

IMA Series on Healthcare

White Paper: Healthcare Reforms and Investments, 2013

Indian Medical Association





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White Paper on Healthcare Reforms and Investments, 2013

1. Introduction

Health care covers not only simple medical care but also all aspects of preventive care. Nor can it be limited to care rendered by or financed out of public expenditure within the government sector alone but must include incentives and disincentives for self care and care paid for by private citizens to get over ill health. Where, as in India, private out-of-pocket expenditure dominates the cost of financing health care, the effects are bound to be regressive. Health care at its essential core is widely recognized to be a public good. Its demand and supply cannot therefore, be left to be regulated solely by the invisible hand of the market, nor by the Government. Nor can it be established on considerations of utility maximizing conduct alone.

The Constitution of India incorporates provisions guaranteeing everyone's right to the highest attainable standard of physical and mental health. Article 21 of the constitution guarantees protection of life and personal liberty to every citizen. The Supreme Court has held that the right to live with human dignity, enshrined in Article 21 derives from the directive principles of state policy and therefore includes protection of health. Further it has also been held that the right to health is integral to the right to life and the government has a constitutional and moral obligation to provide health care facilities to every individual. Also Under United Nations' Universal Declaration of Human Rights, (UDHR) -- "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.

Hence, IMA suggests that a task force be constituted to work on the concept of right to health and its dimensions. Right to health should include:

1. Right to primary, secondary and tertiary levels of care with universal coverage and access, also with equal importance for preventive healthcare.
2. Right to basic levels of sanitation and safe drinking water.
3. Right to basic levels of nutrition

The patient should receive treatment and care in dignity, fairness, without discrimination and in consonance with the basic tenets of a patients' charter.

In India, state, local, and the central government have the responsibility for the healthcare sector. In actual terms of service delivery it is more concerned with the state as health is a state subject. The central government is responsible for health services in union territories without a legislature and is also responsible for developing and monitoring national standards and regulations, linking the states with funding agencies, and sponsoring numerous schemes for implementation by state governments. Both the center and the state government have a joint responsibility for programs listed under the concurrent list.

2. Key Features of Public Health in India

1. Public health expenditure in India has declined from 1.3% of GDP in 1990 to 0.9% of GDP in 2012. The Union Budgetary allocation for health is 0.9% while the State's budgetary allocation is 5.5%.
2. Union Government contribution to public health expenditure is 15% while States contribution about 85%.
3. Vertical Health and Family Welfare Programs have limited synergisation at operational levels.
4. Lack of community ownership of public health programs impacts levels of efficiency, accountability and effectiveness.
5. Lack of integration of sanitation, hygiene, nutrition and drinking water issues.

6. There are striking regional inequalities.
7. Population Stabilization is still a challenge, especially in States with weak demographic indicators.
8. Curative services favour the non-poor: For every Re.1 spent on the poor 20% population, Rs.3 is spent on the rich quintile.
9. Not even 10% Indians have some form of health insurance, mostly inadequate.
10. Hospitalized Indians spend on an average 58% of their total annual expenditure
11. Over 40% of hospitalized Indians borrow heavily or sell assets to cover expenses
12. Over 25% of hospitalized Indians fall below poverty line because of hospital expenses
13. While the recent Economic Survey claims that India's GDP has extended its spending on health by 13% the same survey also points out that it has the lowest health spending as a proportion of its GDP. In fact, though the number-crunchers say that we spend 4.1% of our GDP on health, the fact is that 70% of it is from people's own pockets or private spending, meaning that the government spends barely 1% on health. Even the private plus government spending is abysmally low compared to other nations. Both Brazil and South Africa spend around 9% and only Indonesia spends lesser than India among the 11 countries surveyed.

3. 1 Organizational Structure of Health Sector



- **National level-** The organization at the national level consists of the Union Ministry of Health and Family Welfare with full-fledged secretariat under a Cabinet Minister with all other officials.
- **State Level-** The organization at State level is under the State Department of Health and Family Welfare in each State headed by Minister and with a Secretariat under the charge of Secretary/Commissioner (Health and Family Welfare) belonging to the cadre of Indian Administrative Service (IAS).
- **Regional level-** Each regional/zonal set-up covers three to five districts and acts under the authority delegated by the State Directorate of Health Services.
- **District Level-** The district level structure of health services is a middle level management organisation and it is a link between the State as well as regional

structure on one side and the peripheral level structures such as PHC as well as sub-centre on the other side.

- **Sub-divisional/ Taluka level-** At the Taluka level, healthcare services are rendered through the office of Assistant District Health and Family Welfare Officer (ADHO).
- **Community level-** one Community Health Centre (CHC) has been established for every 80,000 to 1,20,000 population, and this centre provides the basic specialty services in general medicine, pediatrics, surgery, obstetrics and gynecology.

3.2 Recommendations

1. Effective Centre State Coordination, with the Centre playing the key role as the financier.
2. Strengthening our Sub-divisional/Taluka level and community level medical facilities, by providing proper infrastructure.
3. Working environment for the health professionals should be improved by providing safety and security with proper appraisal.
4. We can also strengthen our organisational structure by adding more professional people and making the present working force more professional.

4. Primary, Specialty and Hospital Care

- **Primary:** At present there is one Primary Health Centre covering about 30,000 (20,000 in hilly, desert and difficult terrains) or more population. Many rural dispensaries have been upgraded to create these PHCs. Each PHC has one medical officer, two health assistants - one male and one female, and the health workers and supporting staff.

- **Specialty:** Specialty care is available at Taluka and District headquarters hospitals.
- **Hospital Care:** varies from secondary care available at Taluka and district headquarters' hospitals and tertiary/ corporate care Hospitals in cities.

5. Role of Private Sector

The Indian Policy welcomes the participation of the private sector in all areas of health activities - primary, secondary or tertiary. However, looking to past experience of the private sector, it can reasonably be expected that its contribution would be substantial in the urban primary sector and the tertiary sector, and moderate in the secondary sector. In the rural scenario, the contribution is recognizable in the primary and secondary sector to some extent and nil in the tertiary sector.

The Policy also encourages the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages, but cost given to service provider from the insurance company, CGHS and other government agencies are too low to make it popular.

In the context of the very large number of poor in the country, it would be difficult to conceive of an exclusive Government mechanism to provide health services to this category. It has sometimes been felt that a social health insurance scheme, funded by the Government, and with service delivery through the private sector, would be the appropriate solution. The administrative and financial implications of such an initiative are still unknown.

Policy should also be there to cover OPD services in RGBY and other government sponsored insurance schemes for BPL card holders so that illnesses are treated in the beginning itself.

Schemes like RSBY offer very low premiums, low medical cover of the whole family and virtually no OPD cover. Hence, tariff should be raised for private practitioners and hospitals.

It envisages the co-option of the non-governmental practitioners in the national disease control programs so as to ensure that standard treatment protocols are followed in their day-to-day practice.

This Policy recognizes the immense potential of information technology applications in the area of tele-medicine in the tertiary health care sector. The use of this technical aid will greatly enhance the capacity for the professionals to pool their clinical experience.

