HSTP
Health Systems Transformation Platform

FINANCING PRIMARY HEALTHCARE

Dissemination of the Lancet Global Health Commission Report

17th February 2023

New Delhi

Foreword

Primary healthcare is the first point of contact for individuals seeking healthcare services and is the foundation of high-performing health systems in many low and middle-income countries. Effective financing of primary healthcare is critical for ensuring that primary healthcare services are available, accessible, and affordable to all individuals, regardless of their socioeconomic status. However, a major challenge to the effective delivery of quality primary healthcare services in most low and middle-income countries is inadequate financing for primary healthcare. This limits access to healthcare services, results in poor quality of care, increases out-of-pocket expenses, exacerbates health disparities, and leads to poor health outcomes. The Lancet Global Commission on financing primary care was convinced that identifying effective and proven ways of strengthening financing and exploring new ideas and approaches would enable countries to change how finances for primary healthcare are managed and delivered.

The report of the Commission attempted to look at the quantum and patterns of global expenditure, the modalities of provision and payment methods along with identifying the political economy, technical and information challenges faced in financing primary healthcare. It suggested a few practices for improving health financing functions for effective primary healthcare. The Commission also recommended policies for raising, allocating and channelling resources to support effective primary healthcare. One of the issues of the report being done at the global level is that all these services are highly contextualized and understanding them from a country perspective requires a deeper understanding of each nation's political and fiscal context. Deliberating on issues addressed by the Commission and beyond in India becomes imperative given the vast differences across states in financing and delivering primary healthcare. For this, Health Systems Transformation Platform (HSTP) organized a dissemination event for the report and panel discussions with experts in India and at the global level to further the discussions. The discussions led to an insightful analysis of the sector and generated several ideas, as will be evident in this document.

I would like to take this opportunity to express my deepest appreciation to all those who made this undertaking a reality. Special gratitude to Professor Kara Hanson, the panellists Ms Roli Singh, Mr Manoj Jhalani, Dr Rajani Ved, Dr Ajay Tandon, Dr Grace Achungura, Dr Indranil Mukhopadhyay, and Dr Shankar Prinja for taking out time from their busy schedules and joining us for the course of discussions.

I would also like to express my appreciation to Dr Pratheeba John, Dr Sudheer Kumar Shukla, and Ms Sakshi Khemani at HSTP, for their contribution to the planning process and for documenting the discussions in this report.

Furthermore, I would like to acknowledge with much appreciation the crucial role of the HSTP Team, especially Mr Sridhar Guduthur, Mr Diwakar Gautam and Mr Peter Parekattil for providing administrative and logistical support.

We hope this document will help identify potential areas for research, policy, and programme intervention to strengthen the country's health system and increase finances for primary healthcare.

Rajeev Sadanandan
Chief Executive Officer
Health Systems Transformation Platform

Acronyms

ACSCs	Ambulatory Care Sensitive Conditions
ANC	Antenatal Care
COVID-19	Coronavirus Disease 2019
DALYs	Disability-Adjusted Life Years
DNA	Deoxyribonucleic Acid
GDP	Gross Domestic Product
HPV	Human Papillomavirus
HSTP	Health Systems Transformation Platform
HTA	Health Technology Assessments
HTIN	Health Technology Innovation National
IMR	Infant Mortality Rate
INR	Indian National Rupee
IPHS	Indian Public Health Standards
JKN	Jaminan Kesehatan Nasional Program
JSSK	Janani Shishu Suraksha Karyakaram
LMICs	Low- and Middle-Income Countries
NCDs	Non-Communicable Diseases
NFHS	National Family Health Survey
NHM	National Health Mission
NHS	National Health Service
NRHM	National Rural Health Mission
NSSO	National Sample Survey Office
OOPE	Out-of-Pocket Expenditure
PAP	Papanicolaou Test
PFM	Public Financial Management
PFMS	Public Financial Management System
PIP	Program Implementation Plan
PM-ABHIM	Pradhan Mantri Ayushman Bharat Health Infrastructure Mission
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PPP	Public-Private Partnerships
RCH	Reproductive and Child Health
SDGs	Sustainable Development Goals
SEARO	South-East Asia Regional Office
TFR	Total Fertility Rate
U5MR	Under-five Mortality Rate
UHC	Universal Health Coverage
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

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Introduction

An event was organized by Health Systems Transformation Platform (HSTP), New Delhi for the dissemination of the report of the *Lancet Global Health Commission* report *on "Financing primary health care: putting people at the centre"* on 17th of February 2023, at India Habitat Centre, New Delhi.

The event began with Mr Rajeev Sadanandan, Chief Executive Officer of HSTP, also a commissioner of the Lancet Global Health Commission on financing primary healthcare welcoming the audience and the speakers by giving a brief overview of the report and the reason behind organizing the event. As the purview of the report is global, the arguments put forth are generic and need to be contextualised to understand them from the country's perspective. The event was an attempt to do that through in-depth discussions.

The discussions started with a session chaired by Dr Rajani Ved and Professor Kara Hanson giving a presentation on the report. The second session was on the "*Financing of Primary Care in Asia and India"* chaired by Ms Roli Singh. In this session, Mr Manoj Jhalani gave a presentation on '*Primary Healthcare Financing in the World Health Organization (WHO) Southeast Asia Region with a focus on India'* and Dr Ajay Tandon presented on '*Primary Healthcare Financing in India'*. The last session on "*Managing Finances for Primary Healthcare"* was chaired by Professor Indranil Mukhopadhyay and had presentations from Dr Grace Achungura on '*Financing Primary Healthcare in India – Public Financial Management challenges'*, and from Dr Shankar Prinja on '*How costing studies contribute to designing Primary Healthcare reforms'*. Each session was followed by active discussions with the experts and audience.

Session Wise Proceedings

Session One

Chairperson: Dr Rajani Ved

Presenter: Professor Kara Hanson

Dr Rajani Ved in her opening remarks thanked the Health Systems Transformation Platform for inviting her as the chair for the session on "The Lancet Global Health Commission on financing primary health care: putting people at the centre". She requested Professor Kara Hanson to present key findings from the report and help the audience think through how the commission's report can influence and modify India's primary healthcare financing landscape and highlight a few areas that can be researched further, especially in the Indian context.

Highlights from Professor Kara Hanson's presentation

Professor Kara Hanson gave a bird's eye view of the report's main findings followed by explaining the structure of the report and the focus of the sections in the report and discussing the major recommendations of the Commission. She also listed the areas for future research.

Key findings of the report

Professor Hanson initiated her presentation by stating that the challenge of primary healthcare is very well known, and it is difficult for health systems to invest in primary healthcare. This is because not enough is spent on primary healthcare and there are blockages in how those resources reach the

frontline. Moreover, funding for primary healthcare is fragmented, inflexible and inefficient. Professor Hanson mentioned that the report has attempted to address issues such as how to allocate more resources equitably towards primary healthcare, and in ways that protect them till they reach the last mile. Aligning incentives and funding flows will motivate and engage primary healthcare providers to deliver primary care services effectively. It is not only important to spend more on primary healthcare but also to spend better. She stated that the objectives of the Commission were to present new evidence on the levels and patterns of global spending on primary healthcare, to analyse the key technical and political challenges faced in increasing finances for primary healthcare and to look for promising and proven practices in different settings that would support primary healthcare across the health financing functions and then to identify some actionable policies that would help countries to raise, allocate, and channel resources to support efficient, equitable, effective and people-centred primary healthcare.

