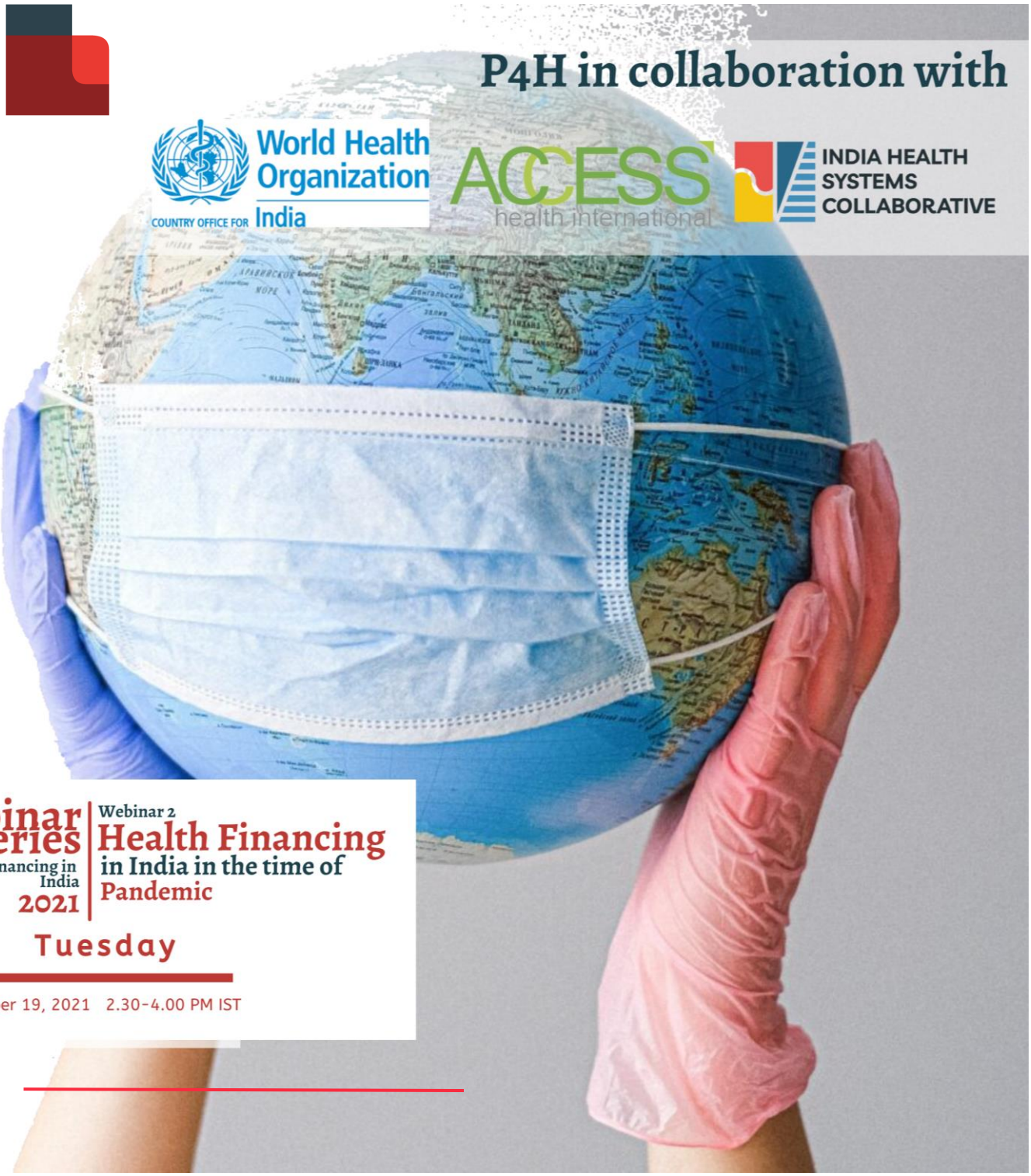
The Global Network for Health Financing
and Social Health Protection

SOCIAL HEALTH PROTECTION NETWORK



P4H News. India Webinar #2: Health Financing in India in Time of Pandemic

The second India-specific webinar was held on 19 October 2021 as part of the P4H Network's webinar series. It brought together national and international experts to discuss health financing and social health protection issues and potential ways forward. The webinar focused on health financing in India during the COVID-19 pandemic. Attendees numbered 105 national and international health financing experts and researchers. The P4H Network, the global network for health financing and social health protection, is organising this webinar series in collaboration with ACCESS Health International (AHI) and the India Health Systems Collaborative (IHSC).

Susan Sparkes, Health Financing Technical Officer, WHO Geneva, delivered the keynote address, setting the tone for the panel discussion. In her address, Susan highlighted the impact of the COVID-19 induced economic crisis on household income and health seeking behaviour across the globe. She listed some country examples where health financing policy levers were adjusted in response to the pandemic. Opening the floor for discussion, she urged the research community to consider all financing functions, leverage existing financing mechanisms and focus on priorities to ensure common goods for health.

