The Road to Universal Health Coverage In India

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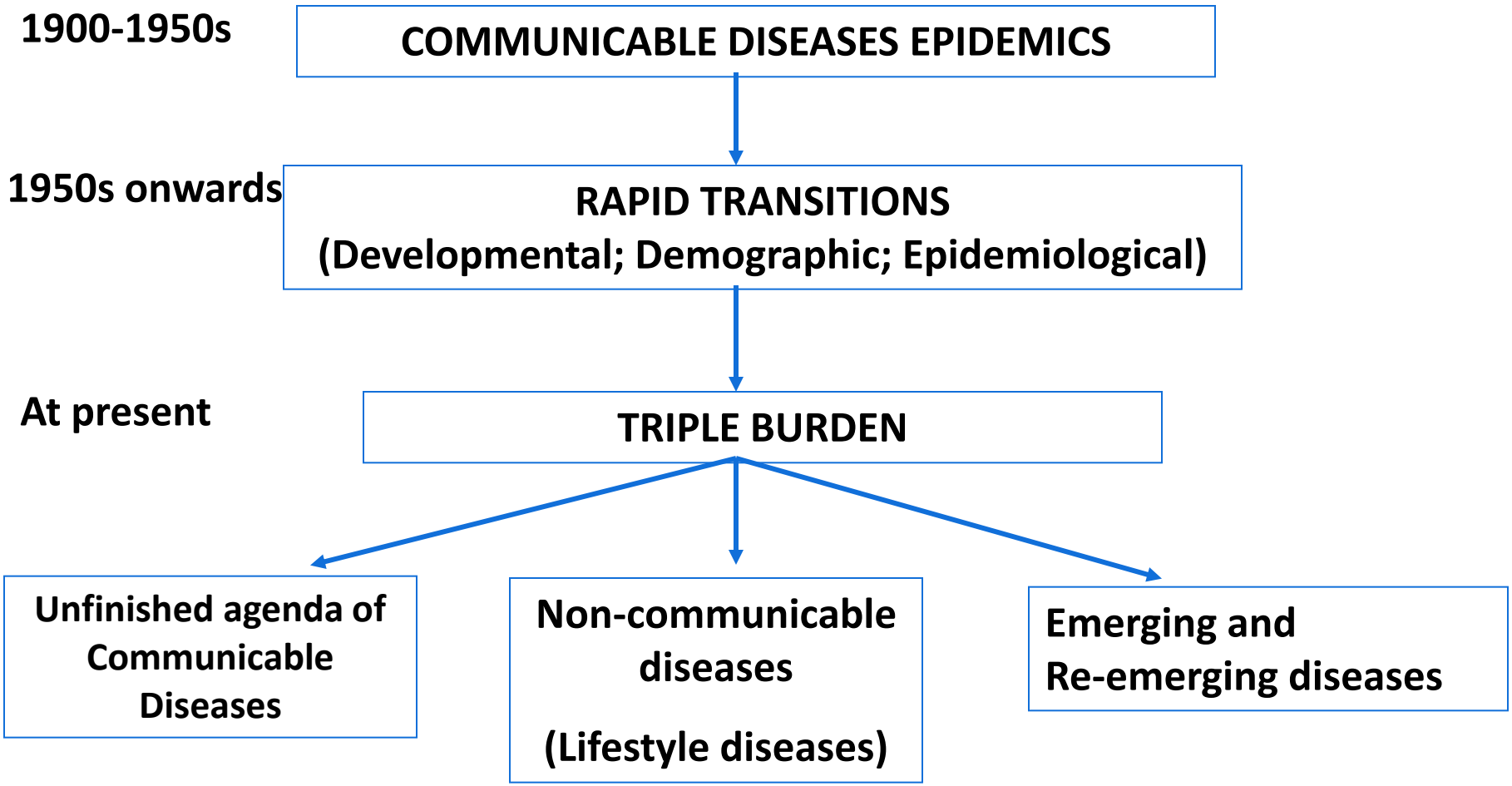
INDIA IN 2012: MULTIPLE TRANSITIONS

• Social	• Nutrition
• Economic	• Demographic
• Political	• Epidemiologic
• Governance	• Health System
• Managerial	• Technological

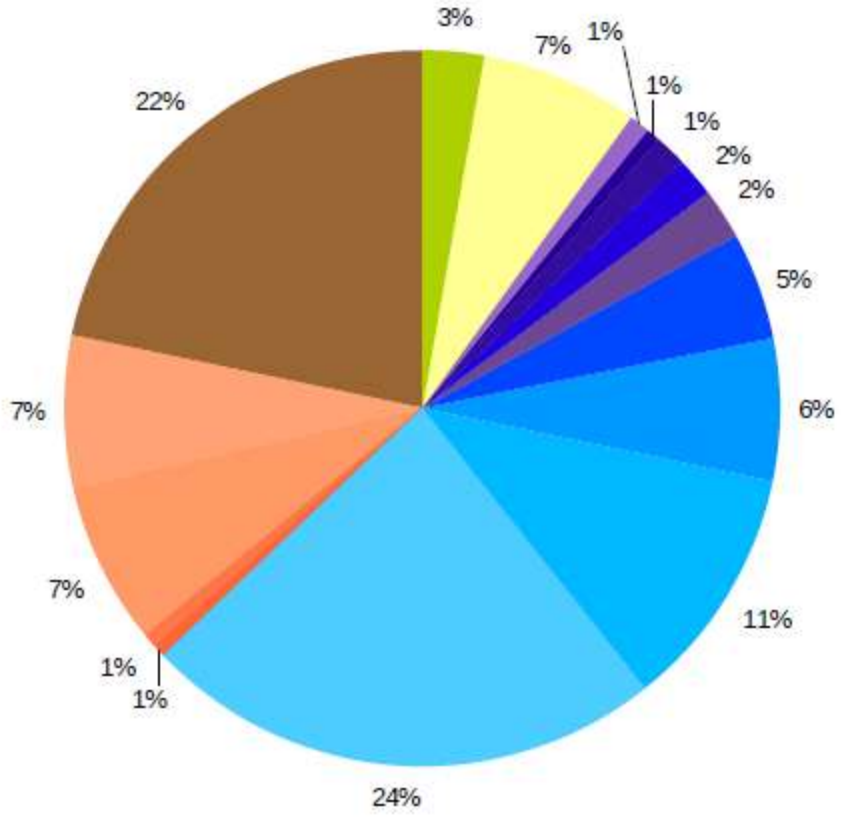
HEALTH TRANSITION

MULTIPLE DISEASE BURDENS



Disease Burden in India, 2008

(Estimated number of death by causes)



- Infectious and parasitic diseases
- Respiratory infections
- Perinatal conditions (h)
- Maternal conditions
- Nutritional deficiencies
- Cardiovascular diseases
- Respiratory diseases
- Malignant Cancer
- Digestive diseases
- Genitourinary diseases
- Diabetes mellitus
- Neuropsychiatric conditions
- Congenital anomalies
- Others
- Unintentional injuries
- Intentional injuries

Communicable Diseases (37%)
Non Communicable Diseases (53%)
Injuries (10%)

Source: Mortality And Burden Of Disease Estimates For Who Member States in 2008

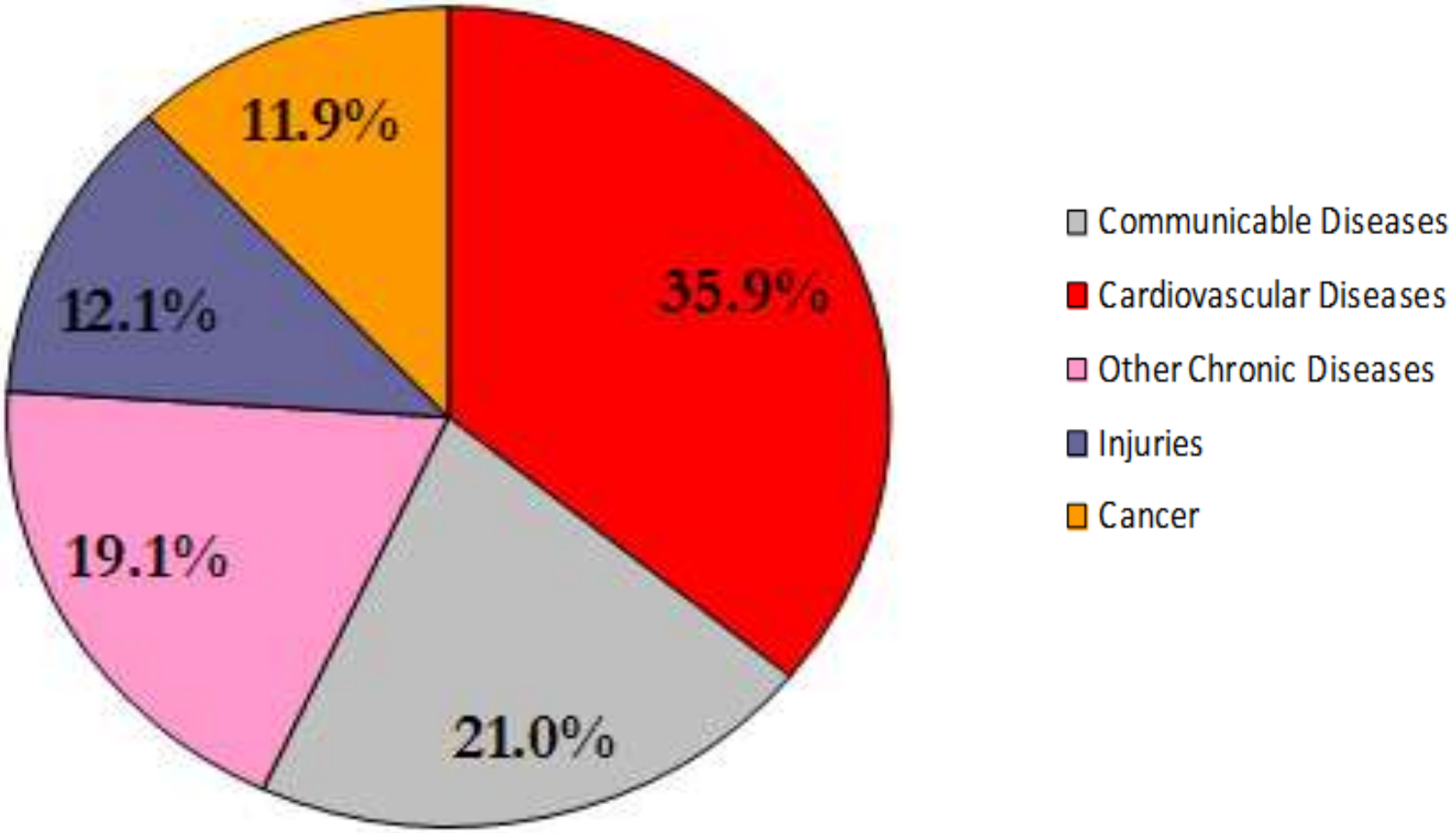
India's Current Health Scenario

- **Largest number of underweight children (42% under 5 yrs);**
- **Current infant mortality rate of 47 per 1000 live births;**
- **Maternal mortality ratio presently 212 per 100 000 live births;**
- **Challenge to meet national goals of 27 per 1000 (IMR) or 100 per 100 000 (MMR) by 2017**
- **Rising burden of Non-Communicable Diseases**

