

Family Physician-led Primary Care System

with CHOICE and COMPETITION

EFFECTIVE | ACCESSIBLE | AFFORDABLE | ACCOUNTABLE

22nd January, 2024

Primary Care – key to improving crores of lives



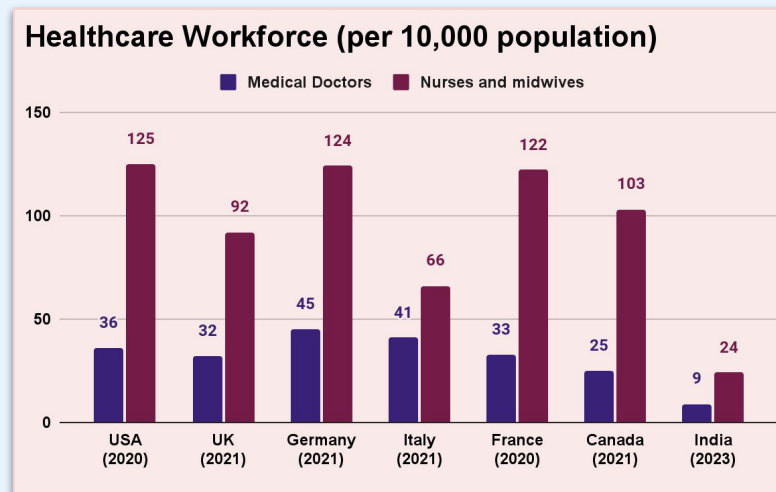
- At more than 50% of the current healthcare expenditure in the country,¹ **out-of-pocket expenditure continues to be debilitating** for large sections of Indians.
- About **5.5 crore Indians descend into poverty** every year because of health care costs.²
- Effective, accessible, affordable and accountable primary care is **the single biggest unmet need** for most of the population.
- Such a primary care system will be **hugely popular** and will give governments the **political space** needed to pursue long-term economic growth and poverty eradication.

1. National Health Accounts 2019-20, Ministry of Health and Family Welfare, Government of India.

2. Sakthivel Selvaraj, et al., “Quantifying the financial burden of households’ out-of-pocket payments on medicines in India: a repeated cross-sectional analysis of National Sample Survey data 1994–2014”, BMJ Open 2018, pg. 5.

Healthcare Sector – Untapped Economic Potential

- Potential to generate **1-1.5 crore jobs** in the healthcare sector alone
 - Currently, only **47 lakh** healthcare workers (doctors, and nurses, auxiliary nurses & midwives) in India.¹
 - **Low coverage** by global standards.
- India – a **global healthcare hub**
 - This year, **a million overseas patients** are expected to receive healthcare services in India.
 - Foreign exchange earned by providing healthcare services to foreigners is expected to reach **USD 13 billion by 2026**.¹
 - In ten years, with some effort, this figure can reach USD 100 billion in income.



Source: Global Health Workforce Statistics, WHO (retrieved 02/12/2023); Government of India¹.

1. Keynote Address delivered by the Union Health Minister at the One Earth One Health - Advantage Healthcare India Inauguration, 17/08/2023, Gandhinagar.

Gol's Initiatives – steps in the right direction

Ayushman Bharat - Health and
Wellness Centres

PM – Jan Arogya Yojana

PM Bhartiya Janaushadhi
Pariyojana

Free Diagnostics Service
Initiative

Ayushman Bharat Digital
Mission

Mission Indradhanush

- Massive **expansion of vaccination coverage** in universal immunisation programme.
- Expansion in primary care services **beyond maternal and child care** is in keeping with current needs:
 - **Epidemiological transition**
 - **High share of out-of-pocket expenditure (OOPE)** in health care
- Marks a shift from segmented approach to health care through **comprehensive health care services**.
- Focus on **diagnostics and drugs** ensures availability of support services leading to more effective treatment.
- Creation of an **integrated digital health ecosystem** would go a long way in facilitating delivery of safe, timely and effective health care for all.

Expanded range of services – encompassing preventive, promotive, curative and rehabilitative care

1. Care in pregnancy and childbirth
2. Neonatal and infant health care services
3. Childhood and adolescent health care services
4. Family planning, contraceptive services and other reproductive health care services
5. Management of communicable diseases including National Health Programmes
6. Management of common communicable diseases and outpatient care for acute simple illnesses and minor ailments
7. Screening, prevention, control and management of non-communicable diseases
8. Care for common ophthalmic and ENT problems
9. Basic oral health care
10. Elderly and palliative health care services
11. Emergency medical services
12. Screening and basic management of mental health ailments

The Health & Wellness Centre Ecosystem

First Referral Unit – CHC/Block-level PHC

1 for 1.2-2 lakh
population

- Supposed to have 4 General Practitioners & 5 Specialists.
- Should go beyond emergency obstetric care and offer **specialist care**, and elective & emergency **surgical services** of secondary level.
- Integrate clinical services and public health surveillance.



HWC-PHC

1 for 30,000
population

Linked to 5
HWC-SHCs

- Supposed to have 2 doctors and provide the expanded package of 12 services.
- **Complexity of care would be higher** than that delivered at HWC-SHC, indicated in care pathways and standard treatment guidelines.



HWC-SHC

1 for 5,000
population

- Team led by a **mid-level health worker** (Community Health Worker) and also include all ASHAs, 2 ANMs & 1 multipurpose worker (male).
- To deliver the expanded **package of 12 services**.

Centralised procurement of essential drugs – Tamil Nadu model.

List of drugs to be stocked at various levels will be based on standard treatment guidelines.

Pooling of diagnostic services at different levels.

Minimum package of basic diagnostics to be available at HWCs. More complex diagnostics to be available at a centralised diagnostic unit catering to ~20 HWCs.

Critical challenges remain...

