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The US Healthcare System: Current Issues And Proposal For Further Reform

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My opinion

Abstract

This article discussed the strength and limitations of the current US healthcare system and provided some preliminary reform proposals. The US health system spending is the highest around the world, yet its performance is disappointing. The issues of the US health system include ideological clash on health care right, the uninsured population that compromise the equity and responsiveness, the high health spending that made the government-sponsored programs unsustainable and put US business at competitive disadvantage, the disappointing quality of care and performance measures, as well as the political struggle to reform. A number of changes are proposed to establish a national health insurance program to provide basic health care for every citizen in this country. The policy level changes are proposed at systematic, programmatic, organizational, and instrumental levels. In addition to the ongoing health reform initiatives from the government, it is necessary to call for a more fundamental reform that would require ideological reform to recognize health care as a fundamental right, government reform to run and regulate the program, and economic reform to fund the program. The focus of the proposal will be on equity, government regulation, cost effectiveness/price control, and prevention/education.

Keywords: health system, equity, reform, balance, health spending, national health insurance system

Introduction

According to the definition of the World Health Organization (WHO) [1], health systems consist of all the people and action whose primary purpose is to improve health. Health systems serve three fundamental goals: improve health, enhance responsiveness to people's expectations, and assure fair financial contribution [2] by performing four basic functions: namely financing, service provision, resource generation, and stewardship. There are approximately 200 countries and areas in the world, and each has its own health system to fund and provide health care to its people. The basic health system models include: the national health service model (Britain, Cuba), the social insurance model (Germany), the national health insurance model (Canada), and the out-of-pocket model (Cambordia, Burkina Faso) [3]. The features of the four health system models are presented in Illustration 1 and Attachment 1. The performance of health systems vary greatly among the different countries, which is measured by assessing the goal attainment with the available resources [2, 4]. The performance measurement helps to develop policies for improvement and to monitor the outcome of reforms in health systems [4].

The US health system has features of all the four basic models based on different population groups. While majority of people purchase private health insurance through their employers, the government finances the Veteran Health Administration for veterans, Medicare for senior citizens older than age of 65, Medicaid for low income citizens, and workers' compensation for work-related disability. However, there are about 45 million, or 15%, citizens who do not have any health insurance, a phenomenon not seen in other industrialized countries. As Physicians for a National Health Program [3] stated, "When it comes to treating veterans, we're Britain or Cuba. For Americans over the age of 65 on Medicare, we're Canada. For working Americans who get insurance on the job, we're Germany. For the 15 percent of the population who have no health insurance, the United States is Cambodia or Burkina Faso or rural India …" (para. 3).

The US spend 15% of GDP on health care, or $6,714 per capita, which is the highest in the world (Illustration 3, Attachment 2). In addition, the health care spending is increasing fast, expecting to reach almost 20% of GDP by the year 2017, at a much faster rate than wages or inflation. Despite of abundant funding and advanced health care technology, the US health system is constantly under-perform, lagging behind major developed countries, such as the OECD countries (Illustration 3, Attachment 2) [5, 6]. The efficiency of US health system is barely above average worldwide [4]. The healthy life expectancy is lagging behind major OECD countries, and the health service and coverage are highly categorical, falling short the expectations of the public.

One wonder why the US, with such high GDP, sophisticated health care technology, and high health care spending, fails to do well in healthcare

performance. What are the reasons? And how we can improve? This article gives an overview of the US health system as compared to other health system models, discusses the current issues the US health system faces, and makes a proposal for US health care reform.

Current Issues in the US Healthcare System

Ideological Clashes

In the US, there is no ideological foundation on health care. There are constant debates on whether health is a privilege or a right. The ideological difference resulted in lack of moral and cultural support of a public universal health system. Some people may fear the ideology of socialism in health care as rationing, while others think a mandatory insurance coverage is against the freedom of citizens. To get things worse, “Insurers, providers, business interests, and other opponents of reform loudly equate all such aggregate constraints with ‘rationing’, and the equation has dependably terrified public opinion” (p. 53) [5]. As a result, numerous reform attempts by governments met strong resistance and failed eventually.

Equity and Responsiveness

The health coverage in the US is highly categorical, as discussed previously. There are currently 15% or 46 million of citizens do not have any health insurance at all. A study showed that 62% of personal bankruptcies in the US are related to health expenditure in 2007, and meanwhile, average families have to pay additional $1000 each year in insurance premiums to cover the uninsured, which President Obama called “a hidden and growing tax” [7].

