

## Review Article

# Universal health coverage: Current status and future roadmap for India

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### ABSTRACT

Universal health coverage (UHC) has been recognized as the most important immediate goal for global health. Attempting to achieve this goal for the country, the Government of India, has been taking measured steps, trying to ensure equitable access to high-quality affordable health-care services for all citizens. This article attempts to identify the success of these efforts through a baseline situation assessment of UHC dimensions in India, followed by a critical analysis of what is being done to fulfill the gaps, and finally propose a health policy roadmap for UHC with implications at national and state level. Literature review presents a varied scenario with respect to the coverage of key services essential for service packages, reflecting need for significant improvement. Large-scale inequities in health-care service delivery and health indicators have been observed, with poor financial risk protection of the community from catastrophic spending on health care. Various reasons for this were identified, such as low public investment in health services, poor health-care service delivery system, poor quality of services offered to the community, and lack of robust financial protection mechanisms. The study proposes a contextual restructuring of the health system, initiating with an increase in financial investments in public health-care sector. This should be supplemented with health system strengthening by improving overall service availability for the community with optimal quality and at low cost. Private sector service provisioning should be regulated by developing and implementing strong accountability measures. The governance capacity of public sector should be augmented to improve success rates of the demand-side financing schemes. Health technology assessments should become the mainstay of taking decisions on benefit package. A holistic multipronged approach constituting all these changes is required if health coverage has to be made universal in the country.

**Keywords:** Health system strengthening, publicly financed health insurance schemes, universal health coverage


### Introduction

Commitment toward universal health coverage (UHC) aspires to provide the quality health-care services to those in need, without any financial hardship. After passage of United Nations General Assembly Resolution regarding UHC in 2012, it has become central to the policies of many national governments, including those in low- and middle-income countries.<sup>[1]</sup> It has been recognized as the most important immediate goal for global health that will have an influence on all other health-related goals.<sup>[2]</sup> Most of the development organizations such as the World Health Organization, the United Nations Children's Fund

and the World Bank Group have recommended and sanctioned new initiatives promoting UHC.<sup>[3]</sup> Financial risk protection and access to quality essential health-care services for all have also been included in the Sustainable Development Goals.<sup>[4]</sup>

UHC entails population coverage, i.e., equal rights to the benefits of a health system to all sections of the society.<sup>[5]</sup> Thus, all sections of the society, regardless of their income

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level, social status, gender, caste, or religion, have a right to get the health-care services they need. This has an implicit notion of equity embedded in its concept. The other dimension of UHC is that of protection against the economic consequences of ill-health.<sup>[6]</sup> This means that health financing systems need to be specifically designed to ensure that the use of needed health services does not expose the user to any kind of financial hardship.<sup>[7]</sup> The final dimension of UHC service coverage puts the focus on the provision of a minimum basic package to cover priority health needs of the population.<sup>[8]</sup> These packages can be developed on the basis of established understanding of the effectiveness and efficiency of low-cost interventions for major public health problems.

The Government of India is also trying to take steps to ensuring equitable access to high-quality affordable health-care services for all Indian citizens.<sup>[9]</sup> As UHC is a multidimensional construct, these efforts have been not only toward increasing coverage or volume of services but also include introduction of new financial risk protection mechanisms. Measuring success of these efforts requires a baseline situation assessment, understanding the current status of UHC dimensions in India. These have to be complemented with a critical analysis of what is being done by the government to fulfill the gaps. This can only lead to a discussion on what future course of action should be taken. A related complexity which is peculiar to Indian health system emanates from its federal structure, and health continues to be on the State list of constitutional provisions, with central government having a role in certain limited way. As a result, it becomes more appropriate while discussing its progress, to focus at state-specific performance and its related policies. In this paper, we present the baseline status with regard to UHC in northern states of India and assess the policies being undertaken. While assessing the effectiveness of policies, we also draw upon the experiences of policies in other states. Finally, we propose a health policy roadmap for UHC with implications at national and state level.

