

Universal Health Coverage for India

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

**Washington DC
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Public Health Foundation of India**



WORLD

THE CHINDIAN CENTURY

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 ABDOOLCARIM

**THE CASE FOR INDIA:
FREE TO SUCCEED
By MICHAEL
SCHUMAN**

TIME : NOVEMBER 21, 2011

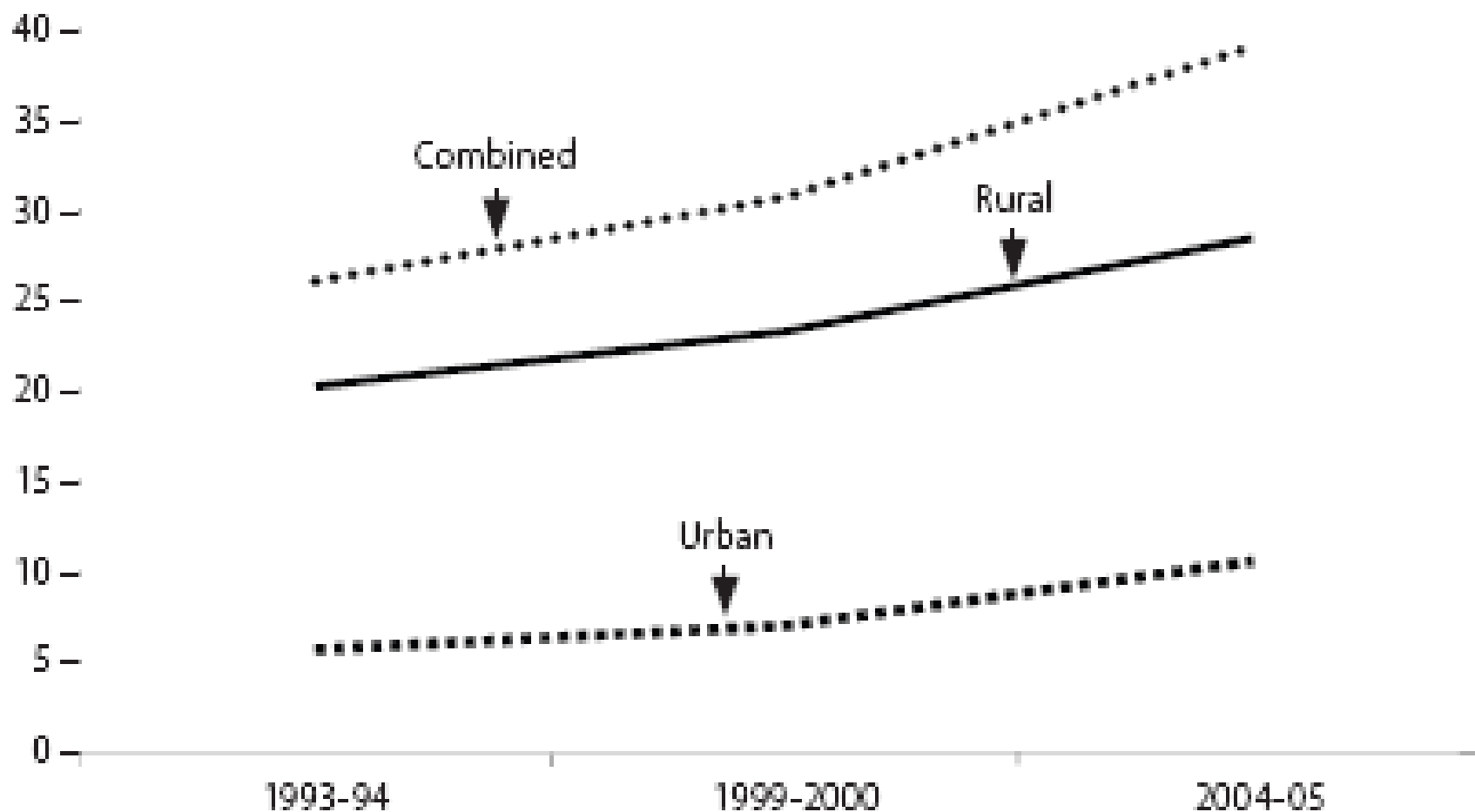
India's Current Health Scenario

- 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%

	2011 (in Millions)	2030 (in Millions)
Diabetes	61	84
Hypertension	130	240
Tobacco Deaths	1+	2+

