Editorial

Universal health coverage in India: A move with hope and despair

Bontha V Babu[1], Yadlapalli S Kusuma[2]

[1]Health Systems Research Division, Indian Council of Medical Research, New Delhi, India.
[2]Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi, India.
Correspondence to: Bontha V Babu, E-mail: babubontha@gmail.com

Received January 23, 2016. Accepted February 3, 2016

For the last 10 years, Universal Health Coverage (UHC) gained momentum across countries. In 2005, WHO Member States collectively expressed the belief that all people should have access to the health services they need without risk of financial ruin or impoverishment. This idea underpinned the resolution of World Health Assembly (WHA) urging its member states to plan the transition to UHC of their citizens so as to contribute to meeting the needs of the population for health care and improving the quality of care, to reducing the poverty and to attaining the internationally agreed development goals.[1] In 2008, WHO reiterated the need for strengthening the primary health care. The World Health Report-2010, focused on health systems financing, has set the stage for advancing the concept of UHC.[2] And it is obvious that the concept of UHC emerged in the context of neo-liberalization, and specifically of income growth, burgeoning middle classes, demographic and epidemiological transitions, and increasing inequalities and inequity in service access. Health is recognized as a precondition and as an outcome indicator for sustainable development and thus called for more attention to health as an important cross-cutting policy issue in the international agenda. Thus, UHC as a concept gained momentum and resulted in United Nations' (UN's) resolution on UHC. On December 12, 2012, the 67th session of the UN General Assembly passed a resolution to promote UHC including social protection and sustainable financing.[3] This resolution acknowledges that UHC implies that all people have access, without discrimination to quality health care and medicines, without exposing people to financial hardship. Thus, all people are able to receive needed health services of sufficient quality to be effective without fear that the use of those services would expose the user to financial hardship.[4] As popularized by WHO, UHC is based on three dimensions of coverage, viz., the population (Who is covered?), services (Which services are covered?), and cost sharing (What proportion of costs are covered?).[2] Much was written on what and why UHC and the question of "how" is still remained a puzzle to many developing nations like India.

Access this article online	
Website: http://www.ijmsph.com	Quick Response Code:
DOI: 10.5455/ijmsph.2016.23012016332	

The 67th UN General Assembly on Global Health and Foreign Policy recognized the responsibility of the governments to urgently and significantly scale up efforts to accelerate the transition toward universal access to affordable and quality healthcare services.[3] It also recognized that effective and financially sustainable implementation of UHC is based on a resilient and responsive health system that provides comprehensive primary health-care services. These services are to be with extensive geographical coverage, with a special emphasis on access to populations most in need, and with adequate skilled, well-trained and motivated workforce, as well as capacities for broad public health measures, health protection, and addressing determinants of health through policies across sectors, including promoting the health literacy of the population.[3] The UHC has been mentioned as one of the Sustainable Development Goals.[5] Thus, UHC is the common agenda across many countries and the governments in principle agreed to achieve UHC to their populations. The UHC has been mentioned as one of the Sustainable Development Goals.[5] Thus, UHC is the common agenda across many countries and the governments in principle agreed to achieve UHC to their populations.

India is also a signatory for achieving UHC. The draft National Health Policy-2015 endorsed the goal of UHC, and High-Level Expert Group (HLEG) instituted by the Planning Commission of India recognized that UHC is possible for India, even within the available financial resources.[6,7] The present government unveiled plans for universal health care in the name of national health assurance mission[8]; however, it was delayed on account of budgetary constraints.[9] Thus, the Indian scenario exemplifies that saying and doing are not the same thing but two very different things. The academicians, policy makers, and visionaries support the ideology of UHC with a great concern for the poor, and suggested various steps to attain UHC, which often converge on few issues such as health system's resilience/strengthening, improving access (in terms of geographical and population coverage),

expansion of services (inclusion of various services and drugs to be given free of cost), improving the quality of care, accountability, and attaining universality in financial risk protection mainly through health insurance schemes. However, in the background of the various constraints including financial hardships and lack of political will,[10] we should focus on how we should proceed to achieve the goal in a sustainable manner and accelerate the travel on the presently laid down path of health-care system in India.