6. Reforms in Health Care System

The main objective of the revised National Health Policy, 2002 is to achieve an acceptable standard of good health among the general population of the country and has set goals to be achieved by the year 2015. The major policy prescriptions are as follows:

1. Increase public expenditure from 0.9 percent to 2 percent by 2010.
2. Increase allocation of public health investment in the order of 55 percent for the primary health sector; 35 percent and 10 percent to secondary and tertiary sectors respectively.
3. Gradual convergence of all health programs, except the ones (such as TB, Malaria, HIV/AIDS, RCH), which need to be continued till moderate levels of prevalence are reached.
4. Need to levy user charges for certain secondary and tertiary public health services, for those who can afford to pay.
5. Mandatory two year rural posting before awarding the graduate medical degree.

6. Decentralising the implementation of health programmes to local self-governing bodies by 2005.
7. Setting up of Medical Grants Commission for funding new Government Medical and Dental colleges.
8. Promoting public health discipline.
9. Establishing two-tier urban healthcare system - Primary Health Centre for a population of one lakh and Government General Hospital.
10. Increase in Government funded health research to a level of 2 percent of the total health spending by 2010.
11. Appreciation of the role of private sector in health, and enactment of legislation by 2003 for regulating private clinical establishments.
12. Formulation of procedures for accreditation of public and private health facilities.
13. Co-option of NGOs in national disease control programs.
14. Promotion of tele- medicine in tertiary healthcare sector.
15. Full operationalisation of National Disease Surveillance Network by 2005.
16. Notification of contemporary code of medical ethics by Medical Council of India.
17. Encouraging setting up of private insurance instruments to bring secondary and tertiary sectors into its purview.
18. Promotion of medical services for overseas users.
19. Encouragement and promotion of Indian Systems of Medicine.

The first National Health Policy in 1983 aimed to achieve the goal of 'Health for All' by 2000 AD, through the provision of comprehensive primary healthcare services. It stressed the creation of an infrastructure for primary healthcare; close co-ordination with health-related services and activities (like nutrition, drinking water supply and sanitation); active involvement and participation of voluntary organisations; provision of essential drugs and vaccines; qualitative improvement in health and family planning

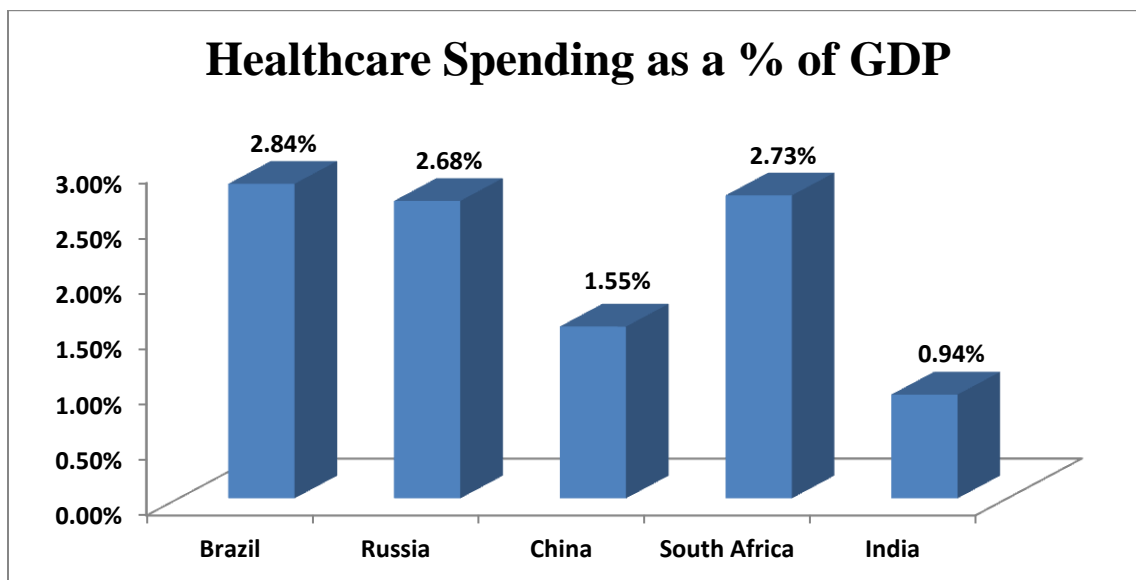
services; provision of adequate training; and medical research aimed at the common health problems of the people.

7. Public Spending on Health

Public spending (i.e. expenditures incurred by health departments of Central and State Governments) on health gradually accelerated from 0.22% in 1950-51 to 1.05% during the mid-1980s, and stagnated at around 0.9% of the GDP during the later years. Public health spending is about 0.9% of the GDP, which is comparatively very low to other developing countries which normally spend between 3 – 5 % of their GDP on healthcare delivery. National commission on macroeconomics and health estimates indicate that public investment for provisioning of public goods and primary and secondary services alone will require about Rs 74,000 crores or 2.2% of GDP at current prices. When added to the current level of 0.9%, the total public health spending (i.e. expenditures incurred by health departments at Central and State level) in proportion to GDP the amount required will be about 3%. Such spending will bring down the household expenditures by over 50% and entail substantial health gains. There is also a strong association between per capita income and health status (LEB and Infant Mortality Rate) of the population. There is an inverse relationship between poverty and LEB (Life Expectancy at Birth). There is a two-way causation between economic growth and health status. The effect of health measured by life expectancy is positive and significant on economic growth. There is evidence of a significant effect of per capita income and per capita public expenditure on health on LEB. A thousand rupee increase in per capita health expenditure would lead to a 1.3% increase in LEB, while a 10% increase in per capita income is required to increase the LEB by about 2%. Estimates indicate that the effect of health (LEB) on Net State Domestic Product (NSDP) is very high, in fact, much higher than the effect of the conventional inputs of capital and labour. Increasing investment in health is a required policy intervention for accelerating the economy's growth rate.

Overall, there is a compelling reason for stepping up both public and private investment in health which would pay off in the long run

India's healthcare spend is significantly low when compared to the global, developed and other similar emerging economies. If we compare spending on healthcare with China, South Africa, and Brazil then we see that we are much behind to these countries when it comes spending on health.



14. It is believed that an important factor contributing to India's poor health status is its low level of public spending on health, which is one of the lowest in the world. In 2007, according to WHO's *World Health Statistics*, India ranked 184 among 191 countries in terms of public expenditure on health as a percent of GDP. In per capita terms, India ranked 164 in the same sample of 191 countries, spending just about \$29 per person. This level of per capita public expenditure on health was around a third of Sri Lanka's, less than 30% of China's, and 14 percent of Thailand's (WHO, 2010). What is more, public spending on health as a percent of GDP in India has stagnated in the past two decades, from 1990-91

to 2009–10, varying from 0.9 to 1.2 percent of GDP. While public spending on health care is low, the out-of-pocket (OOP) expenditure by households has been large. In 2007, total expenditure on health in India (public and private) was about 4.1 percent of GDP, which was higher than the level in Thailand and around the levels of Sri Lanka and China. In 2007, private spending in India constituted nearly 74 percent of the total spending on health (in contrast to 18 percent in the United Kingdom. Nearly 90 percent of this private expenditure in India was in the form of OOP expenditure on health by households (WHO, 2010), a share that is one of the highest in Asia (Van Doorslaer and others, 2007). The high OOP expenditure has put an increasing financial burden on the poorer sections of the population. Data from the National Sample Survey Organization (NSSO) in India indicate that between 1986–87 and 2004, the share of ailments not treated due to financial reasons has increased from around 15 percent to 28 percent in the rural areas. Part of this increased financial burden arises from the fact that the share of visits to private health facilities has increased in recent years. According to the NSSO data, the share of outpatient visits to public facilities has dropped from 25 to 20 percent and for inpatient visits from 60 to 40 percent (Selvaraj and Karan, 2009, cited in Shahrawat and Rao, 2011). Notably, outpatient treatments account for nearly three-fourths of OOP expenditure by households; a large part of this could be reduced through adequate provision of primary and secondary care (NSSO, 2007).