The model of government-run PHCs has been ineffective as the first point-of-contact

Historical **lack of trust** in public facilities

Lack of choice – **low patient satisfaction**

Rampant **absenteeism & vacancies** in rural areas

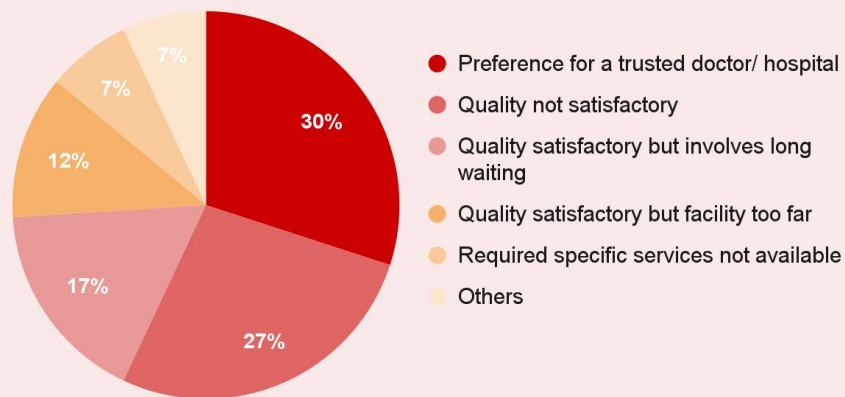
Insufficient **diagnostics and drugs**

Low patronage – only ~30% of all healthcare visits¹

~70% of rural healthcare visits are to **informal providers**²

Reasons for not availing government services, % of people (India)

"Health in India", NSS 75th Round, Report No. 586, July 2017 - June 2018, pg. A-989.

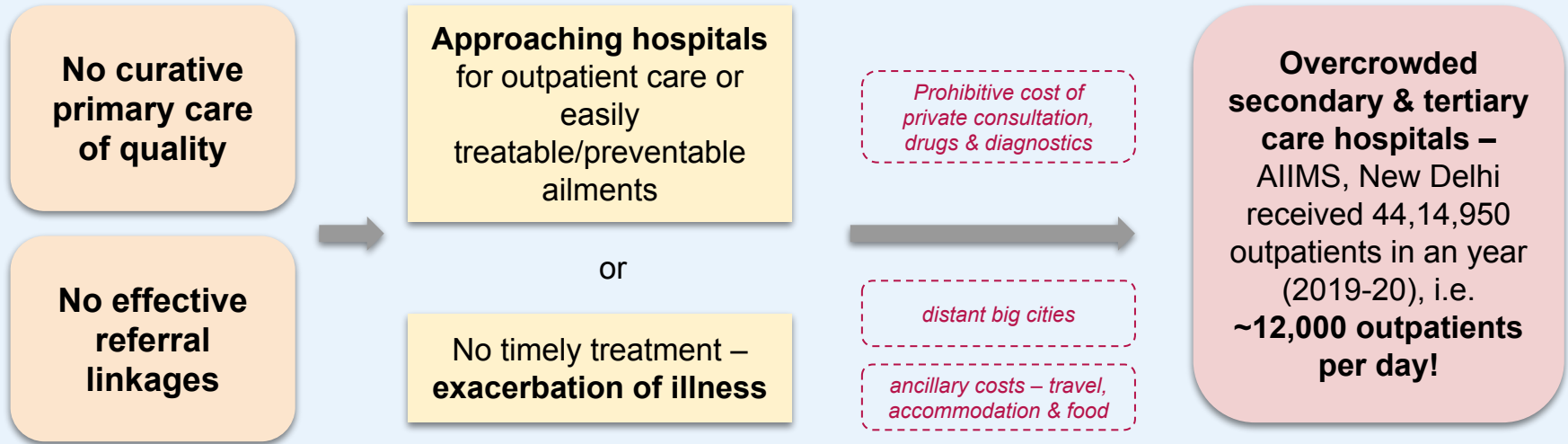


There is a need to alter incentives to ensure QUALITY and ACCOUNTABILITY

1. Key Indicators of Social Consumption in India: Health, NSS 75th Round, 2017-18, Ministry of Statistics and Programme Implementation, Government of India, pg. 11.
2. Jishnu Das, et al., "Two Indias: The Structure of Primary Health Care Markets in Rural Indian Villages with Implications for Policy", Social Science & Medicine, 2020, pg. 2, 5.

Impact of an underperforming primary care system

- There is an **over-reliance on hospitals** for outpatient care – both public and private facilities.
- Patients are forced to **endure avoidable hardships and costs** in travelling to distant big cities for minor ailments.



Key to fully unlocking India's potential

- **Death and disability** caused due to both communicable and non-communicable diseases (NCDs) is **higher in India** than in most other major countries.
- High NCD burden despite a young population indicates **poor preventive and primary health care**.
- **PHC and H&W centres** have proven to be extremely effective in public health measures – immunisation, cold chain, family planning, maternal and child care, increasing awareness etc.
- Need for a **different approach for medical care** while retaining the strengths of the PHC and H&W centres network.

Country	DALYs due to All Causes	DALYs due to CMNNDs	DALYs due to NCDs
South Africa	49,954	23,778	20,844
India	37,843	11,801	22,071
Brazil	29,427	4,838	20,309
Vietnam	27,542	3,910	20,466
South Korea	17,191	1,217	13,534
United Kingdom	20,956	1,380	18,000
France	18,781	1,014	15,461
Canada	19,683	1,254	16,352
United States	26,061	1,597	21,717
Germany	20,075	1,036	17,277
Russia	31,110	2,740	23,206
Italy	18,185	944	15,752
China	22,270	1,889	18,058

DALYs: Disability Adjusted Life Years; **CMNNDs:** Communicable, maternal, neonatal and nutritional diseases; **NCDs:** Non-communicable diseases.

Source: Global Disease Burden Database, Institute for Health Metrics and Evaluation.

Burden of Outpatient Care

- Outpatient care expenditure has proven to be **more impoverishing** than inpatient care as the latter is more infrequent (NSS 2004-05).¹
- The increase has largely been driven by expenditure on **diagnostics and 'other' ancillary needs**.

