

LOK SATTA
People Power

Ensuring a Healthy Future

Consultation Workshop on Health
22nd September 2004 at New Delhi

“If you dump all the drugs and formulations listed in *Materia Medica* into the ocean, mankind will be that much better off and fish will be that much worse off”

Achievements Through The Years - 1951-2000

Indicator	1951	1981	2000
Demographic Changes			
Life Expectancy	36.7	54	64.6(RGI)
Crude Birth Rate	40.8	33.9(SRS)	26.1(99 SRS)
Crude Death Rate	25	12.5(SRS)	8.7(99 SRS)
IMR	146	110	70 (99 SRS)
Epidemiological Shifts			
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small Pox (no. of cases)	>44,887	Eradicated	
Guinea worm (no. of cases)		>39,792	Eradicated
Polio		29709	265
Infrastructure			
SC/PHC/CHC	725	57,363	1,63,181 (99-RHS)
Dispensaries & Hospitals (all)	9209	23,555	43,322 (95–96-CBHI)
Beds (Pvt & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
Doctors (Allopathy)	61,800	2,68,700	5,03,900 (98-99-MCI)
Nursing Personnel	18,054	1,43,887	7,37,000 (99-INC)
<i>Source: National Health Policy – 2002</i>			

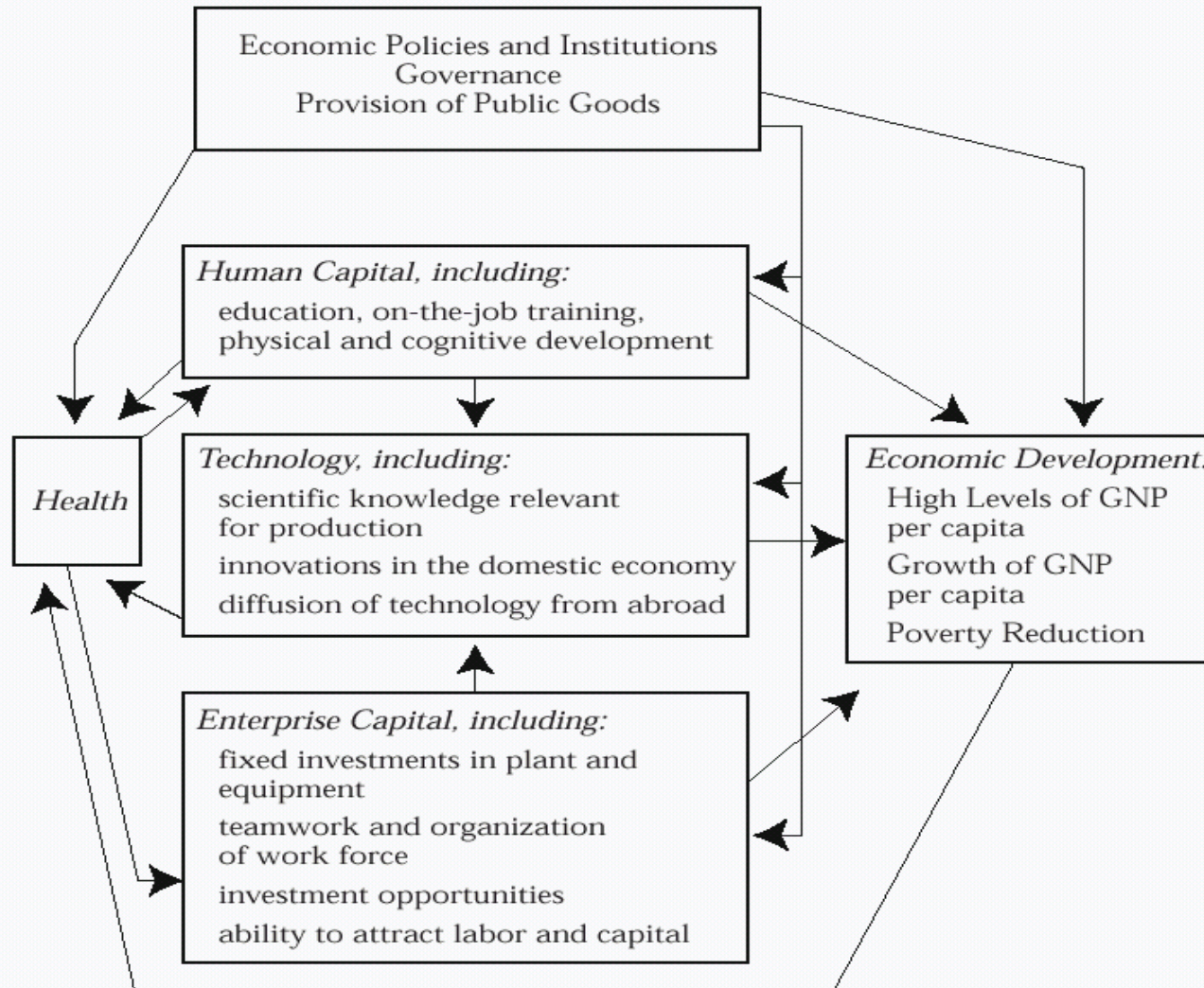
Difference Between Actual and Sustainable Number of Physicians

