India Infrastructure Report 2013|14

The Road to Universal Health Coverage

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Focus of IIR 2013|14

- The Report in the light of the current Health Sector scenario in India:
  - Looks at the **challenges for ensuring availability**, **accessibility**, **affordability** and **quality of comprehensive healthcare** to all
  - Explores **strategies to overcome the impediments** along the road to Universal Health Coverage (UHC)

- The Report also draws attention to the emerging issues of:
  - Rising burden of non-communicable diseases, particularly mental health
  - Human resource crisis
  - Health concerns of the informal sector workers

Current Scenario of Health Sector

- **India's HDI rank is pitiful 136 out of 187 countries**
- **On key health indicators**, out of 194 countries, India ranks:
  - 145 for Infant Mortality Rate (IMR) and Under-five Mortality Rate (U5MR)
  - 122 for Maternal Mortality Ratio (MMR)
  - 162 for immunisation coverage against Measles among one-year olds
- **Likely to miss MDG target in 2015**, despite improvements
  - IMR from 66 in 2001 to 42 in 2012 (MDG Target – 28)
  - U5MR from 85 in 2001 to 52 in 2012 (MDG Target – 42)
  - MMR from 301 in 2001–03 to 178 in 2010–12 (MDG Target – 109)
  - Immunisation against Measles from 51% in '98-99 to 74% in 2009 (MDG Target - 100%)
- India certified 'Polio Free' by WHO in 2014
- **Dual burden of diseases**: Rising Non-Communicable Diseases (NCDs) while communicable and infectious diseases continue
- **Triple burden of nutrition:**
  - Under-nourishment of children (causing low birth weight, stunting and underweight)
  - Over-nutrition (causing escalation in incidence of NCDs)
  - Micro-nutrient deficiency (large section of the population is anaemic)

Low Public Spending on Health

- Low expenditure on health
  - Total Health Expenditure ~ 4% of GDP
  - **Public Expenditure on Health ~ 1% of GDP**
  - Share of Central & State Govt in total Health Expenditure ~ 28%
  - **Public spending more input-oriented with limited focus on outcomes**

Countries	Health Expenditure as Share of GDP (%)	
	Total Expenditure	Public Expenditure
Bangladesh	3.7	1.4
Brazil	9.0	4.2
China	5.0	2.7
India	**3.7**	**1.0**
Sri Lanka	3.5	1.6
Thailand	3.9	2.9
United Kingdom	9.6	8.0
United States	17.6	8.5

Consequences of Low Public Spending

- **Inadequate and antiquated infrastructure with poor service quality**
- **Shortage of Health Infrastructure in Rural Areas**:
  - Sub-Centre ~ 23%; PHC ~ 26%; CHC ~ 40%
  - Shortage of Facilities within Sub-Centres, PHCs and CHCs
- **Severe shortage of Human Resources; in Rural areas the shortfall is:**
  - Doctors at PHCs ~ 10%
  - Pharmacists at PHCs and CHCs ~ 18%
  - Laboratory Technicians at PHCs and CHCs ~ 43%
  - Nursing Staff at PHCs and CHCs ~ 23%
  - Specialists at CHCs ~ 70%
- **Rising dependence of patients on Private Sector**
  - Proportion of Out-patients in Private Sector – Rural ~ 78%; Urban ~ 81%
  - Proportion of In-patients in Private Sector – Rural ~ 58%; Urban ~ 62%

Rising Dependence on Private Providers

- **Growth of private sector could be attributed to:**
  - Trust deficit in public healthcare due to poor access and poor service quality
  - Willingness of the people to pay for health services
  - Pro-market policies in Healthcare - subsidies and tax concessions to private sector
  - Weak regulatory framework to curb unrestrained growth of private sector

- **Resulting in:**
  - Shift in focus to curative tertiary care & marginalisation of preventive and primary healthcare
  - High cost of treatment; quality not ensured
  - Over diagnosis and over treatment due to strong commercial focus
  - Over dependence on clinical investigation and less on clinical judgement
  - Increased use of medical devices and diagnostic tests