Compound Annual Growth (%) of OOPE and its Components across Quintiles (1993-94 to 2011-12)

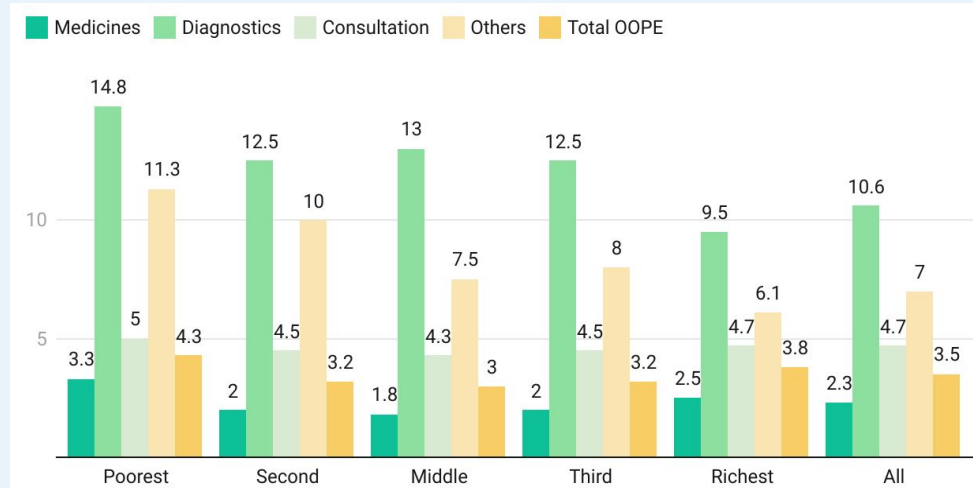


Chart: Foundation for Democratic Reforms • Source: Indrani Gupta et al., "Financing for Health Coverage in India: Issues and Concerns", IEG Working Paper No. 346, Institute for Economic Growth, Delhi, 2015, pg. 10. • Created with Datawrapper

1. Renu Shahrawat, et al., "Insured Yet Vulnerable: Out-of-Pocket Payments and India's Poor", Health Policy and Planning, 2012, pg. 217

Slight modifications in design will ensure –

Improved QUALITY

Better ACCESS

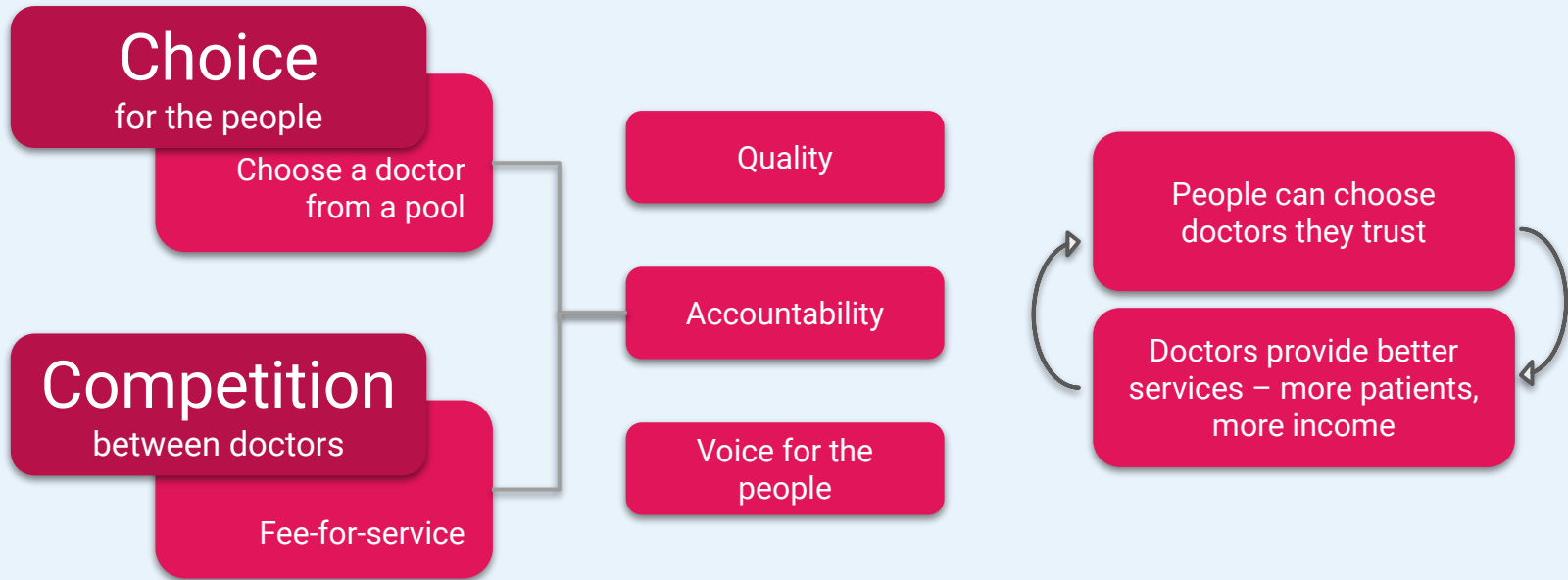
Sustained ACCOUNTABILITY

Greater PUBLIC TRUST & SATISFACTION

Enhanced HEALTHCARE OUTCOMES

What made PM-JAY successful?

- Public-funded programme with **private participation**
- **Competition among providers** incentivising better service
- **Choice to the consumer/patient** ensuring voice, accountability and patient satisfaction



Family Physician-led Primary Care with Private Participation



Three components:

FP Clinics

A public-funded but privately run pool of Family Physician (FPs) clinics in centrally located small towns (“centres”) with choice for patients and competition between FPs.

Diagnostics

Provision of tests at two levels in PPP mode (Gol’s Free Diagnostics Service Initiative). Pooling of diagnostics for every pool of FPs for economies of scale.

Drugs

Expanding Jan Aushadhi Kendras with one Kendra in each “centre” with centralised government procurement of generic drugs and limited essential branded drugs.