GDP group	Country	Physicians per 10,000 population		
		Actual	Sustainable	Excess or shortage
GDP less than US \$ 800 per capita	Brazil	4.6	3.2	+1.4
	Egypt	5.5	1.6	+3.9
	India	2.1	0.6	+1.5
	Indonesia	0.3	0.7	-0.4
	Iran	3.1	3.1	0.0
	Pakistan & Bangladesh	3.9	1.2	+2.7
	Philippines	3.5	1.3	+2.2
	Sri Lanka	2.5	1.2	+1.3
GDP US \$ 800 to US \$ 2,000 per capita	Greece	16.7	9.0	+7.7
	Ireland	11.8	11.0	+0.8
	Romania	13.1	9.0	+4.1
	Venezuela	9.3	8.6	+0.7
GDP over US \$2,000 per capita	Australia	13.9	26.5	-12.7
	Federal Republic of Germany	17.7	29.0	-11.3
	Japan	11.4	16.1	-4.7
	United Kingdom	13.3	18.5	-5.2
	United States of America	15.5	49.0	-33.5

Source: WHO Technical Report – Migration of Physicians and Nurses (1979)

Macroeconomics and Health

Figure 1. HEALTH AS AN INPUT INTO ECONOMIC DEVELOPMENT



GDP Per-capita, Health Expenditure DALE Rankings

Country	GDP per capita (in PPP terms - \$)	Health Expenditure per capita ranking (in \$ terms)	Health Level Ranking (DALE)
Low Income Countries			
Sri Lanka	3530	138	76
Indonesia	3043	154	103
Pakistan	1928	142	124
Egypt	3635	115	115
India	2358	133	134
Middle Income Countries			
Russian Federation	8377	75	91
South Africa	9401	57	160
Brazil	7625	54	111
OECD Countries			
United States	34142	1	24
France	24223	4	3
Germany	25103	3	22
Japan	26755	13	1
United Kingdom	23509	26	14
<i>Sources: The World Health Report – 2000 and UNDP Human Development Report – 2002 (UNDP)</i>			

