Progressive strengthening of public facilities is the only way to reach medical services to the population as a whole.

"The best form of providing health protection would be to change the economic system which produces ill health, and to liquidate ignorance, poverty and unemployment. The practice of each individual purchasing his own medical care does not work. It is unjust, inefficient, wasteful and completely outmoded. In our highly geared, modern industrial society, there is no such thing as private health — all health is public. The illness and maladjustments of one unit of the mass affects all other members. The protection of people's health should be recognised by the Government as its primary obligation and duty to its citizens."

These are the words of the distinguished Canadian surgeon, Norman Bethune, who, in 1936, called for universal health protection in which health services would be provided to all through public funds. He pointed out that the major causes of ill health among the poor in Canada, at that time, were: financial inability to pay, ignorance, apathy and lack of medical service. These are true of present-day India, where health insecurity continues to increase with growing economic prosperity.

What is UHC?

Universal health coverage (UHC) has now been widely adopted by Canada and many other developing countries both as a developmental imperative and the moral obligation of a civilised society. India embraced this vision at its independence. However, insufficient funding of public facilities, combined with faulty planning and inefficient management over the years, has resulted in a dysfunctional health system that has been yielding poor health outcomes. India's public spending on health — just around 1.2 per cent of GDP — is among the lowest in the world. Private health services have grown by default, without checks on cost and quality, escalating private out-of-pocket health expenditures and exacerbating health inequity. While the National Rural Health Mission and the several government funded health insurance schemes have provided a partial response, out-of-pocket expenditure still remains at 71 per cent of all spending, without coverage for outpatient care, medicines and basic diagnostic tests.

The High Level Expert Group (HLEG) established by the Planning Commission has submitted a comprehensive framework for providing UHC in India. A health entitlement card should assure every citizen access to a national health package of essential primary, secondary and tertiary care, both inpatient and outpatient. The HLEG is very clear that services included under UHC must be tax funded and cashless at delivery. User fees are to be abolished because
they are inefficient, inadequate and iniquitous. Contributory social insurance is not appropriate for countries like India where a large segment of the workforce — close to 93 per cent — is in the unorganised sector and vast numbers are below or near the poverty line.

**Four priorities**

Increasing public spending on health is the first immediate requirement. The President of India has affirmed that “to attain the goal of universal health care, my Government would endeavour to increase both Plan and Non-Plan public expenditure in the Centre and the States taken together to 2.5 per cent of the GDP by the end of the 12th Plan.” However, even the doubling of public financing will not be adequate to support all the components of a fully evolved UHC. Priorities need to be defined.

The first priority for achieving UHC, as the Prime Minister has pointed out, should be “a determined effort to strengthen our public health systems.” Primary health care must be improved, starting with sub-centres, the first health post for the community. By staffing them with well-trained non-physician health care providers, both facility-based and outreach services can be provided without being doctor dependent. District hospitals too should be strengthened to provide high quality secondary care, some elements of essential tertiary care and training to different categories of health care providers.

The second priority should be to improve the size and quality of our health workforce. Without this, the promise of UHC will remain an empty entitlement. Since primary health care is our first priority, resources must be devoted to the production of competent and committed community health workers for the frontline, mid-level health workers or AYUSH doctors for the sub-centres, and general and specialist nurses as well as non-specialist doctors for primary health centres. More specialists are needed for higher levels of health care including the district hospitals. New nursing and medical colleges should be preferentially set up in States which presently have very few, linking them to district hospitals. Public health competencies must be increased through inter-disciplinary education which is aligned to health system needs. Improved management of all of these human resources must involve better incentives for recruitment and retention, cadre review and creation of well defined career tracks.

The third priority should be to provide essential medicines and diagnostics free of cost at all public facilities. At the same time, referral linkages and patient transport services should be improved to integrate primary, secondary and tertiary health care in the public system. Difficult to reach areas and vulnerable population groups should receive special attention, even as the principle of universality must be applied while designing health services.

The fourth priority must be to put in place the necessary public systems for UHC. Regulatory systems need strengthening — from hospital accreditation to health professional education and from drug licensing to mandatory adoption of standard management guidelines for diagnosis and treatment of different disease conditions at each level of health care. A national inter-operable Health Information Network is needed to improve governance, accountability, portability, storage of health records and management. Community participation must be supported to actively engage people in the design, delivery, monitoring and evaluation of health programmes. And finally, larger investments should be made in health promoting programmes in other sectors such as water, sanitation, nutrition, environment, urban design and livelihood generation.

**Role of the private sector**

The Kolkata Group led by Amartya Sen, in its 2011 Public Declaration, pointed to the many limitations of the private sector in health. “Influential policymakers in India seem to be attracted by the idea that private health care, properly subsidised, or private health insurance, subsidised by the State, can meet the challenge. However, there are good analytical reasons why this is unlikely to happen because of informational asymmetry (the patient can be easily fooled by profit-seeking providers on what exactly is being provided) and because of the ‘public goods' character of health care thanks to the interdependences involved. There are also major decisional problems that lead to the gross neglect of the interests of women and children in family decisions.” It is also well known that insurance schemes (whether funded by the Central and State governments) at best provide limited health care and at worst divert a large part of the health budget to expensive hospitalised tertiary and secondary care, to the great neglect of primary care.

Clearly, there is no alternative to a progressive strengthening of the public facilities and thereby reduce people’s dependence on private providers. However, the public system may need to “contract-in” the services of willing private providers, to fill gaps in its capacity to deliver all the services assured under UHC. Such “contracted-in” private providers will have to deliver cashless services and would be compensated on the basis of pre-determined cost per package of health services rather than “fee for service” for each visit or procedure. In such an arrangement, the private sector acts as an extension of the public sector where needed and will not compete for the same set of services for the
Final remarks

It is time to recognise that everyone, not just the poor, needs to be protected against rising health costs that can impoverish any family. We are on the threshold of a historic transition to guarantee health security for all Indians. UHC will greatly reduce out-of-pocket expenditures and provide much needed relief to people. Apart from improving people's health, adopting UHC is likely to generate millions of new jobs, enhance productivity, and promote equity. Statesmanship must assert itself to create a national framework of UHC that is capable of State-specific adaptations. It is time to give the people of India the efficient, affordable and equitable health system they desire, deserve and demand.

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