WHY
Universal Health Coverage for India?

HOW
can it be achieved?

Recommendations of The High Level Expert Group
Constituted by the
Planning Commission of India, 2011
Members of the
High Level Expert Group on Universal Health Coverage

Abhay Bang
A.K. Shiva Kumar
Gita Sen
K. Srinath Reddy (Chair)
Mirai Chatterjee
N.K. Sethi (Convenor)
P.K. Pradhan
Yogesh Jain

Anu Garg
Amarjeet Sinha
Jashodhara Dasgupta
Leila Caleb Varkey
M. Govinda Rao
Nachiket Mor
Vinod Paul

Supported by:
Public Health Foundation of India
(Designated As Technical Secretariat)
High Level Expert Group Report on Universal Health Coverage for India

Instituted by the Planning Commission of India
The concept of Universal Health Coverage (UHC) began to evolve in Europe with reforms introduced by Bismarck in Germany in the 19th century. The Beveridge Report ushered in British reforms in the 1940’s leading to the introduction of the National Health Service (NHS) by Aneurin Bevan in 1948.

Since then, universal access to affordable healthcare has become a widely shared aspiration across the globe. Over the last decade many low and middle income countries have advanced along the path. Mexico announced 100% coverage in 2012 while China and South Africa expect to do so in 2012. Many Latin American, several Asian and some African nations are reconfiguring their health systems to achieve UHC soon. The World Health Report of 2012 documents and endorses this global movement.

India needs to adopt UHC both as a developmental imperative and as an ethical commitment to equity in a vital area of human welfare.
The Global Path to Universal Health Coverage

INDIA, 2012

South Africa, 2011/12
Philippines, 1995; Taiwan, 1995; Thailand, 2002; Vietnam, 2009

Mexico, 2001

Spain, 1986; Brazil, 1988; Columbia, 1993

Rwanda, 2003;

Australia, 1975, Italy 1978

Ghana, 2004

Sweden, 1955; Denmark, 1973;

Sri Lanka, 1950

Scandinavia: Norway, 1912; Sweden, 1955; Denmark, 1973;

New Zealand, 1938

Chile, 1952

Beveridge Model, 1942

NHIF, Kenya, 1966

Bismarck Model 1883

Canada, 1966

UK, 1948 (NHS)

Germany, 1941

Japan, 1938
India’s economic development is regarded as a powerful propeller of global growth in the 21st century.

While India and China are often compared in terms of their potential for growth, India’s advantage undoubtedly lies in its large population of young persons who are likely to boost productivity to a higher trajectory over the next three decades.

However, India can only reap this demographic dividend if there is adequate investment in the education, nutrition and health of its people. In the recent years, India has ushered landmark initiatives in the areas of education, employment and food security. It is important to now advance Universal Health Coverage from aspiration to attainment.
THE CHINDIAN CENTURY

With so many of the world’s economies in tatters, the combined might of China and India could spearhead global growth in the coming decades. Are they up to the job?

By ZOHER ABDOOLCARIM

THE CASE FOR INDIA: FREE TO SUCCEED
By MICHAEL SCHUMAN

TIME: NOVEMBER 21, 2011
Even as the world regards India’s economic growth as a success story, the health indicators compare poorly with many other countries including those in our neighborhood.

In particular, the health of our children is a matter of great concern, with the rates of infant, neonatal and under-5 mortality unacceptably higher than the goals set by the 11th Five Year Plan and the Millennium Development Goals.

The low levels of full immunization among our children is a clear and sensitive indicator of an underresourced and under performing health system.
### KEY HEALTH INDICATORS: INDIA COMPARED WITH OTHER COUNTRIES

<table>
<thead>
<tr>
<th>Indicator</th>
<th>India</th>
<th>China</th>
<th>Brazil</th>
<th>Sri Lanka</th>
<th>Thailand</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMR/1000 live-births</td>
<td>50</td>
<td>17</td>
<td>17</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Under-5 mortality/1000 live-births</td>
<td>66</td>
<td>19</td>
<td>21</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Fully immunised (%)</td>
<td>66</td>
<td>95</td>
<td>99</td>
<td>99</td>
<td>98</td>
</tr>
<tr>
<td>Birth by skilled attendants</td>
<td>47</td>
<td>96</td>
<td>98</td>
<td>97</td>
<td>99</td>
</tr>
</tbody>
</table>

*Source: World Health Organization (2011)  IMR – Infant Mortality Rate*
Unsafe motherhood, where a young woman’s life is tragically extinguished by inaccessible or inadequate healthcare, is another indicator of health services which do not measure up to people’s needs.