15. While the recent Economic Survey claims that India's GDP has extended its spending on health by 13% the same survey also points out that it has the lowest health spending as a proportion of its GDP. In fact, though the number-crunchers say that we spend 4.1% of our GDP on health, the fact is that 70% of it is from people's own pockets or private spending, meaning that the government spends barely 1% on health. Even the private plus government spending is abysmally low compared to other nations. Both Brazil and South Africa spend around 9% and only Indonesia spends lesser than India among the 11 countries surveyed.

7.1 Recommendation:

1. Government of India shall spend a minimum of 5% of its GDP- on basic healthcare requirements if it wants its universal health coverage Programme to be result oriented and effective.
2. Conditional grants have to be restructured to encapsulate primary health care expenditure in addition to the hospital component of the grants. Alternatively, a mechanism will have to be found to empower the healthcare sector to ensure that respective States and union territories and provinces allocate adequate and essential resources to implement the national health programme.

8. Infrastructural Requirements

Today the health infrastructure of India is in pathetic condition, it needs radical reforms to deal with new emerging challenges. On one hand the role of private players is continuously increasing in healthcare sector, and simultaneously healthcare facilities are getting costlier and non-accessible for the poor. The government hospitals are facing the problem of lack of resources and infrastructure; there are inadequate number of beds, rooms, and medicines. On the part of government there is lack of monitoring of the funds and resources, which are devoted towards the improvement of healthcare sector.

A model healthcare plan, which devolves around preparing a long term strategy for qualitative as well as quantitative improvements in our healthcare infrastructure by focusing on workforce capacity and competency, information and data systems, and organizational capacity, is sorely needed. The government is required to take an integrated approach, which must take into consideration meeting the regional differences with the help of the local people; it must prepare a decentralized structure which would be district based, involving active role for the local level institutions like Panchayats.

It has been further observed that every year many people die because of the spread of different epidemics, and till now the government has failed to create a proper strategy which can prevent the spread of these epidemics and can provide for emergency measures in the affected areas. It is suggested that that government must prepare a comprehensive strategy to deal with epidemics, which must include a universal vaccination policy (in affected areas), establishment of special medical care centres, emergency response plans, and measures for the improvement in habitation. There is a need for continuous action for the improvement of healthcare facilities in rural areas because generally there are very few government hospitals and even those are devoid of most of the medical facilities. Moreover, in the rural areas most of the people are poor and these areas are most prone to be affected by different types of epidemics as the people are unaware of the better hygiene practices and other disease preventive measures. Although the National Rural Health Mission (NRHM), initiated by the central government, has impacted the lives of rural masses to some extent, it has miserably failed to bring radical changes because of lack of implementation. It is opined that NRHM should be extended beyond 2013 and the government must regularly monitor the funds and other resources provided for the mission. We know by experience and hindsight that there is no magical plan to improve the medical facilities for a vast population as of India, but the central government must take actions from all sides along with the help of other actors like state governments, NGOs, and media. Investment in healthcare sector to the tune of two to three percent of GDP is inevitable but insufficient to bring in radical changes; the government is required to keep vigilance on the utilization of allotted funds, and needs to create a motivation as well as commitment among the healthcare personnel for welfare of the people. The penetration of healthcare infrastructure in India is much lower than that of developed countries and even lower than the global average.

One important deficiency in planning is poor data collection for different diseases leading to poor planning. Moreover, under-reporting of diseases by the public sector as

well as the private sector, because of fear of public outcry or pressures from supervisors and public health authorities, also leads to deficient medical services.

The healthcare infrastructure in India is inadequate compared with the global standards. It lags behind the global average in terms of healthcare infrastructure and manpower. India has an average 0.6 doctors per 1000 population against the global average of 1.23 which suggests an evident manpower gap.

Indicators	Year	India	USA	UK	Brazil	China
Hospital Bed Density (per 10000population)	2000-2009	12	31	39	24	30
Doctor Density (per10000 population)	2000-2009	6	27	21	17	14

AR, Government of India Ministry of Health and Family Welfare, September 2010; World Health Organisation, World Health Statistics 2010; CII, Technopak report

Indicators	Year	India	USA	UK	Brazil	China
Births attended by skilled health personnel (percent)	2000-2009	47%	99%	NA	97%	98%
No of doctors	2009	6,43,520	7,93,648	1,26,126	3,20,013	18,62,630
No. of Nurses	2009	13,72,059	29,27,000	37,200	5,49,423	12259240
No. of Dentists	2009	55,344	4,63,663	25,914	2,17,217	1,36,520
Avg. no. of doctors per bed	2009	0.6	0.81	0.53	0.69	0.46

Avg. no. of nurses per bed	2009	1.27	3.0	0.16	1.18	3.02
No. of doctors per1000 population	2009	0.6	2.7	2.1	1.7	1.4
No. of nurses per1000 population	2009	1.3	9.8	0.6	2.9	1

Source:www.oecd.org, www.whoindia.org

In 2009, the number of beds available per 1000 people in India was only 1.27, which is less than half the global average of 2.6. There are 369,351 government beds in urban areas and a mere 143,069 beds in rural areas.

	2008	2018	2028
Additional Beds required	1.1 million	3.1 million	2 million
Bed/1000 Population ratio	0.7 to 1.7	4	5

Source: CII Technopak

At six doctors per 10,000 people, the number of qualified doctors in the country is not sufficient for the growing requirements of Indian healthcare. Moreover, rural “doctors to population” ratio is lower by 6 times as compared to urban areas.

Parameter	Current Annual Production	To fill the gap
Physicians	30,558	9,93,500
Nurses	1,14,218	2,510,250

Source: CII Technopak; National Health Profile 2009

As of 2010, India had approximately 300 medical colleges, 290 colleges for Bachelor of Dental Surgery and 140 colleges for Master of Dental Surgery admitting 34,595, 23,520 and 2,644 students annually respectively. India needs to open 600 medical colleges (100 seats per college) and 1500 nursing colleges (60 seats per college) in order to meet the global average of doctors and nurses.

Moreover, the medical personnel are concentrated in urban areas. Around 74 percent of the graduate doctors in India work in urban settlements which account for only approximately one-fourth of the population. The countrywide distribution of these institutes is also skewed. 61 percent of the medical colleges are in the 6 states of Maharashtra, Karnataka, Kerala, Tamil Nadu, Andhra Pradesh and Puducherry, while only 11 percent are in Bihar, Jharkhand, Orissa and West Bengal and the north-eastern states.

8.2 Key Issues:

1. Insufficiency of Hospital Beds.
2. Inadequate availability of Medical personnel
3. Inadequate availability of qualified nurses and paramedical personnel.
4. Especially the nurses & paramedical persons for the fast growing Geriatric Populations.
5. Dismal Number of Healthcare Centers & the pitiable state of their maintenance, deficient infrastructure and facilities.
6. Insufficient Number of Blood Banks.
7. Urgent Need of more Medical Colleges, with good control over their infrastructure, facilities, the quality of the staff & education imparted.
8. Concentration of Healthcare in Metro-cities.
9. Non-Availability of Urgently Needed Vaccines.

