Dr Nata Menabde, WHO Representative to India and Dr Arunachalam Gunasekar, Technical Officer, WHO India Country Office for India elucidate on the steps needed to taken in the coming year for achieving Universal Health Coverage in India and stress that access for all would come with financial protection.

Encouraged by the country’s unprecedented economic progress, the Prime Minister-led call for achieving universal health coverage in India is gathering further momentum. Described by the WHO Director General, Margaret Chan as “the single most powerful concept that public health has to offer”, universal health coverage seeks to ensure that all people have access to the needed comprehensive health services of sufficient quality and effectiveness, at the same time ensuring that people do not suffer financial hardship while accessing health services. Universal health coverage is expected to allow everyone - the rich and poor, men and women, ethnic or religious majorities and minorities - to enjoy full and equal access to the services concerned.

International experience shows that universal health coverage is not only a matter of rich countries. Even lower-middle income countries, for example Ghana and Indonesia, have made substantial progress, provided that the idea receives sufficient political support.

Though India’s total health expenditure at 4.2 per cent of GDP is not too small a figure in comparison to many countries, the country’s public expenditure on health (1.04 per cent of GDP in 2011-12) is too small to make sufficient progress towards universal health coverage. The government expenditure on drugs, for example, in 2010-11, was only Rs. 5,034 crores (4.9 per cent of total government expenditure on health), a much lower figure than most countries.

The persistent low levels of public health expenditure has possibly been also one main reason for service quality and infrastructure deficiencies in public sector health facilities resulting in steady increase of population preference for private sector providers since 1995-96 (National Sample Surveys). In fact, the main reasons given by the population for private sector preference are non-availability of services in public facilities, lack of satisfaction with provided services, distance and long waiting time.

The high costs of health care has also led to large numbers of ailments going untreated, and increasing numbers being pushed into poverty due to out-of-pocket expenditure (from 26 million in 1993-94 to 39 million in 2004-05). Out-of-pocket health expenditure in India is 60.2 per cent of total health expenditure. This is far
More is needed, please!

A major step the Government of India took in this direction was the launch in 2005 of the National Rural Health Mission (NRHM), with the main focus on improving primary health care. The NRHM has led to an increase in public spending and brought some flexibility into the financing mechanism. On the minus side, it has failed to adequately offset the fiscal limitations of the poorer states, leaving some states having poor health indicators with large unmet expenditure needs.

Shortfalls of health facilities remain at 20 per cent for Sub-Centres, 24 per cent for PHCs and 37 per cent for CHCs, with the worst situation in Bihar, Jharkhand, Madhya Pradesh and Uttar Pradesh. Despite some improvements in human resources for health in the public sector, serious shortages in staffing remain – 52 per cent for ANMs and nurses, 76 per cent for doctors, 88 per cent for specialists and 58 per cent for pharmacists.

Also maternal mortality ratio at national level remains unchanged (5.5 per cent in 2001-03 to 2004-06 and 5.8 per cent during 2004-06 to 2007-09) despite the efforts, with suboptimal performance in the very Empowered Action Group (EAG) states focussed for attention by NRHM. The likely explanations are gaps in ante-natal care, skilled birth attendance and emergency obstetrical care.

Part of the difficulty comes from the diversity of the country. The decline in infant mortality rates, for example, has accelerated in recent years but is still about four to five fold higher in the large states of Madhya Pradesh (59), Uttar Pradesh and Orissa (57), Assam (55), Rajasthan (52) when compared to more successfully performing states such as Goa and Manipur (11) and Kerala (12).

The Janani Suraksha Yojana (JSY) scheme has increased institutional deliveries in rural (39.7 to 68 per cent) and urban areas (79 per cent to 85 per cent) over the 2005–09 period, but low levels of full ante-natal care (22.8 in rural, and 26.1 in urban in 2009) and quality of care continue to be areas of concern. Also, a recent study in Jharkhand on 500 new mothers showed that bad roads, poor connectivity and unavailability of transport at night continue to force more than one-third of pregnant women to deliver at home. Full immunisation in children has only improved coverage from 54.5 per cent in 2005 to 61 per cent in 2009 during the Eleventh Plan.

A few years after the NRHM, the Rashtriya Swasthya Bima Yojna (RSBY) scheme run by the Ministry of Labour & Employment aims to provide financial risk protection for in-patient care (mainly) to the population living below poverty line. It uses an insurance mechanism and currently covers 80 million beneficiaries (in contrast, the NRHM is tax-based). Along with the comprehensive union-funded insurance schemes (Employee State Insurance Scheme, with 60 million beneficiaries and the Central Government Health Scheme covering three million), some 143 million people are now covered in India.

In recent years health insurance schemes funded by some states have emerged, already covering about 110 million people mainly for tertiary care (Andhra Pradesh – 70 million; Karnataka ? 5 million and Tamil Nadu – 35 million).

All the above routes need to be developed by pooling their financial resources, also reaping the benefit from extra efforts and even the strengths of individual schemes.

The Twelfth Plan strategy towards universal health coverage envisages a rise in public funding by the Centre and States to 1.87 per cent of GDP by the end of the Plan. At the time of writing this article, the Minister for Health & Family Welfare Shri Ghulam Nabi Azad stated in a reply to a question in the Parliament on 11 December 2012 that the tentative allocation for the 12th Five Year Plan for Ministry of Health and Family Welfare is Rs 300,018 crores as compared to the actual allocation of Rs. 99,491 crores during 11th Plan period. The 202 per cent increase in health budget in the 12th Plan over the 11th Plan allocation compares well with the 123 per cent and 109 per cent increase under the “social services budget” and “total budget” respectively.

The Twelfth Five-Year Plan (2012-17) intends to address India’s key financial and service provision challenges and realise the goal of universal health coverage in two parallel steps:

- Clinical services at different levels, defined in a government financed, public health system- provided Essential Health Package, supplemented whenever required to fill in critical gaps by contracted-in private providers; and
- Provision of high impact, preventive and public health interventions which the government would ensure universally.

The plan for widening the umbrella of NRHM into a National Health Mission for providing primary health care to the urban poor, estimated to be 9.3 million in size, is a further step in the right direction.

International experience shows that India’s march towards UHC would not only require health financing and financial protection reforms but also sustained efforts to
promote, organise and speed up development of systems for better access to quality medicines, vaccines and new and appropriate technologies; strengthening of human resources; participation of communities and private health sector; and institutional and management reforms.

There are other issues on regulation in India which include governance, human resources, corruption, public private partnerships, contracting-in services etc. that also deserve attention. The problem lies in not having a single, unified system to establish standards (for structures, processes about quality, rationality and costs of care, treatment protocols and ethical behaviour) applicable to both the public and the private sector. Such a unified system would be essential for ensuring accountability of these institutions and organisations.

It is also vital that States are taken on board not only through their financial strength but also their endorsement/ratification of necessary service provision regulation (e.g. Clinical Establishments Act), without which service quality just cannot become a reality.

**Conclusion: cautious optimism**

Sustained political action is one of the foremost requirements for giving momentum for India’s march towards universal health coverage, reflecting the new opportunities for providing the essential health services that the economic growth is creating and meet the fast growing expectations of Indian citizens.

WHO’s 2012-2017 Country Cooperation Strategy with the Government of India, launched jointly by WHO-India Country Office and the Ministry of Health and Family Welfare after an intense policy dialogue and consultative process, supports the progress of the country towards universal coverage and hails with moderate optimism the prospects in this regard.
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