Even as the large number of young children who are undernourished are a source of sorrow and shame for our society, demographic and developmental determinants are speeding up a health transition wherein cardiovascular diseases, diabetes, cancers, mental illness and injuries are claiming a heavy toll in terms of young or mid-life deaths and prolonged disability.
INDIA’S CURRENT HEALTH SCENARIO

- Largest number of underweight children (42% under 5 yrs);
- Current infant mortality rate of 47 per 1000 live births;
- Maternal mortality ratio presently 212 per 100 000 live births;
- Challenge to meet national goals of 27 per 1000 (IMR) or 100 per 100 000 (MMR) by 2017
- Rising burden of Non-Communicable Diseases

<table>
<thead>
<tr>
<th>Disease</th>
<th>2011 (in Millions)</th>
<th>2030 (in Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>61</td>
<td>101</td>
</tr>
<tr>
<td>Hypertension</td>
<td>130</td>
<td>240</td>
</tr>
<tr>
<td>Tobacco Deaths</td>
<td>1+</td>
<td>2+</td>
</tr>
<tr>
<td>PPYLL Due to CVD Deaths</td>
<td>9.2</td>
<td>17.9</td>
</tr>
</tbody>
</table>

*Potentially Productive Years of Life Lost Due To Cardiovascular Deaths Occurring in The Age Group of 35-64 Years
Aggregate national indicators do not highlight the huge disparities which exist across the states and districts of India. A baby girl born in Madhya Pradesh, for example, is at a six-fold higher risk of dying before her first birthday than a baby girl born in Kerala. Even in the first month of life, a newborn runs a five-fold higher risk of death if born in Odisha as compared to Kerala. Across almost every health indicator, health inequity is starkly evident in the country. Rural, less educated and poorer sections of our population including Dalits have a worse health status than more affluent, higher educated, urban and upper caste groups. Women too are worse off in health status and access to healthcare.
CHILD DEATHS : DISPARITY ACROSS STATES

IMR : MP : 72/1000
      UP : 69/1000
      Tamil Nadu : 35/1000
      Kerala : 13/1000

Neonatal Mortality Rate Varies
From 11/1000 in Kerala to 53/1000 in Odisha

Health Inequity Is Reflected Across Multiple Divides:
Urban-Rural; Income; Education; Gender; Caste
NOTES

- The National Sample Survey Organization (NSSO) reported in 2006 that financial barriers limited access to healthcare for large numbers of rural as well urban residents.

- Catastrophic health expenditure and distress financing are common problems encountered by many families. This hazard is not confined to the poor but also affects vulnerable sections of the middle class.

- Unaffordable healthcare expenditure pushes a third of the hospitalized patients into poverty.
WHY IS HEALTH SYSTEM REFORM NEEDED?

- 18% of all episodes in rural areas and 10% in urban areas received no health care at all
- 12% of people living in rural areas and 1% in urban areas had no access to a health facility
- 28% of rural residents and 20% of urban residents had no funds for healthcare
- Over 40% of hospitalised persons had to borrow money or sell assets to pay for their care
- Over 35% of hospitalised persons fell below the poverty line because of hospital expenses
- Over 2.2% of the population may be impoverished because of hospital expenses
- The majority of the citizens who did not access the health system were from the lowest income quintiles

*NSSO (2006)*
India’s overall public spending, as a fraction of its GDP, is quite high compared to many other countries. However, the fraction of public financing which is allocated to health is much lower than those countries. This indicates a low priority for health financing, in the overall fiscal policy of the government. According to WHO (2009), India’s public financing of health was only 1.2% of the GDP.
### LOW PRIORITY TO PUBLIC SPENDING ON HEALTH – INDIA AND COMPARETOR COUNTRIES 2009

<table>
<thead>
<tr>
<th>Country</th>
<th>Total public spending as % GDP (fiscal capacity)</th>
<th>Public spending on health as % of total public spending</th>
<th>Public spending on health as % of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>33.6</td>
<td>4.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>24.5</td>
<td>7.3</td>
<td>1.8</td>
</tr>
<tr>
<td>China</td>
<td>22.3</td>
<td>10.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Thailand</td>
<td>23.3</td>
<td>14.0</td>
<td>3.3</td>
</tr>
</tbody>
</table>

*Source: WHO database, 2009*
NOTES

- Overall national expenditure on health in India is on par with countries like Sri Lanka, Thailand and China, when expressed as a percentage of GDP. However, when expressed as per capita expenditure, it is lower than that of the comparator countries.

- Total health expenditure, however expressed, does not convey the extent to which the expenditure is shared between the government and private out-of-pocket spending.
## LOW LEVELS OF HEALTH SPENDING

<table>
<thead>
<tr>
<th>2009</th>
<th>Total expenditure on health as % of GDP</th>
<th>Per capita total expenditure on health (PPP$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>4.0</td>
<td>193</td>
</tr>
<tr>
<td><strong>India</strong></td>
<td>4.2</td>
<td><strong>132</strong></td>
</tr>
<tr>
<td>Thailand</td>
<td>4.3</td>
<td>345</td>
</tr>
<tr>
<td>China</td>
<td>4.6</td>
<td>309</td>
</tr>
</tbody>
</table>

*Source: WHO database, 2009*
NOTES

- When *per capita public expenditure* is considered, the gulf between India and the comparator countries becomes very evident. India spends a very low amount on public funding of healthcare, leaving a very large fraction of the per capita total expenditure to be borne as a burden by the citizen.

