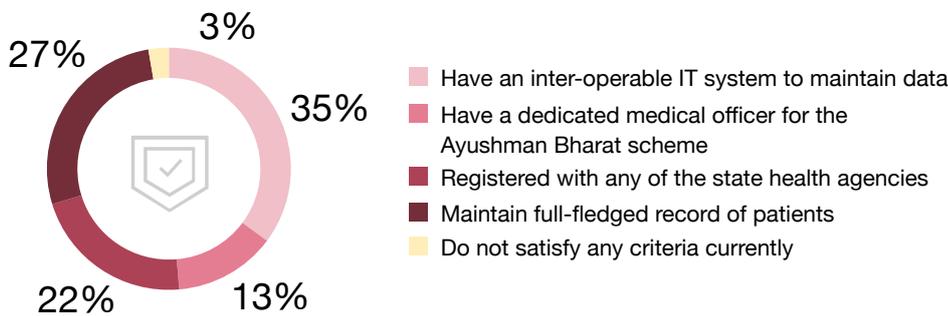


Provider perception of Ayushman Bharat

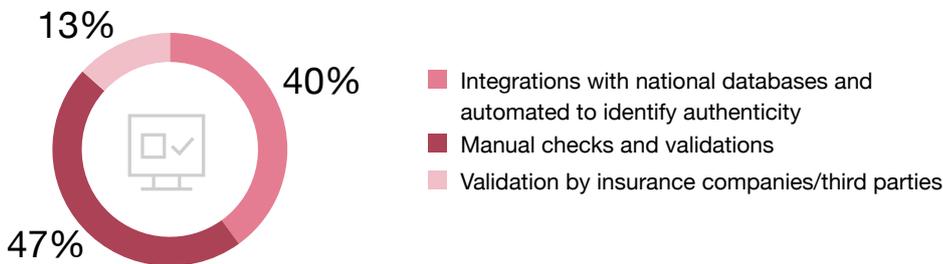
Opinion about the Ayushman Bharat scheme



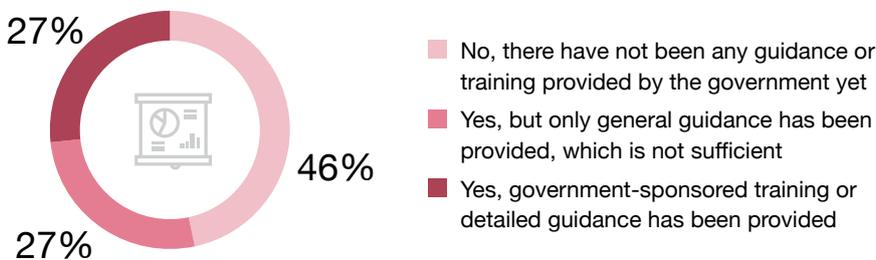
Compliance with eligibility criteria to be an empanelled partner of this scheme



Current preparedness to identify the eligibility of a patient for availing this scheme



