

# Choosing Health: an opportunity for India

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Supported in part by grants from the NIH, IDRC, Bill and Melinda Gates Foundation, CIHR, PRB, and by the University of Toronto

# Preliminary conclusions

1. Half of the deaths in EAG states and Assam are from communicable, maternal and perinatal diseases
2. Non-communicable diseases are major killers in all states
3. Highly effective and cost-effective and intervention packages that address most causes of death exist
4. Intervention costs would be in the range of \$4-8/per capita (\$4-\$8 billion or <1% of GDP) to cover the EAG and Assam
5. About 100 M premature deaths might be averted over the next 3 decades with expansion of effective interventions
6. Reform of the health system to focus sharply on the high impact interventions plus addressing a handful of key system constraints is likely to be effective
7. The NRHM can form a “stepping stone” to a universal, publicly financed system for all, and appropriate directions might save \$10-\$20 billion

# Outline

1. Historic opportunity
2. What's at stake: 100 M premature deaths, or perhaps \$10-20 B in inefficient spending
3. Risks of usual business
4. A rational and transparent process for setting priorities:
  - Choosing interventions: a few disease matter
  - Tackling constraints: a few things matter
5. A building block for a universal, publicly financed system

# Past and future

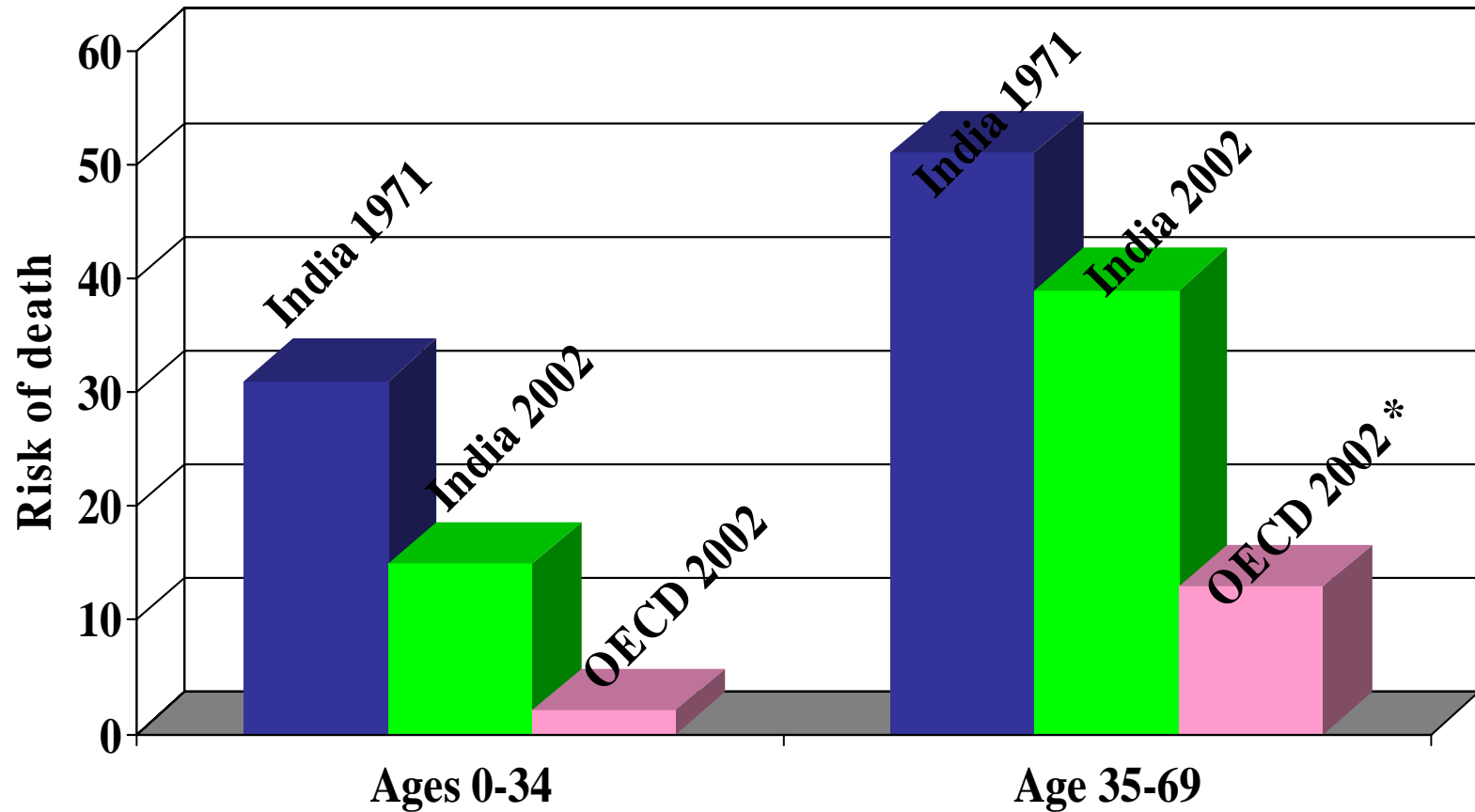
## 1. Historic opportunity

- 1990s program \$2 B/10 years (10 times bigger now, and domestic finance)
- Build on increasing evidence (eg HIV/TB)

## 2. Risks of usual business

- Muddling along may loose the middle class
- Cost-escalation
- Worsen inequalities among districts/states in health outcomes
- Surveillance infrastructure poor- thus SARS/ influenza/other unpredictable outbreaks

# Achievable reductions in mortality



\* Non-smoker rates

Source: Jha 2006

# 9 million deaths in India, 2004

Age range	No. of deaths (millions)	YLL per death	
0 to 4	2	60-65	} 3.2 M, mostly acute conditions
5 to 34	1	40-45	
