

A Review on the Report on India and Universal Health Coverage

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DOI: <https://doi.org/10.24321/2455.9199.201804>

Abstract

The world is getting together for *universal health coverage* (UHC) as a prevalent health goal, where everyone will receive the quality health services without any hardships of financial suffering (WHO 2010). UHC has been incorporated as a sub-goal within the overall health sustainable goals. Many of the leading health agencies including World Bank are promoting UHC as the best strategy to achieve the overall health. The World Bank and WHO have estimated that around 400 million people lack access to basic health services, and that 6% of people in low and middle income countries are tipped into or pushed further into extreme poverty because of health spending (WHO 2015). India has been ranked 116 out of 157 nations on a global index that assesses the performance of countries towards achieving the sustainable development goals. The index score of India is 58.1 which is behind the comparable countries such as Nepal, Sri Lanka, Bhutan and China. India is among the countries described by WHO as facing a health workforce crisis. India is facing a great shortage of nurses and other allied health professionals. The macrocosmic aspect of the concept limpidly designates that everybody should be covered – nobody should be left behind.

Keywords: Universal Health Coverage, Global index, India, National insurance health schemes, Financial insurance, Out of pocket

Introduction

Universal health coverage means that all people and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services from health promotion to prevention, treatment, rehabilitation and palliative care. UHC enables everyone to access the services that address the most important causes of disease and death, and ensure that the quality of those services is good enough to improve the health of the people who receive them. Protecting people from the financial consequences of paying for health services out of their own pockets reduces the risk that they will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets or borrow.

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Achieving UHC

It is one of the targets the nations of the world set when adopting the sustainable development goals in 2015. Countries who progress towards UHC will make progress towards the other health-related targets and goals. Good health allows children to learn and adults to earn, helps people escape from poverty and provides the basis for long-term economic development. The 65th World Health Assembly meeting in Geneva identified universal health coverage as a key imperative for all countries to consolidate

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How to cite this article: Cannie S. A Review on the Report on India and Universal Health Coverage. *Int J HealthCare Edu & Med Inform* 2018; 5(1): 26-31.

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the public health advances. Several countries have been working to reform their health system during the last few decades. The high-level expert group on UHC was constituted by the orchestrating commission of India in October 2010, with the mandate of developing a framework for providing facily accessible and affordable healthcare to all Indians. HLEG submitted its report to the Planning Commission in November, 2011

Measuring Progress towards UHC

As countries plan and implement strategies to reach UHC, they will require to address a broad range of system reforms, involving all of the health systems 'building blocks' identified by WHO (WHO 2007) including governance, healthcare financing, health workforce, medical products and technologies, information and research, and accommodation distribution. However, as WHO identified itself in its report in 2010, the area that is liable to have the greatest impact on improving equity will concern reforming the health financing system.

India has been ranked 116 out of 157 nations on a global index that assesses the performance of countries towards achieving the sustainable development goals. The index score of India is 58.1 which is behind the comparable countries such as Nepal, Sri Lanka, Bhutan and China. Sweden is at rank one as of 2017 global index with a score of 85.6.

The progress and functions should focus on:

1. The proportion of a population that can access essential quality health services.
2. The proportion of the population that spends a large amount of household income on health.
3. Revenues for health services and how they are pooled to spread financial risks.
4. Type of purchasing mechanism being used for the payment of health services.

India and Universal Health Coverage

The HLEG adopted a broad definition of UHC for the vision of India, which emphasizes access, affordability and assures quality of healthcare to all Indian citizens. It also brings other sectors relevant to public health (such as sanitation, nutrition and environment) into the ambit of action for UHC. The definition calls on the government to assume