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

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

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

Source: World Health Organization (2011)

IMR – Infant Mortality Rate

LOW PRIORITY TO PUBLIC SPENDING ON HEALTH – INDIA AND COMPARATOR COUNTRIES 2009

	Total public spending as % GDP (fiscal capacity)	Public spending on health as % of total public spending	Public spending on health as % of GDP
India	33.6	4.1	1.4
Sri Lanka	24.5	7.3	1.8
China	22.3	10.3	2.3
Thailand	23.3	14.0	3.3

Source: WHO database, 2009

HOSPITAL BED CAPACITY, BY COUNTRY

Country	Beds/ 1000 Population
Sri Lanka	3.1
China	3.0
Thailand	2.2
Brazil	2.4
USA	3.1
UK	3.9
India	0.9
Nicaragua	0.9
Togo	0.9
Indonesia	0.6

Source: World Health Statistics (2011)

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

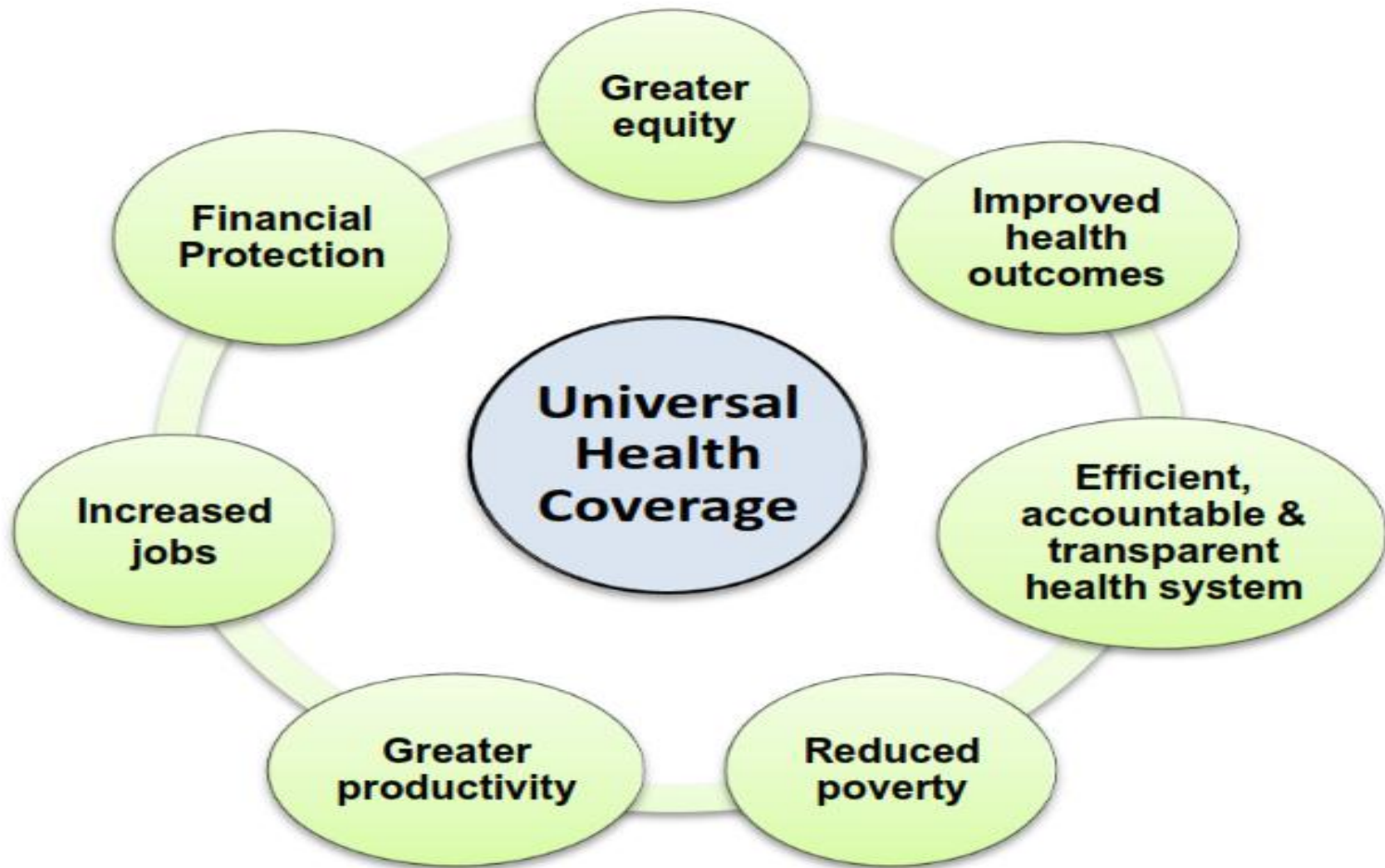
- Urban health**
- Gender**
- Public-Private Partnerships**
- Information Technology-enabled health services**