Allocation vs Prioritization

A better match

Morogoro disease burden, % of total

■ 1992-95 Years of life lost, %

■ 1996 Budget

Malaria

Childhood diseases*

Reproductive health

Immunisation

TB

Other

■ 1998 Budget

Malaria

Childhood diseases*

Reproductive health

Immunisation

TB

Other

*Incl. pneumonia, diarrhoea, malnutrition, measles and malaria

Source: Tanzania Essential Health Interventions Project

Limits to Modern Medicine

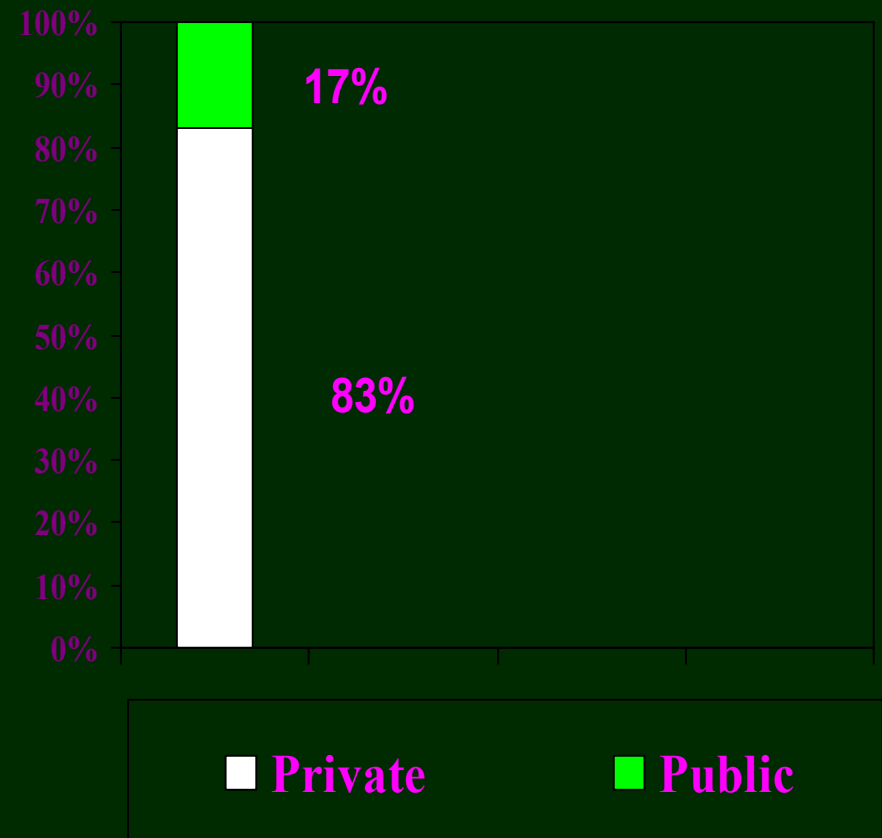
Spectacular Advances – Low Cost	Nutrition, Immunization, Antibiotics, Aseptic surgery, Maternal and child care, Healthy life styles
Grey Areas – High Cost	Degenerative diseases, Autoimmune diseases, Malignancies
Dark Areas	Idiopathic, Iatrogenic, Hospital Infections, Progressive, irreversible disorders

Health Financing

	1990	1999
Public health expenditure	1.3% GDP	0.9% GDP
Union budgetary allocation	1.3%	1.3%
States' budgetary allocation	7%	5.5%
Total per-capita public health expenditure	Rs 200 (15% Union, 85% States)	

Public Health vs Total Health Expenditure

- Total Health Expenditure
5.2% GDP
- Comparable countries:
 - Cambodia
 - Burma
 - Afghanistan
 - Georgia



Public Health Expenditure among Various Countries

Country	Public health expenditure as share of GDP	Private health expenditure as share of GDP
Norway	6.5	1.1
Sweden	6.2	1.8
Japan	5.9	1.8
United Kingdom	5.9	1.4
United States	5.8	7.3
Egypt	1.8	2.3
Sri Lanka	1.8	1.9
India	0.9	4.3

