

Universal Health Coverage: Role of Public Health

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SUMMARY:

The realization of Universal Health Coverage requires adequate healthcare financing and human resources to provide financial protection to the economically disadvantaged population by covering their medicine, diagnostics, and service costs. Conventionally, inadequate public healthcare financing and the lack of skilled human resources are considered as the major barriers towards achieving UHC in India. To strengthen the Indian healthcare system, there has been significant increase budgetary allocation towards healthcare, a national health protection scheme targeting low-income households, upgrading of primary health-care and expansion of the health work-force. Nevertheless, an evolving paradigm for improving holistic health, sanitation, nutrition, gender equity, drug accessibility and affordability, innovative initiatives in national health programs for reduction of maternal deaths, tuberculosis and HIV burden and the utilization of information technology in healthcare provision of the underserved and the marginalized is gaining rapid acceleration. These represent a genuine innovation towards fulfilment of UHC goals for India.

Key words: *Health financing, India, public health, universal health coverage*

INTRODUCTION:

Universal health coverage (UHC) implies that all people and communities can use the promotive, preventive, curative, rehabilitative, and palliative health services they need that is of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship. The idea of coverage in UHC is affirmed as a right of all the people and not just a benefit restricted on income, occupation, or social criteria. The concept of UHC for India was anticipated way back in 1946 by the landmark Bhore Committee Report which envisaged a country where “no individual would fail to secure adequate care because of inability to pay.” Nevertheless, more than seven decades later, catastrophic health expenditure incurred during health shocks pushes millions of economically disadvantaged Indian populations into impoverishment each year creating a vicious cycle of poverty and ill health.

Health financing and human resources in India:

The realization of UHC requires adequate healthcare financing and human resources to provide financial protection to the economically disadvantaged population by covering their medicine, diagnostics, and service costs. Only sufficient governmental spending can ensure UHC as individual voluntary prepayment insurance schemes are inadequate for realizing UHC even in the developed world. However, ensuring adequate health financing is a major challenge in the developing world since the government spending on healthcare is low. As per the 2013 estimates, of 132 of low- and middle-income countries, only 37 will be able to reach the goal of 5% spending of gross domestic product (GDP) on health by 2040.[4]

In India, the total expenditure on health care in 2013–2014 was about 4.02% of GDP, with the government share being 1.15% against the global average of 5.99%.^[5] Less than a quarter of the Indian population has access to any mode of health insurance. Insurance providers cover only around 1.5–2% of the total healthcare expenditure in India. Consequently, out-of-pocket expenses comprise 69% of total healthcare costs in India.

Although the increase in health financing is best achieved under favourable macroeconomic conditions facilitating high economic growth, a fiscal expansion for health can utilize alternate sources of domestic revenue mobilization. This includes, in the Indian context, improving the tax-GDP ratio and earmarking sin taxes on alcohol and tobacco. Furthermore, optimal allocation and increasing efficiency of health-related spending are also vital. The Indian National Health Policy 2017 envisages an increase in health expenditure by the government as a percentage of GDP to 2.5% by 2025 and to increase state sector health spending to >8% of their budget by 2020.

Moreover, it has set a target for the reduction in the proportion of households facing catastrophic health expenditure from the current levels by 25% by 2025. In a step toward this direction, the Union Budget 2018 announced the launch of the Ayushman Bharat (National Health Protection) scheme which would provide coverage of up to ₹500,000 a family a year for secondary and tertiary care hospitalization to almost 100 million low-income families in India.

The second major challenge for achieving UHC is the shortcomings in skilled human resources. India has only 0.7 physicians per 1000 persons and 1.8 nurses/midwives per 1000 persons against the recommended norms of 1:1000 and 4:1000, respectively. Furthermore, the distribution of health resources is rather skewed with a shortage of doctors, especially specialists in rural areas despite several governmental measures to retain doctors in rural settings. The unmet need of qualified health personnel is covered by unlicensed practitioners devoid of any medical qualifications who constitute nearly 69% and 81% of urban and rural allopathic doctors as per the 2001 India census estimates. The government impetus toward medical education is reflected in the substantial increase in MBBS seats and postgraduate medical seats by 13,000 and 7000, respectively, since 2014–2015. Twenty-four new medical colleges will be set up in underserved areas, while 248 nursing and midwifery schools will strengthen maternal and child healthcare services across the country.

The inclusion of Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) practitioners for the delivery of primary health care especially in rural areas and the creation of a cadre of mid-level service providers in underserved and hard-to-reach areas would further bridge these gaps.

Achieving universal health coverage in India: The Changing Paradigm

1. From medical coverage to achieving holistic health: A paradigm shift from provision of essential to quality health care at the primary care level is on the anvil. Subcenters are being transformed into health and wellness centers (H&WC) which is expected to improve utilization of public-sector primary care services and improve the health of communities served. The Ayushman Bharat scheme has allocated 12 billion in the Union Budget in 2018 for the upgrading of subcenters into H&WCs. These wellness centers will provide comprehensive healthcare for the management of non-communicable diseases with lifestyle modifications, maternal and child care, adolescent health, nutritional and health education, promotion of menstrual hygiene, and free essential drugs and diagnostic services. Basic dental, ENT and ophthalmology services will also be provided at these centers. The integration of Ayurveda and Yoga will further promote a holistic approach toward the health of the community.

There are other unique models of primary health care initiatives emerging from the Indian states. The Electronic Urban Health Centre model in Andhra Pradesh accords specialist care at the urban health center level with a heightened focus on patient satisfaction. Boat clinics in

Assam are mobile clinics on water bodies which provide health services to the residents residing in remote islands across the state.