Increasing Financial Burden

Despite of the highest spending in the world, the US health care costs are increasing at a pace much faster than wage increase or inflation. The government sponsored health programs, such as the Medicare and Medicaid, are unsustainable without fundamental reforms. Influx of illegal immigrants further drained the government health budget. Prescription drugs are the most expensive per capita in the world, and there is no control on the monopoly price of patented drugs, which is a big financial burden to patients, insurance companies, and governments. On the other hand, the high costs of health insurance put US business at a competitive disadvantage. US small business becomes more and more reluctant to provide health insurance for their employees.

Unsatisfactory Health Care Performance

The US health care performance lagged behind many industrialized countries by many measurement gauges, including life expectancy, infant mortality rate, health system efficiency, years of potential life lost (Illustration 3, Attachment 2) [4, 8]. The WHO ranked the US 37th in overall performance and 72nd by overall level of health around the world.

Political Struggle on Health Reform

Though surveys show that majority of Americans support a universal health system, political reform on health care met strong resistance. Historically the US government and politicians have tried numerous times to make different forms of universal health programs. For example, Presidents F. D. Roosevelt, Truman, Johnson, and Nixon all attempted to established such programs, which were defeated by either political opposition or lobbying from health industry. Even today, the Republicans and Democrats are deeply split on major health care issues. No Republican supported the health reform bills proposed by President Obama. Each year, the lobbying groups from health care industry (drug companies, providers, and insurers) spend millions to billions of dollars to block health care reform initiatives in order to protect their special interests. Meanwhile, the health care industry in the US are much more profitable than any other country in the world.

Proposed Changes

Based on the discussions and readings learned from this course, I would like to propose to establish a national health insurance system in this country, which would cover the basic care for every citizen (and legal aliens) and would be provided free or with minimal co-pay at service. The reform would proceed at four policy levels at summarized in Illustration 2. The priority of reform would focus on cost effectiveness, preventive measures, and promote healthy lifestyle. It would also balance the finance for each component in the system, the different geographical areas, and the different specialties. It would encourage innovation and human resource development. However, due to the failures of previous reform attempts, it is necessary to initiate ideological, political, and economical reforms at the same time.

Ideological Reform

A fundamental health reform requires ideological reform on health care. If we think that 95% of human life is based on hardware, which is a physically and mentally healthy body, and only 5% of human life is based on built-on activities that we can make choices, such as professional, family, spiritual, and political activities. It would not be difficult for us to make a conclusion that health is a basic, and the ultimate, human right of all. Thus, health should not be treated as a commodity, and health coverage should not base on economic status. Every citizen in this country is entitled, at minimum, basic health care coverage. Universal health coverage reflects the core values of human right, dignity, community, equity, and solidarity.

As Brown [5] stated, “Respect for human dignity demands that no one refrain from seeking medical care from fear of the consequences of doing so, and that no one suffer financial adversity as a result of having sought care” (p. 52). Some people in this country may fear the ideology of socialism in health care, actually respect of human dignity is the basic value of democracy and freedom. On the other hand, it is not right to treat health as a commodity and apply market principles to health care.

People, by perceptions, usually link public health care system to rationing, long wait lists, low health care quality, and high taxation. Experience in other countries indicated that they are not necessarily linked. For example, one study showed that health care quality in Canada, with a universal national health insurance system, is at least as good as that in the US, but at only half of the US health care spending per capita [9].

Government Reform

A good health system requires strong government regulation to ensure fairness and to be responsive to people’s expectations. Health coverage of its citizens is a responsibility of any government. The government will regulate taxation to ensure citizens pay the fair share to the health system, allocate the resources to ensure the system meet people’s needs, and control the prices for services and drugs, which is a key for cost containment, which has been demonstrated in countries with public health systems such as Canada [5].

The government should out-law the practice of lobbying of policy makers from special interest groups. Democracy should not be used as a tool for certain groups with social advantages or economic influence. These groups represent the special interest of their own, not that of the general public, thus lobbying is against the public interest and should be treated as a form of corruption.

The government policy will focus on the following issues: legislate health as a fundamental human right, reduce inequalities in contribution and coverage to ensure fairness, control service and drug prices and meanwhile encourage innovation, educate the public and promote preventive measures, establish strong primary care services and balance between different geographical areas, balance different health care specialties, crack down on abuse and fraud.