	2011 (in Millions)	2030 (in Millions)
Diabetes	61	101
Hypertension	130	240
Tobacco Deaths	1+	2+
PPYLL Due to CVD Deaths (35-64 Yrs)*	9.2 (2000)	17.9

*Potentially Productive Years of Life Lost Due To Cardiovascular Deaths Occurring in The Age Group of 35-64 Years

Main Causes of death in India
Projected : 2030



Source: WHO Infobase

The Global Path to Universal Health Coverage

INDIA, 2012

South Africa, 2011/12

Philippines, 1995; Taiwan, 1995; Thailand,2002; Vietnam, 2009

Mexico, 2001

Rwanda, 2003;

Spain, 1986; Brazil, 1988; Columbia, 1993

Ghana, 2004

Australia, 1975, Italy 1978

South Korea; 1989

NHIF, Kenya, 1966

Canada, 1966

Scandinavia: Norway, 1912; Sweden, 1955; Denmark, 1973;

Chile, 1952

UK, 1948 (NHS)

Sri Lanka, 1950

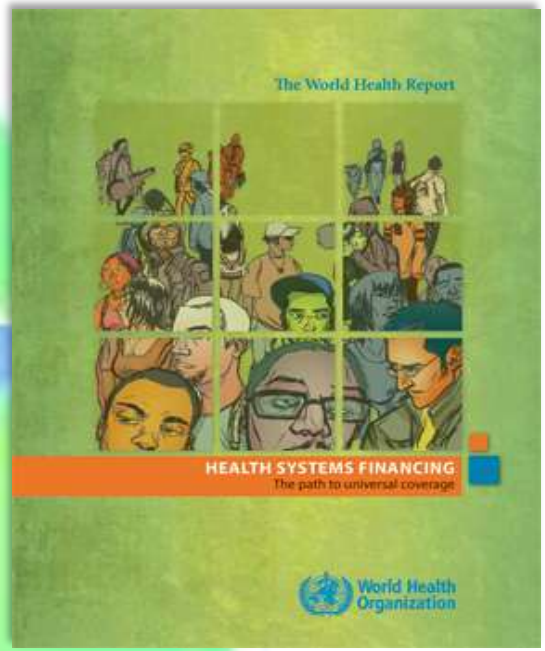
Germany, 1941

New Zealand, 1938

Japan, 1938

Bismarck Model 1883

Beveridge Model, 1942



Global Health: Three Overarching Needs

- **Health financing schemes that cover the costs of care without putting health consumers, governments, or providers at risk of bankruptcy or severe economic hardship**
- **Systems of health-care delivery that can absorb the many now-fragmented services and provide accessible treatment and prevention universally to those in need**
- **A health-care workforce worldwide that should be at a minimum five million persons larger than it is currently, that displays a deeper range of skills, and that features greater attention to health management and community-based caregivers**

- Laurie Garrett, CFR Report on UHC, 2012

Mexico To Have Universal Healthcare By Year's End: Minister

MEXICO CITY, Nov. 4 (Xinhua) - All Mexicans will have access to healthcare by December, more than six months ahead of the schedule, Health Minister Salomon Chertorivski told Xinhua Friday.

By the year's end, "every single Mexican will have access to medical care, and more than 106 million Mexicans will be receiving health care through public financing," he said.

Chertorivski said the government is investing over 3.5 percent of the GDP, or 32 billion U.S. dollars, in the public health sector in the fiscal year 2011, of which 30 percent is used exclusively for medicines given free of charge.

KEY HEALTH INDICATORS: INDIA COMPARED WITH OTHER COUNTRIES

Indicator	India	China	Brazil	Sri Lanka	Thailand
IMR/1000 live-births	50	17	17	13	12
Under-5 mortality/ 1000 live- births	66	19	21	16	13
Fully immunised (%)	66	95	99	99	98
Birth by skilled attendants	47	96	98	97	99

Source: World Health Organization (2011) IMR – Infant Mortality Rate

WORLD

THE CHINDIAN CENTURY

With so many of the world's economies in tatters, the combined might of China and India could spearhead global growth in the coming decades. Are they up to the job?
By ZOHER ABDOOLCARIM

THE CASE FOR INDIA: FREE TO SUCCEED
By MICHAEL SCHUMAN

TIME : NOVEMBER 21, 2011

CHILD DEATHS : DISPARITY ACROSS STATES

IMR

MP : 72/1000

UP : 69/1000

Tamil Nadu : 35/1000

Kerala : 13/1000

Neonatal Mortality Rate Varies
From 11/1000 in Kerala to 53/1000 in Odisha

Health Inequity Is Reflected Across Multiple Divides:
Urban-Rural; Income; Education; Gender; Caste

A “YOUNG” INDIA : DEMOGRAPHIC DYNAMO FOR DEVELOPMENT?

CONCERNS

- 42 % CHILDREN UNDER 5 ARE ‘UNDERWEIGHT’
- 24-32% OF URBAN ADOLESCENTS ARE OVERWEIGHT OR OBESE

SOLUTION

WE NEED HEALTH AND NUTRITION PROGRAMMES THAT REDUCE BOTH FORMS OF MALNUTRITION

A "YOUNG" INDIA : DEMOGRAPHIC DYNAMO FOR DEVELOPMENT?

CONCERNS

- INDIA HAS 1/3RD OF THE WORLD'S MEASLES DEATHS AND TB PATIENTS

- INDIA TO LOSE USD 237 BILLION DUE TO HEART DISEASE, DIABETES AND STROKE (DURING 2006-2015)

SOLUTION

WE NEED A HEALTH CARE SYSTEM THAT CAN TACKLE : DISEASES OF UNDERDEVELOPMENT
AND
DISORDERS OF MALADAPTED MODERNITY

WHY IS UNIVERSAL HEALTH SYSTEM REFORM NEEDED?

- **18% of all episodes in rural areas and 10% in urban areas received no health care at all**
- **12% of people living in rural areas and 1% in urban areas had no access to a health facility**
- **28% of rural residents and 20% of urban residents had no funds for health care**
- **Over 40% of hospitalised persons had to borrow money or sell assets to pay for their care**
- **Over 35% of hospitalised persons fell below the poverty line because of hospital expenses**
- **Over 2.2% of the population may be impoverished because of hospital expenses**
- **The majority of the citizens who did not access the health system were from the lowest income quintiles**

NSSO (2006)

LOW PRIORITY TO PUBLIC SPENDING ON HEALTH – INDIA AND COMPARATOR COUNTRIES 2009

	Total public spending as % GDP (fiscal capacity)	Public spending on health as % of total public spending	Public spending on health as % of GDP
India	33.6	4.1	1.2
Sri Lanka	24.5	7.3	1.8
China	22.3	10.3	2.3
Thailand	23.3	14.0	3.3

Source: WHO database, 2009

Low levels of health spending

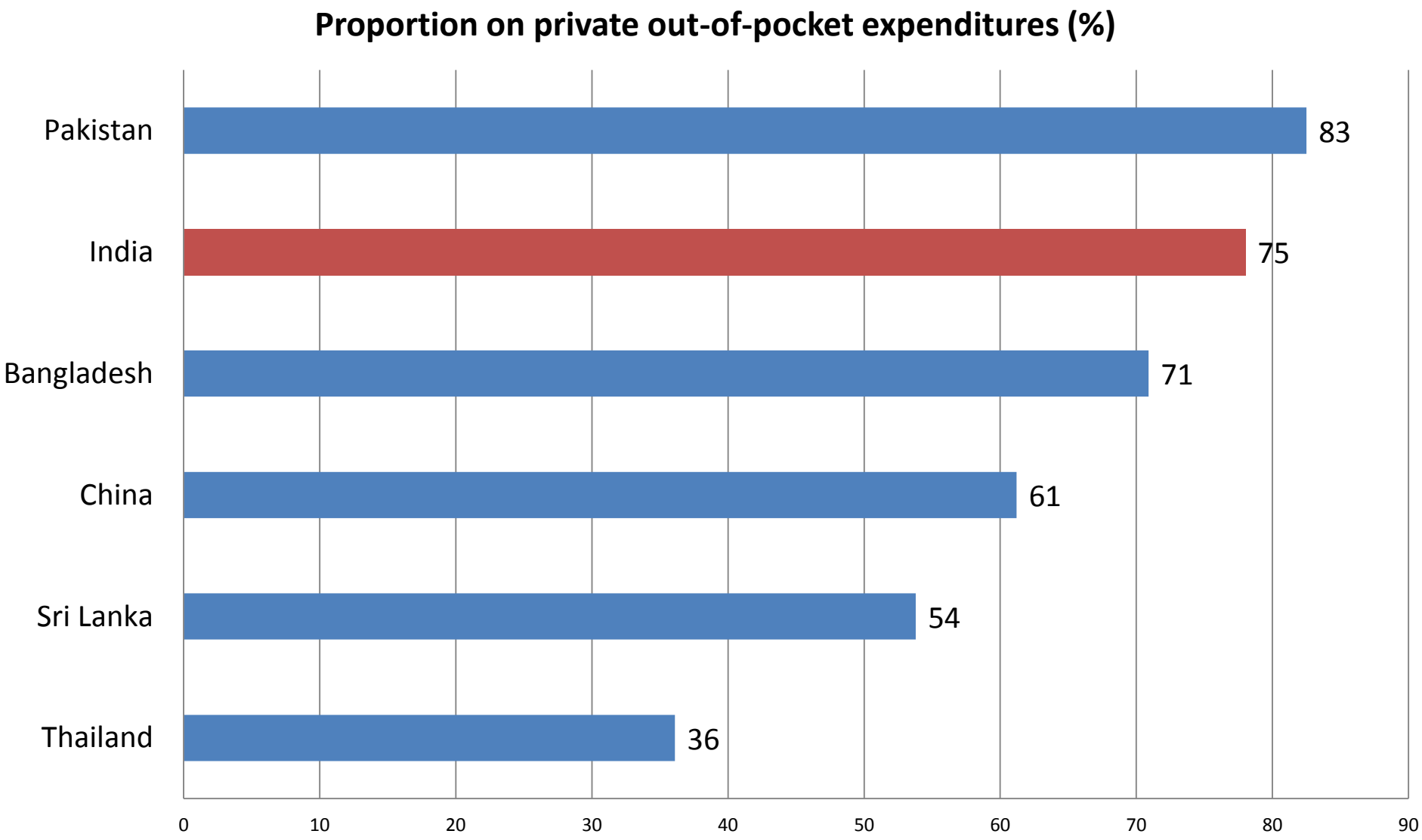
2009	Total expenditure on health as % of GDP	Per capita total expenditure on health (PPP$)
Sri Lanka	4.0	193
India	4.2	132
Thailand	4.3	345
China	4.6	309
Source: WHO database, 2009		

