Strengthening Public Financing of Primary Healthcare in India: A Perspective

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ABSTRACT: Resilient and high-performing health systems that can respond to the global polycrisis hinge upon the effectiveness of their primary healthcare (PHC) system. This requires adequate and sustainable financing for PHC, which should be predominantly government financed. The recent Ayushman Bharat health reforms in India aim to ensure comprehensive PHC services and enhance financial risk protection through increased government financing. The government has augmented investments to fortify the PHC system by establishing Health and Wellness Centers (HWCs), equipped with an expanded benefit package for PHC services & human resource capacity. Aligned with the National Health Mission's targeted and flexible financial mechanisms, this offers States the opportunity to contextualize solutions and offer incentives to health-care workers. However, aligning public financing arrangements to service delivery complexities and health outcomes pose intricate challenges in shaping the required reforms. The economic growth and room for increased taxation on health products provide an avenue for increased funding. Smart and efficient payment mechanism with improved accountability should complement increased investment.

KEYWORDS: Health financing, primary health care, India, government financing, Ayushman Bharat

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Introduction

The world is grappling with an unprecedented polycrisis as countries confront the aftermath of the COVID-19 outbreak as well as rising global temperatures and climate shifts due to increasing, perma-pandemics, acute and chronic humanitarian crises that have escalated prices of oil, food prices and in turn, exacerbated food insecurity arising out of climate change and new public health threats, among other things.[1] The result has been that at the midpoint of the SDG 2030 agenda, there has been a slowdown and a reversal, in some cases in sustainable development with only 12% of the SDGs on track for attainment.[2]

Health related goals have slowed down or stagnated and, in some cases, worsened, with only about 15% of these goals on track to reach their 2030 targets.[3] This has contributed to deepening health inequalities and increased mortality. The recent UHC Monitoring Report, 2023 observes a slowdown in progress on improving service delivery index in most low and middle income countries in the post-pandemic years, and India is no exception.[4] Furthermore, financial hardship related to health has increased during this time. It is important to shore up the health system capacity to ensure resilience and preparedness of health systems to respond to these and other threats. One of the fundamental aspects of this is strengthening primary health care. The recent Lancet Commission on Financing Primary Health Care and others have buttressed this point.[5]

Given that India occupies one fifth of the world's population, the pace of health outcomes in India significantly impacts overall global progress. Considering this, this paper proffers a perspective on the financing landscape in India relative to what has been shown to work. It also proposes context-relevant and evidence-based strategies to improving financing for PHC.

PHC is an essential foundation of UHC and is considered a key element of all high-performing health systems.[6] The Declaration of Astana, 2018 envisions PHC to be the first contact with health services for all people providing a comprehensive range of services and care, prioritizing essential public health functions (EPHF).[5] As defined by World Health Organization (WHO) and UNICEF, *"PHC is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment."*[7] PHC consists of 3 synergistic components including, (i) integrated health services to meet people's health needs throughout their lives; (ii) addressing the broader determinants of health through multisectoral policy and, (iii) action empowering individuals, families and communities to take charge of their own health.[7]

The emphasis is on delivering people-centered services through a functional referral system between primary and other levels of care that enhances the health system's resilience to prevent, detect and respond to infectious diseases and outbreaks.[8] This elaborate vision requires adequate and sustainable

financing of PHC, which should be predominantly government financed.

Background to PHC in India: Ayushman Bharat Health and Wellness Center Program (AB-HWC)

Government provisioned PHC services have since 2005, been channeled through the National Health Mission, with a focused effort to expand and augment services for preventive, primary, and secondary care for rural areas. The National Health Policy (NHP) 2017 provides the policy framework that guides India's approach for strengthening PHC through Ayushman Bharat Yojana (AB), launched by the Union Government in 2018.[9] This has enabled delivery of comprehensive PHC services across the country through the Ayushman Bharat Health and Wellness Center Program (AB-HWC). The AB-HWC program operates on the financing and service delivery arrangements established by the National Health Mission, thus not requiring a paradigm shift across levels of the health system.

