Universal Health Coverage for India

Emerging Practices in Global Health Cooperation: Brazil, China, India, Russia and South Africa

Washington DC
December 6, 2011

Priya Balasubramaniam
Study Director - UHC
Public Health Foundation of India
With so many of the world's economies in tatters, the combined might of China and India could spearhead global growth in the coming decades. Are they up to the job?

By ZOHER ABDULLCARIM

THE CASE FOR INDIA: FREE TO SUCCEED
By MICHAEL SCHUMAN
India’s Current Health Scenario

- Largest number of underweight children (46% under 3 yrs);
- Current infant mortality rate of 50 per 1000 live births;
- Maternal mortality ratio presently 212 per 100 000 live births;
- Challenge to meet national (MDG) goals of 38 per 1000 (IMR) or 100 per 100 000 (MMR) by 2015
- Rising burden of NCDs/ Low immunization rates fewer > 44%

<table>
<thead>
<tr>
<th></th>
<th>2011 (in Millions)</th>
<th>2030 (in Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>61</td>
<td>84</td>
</tr>
<tr>
<td>Hypertension</td>
<td>130</td>
<td>240</td>
</tr>
<tr>
<td>Tobacco Deaths</td>
<td>1+</td>
<td>2+</td>
</tr>
</tbody>
</table>
Impoverishment Due to OOP Payments in India

(In Millions)

Source: Selvaraj and Karan (2009)
WHY IS HEALTH SYSTEM REFORM NEEDED?

- 18% of all episodes in rural areas and 10% in urban areas received no health care at all
- 12% of people living in rural areas and 1% in urban areas had no access to a health facility
- 28% of rural residents and 20% of urban residents had no funds for health care
- Over 40% of hospitalised persons have to borrow money or sell assets to pay for their care
- Over 35% of hospitalised persons fall below the poverty line because of hospital expenses
- Over 2.2% of the population may be impoverished because of hospital expenses
- The majority of the citizens who did not access the health system were from the lowest income quintiles

NSSO (2006)
UHC - Policy Context

- High Level Expert Group (HLEG) on Universal Health Coverage (UHC) constituted by the government of India with the mandate of developing a framework for providing accessible and affordable health care to all Indians and suggesting a 10-year strategy going forward.
- The Public Health Foundation of India (PHFI) appointed as secretariat by the Planning Commission of India, to support to the High Level Expert Group in preparing its report.
UHC- Policy Context

• The review process of the HLEG was complemented with the experience of other countries, highlighting what has worked, relevant and replicable along with limitations of varied approaches.

• **Report consulted a network of experts from**
  – Brazil, China, S. Africa, Thailand
  – Others as well...(N. America, Europe etc)
CHILD DEATHS: DISPARITY ACROSS STATES

IMR

MP : 72/1000
UP : 69/1000
Tamil Nadu : 35/1000
Kerala : 13/1000

Neonatal Mortality Rate Varies
From 11/1000 in Kerala to 53/1000 in Odisha
### KEY HEALTH INDICATORS: INDIA COMPARED WITH OTHER COUNTRIES

<table>
<thead>
<tr>
<th>Indicator</th>
<th>India</th>
<th>China</th>
<th>Brazil</th>
<th>Sri Lanka</th>
<th>Thailand</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMR/1000 live-births</td>
<td>50</td>
<td>17</td>
<td>17</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Under-5 mortality/1000 live-births</td>
<td>66</td>
<td>19</td>
<td>21</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Fully immunised (%)</td>
<td>66</td>
<td>95</td>
<td>99</td>
<td>99</td>
<td>98</td>
</tr>
<tr>
<td>Birth by skilled attendants</td>
<td>47</td>
<td>96</td>
<td>98</td>
<td>97</td>
<td>99</td>
</tr>
</tbody>
</table>

