SOCIAL SECTOR POLICY – THE HEALTHCARE EXAMPLE
Learning from our work in India

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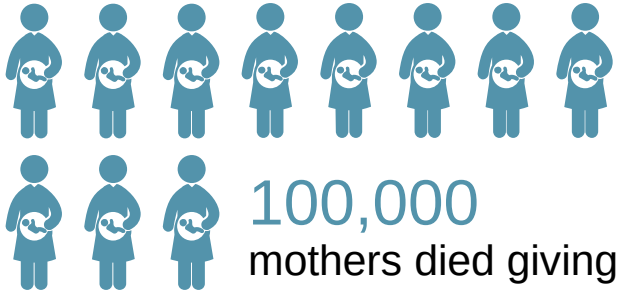
INDIA HAS MADE SIGNIFICANT PROGRESS IN PROMOTING EQUITABLE ACCESS TO HEALTH

1991

Over 2 million
of 30 million children died before their first birthday



100,000
mothers died giving birth

2015

More than 50% decline
in the mortality rate of children within one year of birth

Over 20%
of the world's generics and
50% of vaccines
sold globally are supplied by India

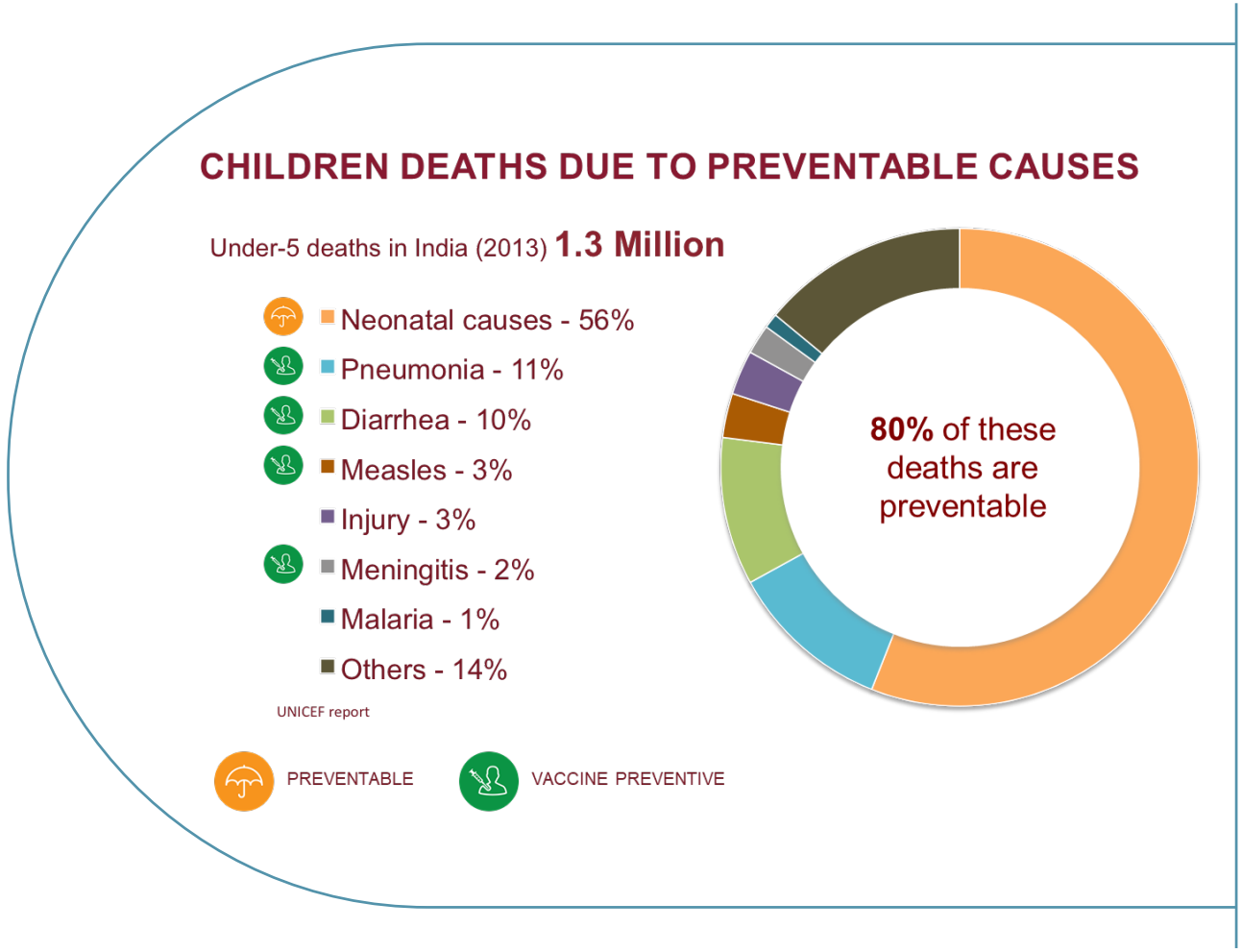
More than 50% decline in the mortality rate of mothers dying during child birth to 48,000

10 YEARS
added to the life expectancy of a child born today as compared to a child born in 1991

Source : MMR Data extrapolated from UNICEF http://data.unicef.org/maternal-health/ delivery-care.html#; all other data extrapolated from World Development Indicators, The World Bank | World Development Indicators, The World Bank | Sagar, 2014