The program focuses on ensuring access to PHC nearer to the community, within a 30-minute travel radius and cater to a population of 5000 individuals, as per established government norms through a network of HWCs. HWCs, which are upgraded sub-centers and primary health centers, or in some cases new units, have been repurposed to provide an expanded benefit package which ensures screening, basic management, counseling, and treatment including for non-communicable diseases and chronic communicable diseases. By July 2023, there were 160,891 HWCs in India and about 15% of these designated HWCs were Primary Health Centers (PHC) and Community Health Centers (CHC).[10]Services are provided through an HWC team including a mid-level Health worker (HW) and 3 other staff cadres providing outreach and referral services to secondary and tertiary care. HWCs are expected to deliver 12 service packages.

Key components of the HWC program to provide improved PHC are (1) flexible financial transfers to states, (2) structural changes to re-organize care nearer to communities by PHC teams (3) technology-enabled service delivery and monitoring including performance-based payments to personnel. (4) The delivery of household and community level services (outreach) (5) maintenance of care continuum through referral linkages and follow up care loops with higher level facilities and (6) tele-medicine services at 80 000 HWCs enabling technology enabled connectivity and timely referral.[11]Service availability is also being improved through contracting-in of health personnel and contracting out of clinical, hospitality services, bio-medical waste management and engineering services etc. through public-private partnerships. Inputs such as medicines and diagnostics are provided as commodities to the health facilities through the Free drugs and diagnostics initiatives.[12]

The program also has a community engagement component anchored by local institutional structures, the Jan Arogya Samitis (JAS) and Village Health, Sanitation and Nutrition Committee (VHSNCs) and multi-sectoral policies anchored by the Ministry of Rural Development to address social determinants of health. The role of the JAS is to: is to support health promotion activities at the community and facility level; social and environmental determinants of health using flexible funds provided for AB-HWCs and to provide mentorship to Village Health, Sanitation and Nutrition Committees (VHSNCs) to facilitate community-level interventions.

Despite the commendable progress the government has made in implementing the program, a recent evaluation of the Health and Wellness Centers (HWC) program suggested the need for intensified program implementation to tackle challenges regarding infrastructure, skilled human resources, financing, and last-mile service delivery.[13] Moreover, the COVID-19 pandemic highlighted the need to establish a care continuum by fixing the gaps, especially in PHC delivery and referral system, to address access barriers.[14]

Challenges and Strategies for Strengthening Public Financing for PHC

The federal structure and socio-economic diversity of the Indian states makes financing and delivery of Comprehensive Primary Healthcare through Health and Wellness Centers complex, though it hinges on the pathways established by the National Health Mission.

***Revenue raising for comprehensive integrated health services*:** Government expenditures for public financing can ensure that everybody, including the poor, receive the health services they need.[15,16] According to the National Health Policy 2017, financing for PHC should occupy 75% of total government health spending in the country. The National Health Mission is funded through a financing mechanism between the Union and State level governments (60:40 ratio respectively). This mobilizes funds for Reproductive, Maternal New-born and Child health programs, Immunization, Communicable diseases, non-communicable diseases and mental health programs and initiatives for strengthening the health system. Recent years have seen a steady outlay of funding to the NHM.

