Towards a National Health Service

Presentation to Dr Montek Singh Ahluwalia
Deputy Chairman, Planning Commission
on behalf of
National Advisory Council
21st December 2004, 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

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

*Source: National Health Policy – 2002*
### Difference Between Actual and Sustainable Number of Physicians

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

Macroeconomics and Health

Figure 1. Health as an Input into Economic Development

Economic Policies and Institutions
  Governance
  Provision of Public Goods

Human Capital, including:
  education, on-the-job training,
  physical and cognitive development

Technology, including:
  scientific knowledge relevant
  for production
  innovations in the domestic economy
  diffusion of technology from abroad

Enterprise Capital, including:
  fixed investments in plant and
  equipment
  teamwork and organization
  of work force
  investment opportunities
  ability to attract labor and capital

Economic Development:
  High Levels of GNP
  per capita
  Growth of GNP
  per capita
  Poverty Reduction

Lok Satta
### GDP Per-capita, Health Expenditure DALE Rankings

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP per capita (in PPP terms - $)</th>
<th>Health Expenditure per capita ranking (in $ terms)</th>
<th>Health Level Ranking (DALE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Income Countries</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>3530</td>
<td>138</td>
<td>76</td>
</tr>
<tr>
<td>Indonesia</td>
<td>3043</td>
<td>154</td>
<td>103</td>
</tr>
<tr>
<td>Pakistan</td>
<td>1928</td>
<td>142</td>
<td>124</td>
</tr>
<tr>
<td>Egypt</td>
<td>3635</td>
<td>115</td>
<td>115</td>
</tr>
<tr>
<td>India</td>
<td>2358</td>
<td>133</td>
<td>134</td>
</tr>
<tr>
<td><strong>Middle Income Countries</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Russian Federation</td>
<td>8377</td>
<td>75</td>
<td>91</td>
</tr>
<tr>
<td>South Africa</td>
<td>9401</td>
<td>57</td>
<td>160</td>
</tr>
<tr>
<td>Brazil</td>
<td>7625</td>
<td>54</td>
<td>111</td>
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<tr>
<td><strong>OECD Countries</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>United States</td>
<td>34142</td>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>France</td>
<td>24223</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Germany</td>
<td>25103</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Japan</td>
<td>26755</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>23509</td>
<td>26</td>
<td>14</td>
</tr>
</tbody>
</table>

Allocation vs Prioritization

A better match
Morogoro disease burden, % of total
- 1992-95 Years of life lost, %
- 1996 Budget
- 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

<table>
<thead>
<tr>
<th>Spectacular Advances – Low Cost</th>
<th>Nutrition, Immunization, Antibiotics, Aseptic surgery, Maternal and child care, Healthy life styles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grey Areas – High Cost</td>
<td>Degenerative diseases, Autoimmune diseases, Malignancies</td>
</tr>
<tr>
<td>Dark Areas</td>
<td>Idiopathic, Iatrogenic, Hospital Infections, Progressive, irreversible disorders</td>
</tr>
</tbody>
</table>
## Health Financing

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health expenditure</td>
<td>1.3% GDP</td>
<td>0.9% GDP</td>
</tr>
<tr>
<td>Union budgetary allocation</td>
<td>1.3%</td>
<td>1.3%</td>
</tr>
<tr>
<td>States’ budgetary allocation</td>
<td>7%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Total per-capita public health expenditure</td>
<td>Rs 200 (15% Union, 85% States)</td>
<td></td>
</tr>
</tbody>
</table>
Public Health vs Total Health Expenditure

- Total Health Expenditure: 5.2% GDP
- Comparable countries:
  - Cambodia
  - Burma
  - Afghanistan
  - Georgia
<table>
<thead>
<tr>
<th>Country</th>
<th>Public health expenditure as share of GDP</th>
<th>Private health expenditure as share of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norway</td>
<td>6.5</td>
<td>1.1</td>
</tr>
<tr>
<td>Sweden</td>
<td>6.2</td>
<td>1.8</td>
</tr>
<tr>
<td>Japan</td>
<td>5.9</td>
<td>1.8</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>5.9</td>
<td>1.4</td>
</tr>
<tr>
<td>United States</td>
<td>5.8</td>
<td>7.3</td>
</tr>
<tr>
<td>Egypt</td>
<td>1.8</td>
<td>2.3</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>1.8</td>
<td>1.9</td>
</tr>
<tr>
<td>India</td>
<td>0.9</td>
<td>4.3</td>
</tr>
</tbody>
</table>

Public Health Expenditure among Various Countries
## Allocations in Public Health Expenditure