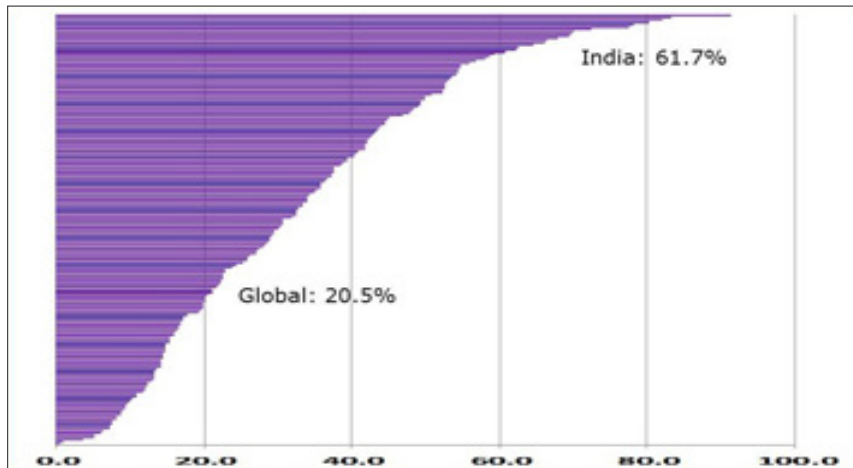
responsibility for guaranteeing the delivery of UHC, even though it may not be the sole provider of services.

Ascertaining equitable access for all Indian citizens, regardless of income level, convivial status, gender, caste or religion to affordable, accountable, appropriate health accommodation of assured quality as well as public health accommodation addressing the wider determinants of health distributed to individuals and populations, with the regime being the guarantor and enabler, although not necessarily the only provider, of health and cognate accommodations.

India has immensely colossal population of poor women in the world as per the statistics of World Bank 2014, office Registrar General of India 2011. The country has high levels of gender-predicted inequality with a gender development index of 0.794 in 2014, which places it in among countries with the lowest parity in human development index achievements between women and men (UNDP 2015). While India has initiated a number of health-financing initiatives with the aim of incrementing coverage of healthcare accommodations to low-income groups, especially for maternal healthcare of women from poor households and less economically developed states of India, the gendered impact of the health-financing schemes is yet to be looked in detail.

India is among one of the countries with an unacceptably high level of out-of-pocket expenditure. Incrementing privatization of health accommodation provision affects women from across the socio-economic spectrum. Low-income women have to pay for all services other than distribution care, while women who utilize private sector facilities for distribution care often incur very high out-of-pocket expenditure. A study utilizing national survey data for 2007-08 reported the mean expenditure incurred for a normal delivery in a private health facility to be USD 84 and for a caesarean distribution as high as USD 256.

Moreover, the household members within male-headed households were twice as liable to be insured as those in female-headed households with implicative healthcare access. Voluntary, community-based health schemes, which intend to meet the gap in insurance coverage in the informal sector through low premia, targeting women, the poor and rural populations, have additionally been unable to provide coverage for those without access to cash – including the elderly and women from non-poor households.



Source: World Health Statistics 2013, WHO, Geneva, 190 countries

Figure 1. Out-of-pocket Health Expenditure as proportion of total Health Expenditure

Figure 1 depicts the out-of-pocket expenditure as a proportion of total health expenditure at 61.7% in comparison to the global average of 20.5%.

National Health Insurance Schemes

- **Rashtiya Swasthiya Bima Yojana:** The scheme provides protection to below poverty line household families. Beneficiaries need to pay only Rs. 30 as registration fee while state and central government pay the premium to the insurer selected by the state government on the basis of competitive bidding.
- **Employment State Insurance Scheme:** This scheme has been extended to shops, hotels, restaurants, cinemas, preview theaters, road-motor transport undertakings and newspaper establishments employing 20 or more persons.

- **Central Government Health Scheme:** This scheme covers comprehensive health care facilities for the central government employees and pensioners and their dependents residing in CGHS covered cities.
- **Aam Aadmi Bima Yojana:** A separate fund called “Aam Admi Bima Yojana Premium Fund” has been set up by the central government to pay the government contribution.
- **Janashree Bima Yojana:** This scheme replaced Social Security Group Insurance Scheme and Rural Group Life Insurance Scheme.
- **Universal Health Insurance Scheme:** The Universal Health Insurance Scheme has been redesigned targeting only below poverty line families. The premium subsidy has been enhanced from Rs. 100 to Rs 200 for an individual, Rs. 300 for a family and Rs. 400 for a family of seven, without any reduction in benefits.