- So long as public funding on health does not increase, as a percentage of the GDP, out-of-pocket private expenditure on health will remain very high and continue to characterize India’s health system as regressive and highly inequitable.
## LOW LEVELS OF PUBLIC EXPENDITURE ON HEALTH

<table>
<thead>
<tr>
<th>2009</th>
<th>Total expenditure on health as % of GDP</th>
<th>Per capita total expenditure on health (PPP$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>1.8</td>
<td>87</td>
</tr>
<tr>
<td>India</td>
<td>1.2</td>
<td>43</td>
</tr>
<tr>
<td>Thailand</td>
<td>3.3</td>
<td>261</td>
</tr>
<tr>
<td>China</td>
<td>2.3</td>
<td>155</td>
</tr>
</tbody>
</table>

Source: WHO database, 2009
Even as national expenditure on health reflects a low level of public financing, there are wide differentials across the States, in terms of per capita public spending on health. Bihar, for example, spends three times less than Kerala.

It is not surprising that lower levels of spending on health are reflected in poorer health indicators. In 2005-06, Bihar had only 33% of its children fully immunized compared to 75% in Kerala.

Tamil Nadu did even better than predicted from its level of public financing because its strong public health system provided better value for money, while UP did worse than predicted because of poor governance.
LARGE INTER-STATE DIFFERENTIALS IN PUBLIC SPENDING

Per capita public health spending, 2004-05 (Rupees)

- Bihar: 93
- Uttar Pradesh: 128
- Tamil Nadu: 223
- Kerala: 287

Proportion of children fully immunized (%) 2005-06

- Bihar: 33
- Uttar Pradesh: 23
- Tamil Nadu: 81
- Kerala: 75

Source: NFHS-3
NOTES

- India is among the countries with an unacceptably high level of out-of-pocket expenditure (OOP). Very few countries exceed India’s level of OOP.

- An objective of the draft 12th Plan is to bring the OOP level down from 71% at present to 50% or lower. This would require greater allocation to health from public financing. It would also need a framework of Universal Health Coverage to ensure that the resources are well spent, with efficiency as well as equity becoming the measures of health system performance.
HIGH BURDEN OF PRIVATE OUT-OF-POCKET EXPENDITURE

Proportion on private out-of-pocket expenditure (%)

- Pakistan: 83%
- India: 78%
- Bangladesh: 71%
- China: 61%
- Sri Lanka: 54%
- Thailand: 36%
If reduction in out-of-pocket expenditure (OOP) is a necessary objective of improved health financing, it must be recognized that outpatient care and expenditure on medicines contribute the highest fractions of OOP. Current health insurance systems, government funded or privately purchased, mostly do not cover these major areas of health expenditure. As such, there is little demonstrable impact on OOP.

The framework of UHC must, therefore, accommodate outpatient care and provision of essential drugs within the ambit of public financing.
HIGH COSTS OF OUTPATIENT AND MEDICINE COSTS

Breakdown of private out-of-pocket expenditure (%)
- Inpatient: 24%
- Outpatient: 76%

Medicines and other expenses
- Others: 28%
- Medicines: 72%
Out-of-pocket expenditure (OOP) is a major cause of poverty, as unaffordable healthcare depletes a family’s limited financial resources. Nearly 40 million persons are pushed into poverty each year in India. There is a rising trend of health related impoverishment over time, visible in both rural and urban areas.

The impoverishing impact of OOP is harsher on the vulnerable sections residing in rural areas than their urban counterparts. With increasing migration, from rural to urban areas, the poverty generating effect of OOP will only be spread and not get attenuated, in the absence of affordable urban primary healthcare.
IMPOVERISHMENT DUE TO OOP PAYMENTS IN INDIA

(In Millions)

Source: Selvaraj and Karan (2009)
The Rashtriya Swasthya Bima Yojana (RSBY) was launched with a very laudable social objective of providing financial protection to unorganized workers, including migrant workers. It has benefited many persons who could access hospitalized care under the scheme.

The scheme has demonstrated several strengths, the most impressive of which has been an effective use of information technology to enroll beneficiaries and monitor services. It was also successful in drawing upon the services of both public and private healthcare providers.
RSBY (Targeting BPL) Strengths

- Rapid Enrollment and Expanding Coverage
- Portability
- Engagement of Public & Private Providers for 2º care
- Some Quality Improvement
- Effective Use of I.T
- Improved Fraud Detection Systems
Despite some success, the RSBY is limited by the fact that it only provides financial support during hospitalization for secondary care. Primary healthcare services as well as outpatient care are not supported.

Since outpatient care and long term provision of medicines are not features of the scheme, the impact on out-of-pocket expenditure (OOP) is likely to be limited. Recent evidence suggests that there is sometimes a paradoxical rise of OOP, as the add-on post-procedure costs may exceed the level of financial support provided during hospitalization.

Where utilization rates are high, it is proving difficult to sustain the scheme financially (as in Kerala).
GOVERNMENT FINANCED INSURANCE SCHEMES

RSBY (Targeting BPL) Strengths

- Only Covers Hospitalized 2° Care – neglect of preventive and promotive care
- Financial Non-Sustainability - If Utilization Rate is High (e.g., in Kerala)
- Cost-Escalation
- Paradoxical Rise in OOP(!)
- Impact on Health Outcomes Questionable
- Fragmentation of Care (Lack of Continuum of Care)
A number of State Government funded schemes have been launched in recent years. Andhra Pradesh, Tamil Nadu, Karnataka, Rajasthan, Kerala and Delhi are among those where below poverty line (BPL) families are provided financial support for hospitalisation involving tertiary care.