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

UNIVERSAL HEALTH COVERAGE FOR INDIA - FRAMEWORK



PROVISION OF HEALTH CARE

- **Strengthen Public Services**
(*Especially*: Primary HealthCare-
Rural And Urban; District Hospitals)
- **Contract Private Providers**
(As Per Need And Availability)
– With Defined Deliverables
- **Integrate 1^o, 2^o, 3^o Care**
Through Networks of Providers
(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)

SHOULD DRUG PRICES BE REGULATED?

Yes, we must ensure universal access; but draconian control leads to shortages and spurious products

DEBATE

Medicines are not commodities. Since physicians and chemists decide on behalf of the patient, the demand for drugs is often supplier-induced. Consumer sovereignty, therefore, doesn't exist in the pharmaceutical sector. This is well established — theoretically as well as empirically. But the Department of Pharmaceuticals (DoP) thinks otherwise. The draft policy recommends market-based pricing that is based on the weighted average price of the three top-selling brands in each segment. In the pharmaceutical sector, the

Given that drug pricing is a very emotive subject, policy makers find it extremely difficult to satisfy all stakeholders — patients, doctors, civil society, industry, trade and the health ministry. Many factors, prominent among them being ignorance about medicines, complexity of the industry and its challenges, and the long-term impact of policy, have contributed to this situation. Add to this the inadequacy of health infrastructure in India and the belief among some sections of society that the industry should take care of all sick people — below or above the

DALIP KUMAR



SAKTHIVEL SELVARAJ
Health economist, Public Health



D G SHAH
Secretary General, Indian

entry of spurious and substandard medicines that have now become a perennial problem. Though DPCO 1995 addressed some of these issues, lack of transparency and the use of discretionary powers led to a situation in which the production of almost half the drugs under price control was curtailed or discontinued. India, which once took pride in being self-sufficient in bulk drugs, has lost its medicine security because 70 per cent of its intermediates and bulk drugs are imported from China. The National Pharmaceutical Pricing Policy, 2011 is an attempt to address some of these ills. The

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

- Report on UHC can be found at:
[http://phfi.org/images/what we do/HLEG Report Dec 2011.pdf](http://phfi.org/images/what_we_do/HLEG_Report_Dec_2011.pdf)
- For more about the report contact -Priya Balu
pribalas@phfi.org