We not only need to spend more on primary healthcare but also spend better to get value for the money invested.

Professor Hanson shared that one of the main findings from this landscaping exercise was governments spend very limited amounts on primary healthcare. As per the WHO, 40-50 dollars per capita should be spent on a comprehensive package of primary healthcare services. The report found that, on average, low-income countries spend around 3 dollars per capita on primary healthcare while lower-middle-income countries spend 16 dollars per capita. Being a lower-middle-income country, India spends 12 dollars per capita, lower than the global average, and India's out-of-pocket expenditure is 25 dollars. It was noted that even in upper-middle-income level countries, half of spending on primary healthcare is out-of-pocket payments, which in turn has consequences for vulnerable households. She mentioned that the Indian case was a little different as we have a much lower reliance on development assistance for health, the out-of-pocket spending is at 50 per cent and government spending is at 37 per cent.

Primary healthcare financing is highly fragmented with many dimensions to it in the form of government spending, and out-of-pocket expenditures and in many low- and middle-income countries (LMICs) development assistance contributes to the fragmentation. In most LMICs, governments spend mostly on curative outpatient care, and spending for preventive services is usually taken care of by donors. Most out-of-pocket expenditure (OOPE) for primary care is predominantly on medicines in these countries. It was also observed that the countries that spend more on primary healthcare are closer to achieving universal health coverage. A comparative analysis of countries with the same amount of spending on primary healthcare revealed that there is variability in universal health coverage ranging from 35 per cent to 70 per cent. Therefore, it depends not only on the availability of funds but also on how the funds are managed. From an overall perspective of country contexts, it gives a clear indication that governments need to spend better to get more value for the money being invested.

The Commission also tried to understand how providers are paid across different settings. In low-income countries, input-based budgets are the predominant ways to pay providers. Lower middle-income countries adopt mixed payment mechanisms where they are paid through input-based budgets, service-based payments, and capitation-based payments.

The Commission further identified provider autonomy as an enabler for empowering the local level managers to make the right choices about how they deliver their services. It was observed from a survey done by the World Bank that public primary healthcare providers have very limited autonomy

on all aspects of service provisions such as procuring medicines and managing and retaining funds over financial years.

Navigating details from the report

The first section of the report "Lancet Global Health Commission on financing primary health care: putting people at the centre" focuses on the main financing functions of how money is raised for health, how it is pooled to allow cross-subsidy between those who are ill and those who are healthy; the second section focusses on the resource allocation; third section describes how primary healthcare providers are paid for and the fourth section captures the political economy context to understand how decisions are made in terms of primary healthcare financing.

Primary healthcare is part of the government health budgets. Government spending on health is a function of fiscal space, where they can spend more on health by borrowing, taking loans or grants from external agencies, through general taxes or social health insurance, earmarked tax or specific health-focused tax known as sin taxes. Primary healthcare is part of a very complex set of negotiations and allocation rules where mobilizing and pooling funds is essential. Efficiency was also considered part of primary healthcare's fiscal space. It was noted that efficiency gains are slow to materialize. The report advocates examining taxation more carefully as a major source to generate funding for public spending in general. It also advocates scrutinising whether public funding is equitably distributed across the population.

Professor Hanson discussed how resources are allocated to primary healthcare - how budgets are constructed and executed and how services are configured. She mentioned that there appears to be a lot of scope for India to attract more budgets for primary care with the introduction of Health and Wellness Centres.

She mentioned that countries are increasing their budgets for primary healthcare based on their performance. The Commission report also highlights the fact that the allocation formula between the state and central governments has resulted in states spending more on primary healthcare and being able to augment resources through incentives. Another means to increase resources is to introduce an earmark in the budget for health as in the case of Nigeria where a basic healthcare provision fund was created and accordingly one per cent of total government revenue is reserved for health.

The Commission report also explored how budgets are executed and spent. It also examined how the budget structures and allocation formulae are aligned to make spending on primary healthcare equitable. Direct facility funding was also explored where problems of fragmentation are addressed, money is pooled at the lower level and distributed to primary healthcare facilities, and benefit packages are specified to determine the resources. Brazil has a very well-documented primary healthcare model that has demonstrated tremendous health impacts. They have a system where central government resources are directly allocated to municipalities based on the population and have multi-disciplinary para-health teams that are funded and operated at the municipal level. Tanzania is an example of direct facility funding with a very fragmented system, and a lot of external assistance. A fair degree of autonomy and pooling of resources has proved beneficial for primary healthcare.

Professor Hanson stated that attracting money for primary healthcare needs clear operational definitions of primary healthcare. From a financing perspective, it is important to define service delivery. Norms and standards attached to these facilities and having a referral system is also a way to incorporate gatekeeping mechanisms to reserve the money at the primary level. In the case of Ethiopia, Turkey and Estonia, new cadres of primary healthcare providers were created as a way of strengthening primary healthcare and indirectly attracting funds for it. In Estonia, a family health physicians' cadre was created along with infrastructure for family health. Turkey also created a cadre for family doctors and Ethiopia created a cadre of Community Health Workers to attract money at the primary healthcare level.

The report also looked at the incentives at the provider level specific to provider payments. A key finding from the analysis was that providers of curative care were prioritised over preventive care providers. Moreover, input-based budgets don't encourage the providers to focus on people. Rather they focus more on line items and budgets.

Professor Hanson stated that the capitation payment model has been considered the best way to pay for primary healthcare. It promotes equity because equal amounts of money are allocated to all providers and can also be customized based on need which makes it even more equitable. Since it pays providers to manage people's health, it incentivises them to prioritize preventive healthcare. It also gives providers an upfront, stable, and predictable income flow. For example, in Ethiopia, when a capitation model for community-based health insurance was pilot tested, funds were allocated at the beginning of the year, and this gained confidence in the facility managers, and they considered it a better model of securing funds for primary healthcare.

Professor Hanson highlighted that the report advocates a blended payment system with a capitation model at its core and then building additional payment mechanisms to achieve specific objectives. If there are services that a country wants to prioritize, paying for them on a fee-for-service basis to providers or introducing pay-for-performance in case of issues around quality, are ways for augmenting the capitation system to achieve more objectives. Estonia introduced a blended payment system in the early 2000s where the capitation payment model along with infrastructure allowance and fee for service for priority services was implemented and over time, more mechanisms such as the quality bonus system, a bonus for training and a number for additional allowances suitable to changing circumstances were added subsequently.

The report sketches a pathway to a more strategic provider payment system and recommends a movement from passive purchasing to an active one. Greater clarity is required on what needs to be purchased. The report recommends providing well-aligned strong incentives to primary healthcare. A capitation model could be introduced as a simple powerful first step and then adjusted by introducing data on other characteristics and making the blend more complex by bringing in other provider payment methods. To bring in these changes, system-level capacities such as good data systems, strong health information management systems, enhanced capacities of the purchaser and the provider, provider autonomy and a public financial management system that is flexible and supportive are needed.

Professor Hanson mentioned that the last section of the report focused on the political economy of financing primary healthcare. The political economy analysis is critical to analyse the power dynamics within stakeholder groups. When there is a political will, having a political strategy alongside a technical strategy is very important for execution because the changes suggested in the report require redistribution of resources from hospitals to primary care and redistribution amongst cadres as well.

