International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

Exploring the Implementation Challenges Faced by Healthcare Providers in Delivering Services Under Ayushman Bharat: Arogya Karnataka Health Scheme in Bengaluru, Karnataka-A Qualitative Study

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ABSTRACT

Background: Ayushman Bharat-Arogya Karnataka (AB-ArK) is a flagship health insurance scheme of Karnataka started in Oct-2018. The integrated health assurance scheme of Ayushman Bharat-Arogya Karnataka is implemented by the State of Karnataka on an assurance/trust mode through the State Health Agency-Suvarna Arogya Suraksha Trust (SAST).

AB-Ark is a Universal Health coverage scheme that provides a comprehensive healthcare to both Below Poverty Line (BPL) and Above Poverty Line (APL) families, covering a wide range of secondary and tertiary healthcare services. This scheme, part of the broader Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), seeks to offer financial protection against catastrophic health expenditures and improve access to quality healthcare services.

Learning the experiences and insights from the scheme's implementers can enhance our understanding of how contextual factors impact a program's success. Therefore, it is crucial to examine the different contextual elements that can either support or obstruct the effective execution of a scheme.

Objective: To understand the specific obstacles and barriers in effectively implementing the Ayushman Bharat Arogya Karnataka health scheme from a healthcare provider perspective.

Methods: The study employed a qualitative approach involving 8 in-depth interviews. Interviews were audio recorded and were transcribed as per the reported verbatim. The transcripts were then analysed in Microsoft excel using thematic analysis for emerging patterns and insights leading to conclusions drawn from the analysis results.

Results: Findings were depicted in broad themes and subthemes under individual, community, health system and policy levels. In brief, factors like infrastructure, patient load, awareness, affordability, quality of care and operational challenges were discussed.

Conclusion: Study finding revealed various challenges faced by the health care provider, which needs to be addressed for the scheme's long-term success and sustainability. Continuous monitoring, policy adjustments, and stakeholder engagement are essential to overcoming these hurdles and achieving the scheme's objectives.

Keywords: Universal Health Coverage, AB-ArK Health scheme, Health Care Providers, Implementation Challenges.

INTRODUCTION

The United Nation's Universal Health Coverage goal (UHC) has evolved from a primary health care (PHC) goal into the more recent SDG (Sustainable Development Goal).

Universal health coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course.

The delivery of these services requires health and care workers with an optimal skills mix at all levels of the health system, who are equitably distributed, adequately supported with access to quality assured products, and enjoying decent work.

Protecting people from the financial consequences of paying for health services out of their own pockets reduces the risk that people will be pushed into poverty because the cost of needed services and treatments requires them to use up their life savings, sell assets, or borrow – destroying their futures and often those of their children.

Government of Karnataka introduced Arogya Karnataka health scheme on March 2, 2018, with the goal of providing Universal Health Coverage to all residents of the State. The Government of India later introduced Ayushman Bharat Pradan Mantri Jan Arogya Yojna (AB-PMJAY) and since both Arogya Karnataka and Ayushman Bharat schemes had the same goal, scope and similar modalities, both the schemes were integrated under a co-branded name called Ayushman Bharat-Arogya Karnataka (AB-ArK) since October 30, 2018.

This integrated scheme is implemented on an assurance mode through Suvarna Arogya Suraksha Trust (SAST), which is the State Health Agency of Karnataka. The primary objective of AB-Ark is Universal Health Coverage rendering services to both Below Poverty Line (BPL) and Above Poverty Line (APL) patients. BPL families are provided a cover of 5 lakhs per annum per family and APL patients can also avail the scheme by paying 70 % of the package, and the remaining 30 % is paid by SAST to a maximum of 1.5 lakhs.

As the State health authority is the implementation agency of the AB-PMJAY, and states are free to continue to provide existing programs alongside the national program or integrate them with the new scheme, Karnataka State has its own operating model with a vast and comprehensive Benefit Health package. The Benefit health care package of Ab-ArK is an amalgamation of the procedures from the earlier successful schemes like Central Government Health Scheme (CGHS), Vajpayee Arogya Shree (VAS) and Arogya Karnataka. The scheme is designed to cover diseases with high incidence / prevalence rates and reduce the Out of Pocket (OOP) expenditure.

RATIONALE FOR THE STUDY

The success of UHC is measured by the access of health services across the population, the types of services that are available, and the financial protection offered to the population. However there are constraints across these three measures. To overcoming this, will require careful monitoring of the implementation of the program to track progress against key budgetary, service, and financial-protection measures and guard against unintended consequences.

There is a need to broaden capacity-building efforts from enabling frontline staff to operate the scheme's IT platform for developing the technical, managerial, and leadership skills required for them. At the hospital level, an empowered frontline worker is the key to efficient hospital-based processes. There is a need to streamline back-end processes to eliminate the causes for delay in the processing of claim payment requests. For policymakers, the most important and urgent need is to reduce out-of-pocket expenses. To that end, there is a need to both revisit and streamline the existing guidelines and ensure adherence to the guidelines.

There is a need for wide reforms across public and private providers of care if India is to meet its stated aims of providing UHC for its population. The success of the program will rely on a reformed and adequately resourced public sector to lead implementation, delivery, and monitoring of the scheme.

The Ayushman Bharat - Arogya Karnataka health scheme, designed to provide comprehensive healthcare coverage to citizens both BPL and APL, presents a promising avenue for improving healthcare accessibility and affordability. However, the effective implementation of such schemes heavily relies on the seamless delivery of services by healthcare providers. Despite the noble intentions behind the scheme, healthcare providers encounter various challenges that impede their ability to deliver services efficiently and effectively.

This study aims to identify and analyze the challenges faced by healthcare providers in delivering services under the Ayushman Bharat - Arogya Karnataka health scheme mainly in areas of Financial Reimbursement, Infrastructure and Resource Constraints, Administrative Burdens, Quality of Care, Capacity Building and Training, Technology Integration, Awareness and Communication and other challenges.