8.3 Recommendations/ Suggestions

1. Government hospitals are not a solution to the present problem. To tackle the above mentioned challenges, private hospital chains should set up bases in emerging cities and big rural areas to provide health-related infrastructure.
2. The Government should come up with investment-friendly policies in the health sector. Tax holidays, bank to support builders of hospitals, special interest rates and loans from banks, benefits for setting up of private practices, hospitals, diagnostic centres and pharmaceuticals, can change the face of healthcare infrastructure in India. In the developed market, health insurance companies can compete with each other. They can also negotiate with hospitals for the quality of services offered to the patients. Eventually, a better competitive market will reduce costs and result in better services.
3. One cannot ignore the possibilities of Medical Tourism. It is considered to be a supplementary market emerging within the urban health portfolio. India is emerging as a popular medical tourism destination, thanks to its relatively low costs and better success rates. It is reported that the cost of treatment in India is one fifth of that of the US. Development in Medical Tourism depends on the advancement in health infrastructure in India. The revenue earned from Medical Tourism could help subsidized medical costs for poorer patients.
4. Easing of regulations in opening and governing of medical colleges is another policy change warranted in this sector.
5. Better compilation of per capita expenditure data of patients and availability of beds at the regional or local levels within states can help investors set up hospitals for the needy. The Government should demarcate health circles and

priority areas for intervention, based on available information, indexed with health standards of each particular area.

6. A major bottleneck for entrepreneurs who seek to enter the health market is the lack of access to banking, to raise the required capital. Health Circles can be auctioned, similar to the mobile phone market, ensuring fair competition amongst bidders and financial support from the Government.
7. Policies governing health infrastructure need to be in black and white, and not left to the discretion of the Government.
8. Both Central and State governments should evaluate their own healthcare expenditure by issuing yearly audited reports and posting the same on public domain.
9. Introduction of low premium group insurance schemes with few OPD visits incorporated for BPL patients so that the visits to the doctors are during the early stages of the illness, thereby lowering the healthcare cost as it prevents costly treatment in case of delays on account of the illness turning severe.
10. Emphasis on higher and good quality of medicine.
11. Affordable and reasonable cost of medicines.
12. Universal health coverage for all where every citizen is covered for basic healthcare services. Such schemes, where all Indian national, regardless of their economic, social or cultural backgrounds should have the right to affordable, accountable and appropriate health services of assured quality defined in a published package of service and benefits.

9. National Rural Health Mission (NRHM)

NRHM is an Indian health program for improving health care delivery across rural India. The mission, initially mooted for 7 years (2005-2012), is run by the Ministry of Health. The scheme proposes a number of new mechanisms for healthcare delivery including training local residents as *Accredited Social Health Activists* (ASHA), and the Janani Surakshay Yojana (motherhood protection program). It also aims at improving hygiene and sanitation infrastructure. Noted economists Ajay Mahal and Bibek Debroy have called it "the most ambitious rural health initiative ever".

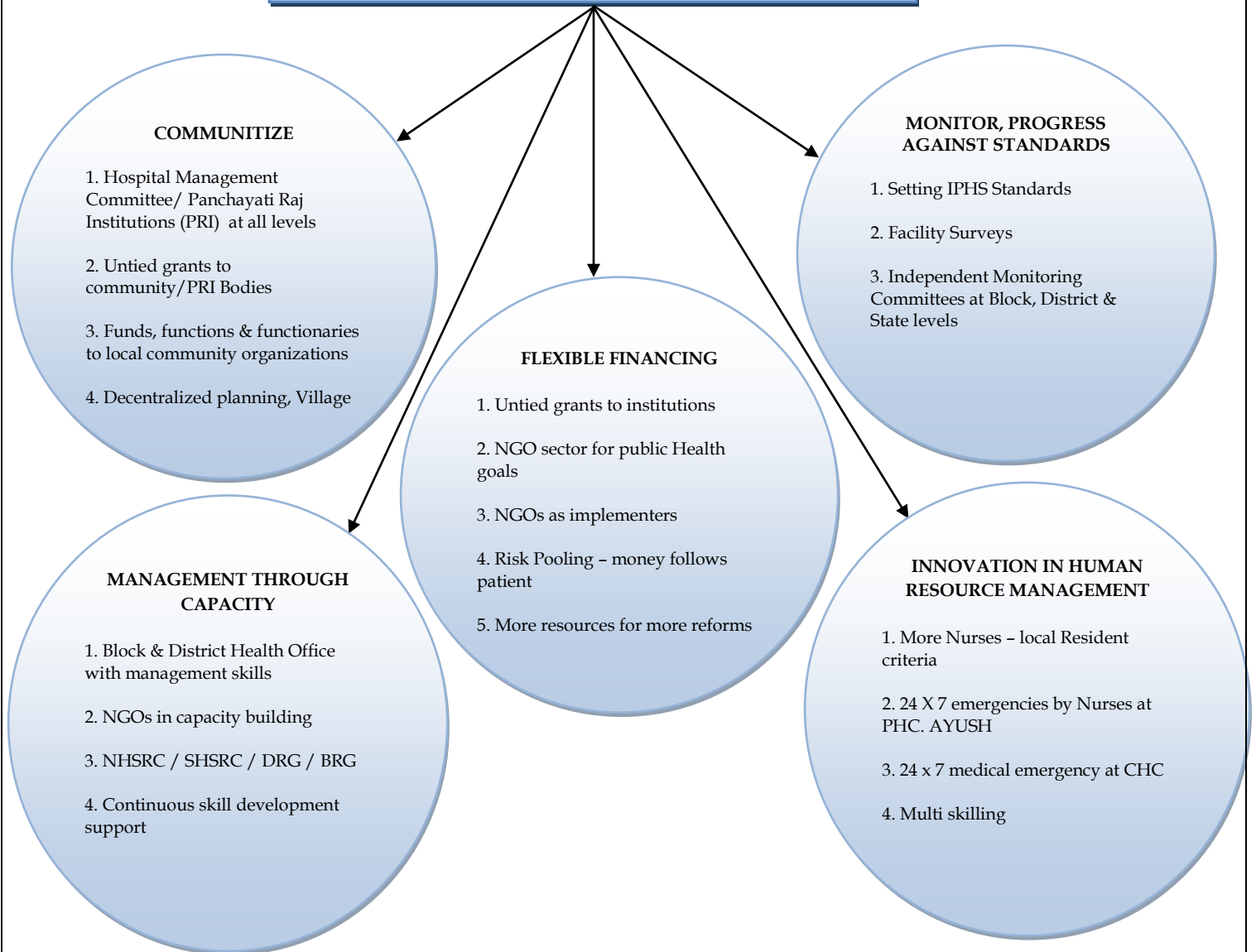
National Rural Health Mission is the radical conceptual change introduced in the year in 2005. Now the Government is progressing on National Urban Health Mission (NUHM). NRHM has been a parallel public health system. Friction between regular state health services and NRHM are evident at 6 all levels. IMA feels that there is duplication and overlapping of responsibilities. While some states have utilized the resources optimally, in some states like UP large scale corruption have been reported. While the flexibility in decision making brought in by NRHM is welcome, the accountability has to be at least in par with the existing Government system. States with good governance have performed better while states with poor governance have performed poorly. So the factor of difference is in good governance.

