

Editorial

Universal Health Coverage in India: The time has come

In 2006, the National Sample Survey Organization reported that 28% of rural Indians and 20% of urban Indians could not access healthcare because of financial barriers.¹ These percentages had doubled over the previous two decades. At the same time, 39 million Indians were noted to have been pushed below the poverty line because of unaffordable healthcare costs. These numbers rise every year.

There is no denying that India's economic growth over the past two decades has not been reflected in its health indicators. Though the country's infant mortality rate has improved recently, it stands at 47 per 1000 live-births, in comparison to Sri Lanka's 10. Similarly, India's maternal mortality ratio of 212 per 100 000 live-births compares poorly with Sri Lanka's 39. In the past decade, the progress of our other neighbours, such as Bangladesh and Nepal, in these vital health indicators has been much more impressive than ours. The fact that the prevalence of undernutrition among our young children is 42% has been described as a 'national shame' by the Prime Minister.²

Within India, there are huge inequities in health across states, between rural and urban areas and among various social strata. A girl born in Madhya Pradesh is six-times more likely to die before her first birthday than her counterpart born in Kerala. A woman from a Scheduled Tribe is far more likely to be anaemic and underweight than an urban upper-caste woman.

The two major contributors to India's poor health status are the lack of attention given to the social determinants of health (such as drinking water, sanitation, nutrition, the environment, education and livelihoods) and the failure of the health system to provide essential promotive, preventive, diagnostic, therapeutic and rehabilitative services to all citizens, with assurance of easy access, appropriate quality and financial affordability. Together, these factors have undermined the average Indian's ability to enjoy good health across a long life span, with the poor being the worst victims of imposed and ignored ill-health.

While paying special attention to the needs of the poor, the principle of universality must be applied to assure essential health services to all citizens. This is because many persons above the controversially defined 'poverty line' are also very vulnerable to the impoverishing impact of health expenditure. Also, programmes designed 'only for the poor' are likely to end up as poor programmes, in design as well as delivery. Every section of society must have a stake in the success and sustainability of social sector services. Targeted programmes often fail to deliver the promised services and do not offer real help to the intended beneficiaries.

A low level of public financing (stagnant at around 1% of our gross domestic product [GDP] for many years) has contributed to the inability of the health system to provide requisite services. This has led to a high level of 'out-of-pocket' or private expenditure on health (currently estimated at 71% of all spending on health). In per capita terms, India's public spending on health is US\$ 43, compared to Sri Lanka's US\$ 87.³ Public financing of health varies widely among the Indian states—Kerala's per capita expenditure is three-times more than that of Bihar.

There is also a severe shortage of human resources in the health sector. The number of health workers per 10 000 population is 19, which is below the WHO's recommended norm of 23.⁴ There are shortages across the board, from community health workers to specialist doctors, with the low nurse-to-doctor ratio (1.5:1 instead of the desirable 3:1) being of particular concern. There is a maldistribution of even those who are available, with 80% of doctors, 75% of dispensaries and 60% of hospitals concentrated in urban areas.

The National Rural Health Mission (NRHM), Rashtriya Swasthya Bima Yojana (RSBY) and several health insurance programmes funded by the state governments (such as Rajiv Arogyashri in Andhra Pradesh) have attempted to increase access to and the affordability of healthcare in recent years. The impact of the NRHM, the focus of which has been mainly on maternal and child health, has been limited by the shortage of health workers in primary healthcare facilities, as well as due to issues related to poor governance and the leakage of funds in some states. The RSBY and the state government schemes provide partial coverage for hospitalization at secondary or tertiary centres. They have had no impact on out-of-pocket expenditure, which is largely determined by outpatient care and medicines.⁵ Primary care is neglected in these schemes and public hospitals lag behind private hospitals in benefiting from governmental funding for these insurance programmes.