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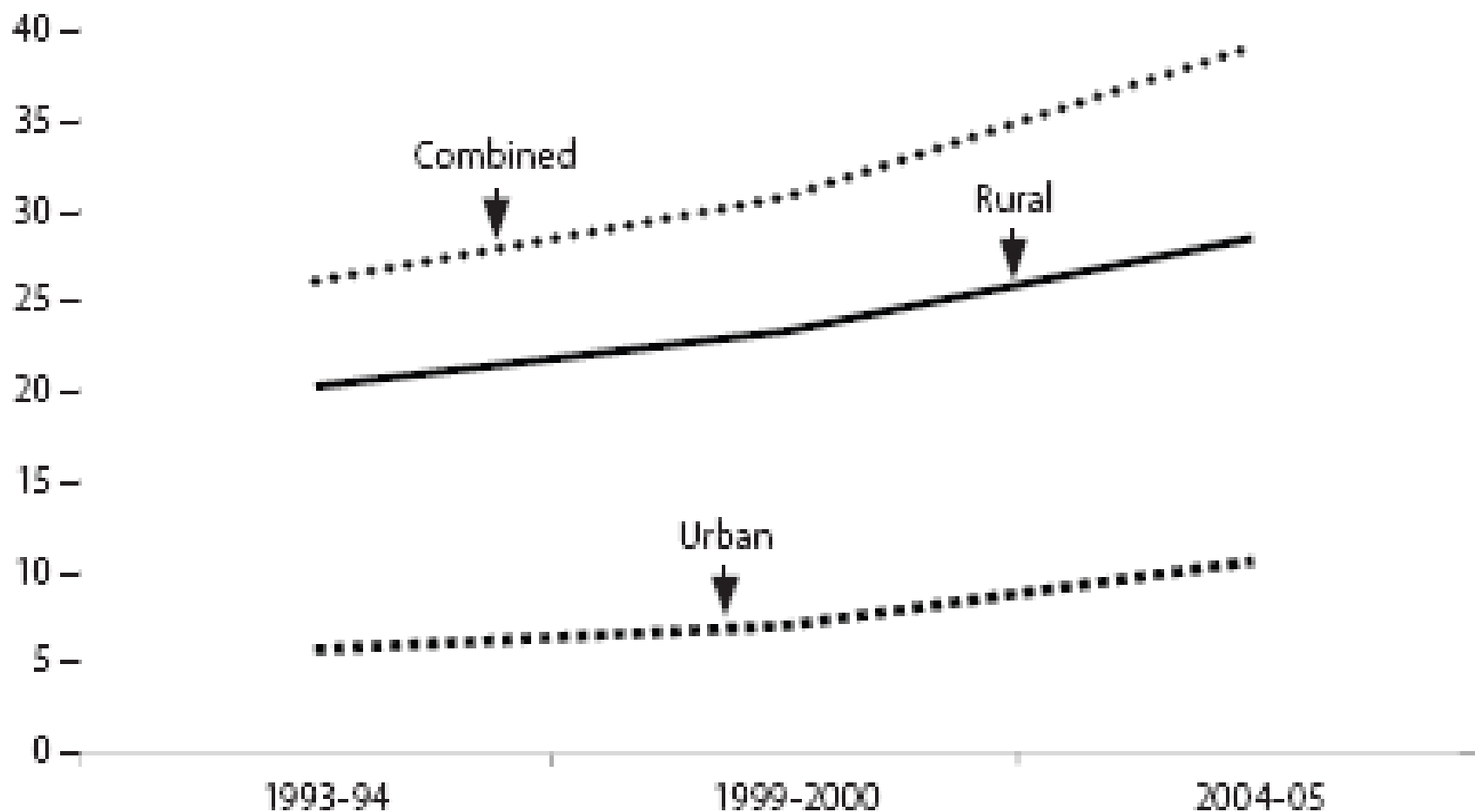
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(In Millions)



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

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Brazil	2.4
USA	3.1
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India	0.9
Nicaragua	0.9
Togo	0.9
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Source: World Health Statistics (2011)

