



The Lancet Global Health
Commission on

**Financing Primary
Health Care**

SCOPING REPORT

Financing Primary Health Care in India

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2021

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Executive summary

This report provides an assessment of the role of financing to realise India's Primary Health Care (PHC) ambitions. It was undertaken for the Lancet Commission on Financing Primary Health Care, which aims to generate evidence-based, actionable policy recommendations on how countries can use health financing tools to improve efficiency and equity of PHC. The report is part of a set of country case studies that present empirical evidence on arrangements for financing PHC, drawing on published and unpublished literature, policy documents, surveys and census data. The other study countries are Brazil, Chile, China, Ethiopia and the Philippines.

The report is organised as follows: Chapter 1 and 2 provide, respectively, an overview of the how the primary health care system in India is organised, and health expenditure at all India level. Chapter 3 describes the mechanisms for resource mobilisation and allocations for primary health care – more specifically, it describes the sources of revenue, financial flows and resource allocation in primary health care system in India. Chapter 4 looks at the how primary health care providers are funded and financial and non-financial incentives that have been introduced at various levels and the degree of autonomy that local /regional governments have to implement innovative provider payment systems. Chapter 5 looks at the scope for financing digital health services and challenges in the implementation of digital health. In the light of the insights gained from the above analysis, the report concludes with a proposal for an in-depth assessment of specific policy instruments that the Centre have to influence states' spending on primary health care, in the context of a few states.

PHC system in India

The National Health Mission (NHM) in India, which brings together the National Rural Health Mission and the National Urban Health Mission, is the country's flagship public health program that aims to provide effective primary health care (PHC) to all citizens and to increase public spending on health. With an initial focus on reaching rural, underserved populations, the NHM has resulted in increased funding at the lower levels of the PHC system and greater provision of PHC through Health and Wellness Centres, culminating in a reduction in inequality in health spending and service coverage between states. The current national health policy aims to expand the number of Health and Wellness Centres in the country as a means of providing comprehensive PHC with linkages to secondary and tertiary facilities.

However, tax-funded public outpatient facilities in India account for only 30% of the total number of facilities, with the majority of PHC provided by the private sector and paid for through out-of-pocket payments by households.

Health expenditure

In 2016/17, the Total Health Expenditure for India was 3.8% of GDP. The largest source of financing for health was household out-of-pocket expenditure at 63.2%. Government revenue, from both the central and state level, accounted for 32% of Total Health Expenditure. National Health Account estimates for the same period show that the proportion of government health expenditure allocated to primary health care was 45.2%.

Resource mobilisation and allocation

Despite being a central component of the current national government's PHC policy, the

allocation of funding towards Health and Wellness Centres is low, comprising just 3% of the total NHM budget. The weak capacity of states to absorb resources, and long delays in the transfer of resources from the centre to state treasuries, has resulted in a large proportion of unspent funds.

Purchasing

Health workers operating at publicly funded PHC centres are paid a salary for their work. Since the implementation of the NHM, alternative methods of paying health workers have been introduced including fixed-term contracts and case-based payments to private providers who are contracted-in to deliver services. The relatively flexible nature of these payment mechanisms has incentivised states to hire personnel under the NHM, and thus benefit from some central level funding for health workers.

Performance linked payments are used at the individual and facility level. Accredited Social Health Activists (ASHA), a cadre of village health workers created under NRHM, receive a payment linked to the quantity of their work. Teams of frontline health workers at primary health clinics can also receive performance-based financial incentives for achieving monthly performance targets and improving the quality of care. Finally, financial incentives have been used to reward personnel working in rural and hard to reach areas.

Digital technologies and health financing

Several digital health technologies have been used to enhance the coverage of health service delivery, improve the quality of services and to assist in monitoring and supervision. With regards to PHC financing, digital technologies have been introduced to facilitate the payment of incentives to ASHAs, resulting in drastic reductions in the time taken to make payments and fewer administrative errors. It is envisaged that digital technology will also be used to monitor the performance of PHC teams at Health and Wellness Centres for performance-linked payments.

Acronyms

AB-HWC	Ayushman Bharat Health and Wellness Centre
ASHA	Accredited Social Health Activists
ANM	Auxiliary Nurse Midwife
CHC	Community Health Centre
CMO	Chief Medical Officer
CPHC	Comprehensive Primary Health Care
GDP	Gross Domestic Product
HFWS	Health and Family Welfare Societies
HWC	Health and Wellness Centres
IP	In-patient
MLHP	Mid-Level Health Provider
MPW	Multipurpose Health Workers
NFHS	National Family Health Survey
NHM	National Health Mission
NRHM	National Rural Health Mission
NQAS	National Quality Assurance Standards
NUHM	National Urban Health Mission
OOP	Out-of-pocket
OP	Out-patient
PLP	Performance linked payment
PHC	Primary Health Care/Primary Health Centre
SHC	Sub-Health Centre
SHS	State Health Society
UPHC	Urban Primary Health Centre

1. Organisation of Primary Health Care System

1.1 Structure of public PHC

The primary health care (PHC) system in India, delivered through the public sector, has over the years evolved into two broad structures: one for the rural population and the other for the urban population. Besides the public sector, a large number of private providers also contribute to the provision of PHC, which is discussed in the section of provisioning.

The rural PHC structure has three-tiers: at the bottom, there are Sub-Health Centres (SHCs), which are closest to the community. As per norms, there is one SHC for every 5,000 population in plain regions and one SHC for every 3,000 population in hilly terrains. There is one Primary Health Centre per 25,000 to 30,000 population, covering about 5 to 6 SHCs. Similarly, there is one Community Health Centre (CHC) for every 100,000 population, with facilities for providing larger range of services.

The structure for urban primary health care delivery system is much simpler: As per norm, there is one Urban Primary Health Centre (UPHC) for every 50,000 population, with many urban health posts catering to smaller communities across the wards of cities/municipalities.

It should be noted that primary health care is also provided through higher levels of public facilities in larger towns and municipalities and at secondary / tertiary hospitals across the states. Since there is no gatekeeping (and tight referral) system in place, they can be accessed for primary care services that are available at lower-level facilities (SHCs/PHCs/CHCs).