High Out-of-pocket (OOP) Expenditure

Share of OOP spend in Total Health Expenditure (%)			
Bangladesh	61.3	**Thailand**	14.0
China	35.3	**United Kingdom**	8.9
India	**61.7**	**United States**	11.8
Sri Lanka	44.6	**Brazil**	30.6

- Share of OOP Expenditure in Total Health Expenditure ~ 62%
- In OOP spending - Share of Medicines is ~ 66% & Diagnostics ~ 8%
- **High OOP spend on medicines due to purchase from private retail:**
  - Shortage of medicines in public facilities, inefficient supply-chain management & unscientific demand forecast of drugs in essential drug list
- **High drug prices due to:**
  - Weak regulatory framework - Absence of appropriate price regulatory regime; Hghly fragmented regulation of pharma industry
  - Move from process patent to product patent regime
- **Most health insurances do not cover medicine expenses**

Consequences of High OOP Expenditure

- High OOP expenditure leads to impoverishment of the population
- Those from the low income groups seeking treatment are forced to sell off their assets and incur debts
- **Number of people impoverished due to spending on medicines increased from about 26 million in 2004-05 to 34 million in 2011-12**
  - Number in rural areas increased from 21 million to 29 million people over the same period
- Large number of the poor and the vulnerable do not seek treatment

Gaps in Government Initiatives

- **National Rural Health Mission (NRHM)**
  - Apart from the ASHA, other aspects of the policy not rigorously implemented
  - Rogi Kalyan Samiti and Village Health Sanitation & Nutrition Committee are non-functional
  - Hardly any improvement in quality of services provided at the public health facilities
  - Focus on inputs and not outcomes - poor quality of service in public facilities
  - Broad objective compromised - focus limited to mother and child welfare programmes
- **Janani Suraksha Yojana (JSY)**
  - May not have resulted in an improvement in MMR and IMR as desired
  - Not reaching all the women in the target group, may be due to the abysmal state of public health infrastructure and quality of care
  - Poor incentive structure - monetary benefits for ASHAs to facilitate institutional deliveries
- **Janani Shishu Suraksha Karyakram (JSSK)**
  - Poor risk protection due to shortage of drugs and investigation devices at public facilities
- **National Urban Health Mission (NUHM)**
  - The scheme has been a non-starter

Gaps in Government Initiatives…(contd.)

- **Universal Immunisation Programme (UIP)**
  - Shortage of cold chain points, equipment non-maintenance, lack of training of personnel, poor accountability, inadequate supervision and monitoring, and lack of coordination between State and Central Governments
  - Inessential vaccines being prescribed and used indiscriminately in the private sector
  - Combination vaccines marketed aggressively by pharma firms and sold at high prices
- **Drug Procurement**
  - Mere adoption of the Tamil Nadu and other State models is not enough
- **PPP in Health Sector**
  - Absence of a PPP policy and strategy for health sector
  - Little understanding of what constitutes PPP in health
  - Most private sector health providers in India are non-institutional providers
  - Most institutional providers don't have accreditation or compliance to minimal standards
  - Lowest commercial bid does not necessarily guarantee better services
  - Trust deficit between government and private sector

Gaps in Government Initiatives…(contd.)

- **State Health Insurance Schemes**
  - Most state-level schemes are limited to tertiary care
  - Absence of health insurance cover outside the respective States

- **Rashtriya Swasthya Bima Yojana (RSBY)**
  - Fails to fully protect the poor – a large section of informal sector workers not covered
  - Covers only hospitalization and does not cover regular outpatient care
  - Coverage for medicines is limited to five days at the time of discharge
  - Challenge to procure smart cards and biometric-related equipment in large numbers
  - Availability of a large contingent of trained manpower is a key challenge
  - Printing and issuing smart cards in remote and difficult terrain
  - Developing a management system to prevent any kind of fraud and misuse
  - Ensuring availability of quality healthcare providers
  - Improving the awareness of the beneficiaries about the usage of smart card