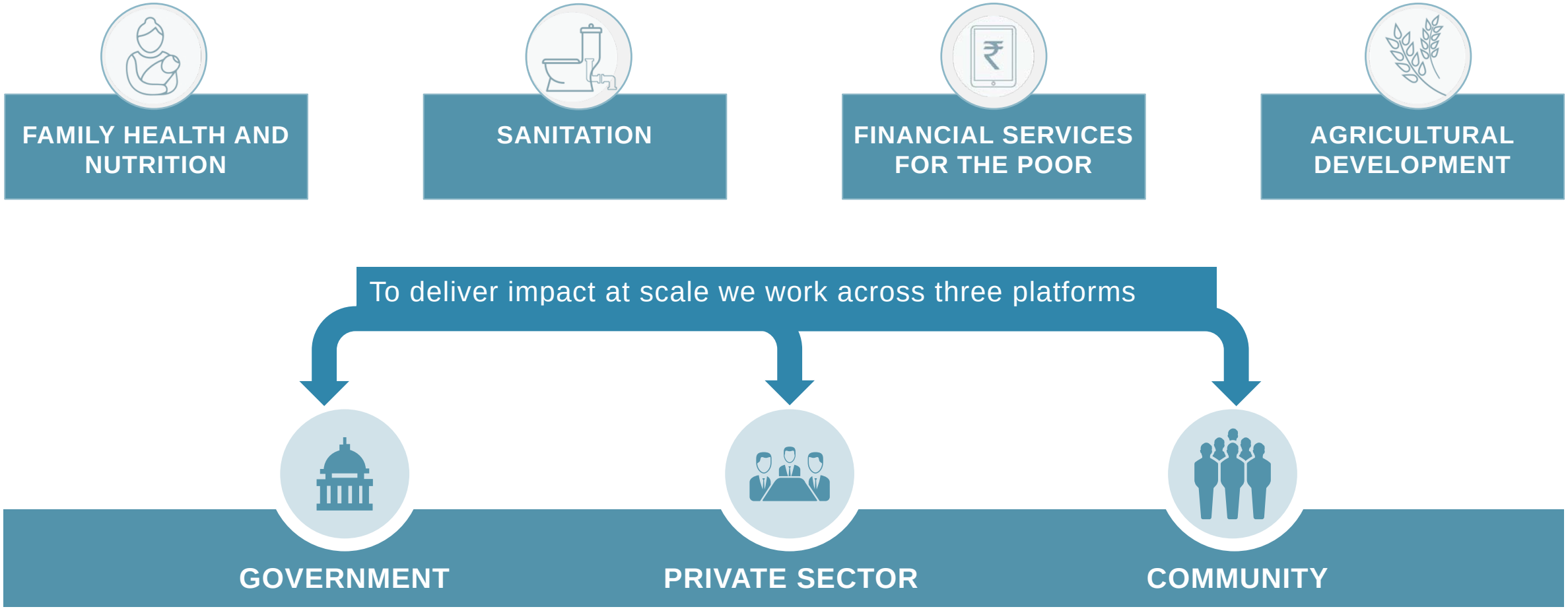
… AND YET, INDIA HAS POOR INDICATORS ON HEALTH AND NUTRITION AND RANKS 143/188 ON THE GLOBAL HEALTH INDEX

- Every **SEVEN MINUTES**, an Indian mother dies from complications of pregnancy or childbirth.
- A baby is **FOUR TIMES** more likely to die in the poorest state than the richest.
- Every **TWO MINUTES**, an Indian baby dies before she is a day old.
- India loses **3,000 CHILDREN** and their infinite potential every day
- TB kills nearly **1,000 INDIANS** every day
- More than **350 million people** are at risk for Lymphatic Filariasis infection
- **4% OF INDIAN HOUSEHOLDS** fall below the poverty line each year as a result of health shocks and high OOPE

