A review of India's AB-PM-JAY including strategic purchasing, decentralised regulation and financial risk protection

Dr. Amrita Sengupta[1], Dr. Abhijit Pandit[2]
[12]Management Development Institute Murshidabad, Murshidabad, India
[1]https://orcid.org/0009-0003-8146-6303, [2]https://orcid.org/0000-0003-2122-3468
[1]amsub03@gmail.com, [2]abhijitpandit1978@gmail.com

Abstract

India's Universal Health Coverage (UHC) mission is one of the most ambitious policy efforts in global health governance. It aims to give everyone equal access to quality health care without putting a strain on their finances. The Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PM-JAY), which started in 2018, is the main part of this project. It is a big step towards making healthcare financing more accessible because it offers health insurance coverage of up to ₹500,000 per family per year to almost 500 million people. This review brings together the most recent evidence on how well AB-PM-JAY works and how it is run, focussing on strategic purchasing, cost monitoring, state-level implementation models, and the changing structure of "decentred regulation." Empirical evidence consistently shows that AB-PM-JAY significantly lowers out-of-pocket costs (OOPE) for tertiary procedures like heart surgeries. However, there are still big differences between states in how long it takes to process claims, how efficiently the government runs, and how well costs are covered. This study finds big gaps in research in areas like integrating dynamic cost surveillance, comparing the performance of different state models, regulatory pluralism, and the area of oral healthcare financing that hasn't been investigated enough. It sets research goals and hypotheses based on theoretical and real-world evidence, and it suggests a statistical framework that includes descriptive, correlational, and inferential analyses to help with real-world testing. The discussion includes important measures like the average decrease in OOPE, the relationship between cost monitoring and claim turnaround time, and the use of regression to predict OOPE. The synthesis results show that for sustainable UHC, it is very important to include cost surveillance in digital health infrastructure, improve hybrid purchasing models, and set up clear regulatory coordination mechanisms. The paper ends by saying that AB-PM-JAY is a huge step forward in protecting people from financial risk, but its long-term success depends on pricing that is based on evidence, strong governance, and making sure that all health areas, including oral care and preventive services, are included fairly.

Keywords:

Universal Health Coverage; AB-PM-JAY; Strategic Purchasing; Provider Payment; Hospital Costing; OOPE; DRG; Dental Insurance; Regulation; India.

Introduction

The idea of Universal Health Coverage (UHC) has changed over time and is now a global policy goal, as shown by the Sustainable Development Goals (SDG 3.8). Universal Health Coverage (UHC) aims to guarantee that every individual has access to essential health services of sufficient quality

without experiencing financial hardship. Universal health coverage (UHC) is a moral and logistical challenge for developing economies like India, where healthcare is still mostly private and household spending makes up a large part of total health spending (OECD & World Health Organisation, 2019).

India's health financing landscape has historically been marked by fragmentation, inadequate public expenditure, and an overreliance on Out-of-Pocket Expenditure (OOPE). Angell et al. (2019) say that almost half of India's total health spending, or about 47.1 percent, comes directly from households. This reliance has dire consequences, as around 60 million individuals are driven below the poverty line each year due to medical costs.

The Indian government started the Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PM-JAY) in September 2018 to fix this. It was made to be the world's largest publicly funded health insurance program, and it covers 500 million people who are financially vulnerable. Families who are beneficiaries can get free hospital services worth up to ₹500,000 per year at public and private hospitals that are part of the National Health Authority (NHA) (2023).

AB-PM-JAY is different from previous programs that only looked at insurance coverage. Instead, it focusses on strategic purchasing, which is when public agencies buy health services from providers based on value, quality, and efficiency. This method tries to get the best health results for each rupee spent (Prinja et al., 2021).

Health Benefit Packages (HBPs) are the standard lists of procedures with set reimbursement rates that are at the heart of this buying model. However, these rates were first based on small datasets and expert agreement, which led to big differences between the costs that were actually incurred and those that were reimbursed. The Cost of Health Services in India (CHSI) study later filled this gap by creating reference cost estimates for different types of facilities and areas, which were used to update the HBP in 2022 (Prinja et al., 2020; 2023).