- **Universal coverage** – expected to **benefit 100 crore people** (70% of the population); the remaining 30% (~40 crore people) may prefer other private care.
- The model builds on the **best practices** seen across the Union and State governments.
- Will increase the annual per capita consultations in the government sector from the current **0.5¹ to two (2) consultations per person per year**.
- **Low cost-high impact** intervention that will **dramatically increase public trust and satisfaction**.

1. Calculated based on findings of NSS 75th Round (July 2017-June 2018). See next slide for details of the calculation.

Calculation of the current per capita consultation rate

1. Annual Per Capita Consultation Rate – Overall			
	Details	Rural	Urban
A	Number of persons reporting ailment during the last 15 days per 1000 population	68	91
B	Number of reported ailments per year per 1000 population (A*24.3) ¹	1652	2211
C	Share of ailments treated on medical advice	86.2%	91.9%
D	Number of ailments treated on medical advice per 1000 population (B*C)	1424	2032
E	Weighted average of ailments treated on medical advice in a year per 1000 population ²	1637	
F	Annual per capita consultation rate	1.6	

2. Annual Per Capita Consultation Rate – Government Facilities			
	Details	Rural	Urban
A	Number of reported ailments per year per 1000 population (see 1.B)	1652	2211
B	Number of ailments treated on medical advice per 1000 population (see 1.D)	1424	2032
C	Share of treated ailments receiving treatment from government facilities	32.5%	26.2%
D	Ailments treated in government facilities in a year per 1000 population (B*C)	463	532
E	Weighted average of ailments treated in government facilities in a year per 1000 population ²	487	
F	Annual per capita consultation rate in government facilities	0.5	

- The "Number of reported ailments per year per 1000 population" has been calculated by extrapolating the "Number of persons reporting ailment during the last 15 days per 1000 population" for the entire year.
- The proportional share of rural and urban population have been taken as weights: rural – 65%; and urban – 35%.

Sources:

- Number of persons reporting ailment during the last 15 days per 1000 population** – “Health in India”, NSS Report No. 586, NSS 75th Round, July 2017 - June 2018, Ministry of Statistics and Programme Implementation, Government of India, pg. A-758.
- Share of ailments treated on medical advice & Share of treated ailments receiving treatments in government facilities** – Key Indicators of Social Consumption in India: Health, NSS 75th Round, 2017-18, Ministry of Statistics and Programme Implementation, Government of India, pg. A6 (Appendix A).
- Percentage Share in the Population** – World Bank Open Data Portal.

Calculation of the current per capita consultation rate

1. Annual Per Capita Consultation Rate – Overall			
	Details	Rural	Urban
A	Number of persons reporting ailment during the last 15 days per 1000 population	54	58
B	Number of reported ailments per year per 1000 population (A*24.3) ¹	1312.2	1409.4
C	Share of ailments treated on medical advice	86.2%	91.9%
D	Number of ailments treated on medical advice per 1000 population (B*C)	1131.1	1295.2
E	Weighted average of ailments treated on medical advice in a year per 1000 population ²	1189	
F	Annual per capita consultation rate	1.189	

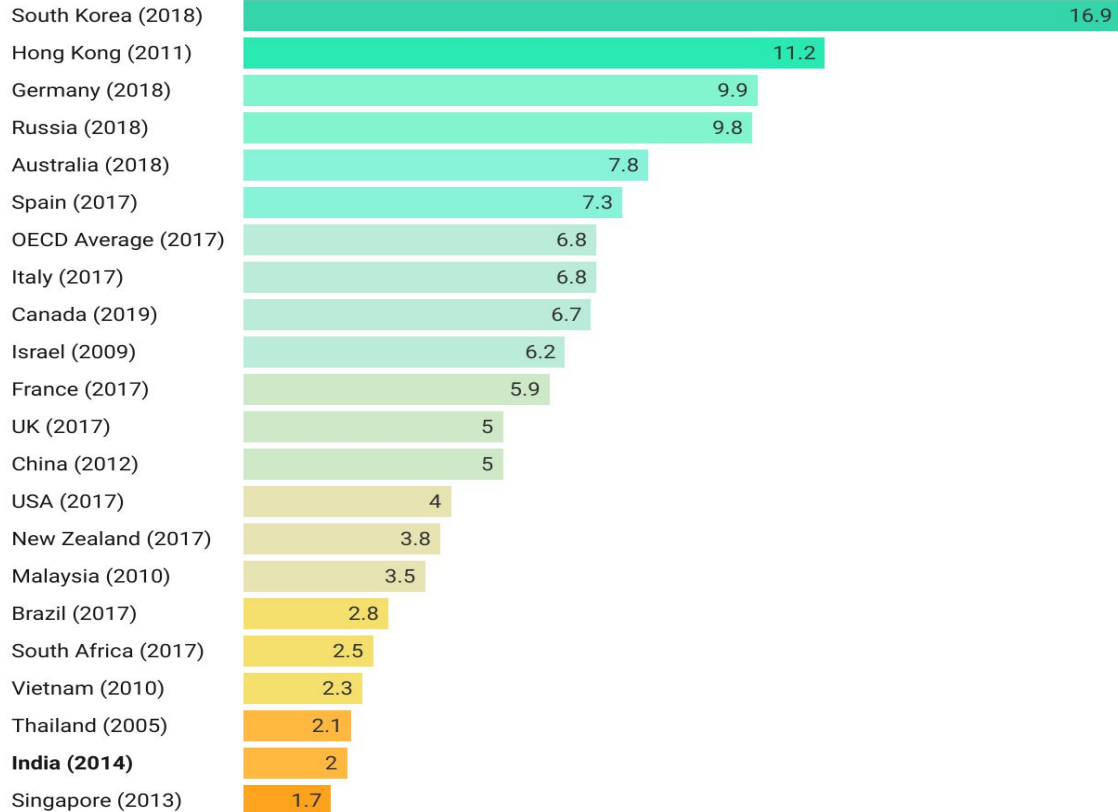
2. Annual Per Capita Consultation Rate – Government Facilities			
	Details	Rural	Urban
A	Number of reported ailments per year per 1000 population (see 1.B)	1312	1409.4
B	Number of ailments treated on medical advice per 1000 population (see 1.D)	1131.1	1295.2
C	Share of treated ailments receiving treatment from government facilities	24.0%	16.4%
D	Ailments treated in government facilities in a year per 1000 population (B*C)	271.46	212.41
E	Weighted average of ailments treated in government facilities in a year per 1000 population ²	250	
F	Annual per capita consultation rate in government facilities	0.25	

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- The proportional share of rural and urban population have been taken as weights: rural – 65%; and urban – 35%.