Population Coverage under Various Health Schemes in India

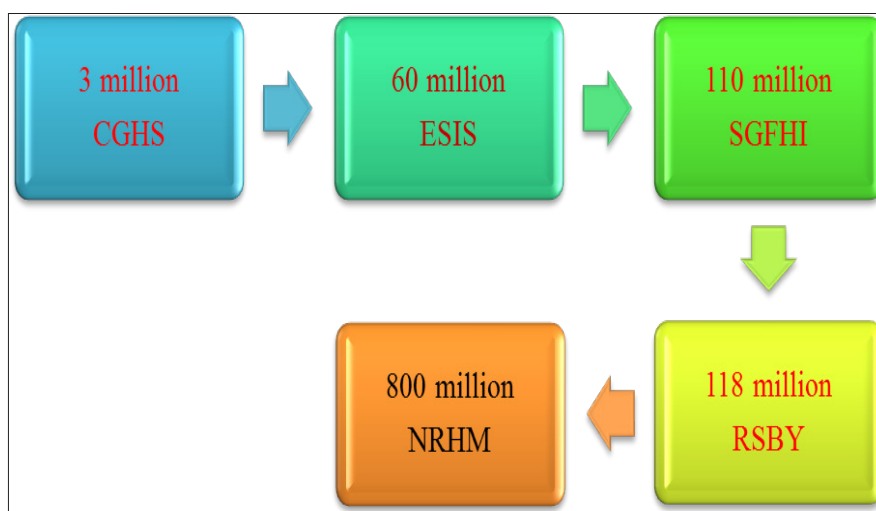


Figure 2

Figure 2 shows that Central Government Health Scheme (CGHS) covers an estimated population of 3 million whereas Employee State Insurance Scheme (ESIS) covers an approximate population of 60 million at primary, secondary and tertiary levels in both schemes respectively. The State Government Funded Health Insurance (SGFHI) and Rastriya Swasthya Bima Yojana (RSBY) provide care to 110 and 118 million population at tertiary care focus and secondary level. The National Rural Health Mission (NRHM) has shown coverage of 800 million populations which is at the maximum by providing primary care to the community at large.

Statistics on Service Coverage and Financial Protection India 2015

1	Service coverage index	56
2	Data availability to construct SDG	High
3	Availability of estimates	Yes
4	Most recent available estimates	Year 2011
5	Incidence of catastrophic expenditure	
	At 10% household total income	17.33%
	Greater than 10%	17%
	At 25% household total income	3.90%

Increase in Poverty Gap due to Household Expenditure on Health, 2015

1	Most recent available estimates	Year 2011
	As a proportion of the \$1.90 a day poverty line	1.12%
	At the \$1.90 a day poverty line	2.13%
	As a proportion of the \$3.10 a day poverty line	2.48%
	At the \$3.10 a day poverty line	7.69 cents

Coverage of Essential Health Services – India

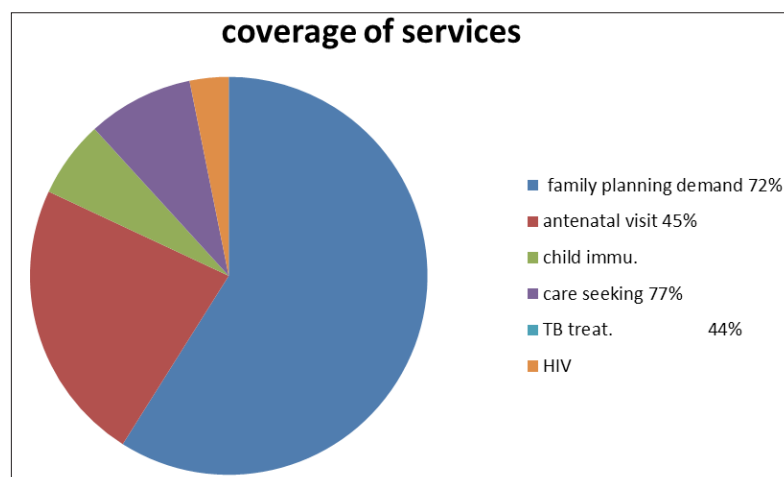


Figure 3. Vision 2020 – UHC, India

Definition

“Ensuring equitable access for all Indians 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, although not necessarily the only provider of health and related services.”