REVIEW OF LITERATURE

A study by Srivastava S et al. (2023) about understanding the factors facilitating or hampering implementation experiences Pradhan Mantri Jan Arogya Yojana (PM-JAY) noted that the State Health Agency, district, and hospital faced uniform challenges with organizational and administrative processes. Data challenges included obsolete or incomplete data used for determining beneficiary eligibility, mismatches in hospital empanelment data at National Health Agency (NHA) and State Health Agency (SHA) levels, inability to link data between hospital empanelment and claims processing data systems which operated on different technology platforms, missing information for specific benefit packages and their procedural requirements and technicalities such as software issues, faulty Information Technology (IT) servers, and poor internet connectivity.

The inconsistencies in PM-JAY data systems and architecture frequently resulted in delayed timelines, resulting in patient inconveniences, inefficiencies, and claim rejection.

There was inadequacy of the benefit package and its reimbursement (package) rates, even after all models adapted the nationally recommended benefit package to state requirements. This was a lesser issue in government hospitals, which additionally received line budget funding. There were gaps in the benefit

package for chronic diseases, co-morbidities, and surgical treatments. Benefit packages did not cover some commonly prescribed drugs, resulting in out-of-pocket patient expenditures. Reimbursement rates for most packages were too low and below industry standards.

All of these endangered the financial viability of hospitals and thus affected all other implementation drivers, and impeded the provision of quality services.

A cross sectional study conducted by Nirala S K et al. (2022) about the awareness and readiness to implement the PMJAY showed that even though there was enough Information, Education, and Communication (IEC) about the PMJAY scheme's benefits, nursing officers' and doctors' average awareness score was relatively low. Resident doctors and nursing officers were less informed than faculty members. As the Health Care Workers (HCWs) become more aware, there was an increase in readiness to implement PMJAY.

Grewal, H. et al. (2023) study on Universal health care system in India noted that given that the Ayushman scheme covers only inpatient illness and healthcare expenses around the period, this is more of a reactive measure than a proactive one. With a large population that has no regular healthcare access or focus on health education, a reactive scheme means more expenses and decreased outcomes. More healthcare schemes focusing on the prevention and early diagnosis of various diseases were required.

Hospitals sometimes prioritize cheaper products without ensuring quality, and early discharge of patients to reduce costs can lead to increased complications. Reimbursement issues arise due to insufficient or delayed payments, discouraging private institutes from participating. A significant portion of beneficiaries were unaware of this program.

Zodpey S et al. (2018) studied that government health schemes may consider providing outpatient care, medicine and diagnostic charges, travel allowance and most importantly wage loss compensation as essential ingredients of the benefit package and not just hospitalization expenses. The benefit package may also be expanded to take care of needs of special groups such as elderly who are on long-term medication support through outpatient services, support for children with special needs, people requiring long-term rehabilitation and victims of road traffic accidents.

A study by Ghia C et al. (2023) about equity and access in Indian healthcare through literature searches of various government data basis, websites and articles revealed that Healthcare delivery in India remains inadequate, despite the increasing demand for quality healthcare. While health insurance schemes are available to urban residents and the middle class, the vast rural population of India and people below the poverty line (BPL) are poorly covered by such schemes.

Garg. S et al. (2020) studied the performance of India's national publicly funded health insurance scheme, Pradhan Mantri Jan Arogaya Yojana (PMJAY), in improving access and financial protection for hospital care in Chhattisgarh state.

The study found that enrolment under PMJAY or other Publically Funded Health Insurance (PFHI) schemes did not increase utilization of hospital care in Chhattisgarh. Out-of-Pocket Expenditure (OOPE) and the incidence of Catastrophic Health Expenditure did not decrease with enrolment under PMJAY or other PFHI schemes. The size of OOPE was significantly greater for utilization in the private sector, regardless of enrolment under PMJAY.

The authors concluded that while PMJAY provided a larger vertical cover than earlier PFHI schemes in India, it has not been able to improve access or financial protection in Chhattisgarh. They recommended major changes in how provisioning is organized to achieve progress towards Universal Health Coverage (UHC) goals.

An observational study by Saxena A et al. was undertaken to understand how the processes was put in place to manage hospital-based transactions from time of beneficiary arrival till discharge and how to strengthen them to improve scheme operation. The findings noted that average turn around time for claim reimbursement was 2-6 times higher than that proposed in guidelines and tender and beneficiaries were incurring Out Of Pocket Expenditure (OOPE) while availing service.

They concluded that there was a need to broaden capacity-building efforts from enabling frontline staff to IT platform. There was need to streamline back-end processes to eliminate the causes for delay.

A cross-sectional study by Lonimath. A et al. (2023) for assessing the awareness, coverage, and utilization of the Ayushman Bharath -Arogya Karnataka Scheme through the implementation of the Family Adoption Program among households in Chikkajala village, Benagluru noted that 50.5% of households were aware of the AB-Ark scheme, with ASHA being the most important source of information (63.20%).

19.2% of households were covered under AB-Ark, and 16.8% availed medical services under the scheme in the past year. Significant differences were found between BPL/APL & socioeconomic status of households with or without AB-Ark scheme.

Majority of households were not covered under the scheme, highlighting the need for increased awareness to reduce out-of-pocket expenses. The study emphasized the importance of increasing awareness of the healthcare schemes to reduce out-of-pocket expenses. It suggested that improvements in awareness, coverage, and utilization of the schemes can be assessed in the future professional years based on these findings.

The study noted the importance of increasing awareness of the healthcare schemes to reduce out-of-pocket expenses.

Sharma M et al. (2023) highlighted that out-of-pocket expenditure reduction on healthcare is not up to the mark due to a lack of awareness about the facilities that can be prevailed in the government and empanelled in private hospitals under the schemes.

Knowledge about various characteristics of both the schemes was very less among the population due to less reach of the IEC materials in the villages and on the digital platforms of the state and central governments regarding the information about the schemes. Promotion regarding self and facility registration on the scheme's portal through Community health workers and the government's digital platforms was needed to increase knowledge, awareness and utilization.