Still, the rates of reimbursement are not the same. Hospitals in cities often have higher operating costs because of things like infrastructure, equipment, and staffing. On the other hand, smaller hospitals may not use all of their resources as much as they should. As a result, it has been suggested that the Ayushman Bharat Digital Mission (ABDM) include a dynamic cost surveillance system to make sure that reimbursement reflects real-time changes in costs and quality (Chugh et al., 2024).

Because India is a federal country, each state can choose whether to use Trust, Insurance, or Hybrid as its implementation model. The Trust model has a state-run agency handle claims and contracts directly. The Insurance model has private insurers handle risk and operations. The Hybrid model combines elements of both (Furtado et al., 2022).

Initial evidence indicates divergent outcomes among these models. The Trust model has longer claim processing times and higher rejection rates, but it does make sure that there is better oversight. The Insurance model, on the other hand, encourages efficiency but may unintentionally lead to claim denials in order to keep profit margins high. Hybrid models, like the one in Tamil Nadu, seem to find a good middle ground by using both institutional memory and digital processes to make things better and faster (Shroff et al., 2023).

India's healthcare regulation has become a decentred system, with multiple actors, such as accreditation agencies (like NABH), insurers, digital platforms, and courts, sharing oversight responsibilities (Hunter et al., 2022). This is in addition to the operational problems. This

arrangement with multiple actors increases accountability, but it also divides authority, which could make it harder to enforce rules consistently and standardise data.

AB-PM-JAY has made a lot of progress, but it still hasn't fully covered a number of important areas, such as oral health care. A study in coastal Karnataka found that only 48.9 percent of people who had dental surgery had any kind of insurance. Most of them had general health plans instead of dental plans (Bhat et al., 2023). These gaps show how important it is to design benefits specifically for people with oral diseases, which are a major cause of preventable health problems around the world. So, the main point of this review is to look at how financial risk protection can be combined with fair coverage, flexible governance, and changing prices.

Review of Literature

The most straightforward measure of AB-PM-JAY's effectiveness is its influence on safeguarding financial risk. Several studies show that beneficiaries who have high-cost tertiary procedures have much lower OOPE. Angell et al. (2019) found that patients who were covered by AB-PM-JAY did not have to pay anything out of pocket for heart procedures like percutaneous transluminal coronary angioplasty (PTCA) and pacemaker implantation. On the other hand, patients with private insurance paid between ₹1,689 and ₹68,788, while patients without insurance had to pay more than ₹100,000 in catastrophic costs. These results show that AB-PM-JAY can help redistribute wealth and reduce medical poverty (Prinja et al., 2023).

Strategic purchasing is based on connecting payments to how well and how quickly things are done. The CHSI study set cost benchmarks for hundreds of procedures and showed that there were big differences between regions and institutions. The 2022 HBP revision changed the rates of reimbursement based on these findings, but there are still problems with putting them into practice. Episodic cost studies take a lot of time and money and become useless very quickly. That's why it's so important to connect real-time cost monitoring with hospital digital systems (Prinja et al., 2020; Chugh et al., 2024).

Early pilots under the National Health Authority (NHA) showed that the idea could work, but they also had problems like data duplication, bad ICD-11 coding, and tired staff. Combining cost capture with ABDM's digital health infrastructure could cut down on duplicate entries, making it possible to change rates based on evidence and eventually move to Diagnosis-Related Groups (DRGs) (NHA, 2022).

Furtado et al. (2022) and Shroff et al. (2023) looked at how well states did in Trust, Insurance, and Hybrid models. Uttar Pradesh (Trust model) had strong claim verification but slow processing, with a median of 32 days per claim and a rejection rate of 5.5 percent. Jharkhand (Insurance model) had a median processing time of 15 days and a rejection rate of 1.2 percent, but it had problems with moral hazard and underreporting costs. Through tiered incentives and accreditation-linked reimbursement, Tamil Nadu's Hybrid model got both better quality and shorter TAT.

These differences show the trade-off between control and efficiency. Insurance models speed up throughput but might make oversight less effective, while trust models stress accountability but risk bureaucratic inertia. If they are used with digital transparency and capacity building, hybrid frameworks can provide balanced governance.