HEALTH SERVICES : URBAN RURAL DISPARITY

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

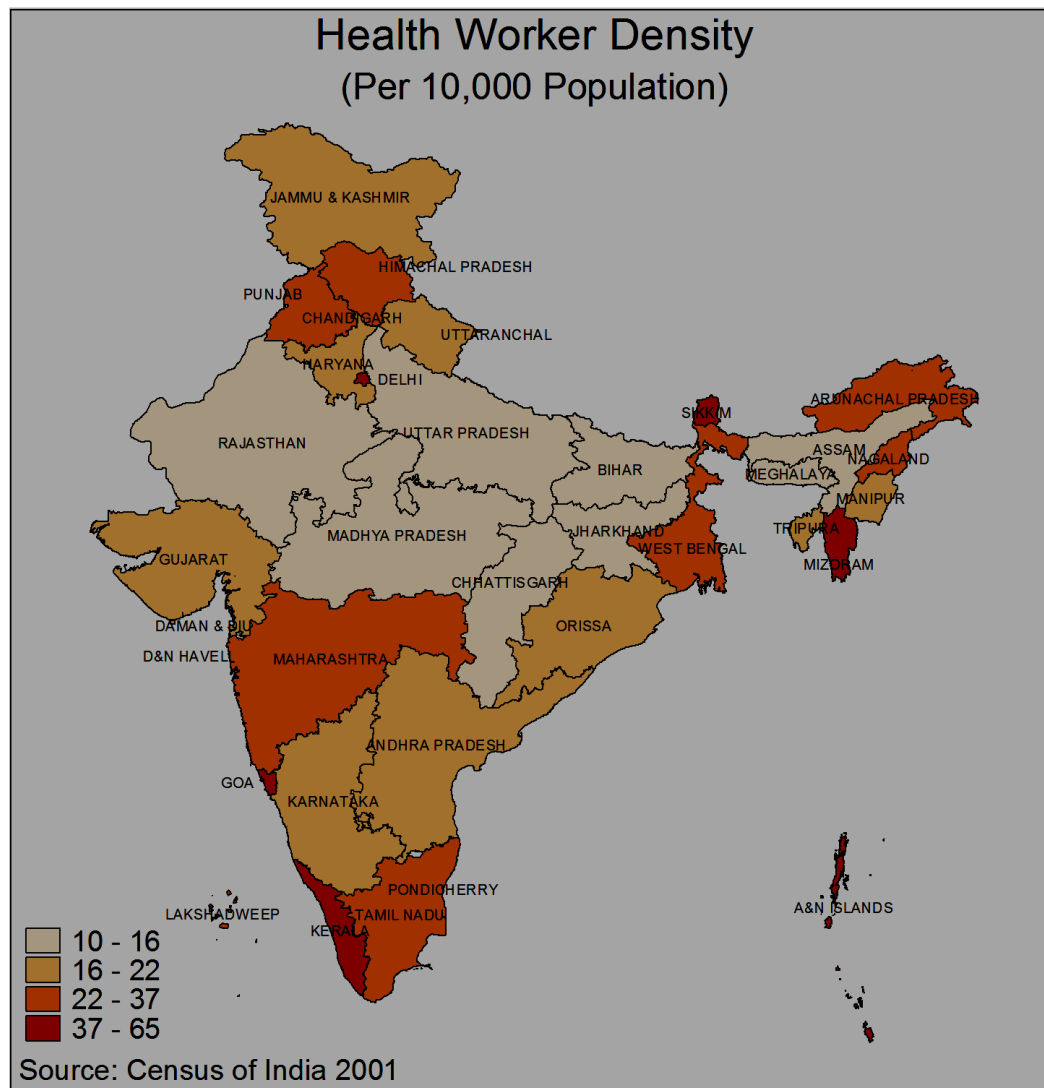
**Are Located In
Urban Areas**

- **Qualified Physicians:**

11.3/10,000 - Urban Areas

1.9/10,000 – Rural areas

HEALTH WORKER DENSITY ACROSS MAJOR STATES OF INDIA



Source: Rao, Krishna D., Bhatnagar, A., Berman, P., Saran, I., Raha, S. India's Health Workforce: Size, Composition and Distribution. Technical Report No.1. Public Health Foundation of India and World Bank. New Delhi 2009 (unpublished report). Based on Census of India 2001.

SOURCES, ESTIMATION OF METHODS, AND RESULTING DOCTOR DENSITIES

Authors	Year	Doctor Density
Anand & Fan (2010)*	2001	2.6 doctors per 10,000 1 doctor per 3,800 1 doctor per 1,320 urban 1 doctor per 15,800 rural
National Commission on Macroeconomics and Health	2004	5.97 doctors per 10,000 1 doctor per 1676 (urban rural breakdown not possible with data)
Rao and colleagues (2009)	2005	3.8 doctors per 10,000 1 doctor per 2,631 1 doctor per 1,000 urban 1 doctor per 10,000 rural
HLEG Secretariat	2011	5.1 doctors per 10,000 1 doctor per 1,953 (urban rural breakdown not possible with data)