Sources:

- Number of persons reporting ailment during the last 15 days per 1000 population** – “Health in India”, NSS Report No. 586, NSS 75th Round, July 2017 - June 2018, Ministry of Statistics and Programme Implementation, Government of India, pg. A-758.
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- Percentage Share in the Population** – World Bank Open Data Portal.

Per capita consultation rate across select countries



The scope of consultations varies across countries, notably in respect of outpatient departments in hospitals.

The figure for India for the year 2014 was 2.3 and for 2018 is 1.6 (revised)(see previous slide).

Sources:

India – "Health in India" reports, NSS 71st and 75th rounds.

Other countries – OECD database.

How can we address the challenges in primary care?

Rising NCD burden & overburdened hospitals



Need for **patient-centric, integrated** and **continuum of care.**



A **Family Physician (FP)** as the first point-of-contact with a **strict referral system**

Unwillingness of doctors & nurses to work in remote rural areas



Assured patient load and income to the FP in an **urban/semi-urban centre** for family care.



Small towns in appropriate locations catering to a cluster of villages to be the “**centre**” for primary care delivery

Low patronage as people lack trust in public healthcare delivery



Similar to **PM-JAY**, need for **choice for patients** to choose the doctor they trust from a pool.



A **pool of 10 competing FPs** for every “centre” for the patient to choose from

Lack of accountability and poor quality of service



Fixed salaries do not incentivise better performance. **Need for competition** between providers.



Competition between FPs through a **fee-for-service model** – government funds based on the number of outpatient visits

Viable diagnostic services and drugs supply

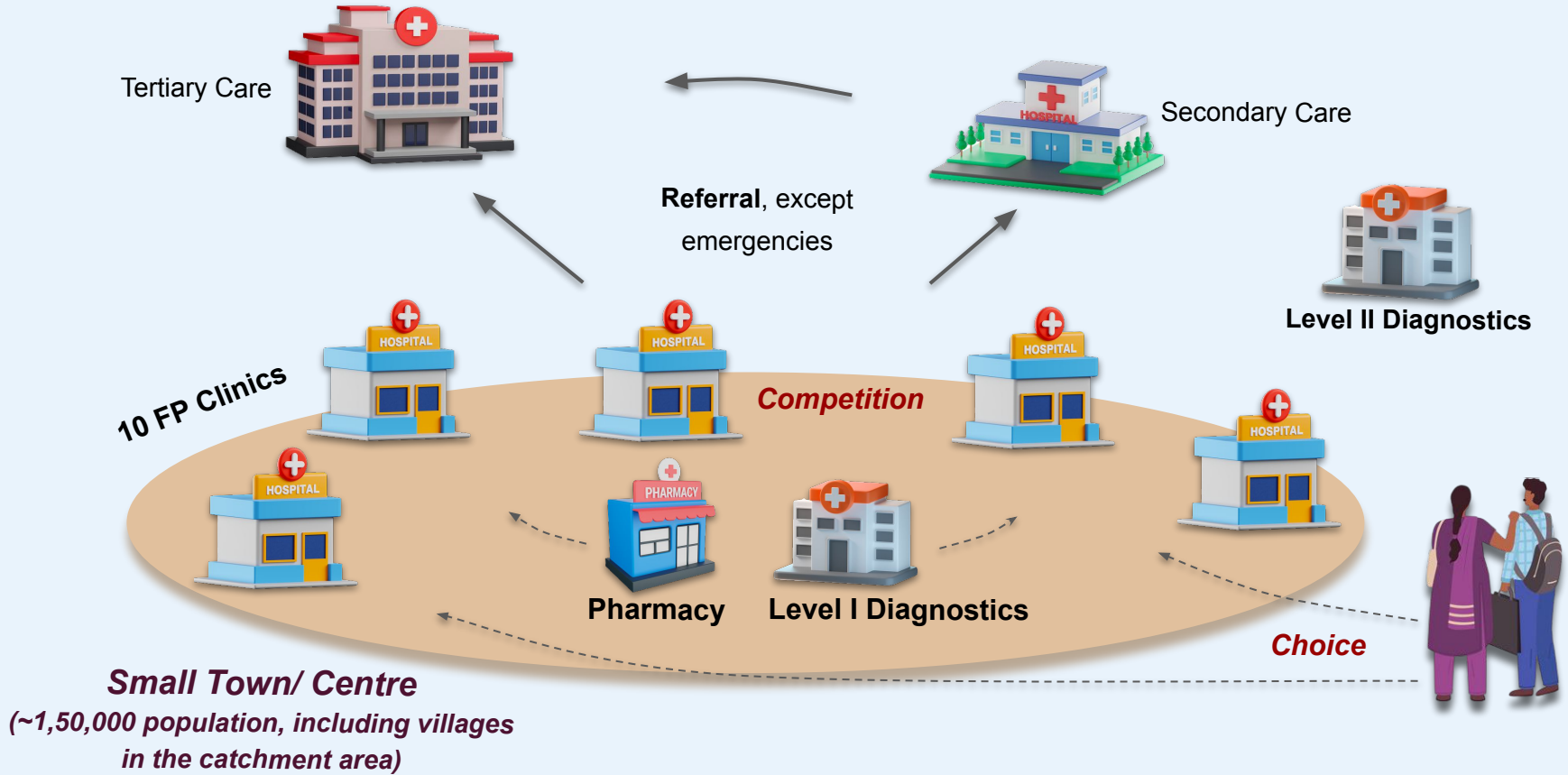


Need for **economies of scale** to make the system viable.