Economical Reform

The biggest question for any reform is the cost. Who is going to pay for a public health system with universal coverage? Do we have the capability to pay for it? This requires swift economical reforms. The government should fund the system with tax revenue, set ceiling on health care spending, control health care prices, control drug prices, regulate profit of health industry, allocate resources to improve efficiency. The government should oversight health service billing to avoid financial motivated wrong doings.

Health Education

The government should increase budget in public health education, promote healthy life style, and focus more on preventive measures. Studies have shown education is linked to health improvement, and it is a cost effective way of intervention. On the other hand, the government should encourage medical research and innovation in health care technologies, with the emphasize on cost efficiency.

Impact of Health Reforms

The proposed changes would have profound impact. President Obama enacted health reform bills to cover the uninsured population, protect patient rights, and cut health care spending. The proposed changes would go further than the Obama plan in the following areas: 1) it calls for ideological reconciliation on health care right; 2) the goal is to establish a national health insurance plan that cover every citizen and legal alien on uniform terms; 3) it requires strong government regulation on health care industry through financing, price/profit control, and planning; 4) it requires a nation-wide health information sharing to track patient health history; 5) The priority will focus on cost effectiveness, preventive measures, and good lifestyle.

Strong opposition to the proposed changes is predicted. Oppositions will come from the fear of higher taxation to support such a national health insurance program, long waiting list or health care rationing, decreased care quality, as well as lower salaries for health care providers. While to some extent the public health programs have such weakness, the proposed reforms will improve to attain goals on health, fairness, and responsiveness overall. That is why many industrialized countries with universal health care are constantly ranked higher than the US on many health measures. Of course, every health model in the world is facing challenges on old aging, worsening economy, insufficient funds, rising health costs, and increasing expectations. The governments should pro-actively seek opportunities for funding and better goal attainment with existing resources.

Conclusion

This article gave a review of the issues in the current US healthcare system and made some reform

proposals. It calls for a fundamental health reform that would require ideological reform to recognize health care as a fundamental right, government reform to run and regulate the program, and economic reform to fund the program. The focus of the proposal will be on equity, government regulation, cost effectiveness, price/profit control, and prevention/education.

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Illustrations

Illustration 1

Comparison of the Four Health Systems

Illustration 1

Comparison of the four health systems

	National Health Service Model	**Mandated Social Insurance Model**	**National Health Insurance Model**	**Out-of-Pocket Model**
Example	United Kingdom	Germany	Canada	Cambodia
Feature	Single payer national health service, financed by general tax revenue, government owns and controls the factors of production	Mandated social insurance, financed by work-based social insurance contribution, public and/or private ownership of factors of production	Mandated national health insurance, financed largely by government through general tax revenue and health insurance contributions, public and/or private ownership of factors of production	Market driven, financed largely by individual out-of-pocket payments, largely private ownership of factors of production
Participation	Compulsory	Compulsory	Compulsory	Open
Coverage	Universal	Categorical/Universal	Universal	Categorical
Entitlement	Citizenship	Occupation	Citizenship	Financial status
Choice of Insurer	No	No/Yes	No	Yes
Financing	Government funding with tax revenue	Employer and employee contributions to nonprofit sickness funds	Government funding with tax revenue and health insurance contributions	Largely individual out-of-pocket payments, premiums, with some government and charity funding
Nature of funds	Public	Public	Public	Private/public
Employer contribution	No	Yes	No	No
Costs	Government pays for health care	Social insurance pays for health care	National health insurance pays for health care	Largely patient pays for health care
Risk pooling	National	Fund	State/province	Individual

Issues	1. Long wait 2. Limited choice 3. High tax rate	1. Coverage may be different for unemployed people 2. Providers feel underpaid 3. Pressure on employment income	1. Occasionally long wait 2. Limited choice 3. High tax rate	1. Inequity among people, the poor is denied of healthcare 2. Limited government support and regulation on health care services 3. Lack of infrastructure of health care systems 4. Lack of core values of solidarity, equity, dignity, and community 5. Inefficient on resources and costs
Markets	Public authority and planning	Public authority and planning, managed competition	Public authority and planning, managed competition	Competition
Supply				Market driven
GDP % on healthcare	8.4	10.4	10	6
Health system efficiency	0.8 – 0.9	0.7 – 0.8	0.8 – 0.9	0.5 – 0.6

Note. Prepared based on [2, 3, 4, 5, 6, 11]. For detailed data from each country, refer to Illustration 3, Attachment 1.

