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# Paying For Results or Paying for Process? Lessons From Results-Based Financing for India

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***Abstract*—Increasing burden of diseases and expectation of high-quality healthcare are the important factors contributing the healthcare expenditure significantly. Financial protection tools are able to reduce the catastrophic health expenditure impact but same time it's also important to analyze whether this money is able to produce desired outcomes or not.**

**A recent analysis of 46 World Bank Program-for-Results health operations found that fewer than 2% of disbursement-linked indicators (DLIs) measured health outcomes. India's main payment channels, including PM-JAY package payments, the National Health Mission (NHM) conditionalities framework and quality incentives, also reward mainly processes and outputs.**

**Process indicators dominate because outcomes are slow, hard to attribute, poorly measured and risky to tie to provider income. Study proposes a graduated "indicator ladder" that moves payment weight from process to output, quality and outcome as data systems mature. Continuous, data-driven quality measurement can bridge payment and health outcomes in India.**

***Index Terms*—Disbursement linked indicators (DLIs), National Health Mission, PM-JAY, LMICs (Low Middle-Income Countries), NQAS, NABH**

## I. INTRODUCTION

Results-based financing (RBF) links at least part of a payment to the verified for achieving the agreed results. It has become a central tool of health financing in low- and middle-income countries (LMICs). Its promise is simple: pay for what matters, and systems will deliver it.

A new analysis from the Center for Global Development (CGD) challenges how far that promise is fulfilled. Estes and Eldridge examined 46 World Bank Program-for-Results (PforR) health operations, representing US$13.6 billion in financing. In these operations, funds are released against disbursement-linked indicators (DLIs). They found that fewer than 2% of DLIs measured

actual health outcomes; most rewarded processes and health system performance (1). An earlier CGD review of the first 35 patients for operations had already noted the heavy weight given to institution-building over results (2).

The wider evidence is similarly mixed. A Cochrane review of paying for performance in LMICs found that its effects on service delivery are uncertain and vary by context and design (3). Others have argued that performance-based financing has been promoted faster than the evidence warrants (4). High-income settings also report modest and inconsistent effects of pay-for-performance (5).

These findings are relevant for India. The country spends heavily on health through both public budgets and household pockets. Out-of-pocket expenditure still accounted for 39.4% of total health expenditure in 2021–22 (6). India also uses several payment channels which are , results-based. This commentary asks whether those channels pay for health, or mainly for process, and proposes a practical way forward.

## II. INDIA'S PAYMENT CHANNELS: WHAT DO THEY REWARD?

India does not use the term DLI, but several national mechanisms work in the same way. Payment follows a defined, verifiable result.

PM-JAY. Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) pays empanelled hospitals a fixed rate per pre-authorised package (7). This has widened access. An evaluation across six states found PM-JAY reduced relative out-of-pocket and catastrophic expenditure, though the gains were concentrated in private facilities (8). Yet the payment trigger is a claimed procedure. Package payment, by design, does not reflect whether the patient recovered, was readmitted, or still paid out of pocket for medicines and diagnostics.

NHM conditionalities. Under the NHM Conditionalities Framework 2024–26, up to 20% of the NHM budget is distributed as incentives or penalties to states (9). The indicators include health and wellness centre functionality, digital logistics use, registration of pregnant women, human resources against norms, NQAS and LaQshya certification, and infrastructure compliance. Only a few, such as tuberculosis treatment success and standard-of-care measures for hypertension and diabetes, come close to outcomes.

Quality incentives. National Quality Assurance Standards (NQAS) certification and Kayakalp awards give financial rewards to public facilities that meet assessed standards (10, 11). Both have raised attention to quality. But they reward performance at the time of assessment, not sustained practice.

| Mechanism | Payment trigger | Dominant indicator type | What may be missed |
|---|---|---|---|
| PM-JAY package rates (7) | Pre-authorized, claimed procedure | Output | Recovery, readmission, residual out-of-pocket spending |
| NHM | State scores on set | Process and | Population health gains |

| Mechanism | Payment trigger | Dominant indicator type | What may be missed |
|---|---|---|---|
| conditionalities (9) | conditions | output | |
| NQAS incentives (10) | Passing external assessment | Quality (structure and process) | Sustained practice between assessments |
| Kayakalp awards (11) | Scores on hygiene and infection control | Quality (process) | Infection outcomes over time |

The pattern mirrors the CGD finding. India's payment channels mostly pay for activity and compliance, and only marginally for health gained.

## III. WHY PROCESS INDICATORS DOMINATE

The scarcity of outcome indicators is not intentional but it is due to few genuine constraints that push designers towards process measures-

- Time lag. Mortality and disease control change over years, while budgets and disbursements run on months.
- Attribution. Outcomes such as infant mortality depend on nutrition, water, income and roads, not only on health services. Providers resist being paid on results they cannot control.
- Data quality. Outcome data in many states is incomplete, delayed or self-reported, and paying on weak data invites gaming.
- Risk to care. Withholding funds when an outcome target is missed can starve facilities of the money they need to keep treating patients, a risk the CGD analysis explicitly flags (1).

