# PROJECT INFORMATION DOCUMENT (PID)
# APPRAISAL STAGE

Report No.: PIDA8248

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| **Project Name** | Uttarakhand Health Systems Development Project (P148531) |
| **Region** | SOUTH ASIA |
| **Country** | India |
| **Sector(s)** | Health (75%), Non-compulsory health finance (15%), Public administration- Health (10%) |
| **Theme(s)** | Health system performance (50%), Child health (20%), Injuries and non-communicable diseases (20%), Other Financial Sector Developmen t (10%) |
| **Lending Instrument** | Investment Project Financing |
| **Project ID** | P148531 |
| **Borrower(s)** | Government of India |
| **Implementing Agency** | Department of Medical Health and Family Welfare, Government of Uttarakhand |
| **Environmental Category** | B-Partial Assessment |
| **Date PID Prepared/Updated** | 01-Sep-2014 |
| **Date PID Approved/Disclosed** | 03-Sep-2014 |
| **Estimated Date of Appraisal Completion** | 19-Sep-2014 |
| **Estimated Date of Board Approval** | 15-Jan-2015 |
| **Decision** | |

## I. Project Context

### Country Context

India's population is 1.2 billion, with a per-capita gross domestic product (GDP) of US$ 1,489 in 2012, which has increased by nearly 35 percent in 2007-2012. The relatively high growth of GDP (8.2 percent per annum in 2007-2012), supported by high rates of investment and savings and strong export growth, has generated substantial public and private resources for large investment in education, health, transportation and communication, and development programs to benefit the poor, as the country positions itself as an emerging middle income economy. The key challenge facing India is to ensure that its economic growth is rapid and inclusive and leads to significant rural poverty reduction — the government's 12th Five Year Plan (2012-17) puts emphasis on "development of human capabilities". However, more than 400 million people, double the population of Brazil, still live under US$1.25/day, with the majority living in rural areas and dependent on agriculture or other land-based resources. India also witnessed a recent slowdown in the economy and a tightening of macroeconomic policies aimed at addressing a high fiscal deficit and high inflation.

Uttarakhand is the 27th state of the Republic of India and was carved out of Uttar Pradesh in 2000 with the primary objective of bringing development to the hill region of the state. Uttarakhand's population of 10.1 million in 2011 has increased by 19.2 percent over the past decade. It is bordering Himachal Pradesh in the north-west and Uttar Pradesh in the South and has international borders with Nepal and China. The state is divided into 13 districts, located in three geographical regions, the High mountain, the Mid-mountain, and the Terai (the low lying area and plains at the Himalayan foothills). Hills account for over 90 percent of its area, and forests cover two-thirds, with numerous, small, scattered communities (almost 17,000 settlements, most comprising of less than 500 persons) — which makes inaccessibility a crucial, cross-cutting issue in Uttarakhand and a formidable challenge for service delivery in the state. The density of population varies across districts, with Haridwar, US Nagar and Dehradun having above 500 persons per square km while Uttarkashi and Chamoli less than 50.

Uttarakhand, one of the fastest growing economies in the country, has achieved 8.8 percent GDP growth in 2012, much of it coming from services and manufacturing, with a much smaller contribution from agriculture. Emphasis has been placed on stimulating these sectors to their fullest potential, considering the limitations owing to the state's geographic profile. The service sector has particularly benefited from the availability of quality human resources due to the high level of literacy compared to the national average.

Given its location, the state is prone to natural disasters, especially to landslides and floods, which can cause severe disruption to transportation and basic service provision for prolonged periods. Moreover, it is an important destination for pilgrimage and tourism, hosting about 30 million tourists per year, often concentrated in specific time periods. However, the state needs to improve its ability to generate systematic evidence and timely information to formulate plans and better prepare itself for such expected tourist arrivals and unexpected natural calamities.

**Sectoral and institutional Context**

Uttarakhand faces persisting challenges in improving maternal and child health. The state's under-5 mortality rate (U5MR) is 50/1000, infant mortality rate (IMR) is 41, neo-natal mortality rate is 29, and the maternal mortality ratio (MMR) now stands at 162/100,000. While all these indicators are slightly better than national averages (Annual Health Survey (AHS) II 2011-12), variations between districts are significant, with districts as diverse in their topography as Haridwar, Pauri Garhwal and Tehri Garhwal reporting some of the poorest indicators in the state. The low rate of institutional deliveries, discussed later, may be suggestive of access constraints for maternal and child health services. On top of all this, a recent trend of declining sex ratio (0-6 years) in some districts of the state is an added area of concern.