IMR – Infant Mortality Rate
## LOW PRIORITY TO PUBLIC SPENDING ON HEALTH – INDIA AND COMPARATOR COUNTRIES 2009

<table>
<thead>
<tr>
<th>Country</th>
<th>Total public spending as % GDP (fiscal capacity)</th>
<th>Public spending on health as % of total public spending</th>
<th>Public spending on health as % of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>33.6</td>
<td>4.1</td>
<td>1.4</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>24.5</td>
<td>7.3</td>
<td>1.8</td>
</tr>
<tr>
<td>China</td>
<td>22.3</td>
<td>10.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Thailand</td>
<td>23.3</td>
<td>14.0</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Source: WHO database, 2009
<table>
<thead>
<tr>
<th>Country</th>
<th>Beds/ 1000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>3.1</td>
</tr>
<tr>
<td>China</td>
<td>3.0</td>
</tr>
<tr>
<td>Thailand</td>
<td>2.2</td>
</tr>
<tr>
<td>Brazil</td>
<td>2.4</td>
</tr>
<tr>
<td>USA</td>
<td>3.1</td>
</tr>
<tr>
<td>UK</td>
<td>3.9</td>
</tr>
<tr>
<td><strong>India</strong></td>
<td><strong>0.9</strong></td>
</tr>
<tr>
<td>Nicaragua</td>
<td>0.9</td>
</tr>
<tr>
<td>Togo</td>
<td>0.9</td>
</tr>
<tr>
<td>Indonesia</td>
<td>0.6</td>
</tr>
</tbody>
</table>

UHC Focus Areas

1. Human Resource Requirements
2. Access to Health Care Services
3. Management Reforms
4. Community Participation
5. Access to Medicines
6. Health care Financing
7. Social Determinants of Health
Additional Focus

– Urban health
– Gender
– Public-Private Partnerships
– Information Technology-enabled health services
Our Vision

• **Universal Health Entitlement** for every citizen - to a **National Health Package (NHP)** of essential primary, secondary & tertiary health care services that will be funded by the government.

Package to be defined periodically by an Expert Group; can have state specific variations.
PROVISION OF HEALTH CARE

• Strengthen Public Services
  \textit{(Especially): Primary HealthCare-
Rural And Urban; District Hospitals)}

• Contract Private Providers
  \textit{(As Per Need And Availability)}
  – With Defined Deliverables

• Integrate $1^0$, $2^0$, $3^0$ Care
  Through Networks of Providers
  \textit{(Public; Private; Public-Private)}

Regulate and Monitor For Quality, Cost And Health Outcomes
Health Financing & Financial Protection

• Government (Central government and states combined) should increase public expenditures on health from the current level of 1.2% of GDP to at least 2.5% by the end of the 12th plan, and to at least 3% of GDP by 2022.

• Ensure availability of free essential medicines by increasing public spending on drug procurement;

• General taxation as principal source of health care financing – complemented by additional mandatory deductions from salaried individuals & tax payers, either as a proportion of taxable income or as a proportion of salary;
Health Financing & Financial Protection

• Do not levy sector-specific taxes for health financing;*
• Remove user fees for NHP services- this applies even for those who have financial capacity to pay
• Introduce specific purpose transfers to equalize levels of per capita public spending on health by different states - to offset general disability and mobilize resources to ensure all citizens are entitled to same level of essential healthcare;
• Accept flexible and differential norms for financing that are proposed by states, recognizing physical and socio-cultural diversities

* Higher taxes on tobacco and alcohol recommended for other reasons
KEY RECOMMENDATIONS FOR MEDICINE AND MANAGEMENT

• At least 15% allocation of public funding for health to drugs; State must procure all **EDL medicines**;
• Centralized procurement at state level
• A two-bid open **transparent tendering** process;
• **Quality generic drugs** ensured; **Warehouses** at every district level;
• An autonomous **procurement agency** for drugs, vaccines & diagnostics;
• Enactment of Transparency in **Tender Act**;
MANAGEMENT AND INSTITUTIONAL REFORMS