Universal health entitlement for every citizen to a national health package of essential primary, secondary and tertiary healthcare services that will be funded by the government.

The government financed insurance schemes targeting below poverty line strengths.

- Rapid enrolment and expanding coverage
- Portability
- Engagement of public private providers for secondary care

- Some quality Improvement
- Effective use of I.T.
- Improved fraud detection system

Principles

Ten principles have guided the formulation of UHC in India:

- Universality
- Equity
- Non-exclusive and non-discrimination
- Comprehensive care that is rational and of good quality
- Financial protection
- Protection of patients' rights that guarantee appropriateness of care, patient choice, portability and continuity of care
- Consolidated and strengthened public health provisioning
- Accountability and transparency
- Community participation
- Putting health in peoples' hands

UHC and Its Benefits for India

- It will provide financial aegis to people by reducing out-of-pocket health expenditure
- It will promote more preponderant 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 amending the quality of health services and the efficacy of their distribution
- It will make the health system more efficient and accountable by defining health services norms, establishing credible and efficacious regulatory systems, promoting transparency in procurement and contracts, mandating quality through accreditation and monitoring
- It will reduce poverty by reducing the jeopardy of ill-health in the first place and by reducing personal costs on healthcare if disease does occur
- It will amend productivity by promoting health care and reducing the losses due to premature deaths and prolonged disability
- It will engender seven million jobs through much needed expansion of health workforce
- Adolescent persons and women will especially benefit from the creation of incipient jobs in both public and private sectors

Nurses and UHC

India is among the countries described by WHO as facing a health workforce crisis. India is facing a great shortage of nurses and other allied health professionals. The shortage is especially great in the Central, Northern and North-Eastern states. The six high-engenderment states are Andhra

Pradesh, Karnataka, Kerala, Maharashtra, Puducherry and Tamil Nadu represent 31% of population but have 63% of nursing colleges. The other eight low-engenderment states account for 46% of India's population and only 20% of the nursing colleges. To achieve UHC, the quality, quantity and relevance of the nursing and midwifery force needs to be assured.

The traditional role of nurses in Indian system is that of a village health nurse and ASHA/ANM. Health system and hospitals have not explored the possibility of nurses as an integral part of multidisciplinary teams in distributing out-patient care in primary and secondary level settings. The BRICS countries like South Africa and Brazil, the nurses are the first contact and back bone of primary care in the management of a breadth of prevalent conditions and sanctioning them for drug prescription under supervision is needed. This can categorically avail in the management of non-communicable diseases where reinforcement of behavioral changes at every visit is time consuming.

Areas of Provision for Improvement of UHC-India

Ecumenically, there are two models of achieving UHC objective and these models vary from country to country. First is tax-financed model, while second is indemnification model. Some countries distribute care through salaried public providers, others have adopted capitation as the preferred model for payment for out-patient care, and free-for-accommodation for in patient care. As an example, while in Canada, UHC is financed through Federal and Provincial tax revenue, in Germany, there is a sickness fund. In New Zealand, the National Health Service is publicly financed through general tax revenue.

The main mechanism here includes direct patient fee, voluntary private insurance schemes, voluntary health saving and personal philanthropic aid. The high-level expert committee has recommended a tax funded and cashless delivery model of UHC.

Besides that, the public private partnership should postulate the roles of promoter, provider, regulator and steward. Good referral systems, better transportation, robust supply chains and data and upgraded facilities should be ascertained. India and state public health sector should develop better human resource practices, adequate national health information technology network, conventional flow of funds and ensuring accountability to patients and communities.

Conflict of Interest: None

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Date of Submission: 2018-04-25

Date of Acceptance: 2018-05-01