As a concept, UHC sounds so appealing; however, the path to achieve is not quite smooth and short but to be achieved through a steady, long walk through uneven terrain. It is obvious that UHC cannot just be attained through a compartmentalized approach and simultaneously urges for reforms outside the health sector. Addressing social determinants is crucial to ensure health of the people thereby reducing illness burden at individual as well as at societal level and thereby reduce the costs to the government. In this context, the governments should think comprehensively to achieve the UHC and simultaneously should invest in other sectors for steady and sustainable development. Reviewing the reforms and models followed in several Latin American countries and Asian countries such as Sri Lanka will be helpful to progress toward UHC.[11,12] The model followed by the Latin American countries, which started their reforms in the social sector and put efforts for strengthening the health systems and provided financial risk protection particularly to the poor are helpful in preparing India-specific interventions and policies toward UHC. It is clear that lesser extent of disparities is key to achieve overall development in any country and thus the challenge is how should a nation try to reduce the disparities and achieve equity. The health systems in coordination with and other sectors should focus on safe water supply and sanitary measures to control infections; should invest in quality education with due importance to value-based education for imparting societal values; food security with nutritional quality (which implies investing in agricultural sector with an impetus on production of food grains and pulses rather than on commercial crops, wide production of indigenous fruits and vegetables). Societal changes and social responsibility into the value systems, through social/mass media and books and through student forums and progressive writers are to be imbibed.

Good quality health care is unreachable grape not only to the poor but also to the middle class, particularly the lower middle classes in India. The present criteria of poverty lines can rightly be called as starvation lines. Those households who were just and even a bit far above these lines are not able to afford quality health care and in the event(s) of illnesses/hospitalization, the health-care expenditures remain catastrophic and push them down in the economic ladder, as they mainly rely on the private sector. The improved government health systems with a range of services and other provisions such as drugs and low-cost diagnostics (as referred to as National Health Package [NHP] by the HLEG) would attract a large section of population to utilize the public services. Strengthening the monitoring and evaluation to address the problems that the health-care centers face would be useful to improve the system from time to time. A sense of responsibility and accountability of the health-care staff, as well as the civil society with societal values, are important to make the systems work for the people.

Improving the existing government health system is far less complex than expanding insurance schemes.[13] Within the health sector; we have an existing platform of well-thought health-care system and what we need is to expand the system (to include health promotion, disease prevention, diagnostic services, and drugs in addition to the maternal and child health, which is the present focus of the primary health care in India) to make it comprehensive with good quality of care leading to people's satisfaction and trust in the system. While people have credibility in the government health system that they were not over treated with unnecessary procedures and drugs on one hand, on the other hand, satisfaction and trust in the system were lacking and the reasons were quite known for the same. While under-provision of service has been thought to influence access negatively, it is not always the case. Particularly in the urban context, despite high concentration of health services, the poor often utilize the service to a lesser extent,[14–16] hence improving the quality (which contributes to satisfaction of the clients/utilizers) and efforts to improve outreach of services are crucial to improve access to government health-care services and thereby extending the coverage of population. This will also have a bearing in reducing the out-of-pocket expenditure. Another issue is that while the primary level health-care facilities and services are underutilized, the secondary and tertiary care facilities are choked. Presently, the main focus of the primary health-care services is maternal and child health care (mainly immunization), though they do provide general health-care services to an extent. In order to improve access, the primary health centers should be upgraded to provide comprehensive health-care services by including the general health-care and diagnostic services (for which generally the patients are referred to next-level hospital) and by improving the quality of services, which contribute to satisfaction and improve the access. Upgrading the primary health-care facilities to provide treatment, diagnostics, and drugs to common illnesses would reduce the burden on the households to travel long distances to higher-level hospitals as well as the pressure on the secondary and tertiary hospitals. Many scholars have highlighted the insufficiency of health-care staff and urged for recruiting various cadres of health-care providers, and for improving their living and working conditions.[13] Improving the physical quality of the health-care premises and people-friendly attitude of the health-care providers are essential. The governments should ensure relatively good infrastructure in its facilities.[17] Hence, it is important to make reforms in the primary health-care system to make it comprehensive with public health interventions, with improved quality of care, including the free drugs supply and diagnostics. Also, it is known that a great proportion of out-of-pocket expenditure is on drugs and diagnostics, even if people utilize the consultation services at government health-

care facilities. To address the issue on the provision of drugs, successful models in various Indian states can be replicated. For example, as in Tamil Nadu, a centralized drug procurement repository and streamlining the supply may be developed.[18] Comprehensive primary health-care models underpinned by biopsychosocial approaches as in Latin American countries should be taken into consideration while proceeding for reforms in primary health care. It is important to reform the primary health-care system on the basis of the principles of Alma-Ata to make the primary health care as a vehicle to achieve UHC.