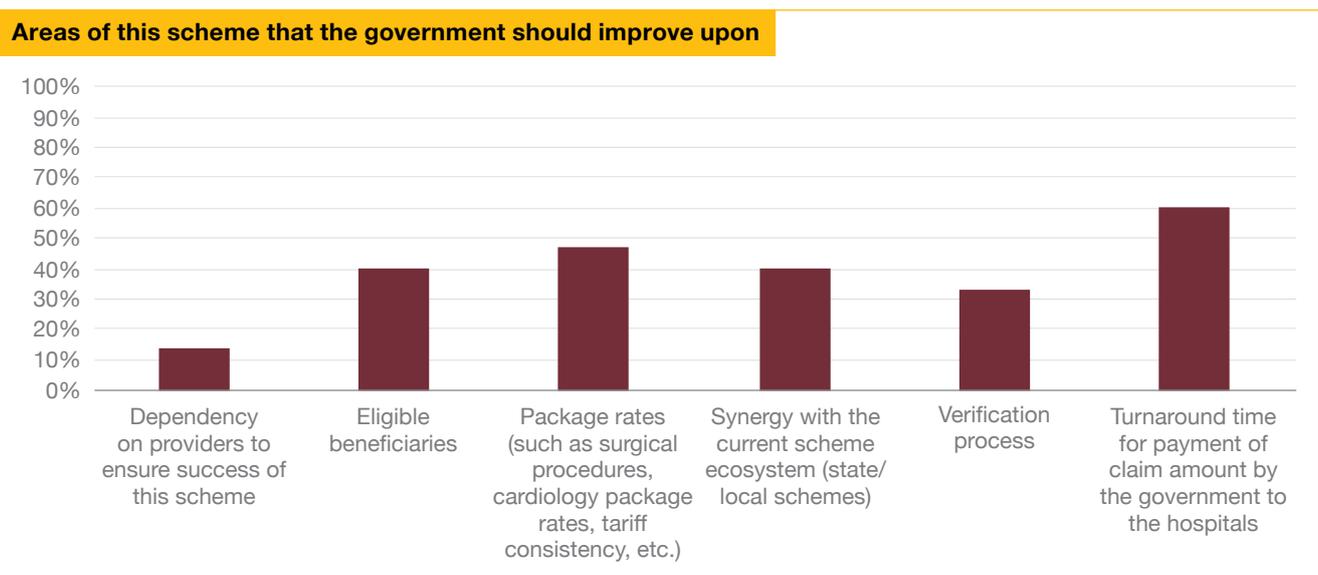
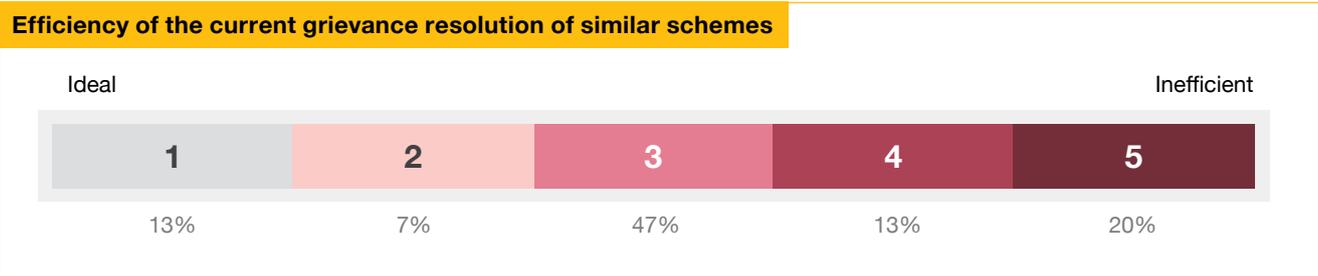
Training and guidance regarding implementation of Ayushman Bharat



Source: PwC survey on hospitals (September to November 2019)