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumption Exp</td>
<td>97%</td>
</tr>
<tr>
<td>Capital Exp</td>
<td>3%</td>
</tr>
<tr>
<td>Salaries</td>
<td>60%</td>
</tr>
<tr>
<td>Material &amp; supplies</td>
<td>35%</td>
</tr>
<tr>
<td>Curative Services</td>
<td>60%</td>
</tr>
<tr>
<td>Public health &amp; family welfare</td>
<td>26%</td>
</tr>
<tr>
<td>Miscellaneous &amp; Administration</td>
<td>14%</td>
</tr>
</tbody>
</table>
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

The diagram illustrates the share of public subsidy in proportion to income quintiles. The income quintiles are:
- Poorest 20%
- 2nd Middle
- 4th
- Richest 20%

The graph shows:
- The Poorest 20% with a share of approximately 10%
- The 2nd Middle with a share of approximately 15%
- The 4th with a share of approximately 25%
- The Richest 20% with the highest share of approximately 35%

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

**Per capita Private expenditure (Rs.)**

- **Poorest 20%**
- **2nd**
- **Middle**
- **4th**
- **Richest 20%**

**Income Quintiles**

- Out of pocket to public facilities
- Out of pocket to private facilities
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 O.2 Percent of Hospitalized Indians Falling into Poverty from Medical Costs, 1995-96

- Bihar
- Uttar Pradesh
- Punjab
- Rajasthan
- Gujarat
- Madhya Pradesh
- West Bengal
- Northeast states
- National average
- Maharashtra
- Orissa
- Haryana
- Andhra Pradesh
- Karnataka
- Tamil Nadu
- Kerala

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)

<table>
<thead>
<tr>
<th></th>
<th>Rural</th>
<th></th>
<th>Urban</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Sector</td>
<td>25.6</td>
<td>19.0</td>
<td>27.2</td>
<td>19.0</td>
</tr>
<tr>
<td>Private Sector</td>
<td>74.5</td>
<td>80.0</td>
<td>72.9</td>
<td>81.0</td>
</tr>
<tr>
<td><strong>Inpatient care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Share of public sector</td>
<td>59.5</td>
<td>45.2</td>
<td>60.3</td>
<td>43.1</td>
</tr>
<tr>
<td>Share of private sector</td>
<td>40.3</td>
<td>54.7</td>
<td>39.7</td>
<td>56.9</td>
</tr>
</tbody>
</table>

## Differentials in Health Status Among States

<table>
<thead>
<tr>
<th>Sector</th>
<th>Population BPL (%)</th>
<th>IMR/ Per 1000 Livr Births (1999 – SRS)</th>
<th>&lt;5Mortality per 1000 (NFHS II)</th>
<th>Weight For Age - % of Children Under 3 years (.2SD)</th>
<th>MMR / Lakh (Annual Report 2000)</th>
<th>Leprosy cases per 10000 population</th>
<th>Malaria +ve Cases in year 2000 (in thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>26.1</td>
<td>70</td>
<td>94.9</td>
<td>47</td>
<td>408</td>
<td>3.7</td>
<td>2200</td>
</tr>
<tr>
<td>Rural</td>
<td>27.09</td>
<td>75</td>
<td>103.7</td>
<td>49.6</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Urban</td>
<td>23.62</td>
<td>44</td>
<td>63.1</td>
<td>38.4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### Better Performing States

- **Kerala**
  - Population BPL (%): 12.72
  - IMR/ Per 1000 Livr Births (1999 – SRS): 14
  - <5Mortality per 1000 (NFHS II): 18.8
  - Weight For Age - % of Children Under 3 years (.2SD): 27
  - MMR / Lakh (Annual Report 2000): 87
  - Leprosy cases per 10000 population: 0.9
  - Malaria +ve Cases in year 2000 (in thousands): 5.1

- **Maharashtra**
  - Population BPL (%): 25.02
  - IMR/ Per 1000 Livr Births (1999 – SRS): 48
  - <5Mortality per 1000 (NFHS II): 58.1
  - Weight For Age - % of Children Under 3 years (.2SD): 50
  - MMR / Lakh (Annual Report 2000): 135
  - Leprosy cases per 10000 population: 3.1
  - Malaria +ve Cases in year 2000 (in thousands): 138

- **Tamil Nadu**
  - Population BPL (%): 21.12
  - IMR/ Per 1000 Livr Births (1999 – SRS): 52
  - <5Mortality per 1000 (NFHS II): 63.3
  - Weight For Age - % of Children Under 3 years (.2SD): 37
  - MMR / Lakh (Annual Report 2000): 79
  - Leprosy cases per 10000 population: 4.1
  - Malaria +ve Cases in year 2000 (in thousands): 56