Human Resources for Primary Health Care

The Primary Health Care at the lowest level of the delivery system at SHC is provided by male and female multipurpose health workers (MPW). Female MPW, also called auxiliary nurse midwives (ANM), provide maternal and child health services and routine basic curative care, besides coordination with other sectors. More than 900,000 ANMs provide PHC services in India. Male MPW provide services for environmental sanitation, disease surveillance and supports the ANM. Doctor-led health services begin to be provided at the Primary Health Centre level, while specialist services are available at CHC and DH level onwards. A new cadre of village level functionary, Accredited Social Health Activists (ASHA), was created under National Rural Health Mission (NRHM) for generating demand for health services. Recently, another cadre of Community Health Officer (CHO) or Mid-Level Health Provider (MLHP) has been created at Health and Wellness Centres (HWCs) for providing comprehensive primary health care.

Besides this, there are several thousands of personnel deployed towards primary health care at state level. For example, in Tamil Nadu state there are about 47,000 persons working under the Directorate of Public Health and Preventive Medicine, including Medical Officers, Staff Nurses, Technicians, officials working towards control of communicable and non-communicable diseases, and field functionaries deployed to deliver primary health care services.

1.2 Administrative structure of PHC services

Each state/region has a state level Department (of Health and Family Welfare) that is headed by a Principal Secretary (who is from the Indian Administrative Services that belongs to respective state cadre). Organizationally, at state level, there is one Directorate that deals with primary health care services, with an administrative head at district level (usually called the Chief Medical Officer or CMO), who manages the entire range of curative, preventive and promotive services along with services provided through HSCs/primary health centres/CHCs, sub-district and district hospitals. They would also be in-charge of implementation of various national schemes (such as national immunization programme, communicable, and NCD programmes), as well as intersectoral coordination. There is a Medical Education Directorate in charge of hospitals attached to government Medical Colleges, providing higher secondary and tertiary care.

In 2005, the Government of India announced its flagship program – National Rural Health Mission (NRHM), now called National Health Mission (NHM). Since the NRHM came into being, the delivery of PHC services through the public sector infrastructure has been governed through an administrative structure created at the national, state and district level. This new administrative structure comprised of specialists with backgrounds in management, finance, information-technology (IT), public health and medical specialities.

Role of State and the Central Governments in the provision of PHC

Although financing and provisioning of PHC are largely States' responsibility, the Central government over the years has played a significant role in shaping (and strengthening) the PHC delivery system in India. 2005 was a landmark in the history of PHC in India, when NRHM was launched – the Mission was to “provide effective health care to rural population throughout the country with a special focus on 18 states” that had poor public health indicators or weak public health infrastructure (p.14, NRHM, Framework for Implementation, 2005). Though it had a special focus on “poor women and children”, the Mission from the beginning had mandates on addressing inter-state and inter-district disparities, and to achieve “equitable, affordable, accountable and effective primary health care” (p.14, Ibid). The Mission had a clear vision on raising the public spending “from 0.9% of Gross Domestic Product (GDP) to 2 to 3% of GDP, by the end of the first phase of implementation (which ended in 2012), with improved arrangement for community financing and risk pooling” (p.14, ibid).

Goals for NRHM were set in terms of health outcomes, services to be provided over the next 3 to 7 years. The implementation strategy clearly laid out the nature and kind of support that NRHM would provide to states, particularly in improving the managerial skills, in building the HR capacity at SHC/PHC/CHC levels (particularly for appointment of field functionaries on contractual basis), deployment of more than 400,000 ASHAs, building infrastructure to make public health facilities fully functional, establishment of a National and State Health Systems Resources Centres (NHSRC/SHSRCs) for capacity development, and to provide technical support to “state level planning efforts” (p.25 Ibid), drug supply and logistics management (in many states that had no Centralised Drug Procurement system). Focus was laid on “organization of periodic public hearing to strengthen direct accountability of health system to community and beneficiaries” through Health Monitoring and Planning Committees (HMPCs) at PHC, Block, District and State levels; and convergence within and with other Departments, as well as engagement with NGOs.

1.3 Current “vision” for PHC

Under the National Health Policy 2017 (NHP 2017), the above-described structure for PHC, is envisaged to transform the entire landscape of primary healthcare delivery system by “assuring a comprehensive care with linkages to referral hospitals” (p.7., National Health Policy (NHP) of Govt of India 2017). These comprehensive primary health care (CPHC) services, comprising 12 different services, spanning “preventive, promotive, curative, rehabilitative and palliative care” would be delivered through HWCs, under the Ayushman Bharat, a national flagship programme of the Government of India, launched in April 2018. Under the Ayushman Bharat Health and Wellness Centres (AB-HWC), a total of 150,000 facilities (comprising SHCs, PHCs and UPHCs) would be converted into HWCs by 2022. As of October 2020, 50,799 HWCs have been established, of which 28,367 were SHCs, 18,976 were PHCs and 3636 were UPHCs. [Health Wellness Centre Portal: <https://ab-hwc.nhp.gov.in/>]

1.4 Planning PHC services

Guidelines for implementation of the National Health Mission

On the implementation side, each state is expected to prepare an annual estimation of financial and human resources required to implement new and existing specific activities at block level and district level. Each year, states are expected to prepare a Programme Implementation Plan (PIP), following a detailed set of guidelines (issued by the Ministry at the Centre) for preparing their PIPs through a series of consultations resulting in District level budgetary requirements for strengthening primary health care system in rural and urban areas. The National Urban Health Mission (NUHM) was launched in 2013; NRHM and NUHM - the two sub-missions - were brought under National Health Mission, NHM. The most recent framework for preparation of PIP for the year 2021 spells out the key operational guidelines to be followed: (a) states should decide the key areas of interventions (through bottom up, district level planning process); 60% of the total resources required will be met from the Central Ministry of HFW and the remaining 40% from state’s budget. The ratio of budget sharing between the centre and states has evolved from 85:15 since early NHM to 60:40 currently (since 2015-16). The ratio for all north eastern states, Himachal Pradesh and Uttarakhand is at 90:10, while it is 100% centrally funded in all Union Territories (except for Puducherry and Delhi where it is 60:40). The states are encouraged to ensure a 10% increase in the State Health Budget over the last year, and that two thirds of the total budget should be on primary health care (Record of Proceedings (RoP) Tamil Nadu, 2020-21, p.8). The guidelines also suggest that the states should increase the share of the health budget to at least 8% of their overall budget expenditure; and that the states should allocate more resources to “priority” districts, now called “aspirational districts” with low public health infrastructure and health outcomes.