Low levels of public expenditure on health

2009	Public expenditure on health as % of GDP	Per capita public expenditure on health (PPP$)
Sri Lanka	1.8	87
India	1.2	43
Thailand	3.3	261
China	2.3	155

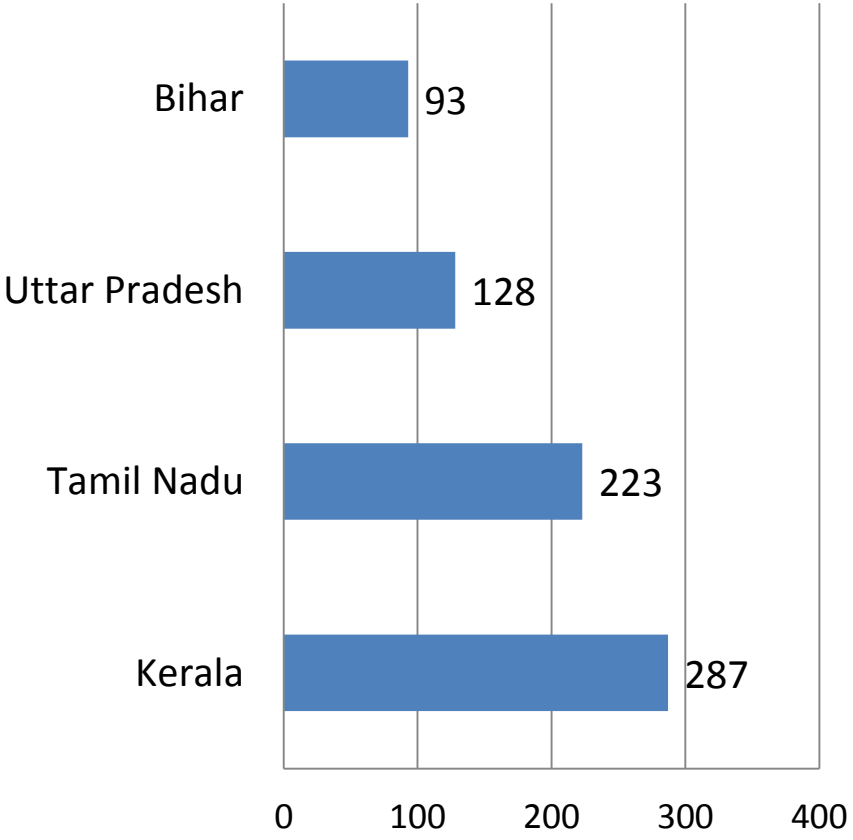
Source: WHO database, 2009

High burden of private out-of-pocket expenditures

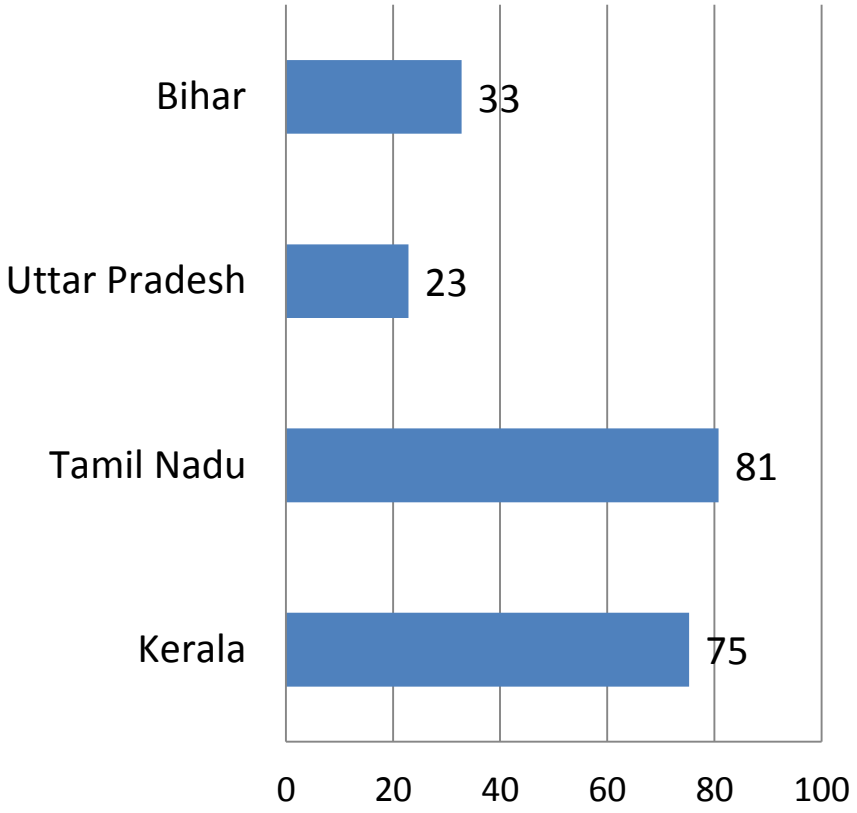


Large inter-state differentials in public spending

Per capita public health spending, 2004-05 (Rupees)

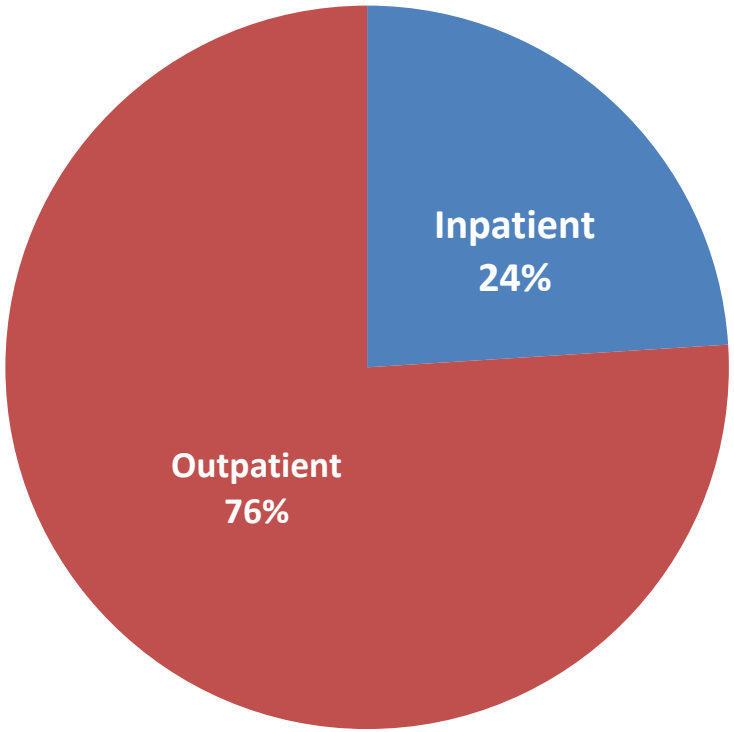


Proportion of children fully immunized (%) 2005-06
Source: NFHS-3

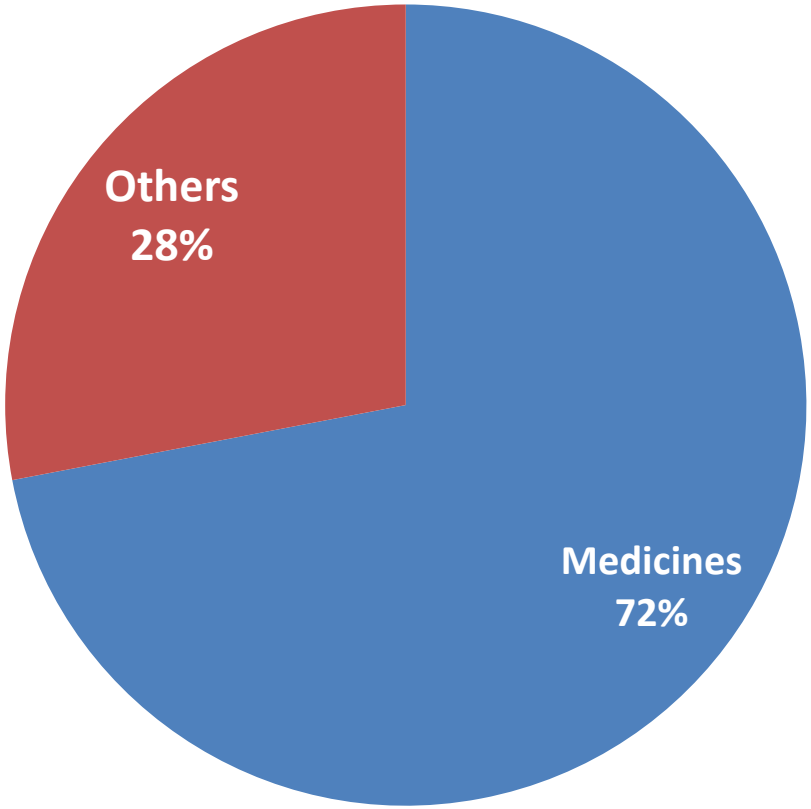


High costs of out-patient and medicine costs

Breakdown of private out-of-pocket expenditures (%)