• Develop capacity and **cadres for public health and health management**

• Adopt **better human resource practices** to improve recruitment, retention motivation and performance; rationalize pay and incentives; and assure career tracks for competency-based professional advancement;

• Develop a **national health information technology network** based on uniform standards to ensure interoperability between all health care stake holders;
Immediate Key Outcomes

• Healthcare spending to go up by 2.5% in 12th Five Year Plan: Montek Singh Ahluwalia
(The Economic Times - Dec 1, 2011)

• Here’s how UPA can seduce the ‘common man’- universal healthcare as the game-changer that will truly reform India
(Daily News & Analysis - Monday, December 5, 2011)
• After many wrongs, Planning Commission has just got it right - universal health coverage to become reality up-coming five-year Plan

(Times of India , December 5th, 2011)

Business Standard, November 30th, 2011 - Transparent and more objective price regulation.
India has firmly joined the Global movement towards Universal Health Coverage & Care ....perhaps a leader in future?

UHC - Placing health in the center stage of Global Country agendas
So – why a south-south CONTEXT

Some similarity in terms of:

- Environment - political, economic, social, historical, geographic
- Living conditions
- Disease Dynamics - targets
- Health systems
Opportunities

Innovations (what already works) related to

• Health systems (capacity building)
• Technology - Low Cost/Telemedicine
• Disease Surveillance/ Pandemic Preparedness/Disaster management
• Affordable medicines/pharmaceuticals
• Primary health – Nutrition, safe water, sanitation
• Institutional/people to people linkages
Some Challenges

- Political will and committed leadership
- Trust
- Importance of supportive & enabling international environment/partners
- Lack of Institutional follow-up/evidence
- North oriented mindset – vertical links
- History - Low level awareness of common problems
- Weak policy frameworks – only national goals
“If we don’t create the future, the present extends itself”

- Toni Morrison (Song of Solomon)
THANK YOU


• For more about the report contact -Priya Balu pribalas@phfi.org
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- The majority of the citizens who did not access the health system were from the lowest income quintiles.

NSSO (2006)
Impoverishment Due to OOP Payments in India

(In Millions)

Source: Selvaraj and Karan (2009)
CURRENT SCHEMES FOR FINANCIAL PROTECTION MOSTLY DO NOT COVER

- OUT PATIENT CARE
- DRUGS
- LAB DIAGNOSTICS

Which collectively contribute to the larger fraction of OOP!
### HOSPITAL BED CAPACITY, BY COUNTRY

<table>
<thead>
<tr>
<th>Country</th>
<th>Beds/ 1000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>3.1</td>
</tr>
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HEALTH SERVICES : URBAN RURAL DISPARITY

- 80% of Doctors
- 75% of Dispensaries
- 60% of Hospitals

- Qualified Physicians:
  - 11.3/10,000 - Urban Areas
  - 1.9/10,000 – Rural areas

Are Located In Urban Areas
HEALTH WORKER DENSITY ACROSS MAJOR STATES OF INDIA

## Sources, Estimation of Methods, and Resulting Doctor Densities

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Doctor Density</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anand &amp; Fan (2010)*</td>
<td>2001</td>
<td>2.6 doctors per 10,000&lt;br&gt;1 doctor per 3,800&lt;br&gt;1 doctor per 1,320 urban&lt;br&gt;1 doctor per 15,800 rural</td>
</tr>
<tr>
<td>National Commission on Macroeconomics and Health</td>
<td>2004</td>
<td>5.97 doctors per 10,000&lt;br&gt;1 doctor per 1,676 (urban rural breakdown not possible with data)</td>
</tr>
<tr>
<td>Rao and colleagues (2009)</td>
<td>2005</td>
<td>3.8 doctors per 10,000&lt;br&gt;1 doctor per 2,631&lt;br&gt;1 doctor per 1,000 urban&lt;br&gt;1 doctor per 10,000 rural</td>
</tr>
<tr>
<td>HLEG Secretariat</td>
<td>2011</td>
<td>5.1 doctors per 10,000&lt;br&gt;1 doctor per 1,953 (urban rural breakdown not possible with data)</td>
</tr>
</tbody>
</table>