Overall, the Mission had projected an estimate of additional resources required annually to attain the goal (as stated by the NCMH 2005) – namely to raise public investment in health from about 1% to about 2% of GDP, which amounted to an annual additional increment in budget in the range of ₹ 400 billions to ₹ 600 billions. In the light of the AB-HWCs, resources required towards infrastructure, human resources, equipment, drugs, etc. would go up much higher.

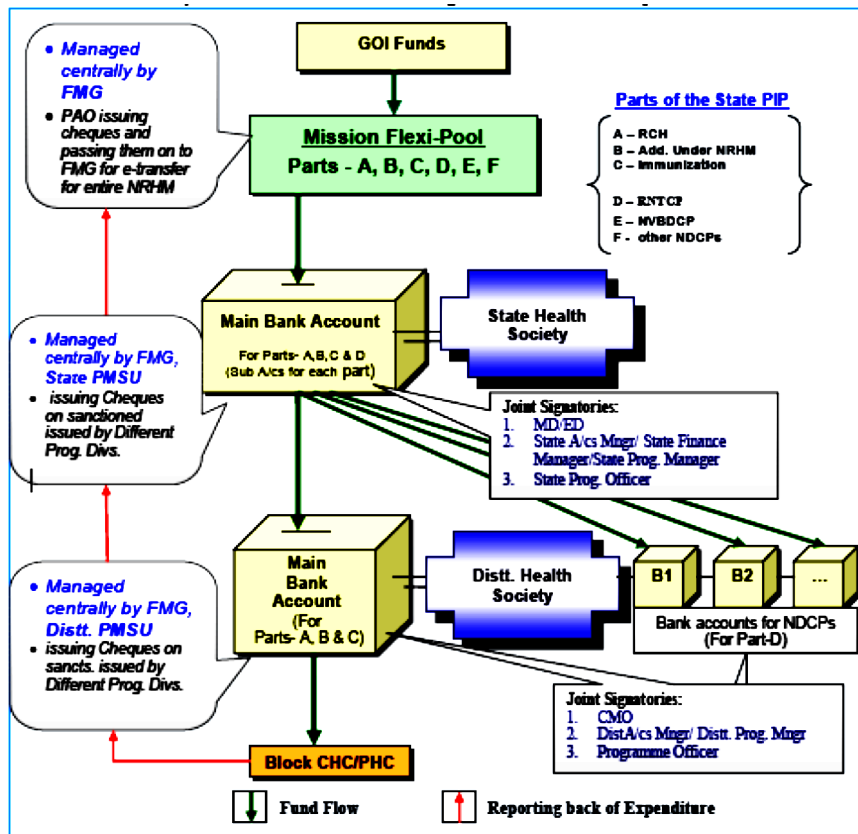
Institutional arrangement for implementation of NHM

The role of various bodies responsible with preparation of resources required (for specific activities under various approved heads of budgetary items have been spelt out right from the early years of NRHM. Broad guidelines for preparation of Village Health Plans with critical inputs from Village Health Committees through consultative processes among members of local bodies, field functionaries consolidated at higher levels (through PHC/Block and district levels) have been laid down but the degree to which these guidelines were followed would depend on capacity, commitment of various stakeholders and several contextual factors that play a role in the overall assessment of resources. There are District Health Monitoring and Planning Committees and a State level Health Monitoring and Planning Committee (with representatives from state legislative body, health and family welfare department, NGOs, regions /districts). [For details, see relevant sections in NHM framework, pp.67-112, 2005-12]

Public Financial Management Under NHM

The flow of funds also had a major change under the NHM. A mix of devolution and delegation exemplifies the level of financial decentralization which accompanied the NHM. Semi-autonomous organizations or societies were created at national, state, district, facility as well as village level were created to manage the funds. The flow of funds is illustrated in the Figure 1 below. Flow of funds since early 2010s was changed from this arrangement to earlier arrangement, namely through treasury routs to enable better tracking and monitoring of resources. Consequences of this are discussed later in this report (under Section 4).

Figure 1: Funds flow for primary health care under National Health Mission



1.5 Role of the private sector

The mechanisms for financing of primary care through private providers and the size of private sector are discussed in chapter 4. Suffice to mention here that there are multiple experiments underway across Indian states spanning several decades, with several “effective” and positive impact on the access to care and health status.

2. Overview of Health Expenditure

India spends nearly 3.8% of its GDP on health care, of which the share of Government is about 1.2%. The trends of health care financing are given in Table 1 below.

Table 1: Trends in health expenditure in India, 2004-05 - 2016-17

Expenditure	2004-05	2013-14	2014-15	2015-16	2016-17
Total expenditure on health as % of GDP (THE%GDP) – public and private aggregate.	4.2	4.02	3.9	3.8	3.8
General government expenditure on health as % of GDP (GGHE % GDP)	0.96	1.15	1.1	1.18	1.2
Per capita government expenditure on health (in Rupees)	242	1042	1108	1261	1418
General government expenditure on health as % of total general government expenditure (GGHE%GGE)	Not available	3.78	3.9	4.07	4.4
General government expenditure on health as % of total health expenditure (GGHE%THE)	22.5	28.64	29	30.6	32.4
Private expenditure on health as % of total health expenditure (PHE%THE)	71	67.74	66.3	64.76	63.2
External resources for health as % of total health expenditure (EXT %THE)	2.3	0.25	0.7	0.7	0.6
Out-of-pocket expenditure as % of total expenditure on health (OOPS% THE)	69.4	64.21	62.6	60.6	58.7
Private prepaid plans as % of total expenditure on health (VHI % THE)	1.6	3.4	3.7	4.2	4.7

Sources: Figures drawn from National Health Accounts for various years (published by National Health Systems Resource Centre, New Delhi)

Share of government in health spending

The Total Health Expenditure (THE) for India, in 2016-17, was Rs. 581013 crores, which is 3.8% of GDP. In per capita terms, it is Rs.4381. Among the various sources of financing health care, government sources (including both central and states share) account for 32%, while the out-of-pocket payments from households is the largest source at 63.2%. Foreign sources of revenue account for less than 1%. The current Health Expenditure (CHE) alone constitutes 92.8% of THE. The Government Health Expenditure (GHE) including current and capital expenditure is Rs.1418 per capita. This amounts to 4.4% of the General Government Expenditure (GGE), with Union government's share at 31.4% and state governments' share at 68.6%. The public healthcare delivery system in India is almost entirely financed through tax, both at central and state level.