Medicines and other expenses



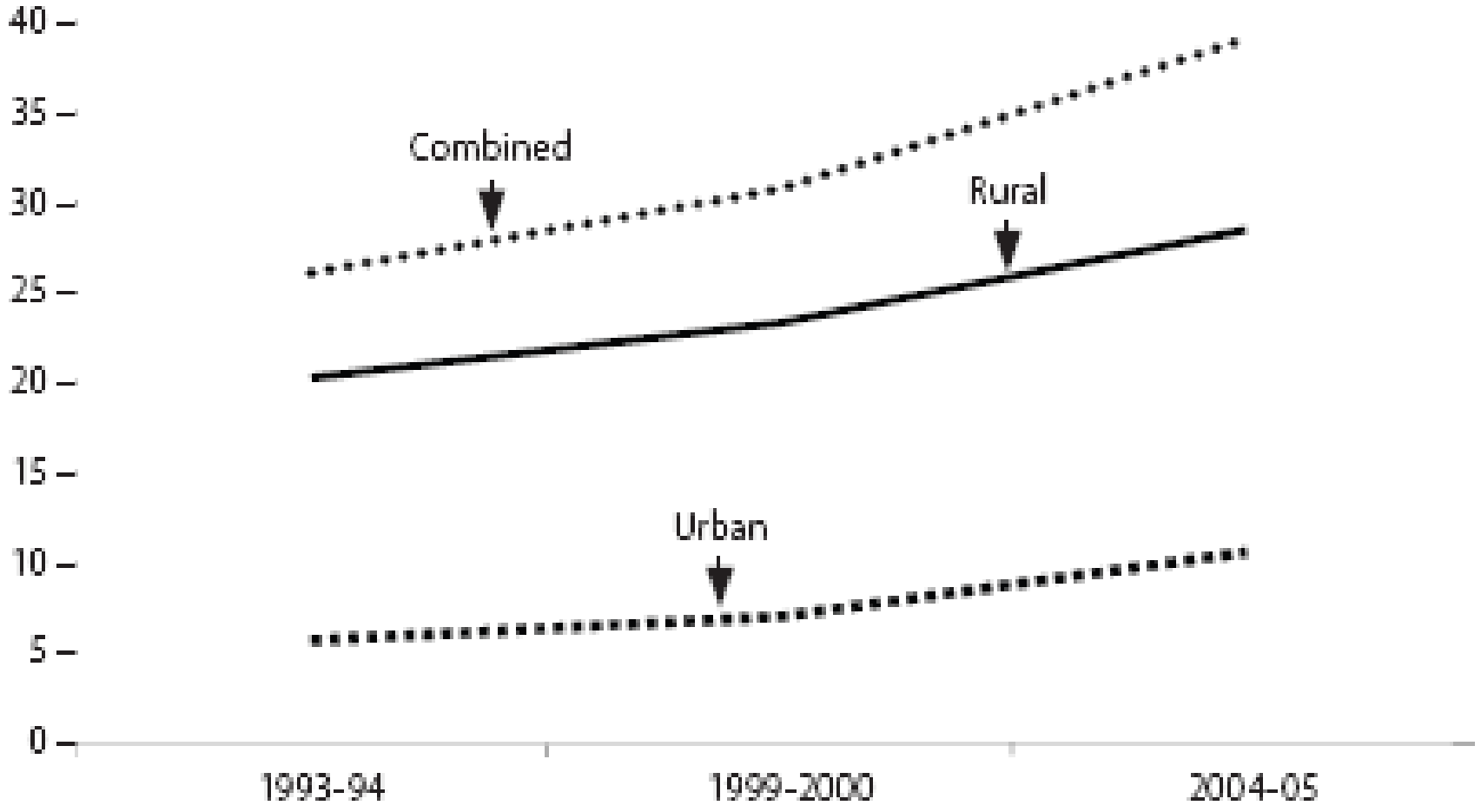
Percentage of Households Spending >10% of HH Expenditure on Health, 2009-10

Quintile Groups	OOP Exp.	Inpatient Exp.	Outpatient Exp.	Drug Exp.	% of Drug to OOP Exp.
Poorest	7.656	1.082	6.329	4.523	**58.44**
2nd Poorest	9.875	1.980	7.394	6.012	**60.71**
Middle	12.237	2.770	8.848	7.392	**61.67**
2nd Richest	16.197	4.496	10.979	9.591	**60.00**
Richest	22.456	7.954	16.207	14.852	**66.15**
All	13.684	3.656	9.951	8.474	**59.54**

Source: Unit Level Records of NSSO

Impoverishment Due to OOP Payments in India

(In Millions)



Source: Selvaraj and Karan EPW (2009)

Population Covered Under Health Insurance
(in Millions)

Scheme	Coverage in 2009-10
Central Government	
Employees State Insurance Scheme	56
Central Government Health Scheme	3
Rashtriya Swasthya Bima Yojana*	70
State Government	
AP (Aarogyasri)	70
TN (Kalaignar)	40
KA (Arogyashri)	1.4
KA (Yeshasvini)	3
Total Government -sponsored	**243**
Commercial Insurers	55
Grand Total (includes others not listed above)	**300**

Note: * Since increased to 150 million persons

Government Financed Insurance Schemes

RSBY (Targeting BPL)
Weaknesses

- Only Covers Hospitalized 2°Care – neglect of preventive and promotive care
- Financial Non-Sustainability - If Utilization Rate is High (e.g., in Kerala)
- Cost-Escalation
- Paradoxical Rise in OOP(!)
- Impact on Health Outcomes Questionable
- Fragmentation of Care (Lack of Continuum of Care)

Government Financed Insurance Schemes

State Level Programmes

- Cover hospitalised 3º care
- High proportion of state health budget diverted for 3º care in private hospitals
- Neglect of 1º care and public facilities
- Dangers of induced demand and inappropriate care

CURRENT SCHEMES FOR FINANCIAL PROTECTION MOSTLY DO NOT COVER

- **OUT PATIENT CARE**
- **DRUGS**
- **LAB DIAGNOSTICS**

Which collectively contribute to the larger fraction of OOP!

Failure of Publicly Financed Health Insurance In Providing Financial Protection

"Poorer sections of households in intervention districts of the Rashtriya Swasthya Bima Yojana, Rajiv Arogyasri of Andhra Pradesh and Tamil Nadu Health Insurance Schemes experienced a rise in real per capita healthcare expenditure , particularly on hospitalisation, and an increase in 'catastrophic headcount' – conclusive proof that RSBY and other state government – based interventions failed to provide financial risk protection''

- Selvaraj S, Karan A.K. EPW, March 17, 2012

TRENDS IN ACCESS TO MEDICINES IN INDIA – 1986-87 TO 2004

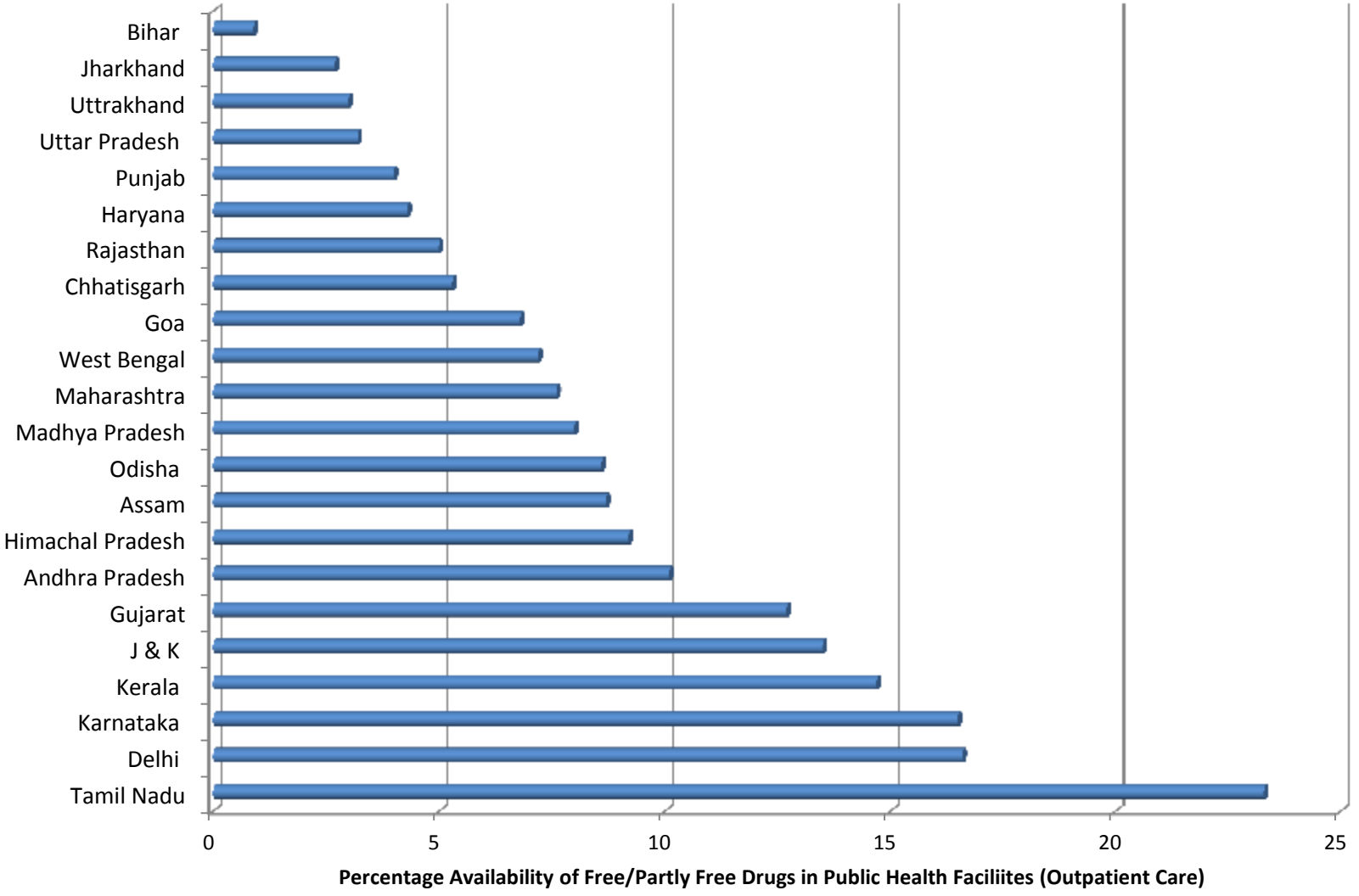
Period	Free Medicines (%)	Partly Free (%)	On Payment (%)	Not Received (%)
In patient				
1986-87	31.20	15.00	40.95	12.85
1995-96	12.29	13.15	67.75	6.80
2004	8.99	16.38	71.79	2.84
Out patient				
1986-87	17.98	4.36	65.55	12.11
1995-96	7.21	2.71	79.32	10.76
2004	5.34	3.38	65.27	26.01

Source: Health data extracted from National Sample Survey Rounds 60, 52, and 42

Government Expenditure on Drugs (% to Overall Govt. Exp)

