Universal Health Coverage in India - What Physicians Must Know

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ABSTRACT

Universal health coverage (UHC) is the means to provide accessible and appropriate health services to all citizens without financial hardships. While financial protection is the principal objective of this global initiative; delivery of UHC also requires availability of adequate healthcare infrastructure, skilled health workforce and access to affordable drugs and technologies to ensure the entitled level and quality of care to every citizen. The Planning Commission of India constituted a High Level Expert Group (HLEG) on UHC in October 2010. HLEG recognizes that only public sector cannot aim to achieve UHC. The contracting-in of private providers is needed to complement government-provided health services and fulfill the health care service guarantees of the UHC system. Dialogue and consensus building among the stakeholders in the government, civil society, and private sector are essential steps to formalise the actions needed and to monitor their achievement. The health professional is the mandatory and major stakeholder in striving towards UHC. Hence health professionals must understand the architecture for UHC as well as their own role in advancing the agenda of UHC in India. The purpose of this article is to sensitize the physicians about the same.

Universal Health Coverage as a concept was born in 1883 when Germany introduced health coverage for achieving health status of its young population.[1] Later, as many countries joined the league; in 2005, World Health Assembly (WHA) adopted the term Universal Health Coverage.[2]

In 2005 WHA, member states of WHO committed to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them. This goal was defined as Universal Health Coverage (UHC). The 2010 World Health Report builds upon the 2005 WHA recommendations and aims at assisting countries in quickly moving towards UHC. [(2)]The 65th World Health Assembly meeting in Geneva in 2012 has identified UHC as a key imperative for all countries, if their goal is to consolidate the public health advances achieved so far. Several countries have been working to reform their health system over the past two or three decades.[3]

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Universal healthcare is often presented as an idealistic goal that remains out of reach for all but the richest nations. That's not the case, if we look at what has been achieved in Rwanda, Thailand and Bangladesh. Over the last three decades various studies have investigated the experiences of countries where effective healthcare is provided at low cost to the bulk of the population. The places that first received detailed attention included China, Sri Lanka, Costa Rica, Cuba and the Indian state of Kerala. Since then examples of successful UHC or something close to that have expanded, and have been critically scrutinized by health experts and empirical economists.[4]

The Lancet Series about India draws attention to thechallenges afecting the health-care system of the world's second most populous country.[5-11] The Planning Commission of India constituted a High Level Expert Group (HLEG) on Universal Health Coverage (UHC) in October 2010, with the mandate of developing a framework for providing easily accessible and affordable health care to all Indians. While financial protection was the principal objective of this initiative, it was recognized that the delivery of UHC also requires the availability of adequate healthcare infrastructure, skilled health workforce and access to affordable drugs and technologies to ensure the entitled level and quality

of care to every citizen. In this context the report has been submitted to the planning commission[1]

The year, 2015, is a significant one from the perspective of health. Internationally, this is the last year for Millennium Development Goals (MDGs) and as part of the post 2015 development agenda, the global community begins to work towards achieving sustainable development goals. At the national level, the Government of India has released the draft of National Health Policy 2015 and is all set to launch the National Health Assurance Mission (NHAM) to progress towards UHC in the country.[12]

There has been enormous discussion and debate on the UHCgoing around in multiple constituencies and among various stakeholders. The health professional is the mandatory and major stakeholder in striving towards UHC. Hence health professionals must understand the architecture for UHC as well as their own role in advancing the agenda of UHC in India. The purpose of this article is to sensitize the physicians about the same.

Definitionof UHC by HLEG

Ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative) as wellas public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services[1]

Fig. 1 illustrates three dimensions to be considered while moving towards UHC.[1,13]

Vision of UHC by HLEG

Universal health coverage proposes a central government guaranteed scheme for all citizens that provide essential primary, secondary and tertiary care services through formulation of a National Health Package (NHP). These packages are to be formed on basis of resources available as well as health care needs of the community. Acknowledging the potential of non-public sector in achieving UHC, HLEG recognizes that only public sector cannot aim to achieve UHC. The contracting-in of private providers (including for-profit companies, NGOs and the non-profit sector) is needed to complement government-provided health services and fulfill the health care service guarantees of the UHC system ***(Fig 2).*** These services can be provided through two options.[1]

Fig 1. **Three dimensions to consider when moving towards universal coverage**

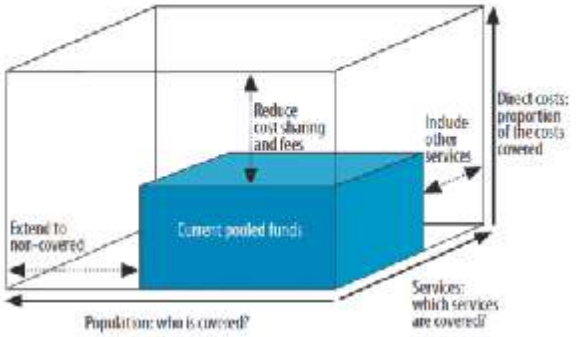


Fig. 2 : **Universal Health Coverage by 2022 : The Vision**

In the first option, all those private providers who enrol themselves under UHC will provide minimum 75% of outpatient department services and 50% of in-patient services to those entitled under NHP. The services will be cashless and the provider will be reimbursed at standardized rates. For remaining portionof services available, the institutions could accept payments or provide services through privately purchased insurance policies. In the second option, institutions enrolled under UHC will provide only those services, which are available under NHP.[1]