IMA suggests that the same budget be channelized through established Government health system instead of NRHM or NUHM

Under the mission, health funding has increased from ₹14,974 crores in 2007-08 to ₹ 34,488 crores in 2012-13. Economists have noted that "the mid-term appraisal of the NRHM has found that there has been a significant improvement in health indicators even in this short period". However, in many situations, the state level apparatus have not been able to deploy the additional funds, often owing to inadequacies in the Panchayati Raj functioning, fund utilization in many states being only around 70%.

9.2 Approach

Main Approaches of NRHM



1. The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

2. It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country.
3. It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care, which are accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and optimal utilization of funds for creating infrastructure and strengthening delivery of primary healthcare.
4. It seeks to revitalize local health traditions and mainstream AYUSH into the public health system.
5. It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health.
6. It seeks decentralization of Programmes for district management of health.
7. It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure.
8. It shall define time-bound goals and report publicly on their progress.

9. It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

9.3 NRHM Goals

1. Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
2. Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
3. Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
4. Access to integrated comprehensive primary healthcare
5. Population stabilization, gender and demographic balance.
6. Revitalize local health traditions and mainstream AYUSH
7. Promotion of healthy lifestyles

9.4 State Governments Role in NHRM

1. The Mission covers the entire country. The 18 high focus States are Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Orissa, Uttaranchal, Jharkhand, Chhattisgarh, Assam, Sikkim, Arunachal Pradesh, Manipur, Meghalaya, Tripura, Nagaland, Mizoram Himachal Pradesh and Jammu & Kashmir. GOI would provide funding for key components in these 18 high focus States. Other States would fund interventions like ASHA, Programme Management Unit (PMU), and up gradation of SC/ PHC/CHC through Integrated Financial Envelope.
2. NRHM provides broad conceptual framework. States would project operational modalities in their State Action Plans, to be decided in consultation with the Mission Steering Group.

3. NRHM would prioritize funding for addressing inter-state and intra- district disparities in terms of health infrastructure and indicators.
4. States would sign Memorandum of Understanding with Government of India, indicating their commitment to increase contribution to Public Health Budget (preferably by 10% each year), increased devolution to Panchayati Raj Institutions as per 73rd Constitution (Amendment) Act, and performance benchmarks for release of funds

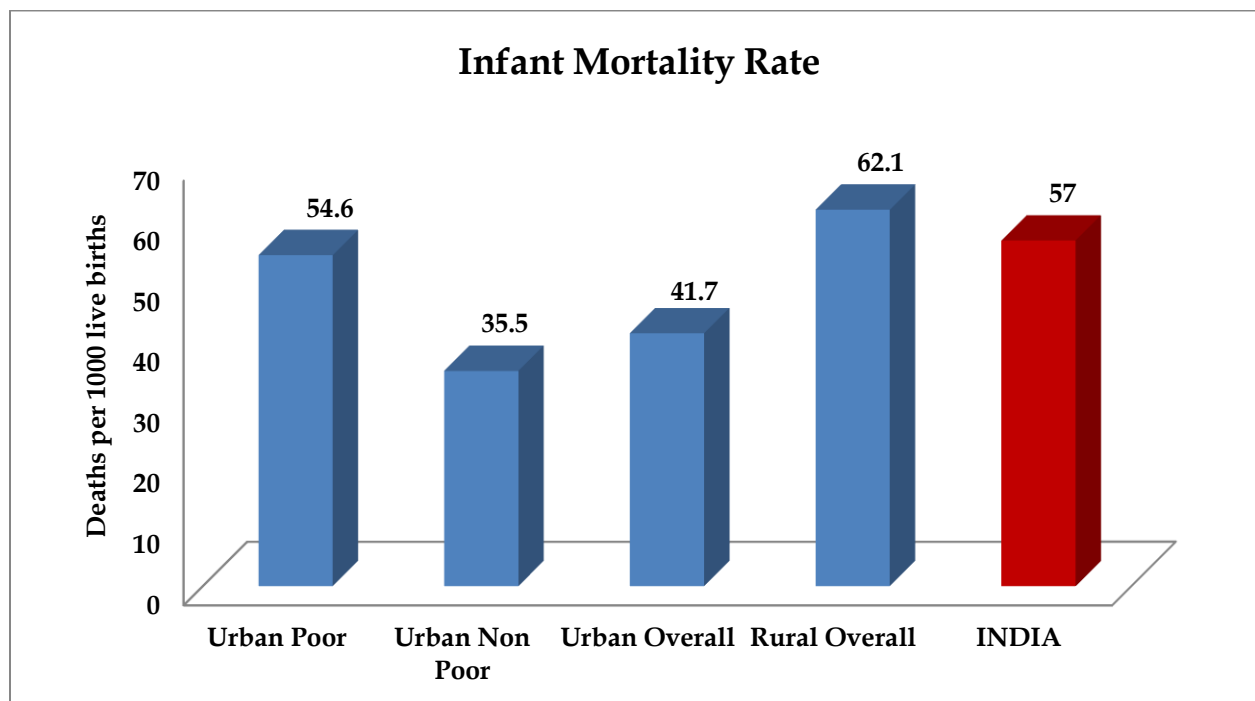
10. Urban Health in India

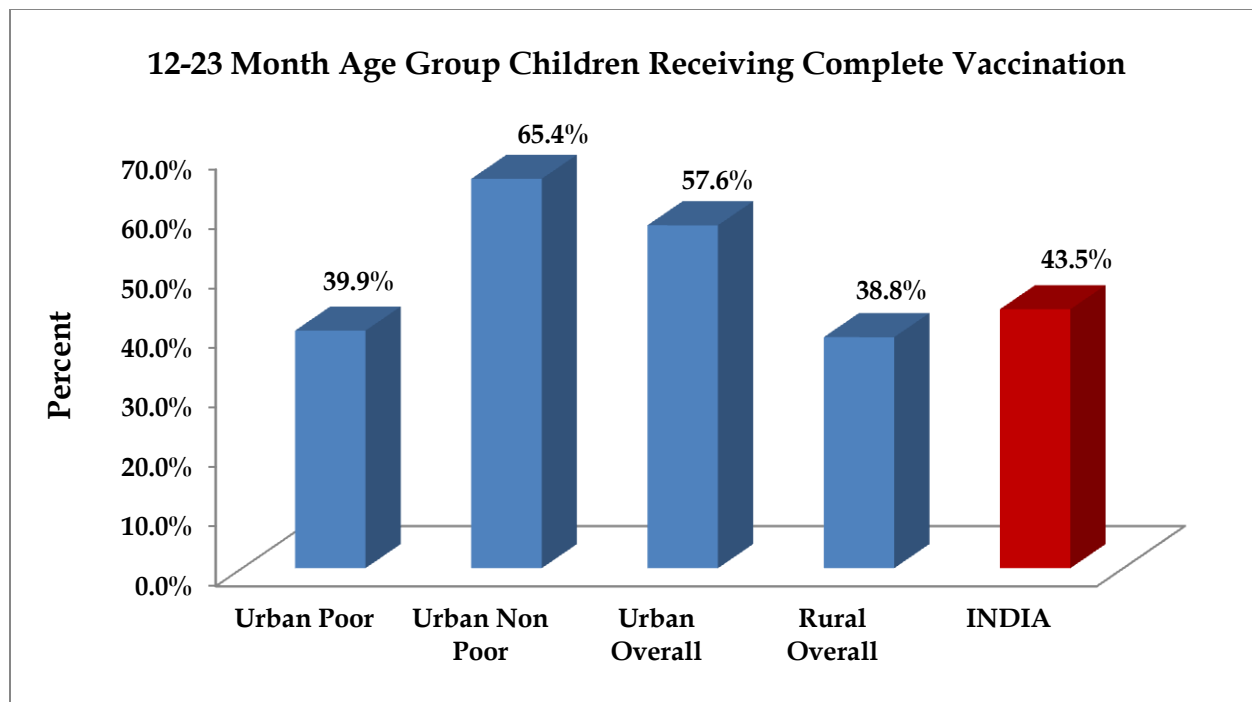
India is witnessing an explosive growth in the population living in urban areas. It is estimated that of the nearly 30% of India's population or about 300 million people live in towns and cities. This population is estimated to reach 534 million by 2026. Along with rapidly urbanization, there has been a more rapid growth in the population residing in slums. It is estimated that nearly one-third of India's urban population or nearly 100 million live in slums characterized by overcrowding, poor hygiene and sanitation and the absence of civic services. The UNHABITAT estimates that the slum population in India will double to 200 million by 2020.