### Low Performing States

- **Orissa**
  - Population BPL (%): 47.15
  - IMR/ Per 1000 Livr Births (1999 – SRS): 97
  - <5Mortality per 1000 (NFHS II): 104.4
  - Weight For Age - % of Children Under 3 years (.2SD): 54
  - MMR / Lakh (Annual Report 2000): 498
  - Leprosy cases per 10000 population: 7.05
  - Malaria +ve Cases in year 2000 (in thousands): 483

- **Bihar**
  - Population BPL (%): 42.60
  - IMR/ Per 1000 Livr Births (1999 – SRS): 63
  - <5Mortality per 1000 (NFHS II): 105.1
  - Weight For Age - % of Children Under 3 years (.2SD): 54
  - MMR / Lakh (Annual Report 2000): 707
  - Leprosy cases per 10000 population: 11.83
  - Malaria +ve Cases in year 2000 (in thousands): 132

- **Rajasthan**
  - Population BPL (%): 15.28
  - IMR/ Per 1000 Livr Births (1999 – SRS): 81
  - <5Mortality per 1000 (NFHS II): 114.9
  - Weight For Age - % of Children Under 3 years (.2SD): 51
  - MMR / Lakh (Annual Report 2000): 607
  - Leprosy cases per 10000 population: 0.8
  - Malaria +ve Cases in year 2000 (in thousands): 53

- **UP**
  - Population BPL (%): 31.15
  - IMR/ Per 1000 Livr Births (1999 – SRS): 84
  - <5Mortality per 1000 (NFHS II): 122.5
  - Weight For Age - % of Children Under 3 years (.2SD): 52
  - MMR / Lakh (Annual Report 2000): 707
  - Leprosy cases per 10000 population: 4.3
  - Malaria +ve Cases in year 2000 (in thousands): 99

- **MP**
  - Population BPL (%): 37.43
  - IMR/ Per 1000 Livr Births (1999 – SRS): 90
  - <5Mortality per 1000 (NFHS II): 137.6
  - Weight For Age - % of Children Under 3 years (.2SD): 55
  - MMR / Lakh (Annual Report 2000): 498
  - Leprosy cases per 10000 population: 3.83
  - Malaria +ve Cases in year 2000 (in thousands): 528

*Source: National Health Policy, 2002*
## Major Indian States, by Stage of Health Transition and Institutional Capacity

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

**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 Uttarakhand.

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
Agenda for Action

- Raising an Army of Community Health Volunteers
- Strengthening the Primary Health Care Delivery System
- National Mission for Sanitation
- Taluk / Block Level Referral Hospitals for Curative Care
- Risk-Pooling and Hospital Care Financing
- Eight Task Forces
Raising an Army of Community Health Workers

- Women from the community
- One VHW per 1000 population (a million gainfully employed)
- Urban Health Worker (UHW) in areas inhabited by low income and poor populations.
- 3 months’ training (Union) + health kit + refresher courses
- Accountable to village Panchayat
- Honorarium of Rs.1000 / month
  - User charges as prescribed by Panchayat
  - Incentives for performance
Raising an Army of Community Health Volunteers

Fund Requirements

- **Training**: Rs.200 crores per year for training of VHWs/UHWs spread over three years – borne by the Union
- **Honorarium**: Rs 1200 crore per annum towards honorarium (shared equally by Union and states)
- **Health kits**: Rs 100 crore per annum – health kit, a few generic drugs etc. (shared equally by Union and states)
- **Refresher workshop**: Rs. 50 crore per annum – 2 refresher workshops – 3 days each (shared equally by Union and states)
Strengthening of Primary Healthcare Delivery System

- Addressing shortage of doctors in 8 states
- Addressing shortage of other paramedical staff
- Direct Union Financing of Male MPWs
- Provisioning of 35 essential drugs in all PHCs
- Intensification of ongoing communicable disease control programmes
- Urban health posts
- New programmes for the control of non-communicable diseases
- Upgradation of PHCs in order to provide 24 hour delivery services
Strengthening the Primary Health Care Delivery System

Male MPWs : Rs. 828 crores/year
Supply of listed drugs : Rs. 500 crores/year
  Intensification of ongoing disease control programmes : Rs. 500 crores/year
Urban health posts : Rs. 200 crores/year
Control of non-communicable diseases : Rs. 260 crores/year
Upgradation of PHCs for 24-hour delivery : Rs 480 crores /year
Supply of auto-destruct syringes : Rs 60 crores / year

Total : Rs. 2828 crores/year
National Mission for Sanitation

- 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
National Mission for Sanitation

Fund Requirements

- 50 million toilets - Rs. 12000 crore – Union+States(one-time allocation)

- The Union’s share will be Rs 8000 crore. Spread over 5 years at 10 million toilets a year, this will mean an allocation of Rs 1600 crore per year for the Union and Rs 800 crore per year for all states put together.

