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REVIEW ARTICLE

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India Strive to Provide Universal Health Coverage

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Abstract

Background: Universal health coverage is the reflection of the political commitment of countries towards health. This paper reviews the functioning and progress of India compared to World towards universal health coverage and identifies the bottlenecks. **Methods:** We searched the following electronic databases: PUBMED, BMJ, LANCET, WHO Website, Unicef Website and Google Scholar for studies related to universal health coverage. All databases were searched form inception. In addition, we checked reference lists of reviews and retrieved articles for additional studies. From the searches, we reviewed the title and abstract of each paper and retrieved potentially relevant references. **Results:** The poor universal health coverage was observed in Africa, Asia, and Middle East. Among south Asian countries, Bangladesh had 0.4%, India 5.7%, Nepal 0.1%, Pakistan 0%, and Sri Lanka 0.1% universal health coverage respectively. The countries like Canada, Tunisia, Egypt, Libya, Korea, Thailand, Japan, Turkey and Yemen enabled success in the path towards UHC. India have one of the highest proportions of household out-of-pocket expenditures on health in the world, estimated at 71.1% in 2008–09. Any form of social or voluntary health insurance covers merely 10% of the Indian population. Community-based health insurance schemes for less than 1% of the population. **Conclusion:** Major challenges to achieve universal health coverage in developing countries are the limited resources. The only way to reduce dependence on direct payments is for governments to encourage payments made in advance of an illness.

Key words: Universal, Health, Care, Scheme, Program, Coverage.

INTRODUCTION

The highest attainable standard of health is a fundamental human right of every individual.[1] The World Health Organization (WHO) Constitution (1948) and the Alma-Ata Declaration (1978) were the foundation stones of universal health coverage[2] The Alma-Ata Declaration strongly affirms that health is a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social goal.[3] The World Health Organization defined universal health coverage as ensuring all people access to promotive, preventive, curative and rehabilitative health services of sufficiently good quality. It also ensures people do not suffer financial hardship paying for health care services. Universal health coverage not only has a direct impact on a people's health but also enables people to be more productive and declines the possibility of being pushed into poverty. Thus, universal health coverage is a critical component for sustainable development and poverty reduction.

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METHODS

We searched the following electronic databases: PUBMED, BMJ, LANCET, WHO website, Unicef website and google scholar for studies related to universal health coverage. All databases were searched form inception. In addition, we checked reference lists of reviews and retrieved articles for additional studies. From the searches, we reviewed the title and abstract of each paper and retrieved potentially relevant references.

RESULTS AND DISCUSSION

Universal Health Coverage: International Scenario

Many countries worldwide are committed to achieve Universal Health Coverage.[5] International Labor Organization estimated countries across the globe that has attained universal health coverage based on health insurance implementation. The poor universal health coverage was observed in Africa, Asia, and Middle East. Among south Asian countries, Bangladesh had 0·4%, India 5·7%, Nepal 0·1%, Pakistan 0%, and Sri Lanka 0·1% universal health coverage respectively.[6]

The countries represent diverse geographic and economic conditions, but all have committed to UHC as a key national goal and are approaching it in different ways. In Canada national health insurance program, also known as Medicare is a government-funded universal health insurance program. Under this program, universal health coverage is provided on a prepaid basis. Publicly funded health care is financed with revenue such as personal and corporate taxes, sales taxes, payroll levies and others. Provinces may also charge a health premium for their residents but non-payment of a premium does not limit access to medical services. To fulfil health care needs, individuals often turn to primary health care services; the first point of contact with the health care system. A patient is referred for specialized care if required. Community boards of trustees, voluntary organizations or regional health authorities, operate the majority of Canadian hospitals.[7]