Professor Hanson also talked about aspects that weren't explored in the report such as the role of the private sector. Going by the recommendations from other Lancet reports, she mentioned that a meaningful way to engage with the private sector is to purchase services from them using public funds. Financing medicines for primary healthcare is another area that has not been addressed in the report. The challenges exist in terms of incentivising the prescriber, making sure commodities are in stock and including medicines in the primary healthcare benefits package such that the medicine expenditures are taken care of for the beneficiaries.

Providing primary care in urban settings is also not addressed in the report. Given that India has at least 40 per cent of its population living in urban areas, using public funds effectively for primary health care provision in these settings can be a future work area that could be explored.

Summarising her presentation, Professor Hanson mentioned that the central message of the report was to not only spend more for primary health care but also spend better, and to introduce people-centric primary healthcare systems through financing mechanisms that are people-centric. The financing arrangements for primary healthcare should be coming in predominantly from government resources in the form of pooled public funds which should be allocated and utilised efficiently through well-planned budgets that accounts for essential medicines and service delivery packages to reach the last mile frontline providers.

It is also important to move towards a provider payment system that not only places capitation at its core but also introduces a blended financing model when required to optimize the incentives for primary healthcare providers. The Commission also identified that while spending better on primary healthcare is an important responsibility of the government, in a country context like India, there is a need for better management of Centre-State relations along with inter-sectoral coordination and engagement. Measuring change in primary healthcare financing is crucial to track progress over time and to understand the importance of financing primary healthcare as a platform instead of a function.

Discussion

Dr Rajani Ved requested Professor Hanson to specify the role of regulation concerning private sector engagement for primary healthcare and the availability of essential medicines. She also emphasized that a public health system managed by the government is necessary as evidenced by COVID-19. Dr Ved was curious to understand from Professor Hanson how financing a primary healthcare service delivery system would also need to include financing essential public health functions.

Dr Ajay Tandon discussed how public financing for primary healthcare is a function of the government, how the size of the economy matters in this context and the importance of decreasing poverty levels by reducing out-of-pocket expenditures for medicines and diagnostics. He mentioned that with the removal of user fees and informal user payments, there's a need to deliberate on negative user fees, issues relating to opening hours and waiting time also need to be addressed as the element of time as it is very important for the informal workers. As primary healthcare is not insurable from an economic sense as with the case of hospitalization there is a need to assess if this scenario creates a challenge for pooling more specifically risk pooling and for mechanisms to encourage pooling for less insurable services.

Professor Kara Hanson mentioned that it is important for the Ministry of Health to closely engage with the Ministry of Finance given that more resources need to be invested into the health sector in accordance with the changing health and epidemiological profile of the population. The importance

of investing in health and its positive impact on creating economic growth and poverty reduction is still not recognized by officials in charge of decision-making. It is also important to assure the Ministry of Finance that the resources provided would be utilised effectively.

Professor Hanson clarified that the report does not focus on cash transfers, but evidence shows that cash transfers can be useful in incentivizing people on the demand side. An inquiry into the waiting time and opening hours reveals that the system is doctor centric as opposed to patient-centric. Appropriate pathways that are beneficial to the users need to be framed. Given the fact that primary healthcare is non-insurable is a key determinant for increased government spending on primary healthcare and hence pooling of resources across the population is essentially the government insuring people for primary healthcare.

Dr Devaki Nambiar requested Professor Hanson to provide some insights on High-Income countries, the role of technology in remitting payments and the impact of different financing models on population health.

Professor Hanson mentioned that in the systematic review of evidence using digital technology to strengthen health financing functions, there are experiences regarding payments using digital technology. However, there isn't much evidence when it comes to the other aspects of digital health and needs to be further researched for evidence generation. To understand the impact of different financing models on population health, Brazil has experienced a visible impact on mortality as evident from the administrative datasets they have compiled.

Dr Grace explained how India has facilitated digital payments at the primary healthcare level, including beneficiary transfers taking place through Public Financial Management System (PFMS).

Ms Pallavi Gupta wanted to understand from Professor Hanson on establishing accountability and governance amongst the providers concerning blended payment models.

Professor Kara Hanson responded that there are certain elements of a blended system where accountability can be addressed. Introducing pay for performance can help create a more direct relationship between payments and outcomes. Any blended system would need careful structures of reporting against expenditure. One of the disadvantages of capitation is that the payment is not related to the activity and therefore it won't be possible to generate the information that is required to understand the activity that is being financed.

Session Two: Financing of Primary Care in Asia and India

Chairperson: Ms Roli Singh

Presenters: Mr Manoj Jhalani

Dr Ajay Tandon

Primary Health Care Financing in the WHO South-East Asia Region with a focus on India – Mr Manoj Jhalani

Mr Jhalani focused on primary healthcare financing in the WHO South-East Asia region (SEARO), specific to India. There has been a strong recognition of the need to prioritize primary healthcare globally and regionally, right from Alma Ata, Asthana Declaration, Operational framework for Primary Healthcare by WHO and UNICEF, Walk the Talk from World Bank, and Southeast Asia Regional Strategy for Primary Healthcare 2020. Going forward, the WHO has identified five strategic priorities and one of them is the re-orientation of health systems towards primary healthcare as the foundation for UHC and health systems resilience.

Mr Jhalani emphasized that primary healthcare is important because it can improve health outcomes, lower hospitalization, reduce out-of-pocket expenditure and address several Sustainable Development Goals (SDGs) besides UHC and wellness. Primary Healthcare is also critical in the post-COVID - 19 context where the need for resilient health systems has gained significance. He endorsed the WHO's commentary on the Lancet Global Health Commission report on primary healthcare financing stating that it combines a shared vision with practical guidance on how to align health financing with overall reform strategies that place primary care service delivery at the core. With regards to the primary healthcare financing context in the SEARO region, Thailand and Bhutan have displayed good health outcomes with relatively low costs and in India, Tamil Nadu is an

exemplar of this phenomenon. Around 80 - 90 per cent of emergency health services can be delivered through primary care.

Amongst all the WHO regions, SEARO has the highest out-of-pocket expenditure and the lowest government spending on health which is associated with high levels of inequity and poverty. Although between 2000 to 2017, the population impoverished due to low levels of healthcare spending has reduced from 30 per cent to 6 per cent, the catastrophic healthcare spending has increased in the region which is a matter of concern. Data from seven of the eleven countries in the SEARO region, reveals that the per capita spending is highest in Thailand and lowest in India. Primary healthcare as a share of GDP in India inclusive of the public and private sectors is 1.36 per cent while the global average is 3.1 per cent. Private financing accounts for more than half of healthcare spending in Myanmar, Sri Lanka, Nepal, and India. Contrarily, government financing is the main source of primary healthcare spending in Thailand and Bhutan.

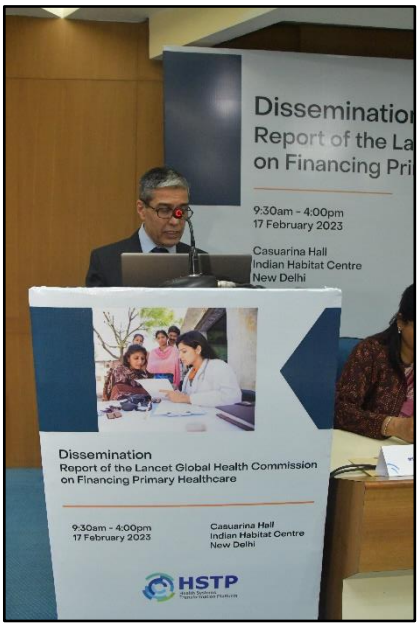
Primary Healthcare as a share of GDP in India inclusive of Public & Private is 1.36% while the global average is 3.1%.