Contributory social insurance is not feasible as a method of risk-pooling and financial protection in India, since 93% of our workforce is in the unorganized sector and a large part of our population lives below or close to the poverty line. Private health insurance is similarly unaffordable for most and is also not the preferred option. In the words of William Hsiao, a leading health economist from Harvard: 'Empirical evidence indicates that a free market for insurance cannot achieve social equity and that serious market failures allow insurers to practice risk selection, leaving the most vulnerable people uninsured. Adverse selection among insurance buyers impairs the functions of the insurance market and deters the pooling of health risks widely. Moreover, the insurance market's high transaction costs yield highly inefficient results.'⁶

The High-Level Expert Group (HLEG) constituted by the Planning Commission of India in October 2010 recommended an increase in public funding of health to a minimum of 2.5% of the GDP during the 12th Five-Year Plan (2012–17) and a minimum of 3% by 2022.³ While a fully evolved programme of universal health coverage (UHC) will require a higher level of public funding (around 4% of the GDP),⁷ that level will probably be attained only in the 14th Five-Year Plan due to fiscal constraints. Nevertheless, many of the essential steps for promoting UHC can be initiated in the 12th Plan.

The HLEG has listed the expansion and augmentation of primary healthcare, strengthening of district hospitals, expansion and upgrading the skills of the health workforce, free provision of essential medicines, abolition of 'user fees', establishment of effective regulatory structures and support for active community participation as high priorities requiring early action.

The health subcentre should effectively provide facility-based as well as community outreach services. To make this possible, the staff in a health subcentre has to be expanded to include two auxiliary nurse midwives, one male multipurpose health worker, one mid-level health worker (bachelor of primary health practice) or an AYUSH (ayurveda, yoga and naturopathy, unani, siddha and homoeopathy) doctor with bridge training and one multipurpose technician (for basic laboratory tests, drug dispensing and data entry). Primary and community health centres should be strengthened, especially through an increase in the nursing staff. District hospitals should be developed so that they become capable of delivering all the elements of secondary care and some elements of tertiary care. In addition, they should be able to serve as training centres for various categories of health personnel.

To ensure the availability of competent and committed health workers, attention must be paid to both numbers and quality. There is a need to establish new medical and nursing colleges. Priority would have to be given to locate these in states which now

have very few, and, preferably, the colleges should have linkages with the district hospitals. The training of health professionals has to emphasize health system connectivity, problem-solving skills, team function and partnership with the community. Interdisciplinary education in public health and health system management should be fostered, leading to the creation of public health and health management cadres.

Every citizen should be entitled to assured free access to a package of essential health services, which will be periodically defined by an expert body, through a national health entitlement card (India Health Card). Public facilities for healthcare will have to be the main delivery system of UHC. Wherever necessary, private healthcare providers can be contracted in by the public system to provide additional services and fill the gaps in coverage. Such contracts have to clearly define the deliverables, fix accountability and link payment to a package of care rather than charge a 'fee for service' for every visit or procedure.

The HLEG has recommended the formation of an autonomous body, the National Health Regulatory and Development Authority, which would be linked to but not located in the Ministry of Health and Family Welfare. This body should have a UHC support system, consisting of a technical wing (for the development of standard management guidelines and quality assurance), a legal-regulatory-financing wing (for the development of norms for contracts, financial flow mechanisms and the regulation of healthcare facilities), and a health information systems wing (for monitoring and analysing the information flow on the functioning of UHC across the country). These should be complemented by an accreditation wing (to develop the norms for affiliation of healthcare facilities and maintenance of a live registry), and a monitoring and evaluation wing (to conduct an independent evaluation through input, process, output and impact indicators). These agencies should also have their state-level counterparts. The latter will play the operational role in the states, while the national body will be mainly normative.

UHC is both a developmental imperative and a moral obligation. Many developing countries (such as Mexico, Brazil, China, Thailand and South Africa) have reached or are close to 100% coverage of their citizens with respect to essential health services. In most cases, this has been achieved through tax-financed services and an adequate level of public funding for health. India is now at the threshold of a historic transition, wherein a dysfunctional and inequitable health system can be transformed into an efficient and equitable provider of UHC. What is needed now is political leadership by the governments at the Central and state levels, which should act in concert to adopt a national framework that is suited to state-specific adaptations.

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