A study by Vitsupakorn S et al. (2021) about early experiences of PM-JAY noted that the scheme has increased the annual maximum reimbursement for beneficiary families and removed the cap on family size. The fragmentation of India's health governance where key decisions on service delivery were at the states' discretion which did little to bridge these gaps.

PM-JAY missed the mark on the chronic issue of OOPE, both by excluding outpatient care and failing to monitor the private health sector. The central government should play a proactive role in capacity-building and regulation, not just policymaking. To improve PM-JAY on the quality and efficiency fronts, the Government of India (GoI) should lead more innovatively by promoting Health Technology Assessment (HTA), as well as piloting risk pool consolidation and Health Benefit Package (HBP) expansion. The central and state governments of India must venture beyond the precedents set by Rastriya Swathya Bima Yojana (RSBY) and recognize that PM-JAY has opened up a new policy window altogether.

STUDY OBJECTIVES

- To explore and understand the implementation challenges faced by healthcare providers in delivering services under Ayushman bharat-Arogya Karnataka health scheme in Bengaluru, Karnataka.
- Recommend suggestions for overcoming these challenges.

RESEARCH METHODOLOGY

Study design: A Qualitative study design to uncover new themes and insights that may not have been anticipated initially in quantitative studies and serves as an exploratory tool to better understand the utilization of the scheme.

Source of data and Study setting: Primary data was collected through the interview topic guide to explore the implementation challenges faced by healthcare providers in delivering services under Ayushman bharat-Arogya Karnataka health scheme. The study was conducted at 2 Public and 2 Private tertiary hospitals and at the head office of the SHA at Bengaluru, Karnataka.

Study Period: The study was carried out for a period of 4 months from Mar-2024 to Jul-2024

Sample size determination: The study involved a total of 8 in-depth interviews, conducted in two rounds. In the first round, 4 participants were interviewed, and the data collected was analysed using a thematic approach, revealing new themes. Based on these emerging themes, the topic guides were refined, and additional interviews were conducted. In the second round, 2 more interviews were carried out, and the data from all 6 interviews were analysed using thematic analysis. At this stage, no new themes emerged, indicating that the study had reached saturation. Later to back the findings, 2 State level officials were interviewed. The data was also analysed using the thematic approach, confirming the findings.

Data collection: Based on the objective of the study, a topic guides for conducting IDIs were developed in discussion with research experts and the literature review. Additionally, field notes were recorded to note down the observations and conversations and audios were also recorded with the permission of the participants.

Data collection approach: Permission in the prescribed format was obtained from the participants before data collection. The study was explained to all the participants; Participants were provided written consent and were informed that they could withdraw at any time if they chose not to share information. Data was collected in both English and the regional language Kannada and transcribed to English accordingly. Coding was done to ensure anonymity and data confidentiality.

Recruitment of participants:

To explore the challenges in implementing the AB-ArK scheme, we approached key implementers at the State Health Agency, SAST, as well as Medical Superintendents and Treating Doctors from selected tertiary public and private hospitals. Appropriate permissions and consents were obtained before conducting the interviews.

In-depth interviews were conducted based on a pre-structured topic guide. Interviews were audio recorded and were transcribed as per the reported verbatim. The transcripts were then analysed in Microsoft excel using thematic analysis for emerging patterns and insights leading to conclusions drawn from the analysis results.

Inclusion Criteria:

Healthcare Providers:

- People above 18 years of age

- Health care providers affiliated with healthcare facilities involved in the delivery of healthcare services under the Ayushman Bharat Arogya Karnataka health scheme
- Participants who are willing to provide consent

Exclusion Criteria:

Individuals not directly involved in healthcare service delivery, such as policymakers, researchers, insurance representatives, or patients, unless their perspectives are specifically required for certain aspects of the study.

Data analysis

Excel was used for coding and interpreting the data. From analysis of the data, the following themes were formed: Individual factors, Community factors, health system factors and policy factors. Sub-themes were later grouped under these main constructs.

RESULTS

Characteristics of the study participants

The study included 8 participants with the age range between 40-69 years residing in Bengaluru district. The selected participants were health care professionals working at different levels with various designations as implementers of AB-ArK representing both public and private hospitals. The identities of each participant was coded (PI_HCP_number) to protect anonymity and data confidentiality.

The emerging themes were formed based on participants' answers to questions during the interview. After analysis of 4 broad themes, sub themes were formed. The broad themes were Individual, community, health system and policy factors.

Individual factors affect the use of the AB-ArK scheme and include health literacy, financial stability, and personal health needs. Community factors, such as social norms, support networks, and local resources, influence access to the scheme. Health system factors involve the resources, processes, and personnel within the healthcare system, affecting the scheme's implementation and use. Additionally, policy-level factors, including regulations, funding, and government initiatives, play a crucial role in the scheme's overall functioning and sustainability.

From health care provider perspective, the themes under individual factors were operational challenges, competency in work and lack of incentives to ASHAs. Community factors included lack of awareness among beneficiaries and people who didn't have BPL card but belonged to poor families.

Health system factors were mainly lack of infrastructure and inadequate resources (staffing & training), resources not evenly spread out, Out of Pocket Expenditure (OOPE) as a result of diagnostics and high end drugs being charged by hospitals, challenges with claims portability & referrals, lack of a robust technology system, fraudulent claims and abuse of the system due to lack of stringent monitoring system.

At the policy level the main themes included low rates of Health Benefit Packages/missed out essential treatment packages, out-patient treatment & diagnosis not covered under scheme and private health sector not well-regulated.