Non-State Enterprises in Healthcare

Social Enterprises (SEs) are providing innovative solutions

- SEs are trying to make quality rural healthcare available and affordable through innovative experiments involving:
  - Hub and spoke strategy (combination of local community-based human resource development and use of tele-medicine and hand-held devices)
  - Use of government infrastructure such as post offices to collect monthly premiums, track payments, and issue health insurance cards
  - Participatory plug and play models
  - Large scale use of technology (HMIS etc)
- Focus on most common set of ailments covering majority of the disease burden
- Some SEs are in the process of creating epidemiological database

Faith-based entities in healthcare serving the poor and remote areas

- Faith-based and not-for-profit entities are engaged in shared care; home-based care; palliative care; task-shifting coupled with skill-building; tele-medicine
- Innovative practices and resources of the not-for-profit entities could be leveraged to improve efficiency of delivery and utilisation of limited resources

Emerging Issues

- **Rising burden of Non-Communicable Diseases (NCDs)**
  - Rise in NCDs (cardiovascular disease, diabetes, cancer and hypertension) due to lifestyle changes, demographic changes, and epidemiological transition
  - NCDs share in Disability-Adjusted Life Years (DALY) is 43%; focus on chronic care needed
- **Increasing burden of Mental Health**
  - Mental health accounts for 7.4% of the global disease burden
  - Leading cause of DALY for men and women in the 15-39 years age group
  - Strong bi-directional linkages between mental and physical health
  - Strong linkage with poverty, social disadvantage and heightened stress
  - Huge gap in burden of mental health problems and availability of mental health services
- **Health Coverage of Informal Sector Workers**
  - High workplace pollution with long and odd hours of work
  - No legal protection and policies on occupational safety and health
  - Safety & health aspects fall across several Ministries
  - Providers lack the knowledge required to manage occupational diseases
  - Large number of informal sector workers do not have any health insurance

Key Recommendations

- **Increase public funding** in healthcare - both Centre & States
- **Prioritise spending on preventive and primary care** including provisioning quality drinking water & sanitation, pest control, and awareness on hygiene and nutrition
- **Define UHC package** that the people are entitled to **and work out realistic estimate of UHC funding** – how much subsidized & free
- **States should carry out pilot projects** to better understand what works
- **Adopt outcome-oriented norms while defining minimum standards**
- **Prioritise creation of infrastructure for driving immunisation programmes**
- **Set up district-level training institutes for paramedics and nurses**
- **Train non-clinician practitioners and nurses to provide primary-level care**
- **Retrain AYUSH doctors to also deliver primary care in modern medicine**
- Streamlined responsibilities, **better training, & incentive structure for ASHA workers**
- Build capacity of Village Health, Sanitation and Nutrition Committees and Rogi Kalyan Samitis to monitor govt programmes, and utilize untied funds
- Build awareness and educate people to maintain a hygienic and healthy lifestyle

Key Recommendations…(contd.)

- **Formulate PPP policy for the health sector**
- Encourage private sector to use CSR Funds, innovative models of SEs and utilize the resources created by not-for-profit and faith-based organisations to avoid duplication and wastage
- Develop strategy for **recruitment and retention of healthcare professionals in rural areas**
- **Prevent essential drugs from being patented and monopolised**
- Essential Drug List should be reviewed at regular intervals
- **States should adopt and adapt a centralised procurement and distribution model**
- **Consolidate under MoHFW the fragmented regulatory regime of pharmaceutical industry to better align drug production and pricing policies**
- Extend RSBY to all unorganised sector workers and raise the benefit package
- **Reform Medical Council of India** - delinking powers to regulate education & practice
- Expedite enactment of Drugs and Cosmetics Amendment Bill, 2013, Mental Health Bill, 2013, and National Commission for Human Resources for Health Bill, 2013

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Thank you!