The private health-care sector has grown big and a major provider for the people of India. Private sector is accounting for 80% of outpatient and 60% of in-patient care in India.[19] A shift from the individual provider to the corporate style health care made the health care costly for the poor and middle classes. It is important that regulatory mechanism on the cost for health care in the private sector should be brought. The private insurance schemes can only work well if the government tightly regulates the insurers and health providers, both in the premium they charge and in the services they provide.[20] The health-care expenditures to the private sector are mainly out of pocket and some public funds are also diverted to the empaneled private hospitals. It is also known that while a small proportion of population benefited through these insurance schemes, mismanagement and provider-induced demand for services are rampant.[21] Unnecessary procedures such as rampant prescription of hysterectomies are known.[22] Evidence from other countries, particularly the Latin American countries, also revealed that these health insurance schemes did not bring the out-of-pocket expenditures down; of course, they offered some protection from being the expenditures catastrophic.[11,23] Except the mandatory health insurance schemes such as Central Government Health Scheme (CGHS), Employees' State Insurance (ESI), and Employees' Health Scheme (EHS), none of the insurance schemes (either private insurance or the government-sponsored schemes such as *Rashtriya Swasthya Bima Yojana*—RSBY) offer complete protection to the people when in need. The private medical insurance schemes are costly. Hence, pooling of resources for health in the form of additional taxes (including sin tax on tobacco products, alcohol, etc.) and contributions of private firms (who engage informal workforce) is necessary for the provision of health security. The public as well as the private firms who engage a great workforce, mainly the internal migrants, in the developmental activities should provide basic amenities, including the health care. Specific strategies are to be implemented to bring the vulnerable groups, which usually get excluded from getting access to the services, into the health system's purview. It is evident that government's efforts will bring desired change. The introduction of National Rural Health Mission (NRHM) in states with poor health infrastructure accelerated the reduction of infant mortality and fertility as well as raising the proportion of institutional deliveries.[24]

Thus, India is moving forward to achieve UHC. Though the UHC is not a dream, its journey is in the depths of despair, in terms of budgetary constraints, missing political will, and lethargic attitude of government health-care machinery. The future strategies and policies and the international pressure, hopefully put India on the track to make progress toward UHC. Improving existing government health facilities, and particularly, revamping the primary health-care system, could be the possible way to achieve UHC. Health insurance schemes may be the supplement to this effort by implementing some tailored schemes for certain sections of populations for selective services. As there is no clear roadmap for UHC with government, efforts must be made to unveil the broad policy-level plans and sub-national and regional-level micro-planning to achieve UHC. More importantly, the government should give priority to the benefits of the people over the market pressures.