Table 1. Themes for limiting factors from health care providers' perspective

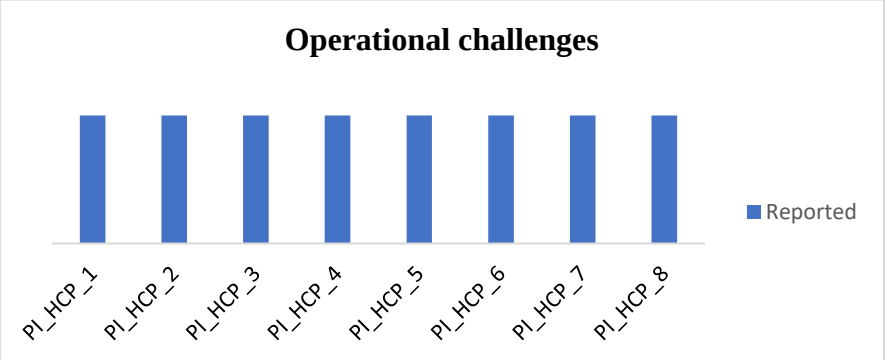
SI.NO.	Individual factors	Community factors	Health system factors	Policy Factors
1.	Operational challenges	Lack of awareness among beneficiaries	Lack of Infrastructure and Inadequate Resources (staffing & training) Resources not evenly spread out	Low rates of Health Benefit Packages/Missed out essential treatment packages
2.	Competency in work	People who don't have BPL card but belong to poor families	OOPE as a result of Diagnostics and high end drugs being charged by hospitals	Out-patient and diagnostic services not covered under scheme
3.	Lack of incentive to ASHAs		Challenges with Claims Portability & Referrals	Private sector not well-regulated
4.			Lack of a Robust technology system	
5.			Fraudulent claims and abuse of the system due to lack of stringent monitoring system	

A. Limiting Factors/Challenges- Individual Level

1. Operational challenges

The health care providers noted a few operational limitations in implementation of the scheme. Due to increased patient load and inadequate resources, the process of preauthorization and claim submission is time consuming. The uploading of preauthorization and claim forms are cumbersome especially for secondary, tertiary cases due to more documents to be up-loaded.

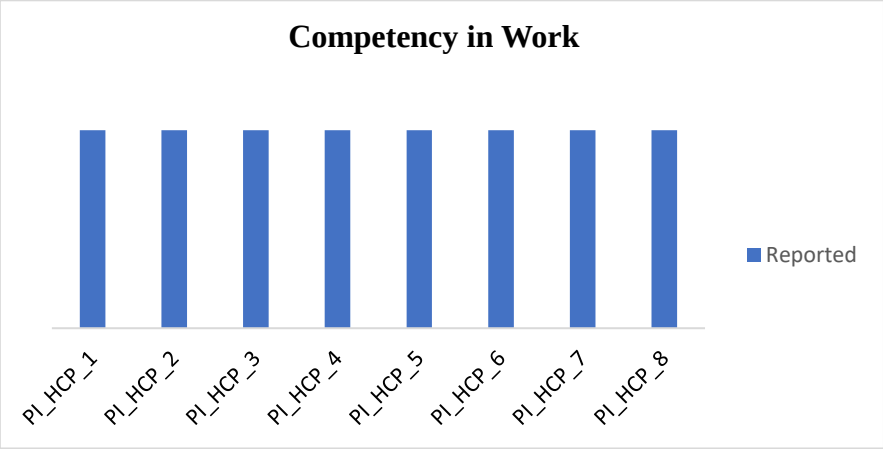
There are no sufficient data entry operators to upload all documents on time, leading to pre-auth/claims rejection. If the pre-authorization process is delayed, the admission of the admission is subsequently delayed leading to inconvenience to the patient.



2. Competency in work

The data entry staff members and Arogya Mitras who enroll the patients and submit preauthorizations and claims are not trained up to the mark. They documented inaccurate or insufficient data, which resulted in the preauthorizations/claims being sent back to the hospital for additional information/documents thereby increasing the turn around time. This may also be due to the overload of claims with less human resources due to which there is erroneous data entry or inadequate documents submitted to SAST for approval.

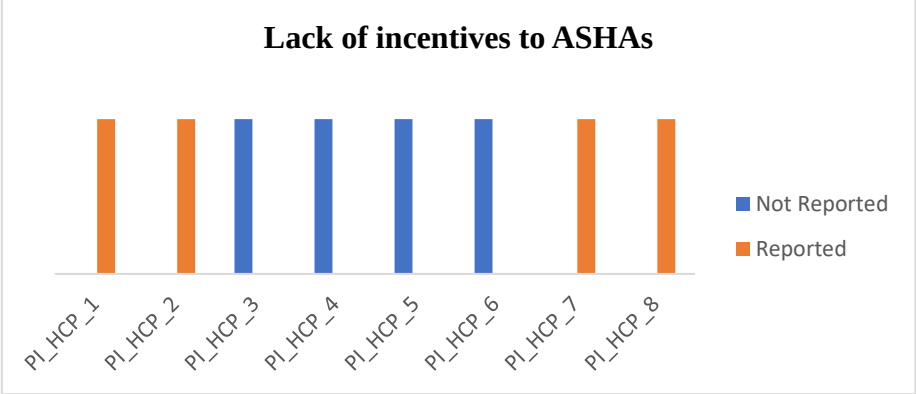
Some of the non- medical staff involved with claims process lack medical knowledge, and hence there was delay in referring them to the right department further delaying the enrolment process.



3. Lack of incentives to ASHAs

The incentive structures for ASHAs are less favorable compared to those in other government health programs, creating a disparity. The absence of adequate incentives can lead to ASHAs feeling demotivated and experiencing low morale. Implementing better incentives for ASHAs could enhance their efficiency and, in turn, boost the community's use and awareness of the Scheme.

Furthermore, ASHAs have reported challenges in the enrolment process and in encouraging the community to participate in the scheme.