In addition, the state is facing a growing burden of non-communicable diseases (NCDs) as the state undergoes an epidemiological and demographic transition. A recent survey revealed a high prevalence of risk factors for NCDs in the population of Uttarakhand, including smoking, overweight, and low level of consumption of fruit and vegetables. The same survey commissioned by the Ministry of Health and Family Welfare (MOHFW) also showed that diabetes affects as much as six percent of the hilly population, while hypertension affected over eight percent, challenging the widely held perception that people living in the hills were generally active and healthy. The emergence of NCDs poses a renewed threat to the financial protection of the state's population,

which is related not only to the high costs of treatment, but also compounded by the long duration of treatment for what are often chronic illnesses or long term disabilities.

Uttarakhand's health system faces severe human resources constraints, contributing to limited access, inequity and highly variable quality of health services. The population in the most remote areas of the state continues to be unserved and/or underserved, as public and private providers are concentrated in urban and plain areas. Most public health facilities in the middle and upper mountainous areas of the state are poorly or non-functional due to the large scale vacancies of health staff, as deployment and retention of health staff in such geographically remote areas has proven to be extremely difficult. The presence of qualified private providers is negligible in the remote areas of the state, due to low population density and limited income opportunities. In 2013, 48 percent of the posts of General Duty Medical Officers (GDMOs) and 75 percent of the specialists' posts were vacant, despite a liberal government policy to hire contractual doctors and to pay them incentives for remote area postings. Even the private operators that now manage a few outsourced Community Health Centers (CHCs) have failed to bring in all the required specialists. Furthermore, the frequent occurrence of natural calamities and the huge number of pilgrims and tourists visiting the state pose additional challenges to the health system, with an increased and more diversified demand for health services. Given the state's difficult terrain and its proneness to natural disasters, the response capability of health facilities to cater to disasters and trauma needs to be improved.

The private sector plays an important role in the provision of services, accounting for 82 and 65 percent of out-patient care and for 57 percent and 66 percent of inpatient care for rural and urban areas respectively (NHA , 2004-05 and NSSO, 57th Round). Individual physicians constitute 68.3% and establishments 15.3% of the 9,956 private health care providers in the state (as of 2002) (National Commission on Macro Economics in Health, 2005). Uttarakhand has the second highest proportion (11.7%) of non-profit health care providers among all Indian states.

Service utilization has been compromised by the limited service availability (both in the public and private sectors) and health-seeking behavior is influenced by geographical access and costs of care. In addition to differences in service provision and utilization between plain and hilly districts, huge variations are reported even across districts with similar geographical terrain. For example, while the rate of institutional deliveries in Uttarakhand is itself low at 54.6 percent (AHS 2011-12), Haridwar, a populated district in the plains, has a rate of institutional delivery (out of expected deliveries) which is one-third that of Dehradun, the capital city. This suggests that additional barriers to access beyond the geographical configuration of the districts may exist. The National Sample Survey Organization (NSSO) data show that the household utilization rate of inpatient care reduces to 0.67 percent in the rural areas from a state average of 0.95 percent (a rate already significantly lower than the national average of 2.5 percent). While the poorest population is not seeking/spending on inpatient care (monthly per capita expenditure is about 36 rupees), household health expenditure is concentrated on outpatient care (114 rupees/month).

Uttarakhand needs to address the financial burden in accessing healthcare and the risk of catastrophic health expenditures. India's total health expenditure (THE) as a share of GDP was 4.2 percent in 2004-5, of which 69 percent was private out-of-pocket (OOP) expenditure (WHO NHA statistics and MOHFW 2009) . In 2012, while THE as a percentage of GDP continued to be in the same range at 4 percent, the share of OOP expenditure witnessed a rapid decline to 58 percent (though still high as compared to the country's income level), and the share of public expenditure

