

India in search of right Universal Health Coverage (UHC) model: The risks of implementing UHC in the absence of political demand by the citizen

ABSTRACT

Amid the global push for Universal Health Coverage (UHC), the agenda is being set for India's health care. In the absence of a constitutional mandate, a national policy and citizen-led political demand for UHC, there exist specific risks in rushing toward its implementation in India. As the debate of UHC continues, the health-care delivery system in India is at cross roads. UHC in India could take two different trajectories. The first one takes India toward becoming "Global Bazaar" of morbidity and ill health, founded on the pillars of a vibrant rapidly multiplying healthcare industry. The other path takes India on a course of preventing wasteful, expensive health-care expenditure by maintaining healthy populations. A poor professional blood donor cannot become rich by selling his or her own blood beyond medically permissible levels; similarly, India cannot become a developed economy by merely allowing exploitation of disease, illness, and morbidity of her citizen. It is the duty of the state and governments to protect individual citizen, population under consideration, as well as country's economy from wasteful and potentially harmful expenditure incurred to address ill health. In the economic sense, any sensible UHC implementation mechanism would seek to regulate wasteful preventable health-care expenditure for the purpose of future economic stability and growth of the country. Due diligence toward safeguarding "public health in public interest," during the process of UHC implementation, is the need of the hour.

Keywords: Health Policy in India, health system development, politics of health care, regulation in health care, Universal Health Coverage

Background

Celebrated on December 12, the Universal Health Coverage (UHC) day commemorates the unanimous United Nations Resolution in 2012 calling for countries to increase access to quality health-care services at affordable cost to every person, everywhere. UHC is one of the 17 sustainable development goals adopted by the United Nations for eliminating poverty and building a more resilient planet. UHC improves how health care is financed and delivered – so it is more accessible, more equitable, and more effective. However, it is the UHC implementation "model or design" which holds the key to success, having a positive impact on the future economic development, and prosperity of India. UHC in India has been defined as "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, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative) as well as public health services addressing the 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."¹

While issues such as economic development, administrative reforms, gender equity, and environment safety are occupying popular space in public discourse, health care seems to have taken a back seat. Although technical deliberations by the Indian and international expert groups are vigorously taking place in the background, nothing much is being discussed or debated in the public space. Even though pressing health-care needs of

population and communities prevail, visibly "health care" has not yet evolved as political demand for the Indian citizen. Unlike the United States, where "Obamacare" dominated the political discourse, UHC has not even been an electoral issue in the elections held at local, state, and national levels in the recent times.

Historically, in the most developed countries, UHC evolved as an outcome of political discourse during the post second world war period. It was a culmination of the ongoing political negotiations evolved from the political situations prevailing during and after the period of industrial revolution.² Strangely, however, any such vociferous demand is near absent in the current Indian political scenario. It is rather unusual that at the time when UHC is being diluted or dismantled in much of the developed countries such as UK; it is being prescribed for the growing economies such as India in form of a massive push for globalization under the pretext of SDGs (Sustainable Development Goals).

Current Scenario

Despite substantial improvements in some health indicators in the past decade, India contributes disproportionately to the global burden of disease, with health indicators that compare unfavorably with other middle-income countries and India's regional neighbors. Large health disparities between states, between rural and urban populations, and across social classes persist. A large proportion of the population is impoverished because of high out-of-pocket health-care expenditures and suffers the adverse consequences

of poor quality of care.^[3] The evidence for age structure transition effect and fiscal sustainability on India's proposed UHC Policy revealed that public health expenditure is marked by age specificities, and the elderly population is costlier to support for their health-care needs. Given the discount and productivity growth rates, the proposed UHC is not fiscally sustainable under India's current fiscal policies except for the convergence scenario.^[4]

The choice of financial model and options for health-care delivery system need explicit planning in terms of implementations and intended impact. India is a diverse country, with heterogeneity among its states and even within the states. Moreover, as per the seventh schedule to the Constitution of India, health has been assigned to the jurisdiction of the state governments rather than the union government. Therefore, a single template for the entire country is not desirable, irrespective of whether it can be implemented or not.^[5]

Why the Global Push for Universal Health Coverage?

Due to push from the key global and local players, within the overtly privatized ecosystem of health-care delivery system in India, the design of UHC seems to be drifting toward a model which can be identified with the following key ingredients and existing trends: (a) development of large tertiary care hospitals through public investment; (b) bulk purchase of drugs through public funding and distribution through public health system; (c) diagnostic services for screening the large sections of population organized through vertical programs; (d) insurance coverage for hospitalization (end point cover) instead of outpatient coverage (health maintenance); (e) development of legal framework for expanding rights of allopathic drug prescriptions beyond licensed doctors of modern medicine; (f) rolling over of public-private partnership model for primary care delivery units; (g) continued support to fragmented public health verticals such as population control, immunization, HIV, and tuberculosis.