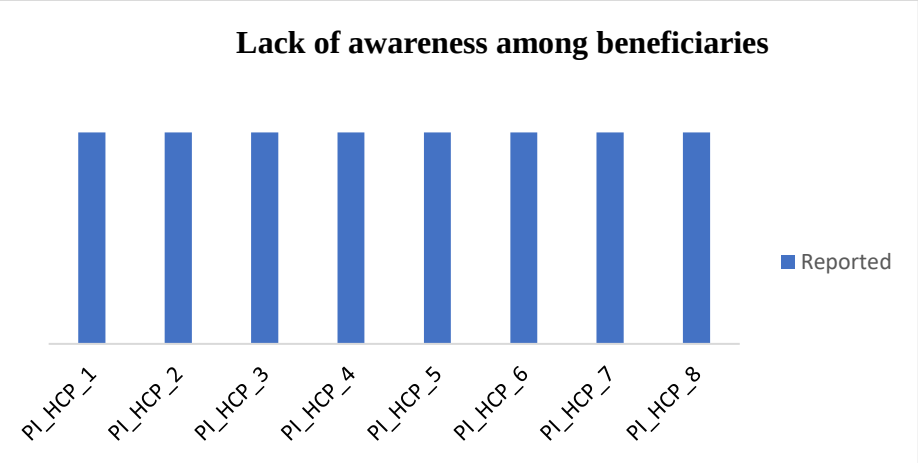


B. Limiting Factors/Challenges Community Level

1. Lack of awareness among beneficiaries

One major problem is that beneficiaries are not aware of the AB-ArK scheme. Many eligible people have limited access to necessary health care because they are ignorant of the benefits of the program and how

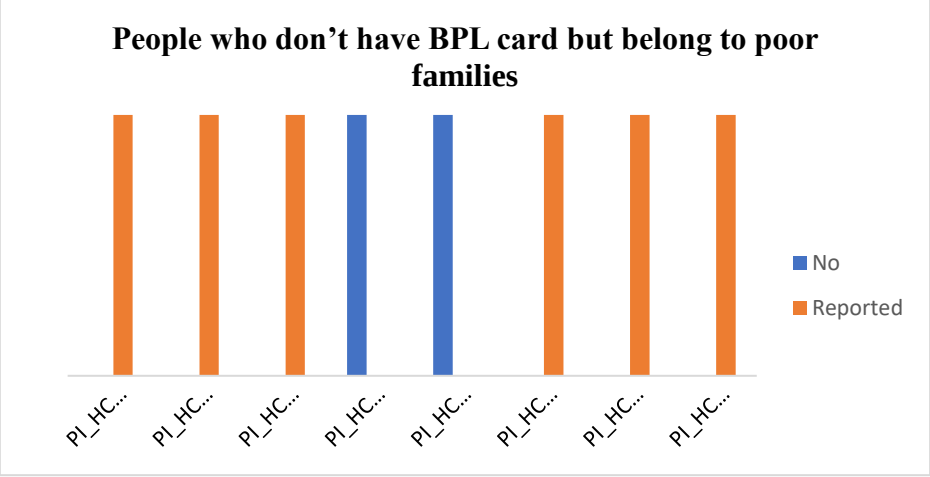
to enrol themselves. Inadequate outreach and communication efforts, particularly in rural and underprivileged regions, are frequently the cause of this awareness gap. It is necessary that this issue be addressed by focused education and community involvement in order to guarantee that all eligible beneficiaries can fully benefit from the program.



2. People who don't have BPL card but belong to poor families

AB-ArK is an UHC scheme where all citizens of Karnataka are covered, based on the BPL/APL status; for BPL patients the scheme is totally cashless where as for APL Beneficiaries, 70 % of the package mount has to be borne by the patient. It was reported that many individuals from poor families, not possessing Below Poverty Line (BPL) cards, face significant financial barriers to accessing healthcare.

These families often fall through the cracks of eligibility criteria, leaving them unable to actually benefit from the scheme. This exclusion can result in delayed or forgone treatments, exacerbating health disparities.



C. Limiting Factors/Challenges -Health system Level

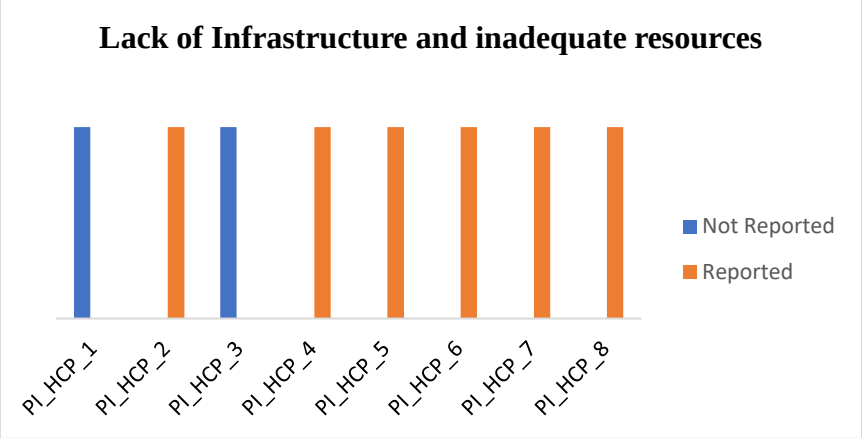
1. Lack of Infrastructure and inadequate resources

The lack of infrastructure and inadequate resources is a critical issue affecting the quality of care, access to services, and overall implementation of the scheme. Most government facilities were under-equipped and understaffed, making it challenging to meet patient needs effectively. The uneven distribution of

resources exacerbates this problem, as some areas, particularly rural and underserved regions, face severe shortages while others are relatively well-supplied. There is shortage of drugs, equipment and diagnostic tools in many government hospitals.