Allocations in Public Health Expenditure

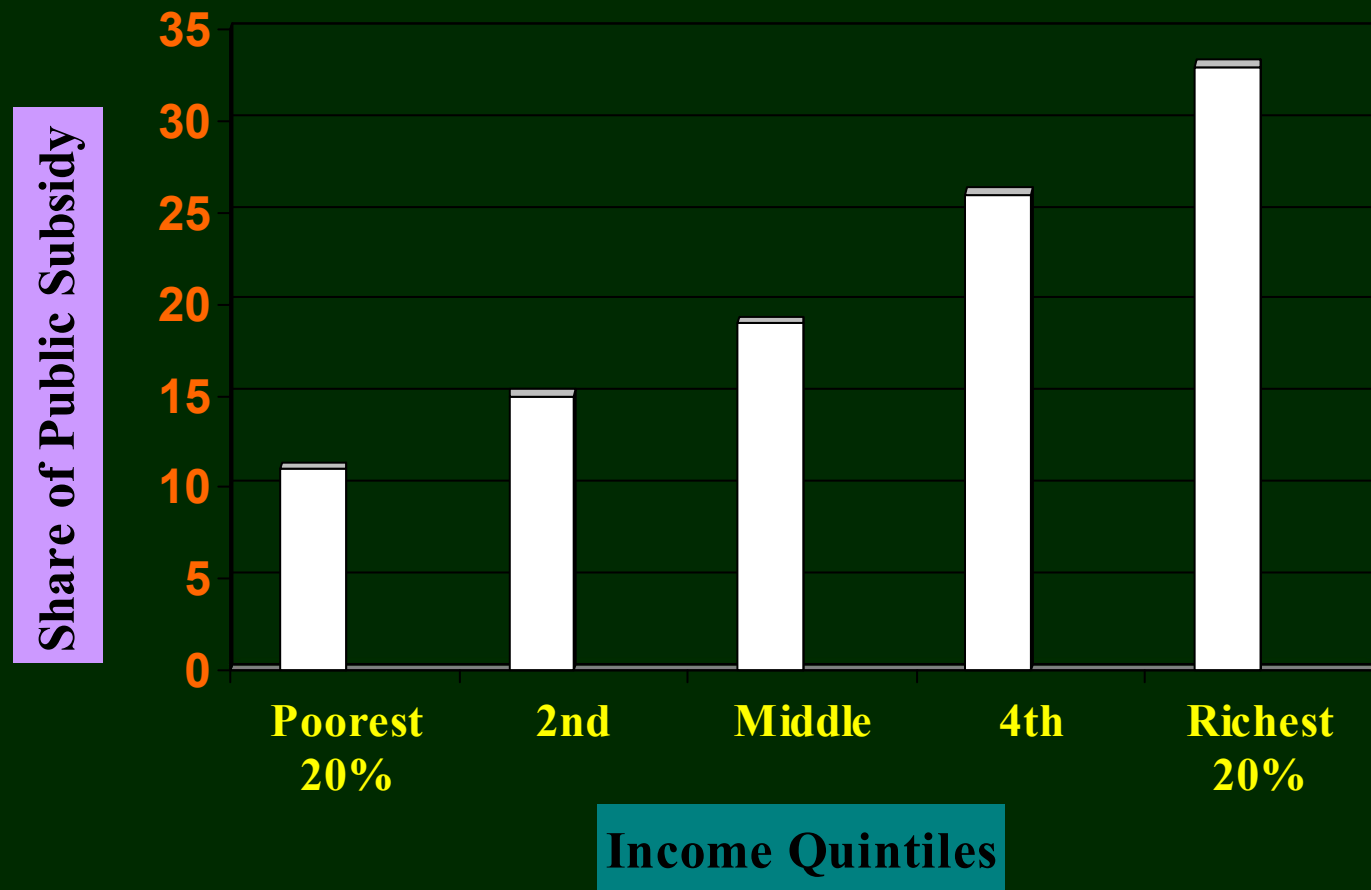
Consumption Exp	97%
Capital Exp	3%
Salaries	60%
Material & supplies	35%
Curative Services	60%
Public health & family welfare	26%