Year	Urban Population	Total Population
1800	2%	140
1950	30%	360
2000	47%	1027
2008	50%	1160
2030	60%	2050

Source: UN

Health of the urban poor is considerably worse off than the urban middle and high income groups and is as worse as the rural population. There are thousands of easily preventable maternal, child and adult deaths each year and millions of days of productivity lost each year. One in ten children in slums do not live to see their fifth birthday. Malnutrition among urban poor children is worse off than in rural areas. Only 42 % of slum children receive all the recommended vaccinations. Over half (56 %) of child births take place at home in slums putting the life of both the mother and new born to serious risk. Poor sanitation conditions in slums contribute to the high burden of disease in slums. Two-thirds of urban poor households do not have access to toilets and nearly 40 % do not have piped water supply at home.





Unlike rural areas which have a dedicated government health care structure, urban areas do not have such a structure. The rapid growth of urban population in recent decades has rendered the already inadequate primary health care facilities further deficient. Cost, timings, distance and other factors put even the primary as well as the secondary care, not to say anything about the tertiary & the private sector facilities out of reach of most urban poor residents. Other factors like slums inhabiting land belonging to other agencies and therefore illegal and vulnerable to eviction, rapid migration and mobility among slum population also affect health delivery in urban poor communities.

The policy scenario in India has also been rural centric as India was predominantly rural till recently. This has resulted in a relative neglect of urban areas especially the urban poor. This is reflected in the shortage of resources, facilities and implementation mechanisms for health in urban areas.

In order to address these challenges, IMA should be invited to work in partnership with government and non-governmental stakeholders to bring about sustainable improvements in health in underserved urban settlements.

10.2 Challenges

1. Administrative issues
2. Policy issues
3. Operational issues
4. Involvement of non-governmental service providers
5. Large size of the population
6. The public sector urban health delivery system, especially for the poor, has so far been sporadic, far from adequate, and limited in its reach
7. Overcrowding and related health issues
8. Rapid growth of urban centers has led to substandard housing on marginal land and overcrowding
9. Outbreaks of diseases transmitted through respiratory and faeco-oral route due to increased population density
10. It exacerbates health risks related to insufficient and poor water supply and poor sanitation systems
11. Lack of privacy leading to depression, anxiety, stress etc.
12. Establishing health care centres to cater to the primary and secondary care needs of the urban poor-the role of IMA in this sector will be most helpful

11. National Urban Health Mission (NUHM)

The Union Cabinet gave its approval to launch a National Urban Health Mission (NUHM) as a new sub-mission under the over-arching National Health Mission (NHM). Under the Scheme the following proposals have been approved:

1. One Urban Primary Health Centre (U-PHC) for every fifty to sixty thousand population.
2. One Urban Community Health Centre (U-CHC) for five to six U-PHCs in big cities.
3. One Auxiliary Nursing Midwives (ANM) for 10,000 people, i.e., the ratio is 1 ANM: 10,000 persons.
4. One Accredited Social Health Activist ASHA (community link worker) for 200 to 500 households, i.e., the ratio is 200- 500 household: 1 Activists.

The estimated cost of NUHM for 5 years period is Rs.22, 507 crores with the Central Government share of Rs.16, 955 crores. Centre-State funding pattern will be 75:25 except for North Eastern states and other special category states of Jammu and Kashmir, Himachal Pradesh and Uttarakhand for whom the funding pattern will be 90:10.

The scheme will focus on primary health care needs of the urban poor. This Mission will be implemented in 779 cities and towns with more than 50,000 population and cover about 7.75 crores people.

The interventions under the sub-mission will result in

1. Reduction in Infant Mortality Rate (IMR)
2. Reduction in Maternal Mortality Ratio (MMR)

The maternal mortality is the worst in India-

What the private sector spends in India is more than double of what the government spends (a trend unique to India) which suggests that it is the

absence of government healthcare which forces individuals to spend money out-of-pocket. This hurts people even more and it is estimated that health expenses forces 39 million people each year into poverty. The latest figures from the UN suggest that India still accounts for one of every three maternal death. Most of them are due to complications like severe bleeding after childbirth, infections, high BP during pregnancy and unsafe abortions.

3. Universal access to reproductive health care
4. Convergence of all health related interventions.

The existing institutional mechanism and management systems created and functioning under NRHM will be strengthened to meet the needs of NUHM. City wise implementation plans will be prepared based on baseline survey and felt need. Urban local bodies will be fully involved in implementation of the scheme.

NUHM aims to improve the health status of the urban population in general, particularly the poor and other disadvantaged sections by facilitating equitable access to quality health care, through a revamped primary public health care system, targeted outreach services and involvement of the community and urban local bodies.

The National Urban Health Mission based on the key characteristics of the existing urban health delivery system proposes a broad framework for strengthening the extant primary public health systems, rationalizing the available manpower and resources, filling the gaps in service delivery through private partnerships through a regulatory framework and also through a communitised risk pooling / insurance mechanism with IT enablement, capacity building of key stakeholders, and by making special provision for inclusion of the most vulnerable amongst the poor. The quality of the services provided will be constantly monitored for improvement (IPHS/ Revised IPHS for Urban areas etc.).

11.2 Funding

1. The Mission is conceived as an umbrella programme subsuming the existing programmes of health and family welfare, including the RCHII (Reproductive and Child Health Programme II), National Disease Control Programmes for Malaria, TB, Kala Azar, Filaria, Blindness & Iodine Deficiency and Integrated Disease Surveillance Programme.
2. The Budget Head For NRHM shall be created in B.E. 2006-07 at National and State levels. Initially, the vertical health and family welfare programmes shall retain their Sub-Budget Head under the NRHM.
3. The Outlay of the NRHM for 2005-06 is in the range of Rs.6700 crores.
4. The Mission envisages an additionally of 30% over existing Annual Budgetary Outlays, every year, to fulfill the mandate of the National Common Minimum Programme to raise the outlays for public health from 0.9% of GDP to 2-3% of GDP
5. The Outlay for NRHM shall accordingly be determined in the Annual Budgetary exercise.
6. The States are expected to raise their contributions to Public Health Budget by minimum 10% p.a. to support the Mission activities.
7. Funds shall be released to States through SCOVA, largely in the form of Financial Envelopes, with weightage to 18 high focus States.