To enable adequate funds for the AB-HWC program, the union budget allocation to the Ministry of Health for the NHM is augmented with funds mobilized through a single non-lapsable reserve fund for health from the proceeds of Health and Education Cess/levy (about USD 618 million from F.Y. 2018-19 to September 2021).[17] Furthermore, funding for other elements of PHC includes sources such as the 5-year Fifteenth Finance Commission (FFC-XV) Grants (about USD 530 million for Rural Local Bodies and USD 320 million for Urban Local Bodies) to address critical gaps in the health care infrastructure at the PHC level,[16] The Finance Commission, in pursuance of clause (1) of article 280 of the Constitution of India is constituted every 5 years, to make

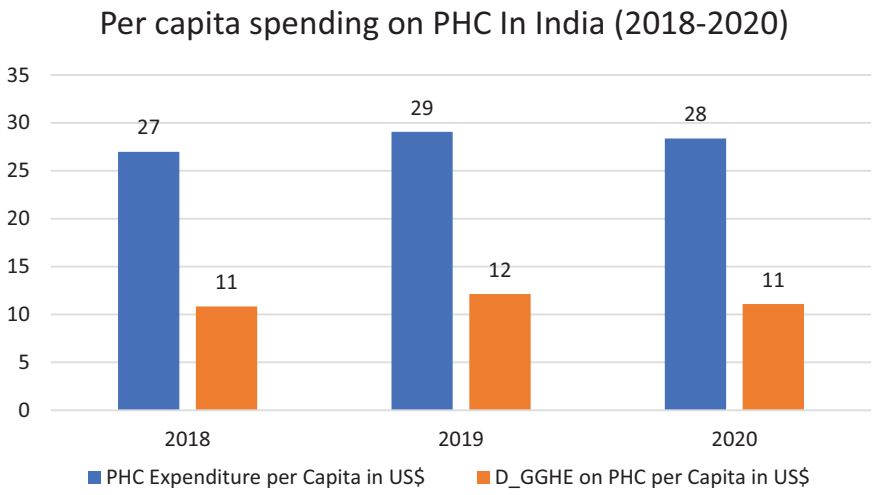

Figure 1. Trends in per capita spending for PHC in India.
Source: Authors, data from Global Health Expenditure Database.[21]

suggestions on the sharing of revenue between the Center and State governments. The Fifteenth Finance Commission (FFC-XV) was constituted in November 2017 and the final report with recommendations for the 2021-26 period was tabled in Parliament on February 1, 2021. These are to be used for establishing building-less Sub centers, PHCs, CHCs in rural and urban areas or upgradation of existing facilities, establishing diagnostic infrastructure and block level public health units in rural areas. Another source of funding for the AB-HWC program is the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM ABHIM). Under the PM ABHIM scheme the total financial outlay for the 5-year scheme period is USD 7.8 billion. The funds are to support rural and urban HWCs, Block Public Health Units, Integrated Public Health Labs and more.[18,19] In addition to these funds, some states have mobilized funds from other sources like: Panchayati Raj Institutions (Manipur), tribal affairs, district mineral funds (Maharashtra, Chhattisgarh, etc); State funds—Andhra Pradesh and Corporate Social Responsibility (CSR)—Maharashtra, Meghalaya, Mizoram.[13] The Funding caters for the strengthening of EPHFs such as strengthening of surveillance systems with block public health units managed by a multi-sectoral teams including the Jan Samitis at the facility level to ensure that a multi-sectoral approach to planning. This has enabled the financing to cater for the 3 thematic components of PHC.[7,20]

Following these investments, PHC spending has increased from 41% in 2004-05 to 56% of current health expenditure (CHE) in 2019-20.[21] It is notable, that the public sector's share of outpatient care has grown in recent years from 19.5% in 1995-1996, to 25% in 2014, to about 30% in 2017-2018. The NHP 2017 also recognizes that states should contribute significantly to financing for health (at least 8% of their budgets) to achieve the goal of public health spending of 2.5% of GDP. Currently, except Meghalaya, states are spending less than 8%, with an average of 5.6% in 2020-21.[9] This is due to the inadequate revenue generation capacity of the states compared to the Union level and the differences in the capacity to generate revenue between states. This has resulted in inequalities in PHC spending.

