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Editorial

Universal Health Coverage in India: Progress achieved & the way forward

The theme of this year's World Health Day is 'Universal health coverage (UHC): everyone, everywhere'[1]. The ultimate goal of UHC is to ensure that everyone, everywhere, should have access to essential healthcare services without facing financial hardship. Progressive realization of UHC is also one of the key features of the United Nations' Sustainable Development Goals[2]. India's commitment towards achieving UHC is clearly reflected in policies and institutional mechanism, which are directed towards increasing coverage and access to health services. India has launched *Ayushman Bharat* - one of the most ambitious health missions ever to achieve UHC[3]. *Ayushman Bharat* encompasses two complementary schemes, Health and Wellness Centres and National Health Protection Scheme. Health and Wellness Centres are envisioned as a foundation of the health system to provide comprehensive primary care, free essential drugs and diagnostic services, whereas National Health Protection Scheme is envisaged to provide financial risk protection to poor and vulnerable families arising out of secondary and tertiary care hospitalization[4] to the tune of five lakh rupees per family per year. Indeed, the dream of achieving UHC or health for all has been a long-standing one for India. India has supported the idea of health for all since independence, and the Bhore committee report had recommended a publicly financed national health services and system for comprehensive preventive and curative care for all, way back in 1946[5].

The World Health Organization (WHO) has identified four key financing strategies to achieve UHC - increasing taxation efficiency, increasing government budgets for health, innovation in financing for health and increasing development assistance for health[6]. Unfortunately, all of these measures fall beyond the control of Ministries of Health (MOH) and less likely to be influenced by their efforts alone. The MOH need to be more assertive in their demands for health budget and should use evidence-driven investment case scenarios to justify higher budgetary allocations. Evidence suggests that tax revenue is a key determinant in progress towards UHC in low- and middle-income countries (LMICs). To generate an additional $9.86 public health spending per capita, the tax revenue needs to increase by $100 per-capita[7]. Not only financing and institutionalization are critical for achieving UHC, but also measuring progress towards UHC is equally important. The three core dimensions of UHC proposed by the WHO[8] are "the proportion of a population covered by existing healthcare systems, the range of healthcare services available to a population, and the extent of financial risk protection available to local populations"[9]. An analysis of South Asian countries reported that access to basic care varied substantially within and across each country. In India, financial risk protection was only 17.9 per cent and prevention and treatment coverage for selected heath conditions was 83.5 per cent[9]. The study also raised equity concerns, highlighting that access to care for maternal and child health services was higher among rich as compared to poor mothers.

To address health inequalities and improve health outcomes, an architectural correction in public healthcare system was made by the Ministry of Health and Family Welfare (MoHFW) through National Rural Health Mission, which was later redesigned as National Health Mission (NHM) to strengthen both rural and urban public health infrastructure, human resource capacity and service delivery. NHM was complemented by other key initiatives that included *Janani Suraksha Yojana* and Mission *Indradhanush*. *Rashtriya Swasthya Bima Yojana* (RSBY) was another innovative initiative launched by the Ministry of Labour and Employment (now with MoHFW), which provided financial risk

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protection to poor families through government-funded health insurance. However, in spite of all the efforts, the total health expenditures (THEs) in India remained at 4.7 per cent of gross domestic product (GDP) in 2014[9]. The contribution of public health expenditure also remained stagnant at 30 per cent, which is one of the lowest among LMICs[9].

Healthcare need is not only uncertain and unpredictable but also catastrophic to families living on the margins. Poor and vulnerable families not only spend money out-of-pocket (OOP) due to ill health but also have to suffer wage loss to seek healthcare. Estimates suggest that in India, around 50 million households fall in poverty annually on account of OOP healthcare expenditures[10]. One of the reasons for high rate of OOP expenditures is limited access to healthcare in public sector, which compels patients to seek care in the private sector. Evidence suggests that a dynamic interaction between three factors forces patients towards private sector in India: (*i*) healthcare provisioning dominated by private sector, (*ii*) high share of private expenditure as compared to public expenditure in THE, and (*iii*) scarcity of public services on account of deteriorated public health sector[11]. For example, private sector accounted for 75 per cent of total outpatient visits and 62 per cent of total inpatient visits in India in 2014 and the contribution of OOP payments as per cent of THE was 61 per cent in 2012[11]. Given such a scenario, it is desirable to move towards UHC-based health system where complex and dynamic private sector is efficiently regulated and market competition and choices are used as tools to enhance quality of care and reduce cost of care. Given the fact that social determinants of health play key role in equity, all efforts should be made for multi-stakeholder engagement in design and delivery of an inclusive and pluralistic UHC-driven health care system.