rose to 33 percent. Formal, detailed sub-national numbers available for Uttarakhand (2004-05) indicate that THE was higher than the national average at over 5 percent of state GDP, while the proportion of public and private expenditure was identical to the national average, with a predominance of the private sector. The NSSO data also reveal that private out-of-pocket expenditure is directed mostly to out-patient care as opposed to in-patient services (75 percent of households spent out-of-pocket on outpatient care, in line with the national average of 76.5 percent). While this could be a result of the introduction of national insurance schemes that cover much inpatient costs, it might also be a sign of denied access and/or of sick patients not seeking appropriate care when needed. The Government of India (GoI) introduced a national health insurance scheme called Rashtriya Swasthya Bima Yojana (RSBY) in 2008, which covers most inpatient care costs in public and private facilities for those living below the poverty line (BPL). In February 2014, Government of Uttarakhand (GoUK) also announced a similar state initiative called Mukhyamantri Swasthya Bima Yojana (MSBY) to be rolled out shortly to extend the same coverage as offered by RSBY to the state's remaining population. Plans to further enhance the coverage of RSBY and MSBY to include additional services, such as primary care, are also on the agenda. Despite these initiatives, the risk of catastrophic health expenditure in Uttarakhand, though slightly less than the national average, is still high and possibly preventing households from seeking care. A preliminary analysis of household survey data suggests that 5.3 percent of households spent more than 25 percent of their non-food expenses on health in 2011-12, indicating very high risks of impoverishment. An increasing number of these at-risk households were families with high outpatient care expenses, adding to the importance of ensuring greater focus on primary care services in the state.

## II. Proposed Development Objectives

The PDO is to improve access to quality health services, particularly in the hilly districts of the state, and to expand health financial risk protection for the residents of Uttarakhand.



## III. Project Description

**Component Name**

Innovations in engaging the private sector

**Comments (optional)**

Innovations in engaging the private sector is the main project component that aims to create a conducive policy and institutional environment to stimulate and finance innovative engagement with the private sector in the delivery of healthcare services as well as in healthcare financing. This component will expand access to services by creating an integrated, technology-enabled health system architecture with enhanced focus and availability of primary care, emergency care and necessary referral services. It will also expand financial protection by defining a benefit package of primary care services for child and adolescent care and for the management of non-communicable diseases.

**Component Name**

Stewardship and system improvement

**Comments (optional)**

This component aims to strengthen the government's ability to engage effectively with the private sector and therefore to enable the government to provide effective stewardship to the entire health system and particularly in its capacity to effectively pursue the innovations being planned under this project. The component will focus on strengthening the institutional structures for stewardship and

service delivery and augmenting the state's human resource capacity, so that the necessary skillsets required for effective implementation of the project and the state's health programs are available.

## IV. Financing *(in USD Million)*

| | | | |
|---|---|---|---|
| Total Project Cost: | 125.00 | Total Bank Financing: | 100.00 |
| Financing Gap: | 0.00 | | |

| **For Loans/Credits/Others** | **Amount** |
|---|---|
| BORROWER/RECIPIENT | 25.00 |
| International Development Association (IDA) | 100.00 |
| Total | 125.00 |

## V. Implementation

The proposed institutional arrangements are based on the implementation experience of the previous Bank supported health project in the state and the ongoing implementation of the National Health Mission (NHM) in the state. The implementing agency for the project will be the Uttarakhand Health and Family Welfare Society (hereafter referred to as the 'Society') constituted under the Department of Health and Family Welfare (DoHFW), GoUK. The Mission Director of the NHM will serve as the Project Administrator for UKHSDP, who will lead the project implementation under the overall guidance and supervision of the Principal Secretary, DoHFW, who is also the Chairman of the Society. Each of the key implementation areas will be coordinated by a focal point within the Society and supported by a core project team. The project will be implemented over a six year period by the GoUK, and utilize the standard on-lending arrangements from the GoI to the state. Appropriate institutional governance structures, including a governing board, a steering committee and a project coordination team, have been proposed under the project. Implementation support agencies for RSBY, as well as independent monitoring and verification agency(ies) for the performance-based contracting under the project, will ensure appropriate internal controls and validated information emanating from the project.



The project has a Results Framework (RF) and M&E system that will enable effective tracking of indicators, results and implementation progress. The progress of the project towards achieving its targets will be monitored against a set of indicators. In addition to using existing state administrative systems for data compilation and reporting, the GoUK/Society will prepare annual reports on the status of the performance indicators listed in the RF to track the overall implementation progress towards achieving the PDO.