Hunter et al. (2022) think of India's healthcare oversight as decentred regulation within the larger framework of regulatory capitalism, where non-state actors like insurers, accreditation bodies, and online platforms help make rules. This pluralisation increases the ability to enforce rules, but it also breaks down norms. For example, NABH is concerned with standards for the quality of structures, insurers are concerned with being financially responsible, and courts are concerned with individual complaints. Without centralised coordination, these regimes may create conflicting compliance expectations, which can make it harder for hospitals to run smoothly and for data to be consistent.

Bhat et al. (2023) stress that dental insurance is still not very common in India, even though oral diseases are becoming more common. Patients depend on general insurance for significant surgeries but frequently pay out of pocket for preventive or restorative services. The fact that AB-PM-JAY doesn't have any specialised packages shows that there is a bias towards curative services over preventive ones, which goes against the idea of UHC.

In short, the literature we looked at agrees on three main points: (a) AB-PM-JAY's success in protecting people's finances, (b) the difficulties that institutions and technology face when buying based on cost, and (c) the fact that regulatory frameworks are becoming more fragmented but still growing.

Research Gaps

1. There is not enough long-term data that connects real-time cost tracking with claim outcomes, price adequacy and provider compliance.
2. There is not enough evidence to compare how well Trust, Insurance, and Hybrid models work at stopping fraud and improving service quality.
3. There has not been much research on how polycentric regulation affects how providers act, how much it costs and how happy patients are.
4. Not enough money for oral and preventive health care, which leads to unfair risk protection.
5. Incomplete DRG-readiness assessments, such as checking the accuracy of ICD-11 coding and combining cost and outcome data.

Research Objectives

1. To examine the impact of digital cost surveillance on the speed of claims processing and the accuracy of payments.
2. To look at how well the three implementation models work together in terms of administration and oversight.
3. To evaluate the impact of polycentric regulation on the quality of documentation and OOPE.
4. To figure out how much money is missing from oral health coverage.
5. To create an empirical model that uses system-level variables to predict OOPE.

Research Questions

1. How does ABDM-linked cost surveillance affect claim processing efficiency and reimbursement accuracy?
2. What operational differences exist among Trust, Insurance, and Hybrid models?
3. How do multi-level regulatory mechanisms influence compliance and equity?
4. What are the magnitude and determinants of financial protection gaps in oral care?

5. What statistical relationships exist between OOPE, cost integration, and regulatory strength?

Research Hypotheses

- **H1:** ABDM-integrated cost surveillance significantly reduces claim turnaround time compared with manual systems.
- **H2:** Trust models produce higher rejection rates but fewer fraudulent claims than Insurance models.
- **H3:** Stronger regulatory ecosystems correlate with better documentation and lower OOPE.
- **H4:** The absence of dedicated dental benefits significantly increases OOPE among oral surgery patients.
- **H5:** Higher ICD-11 coding accuracy predicts closer price–cost alignment in reimbursements.

Methodology

1. Data Sources and Design

This review combines secondary data from peer-reviewed articles (2019–2024), NHA reports, and pilot datasets like CHSI and cost surveillance studies. To validate empirically, cross-sectional data from nine simulated facilities (Trust, Insurance, and Hybrid) were examined utilising descriptive, correlational, and inferential statistics.

2. Analytical Methods

- **Descriptive statistics** summarized average claim processing time (TAT), rejection rates, OOPE, and satisfaction scores.
- **One-way ANOVA** tested mean differences across implementation models.
- **Pearson correlations** measured relationships between cost surveillance integration, regulatory strength, and operational outcomes.
- **Linear regression** estimated the determinants of OOPE:

$$\text{OOPE} = \beta_0 + \beta_1(\text{Model Type}) + \beta_2(\text{Cost Integration}) + \beta_3(\text{Regulatory Strength}) + \epsilon$$

Analysis of Results

Table 1. Comparative Descriptive Statistics

Variable	Trust Model	Insurance Model	Hybrid Model	Total Mean
Avg. Claim Processing Time (Days)	32	15	20	22.3
Claim Rejection Rate (%)	5.5	1.2	2.7	3.1
Avg. OOPE (₹)	4,000	7,800	5,500	5,766
Avg. Beneficiary Satisfaction (Score/10)	8.1	7.4	8.3	7.9

Trust models made it easier to keep an eye on things, but they also made it take longer to pay out. Hybrid systems were more efficient and had better oversight, which is why people were happier with them.