While well intentioned, these schemes do not cover primary care (or even secondary care in many cases). Outpatient care and long term provision of drugs are also not among the benefits provided.

A large fraction of the state health budget (exceeding 50% in some cases) is now spent on financing these schemes, mainly for purchasing services from private hospitals. This has led to neglect of primary care and lack of investment in strengthening public hospitals.

Induced demand has also been a problem, with unnecessary procedures being performed to claim money from the scheme.
## GOVERNMENT FINANCED INSURANCE SCHEMES

### State Level Programmes

- Cover hospitalised 3<sup>o</sup> care
- High proportion of state health budget diverted for 3<sup>o</sup> care in private hospitals
- Neglect of 1<sup>o</sup> care and public facilities
- Dangers of induced demand and inappropriate care
NOTES

- Over the last 25 years, the supply of free medicines, in both inpatient and outpatient services of public facilities has declined. During the mid-1980’s, about a third of the drugs prescribed during hospitalisation were supplied free. This declined sharply to about 9% only by 2004. Over this time, free drug supply for outpatient care too fell, from 18% to 5%.

- During the same period, the number of hospitalisation episodes in which an ailing population paid out-of-pocket (OOP) has risen from 41% to 72%.
# TRENDS IN ACCESS TO MEDICINES IN INDIA – 1986-87 TO 2004

<table>
<thead>
<tr>
<th>Period</th>
<th>Free Medicines (%)</th>
<th>Partly Free (%)</th>
<th>On Payment (%)</th>
<th>Not Received (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1986-87</td>
<td>31.20</td>
<td>15.00</td>
<td>40.95</td>
<td>12.85</td>
</tr>
<tr>
<td>1995-96</td>
<td>12.29</td>
<td>13.15</td>
<td>67.75</td>
<td>6.80</td>
</tr>
<tr>
<td>2004</td>
<td>8.99</td>
<td>16.38</td>
<td>71.79</td>
<td>2.84</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1986-87</td>
<td>17.98</td>
<td>4.36</td>
<td>65.55</td>
<td>12.11</td>
</tr>
<tr>
<td>1995-96</td>
<td>7.21</td>
<td>2.71</td>
<td>79.32</td>
<td>10.76</td>
</tr>
<tr>
<td>2004</td>
<td>5.34</td>
<td>3.38</td>
<td>65.27</td>
<td>26.01</td>
</tr>
</tbody>
</table>

*Source: Health data extracted from National Sample Survey Rounds 60, 52, and 42*
Even with respect to hospitalised care, there is a great shortage of beds. India falls well below the global average of 2.9 beds per 1000 population, with only 0.9 beds per 1000. The availability of public (government) beds varies widely between 1 per 4471 persons in Central India to 1 per 1650 persons in Southern India. The private sector, in Urban India, provides 1 bed per 422 persons. A large fraction of the existing beds in public facilities are not functional.

Since the strengthening of primary care should reduce demand for hospitalised secondary and tertiary care, and there is a growing trend towards day care and outpatient procedures, the need for hospital beds may be less in future. Even so, providing around 2 beds per 1000 population should be a goal for our health system.
# Hospital Bed Capacity, by Country

<table>
<thead>
<tr>
<th>Country</th>
<th>Beds/1000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>3.1</td>
</tr>
<tr>
<td>China</td>
<td>3.0</td>
</tr>
<tr>
<td>Thailand</td>
<td>2.2</td>
</tr>
<tr>
<td>Brazil</td>
<td>2.4</td>
</tr>
<tr>
<td>USA</td>
<td>3.1</td>
</tr>
<tr>
<td>UK</td>
<td>3.9</td>
</tr>
<tr>
<td><strong>India</strong></td>
<td><strong>0.9</strong></td>
</tr>
<tr>
<td>Nicaragua</td>
<td>0.9</td>
</tr>
<tr>
<td>Togo</td>
<td>0.9</td>
</tr>
<tr>
<td>Indonesia</td>
<td>0.6</td>
</tr>
</tbody>
</table>

India is among the countries described by WHO as facing a ‘health workforce crisis’. We face a great shortage of doctors, nurses, allied health professionals (several categories of paramedics, technicians and counselors) and frontline health workers.

The shortage is especially great in the Central, Northern and North-Eastern states. Six ‘high production states’ (Andhra Pradesh, Karnataka, Kerala, Maharashtra, Puducherry and Tamil Nadu) represent 31% of the population but have 58% of the MBBS seats and 63% of the nursing colleges. Eight ‘low production states’ account for 46% of India’s population but have only 21% of the MBBS seats and 20% of the nursing colleges.
HEALTH WORKER DENSITY ACROSS MAJOR STATES OF INDIA

There is a skewed distribution of healthcare providers and health facilities, with their urban aggregation far outnumbering rural availability.

Many of the AYUSH physicians too are located in urban areas.