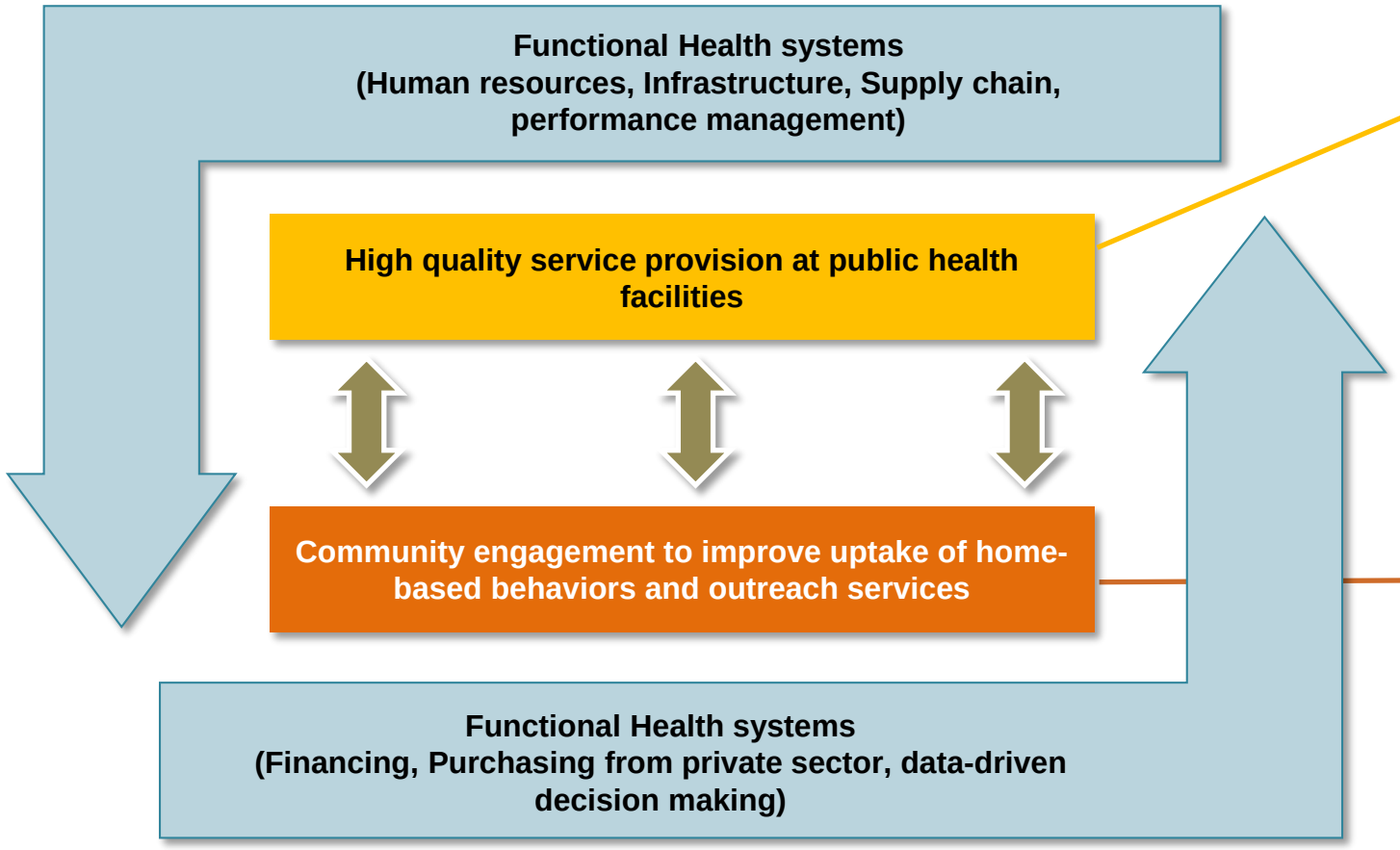


1.UN General Assembly 2016

OUR CORE AREAS AND APPROACH TOWARDS WORK



Our learning points to the need for strengthening systems and capacity to accelerate and sustain progress