Process indicators are therefore the safe choice: measurable, controllable and quick to verify. Donabedian's classic framework reminds us that structure and process matter because they lead to outcomes (12). The danger arises when the means become the end. From the author's experience as a national assessor for NABH and NQAS, facilities respond rationally to what is paid for. When money follows the checklist, documentation can improve faster than care.

## IV. A GRADUATED INDICATOR LADDER

The answer is not to abandon process indicators but to treat them as the first rung rather than the destination. We propose that every payment scheme publish an "indicator ladder" at its outset (Figure 1). Payment initially rests mostly on process and output indicators, so that facilities are not deprived of operating funds. A small, pre-announced and rising share then shifts to quality and outcome indicators as data systems mature.

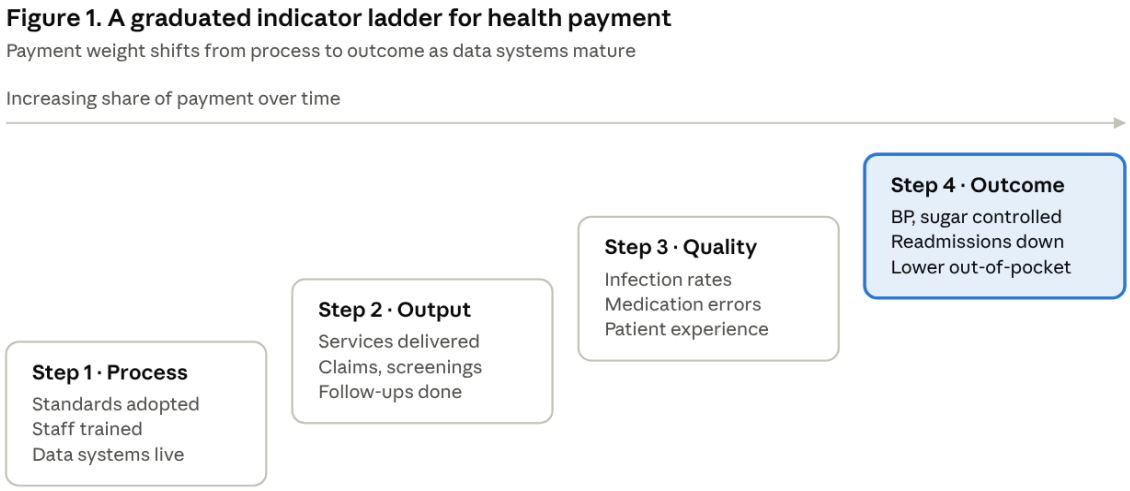



Figure1. Graduated Indicator Ladder for Health payment

India is well placed to climb this ladder. PM-JAY already generates claims data on a very large number of hospital admissions (7), and the Ayushman Bharat Digital Mission is building linked electronic health records. Together, these can track readmissions, repeat procedures and continuity of care. These are early outcome signals that require no new surveys.

## V. QUALITY AS THE BRIDGE BETWEEN PAYMENT AND OUTCOMES

Quality indicators sit between what a facility does and what a patient gains. They are closer to outcomes than process counts, yet remain largely within a provider's control (12). This makes them the natural third rung.

India already has the institutional base: NABH accreditation for hospitals, NQAS for public facilities (10) and Kayakalp for hygiene and infection control (11). The gap lies in how these are used. Today, certification acts largely as a periodic gate or award. It should become a continuous signal linked to payment. Three shifts would help:

1. Pay on measured indicators, not certificates. Link a share of PM-JAY and NHM payments to tracked rates such as surgical site infections, 30-day readmissions and medication errors.
2. Include the patient's voice. Brief, standardized patient-reported measures, including whether patients had to buy medicines or tests outside, would show whether financial protection is real.
3. Measure less, but better. Applying Lean principles, schemes should track a few critical-to-quality indicators from routine data instead of adding registers for already stretched staff.

## VI. RECOMMENDATIONS

1. Audit existing indicators. Classify every payment trigger in PM-JAY, the NHM conditionalities framework and quality incentive schemes as process, output, quality or outcome, replicating the CGD approach for India (1).

2. Publish an indicator ladder for each scheme. Set a transparent, multi-year schedule for shifting payment weight towards quality and outcome indicators.
3. Use data already collected. Analyze PM-JAY claims and digital health records for readmissions, repeat procedures and continuity of care before commissioning new surveys.
4. Protect care while raising the bar. Retain a guaranteed base payment so that no facility curtails services because an outcome target was missed.
5. Invest in embedded implementation research. Payers such as the National Health Authority and state health agencies should commission studies on what their payments actually buy, and what they distort.

## VII. CONCLUSION

Results-based financing remains a powerful idea, but a result that never reaches the patient is little more than a receipt. The CGD evidence shows that even sophisticated international programmes struggle to pay for health outcomes. India, with its resources, expanding digital health infrastructure and established quality frameworks, has potential to do better. Paying for health, rather than for process only, should be the explicit goal of the next generation of Indian health financing reform.

## VIII. DECLARATIONS

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