Initiating the panel discussion, *Tushar Mokashi, Senior Technical Specialist, AHI*, laid the groundwork for the discussion and invited the panellists to share their insights on specific issues*. Mita Choudhury, Associate Professor at the National Institute of Public Finance and Policy*, emphasized the macroeconomic impact of COVID-19 on the fiscal space for health. Following her comments, *Nishant Jain, Director, GIZ India*, explained the role of the health insurance scheme Pradhan Mantri Jan Arogya Yojana (PMJAY) in India's fight against COVID-19. Further adding to the conversation, *Grace Kabaniha, Technical Officer, Health Financing for Universal Health Coverage-Health Care Facilities*, at the WHO Country Office for India, discussed national and subnational resource mobilization and strategic purchasing for COVID-19 response. Later, *Owen Smith, Senior Economist, Health, Nutrition and Population Global Practice,* WBG, examined the role of external funds and their use for COVID-19 response. Last, *Rahul Reddy, National Coordinator, Health Systems Transformation Platform,* deliberated on how India could benefit from learning about health financing response measures and initiatives by South-East Asian countries during COVID-19.

The key discussion points were as follows: The economic slowdown induced by the pandemic and the pressure to increase public spending on health and social security created a scissors effect leading to additional borrowing by the Indian states. However, due to competing demands from other sectors, the fiscal space for public spending in states is unlikely to expand significantly in the short to medium term. To address this challenge, local authorities may have to seek health grants provided by the government of India's Fifteenth Finance Commission, tap unused funds and improve public financial management.

1. The National Health Authority (NHA) has responded proactively to the pandemic in a variety of ways, such expanding benefits to COVID-19 treatment and testing; post-COVID treatment; continued care for non-COVID-19 conditions; empanelment of additional hospitals and standalone labs; and patient support. In addition, the NHA plans to create a digital health backbone through Ayushman Bharat Digital Mission, introduce data analytics to identify patterns and changes in use, implement more sophisticated provider payment mechanisms like diagnostic related groupings and care continuum mechanisms through primary care and other initiatives.
2. India responded quickly to the pandemic by reforming public finance management policies with austerity measures in different forms. It resulted in decreased spending on capital intense programs and increased borrowing for states from 3% to 5% of GDP and budget reallocations to contingency funds. Procedurally, financial powers were delegated to enhance spending, procurement laws and internal controls were relaxed, and existing productivity software was leveraged.
3. Reforms were also introduced in purchasing arrangements. In the public sector, bonus payments were provided to frontline workers, and free testing and treatment of COVID-19 were provided to patients in public hospitals. In the private sector, various initiatives in provider payment mechanisms were introduced, and prices were capped for various COVID-19 related diagnostics and treatment procedures.
4. Discussion on the external financing for health highlighted that fiscal stimulus packages have been much smaller in low- and middle-income countries than in high-income countries and that packages for health have been even smaller than the stimulus packages. It was also noted that all countries except low-income countries primarily leveraged domestic finances to create stimulus packages. India received emergency response funding of around $2.5 billion along with some additional support for broader health system strengthening priorities, which is around 5% of government spending on health in India.
5. The common enablers which steered the government's COVID-19 response—mobilization of domestic and external resources, fund reallocation for focused response, legislative amendments and flexibilities, specific benefit packages for COVID-19 relief, financial incentives for frontline workers and private sector engagement with price capping to avoid out-of-pocket payments (OOPs).

   Specific countries experiences of health financing systems' reforms for COVID-19 relief were reviewed:

   a. Thailand channelled funds through existing schemes, extended social health insurance coverage for six months and provided coverage for the unemployed under a universal coverage scheme. The reimbursement rates were the same for public and private providers.
   b. Japan provided a so-called emergency subsidy to local governments and rewarded the health workforce. Japan also introduced a co-pay for insured persons, deductibles for high-income groups, and compensation for OOPs through public funds.
   c. Indonesia channelled funds through the National Committee for COVID-19 and National Economic Recovery, and the private sector funded vaccination for employees and dependents.
   d. In China, funds were channeled through existing health insurance schemes, and health insurance contributions were waived with out-of-pocket payments (OOPs) paid by public medical assistance funds.

The panel in its concluding remarks suggested that India create an emergency health fund, and focus on OOPs at least for emergency services to the near poor and poor through direct reimbursements from budget to hospitals, labs and pharmacies. India should reduce fragmentation and authorize a single entity for setting standards for service delivery, quality and provider payments working closely with states for flexibility to address local needs. And last, the panel strongly recommended private sector engagement through participatory mechanisms.

The P4H Network thanks the presenters, panellists, participants, and attendees for a rich conversation. The network appreciates partnership collaboration with Indian partners AHI and IHSC and P4H Network members ILO, GIZ, WBG and WHO.

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