*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

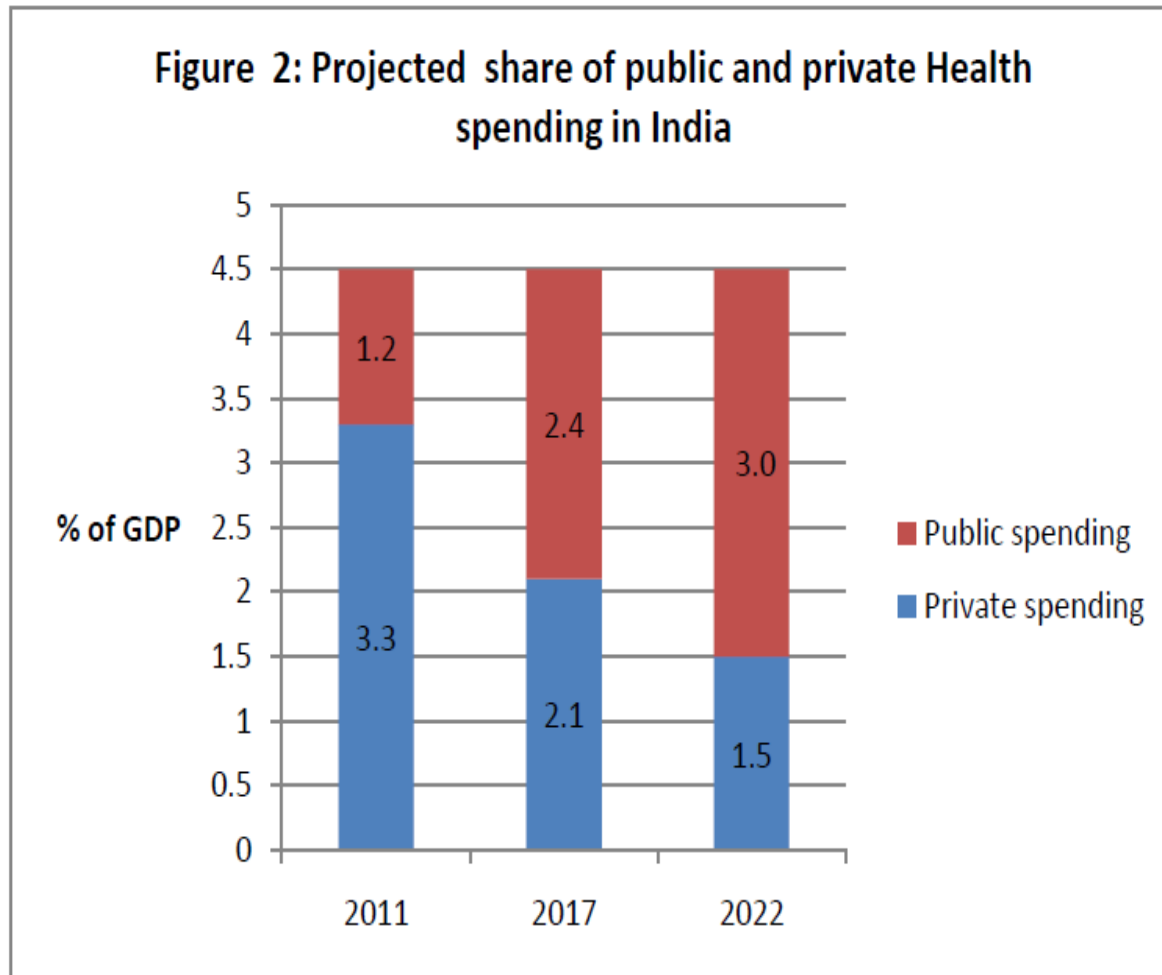
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- Ensure availability of **free essential medicines** by increasing public spending on drug procurement;
- **General taxation as principal source of health care financing** – complemented by additional mandatory deductions from salaried individuals & 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**

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

E
X
C
E
L
L
E
N
C
E

BREADTH

DEPTH

QUALITY

ACCOUNTABILITY

E
F
F
I
C
I
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N
C
Y

EQUITY

PROVISION OF HEALTH CARE

- **Strengthen Public Services**
(*Especially*: Primary HealthCare-
Rural And Urban; District Hospitals)
- **Contract Private Providers**
(As Per Need And Availability)
– With Defined Deliverables
- **Integrate 1^o, 2^o, 3^o 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**