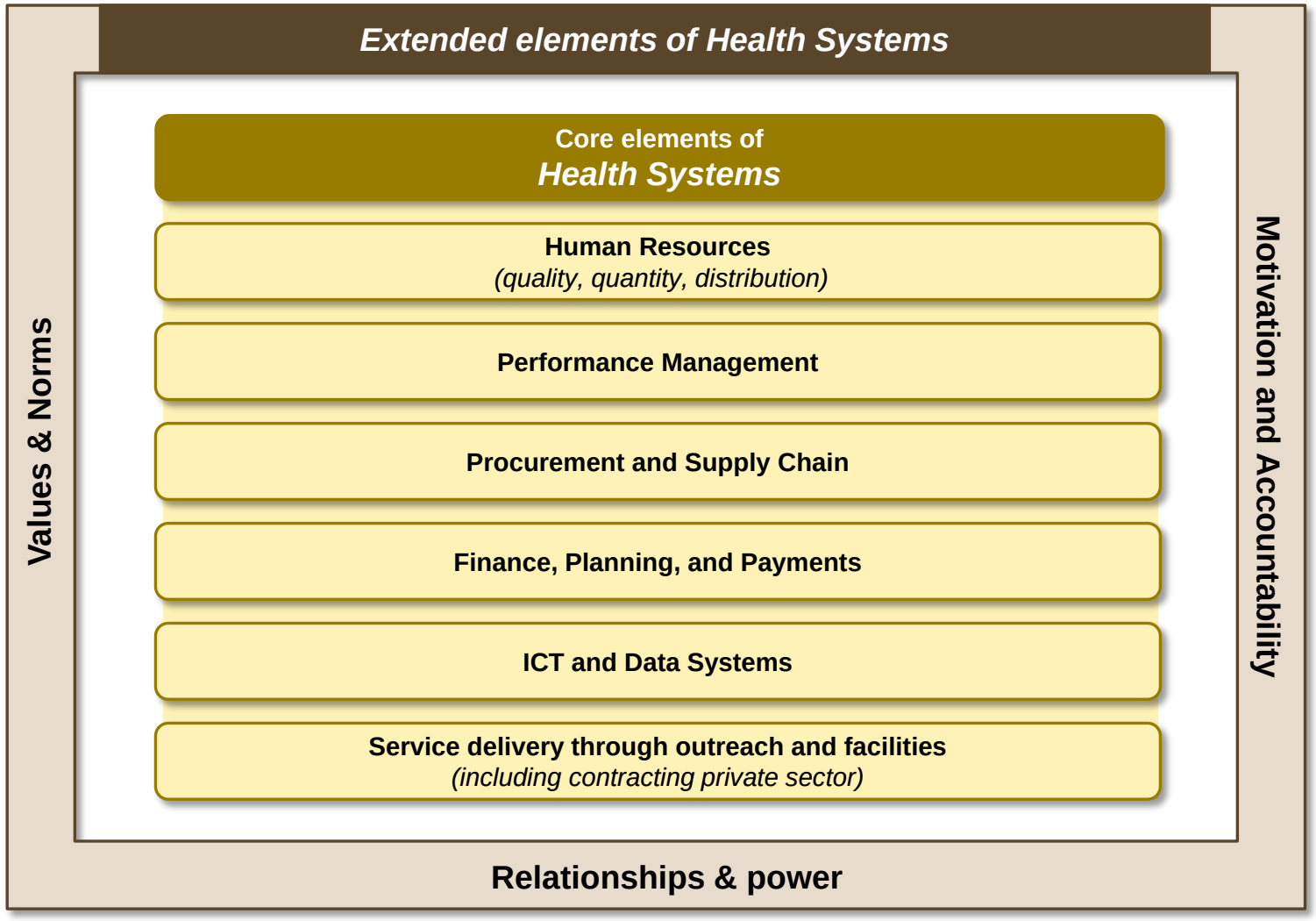
QUALITY OF CARE AT FACILITIES

- Nurse mentoring and Doctor mentoring
- Quality improvement processes
- VLBW tracking
- Clinical reviews
- Family planning services

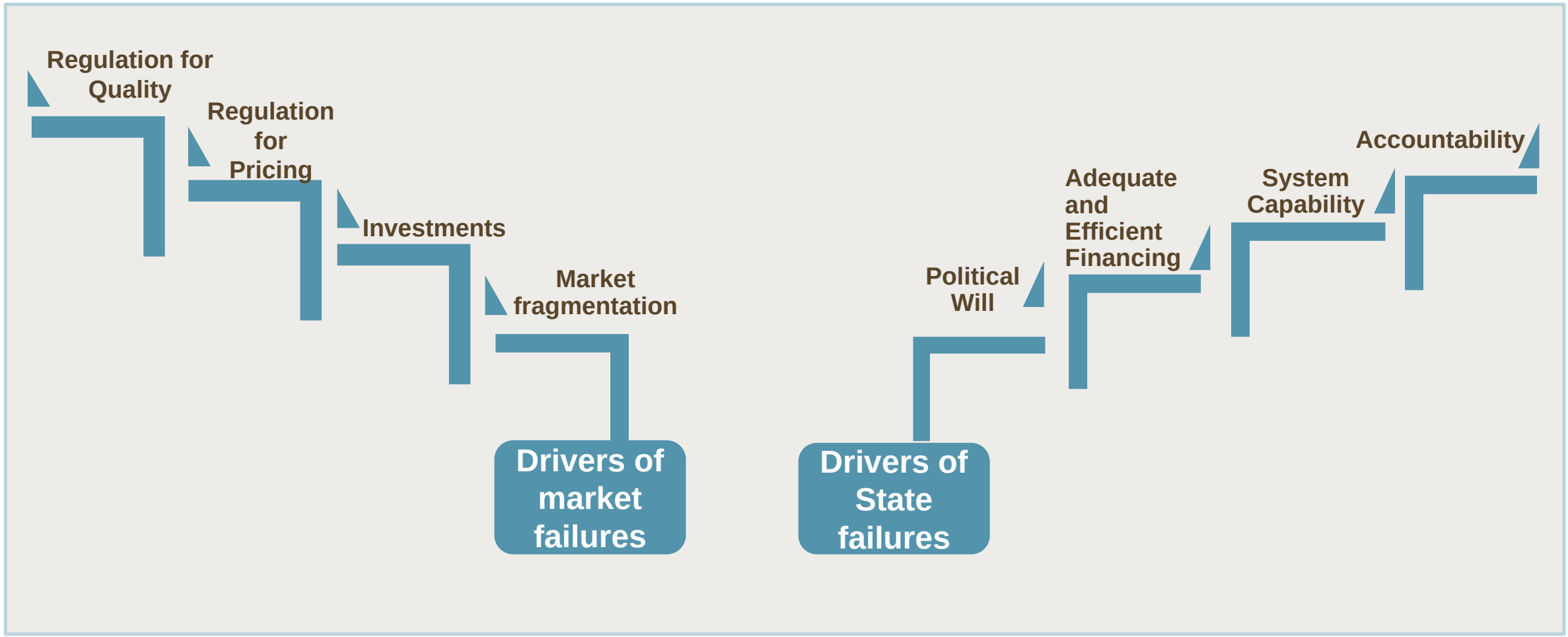
LAST MILE DELIVERY AND BEHAVIOR CHANGE

- Sub-health center level planning, quality BCC
- VHSND strengthening
- Rollout of ICT tools & job-aids for FLWs
- Layering Health & Nutrition in SHGs
- 360* communications support

Health systems strengthening is a critical function



LEARNINGS THAT HAVE SHAPED OUR THINKING & WORK:



LEARNINGS THAT HAVE SHAPED OUR THINKING & WORK IN INDIA

- **Need for an Integrated System View And Related Policies**
- **Adequate and effective Financing**
- **System Capability**
- **Accountability**

LEARNINGS THAT HAVE SHAPED OUR THINKING & WORK IN INDIA

Integrated System View And Related Policies

Several countries have a mixed system of healthcare provision, through public and private facilities.

In India, **healthcare is provided by both - government and private** sector- with 74% of outpatient and 55% of inpatient services provided through the private sector.

Lack of Organizational Consolidation Hinders Development of Market based on Competition for ”Covered” Populations through Institutional Purchasers

The private provider landscape in India is extremely **fragmented**, with the bulk of care being provided by small, individual care providers, hospitals, and often directly by pharmacies.