States	2008-09 (Actuals)	2009-10 (RE)	2010-11 (BE)
Assam	5.7	5.6	5.0
Bihar	6.3	5.9	7.0
Gujarat	6.5	4.9	7.6
Haryana	8.6	6.8	5.5
Kerala	10.6	10.4	12.5
Maharashtra	9.6	5.2	5.2
Madhya Pradesh	9.1	10.1	9.3
Punjab	1.1	1.0	1.0
Rajasthan	3.0	1.9	1.5
Uttar Pradesh	6.9	4.8	5.3
Jharkhand	2.9	2.3	3.4
West Bengal	9.2	6.8	6.8
Andhra Pradesh	7.3	6.8	10.0
Karnataka	8.0	7.2	6.3
Tamil Nadu	11.2	9.3	12.2
Himachal Pradesh	4.5	2.3	1.9
J & K	6.5	5.2	4.3

State-wise Availability of Free/Partly Free Medicines at Government Facilities during 2004



Source: Morbidity & Health Survey, NSS, 2004

Acute Shortages & Chronic Stock-outs: A Study in Contrast (2010)

- The average availability of a basket of essential drugs in Bihar was 43% as against 88% in Tamil Nadu;
- Bihar's health facilities registered an average of 42% stock-outs of drugs with a mean duration of 105 days;
- The proportion of stock-outs for Tamil Nadu stands around 17%, with an average duration of 50 days

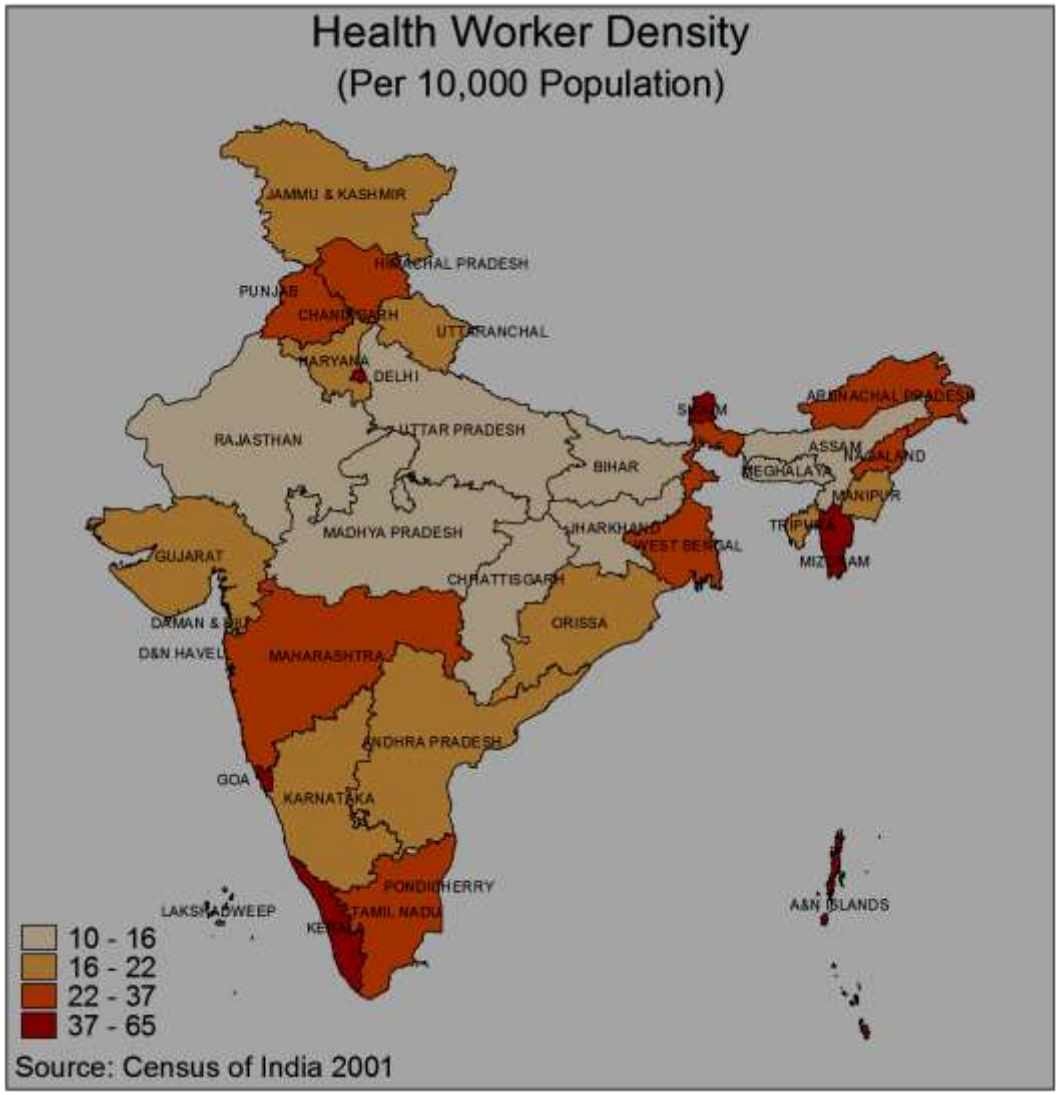
Selvaraj S et al. (2010)

HOSPITAL BED CAPACITY, BY COUNTRY

Country	Beds/ 1000 Population
Sri Lanka	3.1
China	3.0
Thailand	2.2
Brazil	2.4
USA	3.1
UK	3.9
India	**0.9**
Nicaragua	0.9
Togo	0.9
Indonesia	0.6

Source: World Health Statistics (2011)

HEALTH WORKER DENSITY ACROSS MAJOR STATES OF INDIA



Source: Rao, Krishna D., Bhatnagar, A., Berman, P., Saran, I., Raha, S. India's Health Workforce: Size, Composition and Distribution. Technical Report No.1. Public Health Foundation of India and World Bank. New Delhi 2009 (unpublished report). Based on Census of India 2001.

HEALTH SERVICES : URBAN RURAL DISPARITY

- 80% of Doctors
- 75% of Dispensaries
- 60% of Hospitals

Are Located In
Urban Areas

- Qualified Physicians:

11.3/10,000 - Urban Areas
1.9/10,000 – Rural areas

Universal Health Care Vision

Universal Health Entitlement for every citizen - to a **National Health Package** (NHP) of **essential** primary, secondary & tertiary health care services that will funded by the government.

However, historical underfunding in health, weak health systems and capacities have been the key barriers in achieving it

Members of the High Level Expert Group on Universal Health Coverage

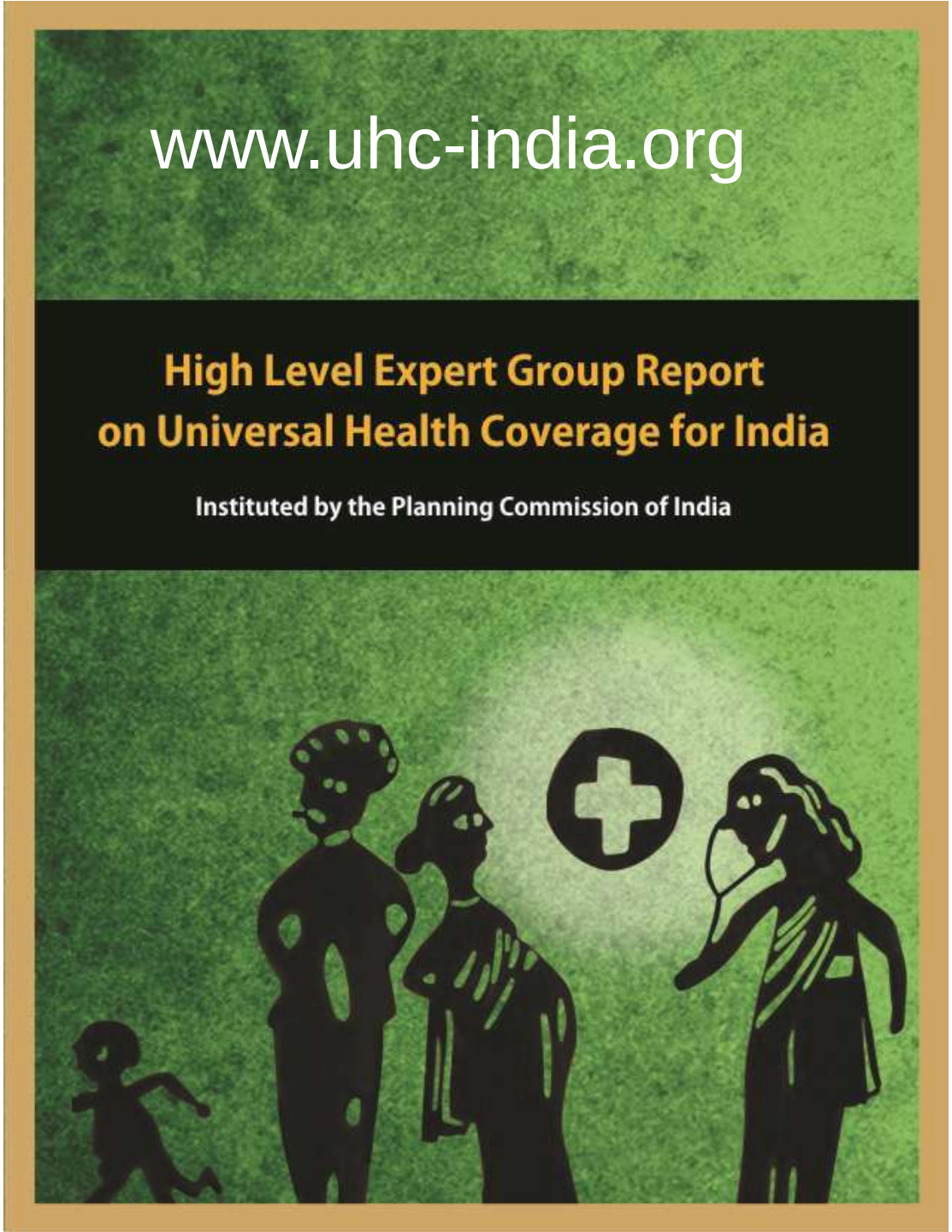
- Abhay Bang
- Anu Garg
- A.K. Shiva Kumar
- Amarjeet Sinha
- Gita Sen
- Jashodhara Dasgupta
- K. Srinath Reddy (Chair)
- Leila Caleb Varkey
- Mirai Chatterjee
- M. Govinda Rao
- N.K. Sethi (Convenor)
- Nachiket Mor
- P.K. Pradhan
- Vinod Paul
- Yogesh Jain

Supported By
Public Health Foundation of India
(Designated As Technical Secretariat)

CONSTITUTED

IN

OCTOBER 2010



REPORT

IN

NOVEMBER 2011

Policy Process:
Developing UHC recommendations

A NATIONAL MANDATE

Oct 2010: the Planning Commission of India constituted an Expert Group on Universal Health Coverage (UHC) TO *review the experience of India's health sector and suggest a national reform strategy*

The Expert Group recognized the need for accompanying action on **social determinants of health**

TERMS OF REFERENCE

1. Optimizing **human resources** for health
2. Defining norms of **access to health services**
3. Planning **management reforms** in health delivery
4. **Community participation** for health
5. Enhancing access to **essential drugs** and vaccines
6. **Health financing** and financial protection
7. **Social determinants of health**

Our Definition of UHC

"Ensuring equitable access for all Indian citizens resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) as well as public health services addressing wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services."

