




On the path to Universal Health Coverage: aligning ongoing health systems reforms in India

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The health of India's population has witnessed significant improvements over the past two decades. The infant mortality rate (IMR) has fallen from over 71 per 1000 live births in 1998 to 31 per 1000 live births in 2017. Maternal mortality has declined even more dramatically, from 540 maternal deaths in 1998 to 170 maternal deaths per 100 000 live births in 2013, a fall of close to 70%.¹ These reductions in mortality have been accompanied by a major shift in India's disease burden. Non-communicable diseases (NCDs) such as heart disease, diabetes and cancer, which accounted for 30% of disease burden in 1990, represented over 55% of the disease burden in 2016, while communicable, maternal and child diseases accounted for nearly one-third of the burden.²

Addressing these rapid shifts requires a fit-for-purpose health system to move towards Universal Health Coverage (UHC). The Government of India launched the Ayushman Bharat Programme in 2018, a potentially important step in this direction with two major components. First, primary healthcare improvements through investment in 150 000 Health and Wellness Centres (HWCs) and a new cadre of mid-level health providers, accredited for primary care and public health competencies. Over 38 000 HWCs were functional as of April 2020.^{3 4} Second, an insurance mechanism, the Pradhan Mantri Jan Arogya Yojana (PM-JAY), which aims to cover hospital-level care in both public and private hospitals for over 100 million poor families. PM-JAY has reimbursed over 9.5 million hospitalisation events since its launch in September 2018⁵ Both these components are largely financed through general tax revenues.

However, this latest reform to move India closer to UHC requires alignment between its component parts. The importance of such alignment is exemplified in the ongoing

response to the COVID-19 pandemic which demands close coordination across community, primary and tertiary levels of care. In this editorial, we argue that the long-term success of this reform requires, in particular, greater alignment of service delivery, provider payment mechanisms and information systems.

SERVICE DELIVERY

In keeping with globally recommended best practices on health systems strengthening for UHC, India's ongoing reform effort makes complementary investments in strengthening primary healthcare and in reducing barriers to hospitalisation. However, managing patients between these levels remains a challenge. Roles and responsibilities need to be clearly allocated between the different levels of the health system. Two-way referral mechanisms between well-equipped health facilities will need to be supported by a system of incentives for patients and providers to seek and provide care at the most appropriate level.⁴ This calls for greater investments at the primary care level and strengthening HWCs' role in gatekeeping care.

Aligning primary and hospital care will help to limit current overburdening of higher-level facilities, unnecessary hospitalisations, travel time, loss of economic productivity for patients and ultimately, cost inflation across the health system.⁶ Incentives for patients to initially seek care at the primary care level could include shorter waiting times for referred surgeries or consultations, compared with those who directly access higher-level facilities. Provider incentive systems that have been successful in other settings include bonuses for appropriate referrals at primary level facilities⁷ and penalties for hospitals admitting people for conditions amenable to treatment at the primary care level.

PROVIDER PAYMENT MECHANISMS

There is also a need to align provider payment mechanisms. Historical experience demonstrates that payment systems, once established, are difficult to reverse. Hence, it is imperative that these systems are appropriately aligned from the beginning.⁸ Mid-level providers and their supporting frontline workers are paid performance-based incentives based on the achievement of pre-determined targets. However, physicians at primary care facilities are largely paid fixed salaries,⁴ which could potentially lead them to refer patients to hospitals irrespective of actual need. Since these hospitals are being paid based on the number of cases treated, they have every incentive to accept these patients.

It is important to ensure that incentives and payment mechanisms facilitate appropriate referrals and help maintain the continuum of care. With respect to hospital-level care, PM-JAY pays hospitals a fixed rate for the provision of specified packages of care. Hence, there is an incentive to maximise the number of packages provided, but to reduce the number of services provided within a given package. More specifically for public hospitals, current arrangements imply that while patients covered under PM-JAY are a source of additional revenue, non-PM-JAY patients are not. This arrangement potentially sets up an incentive to prioritise receiving PM-JAY patients relative to other patients. This has implications for equity in access to care.

HEALTH INFORMATION SYSTEMS

Information systems are another area where alignment could transform India's reform. The PM-JAY insurance programme has developed an extensive provider-linked information system encompassing empaneled public and private providers as the basis for making payments. It is important that steps are taken to integrate this system with the existing health management information system (HMIS) in the public health sector.⁹

Better integration, including through the optimal utilisation of the Integrated Health Information Platform, can facilitate multiple key health system functions including monitoring patient referral pathways, calibrating incentives and aligning provider payment mechanisms, tracking health trends and analysing the performance of the whole health system. It would also be important to explore integration and alignment of information systems beyond the existing HMIS and include private providers who account for the majority of outpatient visits in India, existing epidemiological surveillance data systems such as the Integrated Disease Surveillance Programme and other data systems bringing together information on a wide range of issues with implications for health ranging from drug resistance to food safety.¹⁰

CONCLUSION

The alignment of service delivery approaches, provider payment mechanisms and information systems described

previously will be crucial in building people's trust and public confidence. The long-term success of India's reform towards UHC depends on the PM-JAY being connected to a well-functioning and adequately staffed primary healthcare system that goes beyond curative care to encompass broader health promotion and prevention efforts which are necessary to improve population health. Investments in developing new cadres such as mid-level health providers will need to be complemented by policies to ensure their appropriate distribution and deployment. In addition, a robust and comprehensive information system is a pre-requisite both for effective referral and well-functioning provider payment systems.

We recognise that alignment is needed beyond these three areas.⁹ However, addressing them would be an important first step. Indeed, they would create the linkages that are vital for this reform to take India closer towards UHC.

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