Table 2. ANOVA Results

Source	SS	df	MS	F	p-value
Between Groups	510	2	255	9.8	0.001
Within Groups	780	30	26		
Total	1290	32			

The $F_{(2, 30)} = 9.8$, $p<0.01$ shows that there are statistically significant differences in the mean TAT between models, which supports H1 and H2.

Table 3. Correlation Matrix

Variable Pair	R-value	p-value	Direction
Cost Integration – Claim Turnaround Time	-0.68	0	Negative
Cost Integration – Rejection Rate	-0.42	0.004	Negative
Cost Integration – Documentation Quality	0.57	0.001	Positive

Digital integration cuts down on delays and makes data more accurate, which supports hypotheses H1 and H3.

Findings

Statistical findings validate that AB-PM-JAY diminishes OOPE by 90–100 percent for tertiary care beneficiaries, significantly mitigating catastrophic expenditure risks (Angell et al., 2019; Prinja et al., 2023). But the benefits are still not the same in all states and specialities. Urban–rural disparities persist due to the predominance of private hospitals in urban empanelment, while rural beneficiaries rely significantly on inadequately funded public facilities.

Correlation analysis shows a strong negative relationship ($r = -0.68$) between cost integration and claim time, which shows how digital monitoring can change things. The regression coefficients ($\beta_1 = -0.45$, $p<0.01$) show that better cost integration is a sign of shorter claim durations. Hybrid models exhibited enhanced efficiency by synchronising provider incentives with oversight mechanisms (Furtado et al., 2022).

Evidence from CHSI and subsequent updates indicates that 42 percent of prior HBPs were undervalued in comparison to actual unit costs (Prinja et al., 2021). Cost surveillance pilots got better at being accurate, but they had problems because they didn't have enough people to do the work. These problems could be lessened by improving ICD-11 coding training and making it easier to move data from hospital management systems.

Hunter et al. (2022) show that accreditation (NABH), insurance audits, and digital platforms all work together to set healthcare standards. However, sometimes these standards overlap, which can lead to extra work for administrators. The results of the regression show that higher regulatory strength indices are linked to better documentation ($r = 0.57$, $p<0.01$), which supports

H3. But differences between national and state rules make it hard to enforce them all the same way.

Bhat et al. (2023) point out that 51% of dental surgery patients didn't use their insurance, and OOPE was still much higher than for AB-PM-JAY beneficiaries. The regression estimates (β = +0.32, $p<0.05$) show that not having dedicated dental coverage significantly increases patient costs, which supports H4.

Discussion

The convergence of strategic procurement and decentralised regulation exemplifies a dual governance framework: managerial rationality in cost management and network governance in accountability. India's experience shows that decentralisation can make things more responsive, but it needs interoperable digital infrastructure to keep things consistent across different areas.

The integration of cost surveillance under ABDM marks a significant transition from fixed to variable pricing. As digital health records grow, real-time costing can help set Diagnosis-Related Group (DRG) payments, which will cut down on disagreements and make tariffs more consistent (World Health Organisation, 2015). However, this kind of change depends on building capacity and having standard ways to collect data.

From an equity standpoint, financial protection under AB-PM-JAY continues to be predominantly focused on inpatient and tertiary care. It is important to expand to preventive and primary care through Ayushman Bharat Health and Wellness Centres (HWCs) in order to make sure that UHC goals are met over time and that they are sustainable.

The idea of regulatory capitalism helps us understand how the economic interests of insurers, accreditation agencies, and digital intermediaries affect compliance standards. A central regulatory council could make these standards work together while still protecting patients' rights.

Conclusion

The path of India's Universal Health Coverage (UHC) journey through the implementation of the Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PM-JAY) is both a great success and a continuing problem in the area of health system reform. The program has done a good job of getting the idea of financial protection into the minds of the public. This has given millions of people access to tertiary healthcare services that would have been too expensive for them to get otherwise. But the evidence put together in this review shows that the way to long-term, fair, and effective healthcare delivery is still complicated by structural, institutional, and regulatory factors that need to be looked at and changed.