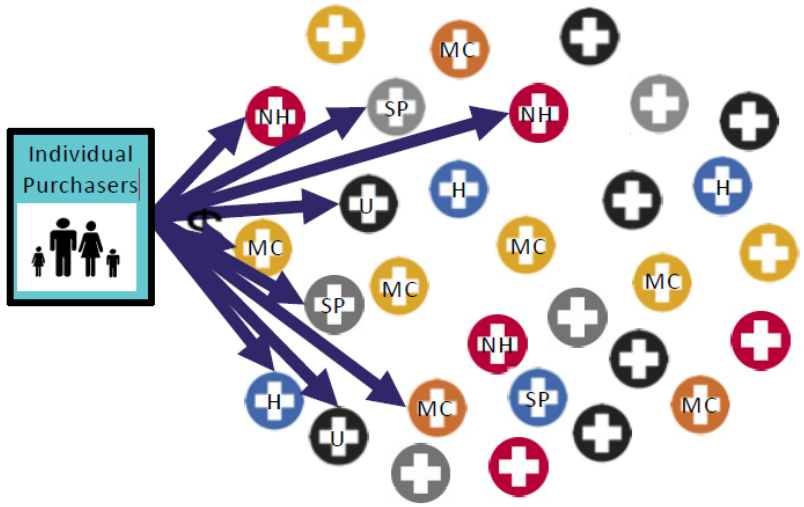
Microsoft PowerPoint Presentation

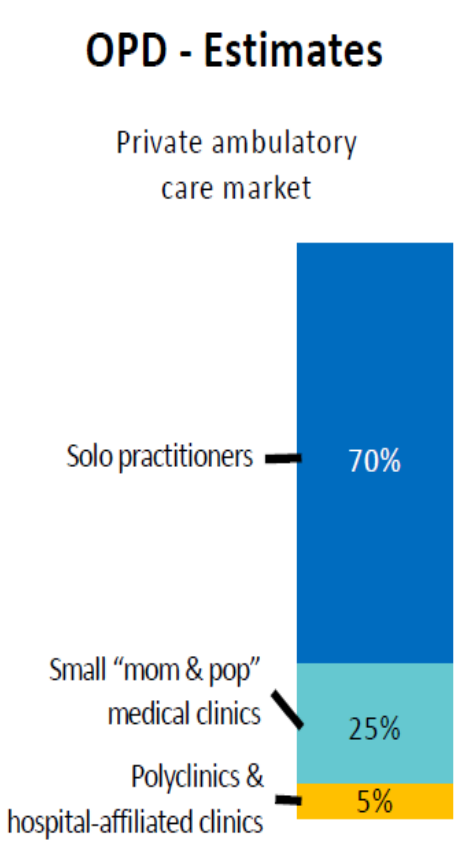
Few countries can achieve UHC without engaging the private sector and there is a need for greater **regulation on costs and clinical protocols**.

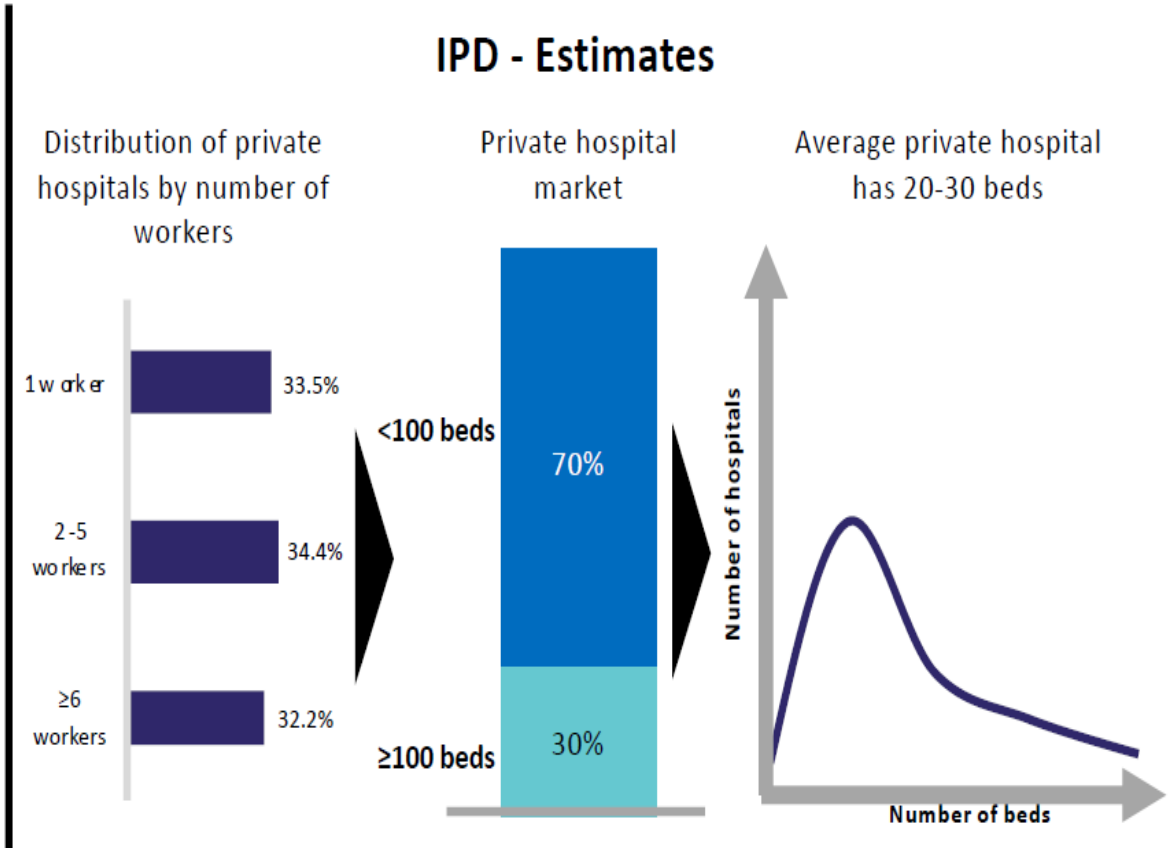
Acknowledgement of the important role of the private sector, but an **insufficient effort to mobilise it** as an integral constituent of the overall health system.