3. Resource mobilisation and allocation

3.1 Government spending on PHC

NHA estimates for 2016-17 show that current Health Expenditure towards PHC is 45.2%, secondary care is 36.1%, tertiary care is 13.9%, and government governance is 3.3%. When disaggregated, the Government expenditure on primary care, secondary care and tertiary care is 52.1%, 23.1% and 10.8% respectively. The distribution of private expenditure on primary, secondary and tertiary care is 41.1%, 42.4% and 15.6% respectively (p.16, NHA, October 2019.)

Overall public expenditure (state plus centre) share of in-patient (IP), out-patient (O)P curative and preventive accounts for 34%, 31%, and 23%, respectively. State's share in IP, OP curative and preventive becomes: 41%, 33% and 17%, respectively (Ibid.)

3.2 Service coverage by private and public institutions

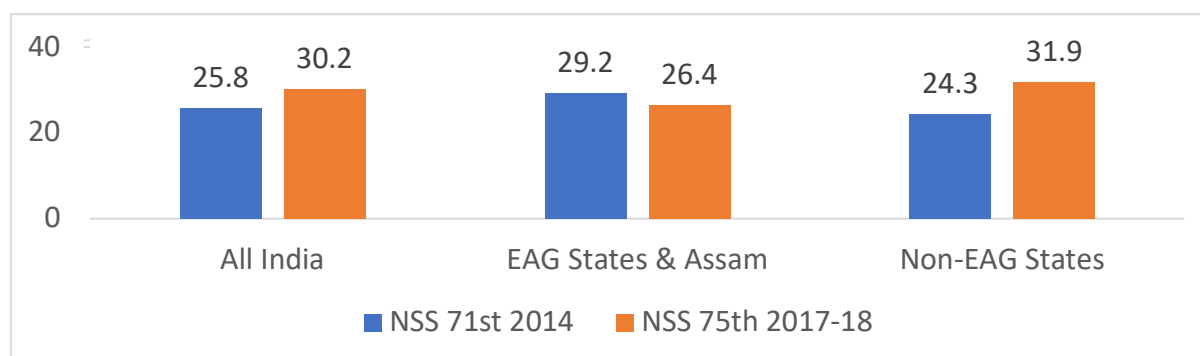
All public institutions (at all levels of care) are accessible to the entire population. Here we provide most recent data on the extent to which public and private institutions are accessed by various social and economic classes in rural and urban regions for outpatient care (primary care), and out-of pocket expenditure for outpatient care in private and public facilities.

Share of public and private facilities: Outpatient care

Here we provide only the key observations at all India level and wherever necessary, some highlights across EAG and Non-EAG states are made.

Overall, at all-India level, share of public facilities (including HSCs/PHCs/CHCs/GHs) in the overall utilization of healthcare services has increased from 25.8% in 2014 (71st Round) to 30.2% in 2017-18 (75th Round). Share of public facilities in non-EAG states increased from 24.3% to 31.9%, while it declined marginally in EAG states from 29.2% to 26.4% during the same period (see Figure 2).

Figure 2: Share of public facilities for out-patient care - All India, EAG states and Assam, and Non-EAG states



(Source: Muraleedharan, V.R. et.al 2020, "Invest more in Public Healthcare Facilities: What Do NSSO 71st and 75th Round Say?", *Economic and Political Weekly* (September 12, 2020)

Share of utilization of public facilities for outpatient care also is higher in rural regions (32.6%) than in urban regions (26.2%) in 2017-18. Urban poor have accessed public facilities to a greater extent (37.6%) than the urban rich (16.6%), while in rural areas the dispersion across quintiles is much less (37.3% for the poorest and 32.4% for the richest).

Scheduled Tribe’s use of public facilities has dropped from 48.6% in 2014 to 41.8% in 2017-18, which is yet considerably higher than that of other groups (SC/OBC/GEN) which depend on private providers to a much greater extent. It is notable that except for this sub-group, and for the second poorest quintile by economic class, in all other sub-groups be urban-rural residence, gender, social group and economic class, utilization of public services for outpatient care has increased from 71st (2014) to 75th (2017-18) round. The observation that in the ST population there has been a drop has therefore to be noted with considerable concern with regard to equity in access.

Out of Pocket Expenditure for out-patient care: private vs public facilities

At all India level, out-of-pocket expenditures (OOPE) for those accessing public institutions for OP care has dropped from Rs.446 in 2014 to Rs.385 in 2017-18 (nominal terms), with those in the richest quintile with much greater fall in OOP expenditure than in other categories. In principle, there is no co-payment for OP /ambulatory care in public institutions; however in practice, there is some amount of OOPE towards pharmaceuticals, diagnostics, and non-medical care as well. [For details of variations across rural/urban. Gender, social groups and economic classes, refer Muraleedharan et al 2020]

Figure 3: OOPE for OP in Public Healthcare Facilities:

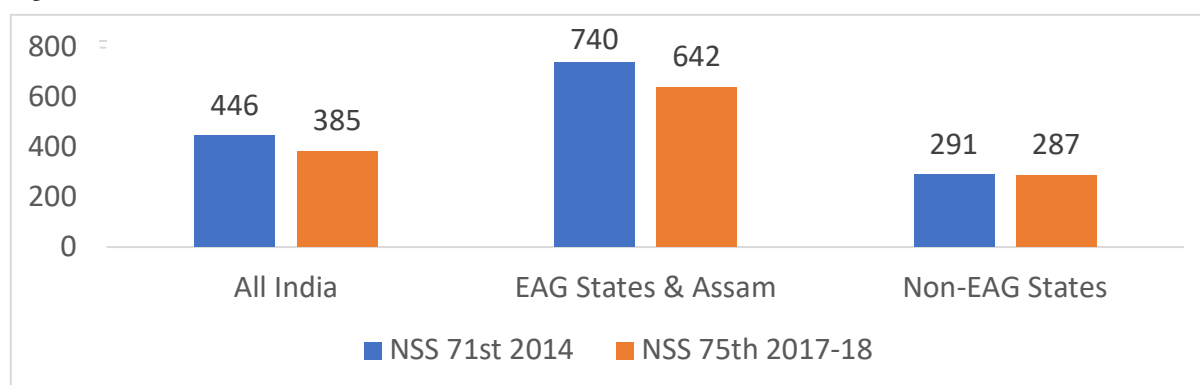
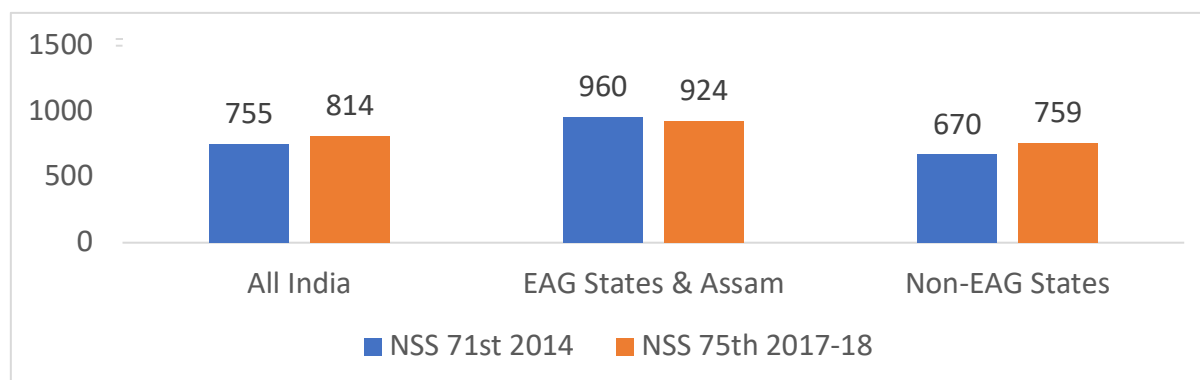


Figure 4: OOPE for OP in Private Healthcare Facilities



Source: Muraleedharan, V.R. et.al 2020, “Invest more in Public Healthcare Facilities: What Do NSSO 71st and 75th Round Say?”, *Economic and Political Weekly* (September 12, 2020)

3.3 Impact of Public Financing of Primary Health Care – National Health Mission

An evaluation of 15 years of National Health Mission to improve primary health care services in India was recently commissioned by the NITI Aayog. As part of this report, the authors conducted a systematic review of studies evaluating the NHM interventions. This review finally included a total 92 studies on interventions focusing on maternal health (n=18), child health (n=49), adolescent health (n=7), reproductive health (n=10), and health inequalities (n=7) to construct pathways to understand the impact of NHM on coverage of services and health outcomes as per a logic model. Overall, the review concluded positive evidence for NHM interventions on the coverage of services, equity in utilization as well as health outcomes.¹

A comparison of NFHS 3, 2005–06, (representing pre NRHM period) and NFHS 4, 2015–16, (representing post NRHM period), after adjustment of confounders, showed significant improvement in the coverage of maternal health indicators in post NRHM period. For example, the proportion of first trimester registrations from 57.3% to 72.7%, institutional deliveries increased from 41.6% to 89.1%, and postnatal check-up rose from 56.3% to 52.9%. Similarly, the child health indicators also showed improvement in post NRHM period as compared to pre NRHM period. The proportion of exclusive breastfeeding increased from 5.9% to 11.6%, full immunization rate increased from 43.7% to 57.7% and the proportion of children suffering from acute respiratory infections decreased from 5.4% to 2.5% from 2005 to 2015, respectively.

It was also reported that the expenses at public health sector facilities for under five child hospitalization (after adjustment for inflation) lowered by Rs.1923, from 2004 to 2014. On the other hand, expenses at private health facilities increased by around Rs.5000 in the same period. The catastrophic health expenditure due to hospitalizations at public health facilities reduced from 24.2% in 2004 to 14.5% in 2014, whereas at private health facilities it increased from around 40.3% to 42% in the same period.

An interrupted time series analysis of the Sample Registration System (SRS) data reported that the rate of decline in Infant Mortality Rate (IMR) was 1.6 infant deaths per 1,000 live births per annum during pre-NHM period, and it accelerated to 2.2 infant deaths per 1,000 live births per annum after the NHM. Further analysis on elasticity of spending on health and the levels of IMR showed that for every 1 additional rupee per-capita spent on health, there is a reduction of 2.3 infant deaths per 100,000 live births.

From a financing point of view, the allocations by NHM have been reported to equalize the differences in health care spending at the State level that existed pre-NHM. The evidence suggests that NHM contributed to reduction of inequality in health spending across states and added funds to the lower tiers of the health pyramid. The contribution of the scheme was, however, limited in strengthening health systems in relatively poor performing 'high-focus' states. Lack of complementary inputs in states, capacity issues and weak public financial management affected the performance of the scheme. As a result of the weaknesses of public financial management, only about 55 per cent of funds

¹Gupta M. National Health Mission: Impact and Learning for Future. A NITI Aayog Study 2020 (Postgraduate Institute for Medical Education and Research, Personnel Communication, 15 November 2020).

allocated for NHM were utilised in 2015–16 and 2016–17². This was partly due to significant delays in release of funds from State treasuries to implementing agencies. The delays were a result of complex administrative procedures associated with the release of NHM funds from State treasuries. The existence of implementing agencies outside the States' administrative setup, and the rigid fragmented financial design of NHM has contributed to the complicated architecture of release processes.

3.4 Efficiency reform

A major source of inefficiency in the primary health care system is the weak (no) gatekeeping mechanism for referring patients through levels of delivery system. A very large section of outpatient care (ambulatory care) takes place in secondary and tertiary care facilities. As a result, for example much of the public expenditures incurred for primary care provided at higher level public facilities could have been reduced had these services been accessed at HWCs. A recent study of UHC pilot in Tamil Nadu showed that as a result of improved provision of primary health care (outpatient curative care) through Sub-Health Centres (now known as HWCs), two important changes were brought about: (a) a significant proportion of patients who would have sought OP care from higher level public institutions began to access HWCs, there-by reducing their travel time, and consequential non-medical expenses, and (b) a significant proportion of patients who would have sought OP care from private providers also started using HWCs, thereby reducing their OOPes substantially. The important point to be observed there is that the cost of providing primary care at HWCs is much lower than at higher level facilities. The efficiency gain here could also result in improving fiscal space for providing more care to other patients at higher levels of public institutions.³

The second source of inefficiency in primary healthcare system is the drug procurement system. Many states are yet to adopt the centrally pooled and purchase system (as in TN, Kerala, Odisha, MP, Rajasthan, Maharashtra). There is enough evidence of large savings effected through central drug purchasing mechanisms and the increasing role of state medical services corporations in funding several other complementary services for primary care (such as purchase of diagnostics equipment for maternal care). The third important source of inefficiency is the lack of human resources (as against existing norms) at primary care level (at higher levels too), resulting in under (non) utilisation of other inputs (e.g., laboratory / diagnostics services), poor quality of care, over-loading of primary care centres with patients, leaving not adequate time to deliver quality care.