There are pros and cons of both the options. Rigorous monitoring and supervision will be required for smooth functioning of any of the options. However, HLEG envisages that over time,

every citizen will be issued an IT enabled National Health Entitlement Card (NHEC) and this will lead to greater equity, improved health, efficient and transparent health system and further reduction in poverty, greater productivity and financial protection.[1]

Key Recommendations of HLEG for provision of UHC

Six critical areas identified by HLEG that are essential to augment the capacity of India's health system to fulfil the vision of UHC include Health Financing & Financial Protection; Health Service Norms; Human Resources for Health; Community Participation & Citizen Engagement; Access to Medicines, Vaccines & Technology; and Management & Institutional Reforms. The key recommendations of HLEG in these areas are as follows :

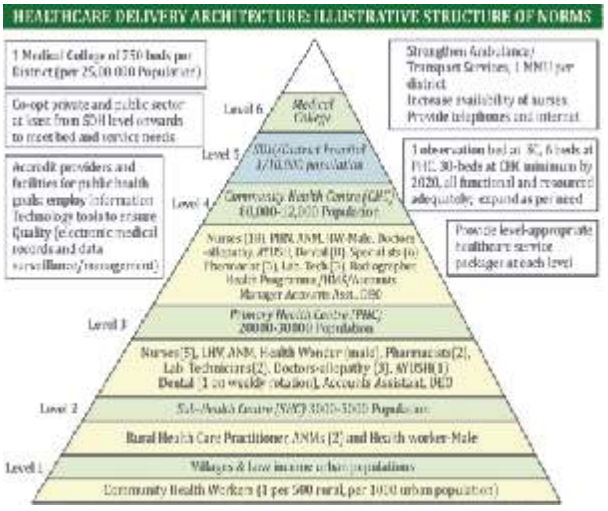
Health Financing & Financial Protection

Government should an increase public expenditure on health from the current level of 1.2% GDP to at least 2.5% by the end of the 12th plan and to at least 3% of GDP by 2022. There should be an increase in spending for public procurement of medicines from 0.1% to 0.5% of Gross Domestic Product (GDP). General taxation plus deductions for health-care from salaried individuals and tax-payers as the principal source of health-care financing should be used, and no fees of any kind be levied for the provision of health-care services under UHC. No insurance companies should be used to the purchase health-care services on behalf of the Government and all Government funded Insurance Schemes should be integrated with the UHC system. There should be flexibility in central financing to help meet diverse health requirements of states and at least 70% of all health-care spending should go to primary health-care. The technical and other capacities developed by the Ministry of Labour for the Rashtriya Swasthya Bima Yojana (RSBY) should be leveraged as the core of UHC operations and transferred to the Ministry of Health and Family Welfare.[1]

Health Service Norms

National Health Package offering essential health services at different levels ***(Fig. 3)*** of the health care delivery system,as part of the entitlement of every citizen, should be developed and a system of National Health Entitlement Cards (NHEC) to be introduced. Well defined service delivery partnership with Government as purchaser and private sector as provider under strong regulation, accreditation and supervisory framework should be ensured. The district hospitals network should be strengthened and upgraded for health-care delivery and training. All health facilities should be licensed by 2017 to comply with the latest Indian Public Health Standards. In Urban areas, there is a need to rationalize services and focus particularly on health needs of the urban poor.[1]

Fig. 3.



Human Resources for Health (HRH)

Adequate numbers of trained health-care providers and technical health-care workers should be ensured by giving primacy to primary health care; increasing HRH density to achieve WHO norms of at least 23 health workers (Doctors, Nurses, Auxiliary Nurse Midwives) per 10,000 population; recruiting adequate number of dentists, pharmacists, physiotherapists, technicians, and other allied health professionals at appropriate levels of health-care delivery; establishing District Health Knowledge

Institutes, State Health Science Universities, and National Council for Human Resources in Health.[1]

Community Participation & Citizen Engagement

Existing Village and Health Sanitation Committees should be transformed into participatory Health Councils. The role of elected representatives, Panchayat Raj Institutions in rural areas and local bodies in urban areas should be enhanced. Regular health assemblies at different levels to enable community review of health plans and their performance should be organized. Civil society and non-governmental organizations should be strengthened and utilized to contribute effectively for community mobilization, information dissemination, community based monitoring of health services. A system of the formal grievance redressal mechanism should be instituted at the block level to deal with confidential complaints and grievances about the health services. Jan SahayataKendras (People's Facilitation Centres) should be co-located with the office for grievance redressal in order to locally provide people with information services.[1]