Areas of focus for Ayushman Bharat

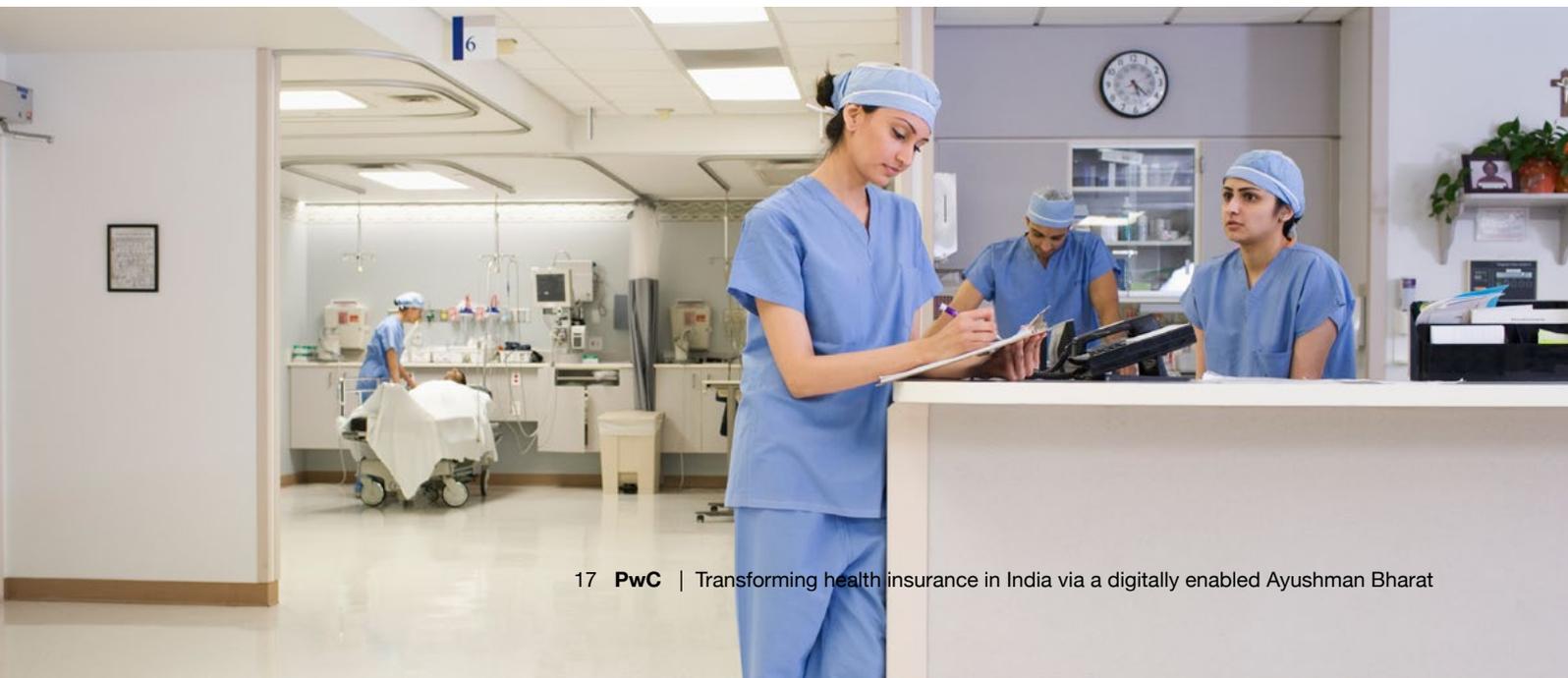
- Grievance redressal was an expected area of concern for the respondents, based on past experiences with government schemes.



Source: PwC survey on hospitals (September to November 2019)

These two surveys highlighted three key views from these two stakeholders (insurance industry and healthcare providers):

- The perception of the scheme by both these stakeholders was mixed, but the common theme was that preparedness towards its adoption needs additional focus.
- The benefits of the scheme for the beneficiaries were well understood by both these stakeholders but their own profitability through the scheme was still lacking.
- Regarding areas of improvement, claim amount and package rates were the two key asks of the healthcare providers.



Role of technology

Owing to advancements in the healthcare space, the health insurance industry is also adopting various digital technologies in order to cater to changing customer needs and business models. The key stakeholders of the health insurance ecosystem (the end consumers, the healthcare providers and the insurance companies) need to collectively explore digital interventions in order to have an integrated ecosystem, streamlined processes and higher efficiencies in their respective domains.

As a scheme, Ayushman Bharat is also transformative because of its visionary approach in accepting its dependency on digital adoption. It mandates all the processes, including identification and verification of end consumers, empanelment of hospitals and settling of claims to be performed digitally. Moreover, the mandate of cashless transactions brings increased transparency and real-time tracking to the system. Such a digital industry landscape addresses the considerations for the scheme well and highlights the scheme's potential to evolve by further adoption of technologies while scaling up.

01 Available facilities

- Leveraging digital tools to ensure that the existing facilities are used well by redirecting patients through integrated channels, with bed availability information in the nearest empanelled care centre or provider for health services

02 Financial viability

- Dynamic pricing tool to vary the rates of health coverage from provider to provider, based on quality of service, if approved
- Scalable insurer financial systems that are integrated among the various state governments and centres to ensure ease of dynamic split of coverage amount subsidisation

03 Balance of demand

- Tool-based tracking of bed availability in hospitals
- Digital capturing of patient information helps route the patients through real-time availability of beds in the nearest hospital
- Demand vs supply statistics help map the exact need of healthcare provisions across each geography
- Backup of the data at regular intervals ensures that even low internet connectivity areas work well in this scheme
- Advanced analytics for equalised demand distribution and calculation of relative rates for cost compensation of providers