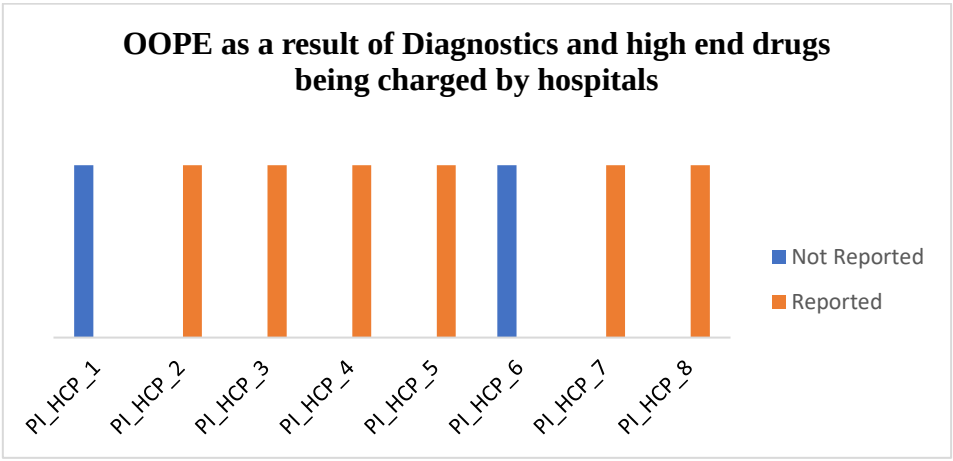
The focus on profit can sometimes lead to cost-cutting measures such as fewer tests or shorter hospital stays in both public and private hospitals leading to compromise in quality of care.

Also, the required training for the staff is not provided making the quality of work sub-standard.



2. OOPE as a result of Diagnostics and high end drugs being charged by hospitals

The high costs of diagnostics and advanced medications are major contributors to out-of-pocket expenditures (OOPE) for patients. These expenses can be overwhelming for many families, particularly those with limited financial resources, often leading to delayed or foregone treatments. This financial burden not only affects the health outcomes of patients but also places a significant strain on their overall well-being. To mitigate this issue, it is essential to improve access to affordable diagnostics and medications through government subsidies, price regulations and insurance coverage, ensuring that all patients can receive the necessary care without facing financial hardship.



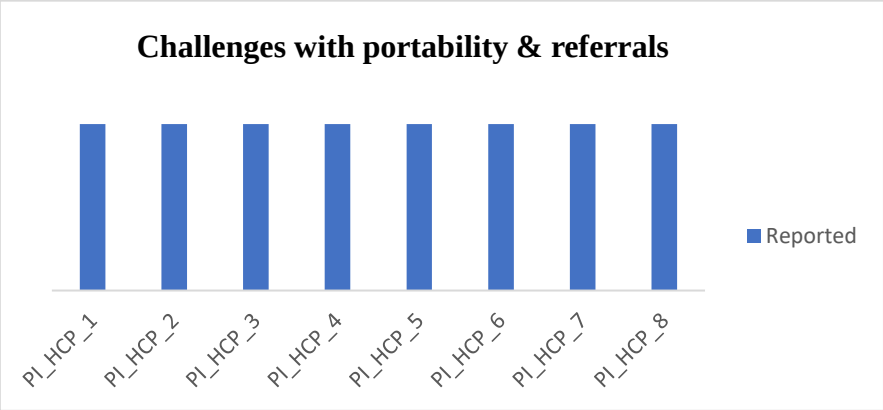
3. Challenges with portability & referrals

The portability cases of PM-JAY have 2 scenarios; one is for the patients who are from Karnataka (BPL card with Karnataka address) seeking treatment outside Karnataka, and those from outside Karnataka seeking treatment in Karnataka. The National portability allows for such patients to be treated under the

portability option of PM-JAY; however the approval process takes weeks and is cumbersome, sometimes with no package codes available as there is a different package utilized by the state versus the PM-JAY package.

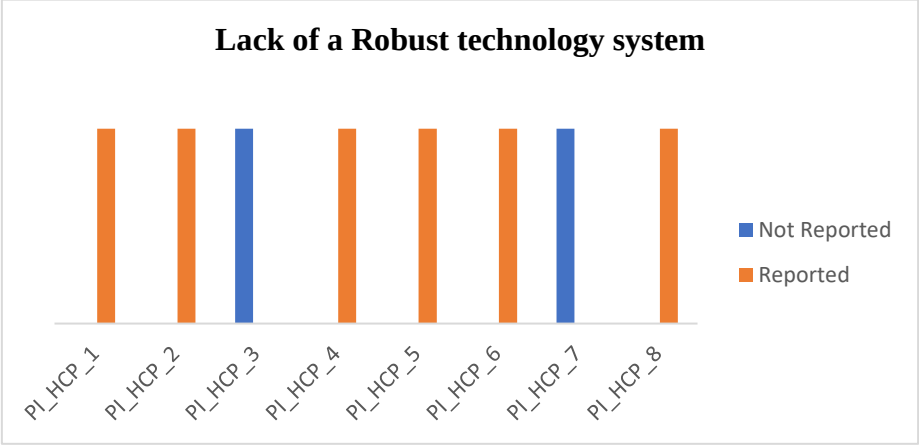
The tickets raised at the NHA level takes a long time to resolve causing inconvenience to the beneficiaries. Also only a few empanelled hospitals provided this service.

Most of the private health care respondents believed that the process of referral for secondary and tertiary cases, which was a gate keeping mechanism to strengthen the public sector, was very inconvenient to the beneficiaries and time-consuming to the hospital. They felt that the beneficiaries should be given the freedom to walk into any of the empanelled hospitals to avail treatment.



4. Lack of a Robust technology system

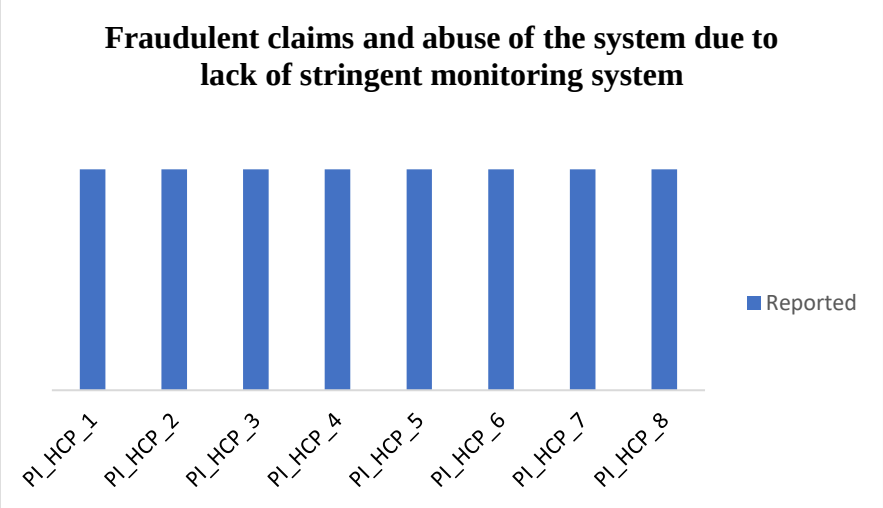
The lack of a robust technology system for AB-ArK is a major concern. There are frequent server and connectivity issues on the online portal causing delays in beneficiaries' enrolment preauthorization and claims process. Without a strong technological framework, the scheme faces challenges in ensuring timely support to patients.