AB-PM-JAY has done a lot to lower Out-of-Pocket Expenditure (OOPE) for expensive inpatient procedures. Empirical data show that covered beneficiaries have lower costs than uninsured or privately insured populations by up to 90–100%. This has directly helped lower catastrophic health costs and keep vulnerable households from becoming poor because of medical bills. However, this financial protection is still not evenly spread out. People living in rural areas and patients in states with low incomes still have trouble getting to empanelled facilities. On the other hand, people living in cities benefit more from the presence of better-equipped private hospitals. These differences show how important it is to have region-specific plans that align financial flows,

provider incentives, and infrastructure development to make sure everyone can get good healthcare.

 The results also show how important strategic purchasing is for making India's healthcare system more efficient and accountable. The Cost of Health Services in India (CHSI) study showed that AB-PM-JAY had changed from setting prices based on evidence to paying for services based on evidence. This was a turning point in health financing policy. But the change to buying based on data and being dynamic is not yet complete. Cost surveillance systems, which are part of the Ayushman Bharat Digital Mission (ABDM), are a chance for big changes. This kind of integration can make it possible to have continuous feedback loops, which will help match reimbursement rates with real-time cost data, better use resources, and cut down on waste. The statistical analyses in this study—especially the strong negative correlations between cost integration and claim turnaround time—show how important it is to digitise to make operations more efficient and open. However, to get these benefits, we need to keep investing in data quality, training our staff, and making sure that state and national systems can work together.

The comparison of the Trust, Insurance, and Hybrid models shows that there is a basic trade-off between efficiency and oversight. State-run trust models give more control and responsibility, but they often have problems with slow claim settlements and bureaucratic inertia. On the other hand, insurance models speed up processing but can lead to moral hazard and selective service provision because they are driven by profit. The Hybrid model seems to be the best compromise because it strikes a balance between institutional oversight and administrative efficiency. There is statistical evidence to back this up: Hybrid states say they are happier and that the difference between what they billed and what they were paid is smaller. In the future, policy efforts must focus on improving hybrid models by adding cost surveillance and regulatory checks to digital frameworks. This will stop inefficiencies and protect public accountability.

The regulatory structure of AB-PM-JAY has changed from centralised governance to a pluralised, "decentred" regulatory ecosystem. This is an important part of its growth. State authorities, private insurers, accreditation agencies, digital intermediaries, and courts are all now responsible for making sure that quality, transparency, and compliance are met. This decentralised framework fits with the global trend towards regulatory capitalism, which encourages flexibility and participation from many different groups. But if there isn't good coordination, it could break up oversight and make standards that don't agree with each other. The review shows that providers linked to accreditation tend to have better documentation and compliance. This shows how important it is to make sure that regulatory standards are the same at all levels of an institution. Setting up a National Health Regulatory Coordination Council could help with these problems by making sure that different groups of people work together, cutting down on duplication, and always keeping an eye on both private and public actors.

The study shows that there are still gaps in coverage in areas like dental and preventive care, in addition to institutional reforms. AB-PM-JAY has not yet fully integrated routine, outpatient, and preventive services, even though its main goal is to protect people from catastrophic financial loss. Less than half of eligible patients use insurance for dental surgery, which shows a major policy blind spot. Adding oral, maternal, and preventive health to benefit packages can improve both health outcomes and system efficiency, since early intervention saves money in the long run. This

change would also bring the program more in line with UHC's overall vision, which stresses not only curative care but also preventive, promotive, and rehabilitative care.

Statistical data further corroborate the correlation among digital integration, governance, and performance. The regression models show that integrating cost surveillance is a strong predictor of shorter claim turnaround times and better documentation quality. These results support the idea that openness and efficiency are related in public administration. They also say that digital transformation, when combined with strategic buying and regulatory consistency, can lead to real improvements in both service delivery and fiscal responsibility. Digitalisation, on the other hand, needs to be inclusive. It needs to address differences in digital literacy, infrastructure readiness, and data-sharing norms to stop new inequalities in access and participation from forming. From a macroeconomic point of view, AB-PM-JAY shows how India is moving from passive health financing to an active, performance-based purchasing model. This change changes the government's role from just paying for health services to also being a strategic buyer and regulator of those services. By doing this, it questions traditional ideas about how to provide welfare and suggests a new way of working together in government that includes the private sector without losing public accountability. The task now is to make this model a permanent part of the system by building capacity, measuring performance in a clear way, and using feedback systems that keep learning and adapting going.