## Situation Analysis

### Service coverage

The four northern states of Haryana, Punjab, Himachal Pradesh, and Jammu and Kashmir and the Union Territory (UT) of Chandigarh present a varied scenario with respect to the coverage of various maternal and child health indicators. Overall, the coverage for various key services, which would be considered as essential in terms of a service package, reflects needs for significant

improvement [Figure 1]. While the full antenatal care (ANC) rates and early initiation of breastfeeding rates are relatively low in these states, rates of postnatal care within first 2 days are better.<sup>[10]</sup> Both between states and within state variations are also observed to a great extent.<sup>[11]</sup> The full ANC rates are almost double in the state of Himachal Pradesh than that reported from Haryana.<sup>[12]</sup> Punjab and Chandigarh are observed to be better in terms of full immunization rate and contraceptive prevalence rate, but a higher proportion of the deliveries taking place in Punjab are in private sector health facilities as compared to other states. Unmet need for family planning ranged from 6% in Chandigarh to 15% in Himachal Pradesh.<sup>[12]</sup> Unmet need for curative care services among rural females was observed to range from 20% to 2% in these states, but almost 11% of the outpatient consultations were from unqualified providers in Haryana.<sup>[10]</sup> There is also a significant variation among the hospitalization rates in these North Indian states [Figure 2]. Second, the contribution of public sector toward provision of curative care is particularly poor in Haryana and Punjab.

### Financial risk protection

A recent study from Haryana revealed only 63% of women delivering in public sector facilities incurred nil expenditure on delivery as expected. The mean out-of-pocket (OOP) expenditure was INR 771 in public sector facilities and INR 12479 in private sector facilities, which was catastrophic for 1.6% and 22% of households, respectively.<sup>[13]</sup> Another study reported about 30% households in the state to incur catastrophic health expenditure due to hospitalizations, which rose to 38% among the poorest 20% population.<sup>[14]</sup> The World Bank reported a marginal increase in public health expenditure as a proportion of total government expenditure in India, from 4.04% in 2004 to 5.05% in 2014.<sup>[15]</sup> The population covered by any government-funded health insurance program increased from about 55 million people (1% of total population) in 2003–2004 to about 370 million (almost 25% of total population) in 2014 in

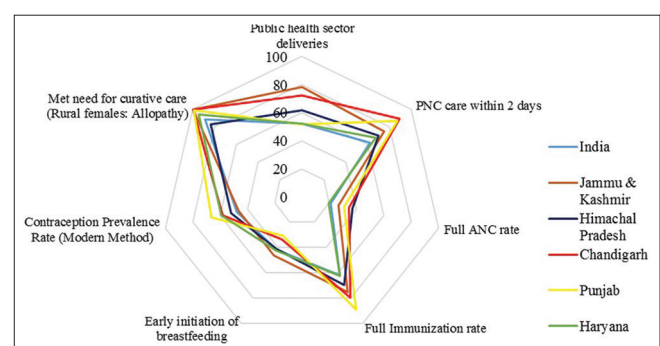


Figure 1: Service coverage for key indicators in North Indian states (National Sample Survey Organisation 71<sup>st</sup> round and National Family Health Survey-4)

India.<sup>[16]</sup> Ravi *et al.* reported that OOP expenditure as a share of total health-care expenditure varied from 77% in Punjab to 55% in Himachal Pradesh.<sup>[17]</sup>

### Population coverage

Published literature is replete with evidence of inequalities in health-care service delivery and coverage of indicators. These inequalities have been documented with respect to age, sex, social category, religion as well as socioeconomic status of the households. A recent study from Haryana reported underweight and wasting to be significantly higher among children born to lower caste families compared to those born to general category.<sup>[18]</sup> Relative disadvantage in obtaining health-care services by those without formal education or those belonging to minority communities has also been documented earlier.<sup>[19]</sup> Although public sector hospitalizations have been reported to have a pro-poor distribution in Haryana, Punjab, and Chandigarh, nearly 57% and 60% households from poorest income quintile in Haryana and Punjab, respectively, faced catastrophic OOP hospitalization expenditure at 10% thresholds.<sup>[20]</sup> Other studies have also shown that the effect of OOP expenditures in the form of user charges disproportionately affect the poor.<sup>[21]</sup> Another study from this region reported 1.3 times higher odds of catastrophic expenditure due to OOP hospitalization expenses in those belonging to Scheduled Caste/ Scheduled Tribe population (in comparison to general population) and 2.6 times higher odds of the same in the poorest 20% households in the community.<sup>[22]</sup> Differential treatment to communities in different districts (geographical inequities) after adjusting for all other social determinants has also been reported from time to time.<sup>[23]</sup> As a result, there are both horizontal inequities in access to health-care services, as well as vertical inequities in health-care financing patterns prevalent in these North Indian states.