As a result, India's current PHC spending per capita is USD 28 in 2020 which is amongst the lowest expenditure in the Southeast Asian region of WHO. The domestic government spending on PHC is 11 USD per capita (See Figure 1) It is estimated that lower middle-income countries need additional PHC spending per capita of at least $25 (current spending is $34) to be able to provide a minimum basic package of services.[22] For India, this requires doubling existing government PHC spending to implement the basic service package, not accounting for the expanded vision for PHC as part of the HWC program. PHC spending in 2020 accounted for 48% of total government spending on health. This was a decline from 55% in 2018.

Out-of-pocket expenditures (OOPE) remains the largest source of health financing in India, constituting more than half (59%) of current health expenditure (See Figure 2).[13] Despite the recent public investments in PHC, this proportion is not likely to decline significantly. There remains therefore room for greater investment in PHC.

While the impact of the COVID-19 has strained many countries fiscally, India has been fortunate in that the economy has rebounded immensely and has maintained its status as the fastest growing economy globally with recent forecasts of 6.2% in GDP growth in 2024.[23] Moreover, the total tax-to-GDP ratio is on an upward swing, with current estimates of it reaching 11.7%.[24] The World Bank estimates that tax revenue 15% of GDP is conducive for economic growth and poverty reduction and therefore India is well positioned to explore additional taxation without negatively affecting economic growth.

In view of this, we propose further investment in PHC through the exploration of pro health taxes on products such as tobacco, Sugar Sweetened Beverages (SSBs) and transfats as

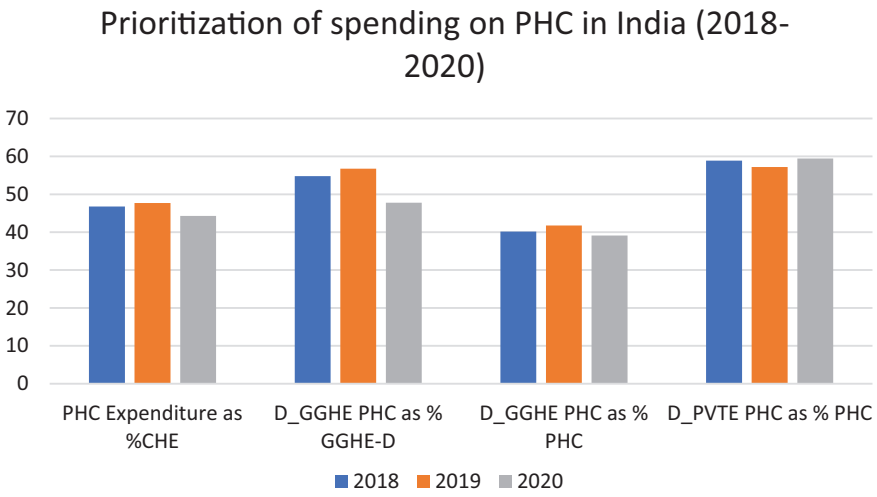

Figure 2. Prioritization of Primary Health care in India.
Source: Authors, data from Global Health Expenditure Database.[21]

well as fossil fuels. The public health benefits of these interventions in India[25-28] and globally[29-38] have been demonstrated with reduction in consumption of harmful risk factors and reduction in morbidity and mortality related to the same. Furthermore, additional revenue raised from such taxes has been used to fund health services in Philippines[39-42] and health promoting activities in Thailand,[43-45] and others, providing learnings. The literature shows the positive correlation in improved human capital and economic growth.[46,47] The health benefits of pro-health taxes and the revenues generated from these products can directly be used to increase investment in social and productive sectors that further stimulate long run economic growth.

The WHO recommends a tax threshold of 75% of the retail price for effective tobacco taxation for improved health outcomes.[35] India is the world's second largest producer and consumer of tobacco.[36] Despite taxation on tobacco and its products including GST, basic excise duty, and recent revision in the National Calamity Contingent Duty (NCCD) and VAT at state level, the overall tax is 52.7% of retail price which is lower than the WHO Framework Convention on Tobacco Control (WHO FCTC) recommendation. Furthermore, studies have shown that the affordability of tobacco and its products is high due to the growth in income far outstripping the pace in increases in taxes on tobacco and its products.[48] The same holds true for taxation on SSBs.[28] This means that there is room for further exploration of these taxes for improved health outcomes and revenue for PHC inter alia.