It is noteworthy that 70% of the health care is provided by the private sector in the socialist democratic republic of India.^[6] With a population of 1.3 billion and profound morbidity in the underserved, a strong market force drives the health sector. One needs to be mindful of the need and purpose of the UHC in such a situation.

According to a recent report by the World Economic Forum and the Harvard School of Public Health titled "Economics of Non-Communicable Diseases in India," India is set to lose 4.5 trillion dollars due to noncommunicable diseases only by 2030.^[7] This amount is sized more than double of the current Indian economy. If indeed incurred, it would be a catastrophic financial loss to the country. Interestingly, this report is also sends a signal to the global health industry for a potential business opportunity in India to be optimized.

Where Is The Risk? What It At Stake?

In the absence of citizen demand for UHC, the agenda for health

care in India is being set by Industry Syndicates, Global Health Agencies, International Philanthropists, and Industry Partnered Public Health Institutions. Not often discussed, but there is tension between the notions of rapidly expanding health-care industry and implementation of health policies in public interest. UHC models have varied across countries, from the countries of Western Europe to the erstwhile USSR. The American model of health-care stands distinct at the other end of the spectrum. Therefore, the most appropriate financial and service delivery model of UHC needs a close public scrutiny before implementation.^[8]

The Great Gross Domestic Product Debate and Universal Health Coverage Risks

There is a long-standing criticism of successive Indian Governments for not spending enough of gross domestic product (GDP) on health care. Any future increment of GDP expenditure on health care is likely to be spent on UHC. However, unless an appropriate UHC model is opted, the discussion on increased GDP expenditure is futile. The current environment of overtly privatized tertiary care dominated health sector, any increment in GDP expenditure in form of subsidy from taxpayers' money is at risk of being indirectly transferred to the health industry through UHC design.

Universal Health Coverage and India: Way Forward

Need for constitutional reforms

The current constitutional provisions provide a limited mandate to the union government for health-care provision over states. The institution of National Rural Health Mission, which has evolved into the National Health Mission (NHM), has done excellent work toward infrastructure development and financial assistance to the state governments. However, in the absence of any constitutional mandate, NHM does not assume the status of implementation authority comparable to the National Health System (NHS) of United Kingdom but remains only a limited financial and logistic assistance body to states. The NHM needs to be elevated to the constitutional status of custodian of health care of people of India in consultation with the state governments. If necessary, constitutional amendments should be enacted to safeguard health status of citizens. Health should be identified as a right of the citizen. Constitutional reform for health care is only feasible and possible when there is sufficient political demand for the same. India needs a national healthcare authority with a status comparable to the Reserve Bank of India (RBI), Election Commission (EC), Securities and Exchange Board of India (SEBI) and Telecom Regulatory Authority of India (TRAI) before the government embark upon the path of UHC.

Optimal model for universal health coverage

UHC debate is an extraordinary opportunity for India to move toward decentralizing health care by moving care out of resource-intensive institutions (such as hospitals), and into models of care delivery and even self-management in the home and community. "Regulation" and "gatekeeping" will remain key determinants for implementing

public health policies in public interest. Following components should be embedded as the essential ingredients of UHC model in India.

- a. Focus on financial cover for “health maintenance,” i.e., outpatient care
- b. “Gatekeeping” of tertiary care facilities with structured referral system
- c. “Geographical coverage” by primary care teams led by licensed physicians who are skilled to provide comprehensive range of preventive and clinical services across all age groups, genders, and organ system
- d. Continued investment in strengthening of “general health system” instead of focus of vertical programs on immunizations, tuberculosis, and HIV
- e. Provision of health services founded on the concepts of primary care
- f. Financial compensation and incentives linked with objective population-based targets
- g. Achievement of high-quality clinical governance, regulation, safety, and quality benchmarks
- h. Provision of personal-centered comprehensive care in the community setting instead of distributing rationed benefits through vertical programs
- i. Establishment of a central authority with a status comparable to the Reserve Bank of India (RBI), Election Commission (EC), Securities and Exchange Board of India (SEBI) and Telecom Regulatory Authority of India (TRAI); through constitutional reforms mandating appropriate authority, accountability and insulation from corruption.

Conclusion

The purpose and evolving model of UHC in India is in stark contrast with the existing and successful models of UHC prevailing in developed economies. Even the most developed economies cannot sustain unregulated health-care expenditure; the underlying financial principle of UHC is driven by the purpose to reduce the expensive wasteful and preventable medical expenditure. In the absence of political demand, debate, and discussion, UHC implementation is a double-edged sword for countries like India in spite of the best intentions. Any superficial implementation plan for UHC in form of a 'National Program like outlay', before enacting an constitutional authority, would be a grave risk to the future of healthcare as well as economy of India. UHC should take the sequential path of electoral demand, political manifestos and constitutional reforms. Universal Health Coverage should be the spontaneous national aspiration rather than being an obligation under massive 'globalization' push of international development goals.

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