04

Synergy with the current structure

- Provides financial systems to incorporate payments and reimbursement through the previous schemes and Ayushman Bharat separately to provide ease of transition
- Insurance billing systems to have the scalability component for collaboration in future for state and central government for joint cashless payment for beneficiaries
- Integration of provider and insurer systems with a central tool containing all scheme-related information

05

Beneficiary identification

- Connected digital tools to input patient-unique identification and confirm their enrollment under the scheme. Unique Identification Authority of India (UIDAI) can be instrumental towards ease of identification and authenticity.
- Online patient verification tool to be used by the empanelled hospitals with provision for cross-verification of patients using a one-time password in cases of missing documentation
- Scheduled batch syncs of patient verification database for low-connectivity areas

06

Technology adoption

- Secure interfaces for integration between provider/insurer systems and government database for verification, payments, etc.
- Centralised web-based tools with empanelled providers and insurers credentials for ease of technology adoption

07

Grievance redressal and governance

- Interactive voice response (IVR) call based feedback mechanism for the patients for reporting inconsistencies in the process
- Front end tool for providers and insurers to register and track complaints and provide feedback for their experience
- Automated patient verification and medication data sync between provider and insurer databases for governance and audit perspective

08

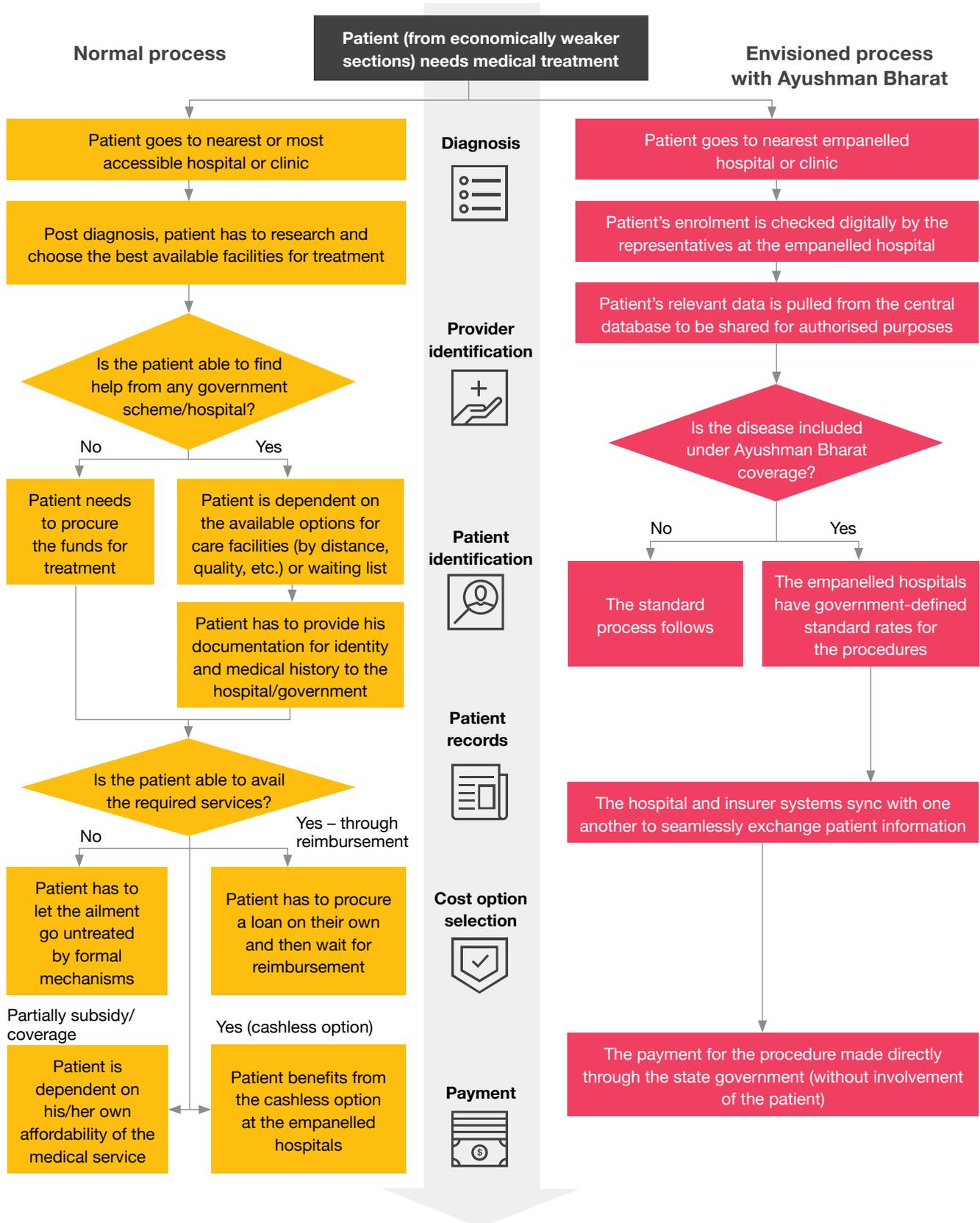
Prevention of misuse and frauds

- Digital channels for reporting fraudulent practices
- Artificial intelligence to proactively identify fraudulent cases
- Billing reports and trends to compare inconsistencies in process at individual locations

The envisioned technology-enabled process

The envisioned process leverages technology to introduce seamless data flow into three primary convenience areas for the scheme's beneficiaries:

1. ease of beneficiary identification due to verification from a centralised digital government repository
2. transparency of hospital empanelment, disease coverage and storage of patient records
3. reduces inconvenience and process billing complexity as the whole process is cashless



Source: PwC analysis

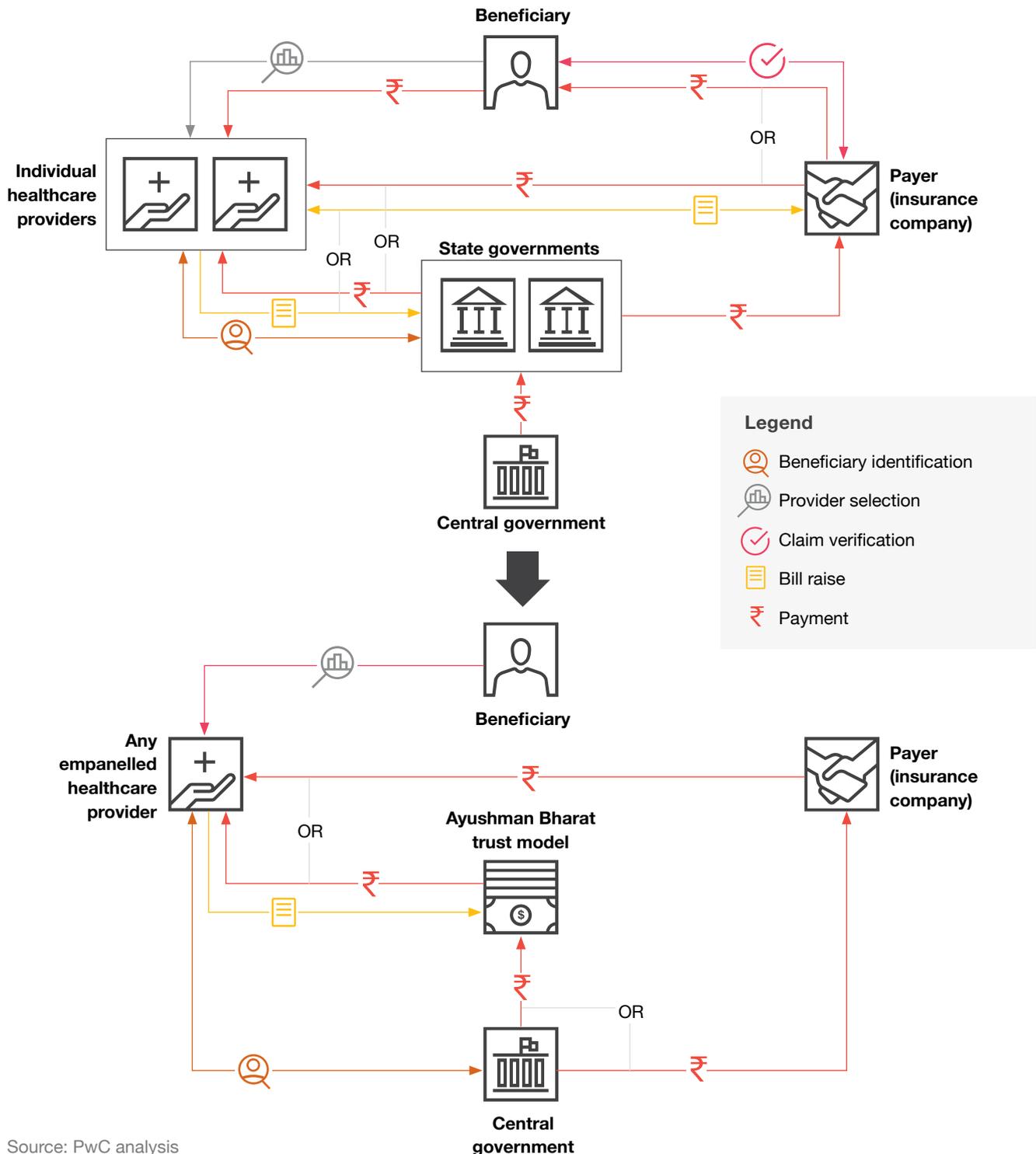
Reduction in complexity of stakeholder interaction