Miscellaneous & Administration	14%

Health Financing & Inequity

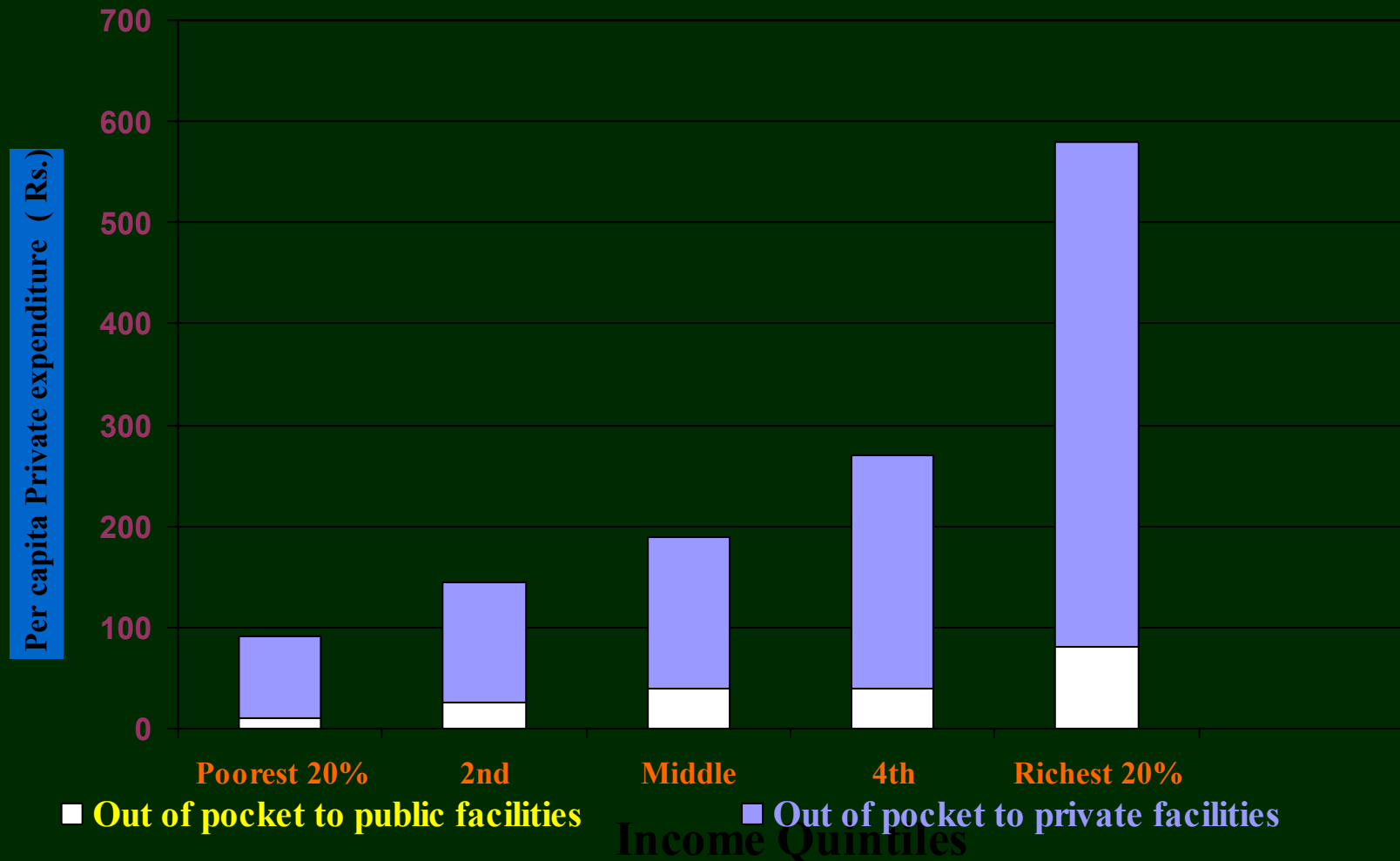
- Curative services favour the rich
- For every Re 1 spent on poorest 20% population,