Pooling of primary care services in a “centre” provides adequate scale to make them viable

Choice and Competition in the Family Physician System



- **Two small towns in each Assembly Constituency to be the “centres” of primary care.**
 - **Hubs of social and economic activity** catering to a **population of ~1,50,000** including the surrounding villages.
 - Will have about **10,000** such “centres” in the country.
- **Pool of 10 Family Physicians (FPs) per “centre”.**
 - FP – private practitioner – as the **first point-of-contact**, gate-keeper of a **strict referral system**.
 - Will have about **1,00,000 FPs** across the country.
- **Publicly-funded based on the number of outpatient consultations (fee-for-service model).**
 - Each FP to be remunerated at a rate **Rs. 200 per consultation**.
 - Assures a **monthly income of Rs. 1.25-1.5 lakhs** to an FP, net of operational costs (rent, staff, services, consumables etc.).

*Choice for the
patients
&
Competition
among FPs*

Estimation of the monthly income of a Family Physician

Expected number of OP visits in a day per FP	50
Annual OP consultations per FP (300 days)	15,000
Fee to be paid by the government per consultation	Rs. 200
Gross annual income to the FP (Rs. 200 x 15,000)	Rs. 30,00,000
Net annual income to the FP (assuming operational cost of Rs. 12 lakhs)	Rs. 18,00,000
Estimated monthly net income of the FP	Rs. 1.25-1.5 lakhs

- Reasonable remuneration under this model **will incentivise doctors** to open clinics in small towns.
- **Competition between FPs to attract patients** will enable better doctors to earn more accordingly.
- **Choice of doctor** to the patient will increase public trust and ensure accountability.

Adequate number of doctors are available

- About **93,000 FPs would be required** across the country (one FP for 15,000 people and population of 140 crores).
 - If the FP system is rolled out over three years, about 30,000 doctors would be required every year.
- About **98,000 fresh doctors are graduating** every year from our medical schools, while **only 60,000 PG seats** are available.

Vast pool of young doctors will greatly benefit from Family Physician practice for a **few years**



Assured income

Experience to young doctors

Preference in PG admission

Medical Seats – Select States and All India, 2022

Select States	MBBS Seats	PG Seats*
Andhra Pradesh	5,585	3,055
Assam	1,250	805
Bihar	2,415	1,215
Chhattisgarh	1,815	679
Gujarat	6,300	2,813
Haryana	1,835	1,201
Karnataka	10,945	7,008
Kerala	4,405	2,627
Madhya Pradesh	4,080	2,101
Maharashtra	10,045	7,606
Odisha	2,325	1,336
Punjab	1,750	945
Rajasthan	5,075	3,258
Tamil Nadu	10,875	5,782
Telangana	6,440	3,440
Uttarakhand	1,150	1,820
Uttar Pradesh	9,153	4,034
West Bengal	4,725	2,568
Total (All-India)	98,013	60,255

*Including DNB/FNB and CPS seats.

Source: National Health Profile 2022

- **PPP mode and pooling of diagnostics – NHM’s Free Diagnostics Service Initiative.**
 - Model – **two levels of basic diagnostics** successfully operationalised in Andhra Pradesh under the Gol programme.
 - The diagnostics labs will be privately run and reimbursed by the government as given below.

Levels	Location	Services	Requirement (AP experience)	Reimbursement Rate (to be adapted to local conditions)
Level I Diagnostics	One lab for every “Centre”	16 basic tests (similar to in-house lab tests in AP)	Required by 25% of all OP visits	Rs. 200 (cost-per-patient)
Level II Diagnostics	Based on local needs	42 tests (similar to PPP-run lab tests in AP)	Required by 10% of the OP visits	Rs. 250 (cost-per-patient)

Economies of scale – pooling of FP services in a “centre” makes Level I Diagnostics and Pharmacies viable

Pooled Diagnostics

S. No.	Name of the test	Tests available in in-house laboratories
1	Haemoglobin	✓
2	MP slide method/malaria rapid test	✓
3	ESR	✓
4	Clotting time and bleeding time	✓
5	Blood group	✓
6	Blood sugar	✓
7	HIV test	✓
8	Sputum for AFB	✓
9	Urine sugar and albumin	✓
10	Urine pregnancy test	✓
11	HBsAg	✓
12	TLC	Not available in PHC
13	DLC	Not available in PHC
14	Urine microscopy	Not available in PHC
15	Peripheral blood film	Not available in PHC/CHC
16	RPR rapid test	Not available in PHC/CHC

Level I Diagnostic Services offered in Andhra Pradesh (as in-house laboratory tests)

Economies of scale – pooling of FP services in a “centre” makes Level I Diagnostics and Pharmacies viable

- **One Jan Aushadhi Kendra per “centre” in PPP mode.**
 - Building on **PM Bhartiya Janaushadhi Pariyojana**
 - All medicines to be provided **free of cost to the public**. Cost to be borne by the government.
- **Centralised procurement of drugs by the government.**
 - Purchase of **generic drugs**; wherever necessary and to a limited extent, **essential branded drugs**.
 - Practice has already been adopted by several states following the pioneering example set by Tamil Nadu.

Economies of scale – pooling of FP services in a “centre” makes Level I Diagnostics and Pharmacies viable

Preparation of **Essential Drugs List** (localised)



Tendering process and **inspection** of facilities



Procurement & Quality Control



Automated payments upon quality control clearance



ICT-based **scientific inventory management**

- **Advantages** of centralised procurement of drugs by the government
 - Rational drug choice
 - Optimum availability of drugs at various facilities
 - Cost-effectiveness – greater negotiating power for the government
 - Reduced OOPE for the patient as drugs constitute a major portion
- **Allocation of Rs. 100 per outpatient visit is a reasonable estimate** based on experience in Tamil Nadu and Andhra Pradesh.