Lastly, India has a long-standing history of public subsidies on fossil fuels which have been shown to have environmental and health consequences. Non-tax revenue is estimated to contribute 11.5% of the revenue receipt and is projected to be 15.2% more than the revised budgetary estimates of Financial Year 2022-23.[49] This is another area that can be explored by the government to raise additional revenue, whilst improving public health outcomes and financing climate change mitigation strategies, including investment in climate-resilient PHC facilities.[50,51]

***Pooling and management of funds*:** Within the federal framework, the government has instituted multi sectoral and inter-governmental structures to coordinate and harmonize PHC financing. Government financing for PHC through the NHM and the State Health Mission is managed by the State Health Societies (SHSs) which are autonomous bodies that pool funds from the central and state governments and manage the transfers of funds to the districts and blocks. A portion of PM ABHIM funds is also managed by the SHSs. The other portion supports EPHF including strengthening of surveillance at points of entry and is channeled through the relevant autonomous bodies and transferred vertically to the states.

FC-XV grants are managed by the Ministry of Gram Panchayat, which manages the local governments (urban and rural) and channeled via the state departments.[18] Thus, decision-making for these grants involves the local governments and the relevant departments (Health and Gram Panchayat) in planning and decision-making.

The major challenge in fiscal decentralization is coordination and harmonization of the pools to ensure that there is minimal duplication of priorities and there are no unfunded mandates critical for effective PHC.[52] Effectiveness of intersectoral planning platforms is undermined by different planning and implementation cycles for different grants and weaker planning capacity at the lower levels of government. The gaps in fidelity of implementation of the harmonization of PHC spending need to be enforced to ensure effective planning to prevent duplications and unfunded mandates. Framing of guidelines for additional sources of revenue should clearly highlight complementarity with existing resources to avoid duplication in planning and ensure that an integrated planning process is established at a local level. The planning for funds at lower levels can be further strengthened by building capacities of cadres at this level to ensure meaningful engagement.

***Public Financial Management (PFM)*:** Currently, overall utilization of PHC funds is low (60% or less) in most states, particularly so in states with low absorptive capacities due to a lack of complementary inputs and capacity issues including those related to PFM. This has resulted in poor performance and limited strengthening of health systems.[53-55] Furthermore, PFM issues, including complex and rigid financial architecture, causes delays in fund transfer from state to districts.[8,53] A recent evaluation supports this finding, especially in the North-east states,[13] where program components which involve relatively more complex planning and execution like procurement and construction have particularly low utilization rates due to resource caps resulting in limited space to propose actual quantities and costs limiting the budgeting scale at both state and union levels.[56-58]

Furthermore, the budget structure consists of numerous line-item codes and there is limited flexibility for reprograming between priorities within the flexipools and even less flexibility across pools.[53] This low flexibility of resource allocation across priorities coupled with budget ceilings and low financial autonomy and management capacity at the service delivery level undermines the execution of the budget according to priorities and objectives of UHC.