5. Fraudulent claims and abuse of the system due to lack of stringent monitoring system

Random audits have revealed that hospitals cut costs by discharging patients too early and submit claims for more number of days compared to the actual days of patients' admission. Also, there is co-payment by the patient due to the hospitals' claim that a few procedures are not covered under the scheme. The lack of a stringent monitoring system allows for unethical practices, diverting crucial

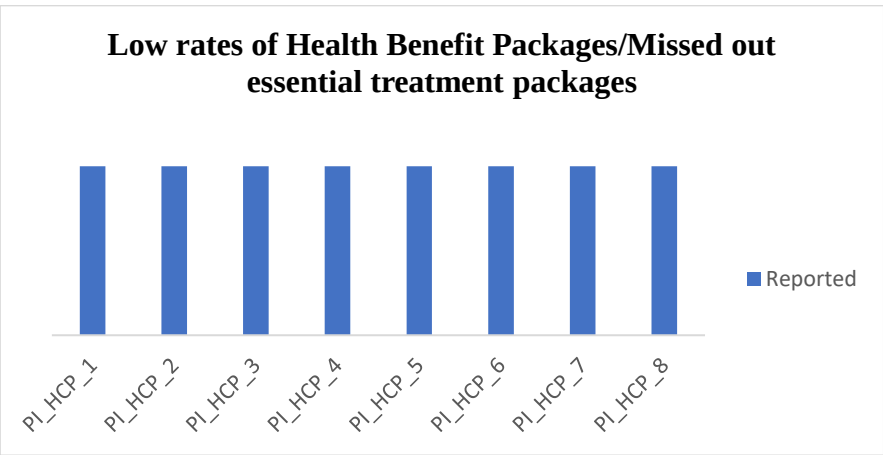
resources away from genuine beneficiaries. These fraudulent activities compromise the integrity of the scheme, leading to financial losses and reducing the overall effectiveness of healthcare delivery.



D. Limiting Factors/Challenges –Policy Level

1. Low rates of Health Benefit Packages/Missed out essential treatment packages

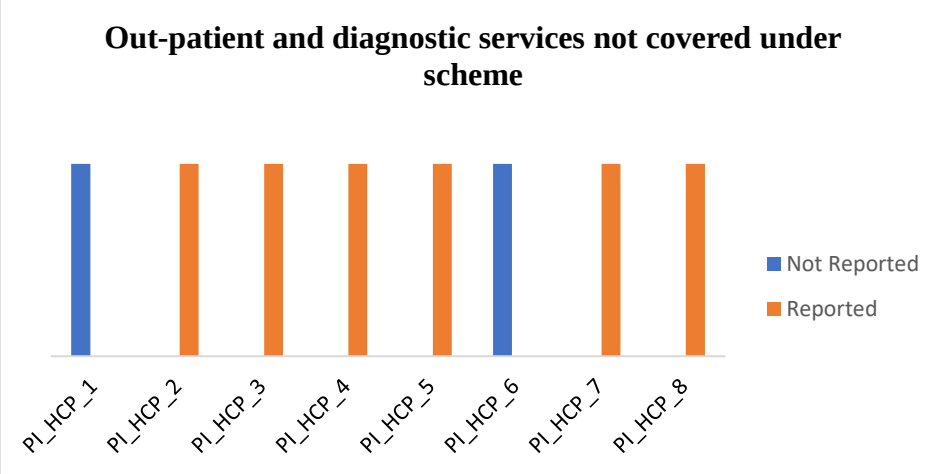
The reimbursement/package rates of AB-ArK are low. The health care providers face a financial burden leading to a compromise on quality treatment. Consequently, hospitals may be hesitant to fully participate in the scheme or renew their empanelment under the scheme. This situation undermines the primary goal of AB-ArK, which is to provide comprehensive and affordable healthcare to the underserved population. Also there is a need for additional procedures to be added to the package as sometimes the eligible patient cannot be covered under the scheme due to non-availability of certain treatment packages.



2. Out-patient and diagnostic services not covered under scheme

AB-Ark is a scheme mainly focussing on in-patient treatment. Patients often rely on out-patient care for preventive treatments, early diagnosis, and management of chronic conditions. Without coverage for these services, many individuals, especially those from low-income families, may delay seeking necessary medical attention due to cost concerns. This delay can lead to the worsening of health conditions,

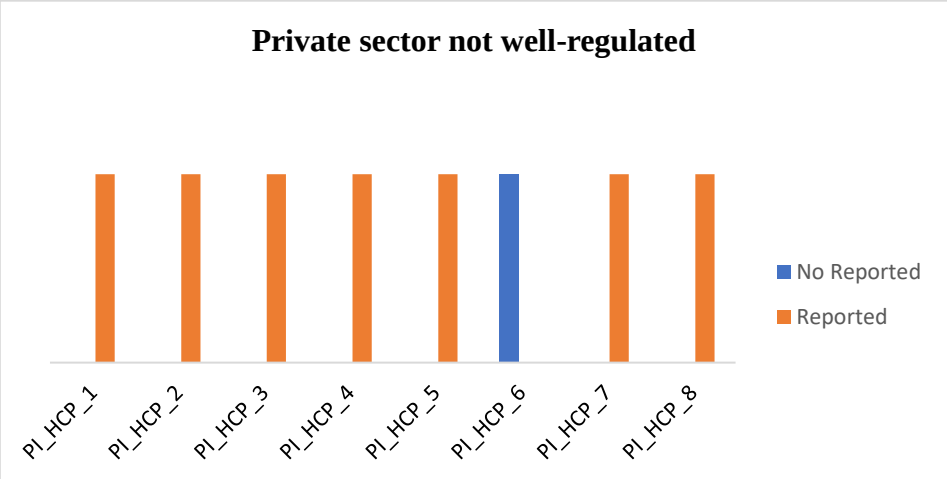
ultimately requiring more extensive and expensive in-patient treatments that could have been avoided with timely out-patient care and diagnostics.