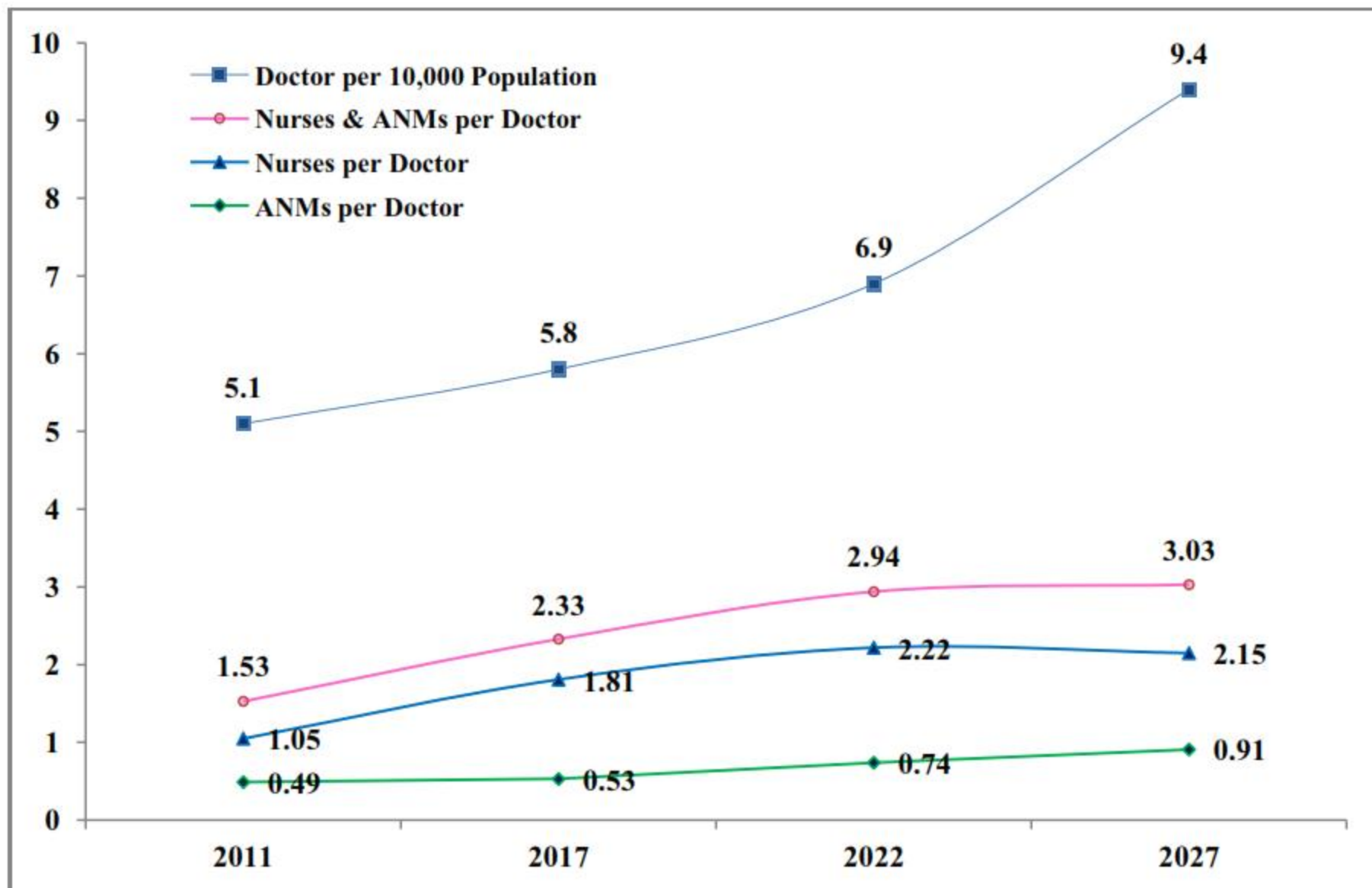
Access to Medicines, Vaccines & Technologies

- **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;**

PROJECTED HRH AVAILABILITY (2012-2022)



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 stake holders;
- 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.