The project builds upon existing health information systems currently used for reporting, including the HMIS (Health Management Information System), the IDSP (Integrated Disease Surveillance Program) and the MCTS (Mother and Child Tracking System). RSBY has its own data flows, involving the hospital network and the insurance company, which get aggregated at the state nodal agency level. New activities under the project, such as the health helpline, will also generate substantial amounts of data that will be very helpful. Many challenges exist with the current health information system, such as delays in reporting, incomplete coverage (e.g. data on private hospitals is not available, with a few exceptions), and duplication. The problems are encountered at different levels: data collection, filling up of forms, transportation by carriers, transcription at CHC level, and report generation at the HQ level. In general, therefore, integration of data sources is weak and its analysis and use at the state level also leaves much to be desired.

The project will finance the strengthening of the state's M&E systems by supporting capacity building and streamlining of M&E systems in the health sector in Uttarakhand. The project will also promote stronger integration of existing data sources and the use of evidence for decision-making. During implementation, the impact of investments will be assessed via selected evaluations. A central aspect of project design is to subject the core activities to rigorous evaluations, in order to help create an evidence base to inform future implementation of the health system reform agenda both in Uttarakhand and beyond. Random assignment of interventions at the facility and district level, and the phased roll-out of activities, will be used to help establish causality of interventions on key outcomes of interest. Further elaboration of impact evaluation design is currently ongoing.

The activities being supported under the project have wide acceptance and buy-in at all levels of the state government, and some of these have already been initiated using the state's own resources. The project is attempting to further rationalize and optimize the design of these activities and to further enhance their allocative and technical efficiency (such as increased focus on primary care, and through rationalizing the design and distribution of medical specialists in outsourced CHCs and mobile medical units), whereby it should be possible to further reduce the recurring cost needs. The state has a rapid rate of economic growth, higher than elsewhere in the country, which should get further strengthened with project activities in the medium and long term.

The state has a good record of sustaining Bank investments too; for example, it has 13 mobile medical vans acquired under the previous Bank project which have continued to be operational and much in demand, and are being scaled up under this project as part of the integrated district-level network. The project design focuses on institutional strengthening and creating a robust health stewardship function, which should provide the technical and operational expertise to sustain these demanding modalities of service delivery being rolled out by the state. Finally, the implementation arrangements for the project also do not create a separate or parallel structure, and instead works through existing state systems, strengthening and supporting them as needed, and also bridging the gaps wherever required. This further 'mainstreams' the project activities and makes them an integral part of the health system, which augurs well for their sustenance.

The earlier World Bank funded Uttaranchal Health Systems Development Project (UAHSDP) initiated sound healthcare waste management systems. The current project will build and improve upon those existing systems, while taking into account emerging environmental issues and the new legislations and policies promulgated by the Government of India, including the BioMedical Waste Management Rules and the Infection Management and Environment Plan instituted under the NHM. On the social safeguard front, the project should make a positive contribution by improving women's access to health services, connecting remote populations to improved health services and by focusing on awareness, communication and equity. No negative social safeguard issues and impacts on the project are expected since the proposed activities do not involve any construction work or involve any land acquisition or involuntary resettlement with Bank financing. However, as the state does have about 3 percent tribal population many of whom reside in the hilly and remote areas of the state, the Bank and client worked together on developing an Environmental and Social Management Plan (ESMP) which includes an Indigenous People Plan.

## VI. Safeguard Policies (including public consultation)

| Safeguard Policies Triggered by the Project | Yes | No |
|---|---|---|
| Environmental Assessment OP/BP 4.01 | × | |

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|---|---|---|
| Natural Habitats OP/BP 4.04 | | × |
| Forests OP/BP 4.36 | | × |
| Pest Management OP 4.09 | | × |
| Physical Cultural Resources OP/BP 4.11 | | × |
| Indigenous Peoples OP/BP 4.10 | × | |
| Involuntary Resettlement OP/BP 4.12 | | × |
| Safety of Dams OP/BP 4.37 | | × |
| Projects on International Waterways OP/BP 7.50 | | × |
| Projects in Disputed Areas OP/BP 7.60 | | × |

**Comments (optional)**

## VII. Contact point

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