3. Private sector not well-regulated

Although private empanelled hospitals are mandated to provide free treatment to BPL patients under the scheme, much of the private sector is not held accountable, leading to low quality treatment coverage, high OOPE, and financial manipulation of patients.

The beneficiaries could also be overcharged, or there could be fraudulent claims against the scheme, draining its resources.



DISCUSSION

The AB-ArK is a flagship Universal Health Coverage scheme of Karnataka covering both APL and BPL beneficiaries. It is implemented on an assurance mode where the pre-auth and claim settlement is made by the State Heath Authority. The implementation of AB-ArK involves a multi-tiered approach, encompassing identification of beneficiaries, empanelment of hospitals, and seamless integration of services. The scheme leverages technology for beneficiary identification through Aadhaar and BPL-based authentication for claim management and processing. Hospitals across the state are empaneled based on certain quality criteria, ensuring that beneficiaries receive high-standard healthcare services. The

government has also set up a dedicated administrative framework to monitor and manage the scheme effectively.

Despite its ambitious goals, the implementation of AB-ArK faces several challenges. One major challenge is ensuring awareness and accessibility, particularly in rural and remote areas where healthcare infrastructure is often lacking. Another significant issue is the financial sustainability of the scheme, as the high cost of tertiary care can strain the allocated budget. Additionally, ensuring quality of care amidst the increased patient load poses a critical challenge, as does preventing fraudulent claims and abuse of the system. Health providers also face operational challenges, such as delay in reimbursements and maintaining adequate staffing and resources to meet the demand.

Another major drawback of the scheme is the Health Benefit Package which needs to be revised both in terms of increasing the procedure rates and addition of new procedures. This is very imperative for the financial sustainability of the scheme, high-quality treatment and continuation of private hospitals under the scheme.

The scheme does not covering out-patient services, stand-alone diagnostics and high end drugs which is a major hindrance in patients seeking treatment at an early stage of the disease. This would later add on to the health system burden due to more intensive therapy at a later stage. This also leads to Out of Pocket Expenditure (OOPE), especially in private hospitals which are not well regulated.

There are patients who are poor and eligible for 100 % cashless treatment; but due to the non-availability of BPL card, 70% of the package rate have be borne by them adding to their financial burden.

Another notable drawback is the lack of a robust National Portability platform for treating out- of-state patients leading to delay in treatment or missed treatment. The referral process which was designed as a gate keeping mechanism for strengthening public hospitals, and referring complex secondary and tertiary procedures to private hospitals pose great inconvenience to the beneficiaries as well as healthcare providers leading to delay in treatment.

All these factors undermine the very essence of Universal Health Coverage.

CONCLUSION

In conclusion, the Ayushman Bharat-Arogya Karnataka (AB-ArK) health scheme faces significant implementation challenges that impede its effectiveness. Operational challenges include a lack of awareness among beneficiaries, inadequate infrastructure, and insufficient resources such as staffing and training. Additionally, resources are unevenly distributed, and the low rates of Health Benefit Packages, along with missed essential treatment packages, further complicate service delivery.

The beneficiaries incur out-of-pocket expenses due to reasons like exclusion of poor families without BPL cards, diagnostics and high-end drugs not covered under the scheme. The absence of coverage for outpatient services exacerbates these financial burdens.

The scheme also struggles with a lack of incentives for ASHAs (Accredited Social Health Activists), difficulties with claims portability and referrals, and inadequate regulation of the private sector. The absence of a robust technology system hinders efficient operations and data management.

The scheme is also vulnerable to fraudulent claims and system abuse, attributed to the lack of stringent monitoring mechanisms. Addressing these diverse challenges requires comprehensive policy adjustments, improved resource allocation, continuous monitoring, enhanced beneficiary awareness, stakeholder engagement and robust regulatory & technological frameworks to ensure the scheme's success and sustainability.

RECOMMENDATIONS

Addressing these challenges requires a multifaceted approach, including better regulation and monitoring, increased funding and resource allocation, improved infrastructure and training, and enhanced coordination between private and public healthcare providers. Ensuring equitable access to quality healthcare under AB-ArK will require concerted efforts from both the government and private sector stakeholders.

To enhance the implementation of the AB-ArK health scheme, it is recommended to incorporate Below Poverty Line (BPL) and migrant status into the Socio-Economic Caste Census (SECC) criteria for identifying beneficiaries.

Organizing community events and localizing Information, Education, and Communication (IEC) campaigns using social media and other digital platforms to amplify communication will raise awareness about the AB-ArK health scheme.

Piloting outpatient coverage, inclusion of stand-alone diagnostics tests under the scheme would help in early detection and prevention of diseases.

Mindful allocation of funds must be done to upgrade healthcare facilities with modern medical equipment, expanding physical space, and ensuring reliable internet/server connectivity to ensure delivery of quality care. Merging various insurance schemes into a single pool to increase risk-sharing can reduce administrative overhead.

Leveraging Health Technology Assessment for evidence-based decision-making in revising the Health Benefit Packages and for optimized healthcare delivery is the need of the hour.

Integrating and streamlining the referral process between Health and Wellness Centers (HWC) and AB-ArK facilities, and creating a unified health information system by integrating public and private health databases would strengthen the existing health system.

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