Finally, the last source of inefficiency is the poor public financial management system, which results in long delays in release of payments. The latter ultimately results in poor absorptive capacity for funds allocated, and this results in shrinking allocations over the years.

² Mita Choudhury and Ranjan Kumar Mohanty, "Role of National Health Mission in Health Spending of States: Achievements and issues (Working Paper No. 317, 2020, National Institute of Public Finance and Policy, New Delhi).

³ Muraleedharan et al (2018), "Universal Health Coverage Pilot in Tamil Nadu: Has it delivered what was expected?" (a report submitted to the Dept of Health and Family Welfare by Centre for Technology and Policy, February 2018).

Some overarching questions

AB-HWCs has the potential to bring about a huge efficiency gain in public spending, as illustrated by the above pilot study in Tamil Nadu. There is also a significant opportunity to reduce OoPE for primary care, to the extent this scheme diverts patients from private providers to public providers.

How far the primary health care initiative through PM-HWCs through NHM mechanism and states' contributions would progress in real terms over the next few years? Would the COVID-19 provide the necessary push to generate sufficient resources?

3.5 Resource allocation in the PHC system

The allocation for AB-HWC by the Union government is not encouraging: The actual budget for AB-HWCs for was Rs.1191.54 crores (including rural and urban HWCs) for 2018-19. This amounts to a mere 3% of the total NHM budget (Rs. 31,044 crores). This was increased to Rs.1598 crores towards AB-HWCs in the following fiscal year 2019-20 and remained the same for the fiscal 2020-21.

NHM's funding to states have reduced disparity among states (high focus and non-high focus states) in terms of per capita state health expenditure, despite a huge portion of unspent money (already transferred to SHSs) -- nearly 40% (close to Rs.9000 cores) of NHM amount was unspent (average of all States) in 2017-18. Two major reasons are attributed to this underspending: a) weak capacity of states to absorb the resources due to lack of manpower and (b) long delay in transfer of resources from Centre to State Treasuries and from state treasuries to State Health Society – SHS is an administrative unit which is outside the state health departments, which was created to receive resources directly from the centre and bypass the bureaucracy at state level in order to eliminate delays in transfer of funds by the previous government; but due to representations from various states, the procedure for transfer of funds was restored. Delays in receipt of funds (transferred from the Centre to State Health Department and then to State Health Society) could be from about 2 months to 10 months.⁴

⁴ Mita Choudhury and Ranjan Kumar Mohanty, "Role of National Health Mission in Health Spending of States: Achievements and issues (Working Paper No. 317, 2020, National Institute of Public Finance and Policy, New Delhi).

4. Purchasing PHC Services

4.1 Provider payment mechanisms

Historically, the primary health care services are delivered in the context of a supply-side financing system, which is publicly financed and publicly delivered. Tax is the primary source of financing PHC. The team of personnel delivering PHC services at SHC, primary health centre CHC are regular employees of the State department of health and are paid based on a fixed salary. Health facilities receive a line-item budget to meet the other expenses. Most of the supplies including drugs, consumables, as well as capital items such as equipment and furniture are centrally procured at state (predominantly) or district (partly) level and distributed to facilities. Most of the expenses incurred at facility level include expenditures on overheads such as electricity, water, maintenance, or some drugs and consumables in the event of non-availability in the short-run.

Since the implementation of the NRHM in 2005 (later in 2013 brought under NHM along with the introduction of NUHM), several reforms have taken place that have influenced the provider payments and the overall financing for PHC.

1. Inclusion of Contractual Employees:

In contrast to full-time regular employees in public sector facilities pre-NRHM, several other categories of human resources were recruited, which were contractual in nature and worked either full-time or part-time. Accordingly, the payments for these contractual employees was either a fixed-salary (full-time), or case-based bundled payment (part-time providers hired in a contracting-in model). The change of contracting for human resources had a few contextual reasons. Firstly, the hiring of contractual personnel was done alongside provision of greater autonomy at local level in terms for selection as well as determining the level of payments. Secondly, there was greater accountability of contractual personnel since the terms of employment had to be renewed every year, which was dependent on performance.

There are a few implications for this change in contracting on the financing of health primary health care. The first implication of the contractual model of employment was the significantly lower salaries paid to the contractual employees, compared to regular employees at the same position and level. This has bearing on the overall health financing. Secondly, the contracting-in model of provision of care meant that the private providers could be hired for provision of care (especially institutional delivery) in public facilities, and were paid on a case-based payment model.

The inclusion of contractual employees led to another implication for the distribution of financing by the Central and the State Government in a federal system. Generally, the hiring of staff is cumbersome involving several layers of approvals and administrative processes. Since the process of recruiting contractual employees was relatively easy, the States were incentivized to even budget and hire personnel under NRHM, in lieu of the sanctioned vacant positions. Now, since these vacant positions were otherwise budgeted under the State financial envelope, converting these into contractual positions meant that these would be paid through the NRHM funds – which is shared between the Central and the State governments.