Mr Jhalani noted that the reasons for high out-of-pocket expenditures in the private sector are medicines and public spending on outpatient curative care. In Thailand and Bhutan, the government is the major payer for primary healthcare spending, and therefore, the share of out-of-pocket expenditures and private sector spending is lower in them. However, in India, about 40 per cent is government spending and the remaining is out-of-pocket expenditures and the private sector. As per the latest National Health Accounts Estimates for India, the total health expenditure as a percentage of GDP is 3.2 per cent, the government spending is about 1.28 per cent, the government's share in total health expenditure is 40 per cent, out-of-pocket expenditure as a percentage of total health expenditure accounts for 48 per cent and primary healthcare accounts for 55 per cent of government expenditure. He also indicated the share of budgets for the National Health Mission (NHM) budget in the overall health budget is declining over the years.

He emphasized that India continues to be the fastest-growing economy and has managed to reduce the fiscal deficit to around 6 per cent indicating that India can invest more in healthcare, especially primary healthcare. Pointing to the commitment made to spending two-thirds of the health budget on primary health care in the National Health Policy 2017, he mentioned that investing in primary healthcare for health system resilience is the most cost-effective way to advance towards UHC.

Until 2005, all investments from the Government of India were towards vertical programmes. Later, these programmes were integrated, and health was looked upon from the systems perspective where investments in human resources, access to essential medical commodities, health information systems, strengthening community health workers, and building capacities at the district, block and state levels were brought in as part of the National Rural Health Mission.

A Niti Ayog study has shown positive outcomes for NHM in terms of coverage of services, equity in utilization and health outcomes. Nevertheless, NHM primarily focussed funding on vertical programs of Reproductive and Child Health (RCH). India did not consider one health system serving the diverse needs of different programs, rather it looked up to diverse programs having health systems built into them. Over the course of years, efforts were made to make the system horizontal instead of vertical. After the introduction of initiatives like the Janani Sishu Suraksha Karyakram (JSSK), remarkable changes were noticed in terms of lower OOPE in public health facilities. He also pointed out the fact that states have not made complimentary investments in India, due to a lack of



funds and delays in the release of funds. There are also issues around governance, use of funds and health information systems data.

Public spending on secondary and tertiary care gets more traction as opposed to primary healthcare. The Prime Minister's Jan Arogya Yojana (PM-JAY) has encompassed other aspects such as the emerging non-communicable diseases (NCDs) within the ambit of public financing. To build a strong primary healthcare investment case for India, a regional primary healthcare forum has been created at WHO to develop a good advocacy document for the member states. Mr Jhalani emphasised the importance of such a document for India using the evidence gathered. He also suggested increased visibility, attention and priority for Ayushman Bharat Health and Wellness Centres like the PM-JAY.

To make a good case for investing in primary healthcare, there is also a need to demonstrate the utility and significance of comprehensive primary healthcare through the health and wellness centres in delivering assured services, increasing outputs, and reducing OOPE. This would eventually entail more funding for primary healthcare. Mr Jhalani mentioned that India needs strong implementation capacity in terms of institutions, management, and governance. He advocated for creating model districts in India like Thailand where there is a district hospital, for a 30,000 to 100,000 population with a capacity of 26 doctors and 18 specialists. He also emphasised the need for India to move towards performance-based incentives linked to facilities and subsequently head towards the capitation model.

Primary Healthcare Financing in India: Some Perspectives – Dr Ajay Tandon

Dr Tandon began his presentation by stating that India is a developing country experiencing a period of change and not in a state of equilibrium. Over the past three decades, India's average annual income (per capita) has increased fivefold. Despite experiencing greater economic hardship during the COVID-19 pandemic, India's vaccine distribution was exceptional, leading to economic expansion through trade and the supply of vaccines to other countries. While the rest of India's neighbours are experiencing a recession, India is expected to maintain its growth and become one of the countries with the fastest-expanding economy in the world. There is a significant gap in wealth across states in India, with Kerala being far more prosperous than Bihar and Uttar Pradesh in terms of income per capita. Shifts at the state level affect both demands for primary healthcare services and funding for infrastructure and healthcare services. The total fertility rate (TFR) in India is close to the replacement level, and the ratio of births to deaths has been falling since 2000, indicating slower population growth.

The declining number of births over a considerable period has significant repercussions for the age distribution of the population. At the same time, life expectancy is growing across the country, albeit at varying rates in each state. As a result, there is a significant chance that the ageing of the population will increase in the coming decades. Hence to augment better healthcare for the elderly population in India, there is a need for additional primary healthcare centres as the ageing population will continue to increase. India also requires more Primary Health Centres not only because of the demographic shift, but also due to other growth factors such as urbanization, shifting diets, changing lifestyle patterns, and the expansion of additional risk factors such as obesity and

pollution. In recent times, Non-Communicable Diseases (NCDs) are the largest growing burden of diseases across the country, with their impact on disability-adjusted life years (DALYs) increasing.

Dr Tandon lauded India's progress in various health indicators such as life expectancy, which is currently about 70 years. The under-five mortality rate (U5MR) and infant mortality rate (IMR) are both falling, representing progress towards achieving the targets of SDG 2030. Additionally, according to the NFHS-5, 85 per cent of women aged 15-49 who had a live birth in the five years before the survey received antenatal care from a skilled provider at least once for their most recent birth. In India, 59 per cent of women have received at least four ANC when pregnant with their most recent child, which is commendable for the country in terms of healthcare services. Increasing institutional deliveries is one of the most critical factors in reducing maternal and neonatal mortality rates. There is significant progress in institutional deliveries and births assisted by skilled providers.

Overall, several health reforms, including the National Rural Health Mission (NRHM), Ayushman Bharat in 2018, health and wellness centres, and Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), have contributed to the strengthening of primary healthcare in India. The importance of health has also been recognized as a result of COVID-19, with the 15th Finance Commission allocating health-specific funds for the first time, distributed through local governments. Nevertheless, it is important to give greater attention to the increasing inequality across states in terms of effective coverage for services such as complete ante-natal care reflected by the NFHS-5.

There are also significant disparities between the income of a state or nation and the infant mortality rate (IMR). Dr Tandon's analysis presenting evidence on the relationship between these two variables reflected that the United States has a high IMR despite its high-income level, whereas Sri Lanka, Thailand, and China exhibit a lower IMR despite their low-income levels. Additionally, while both Cambodia and Pakistan have similar income levels, Cambodia has a substantially lower infant mortality rate than Pakistan. India's IMR falls within the range of "not bad" and "not good," which is significantly better than expected given the country's income levels. Several of India's states, such as Manipur, Bihar, and Meghalaya, exhibit lower infant mortality rates than what would be anticipated based on their income levels. Despite Kerala being five times better than Bihar in terms of income, it is only two to three times better than Bihar in terms of infant mortality rates. Therefore, it is inadequate to evaluate progress based on a single indicator alone, and it is imperative to analyse the trends and patterns of effective coverage.