### Root Causes

Low public investment in health services has been a major reason for low service availability and poor utilization rates. The State Health Accounts for Punjab show < 1% Gross State Domestic Product being invested on health care in the public sector, as compared to 3.1% being invested in the private sector.<sup>[24]</sup> The situation is remarkably similar in other North Indian states as well as in the country as a whole. Around 86% of this public sector expenditure is spent on wages and salaries of the staff, with as little as 5% spent on delivery of services [Figure 3]. If looked at through the lens of health system functions, more than 68% of the public health expenditure is on

curative care service provisioning, with only 15% being spent on preventive services [Figure 4].<sup>[24]</sup>

Lack of service availability in the public health-care sector is another important reason for the state of affairs. This has its reasons in both deficiencies in human resources as well

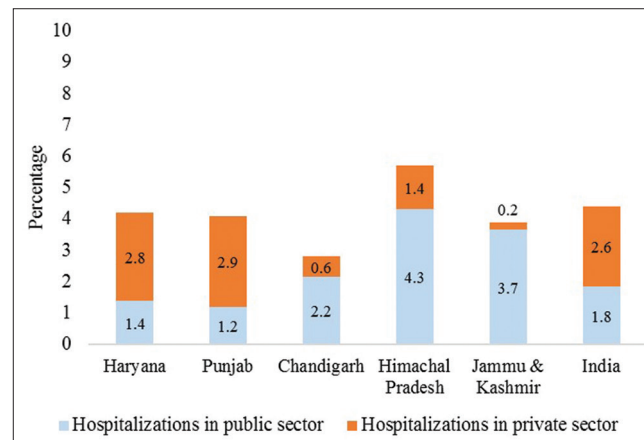


Figure 2: Hospitalization rates in North Indian states, National Sample Survey Organisation Findings, 71<sup>st</sup> round

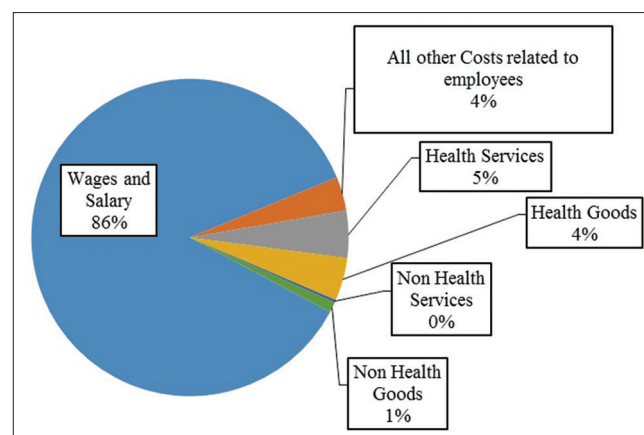


Figure 3: Public health expenditure by inputs in Punjab state (based on State Health Accounts Report)

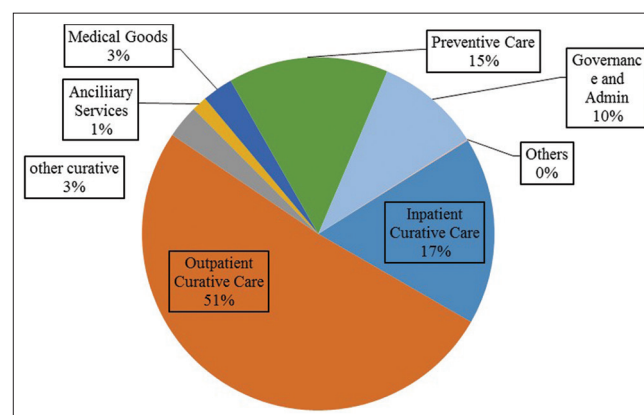


Figure 4: Public health expenditure by functions in Punjab state (based on State Health Accounts Report)

as poor infrastructure across the states. The Ministry of Health and Family Welfare reported 15% and 22% shortfall in human resources at subcenter (SC) level in Punjab and Haryana, respectively, which increases to 26% and 14% at primary health center level.<sup>[25]</sup> In contrast, both the states of Himachal Pradesh and Jammu and Kashmir and the UT of Chandigarh have a surplus workforce at these levels. While Jammu and Kashmir required construction of government buildings for 61% of its functioning SCs, only 18% of the SCs in Himachal Pradesh had infrastructure augmentation requirement.<sup>[25]</sup> Availability of free medicines at public health facilities has been reported to be around 45.2% and 51.1% in Punjab and Haryana, respectively.<sup>[26]</sup> Availability of antihypertensive drugs was around 60% in both the states, while medicines such as thrombolytic agents, anticancer, and endocrine medicines were available in less than 30% of public sector facilities. Lack of medicines in public sector facilities manifests its effect in the form of OOP expenditures.