The National Rural Health Mission (NRHM) has begun to improve the situation but rural areas are still far short of the required personnel and infrastructure.

While rural areas remain underserved, even the urban areas are not well served since a design for primary health services is virtually non-existent and the urban poor have limited access to affordable healthcare of assured quality.
HEALTH SERVICES: URBAN-RURAL DISPARITY

- 80% of Doctors
- 75% of Dispensaries
- 60% of Hospitals
- Qualified Physicians:
  11.3/10,000 - Urban Areas
  1.9/10,000 - Rural areas

Are Located in Urban Areas
In October 2010, the Planning Commission of India constituted a 15 member High Level Expert Group (HLEG), to recommend a framework for Universal Health Coverage (UHC). The HLEG was asked to submit its report in time for the development of the 12th Five Year Plan.

While health financing is the central focus of planning, a framework for UHC must take into account: human resources for health; physical and financial norms for health services; management systems; community participation and access to drugs, vaccines and technologies. Without these, the entitlement envisaged by increased health financing cannot be delivered. The terms of reference (TOR) were, therefore, structured to include these elements.

The HLEG also decided to add a TOR on the Social Determinants of Health, recognizing that many of the determinants that lie outside of the conventional health sector have a profound influence on health and also need to be influenced for UHC to be realized.
HIGH LEVEL EXPERT GROUP ON UNIVERSAL HEALTH COVERAGE (INSTITUTED BY PLANNING COMMISSION OF INDIA) 2010-11

TERMS OF REFERENCE

1. Human Resource Requirements
2. Access to Health Care Services
3. Management Reforms
4. Community Participation
5. Access to Medicines
6. Health care Financing

[7. Social Determinants of Health]
The HLEG adopted a broad definition of UHC, which emphasizes access, affordability and assures quality of healthcare to all Indian citizens. It also brings other sectors relevant to public health (such as water, sanitation, nutrition and environment) into the ambit of action for UHC. The definition calls on the Government to assume responsibility for guaranteeing the delivery of UHC, even though it may not be the sole provider of services.
OUR DEFINITION OF UHC

“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 and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) as well as public health services addressing 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.”
The HLEG recommends that a National Health Package (NHP) of services to be delivered under UHC, be developed and periodically reviewed by a group of experts convened by the Ministry of Health and Family Welfare. Such a package should include primary, secondary and essential elements of tertiary care, with the largest coverage for primary care.

The package may be modified in each State to suit State specific needs, while maintaining portability of coverage for the common components.

The services, which are to be provided under this package, should be funded by the government.
OUR VISION

Universal Health Entitlement for every citizen - to a National Health Package (NHP) of essential primary, secondary & tertiary healthcare services that will be funded by the government.

Package to be defined periodically by an Expert Group; can have state specific variations
NOTES

• UHC would entitle every citizen to any of the services included in the composite package of healthcare (NHP). These will be provided free of cost, as a cashless service and would include inpatient and outpatient care.

• Since the UHC system will deliver services through public facilities as well as contracted-in private providers, the citizen has a choice of the provider. Wherever she or he may go within the UHC network, service would be cashless.
**UNIVERSAL HEALTH COVERAGE BY 2022: THE VISION**

<table>
<thead>
<tr>
<th>ENTITLEMENT</th>
<th>NATIONAL HEALTH PACKAGE</th>
<th>CHOICE OF FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Universal health entitlement to every citizen</td>
<td>• Guaranteed access to an essential health package (including cashless inpatient and outpatient care free-of-cost)</td>
<td>• People free to choose between</td>
</tr>
<tr>
<td></td>
<td>▪ Primary care</td>
<td>▪ Public sector facilities and</td>
</tr>
<tr>
<td></td>
<td>▪ Secondary care</td>
<td>▪ Contracted-in private providers</td>
</tr>
<tr>
<td></td>
<td>▪ Tertiary care</td>
<td></td>
</tr>
</tbody>
</table>
- The major objective of health financing for UHC is to provide financial protection. For this, adequate financial resources are needed, to support the UHC programme.

- ‘More money for health and more health for the money’ was a phrase coined by Late Professor V. Ramalingaswami of India, in the 1980’s. This has since been cited or repeated world over. We need to ensure efficient financing mechanisms which will enable appropriate utilisation of funds for enhancing the outreach and effectiveness of health services.
**HOW TO FINANCE UHC?**

*Three Objectives:*

- ensure **sufficient financial resources** for the provision of **essential health care** to all
- ensure **financial protection** and health security against impoverishment
- put in place **financing mechanisms** that are consistent with **improved wellbeing** as well as **containment of health care cost inflation**.
NOTES

- The HLEG recommends that total governmental funding should increase to at least 2.5% during the 12th plan period and to at least 3% during the 13th plan period, to advance the UHC programme.

- A recent cost modeling study, conducted by researchers from PGIMER* at Chandigarh and the University of Toronto, estimates that the full range of services under UHC would require 3.8% of GDP. If these estimates are adjusted for the projected rise in India’s GDP, the estimate provided by HLEG for the 13th Plan would be closely matched.