*Anand and Fan found that 57.3% of self-reported doctors in the 2001 Census lacked medical qualifications, bringing down the density of doctors in that year from 0.6 per 1,000 to 0.27 allopathic doctors per 1,000*
Our Definition of UHC

Operational Definition

“Ensure equitable access for all Indian citizens resident in any part of the country, regardless of income level, social status, gender, caste or religion, to health services (promotive, preventive, curative, and rehabilitative) that are affordable, appropriate and of assured quality.”

Definition

• “Ensuring equitable access for all Indian citizens resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) as well as public health services addressing wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services.”
Guiding Principles

- Universality;
- Equity;
- Non-exclusion and non-discrimination;
- Comprehensive care that is rational & of good quality;
- Financial protection;
- Protection of patients’ rights that guarantees appropriateness of care, patient choice, portability & continuity of care;
- Consolidated & strengthened public health provisioning;
- Accountability & transparency; and
- Community participation
Our Vision

• Universal Health Entitlement for every citizen - to a **National Health Package (NHP)** of essential primary, secondary & tertiary health care services that will be funded by the government.

Package to be defined periodically by an Expert Group; can have state specific variations.
Health Financing & Financial Protection

- Government (Central government and states combined) should increase public expenditures on health from the current level of 1.4% of GDP to at least 2.5% by the end of the 12th plan, and to at least 3% of GDP by 2022.
- Ensure availability of free essential medicines by increasing public spending on drug procurement;
- General taxation as principal source of health care financing – complemented by additional mandatory deductions from salaried individuals & tax payers, either as a proportion of taxable income or as a proportion of salary;
Even on assuming total spending on health remains at the current level of around 4.5% of GDP, there will be a sharp decline in the proportion of private out-of-pocket spending on health - from 67% today to 33% by 2020.
Health Financing & Financial Protection

• Do not levy sector-specific taxes for health financing;*

• Remove user fees for **NHP services** - this applies even for those who have financial capacity to pay

• **Introduce specific purpose transfers** to equalize levels of per capita public spending on health by different states - to offset general disability and mobilize resources to ensure all citizens are entitled to same level of essential healthcare;

• Accept **flexible and differential norms for financing** that are proposed by states, recognizing physical and socio-cultural diversities

* Higher taxes on tobacco and alcohol recommended for other reasons
“User Fees for health care were put forward as a way to recover costs and discourage the excessive use of health services and the over-consumption of care. This did not happen. Instead, user fees punished the poor.”

-Dr. Margaret Chan, Director-General, WHO (2009)

“Among the ‘quick win’ strategies recommended by the Millennium Project was the removal of user fees for primary education and essential healthcare by the end of 2006.

- Dr. Jeffrey Sachs (2005)
NO USER FEE

UHC PACKAGE OF HEALTH SERVICES (NHP WITH NHEC)

INSURANCE (PVT./EMPLOYER) OR OOP

HOSPITALITY COMPONENT (Pvt. Ward)

PERSONS OPTING FOR NON-NHEC ACCREDITED HOSPITALS

NON-NHP SERVICES
NO USER FEE

UHC PACKAGE OF HEALTH SERVICES (NHP WITH NHEC)

ADDITIONAL SERVICES FOR THE POOR

INSURANCE (PVT./EMPLOYER) OR OOP

HOSPITALITY COMPONENT (Pvt. Ward)

PERSONS OPTING FOR NON-NHEC ACCREDITED HOSPITALS

NON-NHP SERVICES

ADDITIONAL SERVICES FOR THE POOR

ADDITIONAL SERVICES FOR THE POOR
Health Financing & Financial Protection

• Primary healthcare including preventive/curative services at primary level along with health promotion targeted towards specific risk factors, should account for 70% of all govt. healthcare expenditures;

• Provide universal financial protection and access to good health care without involving insurance companies or any other independent agents to purchase healthcare services on behalf of govt. 