Poor quality of services at the public health facilities has been well documented in literature. Inconvenient and limited service timings, absenteeism on the part of health-care personnel, long waiting times for consultation and poor quality of inpatient care have been commonly cited.<sup>[27]</sup> Patients also report poor interpersonal interactions and behavioral issues with medical and paramedical staff, who are often rude and discourteous to the patients and their attendants.<sup>[28]</sup> Confidentiality of patient information and privacy during consultation are other important causes of concern. Inappropriate prescription practices involving overuse of antibiotics by pharmacists and doctors have also been reported.<sup>[29]</sup> Lack of technical competency of employed workforce and the parallel existing corrupt system of informal payments also adds to the dimension of poor service quality.<sup>[30]</sup> Public health facilities also perform poorly in terms of cleanliness and provision of basic amenities to the patients.

Lack of robust financial protection mechanisms gives rise to the issues such as catastrophic health-care expenditures and impoverishment due to OOP spending on treatment for ill-health. Majority of the burden of expenditure on health care (72%) is financed in the country through household's own resources, which includes borrowing from friends and relatives.<sup>[31]</sup> Data from previous studies show that almost 20% of urban and 28% rural households do not seek medical care because of financial constraints.<sup>[32]</sup> Several publicly financed health insurance schemes have been launched in India with the aim of providing financial

protection and negating these ill effects. These have been introduced both at the state and central levels.

While each of these schemes is called "insurance" scheme, the real difference lies in how care is purchased. These schemes are similar to the previous method of supply-side financing, where the government was the main financier of health care. However, while in the former method, government invested in creating public health infrastructure and human resources and subsequent provision of health services through this system, these new schemes create a split in the financing and provisioning role of government. In these publicly financed insurance schemes, while the government remains the main financier of health services through tax money, care is purchased through a mix of public and private health-care providers, which is overwhelmingly dominated by the latter. The evaluations of publicly financed health insurance schemes which have been conducted in India show two main findings consistently.<sup>[33]</sup> First, there is an increased utilization of health-care services. This increase in utilization is not only in the short run but also in the long run which implies that it is sustainable. However, coupled with the fact that the awareness among the insured beneficiaries is relatively low, it implies that the utilization rates are likely to go up significantly further as the awareness improves, which has fiscal implications. It is yet not very clear that whether it is a manifestation of improved access, supplier-induced demand, or both. The current evidence suggests that it is a result of both of these phenomena. Second, the available evidence shows that these schemes have been ineffective in reducing OOP or catastrophic expenditures. Several reasons contribute to this finding. Majority of these schemes cover only hospitalization services for tertiary care or secondary care. On the contrary, 70% of the total OOP expenditure in India is on account of outpatient consultations which are not covered by any scheme. Hence, the overall potential to reduce OOP expenditure is relatively low. However, the insurance schemes have been shown to be ineffective in reducing the OOP expenditure, even for the hospitalization services which are covered under the scheme. This could be due to lack of awareness about the benefits of the scheme, as a result of which the patients continue to access services in nonempanelled hospitals. Second, the hospitals continue to charge bill to the patients, over and above what is being claimed from the insurance company. There is limited monitoring capacity to check this problem. Third, the hospitals indulge in supply of services which may not be necessary. This increases the overall cost of care. Finally, the height of benefit package is insufficient.



The Rashtriya Swasthya Bima Yojana (RSBY) scheme was capped to provide benefits worth Rs. 30,000 per household per year for hospitalization care which was insufficient to meet the needs.

More recent studies from Haryana, Himachal Pradesh, and Punjab have also reported an increase in OOP expenditure and catastrophic expenditures among households enrolled in RSBY Plus and Bhai Ghanhya Sehat Sewa Scheme (BGSSS).<sup>[34-36]</sup> This is despite the positive evidence that the utilization of hospital services increased after introduction of these insurance schemes.<sup>[33]</sup> The Punjab BGSSS evaluation study also raised important concerns regarding uneven claim rates, claim settlement ratios, and burnout ratios.<sup>[34]</sup>