8. The expertise of the IMA is offered to the Government in implementing this wonderful NRHM in our country, subject to the rules and regulations. We request that we be included in the committees formed to frame the guidelines and helping the execution of the Programme to the maximum possible percolation to the really needy poor of our country.

12. Public-Private Partnership (PPP)

The Government has been attempting to engage the private sector in providing services under the National Health Programmes (NHPs). The primary objective of such an attempt has been to expand access to health care, the experience has been far from satisfactory and even the little success achieved is more due to the partnership with the not-for-profit sector and non-governmental organizations (NGOs). The for-profit sector continues to be a parallel development that public policy has yet to take cognizance of. Efforts of the Government to collaborate with the private sector have been programme based, sporadic, disjointed and tentative, and not the result of a well thought-out strategy aimed at achieving national health goals. Despite the mixed and varied experience, it is clear that collaboration with the private sector could enable expansion of access.

It is important to acknowledge that considerable resources have been invested by the private sector. It makes no economic sense for the Government to duplicate investments, when these resources can be directed towards underserved areas and achieving public goals. Therefore, fresh investment should be need-based. Second, expansion of access to health care should now be through innovative financing strategies such as universal social insurance or subsidized community financing and micro financing options. Mechanisms that separate the role of the state from being the provider as well as financier will facilitate contracting private health services. With

public facilities also enabled to improve quality that will create a healthy competitive environment to the advantage of the Government and the consumer. However, the success of such a system will be dependent on having the consensus of professional organizations, consumer advocacy forums, institutionalization of quality assurance mechanisms, a responsive grievance redressal mechanism, an administrative capacity and the will to enforce them.

Deficiencies in the public sector health system in providing health services to the population are well documented. The inability of the public health sector has forced poor and deprived sections of the population to seek health services from the private sector. Evidence indicates that, in many parts of India, the private sector provides a large volume of health services. The private sector is the most potent and untapped sector. To address the inequity in the health system, many state governments have undertaken health sector reforms. One of these reforms has been to collaborate with the private sector through Public-Private Partnership (PPP). State governments in India are experimenting with partnerships with the private sector to reach the poor and underserved sections of the population.

Collaboration with the private sector to provide health services to the poor has generated many challenges. These include the motives of the private sector, scope and objectives of partnership, policy and legal frameworks, benefits of such partnerships, technical and managerial capacity of governments and private agencies to manage and monitor such partnerships, incentives for the private sector, stake holders' perspectives towards partnership, and explicit benefits to the poor through such partnerships.

12.2 Key points for Public-Private Partnership

1. First, it is essential to conduct detailed survey of what the public exactly needs.

2. To run PPP projects, a balance must be struck between “gain’ and “loss” by determining the value of efforts.
3. Gaining the public's trust and support is also of significant importance.
4. Behavioral changes among users often influence the success of PPP projects.
5. It is important to establish a comprehensive set of legal frameworks that govern the running of PPP projects.
6. Since the impact of healthcare projects is often major and sometimes life-threatening, operational risks must be minimized as far as possible.
7. Mutual trust and respect and constant flow of funds are essential.
8. Realistic approach by the government on expectations from private partners. Government must analyze their own cost in treating different categories of patients before fixing rates for the private sector as the present fee structure is pretty low.

12.3 NGO Involvement

From mid-sixties, the government has envisaged a major role for NGOs in the health sector. Most of the plan documents clearly mention the important role that NGOs have to play in all aspects of health care, especially for the underprivileged population and remote areas. Since health is a state responsibility in India, this concern of the Central Government is not very often shared in all the state governments. Consequently, there has been an uneven partnership between the government and the NGOs, depending on the political leaning of the respective state governments.

The other major problem has been that of inadequate involvement of NGOs in health planning. Consequently, governments look for NGOs to participate in the final phase of implementation of programs, the content of which may not be close to the NGO perspective of the problem. These lead to a situation where a large number of sensitive

NGOs do not take part in major government programs, but a large number of NGOs who are coined as GONGOs (government NGOs) jump into the band-wagon of all government programs just for their own financial survival. They operate more like sub-contractors than sensitive representatives of a civil society.

The other problem in this partnership has been the mismatch between the grassroots needs and the government agenda. Very often, an NGO working at the grassroots with the community perceives communicable diseases and reproductive health as a major problem, whereas the government enthusiastically supports proposals that are target-oriented, pre-conceived and may not have anything to do with the local realities. The partnership is further complicated by the unequal nature of relationships and the red-tape involved in getting programs sanctioned and the budget released from the government.

These problems have been discussed in various forums between government representatives and NGOs for the last decade leading to some improvement in the collaborative relationship but lot needs to be done. Some fairly good examples of this could be cited in the areas of immunization, HIV/AIDS related work as well as newly formulated government programs on reproduction and child health. As stated above, however, these dialogues have been mostly at the level of central government and the concerns shared in these dialogues have yet to filter down to many of the States.

13. Governance in Health Care

- Drawing up legislation in a sector like health is complex and requires an understanding of the incentives or disincentives such legislation may have on human behaviour. For example, if the legislation is too inflexible and specific, as envisaged in the recently introduced clinical establishment bill, putting all risks

on the provider, then it may result in mindless litigation, increasing defensive medicine and higher costs for the patient, endanger the patient-doctor relationship which should be based on trust and entail harassment and outright corruption at the hands of the bureaucracy. On the other hand, if it is too considerate to provider concerns, the patient may end up getting shortchanged. Besides, it is the methodology of enforcement of the laws that is more important. In other countries, inspectors and assessors sent to evaluate provider facilities for accreditation or licensing are trained, so that at all times the focus is on achieving the objective of increasing awareness and creating a sense of accountability among providers regarding the quality of patient care, and not the blind and mindless application of a standard or a rule. Thus, supervision requires to be supportive, not prescriptive or fault-finding, as the objective is not to drive away the providers but to persuade and convince them of the need to adhere to quality and patient safety. This calls for a different mindset to be cultivated through intensive training programmes and performance monitoring systems. Supportive supervision is a new skill that needs to be nurtured in the government sector. This applies very much to the newly introduced CEA, giving wide scope for the inspecting authorities to use their own discretion. Here IMA shall be invited to form the guidelines and be a part of the inspecting team at all levels.

➤ **Quackery**

The key challenge to governance is the enforcement of regulations related to the 'quack' or the unqualified practitioner in the villages. In a setting where the public health system does not function and the private sector is too expensive, it is this quack that enjoys social consent. Rational arguments of quality or harmful practices, lack of qualification, etc. do not matter as, for the people, the quack is able to provide instant relief to a need at affordable cost. How then does the

Government achieve its norms for quality and standards of patient care while allowing this clearly illegal and harmful practice to continue?