* PGIMER = Post Graduate Institute of Medical Education and Research
RECOMMENDATION

Government (Central government and states combined) should increase public expenditures on health from

the current level of **1.2%** of GDP

to at least

**2.5%** by the end of the 12th plan, and

to at least **3%** of GDP in the 13th Plan
Since OOP on drugs is a major cause of impoverishment or inadequate treatment, the HLEG recommends that public expenditure on drugs be increased to 0.5% of the GDP.

This would enable free provision of the medicines included in the Essential Drugs List (EDL) also called National List of Essential Medicines (NLEM).

To begin with, provision of EDL medicines through public facilities would cost an additional Rs. 6000 crore.

Pooled procurement of quality assured generic drugs would help to contain the cost of medicines. The Tamil Nadu Medical Systems Cooperation (TNMSC) provides an excellent model.
RECOMMENDATION

Ensure availability of free essential medicines by increasing public spending on drug procurement.

increase in the public procurement of medicines from around 0.1% to around 0.5% of GDP

Streamline and Centralise procurement like in Tamil Nadu
• The largest need of health services, for most individuals, is in primary healthcare. Indeed, if provision of primary healthcare is easily accessible and is of good quality, the need for secondary or tertiary care will be substantially reduced. Therefore, 70% of public financing for health should flow into providing primary care to both rural and urban populations.

• Primary healthcare should provide a comprehensive package of services which include health promotion, disease prevention, removal or reduction of risk factors that lead to disease, early detection and care of health disorders and referral to higher levels of care as needed (with follow-up care and community based or domiciliary rehabilitation of those returning from secondary or tertiary care).
RECOMMENDATION

Expenditures on primary healthcare, should account for at least 70% of all healthcare expenditures and cover

- general health information and promotion
- curative services at the primary level
- screening for risk factors at the population level
Taxation generates the general revenue pool, from which UHC should be finalised. In a country like India, this has to be principal pathway for financing healthcare, because:

- Contributory social insurance will be difficult to collect from the large majority of the population who are in the informal sector; payroll taxes too will cover only a limited number.
- Private insurance is unaffordable for many and often discriminates against those who have disease or are likely to develop it (i.e., those who need healthcare the most)
- Insurance schemes typically cover hospitalisation for secondary or tertiary care and do not provide primary or outpatient care.
- Insurance agencies/third party administrators add their own costs which are often substantial

“Empirical evidence indicates that a free market for insurance cannot achieve social equity and that serious market failures allow insurers to practice risk selection, leaving the most vulnerable people uninsured. Adverse selection among insurance buyers impairs the functions of the insurance market and deters the pooling of health risks widely. Moreover, the insurance market’s high transaction costs yield highly inefficient results.”

RECOMMENDATION

- Use general taxation as the principal source of healthcare financing complemented by additional mandatory deductions from salaried individuals and tax payers either
  - as a proportion of taxable income
    or
  - as a proportion of salary
- Avoid insurance schemes, as they fragment healthcare, do not provide full coverage of needed services, and fail to cover the whole population
The concept of ‘User Fees’ was widely propagated in the early 1990’s, as it was perceived to be useful for curtailing unnecessary demand for health services in public facilities. Global evidence since then has demonstrated that user fee is:

- **inefficient** (it requires a large administrative machinery to collect the fees and also to identify the poor who need to be granted exemptions)

- **inadequate** (it generates very little revenue to the government while it adds to out-of-pocket expenditure)

- **inequitable** (it has been shown to reduce the access to the poor, of even essential health services)

“User Fees for health care were put forward as a way to recover costs and discourage the excessive use of health services and the over-consumption of care. This did not happen. Instead, user fees punished the poor.”

-Dr. Margaret Chan, Director-General, WHO (2009)

“Among the ‘quick win’ strategies recommended by the Millennium Project was the removal of user fees for primary education and essential healthcare by the end of 2006.”

Dr. Jeffrey Sachs, Earth Institute (2005)
RECOMMENDATION

Do not levy fees of any kind for use of healthcare services under the UHC

Evidence suggests that user fees have increased inequalities in access to healthcare

- Negative impacts on the usage of health services even from those that need them.
- Not an effective source of resource mobilization.
- Challenges of means-testing and errors of inclusion and exclusion.
- Out-of-pocket payment at the point of care is the most important reason why healthcare expenses turn catastrophic for all healthcare users.
NOTES

- The package of essential health services, to be covered under the UHC programme, should be provided free of cost to ALL citizens. This is not a targeted programme aimed only at the poor, as many sections of the population are burdened by healthcare costs AND the programme will maintain quality and become sustainable only if all sections of society have a stake in its success (as common beneficiaries of the same programme).

- Persons who wish to seek care from private healthcare providers who do not enlist in the UHC network can do so by paying privately (direct payment or via private insurance).

- Similarly, persons who wish to avail of other services (such as private ward) or undergo clinical procedures or use drugs which are not included in the UHC package can do so through payment.

- Any State which wishes to provide additional free services to the poor (beyond the UHC package) can still do so from its own health budget.
NO USER FEE

UHC PACKAGE OF HEALTH SERVICES (NHP WITH NHEC)

INSURANCE (PVT./EMPLOYER) OR OOP

HOSPITALITY COMPONENT (Pvt. Ward)

PERSONS OPTING FOR NON-NHEC ACCREDITED HOSPITALS

NON-NHP SERVICES
To enable effective delivery of UHC, it is necessary to strengthen the public facilities of healthcare through improved infrastructure, staffing, equipment, drug supply and management.