References

1. World Health Organization. Resolution WHA 58.33. Sustainable Health Financing, Universal Coverage and Social Health Insurance. In: *Fifty-Eight World Health Assembly, Geneva, May 16–25, 2005. Volume 1: Resolutions and Decisions*. Geneva: World Health Organization, 2005.
2. Carissa E, Asamoa-Baah A, Evans DB. *The World Health Report: Health Systems Financing: The Path to Universal Coverage*. Geneva: World Health Organization, 2010.
3. United Nations. United Nations General Assembly Resolution A/RES/67/81. *Global Health and Foreign Policy*. Sixty-seventh session. Agenda item 123, 2012, New York: United Nations, 2012.
4. Kutzin J, Sparkes SP. Health systems strengthening, universal health coverage, health security and resilience. Bull World Health Organ 2016;94(1):2.
5. Schmidt H, Lawrence OG, Ezekiel JE. Public health, universal health coverage, and sustainable development goals: Can they coexist? Lancet 2015;386(9996):928–30.
6. Menabde N, Lahariya C. India's Draft National Health Policy, 2015: Improving policy to implementation effectiveness. J Family Med Prim Care 2015;4(3):291.
7. Thakur J. Key recommendations of high-level expert group report on universal health coverage for India. Indian J Community Med 2011;36(Suppl1):S84–S85.
8. Press Information Bureau. 2014. *Rolling out of National Health Assurance Mission*. July 15, 2014. New Delhi: Press Information Bureau, Government of India, 2014. Available at: http://pib.nic.in/newsite/PrintRelease.aspx?relid=106608 (last accessed on January 25, 2016).
9. Kalra A. *Exclusive: Modi Govt. Puts Brakes on India's Universal Health Plan*. Reuters India. March 7, 2015. Available at: http://in.reuters.com/article/india-health-idINKBN0MM2UT20150327 (last accessed on January 23, 2016).
10. Patel V, Parikh R, Nandraj S, Balasubramaniam P, Narayan K, Paul VK, et al. Assuring health coverage for all in India. Lancet 2015;386(10011):2422–35.
11. Atun R, de Andrade LOM, Almeida G, Cotlear D, Dmytraczenko T, Frenz P, et al.. Health-system reform and universal health coverage in Latin America. Lancet 2015;385(9974):1230–47.
12. Russell SJ. *Can Households Afford to be Ill?: The Role of the Health System, Material Resources and Social Networks in*

Sri Lanka. London, UK: School of Hygiene & Tropical Medicine, 2001.
13. Gupta MD, Muraleedharan VR. Universal health coverage-reform of the government system better than quality health insurance. Econ Polit Wkly 2014;49(35):29.
14. Babu BV, Swain BK, Mishra S, Kar SK. Primary healthcare services among a migrant indigenous population living in an eastern Indian city. J Immigr Minor Health 2010;12(1):53–9.
15. Kusuma YS, Kumari R, Pandav CS, Gupta SK. Migration and immunization: Determinants of childhood immunization uptake among socioeconomically disadvantaged migrants in Delhi, India. Trop Med Int Health 2010;15(11): 1326–32.
16. Kusuma YS, Kumari R, Kaushal S. Migration and access to maternal healthcare: Determinants of adequate antenatal care and institutional delivery among socio-economically disadvantaged migrants in Delhi, India. Trop Med Int Health 2013; 18(10):1202–10.
17. Rao MG, Choudhury M. Healthcare Financing Reforms in India, Working Paper No 2012-100. Delhi, India: National Institute of Public Finance and Policy, 2012.
18. Singh PV, Tatambhotla A, Kalvakuntla RR, Chokshi M. Replicating Tamil Nadu's drug procurement model. Econ Polit Wkly 2012;47(39):27.
19. National Sample Survey Organisation (NSSO), Ministry of Statistics and Programme Implementation (Government of India). Morbidity, Health Care and the Condition of the Aged. Report No. 507, NSS 60th Round (January–June 2004). New Delhi, India: NSSO, 2006.
20. Reinhardt UE. *The Healthcare Systems of Germany and Switzerland. 2011*. Available at: http://www.princeton.edu/~reinhard/pdfs/Synopsis_of_Germanys_Switzerlands_ Health_ Systems.pdf (last accessed on January 24, 2016).
21. Nagulapalli S, Rokkam SR. Should governments engage health insurance intermediaries? A comparison of benefits with and without insurance intermediary in a large tax funded community health insurance scheme in the Indian state of Andhra Pradesh. BMC Health Serv Res 2015;15:370. doi:10.1186/s12913-015-1028-4.
22. Reddy S, Mary I. Aarogyasri scheme in Andhra Pradesh, India: Some critical reflections. Social Change 2013;43(2):245–61.
23. de Andrade LOM, Pellegrini FA, Solar O, Rígoli F, de Salazar LM, Serrate PCF, et al. Social determinants of health, universal health coverage, and sustainable development: Case studies from Latin American countries. Lancet 2015;385(9975): 1343–51.
24. Prasad AM, Bhatia S, Agrawal R. The effect of the National Rural Health Mission on health services and outcomes for childbirth in India: A retrospective analysis of survey data. Lancet 2013;382:11.

How to cite this article: Babu BV, Kusuma YS. Universal health coverage in India: A move with hope and despair. Int J Med Sci Public Health 2016;5:384-387

Source of Support: Nil, **Conflict of Interest:** None declared.