UNIVERSAL HEALTH COVERAGE BY 2022: THE VISION

ENTITLEMENT	NATIONAL HEALTH PACKAGE	INTEGRATED HEALTH CARE DELIVERY

• Universal health entitlement to every citizen	• Guaranteed access to an essential health package (including cashless in-patient and out-patient care free-of-cost)
	  • Primary care
	  • Secondary care
	  • Tertiary care
		• People free to choose between
		  • Public sector facilities and
		  • Contracted-in private providers

How to finance UHC?

Three Objectives:

- ensure **sufficient financial resources** for the provision of **essential health care** to all
- ensure **financial protection** and health security against impoverishment
- put in place **financing mechanisms** that are consistent with **improved wellbeing** as well as **containment of health care cost inflation**.

Recommendation 1

Government (Central government and states combined) should increase public expenditures on health from

the current level of **1.2%** of GDP

to at least

2.5% by the end of the 12th plan, and

to at least **3%** of GDP in the 13th Plan

The Cost of Universal Health Care in India: A Model Based Estimate

"We estimate that the cost of universal health care delivery through the existing mix of public and private health institutions would be INR 1713 (USD 38,95% CI USD 18-73) per person per annum in India. This cost would be 24% higher, if branded drugs are used. Extrapolation of these costs to entire country that Indian government needs to spend 3.8% (2.1% - 6.8%) of the GDP for universalising health care services."

Prija S et al. PLoS ONE 2012; 7:e30362

Recommendation 2

- **Use general taxation as the principal source of health care financing complemented by**

  additional mandatory deductions from salaried individuals and tax payers

  either

  - **–as a proportion of taxable income**

    or

  - **–as a proportion of salary**

- **Avoid insurance schemes, as they fragment health care, do not provide full coverage of needed services and fail to cover the whole population**

"Empirical evidence indicates that a free market for insurance cannot achieve social equity and that serious market failures allow insurers to practice risk selection, leaving the most vulnerable people uninsured. Adverse selection among insurance buyers impairs the functions of the insurance market and deters the pooling of health risks widely. Moreover, the insurance market's high transaction costs yield highly inefficient results. On the other hand, evidence indicates that reliance on market competition for the provision of health care may hold potential for more efficient and higher quality care."

- William (Bill) Hsiao, Health Affairs (2007)

Recommendation 3

Do not levy fees of any kind for use of health care services under the UHC

Evidence suggests that user fees have increased inequalities in access to healthcare

- **negative impacts on the usage of health services even from those that need them.**
- **Not an effective source of resource mobilization.**
- **Challenges of means-testing and errors of inclusion and exclusion**
- **Out-of-pocket payment at the point of care is the most important reason why healthcare expenses turn catastrophic for all healthcare users.**

"User Fees for health care were put forward as a way to recover costs and discourage the excessive use of health services and the over-consumption of care. This did not happen. Instead, user fees punished the poor."

-Dr. Margaret Chan, Director-General, WHO (2009)

"Among the 'quick win' strategies recommended by the Millennium Project was the removal of user fees for primary education and essential healthcare by the end of 2006.

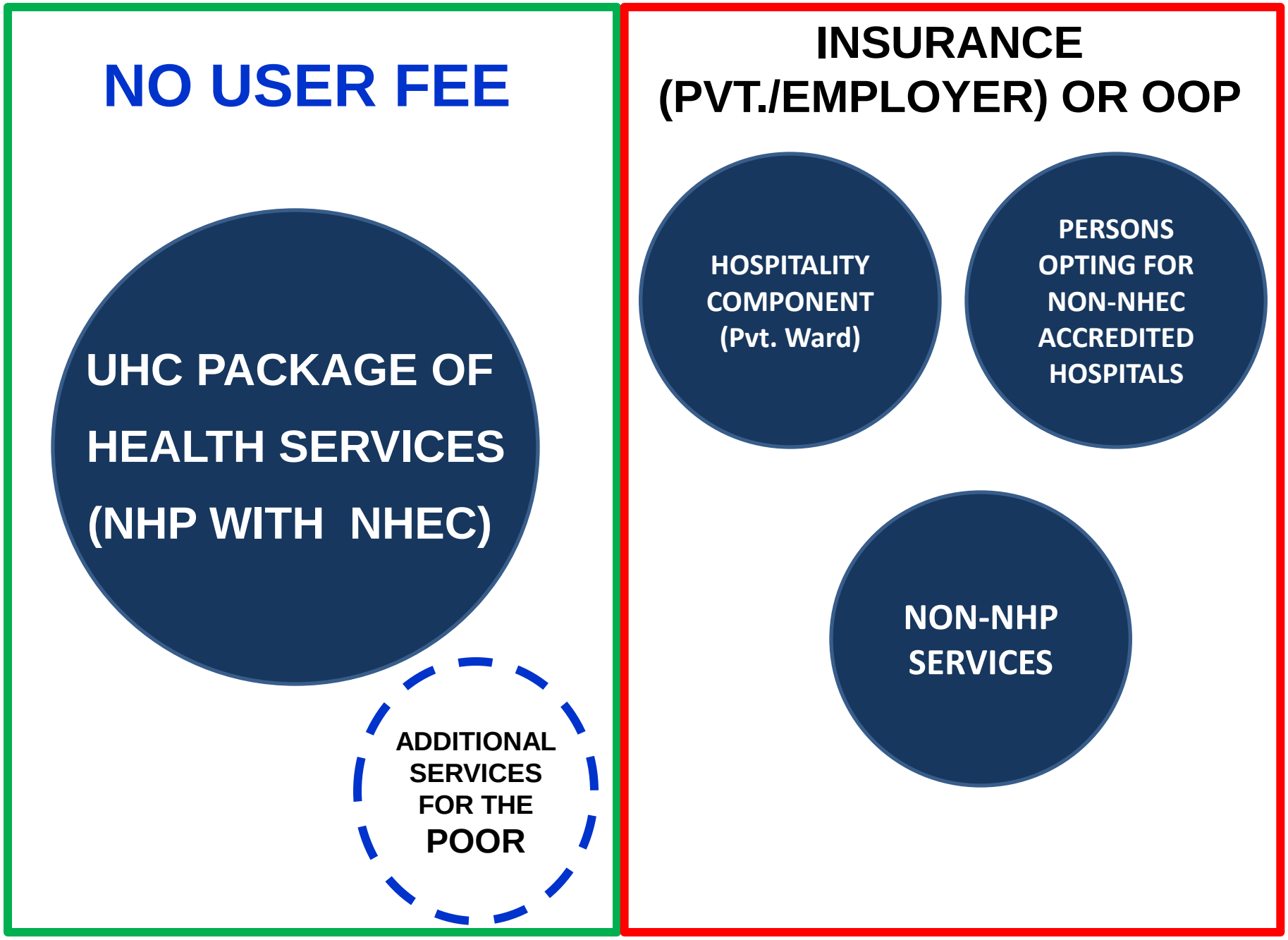
- Dr. Jeffrey Sachs (2005)

Recommendation 4

Expenditures on primary health care , should account for at least 70% of all health care expenditures

and cover

- **general health information and promotion**
- **curative services at the primary level**
- **screening for risk factors at the population level**


NO USER FEE
UHC PACKAGE OF HEALTH SERVICES (NHP WITH NHEC)
ADDITIONAL SERVICES FOR THE POOR
INSURANCE (PVT./EMPLOYER) OR OOP
HOSPITALITY COMPONENT (Pvt. Ward)
PERSONS OPTING FOR NON-NHEC ACCREDITED HOSPITALS
NON-NHP SERVICES

PROVISION OF HEALTH CARE

- **Strengthen Public Services**
  (*Especially*: Primary HealthCare-Rural And Urban; District Hospitals)
- **Contract Private Providers**
  (As Per Need And Availability) – With Defined Deliverables
- **Integrate 1^0, 2^0, 3^0 Care Through Networks of Providers**
  (Public; Private; Public-Private)

Regulate and Monitor For Quality, Cost And Health Outcomes

Recommendation 5

Ensure availability of free essential medicines by increasing public spending on drug procurement.

increase in the public procurement of medicines from around 0.1% to around 0.5% of GDP

Streamline and Centralise procurement like in Tamil Nadu

Key Characteristics of Reliable & Efficient Medicine Supply Systems

- **At least 15% allocation of public funding for health to drugs;**
- **State must procure all EDL medicines;**
- **Separate AYUSH EDL and centralised procurement at state level;**
- **Prescription & Dispensing in accordance with Standard Treatment Guidelines (STG);**
- **A two-bid open transparent tendering process;**
- **Quality generic drugs ensured;**
- **Warehouses at every district level;**
- **An autonomous procurement agency for drugs, vaccines & diagnostics;**
- **An empanelled laboratory for drug quality testing;**
- **Enactment of Transparency in Tender Act;**
- **Prompt payments**

Drug Quality Control

- Strengthen Centres and States Drugs Control Dept., for effective quality control with adequate human resource, technology & institutions;
- Build a network of drug quality testing laboratories, to be accredited by NABL in each state with periodic renewal;
- Establish blood banks and quality of blood banks ensured;