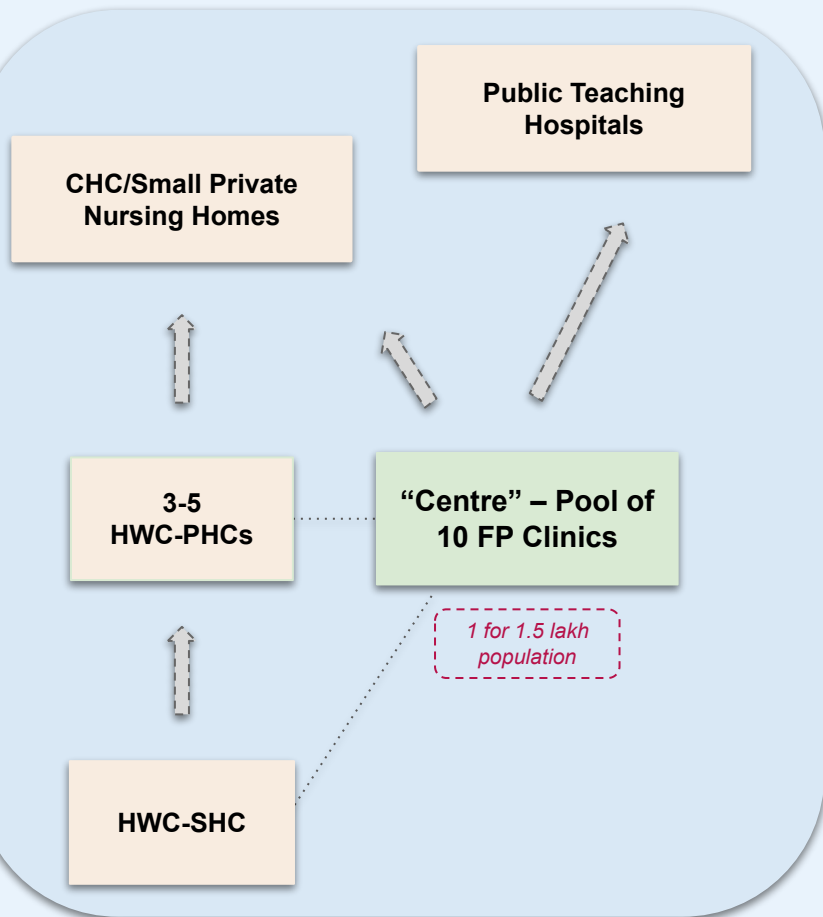
Economies of scale – pooling of FP services in a “centre” makes Level I Diagnostics and Pharmacies viable

Integration with Ayushman Bharat Digital Mission



- FP-led Primary Care System provides the **perfect platform** for rolling out and maintaining **digital health records** under the Ayushman Bharat Digital Mission.
- Govt has been rightly placing a lot of emphasis on developing digital **Personal Health Records** of individuals and a **Unified Health Interface (UHI)** for interoperability of digital health services.
- While the government is making a **concerted effort** to bring more people within the ambit of ABHA (Ayushman Bharat Health Account), **a system of data entry** for all in-patients and out-patients can be created, starting with public healthcare facilities.

Integration with the HWC ecosystem



- The HWC network may continue to provide the **preventive, promotive & rehabilitative** aspects of primary care – surveillance, nutrition, maternal & child care, family planning, sanitation. It can also provide **administrative and logistical support**.
- All outpatient **curative care** ought to be provided by the **pool of FP clinics**. These clinics would drive primary care delivery in the region.
- The FP clinics can be **supported by the HWC network**:
 - **Management of NCDs** – diabetes & hypertension

HWC workers can undertake screening and refer to an FP if anything is amiss, based on protocols. They can be responsible for post-consultation monitoring and management.

HWC team can undertake monthly monitoring and arrange for quarterly or half-yearly visits to the FP.

Estimated Annual Cost per FP Clinic

FP CONSULTATIONS

Cost per outpatient consultation	Rs. 200
Number of annual OP consultations	15,000
Total annual expenditure	Rs. 30 lakhs

DRUGS

Cost per outpatient consultation	Rs. 100
Number of annual OP consultations	15,000
Total annual expenditure	Rs. 15 lakhs

DIAGNOSTICS

Cost per patient for Level I tests	Rs. 200
Number of patients needing Level I tests	3,750
Expenditure on Level I tests	Rs. 7.5 lakhs
Cost per patient for Level II tests	Rs. 250
Number of patients needing Level II tests	1,500
Expenditure on Level II tests	Rs. 3.75 lakhs
Total annual expenditure	Rs. 11.25 lakhs

* per capita consultations of ~1.5 for 70% of the population.

Estimates include expenditure currently being incurred on drugs and diagnostics.

Total Annual Expenditure per FP Clinic

Rs. 57 lakhs

Cost per outpatient visit

Rs. 380

Estimated Annual cost per “Centre”

FP CONSULTATIONS

Cost per outpatient consultation	Rs. 200
Number of annual OP consultations (10 FPs)*	1,50,000
Total annual expenditure	Rs. 3 cr.

DRUGS

Cost per outpatient consultation	Rs. 100
Number of annual OP consultations (10 FPs)	1,50,000
Total annual expenditure	Rs. 1.5 cr.

* per capita consultations of ~1.5 for 70% of the population.

Estimates include expenditure currently being incurred on drugs and diagnostics.

DIAGNOSTICS

Cost per patient for Level I tests	Rs. 200
Number of patients needing Level I tests	37,500
Expenditure on Level I tests	Rs. 75 lakhs
Cost per patient for Level II tests	Rs. 250
Number of patients needing Level II tests	15,000
Expenditure on Level II tests	Rs. 37,5 lakhs
Total annual expenditure	Rs. 1.13 cr.

Total Annual Expenditure for 10 FP Clinics

Rs. 5.7 cr.

Estimated Total Annual Cost – National

FP CONSULTATIONS

Cost per outpatient consultation	Rs. 200
Number of annual OP consultations*	150 cr.
Total annual expenditure	Rs. 30,000 cr.