While India has made significant strides in Reproductive, Maternal, New-born and Child Health, NCDs are increasing, and their management remains an incomplete agenda. NFHS–5 reveals that a significant proportion of diabetes and high blood pressure cases remain uncontrolled, despite the potential for these conditions to be addressed at the Health and Wellness centres. This is a major challenge due to limitations in primary health care and is crucial to address these limitations since patients who remain undetected with diabetes and hypertension are more likely to require

hospitalization once the condition has progressed to a more critical stage. It is essential to consider these issues together in an integrated manner.

The fragmentation in India's health financing system, which was designed to function similarly to the National Health Service (NHS) in the United Kingdom, has not yielded the desired results. Nonetheless, some of the existing social health insurance schemes are implementing changes related to insurance on the demand side, indicating that the issue is not solely limited to fragmentation in primary healthcare finance. Funding for all levels of care remains an issue in India's system, where there is strong coverage for the poor and vulnerable, as well as the formal sector, but not for those who are informal, non-poor, and "missing middle." Despite public funding growing, it comprises one-third at the central level and two-thirds at the state level; the bulk of the total health expenditure continues to be out-of-pocket expenditure due to heavy privatization in the health system and spending on diagnostics and drugs. It is imperative to consider this larger context of health financing when considering how to pay for improvements in primary health care.

Dr Tandon emphasised that to reduce the disastrous effects of healthcare financing on the vulnerable population, it is suggested that since out-of-pocket financing disproportionately affected the poor if there are financial constraints, the needs of the poor must be prioritised. In India, public health spending barely accounts for 1.2 per cent of GDP, even though public financing for healthcare has tripled over the past two decades due to consistent GDP growth. To make further progress, it is necessary to increase the proportion of public health financing to GDP.

In addition to India's low level of public financing, there are also issues with the country's Public Finance Management System (PFMS). Dr Tandon mentioned that the Lancet Commission's conclusions are significant and timely, especially for developing nations like India. At the primary health centre level, basic health interventions such as efficient administration of institutions should be implemented. There is a problem with the distribution of funding for primary healthcare; it is crucial not only how much money is spent but also how it is used. It is essential to record the use of funds more systematically across states and internationally. Robust economic changes are also required for improved healthcare in addition to the need for public financing of basic health services. Efficient primary healthcare services are essential from an economic standpoint, as they eliminate the need for more extensive health reform in secondary and tertiary care, increase the level of productivity that individuals can achieve, and reduce the number of financial resources that are used inefficiently for healthcare, such as unnecessary hospitalizations and readmissions.

Dr Tandon mentioned that public financing of primary healthcare facilities seems to be a viable approach to combat poverty and improve access to care. At the primary healthcare level, the burden of catastrophic out-of-pocket spending is largely attributed to the cost of medications and diagnostics, which constitutes a significant proportion of both inpatient and outpatient care expenditures. Under the framework of the continuum of care, early diagnosis of NCDs such as diabetes and hypertension is crucial. However, since these conditions do not pose an immediate threat to one's health, requiring patients to pay out-of-pocket for their care can deter and delay critical utilization. Moreover, the vague symptoms associated with these illnesses often lead to delayed diagnosis, which can have devastating consequences for patient’s health and financial well-being. Therefore, failure to invest in primary healthcare facilities could result in not only a reduced quality of life but also increased hospitalization expenses under the PM-JAY.

Most of the nations' efforts are primarily focused on treating disease outbreaks that occur as a direct result of inadequate prioritization of disease prevention and early diagnosis. Managing conditions such as diabetes alongside other multi-morbidities or comorbidities can significantly exacerbate the difficulties associated with disease management. This highlights the importance of an integrated care approach. It is not sufficient for nations to concentrate solely on disease outbreaks; they must also prioritize disease prevention. The World Bank is currently focusing its efforts on ambulatory care, as part of the Ayushman Bharat programme. The use of ambulatory care has been demonstrated to reduce hospitalisation rates, and patients with Ambulatory Care Sensitive Conditions (ACSCs) are frequently referred to as experiencing "avoidable hospitalisation for ambulatory care-sensitive conditions". Unfortunately, there is no established list of conditions in India that necessitate ambulatory treatment.

When evaluating primary care efficacy based on avoidable hospital admissions, the discrepancies in demand and supply issues emerging from hospitalisation data need to be considered. Countries such as Malaysia, Vietnam, and China provide examples of this trend. Approximately 30 per cent of Vietnamese social health insurance expenditures were associated with ambulatory care-sensitive conditions. In China, the proportion of expenditures made by the Chinese social health insurance scheme for hospitalisations was similar. Therefore, it is critical for the health information management system to begin considering these factors.

Dr Tandon emphasized the need to further explore and assess the actions taken by various states, to derive meaningful insights. He cited the example of Tamil Nadu, where the insurance program already covers outpatient diagnostic services provided by private healthcare institutions. This implies that individuals who need diagnosis but do not require hospitalization can benefit from a framework package that utilizes state finances to include such services. However, it is worth noting that not all private healthcare establishments provide this option. Nonetheless, a few such establishments have been empanelled, and a few diagnostic packages have been included, with payments being made using negotiated unit prices instead of capitation. This is a positive development and represents a step towards expanding public financing to cover private services under the program, thus making it a promising public-private partnership model.

Public Private Partnerships can be used to not only involve the private sector but also leverage it.

Dr Tandon highlighted the use of public-private partnerships (PPP) to motivate the private sector for increased participation, rather than indicating the government's intent to privatize healthcare. To exemplify this, he discussed Uttarakhand's lack of public facilities and the decision to hire a cluster under the cluster model contractor, where the provision of the hospital, Community Health Centres, and the mobile unit was delegated to a private entity compensated with a monthly fee. However, the impact of this on resolving issues associated with public financial management requires documentation and thorough assessment.

Dr Tandon in his concluding remarks reemphasised the need for adequate coverage and reduction in disparities between states for maternal and child health services, for NCD care and to prepare primary care institutions for providing geriatric care. He supported the Lancet Commission's call to boost public support for basic healthcare institutions, stressing that financing alone is not enough; an incentive structure for integration must be considered to optimize resource utilization.

Discussion

The discussion centred on various aspects of healthcare expenditure, utilisation and service delivery in India. Dr Indranil mentioned that decreasing out-of-pocket expenses and increasing government expenditure on healthcare in India is a positive development. As per the NSSO, healthcare utilization is reducing both for outpatient care and hospitalization. However, the decrease in overall health expenditure as a proportion of GDP is a cause for concern. The lack of data in the public domain was also highlighted, and assistance was sought to overcome these challenges for the benefit of researchers and the community. Mr Manoj Jhalani stated that out-of-pocket expenses were not only regressive but also inefficient and suggested that if the government procures and supplies drugs, it may cost as little as 20 INR per capita, which has efficiency advantages. He also highlighted the progress made in institutional delivery from NFHS-3 (2005-06) to NFHS-5 (2019-21).

Dr Ajay Tandon reiterated the fact that out-of-pocket expenditures are the largest source of financing in India. Government spending continues to be low, and it is satisfying to observe from the NFHS that there is increased utilization of in-patient and out-patient services, thereby necessitating increased government funding for health.

Mr Jhalani reflected that the data for PM-JAY is not available in the public domain; however, the impression given by the states is that utilization has increased, and hence the allocation has also increased, thereby covering the missing middle. What remains important to capture is the forgone care, for those who can't afford to spend out of pocket. **Mr Rajeev Sadanandan** mentioned that forgone care is captured by the NSSO in its health round.