Human Resources For Health

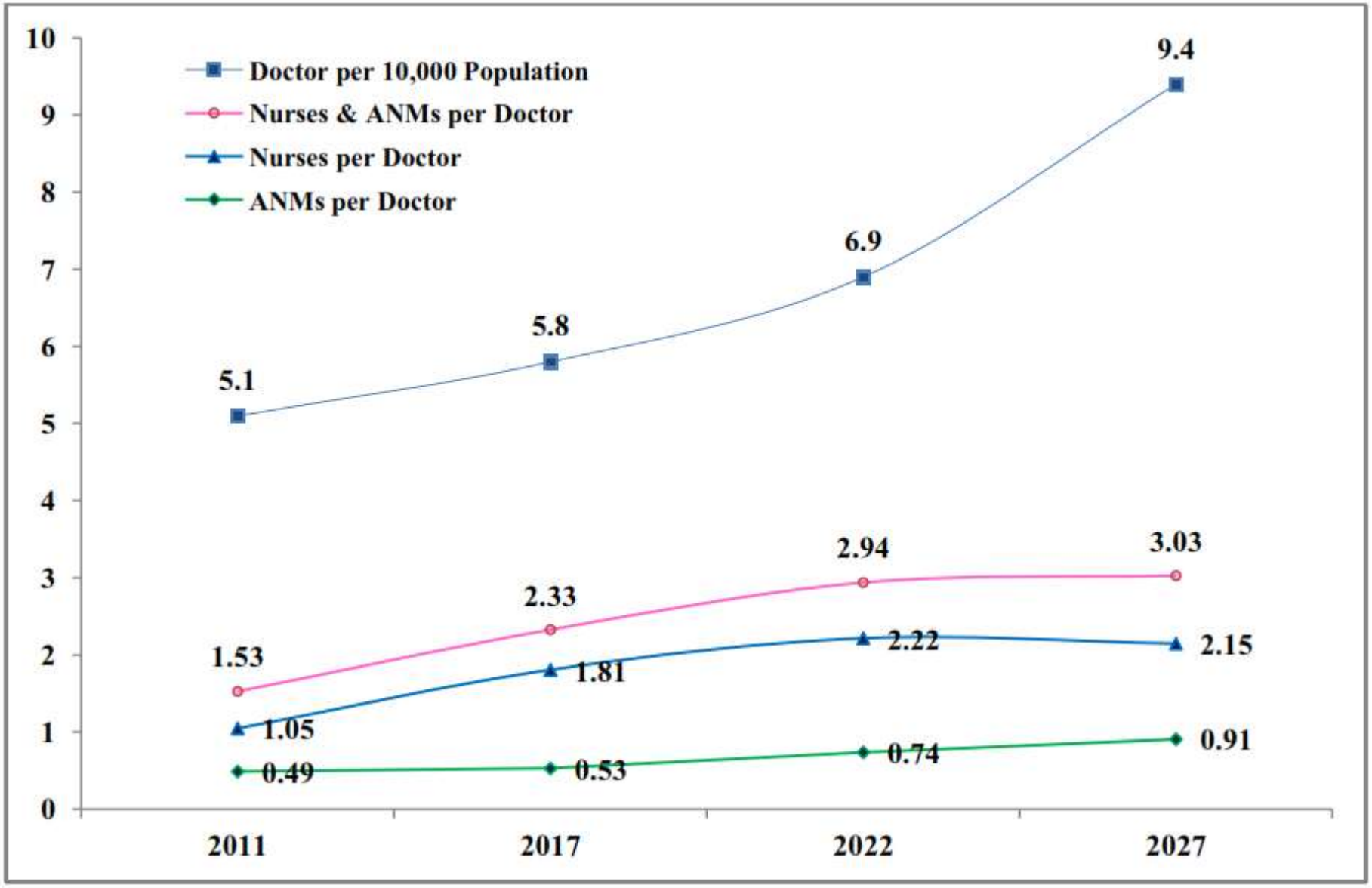
Increase numbers and skills of frontline health workers:

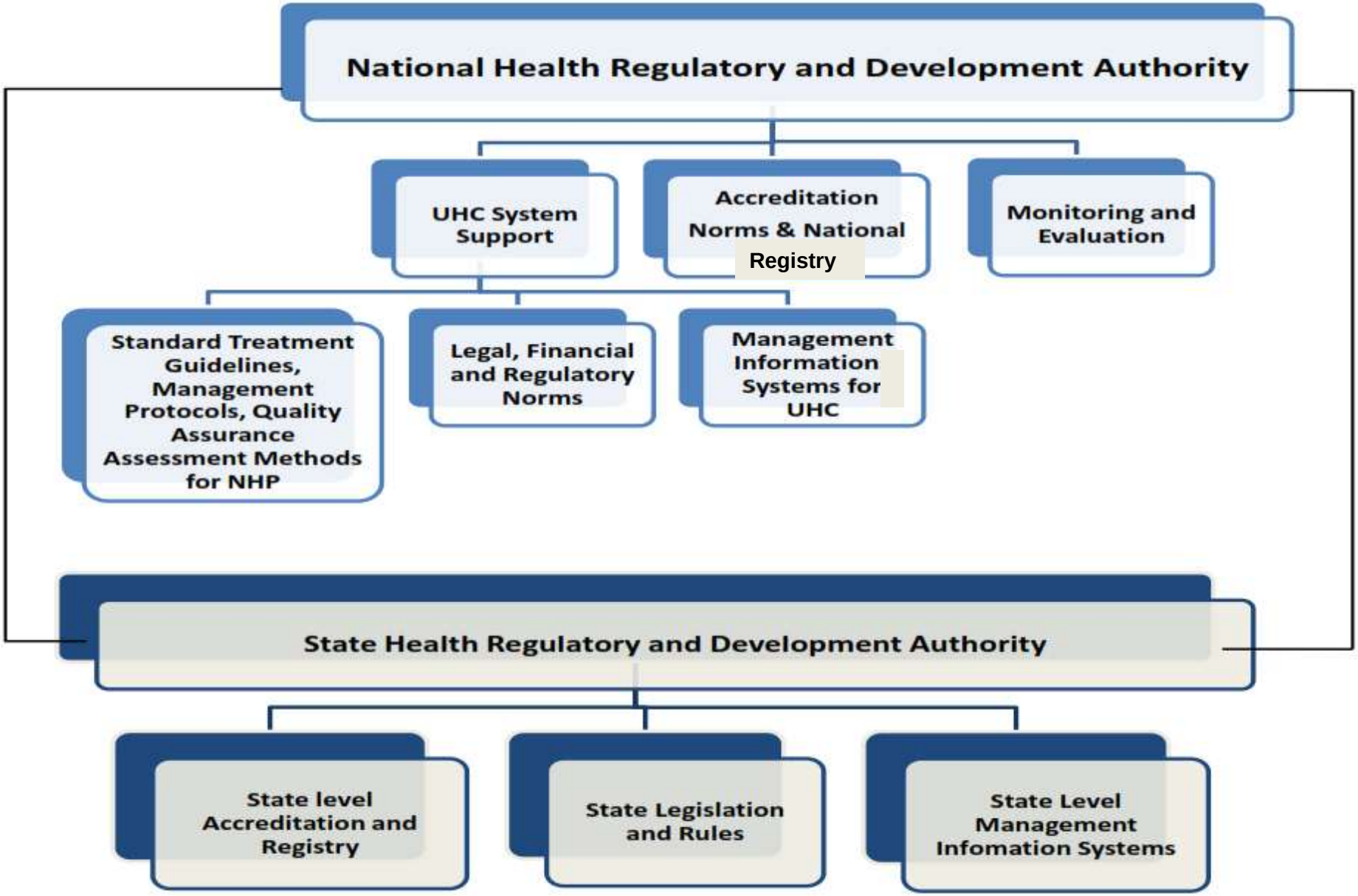
- **Doubling of ASHAs and ANMs;**
- **Male MPW and Mid Level Health Professional (3 year trainee)/AYUSH at Sub-Centre level;**
- **Expand Staff (esp. nurses) at PHC and CHC;**
- **Nurse-Practitioners for Urban Primary Health Care**

Human Resources For Health

- **Establish new medical and nursing colleges in underserved states and districts with linkage to district hospitals; Increase the number of ANM schools**
- **Scale up number and quality of Allied Health Professional training institutions**
- **Establish District Health Knowledge Institutes to coordinate and conduct training of different categories of health workers**
- **Develop Public Health and Health Management Cadres (District, State, National)**

PROJECTED HRH AVAILABILITY (2012-2027)




National Health Regulatory and Development Authority
UHC System Support
Accreditation Norms & National Registry
Monitoring and Evaluation
Standard Treatment Guidelines, Management Protocols, Quality Assurance Assessment Methods for NHP
Legal, Financial and Regulatory Norms
Management Information Systems for UHC
State Health Regulatory and Development Authority
State level Accreditation and Registry
State Legislation and Rules
State Level Management Infomation Systems

COMMUNITY PARTICIPATION AND CITIZEN ENGAGEMENT

- **Transformation of existing Village Health Committees (or Health and Sanitation Committees) into participatory Health Councils;**
- **Organize regular Health Assemblies;**
- **Enhance the role of elected representatives as well as *Panchayati Raj* institutions (in rural areas) and local bodies (in urban areas);**
- **Strengthen the role of civil society and non-governmental organizations.**
- **Institute a formal grievance redressal mechanism at the block level.**

Universal Health Care (UHC) Report's Recommendations on SDH

1. **Initiatives, both public and private, on the social determinants of health and towards greater health equity should be supported**

2. **A dedicated Social Determinants Committee should be set up at district, state and national level**

3. **Include Social Determinants of Health in the mandate of the National Health Promotion and Protection Trust (NHPPT)**
4. **Develop and implement a Comprehensive National Health Equity Surveillance Framework, as recommended by the CSDH**

CHALLENGES TO UHC

POLITICAL

- Center-State relations
- Fiscal space
- Multi-party consensus

ORGANIZATIONAL

- Capacity of Health Ministry & Public Sector
- Human Resources

COMMERCIAL

- Private Insurance
- Big Pharma
- Private health care providers

THE JOURNEY BEGINS (2012)

- **Prime Minister Announces:**
  - **12th Five Year Plan will be 'Health Plan'**
  - **↑ In Public Financing (2.5%)**
  - **Free Provision of Essential Drugs In Public Facilities**
  - **'Cashless and Hassle Free' Out Patient Care**
  - **Public Health Cadre**
  - **Focus on Primary Health Care And Social Determinants**
- **Steering Committee on Health (Planning Commission) : Piloting of UHC**

HLEG's recommendations

(with which MoHFW is in agreement)

- **Scale up public expenditure on Health**
- **Lay emphasis on Primary Healthcare**
- **Strengthen and upgrade District Hospitals**
- **Ensure access to free generic medicines in Government Health Facilities**
- **Expand Human Resources in Health**
- **Emphasize Public Health and its management**
- **Strengthen regulatory systems for Drugs**

Recent Impact of the HLEG UHC Report in the policy space

12th five year plan budget for health

- **The Times of India: September 8, 2012**

Plan panel for 200% rise in health ministry outlay

NEW DELHI: **Good health will be the toast for the UPA's 12th five year plan (2012-17) with the Planning Commission proposing a 200% increase in fund allocation for the ministry of health and family welfare.** The expert group said, "Increasing public health spending to our recommendations will result in a five-fold increase in real per capita health expenditures by the government (from Rs 670 in 2011-12 to Rs 3,432 by 2021-22).“

Access to Medicines

- **The Hindu: Hyderabad, August 1, 2012**
  Free supply of essential drugs through hospitals. The Centre has agreed to facilitate supply of essential drugs through public hospitals free of cost from October 2012 as part of the measures to provide universal health coverage to people.