35 to 69	3	20-25	} 6.6 M, mostly chronic conditions
70+	3	5-10	

# Avoiding 100 M premature deaths: is it possible?

Age at death	Current Deaths (M)	Future Deaths (M)	
		<u>An current rates</u>	<u>Achievable rates</u>
	<b>9 M Deaths</b>	<b>25 M Births</b>	
Childhood/early adulthood*			
age 0-25	~3	3-4	1-2**
Middle Age			
age 35-69	~3	8-10	5-7**
Old Age			
age 70+	~3	11-14	16-19
<b>TOTAL</b>	<b>9</b>	<b>25</b>	<b>25</b>

\*2/3 at ages 0-4; \*\* About 100 M over 30 years

# Financing scenarios by 2020?

% of GDP	Current	“Ideal”	“Inefficient”
Public	1%	4-6%	3-5%
Private	5%	2-3%	7-8% *
TOTAL	6%	6-9%	10-13%

\* US inefficiency is at least 2% of GDP

Note that public finance and provision differ

# Reducing premature mortality

**Most causes of death before middle age (<35) are avoidable:**

- female child survival (including selective abortion)
- childhood infections, ARI, diarrhea, malnutrition
- immunization, including new antigens (Hib, S. pneumonia, rotavirus)
- safe childbirth
- HIV-1 prevention (esp. sex work)
- injuries (less avoidable currently)

**Halving mortality in middle age (35-69) requires control both of infections (particularly tuberculosis) and of chronic diseases (particularly vascular)**

**Avoidable causes:**

- tobacco
- blood pressure (incl. obesity and diabetes)
- blood lipids
- inadequate treatment of chronic conditions (eg polypill for CV)
- cervical cancer/liver cancer

# Health system reform

## A few things matter most:

- **human resource issues (incentives)**
- **procurement of key inputs**
- **accountability- program and political**
- **independent monitoring of outcomes (RGI studies- RGI-CGHR study, district study)**
- **strengthen routine public institutions**

# Key issues for this workshop

1. Critique key messages
2. Identify key gaps (for report, and for future research)
3. Provide specific added value to NRHM:
  - urban as well as rural priorities
  - specific “best buys” within broad NRHM
  - specific challenges in EAG and Assam vs. other states
  - address non-communicable diseases
4. Independence of report
5. Our audience is outside the sector and policy makers at state and national levels