Fragmentation of the public and private systems, and the lack of overall stewardship of the entire provisioning ecosystem, can lead to **two completely separate systems, and missed opportunities for efficiencies and effectiveness.**

Private Market is Deeply Fragmented among Mainly Solo Practitioners and Small Hospitals







SP: Specialty Hospital; H: Hospital; NH: Nursing Home; MC: Medical Clinic;
SP: Solo practitioner without medical clinic; U: Unqualified provider

LEARNINGS THAT HAVE SHAPED OUR THINKING & WORK IN INDIA

Financing

At 4-5% of GDP spend on healthcare in India, the **overall quantum of spend is not a key challenge.**

At 17% of GDP, domestic revenues form a good base, but will need to increase to match the spending ambitions of a rising middle-income economy. OECD countries have a tax GDP ratio of 34.8%, Brazil (34.4%), China (20.1%), Nepal (23.1%)

The challenge lies in the **fragmentation** of these resources with a high out of pocket health expenditure,

which continues to strain the individuals' financial stability as well as ability to demand quality and accountability in service through leveraging pooled and pre-paid amounts.

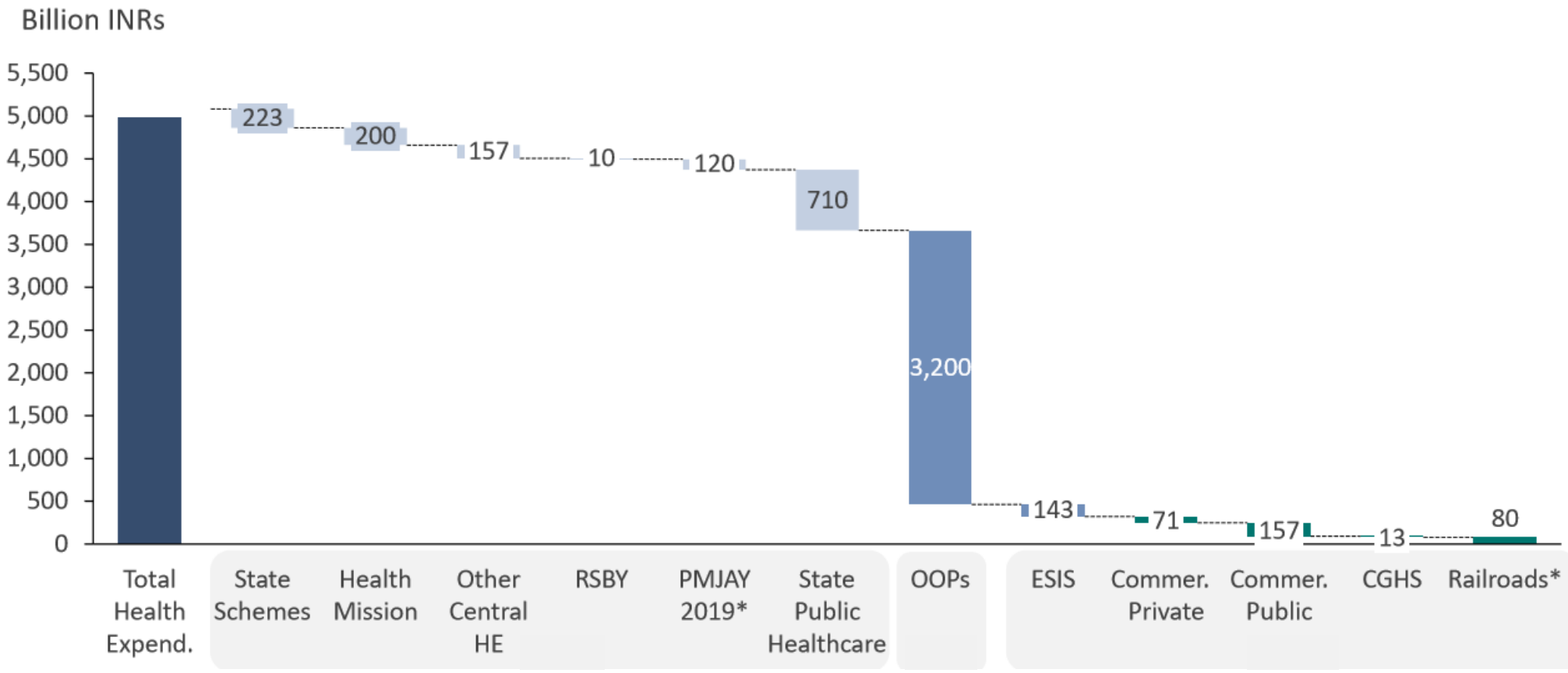
The current revenue of the Centre and states is insufficient to drastically increase public social sector expenditure in the short term

Of the total spend, **public spending** on health is only around 1.4% of GDP

Public spends face the twin challenges of **insufficiency** and **inefficiency**: budget credibility and expenditure efficiency at the national and state levels varies greatly. This undermines any meaningful policy commitments.