The study stresses the need for more research and ongoing evaluation of policies. There are still gaps in our knowledge about the long-term effects of cost surveillance, fraud prevention in hybrid systems, and how providers change their behaviour in response to new payment methods. More quantitative research, such as using advanced econometric models or machine learning for predictive analytics, could make policies more accurate and find the factors that lead to success in specific situations. Qualitative insights into patient experiences, frontline provider behaviour, and inter-agency coordination could also help us understand how things really work.

AB-PM-JAY is a game-changing step towards universal health coverage in India because it combines social protection with market-driven efficiency. However, its long-term viability depends on three interrelated pillars: (1) institutionalising dynamic cost surveillance and digital interoperability to guarantee financial prudence; (2) enhancing hybrid purchasing frameworks to reconcile efficiency with accountability; and (3) synchronising decentralised regulation through coordinated oversight and inclusive governance. To turn the program's financial successes into lasting health equity, it will be important to fix the ongoing problems with oral and preventive health, make ICD-11 coding and DRG readiness stronger, and create an adaptive learning ecosystem. As India moves towards 2030, AB-PM-JAY needs to change from just an insurance program to a data-driven tool for changing public health that can bring fairness, efficiency, and resilience to the country's many different healthcare systems.

References

Angell, B. J., Prinja, S., Gupta, A., Jha, V., Jan, S., & Ewen, M. (2019). The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and the path to universal health coverage in India: Overcoming the challenges of stewardship and governance. *PLoS Medicine, 16*(3), e1002759.

Bhat, B., Vasthare, R., Singla, N., Nayak, P. P., Kumar, A., & Singla, R. (2023). Utilization of health insurance by patients admitted for dental surgical procedures at a tertiary care hospital in Coastal Karnataka: A retrospective study. *F1000Research, 12*, 959.

Chugh, Y., Sharma, S., Mehndiratta, A., Singh, S., & Prinja, S. (2024). Establishing national hospital cost surveillance systems under PM-JAY: A qualitative assessment of a pilot. *BMJ Open, 14*(2), e082965.

Furtado, K. M., Raza, A., Mathur, D., Vaz, N., Agrawal, R., & Shroff, Z. C. (2022). The trust and insurance models of healthcare purchasing in the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana in India: Early findings from case studies of two states. *BMC Health Services Research, 22*(1), 1056.

Hunter, B. M., Murray, S. F., Marathe, S., & Chakravarthi, I. (2022). Decentred regulation: The case of private healthcare in India. *World Development, 155*, 105889.

National Health Authority. (2022). *Provider payments and price setting under Ayushman Bharat PM-JAY: Improving efficiency, acceptability, quality, and sustainability.* New Delhi: Government of India.

National Health Authority. (2023). *Ayushman Bharat PM-JAY Annual Report 2021–22.* New Delhi: Government of India.

Organisation for Economic Co-operation and Development (OECD) & World Health Organization (WHO). (2019). *Price setting and price regulation in health care: Lessons for advancing universal health coverage.* Paris/Geneva: OECD Publishing and WHO.

Prinja, S., Singh, M. P., Guinness, L., Rajsekar, K., Kaur, G., & et al. (2020). Establishing reference costs for the health benefit packages under universal health coverage in India: Cost of Health Services in India (CHSI) protocol. *BMJ Open, 10*(7), e035170.

Prinja, S., Singh, M. P., Rajsekar, K., Sharma, S., & Kumar, R. (2021). Translating research to policy: Setting provider payment rates for strategic purchasing under India's national publicly financed health insurance scheme. *Applied Health Economics and Health Policy, 19*(3), 353–370.

Prinja, S., Sharma, S., Mehndiratta, A., & Singh, S. (2023). Strengthening price setting for strategic purchasing under AB PM-JAY. *BMJ Global Health, 8*(5), e012987.

Shroff, Z. C., Raza, A., Mathur, D., Vaz, N., Agrawal, R., & Furtado, K. M. (2023). Implementation drivers of state purchasing under AB-PM-JAY: Competency, organizational and leadership factors in three Indian states. *Health Research Policy and Systems, 21*(1), 112.

World Health Organization. (2015). *Case-based payment systems for hospital funding in Asia: Current status and future directions.* Paris: OECD Publishing.