The Central government introduced a new system of Single Nodal Accounts (SNA) managed by a Single Nodal Agency for Centrally Sponsored Schemes including NHM.[59] The SNA is a centralized account in which funds for implementing government priorities for the sector are transferred from the center to the state. The corresponding state's share for the specific priority program is also transferred to this account. Funds are transferred from this account to the implementing agencies (IAs) accounts every quarter for service delivery. The release of subsequent funding is contingent on successful reporting of 75% execution of the previous budget released to the implementing agency. Unspent balances are returned from the account of IAs to the SNA and then the allocation for the next quarter is released. The IAs maintain zero balance accounts meaning that there is limited flexibility in spending. Early experiences documented showed that there were large pendencies in disbursement of funds due to delays in designating a bank for the SNA as well as opening accounts for all facilities with the same bank.[60] These pendencies pose a challenge for service delivery. The processes under the SNA that limit autonomy at the PHC facility need to be reviewed to determine the actual impact on availability and execution of funds at the front-line level. The early reports of delayed disbursements and the fixed allocations are likely to lead to inadequate funds availability of funds at the health facility. Global guidance supports increased flexibility and autonomy at the service delivery level whilst improving financial management for improved accountability.[61] This would also require direct financing of health facilities according to locally prioritized needs. The experience in Tanzania shows that facilitating this increases budget availability at the facility, better spending, service availability and utilization.[62,63]

Basic PFM should enable providers to receive a steady, predictable flow of funds[64] with the ability to manage these flexibly.[65] There is need for greater accountability for performance enforced through the budgeting and performance framework that has been instituted Furthermore, frequent multi-stakeholder review of the performance on indicators for health in output-outcome monitoring matrix is critical for improving efficiency in service delivery and resource allocation.

Experiences from several countries shows "enabling PFM processes such as the development and formulation of the fee-compensation budget as a program-based budget (PBB) envelope rather than by economic classification, allowed providers to be compensated for outputs and to manage the funds as needed without line-item constraints.[66] Specifically on program-based budgeting, a review undertaken by the International Budget Partnership on PBBs in LMICs suggests that the fundamental groundwork for defining what constitutes a program, their functional boundaries, objective output and accountability metrics are all important inputs to improve financial management and performance within a health system.[67] Direct disbursement of funds from the Treasury gave PHC facilities timely and direct access to these flexible resources to meet their operating costs. Moreover, the monitoring of expenditure by service outputs rather than inputs shifted accountability from control of inputs to performance of service outputs. These changes in PFM made it possible for PHC facilities to do more with general budget funds that otherwise would have only provided them with additional revenues."[68]

***Purchasing and provider payments*:** PHC services are government financed and provisioned through Health Departments at Union and State level, without a purchaser-provider split. Contracting out of select PHC services to the private sector has been tried but without much success.[69] Line-item budgeting is the primary provider payment mechanism for PHC in India. Efforts were made under the NHM to bring in flexibility to enable strategic purchasing through the introduction of the flexipools that program managers can reallocate across priorities within the program areas.[53] This is limited to a virement of 10% within the same pool. Moreover, monetary incentives through performance-linked payments, and non-monetary incentives for health professionals, mostly doctors, have been provided to ensure equitable distribution of human resources in remote and difficult-to-reach areas and to increase availability of priority services.[70] This is enabled using an IT platform that captures service delivery outputs for the target population covered by each HWC and computes a set of performance indicators for the team. The performance-linked payments (PLPs) have been plagues with challenges, however, including complexity in the calculation of the performance parameters in all states that were included in the recent evaluation of the program.[13] This is further compounded by the

poor collection of the data by the HWC team and updating of the self-reported indicators due to poor orientation of the district level and block level CPHC teams on process of performance measurements. There are also challenges in determining the quantum of the incentive that is to be given and challenges in disbursing the incentive. Some states have not yet implemented the system owing to these challenges.

To mitigate the misalignment of incentives produced by line-item payments, the sub-optimal implementation of the PLPs scheme, we propose that payment methods transition toward blended payment approach including capitation and a mix of the PLPs. Multi-country experience and highly successful models for PHC in Thailand and in Estonia shows that capitated rates that are risk-adjusted, at least by age and sex are beneficial in government provisioning and blended with performance incentives, increase quality of care, utilization and coordination across service providers.[71-73] As noted elsewhere,[20] this will require the strengthening of the Ayushman Bharat Digital Mission[74] and the interoperability between the e-Hospital system for management for patient record at the secondary and tertiary levels, roll out of Electronic medical records at the HWCs and increase uptake and utilization of the Ayushman Bharat Health Account (ABHA) to facilitate creation and utilization of longitudinal patient records for the patient follow-up across the referral system.