Rs 3 spent on the richest quintile

Proportion of Public Expenditures on Curative Care, by Income Quintile, All India, 1995-96



Out-of-Pocket Payments for Health and Household Income, All India, 1995-96

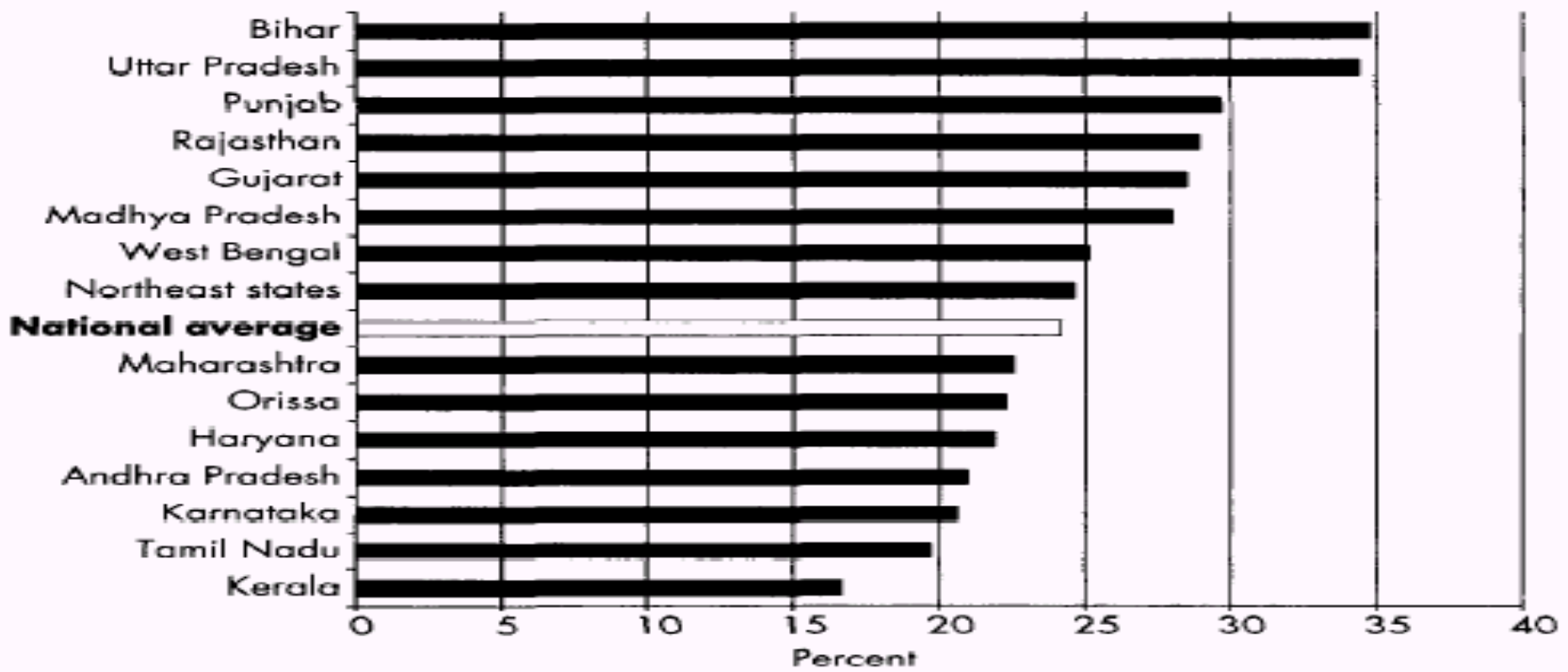


Hospitalization – Financial Stress

- Only 10% Indians have some form of health insurance, mostly inadequate
- Hospitalized Indians spend 58% of their total annual expenditure on health care
- Over 40% of hospitalized Indians borrow heavily or sell assets to cover expenses
- Over 25% of hospitalized Indians fall below poverty line because of hospital expenses

Percent of Hospitalized Indians falling into Poverty

Figure 0.2 Percent of Hospitalized Indians Falling into Poverty from Medical Costs, 1995-96



Note: Northeast states consist of Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, and Tripura.
Source: National Sample Survey Organisation (1998); authors' calculations.

Public – Private sector use for patient care – All India (percentage distribution)

	Rural		Urban	
	1986 – 87	1995 – 96	1986 – 87	1995 – 96
Outpatient care				
Public Sector	25.6	19.0	27.2	19.0
Private Sector	74.5	80.0	72.9	81.0
Inpatient care				
Share of public sector	59.5	45.2	60.3	43.1
Share of private sector	40.3	54.7	39.7	56.9

Source: David.H.Peters, Abdo.S.Yazbeck, Rashmi R. Sharma, G.N.V. Ramana, Lant H. Pritchett, Adam Wagstaff, Better Health System For India's Poor: Findings Analysis and Options, The World Bank, 2002, Washington. p.5

Differentials in Health Status Among States

Sector	Population BPL (%)	IMR/ Per 1000 Livr Births (1999 – SRS)	<5Mortality per 1000 (NFHS II)	Weight For Age - % of Children Under 3 years (,2SD)	MMR / Lakh (Annual Report 2000)	Leprosy cases per 10000 population	Malaria +ve Cases in year 2000 (in thousands)
India	26.1	70	94.9	47	408	3.7	2200
Rural	27.09	75	103.7	49.6	-	-	-
Urban	23.62	44	63.1	38.4	-	-	-
Better Performing States							
Kerala	12.72	14	18.8	27	87	0.9	5.1
Maharashtra	25.02	48	58.1	50	135	3.1	138
Tamil Nadu	21.12	52	63.3	37	79	4.1	56
Low Performing States							
Orissa	47.15	97	104.4	54	498	7.05	483
Bihar	42.60	63	105.1	54	707	11.83	132
Rajasthan	15.28	81	114.9	51	607	0.8	53
UP	31.15	84	122.5	52	707	4.3	99
MP	37.43	90	137.6	55	498	3.83	528

Source: National Health Policy, 2002

Major Indian States, by Stage of Health Transition and Institutional Capacity

Stage of Transition, Degree of Capacity	States	India's Population (percent)
Middle to late transition, moderate to high capacity	Kerala, Tamil Nadu	9.1
Early to middle transition, low to moderate capacity	Maharashtra, Karnataka, Punjab, West Bengal, Andhra Pradesh, Gujarat, Haryana	39.1
Very early transition, very low to low capacity	Orissa, Rajasthan, Madhya Pradesh, Uttar Pradesh	33.1
Special cases: instability, high to very high mortality, civil conflict, poor governance	Assam, Bihar	13.3

Note: Major Indian states are those with a population of at least 15 million. The estimates were made before bifurcation, so Bihar includes the recently created state of Jharkhand, Madhya Pradesh includes Chattisgarh, and Uttar Pradesh includes Uttaranchal

Source: David.H.Peters, Adbo.S.Yazbeck, Rashmi R. Sharma, G.N.V. Ramana, Lant H. Pritchett, Adam Wagstaff, Better Health System for India's Poor: Findings Analysis and Options, The World Bank, 2002, Washington. p.8