- NHM funds utilization are 80% in Bihar, 86% in UP

FRAGMENTED HEALTHCARE FINANCING SYSTEM



Low tax to GDP ratio; low tax allocation to health; federal structure, 3/4th allocation to health is from states High labor informality (90%+ and not decreasing) Weak voluntary health contribution regulation No standardization across pools e.g. packages, data standards

LEARNINGS THAT HAVE SHAPED OUR THINKING & WORK IN INDIA

State Capability

Capability of the system is required to convert political will and public demand into impact.

- Increase in public allocations for health constrained by **capacity to utilize and optimize ROI on existing funds**

Frequent changes in bureaucratic leadership combined with limited incentives across various levels and departments **constrains sustainability and scale of delivery.**

Important to go beyond “capacity” or “capability” language, as that ignores or diminishes the role of motivation – shaped by norms, incentives, and accountability systems – in determining how government ultimately performs.

How government performs and executes its functions depends on both individual and organizational factors, and our draft framework is intended to cover both – although the focus is on organizational execution and performance.

The non state institutional ecosystem, that informs and supports the state, needs strengthening

- Donor dependence for TA continues, largely in project mode and a short term focus. Sustainability remains a challenge.
- Strong institutional capacity is needed, to support the reform process. Countries like Thailand have benefited from the presence of local health systems capacity to aid their change process (e.g. HITAP, HSRI, and IHPP).

GOVERNMENT EXECUTION/PERFORMANCE FRAMEWORK

Capacity / Capability
What you can do

Shaped by:

Skills & Knowledge
- Leadership
- Management
- Financial
- Planning/Strategy
- Technical

Resources
- Financial
- Physical
- Data

Processes

Motivation
What you're willing to do

Shaped by:

Incentive Structure
- Extrinsic
  e.g. financial, career path
- Intrinsic

Accountability System *
- Goals & standards
- Appraisals
- Pressure

Norms & Culture

Performance or Execution
What you actually do

LEARNINGS THAT HAVE SHAPED OUR THINKING & WORK IN INDIA

Accountability

Broader structural weaknesses mean that despite political salience, the system's ability to deliver successfully remains weak

Performance management in government delinked from high quality data on outputs and outcomes implies

- weak chain of accountability for principal-agents across the chain for social, political, bureaucratic and departmental accountability, and
- difficulties in policy implementation and low ROI on public expenditure

Accountability across and within systems is required to convert will and demand into impact.

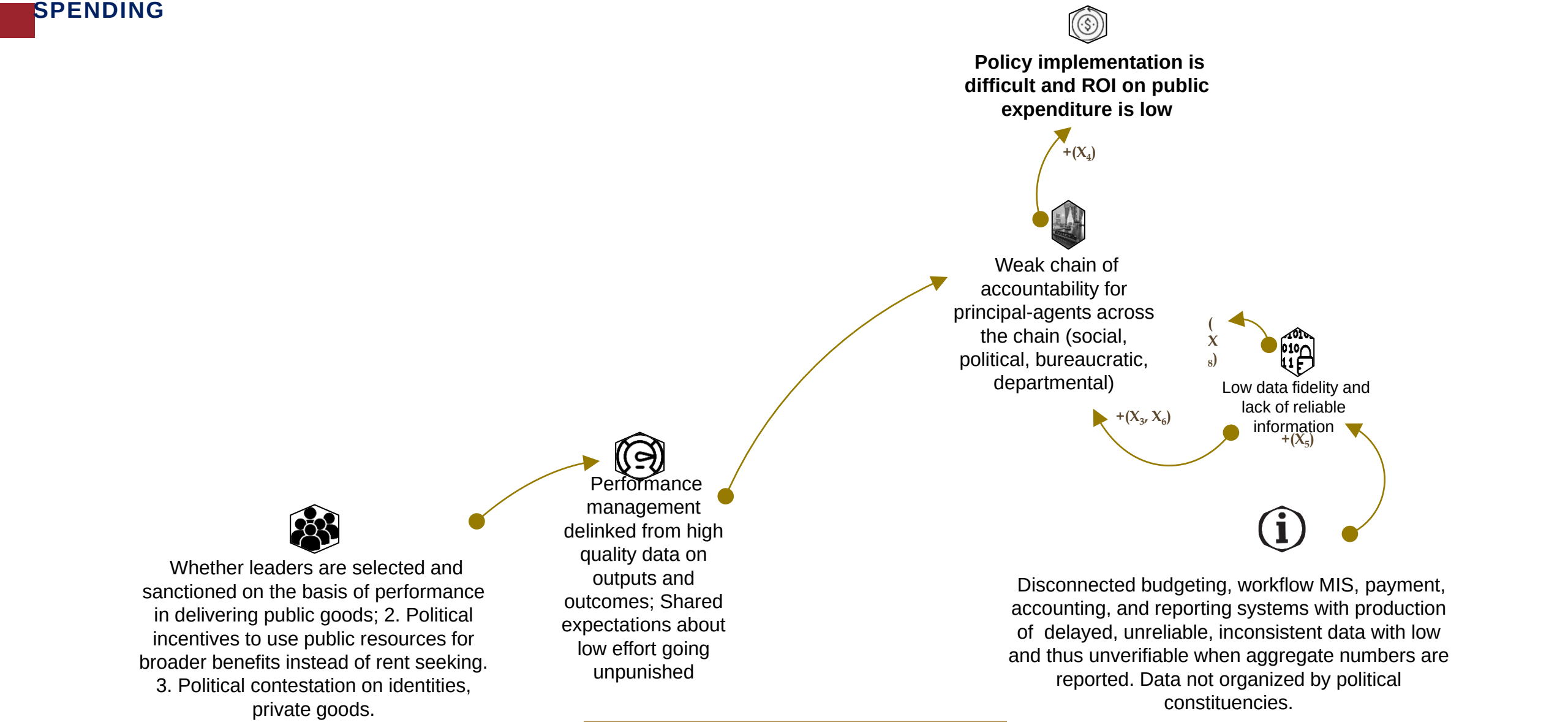
Bureaucratic accountability driven by data is necessary, but a broader ecosystem of political norms and incentives impact accountability efforts