Dr Ajay Tandon also stated that there is evidence that forgone care has gone up due to COVID-19 and it is important to look holistically at out-of-pocket expenditure, forgone care, catastrophic incidence, and health outcomes. Transition in health financing happens similarly to the demographic transition and nutritional transition. When countries grow and develop, they spend more on health and there are indications that India has started transitioning, although not as fast-paced as China or Thailand.

Ms Lopamudra Ray Saraswati inquired whether research on improving political will and commitment would be more productive than evidence-building. **Ms Roli Singh** mentioned that political will and commitment also depend on state capacities and how they deliver the same basket of schemes. **Mr Jhalani** opined that in his experience an effective proposal to the government and a good media campaign strategy to promulgate the initiative to the masses would attract political backing.

Mr Adithyan asked the panellists in a country like India where not many accountability mechanisms exist, what precautions should be kept in mind when engaging with Public Private Partnerships (PPPs). In his response, **Dr Ajay Tandon** stressed the distinction between public provision and private provision and public financing and private financing. He indicated that Public Private Partnerships in other sectors are majorly private financing, however, in the case of health, private financing may not be a good proposition. Before engaging the private sector, it is important to understand why the private sector needs to be involved. However, given the fact that India's health sector is highly privatised, the role of the private sector cannot be ignored. Instead, there needs to be a strategy to work closely with them and identify how to leverage private partnerships. He also agreed with Professor Hanson that incentives need to be built to leverage private provision. There needs to be a check on fraudulent mechanisms and the quality of care among public and private providers.

Ms Roli Singh requested the panellists to discuss a few good practices from other countries that would be useful in the Indian context, how countries have ensured that public money follows the patients, and what mechanisms are in place to assure this.

Dr Ajay Tandon cited examples from Thailand, Indonesia, the Philippines and Vietnam and mentioned that experiences from these countries could be examined to understand how they have managed to bring private primary healthcare into public financing. He mentioned Indonesia has given its population the choice to register at their public health and wellness centres or with a private provider, although all private providers are not empanelled. The money then follows the patient, and the capitation goes to the private primary healthcare providers. This also brings in a sense of competition between the private and public providers so the people are allowed to switch between providers if they don't receive care, and hence, more competition is brought in based on responsiveness.

Mr Jhalani expressed that Thailand is not a good example in terms of private sector involvement, as 90-95 per cent is public sector provisioning. Private sector presence is specific to Bangkok. However, Thailand has developed efficient systems and institutions to manage and monitor their healthcare system. On the other hand, Indonesia has challenges in managing its Jaminan Kesehatan Nasional (JKN) program, a major program for achieving Universal Health Coverage.

Finally, the risks associated with states that have completely banned the dual practice and those that permit the practice were discussed. Ms Roli Singh emphasised the need for integrated thinking to strengthen healthcare provisioning without compromising the vision of the 12 packages of primary healthcare services and the HWC mechanism. She also highlighted that policymakers must understand the need for managing good contracts to attract finances from private financiers into the public financing pool. The existing bureaucratic systems need to be examined to address inefficiencies. Overall, the discussion provided valuable insights into the challenges underpinning the healthcare sector in India and potential solutions to address them.

Session Three: Managing Finances for Primary Healthcare

Chairperson: Dr Indranil Mukhopadhyay

Presenters: Dr Grace Achungura Kabaniha

Dr Shankar Prinja

Financing Primary Healthcare in India – Public Financial Management challenges - Dr Grace Achungura Kabaniha

Dr Grace Achungura's presentation focussed on PFM challenges in India based on work done by WHO in Bihar, Maharashtra, Odisha, Jammu and Kashmir, and Assam. Public Financial Management System is important to our country's context as India continues to invest a considerable amount of money in primary healthcare. Traditionally, the Public Financial Management (PFM) cycle involves budget formulation, budget execution and monitoring; however, in recent years, many countries have started considering output-based budgeting reforms due to their desire to understand if they are realising value for the money that is being invested. With varied funding sources, schemes and programmes being a part of the budgets in India, PFM tends to get influenced by the way the budget is structured.

Dr Grace highlighted fiscal decentralisation, especially the role of the 15th Finance Commission in determining the devolution of funds for primary healthcare. While funds for primary healthcare already exist in the form of the National Health Mission for almost two decades, the way primary healthcare is funded in India has improved during the last eight to ten years. More importantly, post-

COVID-19, the 15th Finance Commission has provided an impetus to influence spending on health, especially through the local governments. This decision therefore aligned with the recommendations of WHO and the World Bank to the Finance Commission for the devolution of more funds to the local government. However, for primary healthcare, introducing local self-governments as another key player has its challenges in terms of planning collectively, transfer of funds and approval.

Dr Grace also pointed out the key challenges in budget execution emerging from the fund flow arrangements and the budget structure. While states like Tamil Nadu do not face delays in receipt of funds thus resulting in 80 per cent budget execution, states like Bihar, Assam, and Maharashtra experience very long delays in the processing of funds. Cumbersome approval processes between the state treasury and state health society inadvertently delay the availability of funds in the districts and the blocks. In Maharashtra, it takes almost two months to approve the budget as the process necessitates 25 approvals to be taken between the treasury and state health society, and in Bihar close to 42 approvals before it is released to the state health society.

Similarly, the budget release is a concern in the states. For instance, in Assam, these were delayed by four months from the treasury to the state health society and thereafter another month to transfer it to the district health society and further an additional month to transfer to the blocks. This hampers the budget implementation as well as its utilisation. Nevertheless, recent changes introduced in the simplification of the budget codes in the NHM PIPs, and the creation of a Single Nodal Account are expected to help the movement of funds and improve efficiency and budget execution in the coming years.

She also expressed concern that there are several challenges in having fixed line-item budgets. For instance, if capitation needs to be accommodated into the budgeting by way of introducing innovations at the provider level, congruence cannot be achieved between the current budget structure and the PFM. There is very little provision in the budget for contracting the private sector providers. Issues around purchasing arrangements, lack of capacity building for budget execution and understanding of the PFM reforms are also challenging and are more evident at the lower levels of planning as observed from the assessments done in Assam, Jammu and Kashmir.

Intersectoral dialogue between the Ministry of Finance and the Ministry of Health and Family Welfare is crucial for the sustained availability of funds for primary health care.

To address these bottlenecks, an intersectoral dialogue between the Ministry of Finance and the Ministry of Health and Family Welfare is extremely critical. Odisha has piloted this initiative, where a Finance Advisor from the Finance Department is placed within the Department of Health. Several other countries have also tested this arrangement to place officials from Finance within the different social sectors as part of their sector-wide approach. This will create a sense of ownership for health programs by these officials, speaking on behalf of the health department, facilitating a better understanding of PFM reforms, reducing the approval time, and improving understanding and shaping the budget.

On the aspect of accountability and monitoring, Dr Grace mentioned there is a degree of monitoring of both financial and non-financial aspects in terms of the program targets as part of the output-outcome framework in the Union budget. However, there is no evidence to measure its impact on budgeting and resource allocation. Incentivising states based on performance has motivated states and enabled them to get additional resources for health. There are also incentives introduced at the team level in recent times, however, capitalising on these requires adequate support for structuring the payments and nudging the disbursements. She concluded by appreciating India's efforts to design and implement digital platforms and innovations around the Direct Beneficiary Transfers for different programs under the National Health Mission. However, it is the sustained commitment and efforts that can ensure congruence to meet India's Universal Health Coverage and primary healthcare objectives.

