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PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: PIDC3250

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	05-Feb-2014
Date PID Approved/ Disclosed	05-Feb-2014
Estimated Date of Appraisal Completion	
Estimated Date of Board Approval	10-Sep-2014
Concept Review Decision	Track II - The review did authorize the preparation to continue

I. Introduction and Context

Country Context

India's population is 1.2 billion, with a per capita gross domestic product (GDP) of US$ 1,489 in 2012. With high rates of investment and savings and strong export growth, India's GDP grew at 8.2 percent per annum during the recently concluded Five Year Plan, which ended in 2012. This implies a nearly 35 percent increase in per-capita GDP during this period. The relatively high growth generated substantial public and private resources for large investment and development programs to provide elementary education, basic health care, health insurance, rural roads and rural connectivity, and other services to the poor, as the country positions itself as an emerging middle income economy. At the same time, India faces formidable challenges ahead: more than 400 million people, double the population of Brazil, still live under US$1.25/day, with the majority living in

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rural areas and dependent on agriculture or other land-based resources.

The key challenge facing India is to ensure that its economic growth is inclusive and leads to significant rural poverty reduction. The government's 12th Five Year Plan (2012-17) focuses on both rapid economic growth and inclusiveness, including an emphasis on "development of human capabilities." To assist the government in achieving rapid inclusive growth, the World Bank is supporting activities which address both cyclical and structural impediments to growth, as well as the constraints to making growth inclusive.

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. The state is bordering Himachal Pradesh in the north-west and Uttar Pradesh in the South and has international borders with Nepal and China. There are 13 districts and the state can also be divided into three distinct geographical regions, the High mountain, the Mid-mountain, and the Terai. 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. The small size of settlements and their widespread distribution amidst tough geographic conditions is a formidable challenge for service delivery in the state.

Uttarakhand's population of 10.1 million in 2011 has increased by 19.2 percent over the past decade. District-wise, there is enormous variation in the density of population, with Haridwar, US Nagar and Dehradun having a high density of above 500 persons per square km; on the other hand, there are districts such as Uttarkashi and Chamoli where the population density is less than 50 persons per square km.

Uttarakhand boasts being one of the fastest growing economies in the country. The state 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 three 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 higher level of literacy than the national average.

Sectoral and Institutional Context

Faced with severe human resource constraints and an unhospitable terrain, Uttarakhand has recognized the need to innovate and strengthen its health system in order to improve its performance. The state's infant mortality rate (IMR) is 41 per 1000 live births and the neo-natal mortality rate is 29 (AHS 2011-12), while the maternal mortality ratio (MMR) now stands at 162/100,000 (AHS 2011-12), all slightly better than national averages. While most health indicators are in line with the national average, they are highly variable between districts, with districts as diverse in their topography as Haridwar, Pauri and Tehri reporting some of the poorest indicators in the state.

In addition to persisting maternal and child health challenges, Uttarakhand is undergoing an epidemiological and demographic transition, due to the increased life expectancy and the risk of developing aging- or lifestyle-related diseases (Kumal et al. 2013). A recent non-communicable diseases (NCDs) risk factor survey in Uttarakhand revealed that the population in the state has a high prevalence of risk factors for NCDs, including smoking, overweight, and low level of

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consumption of fruit and vegetables. A recent survey from theMinistry of Health and Family Welfare (showed that diabetes in Uttarakhand affects nearly six percent of the population, while hypertension is over eight percent. The onslaught 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.

Population in the most remote areas of the state continues to be unserved and/or underserved in terms of access to quality health services. In 2013, 48 percent of the posts of medical officers, and 75 percent of the specialist posts, were vacant, despite a liberal government policy to hire contractual doctors and to pay them incentives for remote area postings. In addition, the state has already initiated innovative PPP arrangements, such as outsourcing the operations of its CHCs on a pilot basis, wherein the selected private operator is required to bring in the complete team of human resources (including medical officers as well as specialist doctors) for running the outpatient and inpatient services at the CHCs, and is also responsible for maintenance of the infrastructure. Even in the outsourced Community Health Centers (CHCs), it has not been easy for private operators to bring in all the required specialists, particularly in very remote areas of the state. Service utilization has therefore been compromised; for example, the rate of institutional deliveries in Uttarakhand is only 54.6 percent, of which 62.8 percent occur at government facilities and 36.4 percent at private facilities (Annual Health Survey2011-12); huge variations are reported across districts — Haridwar has a rate of institutional delivery (out of expected deliveries) which is one-third that of Dehradun. A number of outreach initiatives are, therefore, being attempted to improve access to family planning and maternal and child health in remote areas. In this respect, the Uttarakhand Public-Private Partnership (PPP) Cell within the Government of Uttarakhand has endorsed collaborations with the private sector for healthcare service delivery, such as the contracting of mobile health clinics as part of the GOUK plan to augment the human resource availability in its public health system