2. *Primary healthcare with focus on systems beyond medicine:* There is a renewed governmental focus on hygiene sanitation (Swachh Bharat Abhiyan, open defecation-free India), housing (Pradhan Mantri Awas Yojana), clean indoor air by provision of clean fuels (Ujjwala Yojana, providing free liquefied petroleum gas connections to below poverty line families), and expansion of immunization service and coverage (Mission Indradhanush Kavach). All these initiatives that influence the health of the poor, vulnerable, and underserved population have achieved excellent success in their respective domains.

3. *Focus on protecting maternal health:* India accounts for 15% of the global burden of maternal deaths. Moreover, according to the National Family Health Survey^{¶4} (2015–2016) data, only 51.2% of pregnant women received at least four antenatal care visits. The Maternal Death Surveillance Response program is geared toward reducing maternal mortality and near misses by improving quality of maternal death reporting with the appropriate capacity building. It involves tracking and identifying the cause of every maternal death at both the facility and the community level and using the information generated for health system strengthening and capacity building for precluding future instances.

Similarly, the LAQSHYA program for improving labor room[¶]quality standards earmarks the use of technology for improving intrapartum quality of care. A safe motherhood mobile application for empowering skilled birth attendants includes videos, actions cards, drug lists, and procedures required during intrapartum care. These steps are in alignment with the sustainable developmental goal objectives of achieving the maternal mortality ratio targets of <100 by 2020 and <70 by 2030

4. *Promoting gender equity:* There is a welcome and sustained focus on ending female feticide, improving child sex ratio and education of the girl child through the campaign of the government of India called “Beti Bachao Beti Padhao” (Save the girl child – Educate the girl child). Promoting menstrual hygiene by the distribution of free of cost menstrual pads, prevention and control of Anemia by the distribution of weekly Iron[¶]folic acid tablets in schools, construction of toilets in all schools, scholarships for girls from vulnerable sections of society further indicate enlightened steps in this direction

5. The use of information technology (ICT) for bridging the gap for those lacking access to quality healthcare and reaching the unreached is essential for India which is an information technology powerhouse and has the second highest mobilephone connections globally. The various ICT application in healthcare being explored in India include telemedicine, vaccine and drug inventory control and storage (electronic Vaccine Intelligence Network), training of health workers (ANMOL, m[¶]ACADEMY, safe motherhood), disseminating health education (Swachh Bharat app, India fights dengue app, m[¶]Diabetes text messaging service, KILKARI recorded voice calls), promotion of behavior change (m[¶]cessation text messaging services, stress control app), drug adherence in tuberculosis (TB) (99[¶]DOTS)

6. Promotion of generic medicines and cheaper implants to significantly lower out[¶]of[¶]pocket costs are important as more than 70% out[¶]of[¶]pocket expenses in India are due to medicinal costs. Difficulty to bear these costs increases medication nonadherence in patients, leading to worsening health outcomes which involve enormous economic costs for individuals, families, and the country. The Pradhan Mantri Jan Aushadhi Pariyojana and the Affordable Medicines and Reliable Implants for Treatment schemes reflect prioritization toward amelioration of routine treatment costs for patients lacking insurance coverage for their outpatient expenses. Strict quality control measures and ubiquitous drug availability and affordability through promotion of entrepreneurial opportunities are the key program drivers.

7. *Public-private partnerships (PPP):* Collaborative efforts between private and public sector for improving health service delivery, expansion of coverage, and last mile service delivery have found significant traction in the past two decades. Furthermore, utilizing PPP in critical national health programs such as TB to improve drug adherence and cure rates in patients reaching private sector has received growing impetus

8. *Strengthening of national programs in TB and HIV/AIDS:* India achieved HIV and TB related millennium development goal targets which is a commendable achievement. Furthermore, the initiation of daily drug regimen, rapid molecular diagnostic methods, programmatic management of drug-resistant TB, nutritional support to TB patients, text message based adherence support indicate strong policy commitments towards the achievement of TB elimination targets by 2025. The HIV program has been complemented with the passage of the progressive HIV/AIDS (prevention and control) bill to ensure equal rights while seeking jobs, residence and occupation, absence of stigma and discrimination, and equal opportunities for the people living with HIV.

The potential role of public health professionals in realizing the goals of UHC in India is immense and should be harnessed. Public health professionals can be posted in H&WCs for supporting activities relating to (1) preventive (screening for noncommunicable diseases), (2) promotive (behavioral change communication), (3) curative services (treatment and referral services), (4) gap analysis of services provided by AYUSH graduates and mid-level service providers, and (5) epidemiological expertise in outbreak investigations. Furthermore, the public health professionals can participate in operational research for improving overall service delivery of health programs such as the Revised National Tuberculosis Control Program for improving quality of service delivery, the effectiveness of 99DOTS, and monitoring of rural health practitioners involved in TB care.

In conclusion, the advancement of UHC in India shows a steady evolution. The vital initiatives for enhancing UHC in India range from promoting budgetary outlay, creating new public health resources and the application of ICT for bridging the gap in healthcare for the unreached, and promoting efficient allocation and utilization of our limited health resources. Further, sustainable development regarding universal access to good education, sanitation, clean energy, safe environmental and sound infrastructure which are essential for realizing and maintaining a state of good health is in a state of acceleration. Nevertheless, the challenges of scaling up such developmental initiatives to reach the proverbial “last man” in the remotest corner of India in fulfilment of Mahatma Gandhi’s vision continue to endure.

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