Through technology enablement, the complexity of interactions among different stakeholders, namely patients, healthcare providers, payers (insurance companies) and the government (central and state), has been significantly simplified.

The complexity is reduced in three ways:

- 1. Portability:** Consistency in service and common rates across different providers, hence reducing the beneficiary's need of comparing providers' deals.
- 2. Cashless payments:** Payments by the central government instead of payments via different state schemes.
- 3. Seamless beneficiary identification:** Providers can directly confirm the beneficiary's identity from the central database.

This figure below explains the difference between stakeholder interactions in an envisioned scenario and a scenario without such seamless use of technology.



Source: PwC analysis

Way forward

Schemes such as Ayushman Bharat are disrupting health insurance business models by extending coverage to weaker sections of society and providing huge opportunities to industry stakeholders. With accessibility of healthcare services for all being the need of the hour in the Indian healthcare ecosystem, the Gol has taken a bold step towards addressing this need with Ayushman Bharat. Though aspects such as investment and implementation need a lot of attention before the scheme can become self-reliant, its long-term benefits are clear.

The responses from the key stakeholders surveyed by PwC show that their perception of the scheme's vision is favourable. Moreover, in line with PwC's analysis, the survey respondents feel that although the scheme is highly ambitious, it is much needed. One of the main findings of the survey is that while long-term continuation of the scheme is largely dependent on the government's efforts to ensure its viability for all stakeholders and prevent any leakages, collective participation from the providers and stakeholders involved is also crucial to its sustainability.

The Gol's action with regard to Ayushman Bharat is twofold – first, to oversee on-ground implementation and ensure due governance, and second, to make future scalability more feasible. The government has already taken steps in this direction by lowering healthcare costs through economies of scale and preparing guidelines for the various challenges that can arise – for instance, due to poor internet connectivity. There is immense scope for technology intervention in both areas. For example, an integrated billing

system can be rolled out in the near future. Other similar interventions such as dynamic pricing and integrated data governance require frameworks and policies, which could be implemented after careful assessment of the scheme's sustainability in the long run. If required, the government could decide to frame such policies based on the scheme's supply vs. demand scenario at that stage. The government could also utilise technology for fraud mitigation in availing of the scheme's benefits.

The Gol's announcement in Union Budget 2020–21 to set up more hospitals in Tier 2 and Tier 3 cities is a positive move.⁴ With the right investment and efforts, and after addressing the initial problems, the Gol may need to consider updating its guidelines (such as inclusion of private hospitals at dynamic rates) in the future in order to increase the scheme's appeal and thus its adoption by healthcare providers and insurance companies. Integration and governance are areas where all stakeholders can contribute their points of view and best practices.

For now, the government should continue focusing on leveraging technology further as an enabler across hospitals. Technology can be used to create an advanced and mature digital ecosystem within the health insurance industry. Insurance companies that already use technology on a large scale can benefit from new digital opportunities in terms of increased collection of customer data. These benefits extend across the domains of end customer convenience, fraud mitigation and governance, among others.