Strengths & Opportunities

- Large skilled health manpower
- Significant research capability
- Growing hospital infrastructure
- Mature pharmaceutical industry
- Democratic system and public discourse
- Increasing demand for health services
- Willingness to pay for health
- Breakthrough on population front (TN, AP etc)
- Effective military style campaigns (smallpox, pulse polio)
- Wide network of RMPs

Challenges of the Future

- Immunization coverage (TB: 68%, Measles: 50%, DPT: 70%, overall : 33%)
- Four major infectious diseases: Malaria, TB, HIV/AIDS, RHD
- Preventable blindness
- Population control – large northern states
- Public health expenditure share
- Sanitation (70% households without toilets)

Challenges of the Future

- Accountability in public health care
- High out-of-pocket health expenditure
- Alternative systems – integration
- Unqualified PMPs
- Mounting cost of hospital care
- Decline in family care – over-specialization
- Ideal vs Optimal care
- Health manpower training – inadequacies
- Regional inequalities

Critical Issues

- How to involve community in rural health care
- How to provide effective and affordable family care to urban populations
- How to promote public-private partnerships
- How to extend tertiary care to poor

Lessons of Past Experience

- More expenditure need not mean better health
- Risk-pooling necessary for private care : but not feasible without compulsion and large organized labour
- Consumer choice and producer competition vital to reduce costs and improve efficiency
- Public health and private health are complementary
- Future health care should address demographic transition

Lessons of Past Experience

- Community ownership, decentralization and accountability – key to better delivery
- Better health care delivery should be linked to massive employment generation
- Low-cost – high-impact solutions are possible
- We have great strengths and abilities which can be leveraged at low cost

Viabie Models

CRHP Jamkhed

Year	1971	1976	1986	1993
Infant Mortality Rate	176	52	49	19
Crude Birth Rate	40	34	28	20
Children Under Five				
Immunization, DPT & Polio	0.5%	81%	91%	92%
Malnutrition: Wt for age	40.0%	30%	5%	5%
Maternal Services				
Prenatal Care	0.5%	80%	82%	96%
Deliveries by trained attendants	<0.5%	74%	83%	98%
Couples practicing family planning	<0.1%	38%	60%	60%
Chronic Diseases				
Leprosy Prev. (/1000)		2	1	0.1

Source: Comprehensive Rural Health Care Project (CRHP), Jamkhed

Viabile Models

- VHS Chennai
- TB control – Public-Private partnership –
Mahavir Hospital
- Quality eye care for all – LVPEI

Agenda for Action

Raising an army of Village Health Workers (VHW)

- Women from the community
- One VHW per 1000 population (a million gainfully employed)
- 3 months' training (union)
- Accountable to village Panchayat

Agenda for Action

Cost implication - VHW

- Rs. 600 crore for training – one time. (borne by the Union) – spread over three years
- Rs. 1200 crore per annum – honorarium. (shared equally by Union and States)
- Rs. 100 crore per annum – health kit, a few generic drugs etc. (shared equally by Union and States)
- Rs. 50 crore per annum – 2 refresher workshops – 3 days each. (shared equally by Union and States)

Agenda for Action

Referral Hospitals

- One 30-50 bed referral hospital for every 100,000 population
 - Staff – One Civil Surgeon, 3 or 4 Civil Assistant Surgeons, a dentist, 7 or 8 staff nurses and 2 paramedical personnel.
- To be controlled by the local government (district panchayat or town/city government).
- Recruitment, appointment, control and financial provision by local government, with full assistance from state and Union governments in the form of grants.

Agenda for Action

Cost Implications - Referral Hospitals

- 80 % of all cases can be handled by the VHW, ANM or PHC through prevention. About 15 % of patients need to go to a referral center and 5 % to the tertiary level.
- Out of the total public healthcare budget, at least 50 % should be for preventive care, and no more than 35 % for referral care and 15% for tertiary care.
- The preventive care budget should be supplemented by additional funds to meet cost of drugs for common ailments such as Malaria, Diarrhea, TB, Leprosy etc.
- Functional classification of diseases and jurisdiction among different service providers will be adhered to, not according to medical pathology, but according to the varying levels of knowledge, skills and facilities needed for diagnosis, management and care.

Agenda for Action

Referral Hospitals

- Rs. 6000 crores of capital costs, at Rs. 1 crore per referral centre (spread over period of three years) – The expenditure will be incurred by the Union government.
- Rs. 2,400 crores recurring expenditure, at Rs. 40 lakhs per referral center per annum – This expenditure will be shared by the Union and state governments in 50:50 ratio.

