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Perspective

Universal coverage challenges require health system approaches; the case of India

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ABSTRACT

This paper uses the case of India to demonstrate that Universal Health Coverage (UHC) is about not only health financing; personal and population services production issues, stewardship of the health system and generation of the necessary resources and inputs need to accompany the health financing proposals.

In order to help policy makers address UHC in India and sort out implementation issues, the framework developed by the World Health Organization (WHO) in the World Health Report 2000 and its subsequent extensions are advocated. The framework includes final goals, generic intermediate objectives and four inter-dependent functions which interact as a system; it can be useful by diagnosing current shortcomings and facilitating the filling up of gaps between functions and goals.

Different positions are being defended in India re the preconditions for UHC to succeed. This paper argues that more (public) money will be important, but not enough; it needs to be supplemented with broad interventions at various health system levels. The paper analyzes some of the most important issues in relation to the functions of service production, generation of inputs and the necessary stewardship. It also pays attention to reform implementation, as different from its design, and suggests critical aspects emanating from a review of recent health system reforms.

Precisely because of the lack of comparative reference for India, emphasis is made on the need to accompany implementation with analysis, so that the "solutions" ("what to do?", "how to do it?") are found through policy analysis and research embedded into flexible implementation. Strengthening "evidence-to-policy" links and the intelligence dimension of stewardship/leadership as well as accountability during implementation are considered paramount. Countries facing similar challenges to those faced by India can also benefit from the above approaches.

1. Background

International experience reveals a move towards Universal Health Coverage (UHC) as promoted by the World Health Report 2010 "Agenda for Action" [1]. Raising and pooling funds provides the base for population coverage, and these mechanisms are most effective when prepayment comes on behalf of a large number of people, creating an enabling environment in which the healthy subsidize the sick, the rich subsidize the poor, those of working age subsidize those beyond it, and health services purchasing is used strategically to promote efficient use of resources.

International experience also shows that general government revenues have been at the core of recent UHC

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reforms in low and medium income countries with large informal sectors and numbers outside of salaried employment (where direct taxation is harder to implement). This approach moves away from a principal focus on earmarked payroll taxes and a contributory basis for entitlement, given the structure of the labor market yet recognizes the need to rely on compulsory funding sources (taxation) to move towards universal population coverage [2]. Such is the lesson from recent innovations in Brazil's expanded "right to health" [3], Kyrgyzstan's Mandatory Health Insurance Fund [4], Mexico's "Seguro Popular" [5] and Thailand's Universal Coverage scheme [6] among others.

These approaches are aligned with the concept of UHC which shifted the underlying public policy rationale for health coverage from being a condition of labor status (as was the case from the time of Bismarck until shortly after World War II) to being a condition of citizenship, underpinned by emergent concepts of health as a human right and human security often reflected in national constitutions [7,8]. Recent international experiences also show that reforms in large federal systems (for example, China and Mexico) must devote attention to the role of local governments, with the center using intergovernmental incentives to stimulate attention to health at state/provincial levels.

Those features can also be observed in India, with its schemes since independence (including one for civil servants and another one based on Social Health Insurance contributions from the formal sector). During the past decade, national-level reforms de-linking coverage from employment and increasing public spending by transferring health-specific funds to States have been introduced via two innovative schemes[1]:

- The National Rural Health Mission (NRHM), an umbrella program departing from earlier trends of financing specific health care lines for identified diseases and health conditions. Since 2005 it fosters district and village health plans aggregated up to state level, plus primary care services and infrastructures, from Union level government, encouraging States to match grant money in varying proportions [10]. NRHM takes into account disparities in revenue capacity and differentiates *non-focus states*, with a weight of 1 in the allocation of resources (Andhra Pradesh, Goa, Gujarat, Haryana, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu and West Bengal), *high-focus north-eastern states* (Arunachal Pradesh, Assam, Manipur, Mizoram, Meghalaya, Nagaland, Sikkim, and Tripura, with a weight of 3.2) and *high-focus large states* (Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Madhya Pradesh, Orissa, Rajasthan, Uttarakhand and Uttar Pradesh, with a resource allocation weight of 1.3).
- The Rashtriya Swasthya Bima Yojna (RSBY) is a hospitalization costs insurance scheme launched in 2008 to protect below poverty line households – the vast majority of people in the unorganized sector, including agriculture [11]. While managed nationally by the Labour Ministry, at state level (where implementation occurs) the Health and Labour Ministries each manages the program in about half the states. The usual funding split is Union Government 75% and State government 25%, which in Northeastern states and Jammu and Kashmir goes up to 90:10. About 33 million families have been covered and 4.3 million persons used hospitalisation services under RSBY, according to the 12th Five-Year Plan document [12]. While nearly completely tax-funded, implementation is contracted at state level to private insurance companies based on a tender process to become the single insurer for a state or for a defined geographic region of a state. Beneficiaries can choose from public and private providers contracted ("empanelled") by the insurer.

These programs are quite different in size and focus. Financially, the resources provided for NRHM are about 10 times the amount provided for RSBY. NRHM is predominantly a supply-side funding mechanism, whereas RSBY involves an explicit purchaser–provider split, with public funds flowing to contracted private and public insurers that purchase inpatient care on behalf of the covered population. While difficult to fully identify the consequences, a major concern has been the absence of explicit coordination between these two mechanisms [13].

Analyses of each of these schemes have shown mixed results – both achievements as well as problems in implementation. In the Sixth Common Review Mission for NRHM, progress was reported in key health outcomes – notably in child survival, population stabilisation and maternal mortality reduction plus improvements in immunisation in all states, increased outpatient attendance and in-patient admissions. The *Janani Shishu Suraksha Karyakram* (JSSK) provides free cashless services to normal deliveries and caesarean operations and care for sick new born in Government health institutions [14]. On the down side, problems have been reported concerning lack of accountability and poor quality of spending [15] and even financial scandals [16].

RSBY has also been thoroughly analysed and achievements as well as problems have been hotly debated. By both leveraging increased levels of state spending on health and channelling the combined public subsidies to an insurance fund to purchase services on behalf of covered persons, the scheme has enabled an increase in public spending on health while introducing a purchaser–provider split for an explicit benefits package with no patient cost sharing (cashless care); it has also fostered improved access to both public and private hospitals and enhanced financial protection for the target population. RSBY has implemented an innovative IT platform to support enrolment and provider payment; it assesses regularly information on service use [17] and patient satisfaction; in Delhi a survey of 390 hospitalized beneficiaries found that 18% were highly satisfied, 67% were satisfied and only 3% dissatisfied [18]. Problematic areas include a large remaining gap in reaching the

[1] Several State-level initiatives have been introduced as well, most notably the Rajiv Aarogyasri hospital insurance scheme that covers about 80% of the population in Andra Pradesh, funded by state-level tax revenues [9]. Though state-level schemes are very important both within the states where they are implemented and for informing future policy reforms, in this paper we only focus on national level programs.