These are exciting times for health care reform in India. In November 2011, the High Level Expert Group (HLEG) – appointed by the Prime Minister and headed by Dr. Srinath Reddy, President of the Public Health Foundation of India (PHFI) – submitted its final report on universal health coverage to the National Planning Commission. The report called for an increase in health spending from 1.2% of GDP to 2.5% of GDP by 2022, to ensure that every citizen has access to a broad health benefits package.

Results for Development Institute Managing Director Robert Hecht recently sat down with Dr. Reddy to discuss the HLEG report and its potential impact on India’s health system.

**Hecht:** What was the motivation for the HLEG report?

**Reddy:** Many of the major reasons why the Indian government has started thinking about universal health coverage are related to our health indicators. India’s indicators are relatively poor when compared to our rate of economic progress, for example the large number of undernourished children and the fact that we have high infant mortality rates. We are falling short of both the MDGs and the targets that were set in India’s 11th Plan (2007-12). At the same time, it was clear that a number of health financing initiatives at both the central and state level were being developed to provide financial protection for people below the poverty line, such as...
Rashtriya Swasthya Bima Yojna (RSBY). But there were questions about whether these schemes were having an impact on health outcomes and were providing adequate financial protection.

As a result, the government decided that there should be a review of the feasibility of moving toward UHC, conducted by an independent national panel of experts. The Prime Minister and Planning Commission appointed a High Level Expert Group (HLEG) in October 2010, under my chairmanship. While the HLEG was an independent body of experts, the Public Health Foundation of India (PHFI), was designated as its secretariat.

**Hecht:** What was the scope of the HLEG's work?

**Reddy:** The HLEG organized its activities around seven major themes: financial protection; human resources for health; availability and affordability of drugs and vaccines; management reforms; community participation; and the physical and financial norms for a health system. A seventh area was later added around the social determinants of health.

We were asked to develop the report in eight months so that the recommendations could start feeding into the development of the 12th Plan. Given the enormity of the task, we took one year to complete the report, but we provided some interim findings for the 12th Plan process. In November 2011, our report was discussed by the Planning Commission and its Steering Committee on Health.

**Hecht:** What is the process for integrating the Report’s recommendations into the 12th Plan?

**Reddy:** The final shape of the 12th Plan health chapter will be decided in May or June of this year. The 12th Plan will then be reviewed by the National Development Council, chaired by the Prime Minister and the Chief Ministers of the various states, for endorsement. So the final version of the 12th plan will not be decided until July or August 2012. Only then will we see how much of our universal health coverage recommendations will be adopted.

**Hecht:** As the chair of the expert group, what stands out in your mind as the two or three most important themes in the report on the future of health and universal coverage in India?

**Reddy:** We believe that there should be universal coverage which involves every single citizen and provides an essential health package that will prioritize primary health care but will involve most of secondary care and some elements of tertiary care. How this is going to be provided in terms of shared central and state funding remains to be seen.
The system needs to be predominantly tax financed and we are also advocating for a single payer system. This should be achieved by strengthening public healthcare facilities and contracting with private providers based on clearly identified deliverables and accountability. We envision private participation in the system which would be need based and could be substantial depending on the willingness of private providers to participate. However, they would have to do it on the terms that are clearly laid out and become an extension of the public system.

We are also looking at integrating primary, secondary, and tertiary care into a package of services to be delivered in a manner that does not involve fee for service. This could be done by public networks, private networks, or a mix of the two, based upon availability in each district. To this extent, we are looking at accountable care organizations, which is now a central feature of the Obama Health Care Plan.

Hecht: Does the HLEG report provide a template for states to follow if they decide to implement the recommendations? What guidance does the report provide for integrating the existing state public insurance schemes into the universal health coverage plan?

Reddy: Each state will need to derive their own model based on their own circumstances. We are emphasizing a huge investment in human resources development because without it this whole program would collapse. This is not just about financial entitlements, but also the ability to provide services which requires personnel. We are prioritizing non-physician health care providers for primary health care, but we are also recommending that there should be more doctors and nurses produced, particularly in the under-served states of India in Central, Northern, and Northeastern India.