- Annual fund requirement for 5 years : Rs. 2400 crore.

- In addition, a national public health education programme and propagation of technology may cost Rs 100 crores per year. The Union may take up this campaign.

- Annual fund requirement for 5 years : Rs. 100 crore
Taluk / Block Level Referral Hospitals

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
Taluk / Block Level Referral Hospitals for Curative Care

Fund Requirements

- Capital cost of 7000 CHCs at Rs. 1 crore each = Rs. 7000 crores
- Annual cost (spread over five years) = Rs. 1400 crores
Risk Pooling and Hospital Care Financing

- Traditional health insurance is not an answer for health care requirements of poor
- Most of the disease burden is a consequence of failure of primary care
- Public health system is in disarray
- National health insurance will further strengthen private providers at the cost of public exchequer
Health Insurance – Objectives

- Strengthen public health care
- Raise resources innovatively and make the programme sustainable.
- Ensure access and quality of service to those with no influence or voice
- Create incentives and risk-reward system to promote quality health service delivery
- Encourage competition among health care providers
- Ensure choice to patients among multiple service providers
- Encourage public-private partnerships
Risk-Pooling and Hospital Care Financing

- Financing by the Union, State and citizens (those above poverty), pooling Rs. 90-100 per capita
- Citizens’ share to be collected by the local governments as cess/tax
- Pooling of the money at the District level with a new authority – District Health Board (DHB) under the overall umbrella of elected local governments
- Patients will have a choice to visit any public hospital
- There will be no separate budget for wages and maintenance, or new equipment
- The public hospital care costs will be reimbursed by DHB / money follows the patient
- Reimbursement will be based on standard costs and services
Risk-Pooling and Hospital Care Financing

- Where necessary DHB will involve private providers on the same basis
- A phased programme will be evolved for existing public hospitals to give time for transition
- A part of the fund (15%) will be separately administered for tertiary care / teaching hospitals at the State level
- Patients can go to tertiary hospitals only in emergencies or upon referral by secondary care hospitals
- All vertical programmes will be integrated and controlled at DHB level
- There will be an independent Ombudsman in each district
- There will be regular health accounting to trace expenditure flows, analyze costs and benefits, and demand and supply
- This will be the precursor of a National Health Service which serves all people at low cost
Risk-Pooling and Hospital Care Financing

Funding Requirements

Risk-pooling: from Union and states : Rs. 6000 crore per annum
Less current maintenance cost of public hospitals (estimated) : Rs. 3500 crores / annum

Additional Requirement * : Rs. 2500 crores / annum
Community Based Health Insurance : Rs. 100 crores / annum

Total : Rs. 2600 crores / annum

* Rs. 3000 Crore will be raised separately as local taxes.
Task Forces

- Reproductive and child health and birth control in high fertility states
- Convergence and integration of services
- Medical education and Medical Grants Commission
- Training of Voluntary Health Workers
- Regulation of medical care and medical ethics
- Regulation of medical profession
- Accreditation and integration of rural medical practitioners (RMPs) into health system
- Health financing mechanisms
Interventions Proposed

Current Structure

- District
- CHCs (3100)
- PHCs (23000)
- Sub Centre (137000)
- Village / Community

Interventions Proposed

- District Health Board + District Health Fund + Integrate all vertical programs
- 7000 New CHCs + Funding only for services delivered
- Supply of drugs + Improvement of facilities + Strengthening programs
- Multipurpose Health Workers (Fill all vacancies) + Drug supply
- 100 million household toilets (50 million with government subsidy) 1 million VHWs / UHWs + Training + Kits
Total Funding Requirement for Health Care Interventions

The above five recommendations are in line with the commitments made under the NCMP in health sector. As stated earlier, they are in addition to the on-going programmes and the Tenth Plan commitments. The total costs (excluding capital costs for sanitation and referral hospitals) will be of the order of Rs. 7000 crore per annum – about 0.23% of GDP.

- The total estimated financial outlay of these proposals is as follows:
  - Community Health Workers (Recurrent cost) Rs. 1550 crores/year
  - Strengthening Primary Health care (Recurrent cost) Rs. 2828 crores/year
  - National Sanitation Mission (Capital cost) Rs. 2500 crores/year
  - First Referral Hospitals (Capital cost) Rs. 1400 crores/year
  - Risk-pooling and Hospital care financing (Recurring cost) Rs. 2600 crores/year

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

- Mahatma Gandhi