- Need for sharper internal accountability tools that align with performance management processes

- Community monitoring interventions have had some positive impacts on service delivery, but
  - issues of scale and sustainability remain.
  - institutions are not designed to hold providers accountable.

Limited regulation and information asymmetry leads to lack of accountability in the private system

MODEL OF CURRENT PFM & ACCOUNTABILITY ARCHITECTURE THAT AFFECTS POLICY IMPLEMENTATION AND BUDGET SPENDING



Note: Significant independent variables that we acknowledge , but don't address in this presentation: **X3: Educated, Healthy, Mobilized civil society that has forums to demand accountability**, X4: Additional state capab`ility issues like HR, coordination problem, norms, procurement processes **X5: Lack of incentives to deflate 'reported & certified' program achievement**, X6: Incentives & residual power of public servants in their contracts with their principals, X8: Weaker basis for policy making, inter sector & intra sector allocations; less information on Expenditure-Outputs-Outcomes

POLICY IMPLICATION

- A healthcare provision architecture focused on **aggregation and oversight of the private sector** can address the extensive fragmentation of a varied private sector consisting of small, individual care providers, hospitals and pharmacies. With the recently announced PMJAY, there has been a pathway created to integrate private and public provision.

Move from individual solo practitioners/small clinics/small hospitals competing on a FFS basis for individual patients …to consolidated groups with shared incentives and care coordination, competing for covered populations

- A set of regulatory and purchasing interventions can move towards a **floor for quality and a ceiling for price**. This offers the potential for considerable change in health outcomes as well as facilitate an increased level of prepayment and pooling by consumers as their confidence grows in the ability of the health system to deliver.

- Virtual aggregation through digital platforms, for both private and public delivery systems

POLICY IMPLICATION

Finance

- Reduction in funds spent at the point of healthcare service, through **pooling of small contributions** so that large amounts can be paid by the pool and not by the individual.
- Current health financing design has many of the components necessary for this.
  - Tax resources for health are currently at a little over 1% of GDP: Increasing tax-financing to 2.5% of GDP by 2025, as already articulated in the National Health Policy
  - Employee State Insurance Scheme (ESIS) for blue collar workers is 0.06% of GDP; Building ESIS through better collections and expansion of mandate to include all formal-sector employees could increase its value .
  - Voluntary insurance is 0.14% of GDP: Allowing families and groups such as self-help-groups of women, to buy-into the recently announced PMJAY, could lead to a sizable increase in voluntary insurance.
  - Out-of-Pocket expenditure at point-of-service ~2.5-3% of GDP . Expanding these pools could well lead to aggregate pooled financing at 4% of GDP, reducing the point-of-service expenditures and helping improve health outcomes.
- For the existing public delivery system, stronger **expenditure tracking, better planning, and timely and flexible flows** of government funds will help improve the current low levels of utilization, allocative and technical efficiency, by the government-owned healthcare delivery system. This can happen through:
  - Identifying and addressing the root causes of these delays to facilitate timely disbursement of funds and ensure greater levels of utilization.
  - **Pull vs push**: Reduce number of line-items in the state health budgets to increase flexibility in the manner in which these funds can be used, thus affecting both utilization levels and health outcomes. Gradually move to block grants focusing on outputs and outcomes rather than supply side controls.
  - Design enhancements of **digital PFM** tools improve the capability of Central govt, states & ULBs to increase revenue, improve transparency, enhance quality and timelines of audit, reduce uncertainty and cost of doing business with government, track and control spending and minimize administrative burden of program managers

POLICY IMPLICATION

- Data systems are in place to **allow elected officials to track, celebrate and be accountable to progress in service delivery**
- Increased transparency of budget data enables constituents and elected officials to track implementation and ensure effective utilization by administrative officials
- Government-wide administrative policies linking **annual performance appraisals** to service delivery outcomes are strengthened
- Use of technology: Clear and accepted standards, strong technology platform, and robust usage of data analytics can go a long way in improving accountability, preventing fraud and managing overall efficiency of the system**.** India, and other countries, have the technology skill and need to establish how this can be effectively leveraged in a fragmented system.

POLICY IMPLICATION

- Develop an Indian Human Capital investment strategy (part of broader Indian economic policy) to increase the inclusiveness and sustainability of long-term economic growth through improvements in national health, education and economic opportunity, to address current challenges of:

  - Long-term Indian **macro-economic and poverty-elimination trends positive, but Human Capital metrics remain low.**
  - Despite positive economic outlook, the data suggests uncertainty around long-term inequality, and how much the poorest will drive/benefit from India's success.
  - Health and social services on the GOI agenda**, but usually delinked from economic goals**