Though slightly better-off than the national averages, the risk of catastrophic health expenditure in Uttarakhand is still high and possibly preventing households from seeking care. Analysis of household survey data suggest 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. National Sample Survey Organization data also reveal that the poorest population is not seeking/ spending on inpatient care (monthly per capita expenditure is about 36 rupees) with health expenditures concentrated on outpatient care (114 rupees/month). Only 0.95 percent of the state's households sought inpatient care — a rate significantly lower than the national average of 2.5 percent. In addition to the cost of care, geographic access could clearly be another reason for low rates of care seeking, considering that the utilization rate of inpatient care reduces to 0.67 percent in the rural areas of Uttarakhand. On the other hand, 75 percent of households spent out-of-pocket on outpatient care, in line with the national average of 76.5%. The introduction of the national health insurance scheme, RSBY (Rashtriya Swasthya Bima Yojana), which covers much inpatient costs, might have contributed to a relative increase in the contribution of outpatient expenditure in its share of catastrophic health expenditure, as opposed to inpatient expenditure. However, these results might also be a sign of denied access and/or of sick patients not seeking appropriate care when needed. Providing improved access to quality healthcare, particularly inpatient care, and also financial protection against high outpatient expenses seem to be the twin policy priorities emerging from health expenditure data.

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The project is preceded by the Uttar Pradesh and Uttarakhand Health System Development Project, which closed in December 2008. Although approved in April 2000, in November, after the bifurcation of UP state into UP and Uttarakhand (UK), a separate Development Credit Agreement and a Project Agreement were signed with the new state in November 2001. The objective (PDO) of the previous project was to establish a well-managed health system that delivers more effective services through policy reforms, institutional and human resource development and investments in the health sector. The findings of the project's Implementation Completion and Results Report indicated that the overall performance of the project was highly satisfactory and that most of the targets were largely met. The proposed project will build upon the context of these achievements in the earlier project.

Relationship to CAS

The proposed project supports the goals (Economic growth, Poverty reduction and Shared prosperity) of the World Bank's new Country Partnership Strategy (CPS) 2013-17, particularly in its engagement areas on inclusion and also on integration and transformation.

As articulated in the CPS, in the engagement area of inclusion, the project's key focus is on improved access to health services for some of the most remote population groups in the country. The project supports the CPS outcome of "strengthened public and private health-delivery systems", by strengthening health facilities and accountability arrangements in service delivery through the development of greater stewardship and managerial capacity in the state directorate, improved information systems and a focus on monitoring and research.

The project will also support strengthened engagement with private health care providers, expanding their role in meeting the unmet access needs of the state's population. This engagement will also contribute to the "promote greater private investment in a low income state" outcome.

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Through improving access to public and private providers, coupled with expanding financial protection and strengthening the performance of the public health system, the project supports the government in its efforts towards universal health coverage. In large cities such as Haridwar, where the multi-tiered public health system is virtually non-existent, reaching this population with essential health services requires a whole new set of systems and solutions. The multi-sectoral activities under the project, strengthening of the stewardship and managerial capacity at the state level and its innovative mechanisms to engage with the private sector will provide an opportunity to explore and evaluate possible transformative, systemic solutions for urban health, contributing to the desired "strengthened institutional capacity of urban government" outcome of the CPS.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

The proposed PDO is to support Uttarakhand in progressing towards Universal Health Coverage, as measured by improvement in access to and quality of health services and in providing health financial risk protection .

Specifically, the project would focus on improving access to health services for the predominantly remote population of the state, through strengthening public and private health-delivery systems; promoting greater stewardship and managerial capacity in the state directorate; improving

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information systems; augmenting monitoring and research; and extending coverage of RSBY beyond hospitalization to include primary healthcare services.

A key area the project supports is innovative mechanisms for Uttarakhand to engage with private health care providers, expanding their role in meeting the unmet access needs of the state's population. A greater involvement of the private sector would create additional human resource availability for the public health system as a whole, also providing an opportunity to redeploy existing public staff in a more efficient and effective manner.

Key Results (From PCN)

At the PCN stage, a tentative list of indicators includes:

a) An increase by at least x% in the pool of human resources available to the public health system, for the high vacancy categories of medical officers and specialists;.
b) Independent household surveys report improvements in access and patient satisfaction by x% and y% over the measured baseline scores;
c) At least 'x'% of the state's eligible households access the primary care services integrated with RSBY
d) 'a%' and 'b%' of the state's population is covered by mobile care providers for (i) basic services and (ii) specialist services providing comprehensive case management services for chronic diseases, respectively
e) Access and utilization of inpatient and outpatient services provided by the public health system increased by 'x'% and 'y'% respectively in the hill districts of the state.