### Potential Solutions and Future Roadmap

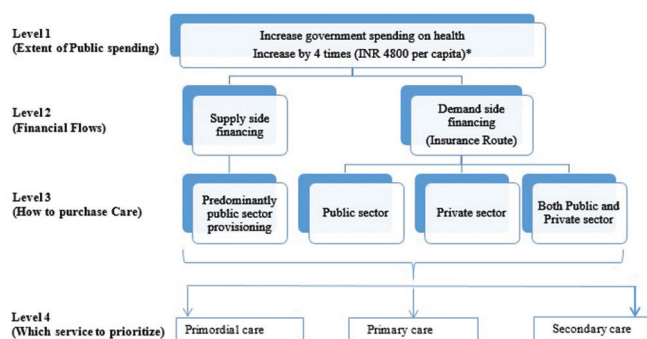
The solutions to all these problems are not just technical but also require a contextual restructuring of the health system [Figure 5]. The starting point should be an increase in financial investments in public health-care sector. While there is a general agreement on the fact, the resources on health need to increase, how much is sufficient is still a matter of debate. International experience suggests that public expenditure in excess of 4%–5% of gross domestic product (GDP) allocated to health is necessary. A previous analysis from India suggests that achieving UHC will require about 4% of GDP allocation.<sup>[31]</sup> The National Health Policy 2017 reiterates government's commitment to increase health expenditure as a percentage of GDP from the existing 1.15% to 2.5% by the year 2025. It also envisages the states to increase their health spending to > 8% of their budget by the year 2020.<sup>[16]</sup> Increasing public health spending per capita is not only central to resource procurement and purchasing better quality services but will also lead to better accessibility and affordability of the public health system for the poorest in the society. Second, there is also an agreement that

within different sources of health-care financing, taxation appears to be the most technically efficient and equitable, as well as feasible mechanism to generate these additional resources.

Strengthening the public sector with availability of greater financial resources would be the key cornerstone to achieving UHC. Public health-care sector needs to be strengthened, first, in terms of resource availability, be it human or material resources in the system, and second, in terms of overall service availability for the community at public health facilities with optimal quality of service delivery and at low cost. The National Rural Health Mission provides an excellent case study to demonstrate the same. Several interventions, both on demand and supply side, were initiated to improve the accessibility and utilization of services for institutional delivery in public sector. Not only did it increase the coverage of service dramatically but also reduced the OOP expenditures and provided financial risk protection.

Primary health care needs to be made more comprehensive. The Government of India's Health and Wellness Centers' approach is a welcome step to augment the scope of primary health care in India, by making it more holistic rather than maternal and child health-centric care. This is also needed in view of the epidemiological transition and an increase in noncommunicable diseases. Since the health system is a part of the social system and does not exist in isolation, it is also important to keep social determinants of health in perspective. Performance of the health system should be assessed holistically for preventive and curative care service delivery.

While supply-side strengthening of public sector will be required, some constraints in capacity will necessitate strategic purchasing of care from the private sector, especially for tertiary care and in some instances for secondary care. However, the private sector exists with a wide array of institutions with varying degrees of sophistication in terms of services and qualified personnel.<sup>[37]</sup> No physical standards currently exist for private hospitals, as there is a lack of norms for workforce requirements within individual hospital units.<sup>[38]</sup> Overprovision of care and unnecessary referrals and diagnostic investigations for monetary benefits is commonly reported from health-care providers in this sector.<sup>[39]</sup> Hence, regulation of private sector service provisioning is another step that needs to be taken. Strong accountability measures should be developed and implemented for this sector. Better regulatory



**Figure 5: Decision framework for choices in road toward universal health coverage**

and legal frameworks are also required to prevent commercialization of medical technology and drugs and medical and paramedical education.

In order to improve the success rates of the demand-side financing schemes which ensure a purchaser–provider split, the governance capacity of public sector needs to be augmented. As a first step, the government should become the single largest purchaser of health-care services, imparting significant degree of monopsonistic power to the public sector. This will provide opportunities for any price control/negotiation with private sector. Finally, government's capacity for monitoring and regulation of these schemes should be improved. Better monitoring mechanisms should be put in place to prevent private sector empanelled hospitals from overprescription and overcharging. Provision of primary and secondary care services should be restricted to the public sector facilities, and only when the public sector capacity restricts provision of care, such services should be strategically purchased from the private sector. Evidence from robust cost-analysis studies should be the basis for deciding provider payments. Furthermore, independent third-party assessments should be sanctioned to identify the impact of such models of purchasing care in terms of their overall cost-effectiveness. Health technology assessments should become the mainstay of taking decisions on benefit package. Setting up of the Health Technology Assessment (HTA) Board in India is again a welcome step.<sup>[40]</sup> However, it needs to become an important factor in influencing health policies. Value for money, reduction in OOP expenditures, and ensuring equitable utilization of services should become the overarching principles for guiding the HTA decisions.

The current situation of the community in terms of health indicators, health-care service provision, and adverse financial effects of OOP spending on health care leaves a lot of scope for improvement. As UHC is a multidimensional construct, a single solution cannot be the answer to all problems. Not only the health system needs strengthening, better mechanisms than the currently existing ones need to be identified and urgently implemented to enhance equity and protect community from financial difficulties due to healthcare spending.

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#### Conflicts of interest

There are no conflicts of interest.

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