BECAUSE

• Independent agents fragment the nature of care being provided and this over time leads to high health care costs and lower levels of wellness at the population level
Health Financing & Financial Protection

• Purchase of all health care services under UHC should be the sole responsibility of Ministries and Depts. of Health at Central and State levels.

• Govt. funded insurance schemes should be integrated with UHC.

• Health insurance cards should be replaced by NHEC (India Health Card?).
Health Financing & Financial Protection

• Technical and other capacities developed by Ministry of Labour for RSBY should become the core of UHC operations – and transferred to MoHFW.

• Integrate the services provided under different programs gradually (NRHM and other vertical programs such as, HIV/AIDS);
HEALTH CARE SERVICES

GOVERNANCE

BREADTH

DEPTH

QUALITY

ACCOUNTABILITY

EQUITY

EXCELLENCE

EFFICIENCY
PROVISION OF HEALTH CARE

• Strengthen Public Services
  (Especially: Primary Health Care- Rural And Urban; District Hospitals)

• Contract Private Providers
  (As Per Need And Availability)
  – With Defined Deliverables

• Integrate 1<sup>0</sup>, 2<sup>0</sup>, 3<sup>0</sup> Care
  Through Networks of Providers
  (Public; Private; Public-Private)

Regulate and Monitor
For Quality, Cost And Health Outcomes
Health Care Services

• Provide **essential & standard health services** as part of entitlement for every citizen to NHP at different levels of health care delivery system;

• Ensure more equitable & improved access to **functional beds** for guaranteeing secondary & tertiary care;

• Ensure adherence to & compliance with **quality assurance** in health care provision at all levels of service delivery;
KEY CHARACTERISTICS OF RELIABLE & EFFICIENT MEDICINE SUPPLY SYSTEMS

- At least 15% allocation of public funding for health to drugs; State must procure all EDL medicines;
- Separate AYUSH EDL, with centralized procurement at state level;
- Prescription & Dispensing in accordance with Standard Treatment Guidelines (STG);
- A two-bid open transparent tendering process;
- Quality generic drugs ensured;
- Warehouses at every district level;
- An autonomous procurement agency for drugs, vaccines & diagnostics;
- An empanelled laboratory for drug quality testing;
- Enactment of Transparency in Tender Act;
- Prompt payments
Access to Medicines, Vaccines & Technologies

• Ensure rational use of drugs;
• Set up national & state drug supply logistics corporations;
• Empower MoHFW to strengthen drug regulatory system;
• Transfer Department of Pharmaceuticals to the Ministry of Health.
Human Resources for Health

• Ensure adequate numbers of trained health care providers and technical health care workers at different levels – giving primacy to the provision of primary health care.

  – Doubling ASHA from one per 1000 population to two per 1000 population in rural and tribal areas;

  – Introduction of 3-year Bachelor of Rural Health Care (BRHC) degree programme of rural health care practitioners for recruitment & placement at Sub-Centres;
Human Resources for Health

• Improve human resource management and supportive supervision mechanisms at block, district, state & national levels to complement health care service providers;

• Enhance the quality of HRH education and training by introducing competency-based, health system-connected curricula and continuous education;

• Invest in additional educational institutions to produce and train the requisite health workforce;

• Establish a dedicated training system for Community Health Workers;

• Establish District Health Knowledge Institutes (DHKIs);

• Establish the National Council for Human Resources in Health (NCHRH).
MANAGEMENT AND INSTITUTIONAL REFORMS

• Develop capacity and cadres for public health and health management

• Adopt better human resource practices to improve recruitment, retention motivation and performance; rationalize pay and incentives; and assure career tracks for competency-based professional advancement;

• Develop a national health information technology network based on uniform standards to ensure interoperability between all health care stakeholders;

• Ensure strong linkages and synergies between management and regulatory reforms and ensure accountability to patients and communities;

• Establish financing and budgeting systems to streamline fund flow.