Illustration 2

The US Health System Reform

Illustration 2

The US Health System Reform

Policy Level	Main Goal	Issues	Current Status	Proposed Change
Systematic	Equity	Basis for population eligibility	Eligible population groups (senior, veteran, employee, low income family, etc.)	Every US citizen and legal alien covered by basic health care
		Health system model	Mixed models (Medicare, Medicaid, Millitary/Veteran Health Administration, State Children Health Insurance, Employer-sponsored health insurance, Out-of-pocket)	Comprehensive national health insurance
		Public agencies involved in health care	Different federal government agencies sponsor public programs for different categories of eligible population	Federal or state government agencies sponsor a universal health care program on uniform terms
		Public/private mix	Government and private employers run different programs	Largely government covers basic health insurance for all people, private insurance optional for extended coverage
Programmatic	Allocation efficiency	Priority setting	Focus more on innovative treatments, metropolitan areas, and competition advantages	Focus more on cost-effectiveness, preventive measures, health education, and good lifestyle, balanced finance on each component of health care system, balance distribution of primary care and different specialties
Organizational	Technical efficiency	Productivity		Improve productivity by eliminating wastes, continuous improvement, and cost effectiveness. Single payer system to eliminate spending on marketing and administration. Crack down on abuse and fraud. Better co-ordination between hospitals, doctors, nurses, and other health professionals for patient care.
		Quality of care	Different quality levels	Guaranteed basic level of care for all population

Illustration 3

Attachment 1: Comparison of Health Systems in UK, Germany, Canada, and Cambodia [12]

Illustration 3

Attachment 1: Comparison of Health Systems in UK, Germany, Canada, and Cambodia [12]

Health Systems Model	**National Health Service Model**	**Social Insurance Model**	**National Health Insurance Model**	**Out-of-Pocket Model**
Country	**United Kingdom**	**Germany**	**Canada**	**Cambodia**
Core Module				
Population, total	61,414,062	82,110,097	33,311,400	14,562,008
Population growth (annual %)	0.67	-0.19	1.01	1.65
Rural Population (% of total)	10.06	26.36	19.6	78.44
Urban Population (% of total)	89.94	73.64	80.4	21.56
Population ages 0-14 (% of total)	17.54	13.7	16.76	34.13
Population ages 65 and above (% of total)	16.3	19.97	13.62	3.39
Contraceptive prevalence (% of women ages 15-49)	84	74.7	74.7	40
Fertility rate, total (births per woman)	1.94	1.38	1.6	2.91
Pregnant women who received 1+ antenatal care visits (%)	--	--	--	69.3
Pregnant women who received 4+ antenatal care visits (%)	--	--	--	27
Prevalence of HIV, total (% of population aged 15-49)	0.2	0.1	0.4	0.8
Life expectancy at birth, total (years)	79.9	80.09	80.96	60.97
Mortality rate, infant (per 1,000 live births)	4.9	3.7	5.7	69.31
Mortality rate under-5 (per 1,000)	5.7	4.3	6.4	89.5
Maternal mortality ratio (per 100,000 births)	8	4	7	540
GDP per capita (constant 2000 US$)	28,955	25,473	26,200	510.81
GDP growth (annual %)	0.71	1.27	0.4	6.7
Per capita total expenditure on health at international dollar rate	2,784.00	3,328.00	3,672.00	167
Private expenditure on health as % of total expenditure on health	12.6	23.4	29.6	73.9
Out-of-pocket expenditure as % of private expenditure on health	92.2	56.7	49	84.4
Gini index	35.97	28.31	32.56	44.2
Adult literacy rate (%)	--	--	--	76.3
	--	--	--	77
Population with sustainable access to improved drinking water sources (% total)	100	100	100	65
Improved sanitation facilities (% of population with access)	--	100	100	28