Access to Medicines, Vaccines & Technology

Price control and price regulation on essential and commonly prescribed drugs should be enforced. The essential drugs list should be revised and extended and rational use of drugs should be ensured. The public sector should be strengthened to protect the capacity of domestic drug and vaccines industry to meet national needs. Ministry of Health and Family Welfare should be empowered to strengthen the drug regulatory system.[1]

Management & Institutional Reforms

All India and State level Public Health Service Cadres and a specialized State level Health Systems Management Cadre should be introduced in order to give greater attention to public health and also strengthen the management of the UHC system. Better human resource practices should be adopted to improve recruitment, retention motivation and performance; rationalize pay and incentives; and assure career tracks for competency-based professional advancement. Establishment of National Health Regulatory and Development Authority having a System Support Unit, a National Health and Medical Facilities Accreditation Unit and Health System Evaluation Unit have been recommended. In addition, establishment of a National Drug Regulatory and Development Authority to regulate pharmaceuticals and medical devices as well as National Health Promotion and Protection Trust to facilitate the promotion of better health culture amongst people, health providers and policy makers has also been recommended.[1]

UHC and Rashtriya Swasthya Bima Yojana (RSBY) :

The RSBY is flagship scheme of the government which provides cashless health insurance cover to below poverty line families. RSBY attempts to demonstrate social insurance delivery in the form of a public private mix in the country. [(14)]This could provide a platform for the launch of UHC in India.[14, 15]

Launched in 2008 by Ministry of Labour and Employment, RSBY provides health cover to BPL households, with beneficiaries entitled to hospitalization cover of Rs 30,000 for a range of diseases; even pre-existing conditions of up to five members in a family are covered. Government has fixed the package rates for the hospitals for a large number of interventions. Beneficiaries need to pay only Rs. 30/- as registration fee while Central and State Government pays the premium to the insurer selected by the State Government on the basis of a competitive bidding[16] Evaluation of RSBY is significant as the scheme is being promoted as the model and vehicle for universal access to healthcare.[17]

Karnataka first in country to give universal health coverage

In 2010, the State had launched the Vajpayee Arogyasri scheme for BPL households. Unlike the national Rashtriya Swasthya Bima Yojana, which used private insurance intermediaries, the reimbursements in Karnataka's scheme are made by a State-run trust. Evaluation of this scheme has shown positive impact on health and economic indicators.[18, 19]

In January 2015, Karnataka became the first in the country to provide UHC with the launch of two schemes, the Rajiv Arogya Bhagya for APL households and the Jyothi Sanjeevini for government employees. The health coverage is estimated to cost the government Rs. 120 crore annually.[20]

APL family members would be entitled for a health check costing up to Rs. 1.5 lakh a year. In special cases, if the expenditure exceeds Rs. 1.5 lakh, the government could sanction an additional sum of Rs. 50,000. The scheme proposes to cover 449 surgical procedures and 50 follow-up packages. Beneficiaries can avail treatment in 160 hospitals, including 14 hospitals outside the State. The government employees will get cashless treatment in 124 empanelled private hospitals under the Jyothi Sanjeevini scheme. It also covers 449 surgery procedures and 60 follow-up packages.[20]

Health ministry plans new trust-based model for RSBY

RSBY was shifted to the Health Ministry from 1stApril 2015 with plans to roll out a National Health Assurance Mission to provide universal healthcare. The Health Ministry has proposed a new trust-based model for RSBY. According to the proposal, state-run trusts with funds contributed by the Centre and states will process and settle claims of hospitals that provide such services to the poor, instead of insurers.[21]

At the ninth Health Insurance Summit organized by Confederation of Indian Industry (CII) in October 2015; a CII statement, quoting Union Health Secretary mentions that RSBY will be restructured to make its coverage wider, intensive and IT driven. The restructured scheme, to be coordinated by the Union Health Ministry, will bring together several disjointed schemes coordinated by different agencies under one umbrella, and is likely to become operational shortly.[22]

Challenges to achieve UHC in India

There is going to be huge opposition from the profitmaking big pharmacy companies and private healthcare providers.[1] Enrolling them under UHC packages present a herculean task before UHC. Standard Treatment Guidelines (STGs) are to be enforced across both public and private sectors to increase access to medicines. Acceptance of STGs by vast private lobby remains questionable. At a national level, distribution of NHEC and timely reimbursement to the contracted-in private hospitals and dispensaries will be a mammoth task.[14] The key areas of concern include broad agreement on the financing model for health-care delivery, entitlement package and the cost of health-care interventions.[3]

Conclusion :

Whatever critics may say, it is however evident that UHC is the way for providing health assurance to the country population. States such as Kerala, Tamil Nadu and Karnataka have shown it is possible to have superior health outcomes with a well-funded and well-designed public health system. The Indian people desire, deserve, and demand an efficient and equitable health system which can provide UHC. This needs sustained financial support, strong political will and leadership, dedication of public health functionaries and other stakeholders as well as active participation of the community. Physician being mandatory and major stakeholder in striving towards UHC, with this understanding of the architecture for UHC; should appropriately and genuinely contribute (like enrolling under UHC packages, following STGs, preparing/revising entitlement packages, fixing the cost of health-care interventions etc.) in advancing the agenda of UHC in India.

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