➤ **Clinical Establishment (Registration and Regulation) Act 2010**

The working group of Planning commission 11th five year plan had recommended the following on registration and regulation of clinical establishments which have not been reflected in the newly enacted Clinical Establishment (Registration and Regulation) Act 2010 :

1. As far as possible, registration should be done on the basis of documents certified by licensed professionals such as Chartered Accountants, approved valuers, assessors etc. The setting up of administrative paraphernalia for inspection is to be discouraged.
2. To the maximum extent possible, the responsibility of actual registration should be entrusted to Panchayati Raj Institutions (PRIs). There is already a multiplicity of licensing/inspector authorities under various health related legislations. These are, therefore, required to be consolidated.
3. Due care would have to be taken to avoid over emphasis on standards for infrastructure. Otherwise investments required to comply with standards might have a spiraling effect on service costs in the health sector. Greater focus would, therefore, be required on standards for service delivery.

The law in its present format is unacceptable to the medical profession of the country. It is admitted that registration of the clinical establishments is necessary for various reasons. However the regulation aspect of it has serious flaws. License raj imposed on healthcare institutions will lead onto disappearance of

single doctor practitioners, corporatization of health care and promote corruption and nepotism. IMA is apprehensive of large scale harassment of private sector, the major recommendations being:

1. IMA supports registration and regulation of clinical establishments by an autonomous body which has democratic and representative character.
2. Single doctor establishments should be exempted from the act.
3. The proposed autonomous body should provide single window clearance for all legislations regarding clinical establishments.
4. The clinical establishments act should include provisions for promotion of healthcare institutions. It should be the clinical establishments (Registration and Regulation and Promotion) Act 2010.
5. For emergency care in private sector, government should allocate funds or launch insurance covers for reimbursing the private sector for the benefit of those patients who cannot pay for the cost or expenses of such care, as the government itself admits that 70% of the healthcare delivery is in the private sector.
6. The private sector spends in India is more than double that of the government spends (a trend unique to India) which suggests that it's the absence of government healthcare which forces individuals to spend money out-of-pocket. This hurts people even more and it's estimated that health spends forces 39 million people each year into poverty. The latest figures from the UN suggest that India still accounts for one of every three maternal death. Most of them are due to complications like severe

bleeding after childbirth, infections, high BP during pregnancy and unsafe abortions. As per latest UN figures, India accounts for one-third of deaths of pregnant women, mainly due to complications such as severe bleeding after childbirth, infections, high blood pressure during pregnancy and unsafe abortions. With limited resources, Govt. is unable to cope up with these issues, so private sector involvement is must but it needs encouragement and patronage.

7. IMA shall be included as a co monitoring authority at the Village, Town, Taluk, District, State and National levels in all the committees, to help in easy compliance in all aspects right from registration, inspection, execution and redressal of grievances from both sides. We are the largest body of health care providers in the whole nation and we are dedicated to co operate with the GOI and all State Governments to take proper health care to the people.

14. Learning Lessons from other Countries & Replication of Best Practices

There is much that India can learn from other countries. One country that India has yet to learn from, in our view, is one of its neighbors, Bangladesh. Despite being a very poor country, Bangladesh has achieved great health outcomes by focusing on selected core child-health interventions, including vaccinations, family planning, oral rehydration therapy, and other maternal and child health services. Likewise, India needs to improve its vaccination coverage for children, which is one of the most cost-effective health interventions. As many as a third or more of the country's children still do not receive the full set of immunizations. India has very low coverage with regard to other key health interventions, including oral rehydration therapy and appropriate antibiotic treatment for childhood pneumonia. Bangladesh's success at mobilizing

community efforts and health workers to improve child health offers important lessons for India to address its burden of disease among women and children.

One common lesson from a variety of international experiences is that healthcare reform is a long, ongoing process that requires significant experimentation and innovation to determine what works in one's own country. Healthcare systems are very complex. Not surprisingly, then, countries have achieved universal health coverage through a variety of pathways, and there are many policy variables that can be adjusted and tweaked. India will thus need to experiment with different tools for reforming its healthcare system, including how the central government pays state governments and the incentives on those payments, as well as how state governments can improve the delivery of healthcare services through changing payment systems, improving regulation and accreditation of facilities, increasing autonomy in public facilities, and using demand-side incentives such as cash transfers or insurance to stimulate the supply of services. This is just a short list of the various tools that can be deployed. Both NRHM and RSBY each have many moving parts and components. State governments will need to take the lead with support from the central government to find out what works for them. While much of India's population suffers from illness and disease associated with high rates of poverty, such as fatal diarrhea, TB, and malnutrition, the country has an increasing rate of non communicable diseases associated with a growing middle class. How then is the Indian health system set up to deal with this dual challenge?

India today faces this dual burden of infectious disease and chronic disease. While both public and private facilities can support the treatment of these diseases, their prevention is a priority for the government. NRHM has several components focusing mainly on infectious diseases, but with much less emphasis, if any, on the prevention of chronic diseases. RSBY is one initiative to support the treatment of certain chronic diseases, but not their prevention.

In IMA's view, the prevention and public-health functions have been somewhat neglected by the government and somewhat crowded out by a focus on and financing for clinical and facility-based care. Education on improved hygiene, hand-washing, and sanitation, for example, is a severely neglected area in the country. Vaccinations are also a key neglected area, as mentioned earlier. History has shown that the burden of infectious disease will not go down by treatment alone; prevention through government actions is critical. The same could also be said of chronic disease. Yet we know that current government policies, both nationally and at the state level, have varied greatly in their success in controlling infectious diseases. Again, states need to experiment and figure out what works best for them.

15. Millennium Development Goals on Healthcare Delivery

The Millennium Development Goals (MDGs) are a set of eight international development goals that were officially established following the Millennium Summit of the United Nations in 2000, following the adoption of the United Nations Millennium Declaration. All 193 United Nations member states and at least 23 international organizations have agreed to achieve these goals by the year 2015.

The goals are:

1. Eradicating extreme poverty and hunger
2. Achieving universal primary education
3. Promoting gender equality and empowering women
4. Reducing child mortality rates
5. Improving maternal health
6. Combating HIV/AIDS/ Malaria/ Tuberculosis, and other containable diseases
7. Ensuring environmental sustainability, and
8. Developing a global partnership for development

Each of the goals has specific stated targets and dates for achieving those targets. To accelerate progress, the G8 Finance Ministers agreed in June 2005 to provide enough funds to the World Bank, the International Monetary Fund (IMF), and the African Development Bank (AFDB) to cancel an additional \$40 to \$55 billion in debt owed by

members of the Heavily Indebted Poor Countries (HIPC) to allow impoverished countries to re- channel the resources saved from the forgiven debt to social programs for improving health and education and for alleviating poverty.

Debate has surrounded adoption of the MDGs, focusing on lack of analysis and justification behind the chosen objectives, the difficulty or lack of measurements for some of the goals, and uneven progress towards reaching the goals, among other criticisms. Although developed countries' aid for achieving the MDGs has been rising over recent years, more than half the aid is towards debt relief owed by poor countries, with much of the remaining aid money going towards natural disaster relief and military aid which do not further development. To achieve the MDGs goals both public and private sectors have to work together.

By and Large, Private sector is reaching 70% of the population due to easy accessibility, timely delivery, maintenance of confidentiality, etc. Sadly the GoI & many of the State Governments do not realize the fact that too many rules, regulations and retrogressive laws are scaring and holding back the medical professionals from whole heartedly responding to the challenge.

Notwithstanding all the negative rules and restrictions which the medical personnel face, we, in IMA, are ready to take up the challenge to improve the health care needs of both the urban and rural India, extending fullest cooperation to the Governments at the National and the State levels in achieving affordable, accessible health care for one and all of our great nation.

JAI HIND!



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