There is emerging evidence that value-based care mechanisms could improve primary care provision through outcome-oriented and patient-centric performance service delivery design, coordination and performance management with focus on quality and appropriateness of care.[75] The Government of India has developed a strategy to transition from volume-based care to value-based care (VBC) which is being piloted in one state.[76] The strategy highlights the importance of continuity of care including the role of ABDM and telemedicine in facilitating VBC in India but falls short of elaborating how integration of care across care pathways and across providers as envisioned in Porter and Tiesberg's framework[77] can be implemented in India. There is need for feasibility studies in the development and implementation of integrated practice units and care pathways for improving value for money in primary care. The current efforts to leverage telemedicine, including a national guideline,[78] the E-Sanjeevni portal that covers out-patient services[79] in primary, secondary and tertiary care facilities and the several efforts, can be further leveraged within a VBC framework as part of the care pathways for rural and remote areas to ensure more efficient service delivery.

For universal reach, integrated care pathways should include strategies for private sector engagement. In Thailand the National Health Security Office (NHSO), engages with the private sector through consistent dialog on empanelment practices and price negotiations, which helped create an ecosystem for active private sector participation.[80] In India, the linkage of ABDM with private sector PHC facilities can be further enhanced through the ongoing efforts to avail Electronic Medical Record Systems that are interoperable would enable the government to have greater visibility into services provided through private sector.[81] The data visibility would enable the government to provide evidence-based regulation on quality of care of PHC services in private facilities, have evidence on service availability that would guide on selective contracting for PHC services especially in areas with low public sector availability and in pandemics.

Conclusion

India's path toward universal health coverage is dependent on its foundational commitment to comprehensive PHC. The multi-sectoral approach to planning and funding ensures that public financing addresses the 3 components of PHC. Nevertheless, the global polycrisis calls for efforts to shore up resilience of the health system to ensure preparedness and adequate emergency response measures in case of public threats. Strengthening PHC, including its sustainable financing is a key measure in this regard. The good economic outlook for India and the existing scope for increasing taxes on harmful products should be leveraged going forward to ensure more investment for PHC. The latter also enhances health and wellbeing through deterrence of health-harming behavior. Innovative payment models coupled with interoperable health information systems as well as reform in public financial management systems will be critical to improve efficiency and value for money.

Abbreviations

ABHA Ayushman Bharat Health Account; AB-HWC Ayushman Bharat Health and Wellness Center Program; AB-PMJAY Ayushman Bharat-Pradhan Mantri Jan Arogya; CHOs Community Health Officers; CHWs Community Health Workers; CPHC Comprehensive PHC; EPHF Essential Public Health Functions; FC-XV Fifteenth Finance Commission; HWCs Health and Wellness Centers; HWs Health workers; JAS Jan Arogya Samitis; NHM: National Health Mission; NHP National Health Policy; NRHM National Rural Health Mission, NUHM National Urban Health Mission; OOP: Out-of-pocket; PFM: Public financial Management; PHC PHC; PLPs Performance Linked Payments; PM ABHIM Pradhan Mantri Ayushman Bharat Health Infrastructure Mission; PMJAY Pradhan Mantri Jan Arogya; SNA Single Nodal Account; UHC Universal Health Coverage; USD: United States Dollars; UTs: Union Territories; VHSNCs Village Health, Sanitation and Nutrition Committees; WHO: World Health Organization; WHO-SEARO WHO South-East Asia Region.

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Author Contributions

RR and GA conceived the paper. RR, JSA and GA drafted, read, and approved the final manuscript.

Ethics Approval and Consent to Participate

Not applicable.

Availability of Data and Materials

Please contact the authors for additional data requests.

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