Government expenditure on health as % of total government expenditure	16.5	17.6	17.9	10.7
Public (government) spending on health as % of total health expenditure	87.4	76.6	70.4	26.1
Donor spending on health as % of total health spending	0	0	0	22.3
Out-of-pocket expenditure as % of private expenditure on health	92.2	56.7	49	84.4
Out-of-pocket expenditure as % of total expenditure on health	11.62	13.27	14.5	62.37
Private expenditure on health as % of total expenditure on health	12.6	23.4	29.6	73.9
Service Delivery Module				
Number of hospital beds (per 10,000 population)	39	83	34	1
Percentage of births attended by skilled health personnel	99	100	100	43.8
DTP3 immunization coverage: one-year-olds (%)	92	93	94	78.3
Contraceptive prevalence (% of women ages 15-49)	84	74.7	74.7	24.1
Pregnant women who received 1+ antenatal care visits (%)	--	--	--	69
Life expectancy at birth, total (years)	79.9	80.09	80.96	60.97
Mortality rate, infant (per 1,000 live births)	4.9	3.7	5.7	69.31
Maternal mortality ratio (per 100,000 births)	8	4	7	540
Prevalence of HIV, total (% of population aged 15-49)	0.2	0.1	0.4	0.8
Children under five sleeping under insecticide-treated bed nets	--	--	--	4.2
Children under five years with diarrhea receiving oral rehydration	--	--	--	49.9
ART coverage among people with advanced HIV infection (%)	--	--	--	54
Human Resource Module				
Physicians (density per 10,000 population)	2.2	3.48	1.91	0.16
Nursing and midwifery personnel density (per 10 000 population)	6.3	79.9	100.5	8.5
Pharmacists (density per 10,000 population)	5	6	8	--
Lab technicians (density per 10,000 population)	3	--	11	--
Pharmaceutical Module				
Total expenditure on pharmaceuticals (% total expenditure on health)	14.1	13.6	14.9	36.7
Total expenditure on pharmaceuticals (per capita at average exchange rate) in US$	253	328	313	11
Government expenditure on pharmaceuticals (per capita at average exchange rate) in US$	167	227	113	1
Private expenditure on pharmaceuticals (per capita at average exchange rate) in US$	86	102	200	10

Percentage of surveillance reports received at the national level from districts compared to number of reports expected (Completeness of reporting,%)	90% or more	25%-74%	--	90% or more

Note. Prepared based on: http://healthsystems2020.healthsystemsdatabase.org/datasets/CountryReports.aspx

Attachment 2: Profile of the US health system, compared to the that of the OECD Countries[12]

Health Systems Data	Source of Data	United States Data	Year of Data	Average Data for OECD Countries	Year of Data
Core Module					
Population, total	WDI-2010	304,060,000	2008	35,980,240	2008
Population growth (annual %)	WDI-2010	0.92	2008	0.77	2008
Rural Population (% of total)	WDI-2010	18.3	2008	23.8	2008
Urban Population (% of total)	WDI-2010	81.7	2008	76.2	2008
Population ages 0-14 (% of total)	WDI-2010	20.44	2008	16.92	2008
Population ages 65 and above (% of total)	WDI-2010	12.63	2008	15.54	2008
Contraceptive prevalence (% of women ages 15-49)	WDI-2010	76.4	1995	77.78	1995
Fertility rate, total (births per woman)	WDI-2010	2.1	2008	1.69	2008
Pregnant women who received 1+ antenatal care visits (%)	UNICEF_Chidinfo.org	--	--	99.75	1991
Pregnant women who received 4+ antenatal care visits (%)	UNICEF_Chidinfo.org	--	--	--	--
Prevalence of HIV, total (% of population aged 15-49)	UNAIDS 2008	0.6	2007	0.24	2007
Life expectancy at birth, total (years)	WDI-2010	78.44	2008	79.95	2008
Mortality rate, infant (per 1,000 live births)	WDI-2010	6.7	2008	3.81	2008
Mortality rate under-5 (per 1,000)	WDI-2010	7.8	2008	4.58	2008
Maternal mortality ratio (per 100,000 births)	WDI-2010	11	2005	6.22	2005
GDP per capita (constant 2000 US$)	WDI-2010	37,867	2008	25,876	2008
GDP growth (annual %)	WDI-2010	0.4	2008	0.91	2008
Per capita total expenditure on health at international dollar rate	WHO	6,714.00	2006	3,110.33	2006
Private expenditure on health as % of total expenditure on health	WHO	54.2	2006	25.62	2006
Out-of-pocket expenditure as % of private expenditure on health	WHO	23.5	2006	72.82	2006
Gini index	WDI-2010	40.81	2000	31.88	2000

