Focus of IIR 2013|14

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

• The Report also draws attention to the emerging issues of:
  o Rising burden of non-communicable diseases, particularly mental health
  o Human resource crisis
  o 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

<table>
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<tr>
<th>Countries</th>
<th>Health Expenditure as Share of GDP (%)</th>
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<tr>
<td></td>
<td>Total Expenditure</td>
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<tr>
<td>Bangladesh</td>
<td>3.7</td>
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<tr>
<td>Brazil</td>
<td>9.0</td>
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<td>China</td>
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<td>India</td>
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<td>Sri Lanka</td>
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<td>Thailand</td>
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<td>United Kingdom</td>
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<td>United States</td>
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Consequences of Low Public Spending

• Inadequate and antiquated infrastructure with poor service quality

• Shortage of Health Infrastructure in Rural Areas:
  o Sub-Centre ~ 23%; PHC ~ 26%; CHC ~ 40%
  o Shortage of Facilities within Sub-Centres, PHCs and CHCs

• Severe shortage of Human Resources; in Rural areas the shortfall is:
  o Doctors at PHCs ~ 10%
  o Pharmacists at PHCs and CHCs ~ 18%
  o Laboratory Technicians at PHCs and CHCs ~ 43%
  o Nursing Staff at PHCs and CHCs ~ 23%
  o Specialists at CHCs ~ 70%

• Rising dependence of patients on Private Sector
  o Proportion of Out-patients in Private Sector – Rural ~ 78%; Urban ~ 81%
  o 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 (%)

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<tr>
<th>Country</th>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>61.3</td>
<td>Thailand</td>
<td>14.0</td>
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<td>China</td>
<td>35.3</td>
<td>United Kingdom</td>
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<td>India</td>
<td>61.7</td>
<td>United States</td>
<td>11.8</td>
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<tr>
<td>Sri Lanka</td>
<td>44.6</td>
<td>Brazil</td>
<td>30.6</td>
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• 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:
  o Shortage of medicines in public facilities, inefficient supply-chain management & unscientific demand forecast of drugs in essential drug list
• High drug prices due to:
  o Weak regulatory framework - Absence of appropriate price regulatory regime; Highly fragmented regulation of pharma industry
  o 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**
  o 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)
  o 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
  o Inessential vaccines being prescribed and used indiscriminately in the private sector
  o Combination vaccines marketed aggressively by pharma firms and sold at high prices

• Drug Procurement
  o Mere adoption of the Tamil Nadu and other State models is not enough

• PPP in Health Sector
  o Absence of a PPP policy and strategy for health sector
  o Little understanding of what constitutes PPP in health
  o Most private sector health providers in India are non-institutional providers
  o Most institutional providers don’t have accreditation or compliance to minimal standards
  o Lowest commercial bid does not necessarily guarantee better services
  o 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:
  o Hub and spoke strategy (combination of local community-based human resource development and use of tele-medicine and hand-held devices)
  o Use of government infrastructure such as post offices to collect monthly premiums, track payments, and issue health insurance cards
  o Participatory plug and play models
  o 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
Thank you!