Dr Mukhopadhyay highlighted some of the key points made by Dr Grace, emphasizing the challenges and contradictions in the fiscal federal architecture of India, where the union government holds most of the progressive financing and taxation responsibilities, while states rely more on indirect taxes. This poses a significant challenge in increasing the total health budget. The synergies and contradictions between PFM and health financing reforms were also discussed.

How costing studies contribute to designing Primary Healthcare reforms - Dr Shankar Prinja

Dr Shankar Prinja in his presentation emphasised that improving efficiency in healthcare spending requires more money, better utilization, as well as a responsive financing mechanism that allows for flexibility considering the significant variation across healthcare facilities. Blended payments and provider autonomy at the facility level could also be considered as potential solutions. Dr Prinja discussed the need for better cost data and analytics to inform financing reforms and improve healthcare efficiency. He identified three key areas where better cost data could help improve the financing process. The first area is resource generation, where it becomes necessary to determine how much funding is required for comprehensive primary healthcare. The second area is regarding purchasing healthcare services, where identifying cost-effective interventions that are not currently provided adequately is critical, along with determining how to deliver them efficiently. Third is the payment systems reform, which involves considering the available data to determine how much to pay providers and its implications for budget impact and efficiency norms.

Dr Prinja presented findings from his recent study that assessed the resource requirements for scaling up Ayushman Bharat Health and Wellness Centres using cost data from healthcare facilities from an economic and financial perspective, primarily looking at budget increments needed to meet standards. The study focused on identifying the extent to which the current health system lacks primary healthcare per the Indian Public Health Standards (IPHS) and additional services that should be incorporated as part of health and wellness centres in a phased manner. From an economic perspective, the study attempted to estimate a capitation payment that could potentially be made if this model were open for private-sector contracting. Using primary data on health facility costs collected across a range of different facilities, the study made projections on the overall coverage of services and increase in service uptake. The analysis suggests that the per capita

The per capita costs for scaling up are approximately 4 to 5 USD for sub-centres and about 5 to 6 USD for primary health centres.

costs for scaling up are approximately 4 to 5 USD for sub-centres and about 5 to 6 USD for primary health centres. He emphasized the importance of better cost data and analytics to inform financing reforms and improve healthcare efficiency.

Dr Prinja proposed utilizing cost evidence derived from diverse Health Technology Assessments (HTA) to make informed decisions regarding the scaling up of various interventions within primary healthcare packages. The institutional structure governing HTA assessments in India is formal and aims to increase healthcare expenditure and ensure better value for money. To achieve this goal, access to reliable cost evidence is crucial, and the Health Technology Innovation National (HTIN) has made significant progress in developing a cost database that provides information on the cost of delivering different types of healthcare services across various levels of care. This database encompasses a broad range of healthcare facilities from sub-centre level to district hospitals, and ongoing efforts to gather data from tertiary care institutions are also being incorporated. Ultimately, this cost evidence will inform decisions related to primary healthcare financing.

He presented a noteworthy example of the significance of operational guidelines through an exemplary cancer screening program for survival. The focal point of the discussion was not on whether to conduct cervical cancer screening but rather on the appropriate approach to conduct it. This involves selecting the optimal screening method (Pap or HPV DNA), determining the age bracket for screening, and deciding on the frequency of screening. These factors are pivotal considerations for program managers in designing an effective program. His analysis emphasized that even with the most optimal screening strategy, it may not be cost-effective if the treatment coverage remains below 40 per cent. Thus, it is essential to establish a linkage between screening and treatment to provide appropriate care for identified cases.

He proposed the implementation of a responsive financing payment system that combines payment for various services in different ways. Outpatient, inpatient, and ancillary services are the three main types of services, with indirect services such as medical officers performing post-mortem duties or being assigned to VIP duties. However, capitation-based payment, which is ideal for primary care delivered in an outpatient setting, may not be suitable for this scenario. The financing mechanism is norm-based, with the salary of human resources being the most significant cost. Hence, the payment system cannot be linked to the population size that a facility caters to. Nevertheless, it is crucial to consider the population's healthcare needs when determining payment. A lump sum or global budget that is risk-adjusted for the prevailing healthcare needs in each region or area could be an appropriate payment system.

Dr Prinja also stated that the risk-adjusted global budget for patient care involves two significant adjustments. Firstly, patient care is remunerated through a bundled payment based on cases. Secondly, indirect services are compensated through a global budget. Although the global budget is not a fixed amount for each hospital, it is ultimately linked to the size of the facility. The number of beds in a hospital determines the amount of indirect cost budget that is allocated. Therefore, there is a certain degree of responsiveness to the overall payment that a facility receives in terms of the needs it caters to, differences in cost relative to other facilities, or the size of the hospital.

Establishing norms for efficiency is crucial, and cost data can provide useful insights into developing standards or norms for efficiency, monitoring standards, governance and accountability frameworks. During an assessment of referral transport services in northern Indian states, the norm for the placement of an ambulance was proposed based on the average cost of running an ambulance and the average volume of services delivered. Positioning an ambulance at a point where there is a patient volume of 4 to 5 per day was recommended and subsequently included in the NHSRC guidelines. Dr Prinja suggested the use of cost evidence to be incorporated in various HTAs to provide recommendations for scaling up different interventions under the primary healthcare packages. He discussed the importance of establishing a linkage between screening and treatment to provide appropriate care for identified cases. Overall, he emphasised that better cost data and analytics can inform financing reforms and improve healthcare efficiency.

Discussion

Dr Indranil Mukhopadhyay requested **Dr Grace** to share her views on making health systems accountable to people at the local level and any global evidence that has improved PFM systems across the country. Dr Grace suggested that using Panchayats for improved accountability would be a good way to look at it because they have legitimacy at the local level and the ability to convene in an intersectoral manner to address the social determinants of health. She quoted the example of the Direct Facility Financing system introduced in Tanzania which emphasised the role of decentralization.

Dr Indranil Mukhopadhyay wanted to understand from Dr Prinja the data challenges in effective purchasing and financing reforms within the existing system of governance. Dr Prinja emphasised that accountability can only be ensured if there is adequate capacity, decision-making space, and provider autonomy. There was also discussion on data challenges, how data is often perceived as a critique of their performance, and the importance of collecting sensitive data necessary for monitoring real-time performance at the primary healthcare level. He also mentioned the use of cost surveillance systems built into routine MIS systems in the PM-JAY ecosystem and general healthcare delivery system as well.

Professor Hanson enquired Dr Prinja on the topic of how to set up a budget for the capitation-based system. Dr Prinja stated that coming up with a payment method based on the capitation system has challenges like human resources cost being the largest share of the overall cost which is 70-80 per cent. In certain facilities since the norms for human resources are not contingent upon the population that is being served by the facility, it is difficult to come up with a number but when the cost is calculated without the human resources element then some relationship is visible.

Dr Sudha Chandrashekhar requested **Dr Grace** to elaborate on the progress in assessing the impact of the PFMS system in states. Dr Grace explained that although the adoption is still in its early stages, states have taken steps to improve the system at their level. For instance, Jammu and Kashmir is putting systems in place to bridge the gap in the PFMS system. **Dr Prinja** also responded to a question posed by **Dr Sudha Chandrashekhar** about the budget allocation based on evidence for Health and Wellness centres. He mentioned that the overall budget allocations for this initiative have largely remained stagnant.