Voice Accountability - Point Estimate	WB-Governance Indicators	1.12	2008	1.26	2008
Voice and Accountability - Percentile Rank	WB-Governance Indicators	86	2008	89.55	2008
Political Stability - Point Estimate	WB-Governance Indicators	0.59	2008	0.91	2008
Political Stability - Percentile Rank	WB-Governance Indicators	68.4	2008	79.21	2008
Government Effectiveness - Point Estimate	WB-Governance Indicators	1.65	2008	1.49	2008
Government Effectiveness - Percentile Rank	WB-Governance Indicators	92.8	2008	89.33	2008
Rule of Law - Point Estimate	WB-Governance Indicators	1.65	2008	1.47	2008
Rule of Law - Percentile Rank	WB-Governance Indicators	91.8	2008	89.11	2008
Regulatory Quality - Point Estimate	WB-Governance Indicators	1.58	2008	1.43	2008
Regulatory Quality - Percentile Rank	WB-Governance Indicators	93.2	2008	90.06	2008
Control of Corruption - Point Estimate	WB-Governance Indicators	1.55	2008	1.51	2008
Control of Corruption - Percentile Rank	WB-Governance Indicators	91.7	2008	87.64	2008
Health Financing Module					
Total expenditure on health as % of GDP	WHO	15.3	2006	9.07	2006
Per capita total expenditure on health at average exchange rate (US$)	WHO	6,714.00	2006	3,482.22	2006
Government expenditure on health as % of total government expenditure	WHO	19.1	2006	15.71	2006
Public (government) spending on health as % of total health expenditure	WHO	45.8	2006	74.38	2006
Donor spending on health as % of total health spending	WHO	0	2006	0	2006
Out-of-pocket expenditure as % of private expenditure on health	WHO	23.5	2006	72.82	2006
Out-of-pocket expenditure as % of total expenditure on health	WHO	12.74	2006	17.77	2006
Private expenditure on health as % of total expenditure on health	WHO	54.2	2006	25.62	2006
Service Delivery Module					
Number of hospital beds (per 10,000 population)	WHO	32	2005	53.73	2005
Percentage of births attended by skilled health personnel	WDI-2010	99.3	2003	99.76	2003
DTP3 immunization coverage: one-year-olds (%)	WHO	96	2004	94.3	2007
Contraceptive prevalence (% of women ages 15-49)	WDI-2010	76.4	1995	77.78	1995

Human Resource Module					
Physicians (density per 10,000 population)	WDI-2010	2.67	2004	2.41	2007
Nursing and midwifery personnel density (per 10 000 population)	WHO	98.2	2005	103.67	2007
Pharmacists (density per 10,000 population)	WHO	9	2000	7.82	2006
Lab technicians (density per 10,000 population)	WHO	23	2000	--	--
Pharmaceutical Module					
Total expenditure on pharmaceuticals (% total expenditure on health)	WHO-The World Medicines Situation-2004	11.9	2000	15.99	2000
Total expenditure on pharmaceuticals (per capita at average exchange rate) in US$	WHO-The World Medicines Situation-2004	541	2000	262.22	2000
Government expenditure on pharmaceuticals (per capita at average exchange rate) in US$	WHO-The World Medicines Situation-2004	99	2000	155.15	2000
Private expenditure on pharmaceuticals (per capita at average exchange rate) in US$	WHO-The World Medicines Situation-2004	442	2000	107.96	2000
Health Information System (HIS) Module					
Maternal mortality ratio reported by national authorities (Timeliness of reporting, years)	WDI-2010	3-5 years	--	3-5 years	--
Mortality rate under-5 (Timeliness of reporting, years)	WDI-2010	0-2 years	--	0-2 years	--
HIV prevalence rate in total population aged 15-24 (Timeliness of reporting, years)	UNAIDS 2008	less than 2 years	--	less than 2 years	--
Low birth weight newborns (Timeliness of reporting, years)	WHO	6-9 years	--	6-9 years	--
Number of hospital beds (Timeliness of reporting, years)	WHO	2-3 years	--	2-3 years	--
Contraceptive prevalence (Timeliness of reporting, years)	WDI-2010	4 years or more	--	4 years or more	--
Percentage of surveillance reports received at the national level from districts compared to number of reports expected (Completeness of reporting,%)	--	No National Database/No Data	--	--	--

Note. Adopted from: http://healthsystems2020.healthsystemsdatabase.org/datasets/CountryReports.aspx

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