A small African country, Tunisia, the majority of the population is served by the public health sector, financed and managed by the State. The social health protection system in Tunisia is amongst the best of all developing countries. There are over 12 different health schemes, based on professional categories. Moreover, the Government provides free healthcare services to the poor, low-income and disabled persons. The basic health scheme is within 5 km of range of the majority of the population. It is mainly financed by households, contributes about half of all health expenditure and its development is likely to accelerate with the health insurance reform. The State has also implemented an incentive system, based on an increase of professional wages and authorization to practice on private sector to improve the territory coverage for doctors. Similarly, social and political changes had enabled success in the path towards UHC in the Arab world with regard Egypt, Libya, and Yemen.[8]

Korea over the last few decades has changed from a fragmented health financing system covering a relatively low proportion of the population to establishing a health care system characterized by universal health coverage. Over 95% of the Korean population is covered by national health insurance. The national health insurance funds are pooled from member premiums, employer contributions and government payments. All Koreans, except those in the lower-income groups, are required to pay for the health insurance premiums. The government subsidizes the poor. Although private practitioners or organizations provide around 90% of health services, government sets the framework for health service delivery with quality requirements. By law, private hospitals cannot be for-profit organizations, and it is illegal to finance health services from capital markets.[9]

In Thailand, health care coverage consists of three schemes, namely fringe benefit schemes; health insurance under the social security schemes; and the universal health care scheme. The fringe benefit schemes consist of the Civil Servant Medical Benefit Scheme that covers government employees, pensioners, and dependents and the State Enterprise Medical Benefit Scheme that covers state enterprise employees and their dependents. Thailand achieved universal health coverage by introducing a tax-funded scheme, called the UC scheme.5Implementation of UC scheme significantly increase in utilization of outpatient and inpatient facilities. There was also a major shift of utilization of tertiary provincial hospitals to primary care units and district hospitals. Moreover, in Brazil and Thailand, long-standing networks of doctors and public health professionals, concerned with expanding health equity and improving access to health care, put pressure on politicians to adopt universal coverage in moments of democratic change.[10]

Japan achieved UHC through Citizens Health Insurance via municipality. Japan expanded health coverage to informal, self-employed, and unemployed populations through residence-based health insurance programs managed by municipalities. Plans were initially on a voluntary basis for residents, and gradually became mandatory by increasing government subsidies to cover additional beneficiaries. Even France could achieve full UHC when it introduced a state-subsidized program for low-income groups. The financial controls were through compulsory spending targets; primary care gate keeping strengthening; pay for performance for general practitioners and reforming the hospital payment system.[11]

In Turkey, Health Transformation Program, led the basis of Universal Health Coverage. This created new opportunities for reforming health by breaking up older political arrangements. They had introduced a new contracting mechanism with private providers through capitation payments that ushered in a more sustainable approach to health care provision, helping to make universal health coverage possible.[12]

Universal Health Coverage: Indian Scenario

India has the world's largest democracy and the second most populous country. India is one of the world's fastest growing economies with an average annual GDP growth rate of 5.8% over the past two decades.[13] Not only the economy, but also it has also progressed in almost every aspect, including health care. The health promoters are improving slowly but steadily.[6] India is ranked 134 of 182 countries on Human Development Index.[14] Use of preventive services such as antenatal care and immunizations has much variation in their use by gender, socioeconomic status, and geographical distribution. Women in the richest quintile were many times more likely to deliver in an institution than those in the poorest quintile. The number of beds in government hospitals in urban areas is more than twice that in rural areas. Health survey coverage remains higher in urban areas than in rural areas.[15]

Estimated India's total expenditure on health was 4.13% of the Gross Domestic Product in 2008–09, with public expenditure on health being 1.10% of the share of GDP. Private expenditures on health have remained high over the last decade, with India having one of the highest proportions of household out-of-pocket expenditures on health in the world, estimated at 71.1% in 2008–09.[16,17]