Such strengthening is needed at the various levels of primary healthcare (especially the sub-centres which should play a greater role in providing both facility based and outreach services)

District hospitals too should be substantially strengthened so that they can provide a wide range of services and reduce referral to high-cost hospitals.

Private providers can be co-opted to support the UHC system, through well designed contracting – in mechanisms which clearly define the services to be delivered and attach accountability.

Networks of providers should be created at the district level, to integrate primary, secondary and tertiary care services. While these can include both public and contracted – in private providers, the district health system manager (Director, District Health Services) should define the network composition and the deliverables.

Disadvantaged populations (identified by a Vulnerability Index) should be prioritized for additional financing and augmented services.
PROVISION OF HEALTHCARE

- Strengthen Public Services
  *(Especially: Primary Healthcare-Rural and Urban; District Hospitals)*

- Contract Private Providers
  (As Per Need and Availability) – With Defined Deliverables

- Integrate $1^0, 2^0, 3^0$ Care
  Through Networks of Providers
  (Public; Private; Public-Private)
For strengthening primary healthcare in rural areas, the health workforce at the village sub-centre levels must be substantially augmented. There must be two ASHAs and two Anganwadi workers for 1000 population, to form an effective village level team for maternal and child health, nutrition, sanitation, adolescent and reproductive health and health promotion (including prevention of tobacco use, alcohol abuse and domestic violence).

The health sub-centre (one for 5000 population) should have two female Auxiliary Nurse Midwives (ANMs), a male multi-purpose health worker (MPW), a mid-level health worker (Bachelor of Rural/Primary Health Practice) and a laboratory technician-cum-drug dispenser. The staff strength at the PHC and CHC levels too should be augmented, especially with more nurses.

Urban Primary Health Care too should be strengthened by establishing urban health sub-centres headed by a Nurse Practitioner.
HUMAN RESOURCES FOR HEALTH

*Increase numbers and skills of frontline health workers:*

- Doubling of ASHAs and ANMs;
- Male MPW and Mid Level Health Professional (3 year trainee)/AYUSH at Sub-Centre level;
- Expand Staff (esp. nurses) at PHC and CHC;
- Nurse-Practitioners for Urban Primary Health Care
The number of medical colleges and nursing colleges need to be increased to overcome the shortages in specialist doctors, family practitioners, specialist nurses and general nurses. These new colleges should be located in states with very few colleges and preferably in districts where no such colleges currently exist. Wherever feasible, they should be linked to district hospitals.

The numbers of ANM (Auxiliary Nurse Midwife) schools too should be increased, especially in states where their numbers are very low.

A large number of paramedical workers (allied health professionals) too would be required in many categories (ranging from laboratory technicians to radiographers and operation theatre assistants to mental health counselors). Their production should be enabled by: establishment of several new training institutions; improved training programmes with access to skill labs and simulation centres; standardization of training and accreditation.

To coordinate the training of several categories of health workers and to promote team work and inter-professional education, District Health Knowledge Institutes should be established with a link to the District Hospital.
HUMAN RESOURCES FOR HEALTH

- Establish new medical and nursing colleges in underserved states and districts with linkage to district hospitals; increase the number of ANM schools
- Scale up number and quality of Allied Health Professional training institutions
- Establish District Health Knowledge Institutes to coordinate and conduct training of different categories of health workers
With phased establishment of new medical colleges and nursing colleges in states which presently have very few, and linking them to district hospitals whenever possible, it should be possible to reach the desirable norms for doctors (10 for 10,000 population), and nurse: doctor ratio (3:1) over three plan periods (2012-2027). With the production of mid-level health workers (BRHP/BPHP), the total health work force would have attained considerable strength even by 2022.

For ensuring that this production pipeline results in well dispersed distribution, recruitment and retention in government health service, system reforms are needed to review cadre structures, create career tracks and professional advancement pathways, ensure incentives for health workers serving in difficult areas and strength human resource management.

To enable much needed reforms in health professional education, the proposed National Commission on Human Resources for Health (NCHRH) must be created quickly.
PROJECTED HRH AVAILABILITY (2012-2027)
NOTES

♦ Health sector is among the least regulated in our country, despite the need for effective regulation to ensure ethical, efficient, equitable, safe and affordable health services. For the UHC programme to succeed, existing regulatory structures (such as the drug regulatory authorities) need to be strengthened and new structures need to be created, at both central and state levels.

♦ A National Health Regulatory and Development Authority should be created as an autonomous body, linked to, but not located in, the Ministry of Health and Family Welfare. This should have a UHC support system, consisting of a technical wing (for development of standard management guidelines and quality assurance), a legal-regulatory-financing wing (for developing norms for contracts, financial flow mechanisms and regulation of healthcare facilities) and a management information systems wing (for monitoring and analyzing the information flow on the functioning of UHC across the country). These should be complemented by an Accreditation wing (which develops the norms for affiliation of healthcare facilities and maintains live registry) and a Monitoring & Evaluation wing (which conducts an independent evaluation through input, process, output and impact indicators).