We are recommending that essential drugs be provided free of cost. Providing drugs does not require a huge investment of public financing and if there is pooled procurement using the methods similar to those adopted in Tamil Nadu, it is possible to cut down the cost of procuring these drugs. We believe by doing this we should be able to make a substantial initial dent in the huge out of pocket expenses that are a feature of India’s health care system.

The public health financing schemes like RSBY and special state programs such as Aarogyasri have laudable social objectives. But since they are limited to secondary and tertiary care and do not include out-patient and primary services, they should be integrated into a larger universal health coverage scheme. How that will be framed in terms of design and how politically acceptable that will be remains to be seen. That’s going to be a challenge for the coming months.

Hecht: You’ve talked about the importance of piloting and testing UHC capacity in certain states of India. How
might this be done?

**Reddy:** The draft health chapter of the 12th Plan suggests that one district in every state should start a pilot this year and then scale up. Others have said that we should test UHC models in about 10 percent of all districts in India while others are arguing for a larger scale approach. The Planning Commission has yet to take a position on this.

Some states have declared they are ready to participate. I think the reason for the interest is that we included some of the state health secretaries in the HLEG process, so they understand universal health coverage and are committed to it. But there are others that are just now becoming interested and as the Planning Commission makes its recommendation and the states begin to understand the implications of this report, I believe there will be widespread enthusiasm.

**Hecht:** How has the HLEG report been received by different audiences? What areas have been accepted and which are most likely to be controversial?

**Reddy:** At the moment, the recommendations related to essential drugs seem to be universally endorsed and have seen very little opposition. The pharmaceutical sector sees an opportunity there and the health sector certainly welcomes the idea that more drugs should be available. There could be substantial public welcome for this as well.

We believe that the Ministry of Health is quite supportive of the fact that primary care should be strengthened, but the number of personnel to be employed is still being debated. In terms of improving district hospitals, there seems to be a fair amount of unity within the Ministry of Health and the HLEG. I think this is something that is going to be prioritized during the 12th Plan.

In terms of bringing in private providers, I don’t think there is much debate. It is the mechanism that is being debated. Will there be contracting-in of private providers, as the HLEG recommended, or the current widespread use of private hospitals by the public schemes like RSBY? Will these schemes be run by public officials or private third party administrators? This is still being debated given the fact that many of the central government financed schemes like RSBY and some of the state-sponsored schemes like Aarogyasri in the state of Andhra Pradesh are quite active.

**Hecht:** What are the major challenges/obstacles you see to implementing the necessary policies for UHC?
Reddy: When India began this process in 2010 our growth rate was round 10 percent. Now we are at 7 percent and there is some concern that our fiscal space is cramped. Nevertheless, our Prime Minister has announced that even with the current growth rate he is willing to allocate funds for health. Which I think in real terms is going to translate into two percent for health and half of one percent for drinking water and sanitation, as the latter are very important determinants of health.

If the current level of political commitment stands and health does receive the level of funding that has been promised, then I think many of the steps will get implemented without resistance. The key challenge will come from private insurance, which is not a big player now, but is an intermediary in the government-funded schemes. It remains to be seen whether they will fade away or stand their ground and protest. Whether the current managers of the government health insurance schemes would like to expand their schemes to include primary health care rather than have a new setup is also unclear.

Hecht: What is the timeline for implementing the recommendations made by the HLEG?

Reddy: What we are seeing is that universal health coverage takes time to evolve, possibly over two plan periods which is 10 years. So the new policies need to be gradually introduced and integrated rather than making an overhaul overnight. However, even if only some elements are introduced at the beginning, their viability depends on the whole framework succeeding. The remaining features thus need to at least be initiated, particularly the regulatory reforms in terms of having accreditation of institutions, standard management guidelines and technical audits, health information systems, as well as legal and regulatory systems that will ensure quality and cost control.