Merely 10% of the Indian population are covered by any form of social or voluntary health insurance, which is mainly offered through government schemes in the organized sector (e.g., state insurance scheme for employees, central government health scheme). Private insurance companies account for merely 6.1% of health expenditures on insurance. Community-based health insurance schemes and schemes for the informal sector that encourage risk pooling provide for less than 1% of the population. Expenditures on inpatient and outpatient health care are consistently higher in private facilities than in public facilities. Expenditure on drugs has been increasing with time, and drug costs constitute a greater proportion of out-of pocket expenditures. Individuals, who are poor, are more vulnerable to catastrophe of the health care costs.[16-18]

Current strategy in India

The Government of India launched the National Rural Health Mission (NRHM) 2005, which transformed to National Health Mission in 2013 with the goal to improve the availability of and access to quality health care in rural areas. The NRHM has a special focus on 18 states, including eight Empowered Action Group states, the eight North-Eastern States, Jammu & Kashmir and Himachal Pradesh. The key features include making the public health delivery system fully functional and accountable to the community, human resources management, community involvement, decentralization, rigorous monitoring and evaluation against standards, convergence of health and related programs, innovations and flexible financing and interventions for improving the health indicators. The NRHM introduced interventions such as Accredited Social Health Activists, strengthening various levels of health care and disease control programs, converging sanitation and hygiene, public-private partnership for health goals and reorienting health/medical education to support rural health issues. This aims at empowering local governments to manage, control and be accountable for public health services at various levels.[19]

Janani Shishu Suraksha Karyakram (JSSK) launched in 2011, has provision for both pregnant women and sick new born till 30 days after birth, Free and zero expense treatment, Free drugs and consumables, Free diagnostics & Diet, Free provision of blood, Free transport from home to health institutions, Free transport between facilities in case of referral, Drop back from institutions to home, and Exemption from all kinds of user charges. The initiative promotes the institutional delivery, eliminate out of pocket expenses which act as a barrier to seeking institutional care for mothers and sick newborns and facilitate prompt referral through free transport.[19] Hypertension, cardiac problems, diabetes, joint pains, kidney infections, cancer, tuberculosis

eye problems and other common ailments are diagnosed and treated for free in government health facility.[20]

Social health insurance, private health insurance and community-based insurance are three of the country's hallmarks. Social health insurance like the Central Government Health Scheme (CGHS) was started under the Indian Ministry of Health and Family Welfare in 1954 with the objective of providing comprehensive medical care facilities to Central Government employees, pensioners and their dependents residing in CGHS covered cities. Here the employees contribute through payroll deductions and employers provide grants. Free drugs, hospitalization, Diagnostic and imaging services are empanelled with the CGHS.[21] Similarly, there is Employees Health Scheme intended to provide cashless treatment to all the State Government employees in few states like W.B. Health Scheme, Delhi Government Health Scheme and others.[20] Employees state insurance is a self-financing social security and health insurance scheme for Indian workers.[22]

There are three prominent social security schemes for the unorganised sector, by the Government of India, that offer life insurance, health insurance and pension are Aam Aadmi Bima Yojana (AABY) Life Insurance scheme, Rashtriya Swasthya Bima Yojana (RSBY) Health Insurance and National Pension Scheme – Swavalamban (NPS-S). The central government launched RSBY to provide health insurance coverage for below poverty line families. The central government, the remaining by the state, provided about 75 percent of the financing other than northeast and Jammu and Kashmir states. Beneficiaries under RSBY are entitled to hospitalization coverage up to Rs 30,000 with a registration fee of Rs 30. Coverage extends to five members of the family, which includes the head of household, spouse and three dependents.[23]

Rajiv Aarogyasri Scheme, Community Health Insurance Scheme implemented in Andhra Pradesh in 2007. This provides financial protection to families living below the poverty line of Rs 2 lakh in a year for the treatment of serious ailments requiring hospitalization and surgery. The scheme is to improve access of BPL families to quality medical care. The benefit on family is on floater basis. I.e. the total reimbursement of Rs1.50 lakh can be availed of individually or collectively by members of the family. An additional sum of Rs 50,000 is provided as a buffer.[24] The Yeshashvini health Insurance Scheme between the government of Karnataka and Narayana Hrudayalaya Hospital, Bangalore is an excellent example of public-private partnership. This scheme covers the rural farmers and peasants wherein for a premium payment of Rs 210 per annum providing a health facility for the poor at an affordable rate.[24]