  - **The Times of India, August 14th , 2012**

  India to increase supply of free generic medicines: Recent reports indicate that the Indian government plans to increase manifold its spending on procurement of generic medicines for supply free to patients. The proposal by India is based on the recommendations of a High Level Expert Group on Universal Health Coverage (HLEG-UHC) constituted by the Planning Commission of India.

National Health Package

- **Hindustan Times: July 8, 2012, A Cure for all ills**
- **The Hindu:/Times of India/Indian Express April 2, 2012**

New Central scheme to supply free generic drugs

Moving towards major reforms, the Centre is in the process of rolling out a universal health coverage package in at least one district in each State on an experimental basis. This would include a clearly defined basket of services to those who come to any public health facility for treatment or free supply of generic drugs, doing away with user charges and upgrading public health infrastructure right from the primary to tertiary levels. The private sector would have a role to play only when needed. These recommendations had been made by the High Level Expert Group (HLEG) in its report on universal health coverage. The panel had also recommended against any insurance scheme as a mechanism for health coverage.

Drug price control

- **The Hindu:/Times of India September 27, 2012**

348 vital drugs to come under price control- The Group of Ministers (GoM), headed by Agriculture Minister Sharad Pawar, on Thursday, gave its approval to the final pharma pricing policy, bringing 348 essential drugs under the government's price control regime.

- **The Hindu: September 2, 2012**

Patients lose out to patents & profits- By the government's own admission, medicines constitute 74 per cent of out of pocket expenditure on health. **Waking up to the crisis, the Centre recently announced measures to bring about alterations to the system — free drugs starting October at state hospitals and price control for patented drugs**. Both long-pending proposals require a four-fold increase in public spending on medicines, from 0.1 to 0.5 per cent of the Gross Domestic Product, as recommended by the High Level Expert Group (HLEG) on Universal Health Coverage.

- **The Hindu: : March 14, 2012**

The bold move on compulsory licensing should be a first step in a process of reform and price controls that will make available essential drugs to all Indians at little or no direct cost. This initiative is crucial to the universal health coverage that the Indian government wants to provide to all its citizens in coming years, starting with the Twelfth Plan.

3-year Bachelor of Rural Health Care (BRHC) degree programme

- **The Times of India, September 24, 2012**

Medical Council of India approves 3-and-a-half-year medical course

NEW DELHI: **The Medical Council of India (MCI) has finally cleared introduction of the three-and-a half- year long medical course. Calling it BSc in Community Health, it will be open to anybody after class 12.** The Planning Commission's high level expert group has strongly backed the all new health cadre and said that as a career progression incentive, they should be promoted to the level of public health officers after 10 years of service.

Shortage of Doctors

- **The Times of India: August 27, 2012**

Centre plans more doctors for better healthcare

MUMBAI: **On the recommendation of a high-level expert group, the Centre has drafted an ambitious plan to increase the number of doctors for providing better healthcare. Against the current doctor-population ratio of 1:2000, the Centre has proposed to increase availability of doctors to 1:1000,** in a time-bound period. "The planning commission had set up a high-level expert group on universal health coverage. The Centre has accepted the recommendations of the group and accordingly guidelines are being issued,'' a senior official told TOI on Saturday.

National Advisory Council (NAC)

- **Live Mint: The Wall Street Journal- August 24, 2012**

NAC forms panel for health plan roll-out- The Sonia Gandhi led-National Advisory Council (NAC) on Friday formed a working group on universal health coverage for phasing-in the roll-out of the proposed scheme in the 12th Five-Year Plan period.

- **The Hindu: August 25, 2012**

NAC panel to study report on universal health coverage

The National Advisory Council has set up a multi-member working group to study the report on Universal Health Coverage (UHC) prepared by the High Level Expert Group and the government's proposal to expand the scope of the National Rural Health Mission (NRHM) and convert it into a National Health Mission.

Thegroup, comprising Mirai Chatterjee and A.K. Shiva Kumar, will work closely with the Ministry of Health and Family Welfare and the Planning Commission to resolve any possible issues arising between the two over the implementation of the UHC report and the National Health Mission.

- **Live Mint: The Wall Street Journal, September 27, 2012**

Government to assure, not insure, health

New Delhi: **The National Advisory Council (NAC), which sets the policy agenda for the Congress party led United Progressive Alliance (UPA) government, wants the Rashtriya Swasthya Bima Yojna (RSBY) insurance scheme to be absorbed into the new policy for universal health coverage (UHC), taking the latter closer to realization. According to the terms of reference for the newly formed working group on universal health coverage, the council is going to "examine the available evidence on the functioning of RSBY and outline an approach to merging of RSBY with UHC."** Mint has reviewed a copy of the document. Over the next four months, the working group will work closely with the health ministry and the Planning Commission to iron out the details and recommend an approach for piloting the universal health coverage policy at district level.

From Draft Health Chapter of 12th Plan

Health System Elements
Suggested Health System Strengthening Activities by States

Health Services

- Rolling out UHC in one district of State/UT on a pilot bases
- Master plan for achieving Indian Public Health Standard for all facilities
- Public health care facilities are provided financial and administrative autonomy.
- Develop an effective grievance redress system

Ensure access to Medicines, Vaccines & Diagnostics

- Create a Special Purpose Vehicle to procure, store and distribute medicines, vaccines & diagnostics through an open, tender based procurement
- Mandate availability of drugs under the National List of Essential Medicines in all health facilities
- Ensure Jan Aushadi stores in all Block Hqs.

Health System Elements
Suggested Health System Strengthening Activities by States

Health Financing

- Increased expenditure on Health Sector

3. Health Regulation

- Extend and enforce Central Clinical Establishment Act
- Empower Public Health functionaries under relevant laws namely Pre-conception and Pre-natal Diagnostic Techniques Act, Food Safety Standard Act, and Drugs and Cosmetics Acts

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Health System Elements
Suggested Health System Strengthening Activities by States

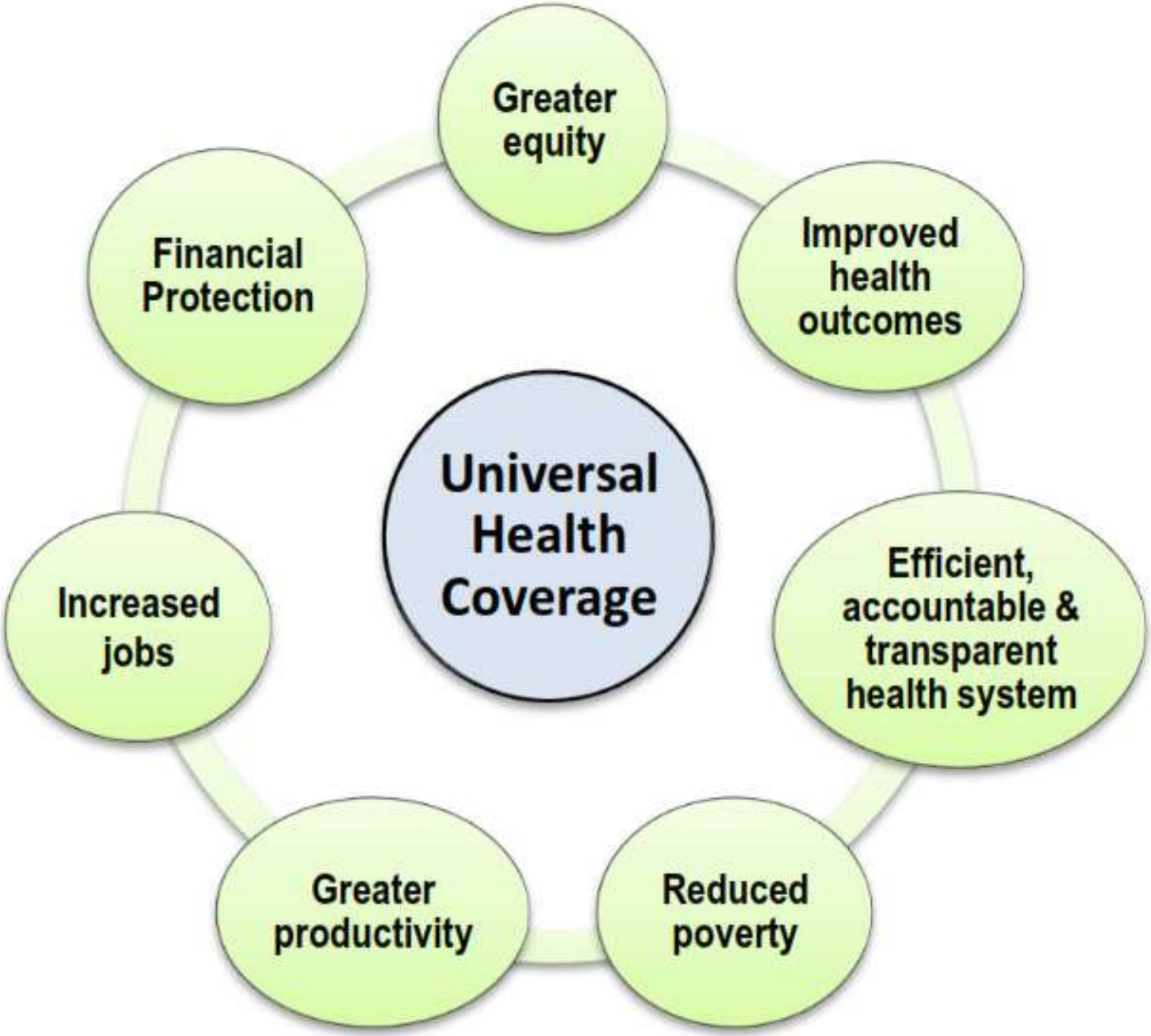
Develop Human Resource for Health

- Develop District Hospitals and Community Health Centres (CHCs) into Medical and para-medical training institutions
- Organise bridge Courses for AYUSH graduates and legally empower them to practice as Primary Health care physicians on the lines of Tamil Nadu
- Encourage career progression of ASHA, AWW into ANM, and assure career tracks for competency-based professional advancement of nurses as recommended by High Level Expert Group (HLEG) on Universal Health Coverage

Health Information Systems

- Build a Health Information System by networking of all health service providers, universal registration of births and deaths to give accurate picture of health of population.

From Draft Health Chapter of 12th Plan


Universal Health Coverage
Greater equity
Improved health outcomes
Efficient, accountable & transparent health system
Reduced poverty
Greater productivity
Increased jobs
Financial Protection

“If we don’t create the future, the present extends itself”

- Toni Morrison (Song of Solomon)