Agenda for Action

Cooperative Medical Care – Lessons from China

- Recurring expenditure on Health care – shared by the Union (1/3rd), the State (1/3rd), and the individuals (1/3rd) – 10 yuan each – 30 yuan per capita

Risk pooling – Citizens' Cooperative Fund – managed by local authorities

- Local management of delivery of health services
- Patients can visit any public hospital – choice and competition

Agenda for Action

Operationalizing in India:

- Target Population : 1,00,000
- Per capita expenditure : Rs.30 (Union Rs.10; State Rs.10; Individuals Rs.10)
- Citizens' Cooperative Fund : Rs. 30 lakhs
- Delivery of healthcare services to be managed completely by local governments.

Accountability of Health Care Delivery Systems

- Risk pooling at local govt. level, where authority and accountability fuse.
- Complete control to local governments (budget, personnel, transfers)

Agenda for Action

- Great Sanitation Movement
 - Health, hygiene, dignity and aesthetics
 - A toilet for every household
 - 100 million toilets in 5 years
 - 50 million units with private funds + 50 million with subsidies
 - Rs 3000 / unit: 20% owner
 - Balance : Union: State – 2:1
 - Cost: Rs 12000 crore spread over 5 years
 - Rs 1600 crore / year Union
 - Rs 800 crore / year States

Agenda for Action

Health Insurance

- Average actuarial costs – Rs. 200 per capita per annum
- Target population 30 crores – Rs. 6,000 Cr. per annum
- Lower middle class – 50% subsidy – Rs. 4,000 Cr.
- Total Cost – Rs. 10,000 Cr. per annum
- Per capita public health expenditure Rs. 200. The total public health expenditure – Rs. 20,000 Cr. (approx)
- Consequences:
 - Diminish resources for preventive and public health.
 - Escalation of demand for high-cost curative medicine.

Agenda for Action

Public Health System – Health Risk Fund

- A fund to be created at Rs. 30 per capita
- 1/3 contributed by Union, 1/3 by the state and 1/3 collected from the individuals
- The Union will subsidize the 1/3 contribution of BPL population
- The Health Risk Fund will be managed at the local government level
- People will have freedom of choice to go to any public hospital within the district
- Public Hospitals get reimbursement based on service delivery
- All other funding from government to hospitals will cease

Agenda for Action

Health insurance (Private Sector)

- Link with existing institutions
- Expand to a whole territory or group
- Ensure effective health infrastructure
- Subsidize BPL families with matching grants
- Review after 5 years

Cost: Rs. 100 crore / year – Union

Agenda for Action

Public hospitals – Demand-driven approach

- User charges – nominal for OP (free for the very poor)
- Free inpatient for BPL families

Cost recovery for others

- Hospital committees
- Hospital fund for local utilization only

Agenda for Action

Campaign mode – Select diseases

- Malaria
- Child hood heart diseases
 - Rheumatic heart disease
 - Congenital heart diseases
- Tuberculosis
- AIDS
- Preventable blindness

Agenda for Action

Reproductive Health Services and Birth Control Measures

- Tamil Nadu vs Andhra Pradesh model
- Basic infrastructure for RCH services
- Incentives
- Coordination
- Sustained campaign in select states

Agenda for Action

Medical education

- Curriculum
- Training
- Integration
- Public-private participation

Agenda for Action

Medical ethics

- Drug policy – Bangladesh model
- MCI revamping
- Standardization and cost control
- Independent ombudsmen
- False Claims Act
- Transparency mechanisms
- Independent rating

Governance and Health

- Fiscal crisis
- Redefining state's role
- Electoral reform
- Decentralization
- Public-private convergence

Total Additional Allocation Proposed

- Capital Costs: Rs. 19,600 crores for five years – Union.
- Recurring Costs: Rs. 3,750 crores per annum – Union and states.
- NHP – 2002 proposal: 1% GDP additional expenditure per annum by 2010
- NCMP 2004 proposal: 1 – 2% GDP additional expenditure per annum by 2009

- These proposals will amount to an additional commitment of less than 1 % of GDP to be spent cumulatively over five years towards capital costs, and about 0.15 % GDP additional commitment per annum as recurring healthcare expenditure.

“Politics encircles us today like the coil of a snake from which one cannot get out, no matter how much one tries ”

- *Mahatma Gandhi*