2. Performance Linked Payments:

- a. Regional Level (State and District): There are two connotations of performance-linked payments (PLPs) for overall health financing. Allocation of approved budgets from the Centre to states are released in quarterly tranches. Each of the subsequent instalment is released based on the reporting of successful achievement of targeted workload and utilization of previous allocation. In this way, the allocations from Centre to the State government were linked to performance. Well-performing States received more funds in subsequent instalments, and also became entitled to even receive funds in excess of the initial budgetary allocations. Tamil Nadu and Kerala are 2 such examples which gained through this PLP. Similar rules of engagement for release of funds took place between the State and the district or sub-district level. In recent years, an “incentive / penalty point system” driven PLPs for states has been introduced based on seven criteria: (1) state’s ranking on performance on health outcomes, (2) grading of district level service delivery, (3) AB-HWC score (4) management of IT software up to primary health centres (5) % of districts covered under mental health programmes (6) % of districts providing services for Hepatitis and (7) dissemination of district action plan through NHM portals. Points /weightages have been announced against each of these criteria. The net score achieved by the States are then converted into a budget, keeping in mind the available budget, which would not exceed 20% of total NHM budget.
- b. Individual Provider Level: While majority of the employees continue to be paid on salary basis, certain key personnel under the NRHM are paid based on their performance. The most apparent example of this nature, is the payment for ASHAs, a cadre of village level health worker created under NRHM. The payments for ASHA workers is a bundled payment which has two components – firstly, a fixed monthly honorarium which is unlinked to performance, secondly a PLP. The PLP part is paid in several forms. Firstly, a case-based payment linked with each beneficiary or client registered for service, for example, per new-born case registered for home-based care which covers 6 visits. Secondly, a fee-for-service model for each individual service delivered to a client, for example, payment linked with mobilizing and accompanying high-risk pregnant woman for HIV test. A third form of PLP for ASHA workers is an annual lump sum (global) payment for issuance of vital records to population, linked to a coverage of 80%. The payments are structured in order to incentivise certain services which are paid on FFS basis. Each payment is linked to the volume or quantity of work. There are very minimal indicators which measure the ‘quality’ of work.
- c. Facility or PHC Team Level: The guidelines of the *Ayushman Bharat* Health and Wellness Centres (AB-HWC) identify Performance Linked Payments as a strategy to improve motivation levels, strengthen quality of services, enhance accountability for population health outcomes and serve as a mechanism to identify performance and skill gaps, at the Health and Wellness Centres at sub centre level. The PLP are provided for the team of frontline functionaries and the Community Health Officers who will play a key role in enabling continuum of care.

These payments are to be made on a monthly basis. Team and individual performance will be assessed on the basis of data obtained from existing information systems. However, states also have the flexibility to undertake

independent monitoring, to validate the information systems. This could be done through partnerships with research organizations, non-governmental organizations, State Health System Resource Centres and medical colleges or through training the existing staff at district and block level to undertake population-linked surveys to monitor progress on outcomes on a periodic basis.

Key criteria for selection of indicators is that they cover essential activities related to the first seven service packages of CPHC that have been rolled out. Thus, outpatient services for acute simple illnesses, provision of ANC, Immunization, services, screening and management for NCDs and TB, and management of Vector borne diseases have been included. In addition, other public health and management functions of HWC-SHC teams such as community level meetings for health promotion and prevention, and monthly meetings at HWC-SHCs have also been included. The selected indicators are those that are reported in the HMIS, RCH portal, CPHC-NCD Application, AB-HWC Portal and Nikshay. Monthly performance of the functionaries will be assessed on a set of 15 indicators.

- d. Incentives for Quality: A few programs specifically provide financial incentives for improving quality. The measurement of quality is a complex task, and as a result the PLPs which are linked to quality adopt a more pragmatic approach towards measurement. The Government of India developed the National Quality Assurance Standards (NQAS) to promote quality of health care delivered at health facilities. The National Quality Assurance Standards are broadly arranged under 8 "Areas of Concern" – Service Provision, Patient Rights, Inputs, Support Services, Clinical Care, Infection Control, Quality Management and Outcome. These standards are ISQUA accredited and meets global benchmarks in terms of comprehensiveness, objectivity, evidence and rigour of development. Achievement of NQAS standards at primary health care facilities is linked with incentives.

The incentives could be classified into following three categories – institutional, team and individual incentives. Each of these incentives are monetary and non-monetary. Financial incentives could be rewards for individuals and quality team, who have been the 'change agents' at the facility level and District Quality Unit, and were instrumental in NQAS implementation and certification of the health facility. However, nearly three-fourths (75%) of incentive money is to be used for improving infrastructure and amenities for the staff and patients, while the remaining incentive is distributed to the personnel.

A second scheme which aimed at providing incentives for improving quality is the '*Kayakalp* Award Scheme', which was announced on May 15, 2015, as an extension of '*Swachh Bharat* or Clean India Mission'. The aim of initiative is to improve and promote the cleanliness, hygiene, waste management and infection control practices in public health care facilities and incentivize the exemplary performing facilities. The scheme is intended to encourage and incentivize public health facilities in the country to demonstrate their commitment for cleanliness, hygiene and infection control practices. Initiated from District hospitals in 2015, the scheme expanded to PHC level (2016), and then covered all urban health facilities by 2017.

3. Other monetary and Non-monetary incentives

Besides the PLPs, other forms of monetary and non-monetary incentives have been introduced for health care providers in recent years with 2 primary objectives – correct the distributional imbalance of health care providers, and to improve the access to services in hard to reach and disadvantaged areas. Examples of such monetary incentives includes higher salary for health care providers serving in rural and hard to reach areas. Non-monetary incentives include preference for doctors having served in such areas for admission to postgraduate courses.

Degree of autonomy and contextual factors in implementation of PLP & incentives

The traditional governance structure for public health funds involved a rigid system of treasury. Following the introduction of NRHM, two major forms of decentralization accompanied the reforms in financing – devolution and delegation. Several administrative and financial powers were devolved from the Central to the State and District administrations. Since there is significant degree of division between the Constitutional functions between the centre and the state in India's federal structure, this form of decentralization fits into the category of devolution. Secondly, new parastatal organizations or 'Health and Family Welfare Societies' (HFWS) were created at the state, district, facility and village level, with functions for planning and implementation and enhanced administrative and financial powers, this would get classified as delegation. These HFWS comprised of members from the department of health, education, child development, rural development, water and sanitation etc. These exercised powers to develop annual plans – both technical and financial. Further, the HFWS at each level exercised powers to administer and also manage finances, including setting provider payment rates and level of incentives.

Financing the provision of PHC from private providers

Several models of financing PHC from the private sector exist in India. These can broadly have a mix of the following models - (1) User fee, (2) Public funding and partnership, (3) Cross subsidies of primary healthcare from secondary and tertiary operations, and (4) Community financing. User contribution includes user fees and margins on drugs or other healthcare products. This contribution can cover 90% of the operational expenses. The majority of private sector provisioning models focus on provision of curative care. The share of expenditure in such models on preventive care generally varies from 10% to 40%. Organizations such as Karuna Trust and Basic Healthcare Services manage government Primary Health Centres under the public-private partnership (PPP) mode. In such cases, depending on the contract with the government, 25–100% of operational costs are borne by the government. In terms of financing, initially Government used to bear only 25–75% of the operational costs. With the increasing trust between the parties, the Government now reimburses up to 100% of the operational costs. Karuna Trust sources the management cost, which is 10% of the total cost of operations, from external funders such as CSR arms of companies. The regulatory issues with regard to private providers have not yet been effectively addressed in India. Relevant laws (polices) are in place in certain states but how effectively they have been implemented is a matter of concern to policy makers.