Other Health Insurance scheme in are Vajpayee aarogyasri Scheme, Karnataka, RSBY Plus, Himachal Pradesh, Chief Minister Kalaignar's insurance scheme, Tamil Nadu. The Comprehensive Health Insurance Scheme was implemented in Tamil Nadu in 2012 for families whose annual income was Rs 72,000/- or less. Members of unorganized labour, welfare boards, and the spouse, children and dependent parents of such members in urban and rural areas were covered. Under the scheme, the sum assured for each family was Rs 1 lakh every year for a total period of four years.[13] The government of India laid provision of free supply of essential medicines in public health facilities. Jan Aushadhi is one of these initiatives. Andhra Pradesh, Chandigarh, Delhi, Haryana, Himachal Pradesh, Jammu & Kashmir, Orissa, Punjab, Rajasthan, Uttarakhand, and West Bengal, have started retail outlets for generic drugs to ensure that people get reliable, good-quality drugs at affordable prices.[25]

CONCLUSION

Major challenges to achieve universal health coverage in developing countries are the limited resources. There is inefficient and inequitable distribution of resources. Developing countries like India have over depends on direct payments for seeking health care. It will be difficult to attain universal health coverage if out of pocket expenditure remains high. The only way to reduce dependence on direct payments is for governments to encourage payments made in advance of an illness. Along with the domestic financial support, the international community also needs to support domestic efforts in the poorest countries to achieve universal health coverage. The political economy and policy process for adopting, achieving, and sustaining UHC are weak. Social health insurance programs which could result in steering government resources toward workers in the formal sector and away from less affluent farmers and informal sector workers. Moreover, lack of uniformity among various schemes across states in India makes the journey of UHC difficult. There are inefficient health financing policies to enhance health coverage. There is a lack of human resources for health policies for achieving UHC. A strong multipronged private for profit health delivery system plays a huge and varied role in universal health coverage. UHC is difficult to achieve if some population groups have better coverage than other does. Closed-ended capitation contracting with diagnosis-related group hospital payment, Strong primary care gate keeping, Tough negotiations with pharmaceutical companies, Priority setting for expanding the benefits package and System focused on primary care

are major barriers to achieving UHC. The political parties often adopt UHC reforms, but social movements are crucial in helping to drive and support them. Flexibility in policy, investment in innovation, and community engagement are three prerequisites for achieving UHC by a country.

RECOMMENDATIONS

The most crucial step to attain universal health coverage is to ensure that the poor countries have sufficient funds and that funding increases consistently over the coming years to enable the necessary scale up. This can be accomplished by increasing the efficiency of revenue collection, prioritize government budgets, innovative financing and development assistance for health. Political commitment is vital for achieving the goal of universal health coverage. There is the need to raise the proportion of gross domestic product spent on health by government of India, so that the health facilities in the public sector are made available, ultimately increasing the public health sector utilization and decreasing the out of pocket expenditure. The increased budgetary allocation should be used for improving the availability of essential drugs. There should be health insurance which covers all sections of the society and not only the below poverty line. Such health insurance should be broadly homogeneous throughout the country. Paying a premium for health insurance should be incorporated like other revenues. The public private partnership needs to be strengthened to achieve the goal of UHC. Every individual in the health system must be accountable towards the goal of universal health coverage. Eventually the essence of attaining universal health coverage is generating felt needs of the people by intensive IEC activities. The findings from different countries across the world to adopt, achieve, and sustain UHC. Although the path to UHC is specific to each country, countries can benefit from the experiences of others in learning but different approaches and avoiding potential risks.

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