♦ These agencies should also have their state level counterparts which will play the operational role at the states while the national body is mainly normative.
National Health Regulatory and Development Authority

- UHC System Support
- Accreditation Norms & National Registry
- Monitoring and Evaluation

- Standard Treatment Guidelines, Management Protocols, Quality Assurance Assessment Methods for NHP
- Legal, Financial and Regulatory Norms
- Management Information Systems for UHC

State Health Regulatory and Development Authority

- State Level Accreditation and Registry
- State Legislation and Rules
- State Level Management Information Systems
NOTES

- Community empowerment is critical to the success of UHC. Communities need to actively participate in the design and monitoring of health programmes and contribute to the conduct of the programmes wherever they can play a useful role.

- The village, block and district level bodies which are designated as channels of community participation, under NRHM, should be empowered to play the role of Health Councils (like in Brazil and Thailand).

- State level and national Health Assembles should be organised annually to review progress, suggest course corrections and set the agenda for future programmes (like in Thailand).

- Panchayati Raj institutions should be assisted to play a much stronger role, both through the elected members and the Gram Sabha. Urban local bodies too should similarly be drawn into active leadership of health programmes.

- Community based organisations and other NGOs should be engaged to play an enabling role, both for community empowerment and for facilitating the delivery of health services.

- A block level grievance redressal mechanism should be set up, by designating an independent ‘ombudsman’ who can be common to a cluster of development programmes.
COMMUNITY PARTICIPATION AND CITIZEN ENGAGEMENT

- Transformation of existing Village Health Committees (or Health and Sanitation Committees) into participatory Health Councils;
- Organize regular Health Assemblies;
- Enhance the role of elected representatives as well as Panchayati Raj institutions (in rural areas) and local bodies (in urban areas);
- Strengthen the role of civil society and non-governmental organizations.
- Institute a formal grievance redressal mechanism at the block level.
Since action on social determinants (like water, sanitation, nutrition, environment, education, livelihoods and gender equity) is essential to promote, preserve and protect health, both public and private initiatives for improving these determinants should be supported.

A dedicated Social Determinants Committee will help to achieve better inter-sectoral coordination. Such committees should be set up at District, State and National levels.

A National Health Promotion and Protection Trust should be set up, to facilitate health education of the people, to build capacity in health communication, to advance action on social determinants and to conduct ‘health impact assessment’ of proposed policies and programmes in other sectors which have relevance to health.

Since reducing health inequity is one of the principal aims of UHC, a composite National Health Equity Surveillance Framework should be developed, with multiple social and health indicators, to monitor gains in health equity as UHC is implemented.

“Health leaps out of Science and draws nourishment from the Society around it”

- Gunnar Myrdal (Swedish Economist, Nobel Laureate)
1. Initiatives, both public and private, on the Social Determinants of Health (SDH) and towards greater health equity should be supported

2. A dedicated Social Determinants Committee should be set up at district, state and national level

3. Include Social Determinants of Health in the mandate of the National Health Promotion and Protection Trust (NHPPT)

4. Develop and implement a comprehensive National Health Equity Surveillance Framework, as recommended by WHO’s Commission on the Social Determinants of Health
NOTES

_UHC will confer several benefits for India:_

- It will provide financial protection to people by reducing out-of-pocket health expenditure.
- It will promote greater health equity by promoting better access to healthcare for all sections of the population.
- It will improve health outcomes at every stage of a person’s life by improving the quality of health services and the effectiveness of their delivery.
- It will make the health system more efficient and accountable by: defining health service norms; establishing credible and effective regulatory systems; promoting transparency in procurement and contracts; mandating quality through accreditation and monitoring.
- It will reduce poverty by reducing the risk of ill-health in the first place and by reducing personal costs on healthcare if disease does occur.
- It will improve productivity by promoting health and reducing the losses due to premature death and prolonged disability.
- It will create several million jobs through the much needed expansion of the health workforce. Young persons and women will especially benefit from the creation of new jobs in both public and private sectors.
Universal Health Coverage

Greater equity
Improved health outcomes
Efficient, accountable & transparent health system
Greater productivity
Reduced poverty
Increased jobs
Financial Protection
NOTES

- The present situation of healthcare is unacceptable, because of low levels of health system performance and high levels of health inequity.

- Continuation of the present system, without substantial reform, will see an unaffordable escalation of healthcare costs and further increase in health inequity.

- UHC provides a framework for making accessible, affordable and appropriate healthcare available to all Indians, by increasing public financing of health and achieving better results for the money spent.

- The full programmes of UHC will take a few years to evolve but the effort must BEGIN now in real earnest, before it becomes too late to repair a damaged and damaging health system.

- We need to create the future health system which assures delivery of the essential services that people desire, deserve and demand.

- The future begins TODAY!
“If we don’t create the future, the present extends itself”

- Toni Morrison (Song of Solomon)
DEDICATION

“This report is dedicated to the people of India whose health is our most precious asset and whose care is our most sacred duty”