5. Digital technologies and health financing

Several digital technologies have been used in the field of health. Many of these technologies have been applications for enhancing the coverage of service delivery, improving quality of services as well as monitoring and supervision. There are also several examples of digital technology being used in payment for secondary and tertiary health care services as part of the tax-financed health insurance schemes. However, there is relatively limited interface of digital technologies for financing primary health care services. The following section lists some of these digital technologies.

Use of Digital Technology for ASHA PLP Payment (ASHA Soft)

A new digital platform – ASHA Soft, has been developed. It is an integrated system to measure the performance of ASHAs and to ensure timely and transparent payment of incentives to ASHAs. Performance measurement of ASHAs on case-to-case basis with the help of ASHA Soft has resulted in significant improvements in concerned functional areas of Health & Family Welfare in the State.

Prior to ASHA Soft, there were no standard procedures for performance and payment monitoring for ASHAs and there were multiple payment points. Cash was maintained at every sub centre, PHC, CHC etc. For example, in some states, the total locations for cash handling for this purpose exceeded 20,000. Incentive payments for certain activities was made by ANMs up to sub centre while incentives for other activities was made through different cheques at PHC level (separate cheques for RCH activities, national health programmes etc.), which were handed over to the ASHA in the monthly meetings. Invariably, there was delay of at least 2-4 months in the payment. The process of approval on case basis generated lot of clerical work at all levels.

ASHA Soft has been simplified the process significantly, which has introduced standardized claim forms for ASHA for all 26 activities. The forms are submitted by ASHA at her Sub centre where the ANM verifies them. The Claim forms for all 26 activities in a month are submitted at the end of the month by the ASHA and once verified by the ANM, the forms are sent to the concerned PHC, CHC and Block PHC for data entry. All claim forms are entered into the system as per predefined schedule of data entry and verification (generally 26th of every month to 2nd day of next month). As the next step, sanctions for each of the service category are generated by the MOIC (Medical Officer in Charge) for all ASHAs in his/her jurisdiction and all these sanctions are generated as per predefined schedule (generally 3rd day of next month to 5th day). Sanction letters are generated accordingly, with the system and maintained online in pdf format for later reference and finally the Fund Transfer Order is generated at the district level by concerned CMHO using DSC. Thus the online payments are transferred by 7th of next month. The time taken to make the payment has been drastically reduced, from about 2 months to 7 days. The process of payment is very transparent and has almost eliminated the requirement of repetitive manual work which was also prone to many errors.

Use of digital technology for PLP payment to HWC teams

It is proposed to use digital technology to determine the performance of the PHC teams at Health and Wellness Centres. The PHC Medical Officer under whose jurisdiction the HWC-SHC is assigned or (any other suitable representative as decided by the state) will be responsible for assessing the performance of the HWC-SHC team. A pre-requisite of implementing performance-based payments is a robust IT system that is able to track the

number of individuals (service users) empanelled with the HWCs, range of services delivered at HWCs and coverage of HWCs and the outputs/ outcomes achieved. The PHC medical officer will ensure that CHOs/MPWs are trained in using the CPHC IT system for online auto compilation and transmission of performance data for HWC-SHC team. However, till the time such a system is in place, CHOs will use the data entered in the respective information system to submit performance reports on service delivery outputs for the particular month in a standard format developed by the state.

Direct benefit transfer for demand-side financing

Several demand-side financing schemes such as cash incentives for pregnant women or mothers of infants completing immunization, or babies completing a set of growth monitoring and nutrition services etc. have been initiated by the Government of India in the last 15 years. The initial 5-10 years saw disbursement of cash incentives through either cash or cheque payments. However, the last 5-7 years have seen a greater use of direct transfer of cash incentive to the bank accounts of beneficiaries. This was also facilitated by the Government's initiatives on enhancing the coverage of digital unique identification (Aadhar) and increasing the reach of banking services (*Jan-Dhan*). The IT portals of the respective programs generate line list of clients who are entitled for demand-side incentives, and these are directly processed for release of payments to their bank accounts.

Digital health mission and health financing

The Digital India programme is a flagship programme of the Government of India with a vision to transform India into a digitally empowered society and knowledge economy. "Faceless, Paperless, Cashless" is one of the professed roles of Digital India. Promotion of digital payments has been accorded highest priority by the Government and is one of the key highlights of the Union Budget 2017-2018. Accordingly, a pan-India target of total 2,500 crore digital transactions through five payment modes namely UPI, USSD, Aadhar Pay, IMPS and Debit cards, and Government of India has achieved a target of 2060 Crore digital transactions during FY 2017-18. New target of 110 Crore transaction has been assigned to department of Health and Family Welfare for FY 2018-19 and incentive schemes have been initiated for promotion of digital Payments;

Touch Points for accepting Digital Payment in Health Care Organisations (HCO)

Ministry of Health & Family Welfare promotes all the public and private HCO for enabling all customer touch points with Digital Payment acceptance infrastructure. Patients/Citizen can pay by means of UPI, BHIM, Mobile Wallet, Credits & Debits Cards in various health care organisation.

6. Conclusion: Proposed case study

In the light of the above analysis and understanding of the financing mechanisms for primary health care in India, and based on the discussion with the members of the Lancet Team (India case study), we propose an in-depth assessment of the following questions: “What policy instruments does the Centre have available to influence states' spending on Primary Health Care and how effective have they been? (Focus on sharing rules and performance based allocation -- conditionalities in particular). How should these instruments be refined to be more effective in the future?” These questions will be examined with reference to the states of Bihar, Haryana, Kerala and if possible Tamil Nadu.

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Acknowledgements

We thank the Lancet Global Health Commission for the opportunity to prepare this scoping review on financing for primary health care in the Indian context. We thank Professor Kara Hanson, Dr. Rajeev Sadanandan, Dr. Darius Erlangga, Dr. Alexo Esperato, and Dr. Brigid Strachan for their comments and guidance in drafting this scoping review.