4. <https://www.pwc.in/budget/union-budget-2020.html>



About ASSOCHAM

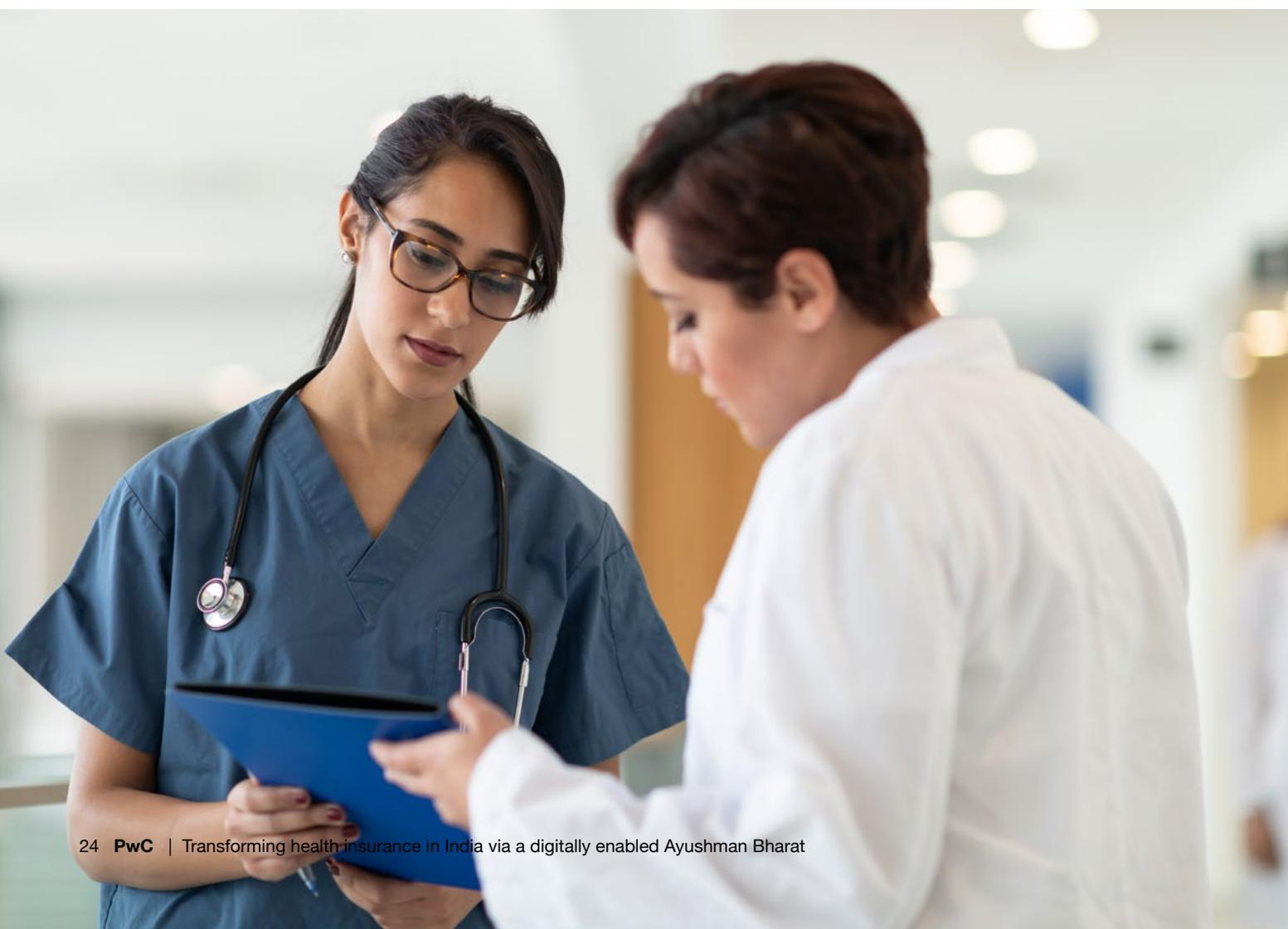
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