DRUGS

Cost per outpatient consultation	Rs. 100
Number of annual OP consultations*	150 cr.
Total annual expenditure	Rs. 15,000 cr.

DIAGNOSTICS

Cost per patient for Level I tests	Rs. 200
Number of patients needing Level I tests	37.5 cr.
Expenditure on Level I tests	Rs. 7,500 cr.
Cost per patient for Level II tests	Rs. 250
Number of patients needing Level II tests	15 cr.
Expenditure on Level II tests	Rs. 3,750 cr.
Total annual expenditure	Rs. 11,250 cr.

* per capita consultations of ~1.5 for 70% of the population, population taken as 140 crores as estimated by the UN in *World Population Prospects 2022*.

Estimates include expenditure currently being incurred on drugs and diagnostics.

Total Annual Expenditure – National

Rs. 57,000 cr.

Number of patients covered

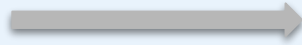
100 cr.

Number of annual outpatient visits

150 cr.

Operationalising the model

Rs. 57,000 cr.
per annum

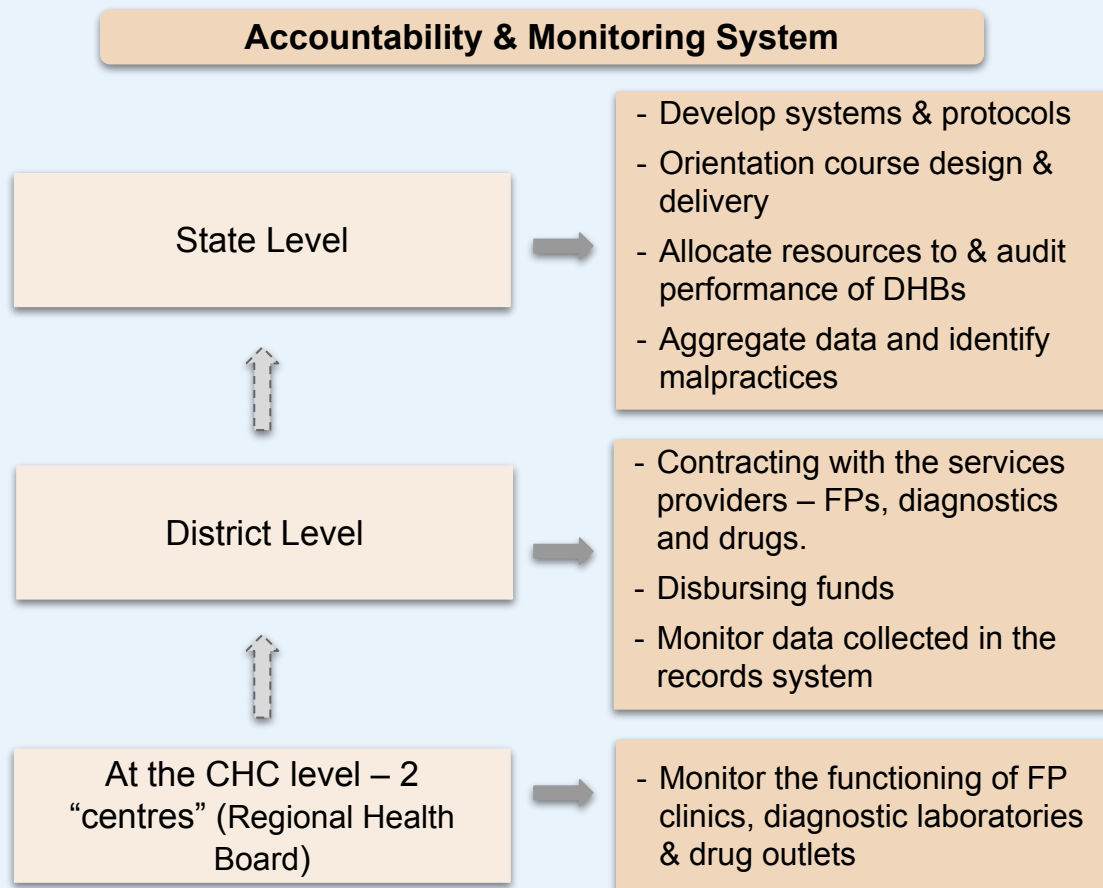


substantial relief to **100 crore Indians**
(70% of the population), both medically and financially

- The model requires additional expenditure of **only ~0.19% of GDP**.
- The model can be **piloted in certain regions** and then scaled up with necessary modifications based on experience.
- It can be implemented in a **phased manner across 3 years**, with an incremental annual expenditure of about **Rs. 19,000 crores**.
 - If rolled out as a **Centrally Sponsored Scheme**, the Union and the State can share the expenditure burden in the ratio **50:50**, i.e. incremental annual cost of **Rs. 9,500 crores** for the Union.
- The total government health expenditure after the full roll out of FP model will still remain **well below 1.5% of GDP**.
- The model will be hugely popular – **high patient satisfaction, reduction of out-of-pocket expenditure and poverty, and enhanced productivity**.

The required framework

- Design of **protocols and standards of care** in Family Practice.
- Short **4 week-long Orientation Course** in Family Practice for contracting FPs.
- **Multi-tier accountability system** – across “centre”, district and state.
- The government **may** consider charging **nominal co-payments** from the patients who can afford – accountability to the people, cost control and prevents overuse.



Laying the foundation for effective health care

- An effective and accountable Primary Care System will **reduce the undue burden on Public Tertiary Care Hospitals** and will aid in improving their functioning.
- For **Secondary Care**, PM-JAY coverage can be expanded to the **whole population** and high cost procedures can be **limited** to public hospitals. Effort should be made to **empanel small private nursing homes** for secondary care procedures.
- The quality of care in **Public Tertiary Hospitals** can be improved through **higher per-bed allocations** and **improvements in infrastructure**, and **flexible systems** to avail the services of reputed experts from private sector as consultants and attending physicians.