To address the policy challenges and fill critical gaps in achieving UHC, the National Health Policy (NHP)-2017 has been approved by the Union Cabinet[12]. The NHP aims to deliver quality health services at affordable cost for the achievement of UHC. It also envisages increasing public health expenditure to 2.5 per cent of the GDP to achieve its intended objectives. To translate its vision of the NHP-2017 into reality, the Government of India has approved Centrally Sponsored *Ayushman Bharat*-National Health Protection Mission (AB-NHPM)[3]. Socio-Economic Caste Census (SECC) database[3] shall be used to identify target beneficiaries of the proposed scheme. The press note on AB-NHPM suggests that the scheme is expected to have major impact on reduction of OOP expenditure on ground of "(*i*) increased benefit cover to nearly 40 per cent of the population (poorest and vulnerable), (*ii*) covering almost all secondary and many tertiary hospitalizations (except a negative list), and (*iii*) coverage of 5 lakh for each family, (no restriction of family size)"[3]. However, evidence on success of insurance schemes (RSBY, in particular) on OOP expenditure suggests otherwise. For example, an impact evaluation of the RSBY scheme suggested that RSBY scheme neither affected the likelihood of inpatient OOP spending nor affected the probability of outpatient OOP expenditure. On the contrary, likelihood of incurring OOP spending (both inpatient and outpatient) increased by 30 per cent[13]. Hence, it is critical to ensure that gatekeeping function of insurance regulators is up to the mark. This will prevent both supply-side and demand-side moral hazard that is the hallmark of the insurance-driven schemes.

Evidence suggests that not only hospitalization but also outpatient care leads to impoverishment of households. For families living on daily wages, hospitalization probably is the last resort in an illness episode as it not only leads to catastrophic expenses but also to loss of wages of more than one earning member of the family. In addition, a healthcare consultation unleashes additional demands for health such as care for comorbidities and patient support services, and many of these services are not covered as part of health insurance. Hence, possibility of increase in households OOP expenditure cannot be ruled out with increased access because the product that is offered under AB-NHPM is geared towards secondary and tertiary inpatient care over comprehensive outpatient care. In addition, with increased longevity, an epidemiological transition towards non-communicable diseases such as hypertension, diabetes, mental illnesses and other comorbidities is inevitable. These conditions require long-term care and are best managed through comprehensive primary care provided in outpatient setting. Any health scheme favouring hospitalization alone over comprehensive outpatient care and coverage may not be an appropriate product for health needs of the society. Learning from our experiences of RSBY scheme, the benefit package to the beneficiaries should be designed appropriately by keeping in account their social and economic context and their healthcare needs. For example, AB-NHPM may consider providing outpatient care, medicine and diagnostic

charges, travel allowance and most importantly wage loss compensation as essential ingredients of the benefit package and not just hospitalization expenses. The benefit package may also be expanded to take care of needs of special groups such as elderly who are on long-term medication support through outpatient services, support for children with special needs, people requiring long-term rehabilitation and victims of road traffic accidents.

Global evidence suggests that tax-based financing is the most progressive form of financing mechanism to fund healthcare services followed by social health insurance whereas OOP expenditures are most regressive[14]. However, if government decided to go for insurance-driven financing mechanism for healthcare services because of strategic reasons such as developing healthcare market or utilizing strengths of existing private sector, a cautious approach is warranted to prevent regulatory capture. As a way forward, it is suggested to strengthen regulatory framework and institutions (such as Insurance Regulator and Development Authority and Competition Commission of India) and public health facilities to ensure competition and choice in the healthcare market. It is also suggested to have synergy between AB-NHPM and Health and Wellness Centres as a desirable goal as this would ensure complementarity between secondary and tertiary care services covered through AB-NHPM with comprehensive primary care of Health and Wellness Centres and would prevent demand-side moral hazard and healthcare cost escalation.

***Conflicts of Interest*:** None.

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