Additional indicators for quality of care and financial protection will be discussed and included during further preparation.

III. Preliminary Description

Concept Description

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Taking into account evidence around the shifting trends in morbidity and mortality, the Project would support the stewardship role and capacity of the state's Department of Medical Health and Family Welfare (DoMHFW) for improving health outcomes through multi-sectoral actions; innovations in developing and engaging the private sector; institutional strengthening; and improved management of health services.. Interventions support the state's plans for scaling up health system reform initiatives and making progress towards universal health coverage. Special focus would be on improving access to quality health services for the geographically dispersed and remote populations in the state, and finding innovative ways to engage with the private sector. The project also aims to reduce financial risk and make affordable, high quality healthcare available to all of the state's citizens.

The proposed project will have two components as follows:

(i) Stewardship and system improvement component that aims to address system-wide challenges in strategic planning, data generation and management, health communication, human resources management and development, procurement and supply chain management and multisectoral coordination (US$ 35 million). The project will build upon the foundations of the previous Bank project in the state. It will work closely with the present structure of the National Rural Health

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Mission (NRHM), which is the flagship initiative of the national government, providing additional financial resources to strengthen the state's health delivery infrastructure, with a focus on public health, maternal and immunization services, and disease control programs. The project will expand the existing financial protection scheme for inpatient care (RSBY) to incorporate primary care services related to child health and NCDs.

The project will maximize the use of available human resources and expand the manpower available to provide health services by engaging the private sector, as described in the second component below. At the state level, this component will strengthen the program management capacity for the health system as a whole, by hiring contractual expertise to augment and supplement the available human resources in specific areas where skills and expertise are not adequately available in the state's health system, and yet vital for the state's stewardship and strategic management functions. This includes expertise in areas such as health economics, hospital administration, quality assessment, health informatics, operational research, health communications, epidemiology and biostatistics, logistics management, project management, and contract management.

This component will also be used to make investments in designing and implementing information systems, to support research studies in public health including impact evaluations of project interventions, and to promote capacity building initiatives aimed at human resources across all levels of the health system.

(ii) Innovations in engaging the private sector component would augment the state's capacity in improving access to health services, particularly for remote populations, and in strengthening of primary care. The component would improve upon the current PPP practices in the state to enhance the reach and quality of health care service delivery, integrate primary care coverage into the state's health insurance program (RSBY), as also address the capacity building needs of the health system. This component , will have three key sub-components: (a) Outsourcing of community health centers (CHCs) (US$45 million); (b) Expanding RSBY to include primary care (US$35 million); and (c) Performance-based contracting for mobile medical units for basic as well as specialist care (US$10 million). These are further detailed below.

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The RSBY sub-component is unprecedented in the country's context and will focus on designing, implementing and evaluating benefit packages around childhood and adolescent health as well as case management of non-communicable diseases in primary care settings. By focusing on children's health and NCDs, the project will tackle two key priorities for the GoUK and essential determinants of catastrophic health expenditure for the poor.

The outsourced mobile medical units, already being piloted in the state, also hold potential for improving access to primary medical care, particularly if closely integrated with the state's plans for a medical helpline and telemedicine services to complement the same. The 'Specialist Mobile Units', again a first-time innovation, would require the private operator to deploy teams comprising of a medical specialist, nurse, laboratory technician and a driver, following a hub-and-spoke model. These teams would be headquartered in semi-urban locations for part of the week, and in the remaining days, they would reach out to PHCs and CHCs within their geographic jurisdiction, as per a predetermined schedule. This will ensure that specialists are available to manage elective services at the local level, minimizing the need for referral and transportation costs.

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Safeguard: The team will work with the GOUK to consider the environmental and social impacts of the project in an integrated manner to promote sound and sustainable environmental and social performance and project outcomes. Environmental and Social Management Plan (ESMP) will be developed and monitored throughout the project cycle. The team will particularly support the GOUK to assess environmental impact of outsourcing the CHCs and contracting of mobile medical units. A social assessment is also planned to measure the social impact –both positive and negative- of the project on the tribal groups in the remote areas of Uttarakhand.

IV. Safeguard Policies that might apply

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

V. Financing (in USD Million)

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

Financing Source	Amount
BORROWER/RECIPIENT	25.00
International Development Association (IDA)	100.00
Total	125.00

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