Dr Grace wanted to understand from **Dr Prinja** about the role of costing in improving the efficiency of primary healthcare financing. **Dr Prinja** explained how cost data is being used to

inform service delivery time and design in selected contexts. **Dr Ajay Tandon** provided insights from his experience working in many countries, where capitation is prevalent as partial payment for healthcare, especially in the public sector. He also enquired with Dr Prinja about how inflation can be factored into the costing exercise. Dr Prinja suggested a cost surveillance system to address the issue of inflation and use the NSSO's commodity-based inflation data to adjust for inflation. The discussion concluded with Professor Hanson emphasizing the importance of recognizing that even small amounts of discretionary funds can be immensely valuable for realising healthcare quality.

Key Takeaways and Way Forward

Professor Kara Hanson summarised the discussions and presented the takeaways from the panel discussions emphasising that the follow-up should involve issues that were not addressed in the Commission as well as issues that need to be contextualised. The key takeaways are detailed below:

- As essential public health functions need to be delivered at the primary healthcare level, it is important to understand how best to finance it. There are no specific norms about what should be financed and where to channel them. Instead, it is more important to make sure that services are delivered. There is a need to think of alternative financing instruments to ensure that these functions are performed.
- Detailed research on models of primary health care in urban settings and its financing mechanisms need to be undertaken to design the right kind of urban primary health care service delivery models.
- Explore mechanisms to streamline conditional cash transfers as a financing mechanism for primary healthcare and examine how best to link it for a better interface with the primary healthcare financing systems. It is important to think of multimorbidity and its management from a financing lens and incentivise the team working around the management of complex NCDs, not due to its magnitude but because it demands a different type of response for service delivery.
- Given the wide variation across states, innovations in primary healthcare financing and its delivery could be learnt from within India. Experiences from other country settings such as Thailand although different from India, provide interesting insights on reducing out-of-pocket payments through increased public funding and effective purchasing arrangements. OOP payments in Thailand are 10 per cent with a minimum level of impoverishment. However, Indonesia which is more like the Indian context has introduced an insurance system that covers 97 per cent of the population which in turn has reduced OOP payments by 50 per cent and managed to purchase care from private providers.
- In a devolved system like India, it is very important to build allies with different stakeholders within the government, particularly with the department/ministry of Finance. They need to be constantly persuaded to bring in flexibilities within the standardised budget line items to facilitate other payment mechanisms like capitation.
- The messages from the Commission and specifically from the event should be shared with state-level authorities to explore opportunities for deep dive analysis of primary care financing that could be useful learning experiences as well as contextualise primary healthcare financing reforms.

Professor Hanson concluded her remarks by emphasising that young researchers should take the discussions forward and work on issues that may find answers for ensuring that India's primary healthcare financing system is better equipped to accommodate the emerging primary healthcare priorities.

Mr Rajeev Sadanandan thanked the participants on behalf of HSTP and the Lancet Global Health Commission for joining the event. He mentioned that the discussions went far beyond the contents of the report of the Commission and HSTP would carry forward some of the work based on the Commission report and the discussions from the event.

Annexure 1

Dissemination of the Report of the Lancet Global Health Commission on financing primary healthcare

Friday, 17th February 2023

India Habitat Centre, New Delhi

Agenda	
9.30 - 9.40	Mr Rajeev Sadanandan
9.40 - 10.40	Presentation of the report – Professor Kara Hanson Chair - Dr Rajani Ved
10.40 - 11.00	Questions & Answers Session
11.00 - 11.30	Coffee Break
11.30 - 12.00	Primary Health Care Financing in the WHO South-East Asia Region with a focus on India - Mr Manoj Jhalani Chair - Ms Roli Singh, IAS
12.00 - 12.30	PHC Financing in India - Dr Ajay Tandon
12.30 - 13.00	Questions & Answers Session
13.00 - 14.00	Lunch
14.00 - 14.30	Financing PHC in India – Public Financial Management (PFM) challenges - Dr Grace Achungura Chair - Professor Indranil Mukhopadhyay
14.30 - 15.00	How costing studies contribute to designing PHC reforms - Dr Shankar Prinja
15.30 - 16.00	Questions & Answers Session
16.00 - 16.15	Concluding Remarks – Professor Kara Hanson

Annexure 2

Panellists		
S. No.	**Name**	**Organisation**
1	Ajay Tandon	The World Bank Group
2	Grace Achungura	World Health Organization
3	Indranil Mukhopadhyay	O.P. Jindal Global University
4	Kara Hanson	London School of Hygiene & Tropical Medicine
5	Manoj Jhalani	World Health Organization South
6	Rajani Ved	Bill and Melinda Gates Foundation
7	Roli Singh	National Health Mission, MoHFW
8	Shankar Prinja	Post Graduate Institute of Medical Education and Research

Annexure 3

Participants		
S. No.	**Name**	**Organisation**
1	Adithyan G S	World Health Organization - SEARO
2	Atul Bhanu Rairkar	National Health Systems Resource Centre
3	Ayushi	FICCI
4	Devaki Nambiar	The George Institute for Global Health
5	Granthika Chatterjee	Sattva
6	Himani Sethi	ACCESS Health International
7	Jaidev Anand	World Health Organization
8	Keerti	GIZ
9	Lopamudra Ray Saraswati	RTI International India
10	Madhura Kapdi	Save the Children International
11	Mampi Bose	National Health Systems Resource Centre
12	Maulik Chokshi	ACCESS Health International
13	Nandini Sharma	GIZ
14	Neeraj Jain	PATH
15	Neha Kashyap	RTI International India
16	Sheena Chhabra	The World Bank Group
17	Shobha Reddy	Karnataka Health Promotion Trust
18	Sita Rama Budaraju	Tata Trusts
19	Swaroop N	Karnataka Health Promotion Trust
20	Swati Mahajan	PATH
21	Taruna Juneja Gandhi	National Health Systems Resource Centre
22	Viplav Aleti	JvMarkis
23	Yashasvi Murali	Sattva

Annexure 4

HSTP Team		
1	Rajeev Sadanandan	Chief Executive Officer
2	Sridhar Guduthur	Chief Finance Officer
3	Pranay Lal	Senior Advisor
4	Sudha Chandrasekhar	Advisor
5	Pratheeba J	Technical Specialist – Health Financing
6	Sudheer Kumar Shukla	Specialist - Resource Planning for Health
7	Kumaravel Ilangovan	Specialist – Primary healthcare and PMJAY linkages
8	Shilpa John	Specialist – India Health Policy & Systems Research Fellowships
9	Pallavi Gupta	Specialist – Health Systems Governance
10	Ruchi Verma	Specialist - Health Informatics
11	Veenapani Verma	Junior Specialist
12	Sakshi Khemani	Research Associate – Health Systems Governance
13	Sonali Randhawa	Research Associate – Health Systems Governance
14	Diwakar Gautam	Finance Officer
15	Peter Parekattil	Operations Officer
16	Rahul S. Reddy	National Coordinator
17	Aaliyah Ali Khan	Program Associate, Program Management Unit
18	Rugma M.	Program Assistant, Program Management Unit
19	Vibhu Tomar	Administrative Executive
20	Prince Mediratta	HPSR - IT Support

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