In Pursuit of an Effective UHC
Perspectives Lacking Innovation

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There are certain bold directions outlined by the High Level Expert Group in its recommendations, which, if acted on, will have a great impact on the health status of the population. The key as always is in implementation, which has not been clearly spelt out.

Prime Minister Manmohan Singh declared in his Independence Day address on 15 August 2011 that health would be accorded the highest priority in the Twelfth Five-Year Plan which would become operational in April 2012. In this, there is an expression of intent that the government will increase public spending on health to 2.5% of India's GDP. The High Level Expert Group (HLEG) on Universal Health Coverage (UHC) was constituted by the Planning Commission in October 2010 with the mandate of developing a framework for providing easily accessible and affordable healthcare to all Indians. UHC is linked firmly to the right to health. For UHC to succeed there has to be political as well as financial commitments from the central and state governments.

Financial protection seems to be the principal objective of the initiative. The recommended scheme gives an impression of wanting to create a cashless health service of a certain quality irrespective of caste, creed and economic status. Financing is the most critical of all determinants of a health system. The nature of financing defines the structure, the behaviour of different stakeholders and quality of outcomes. It is indivisibly linked to the provisioning of services and helps define the outer boundaries of the system's capacity to achieve its stated goals. A sharing of the financial burden of this programme between the national, state and local governments with a certain level of flexibility (depending on each region's requirements) seems to be the goal, but devising an effective mode and strategy of implementation of its operations will be a Herculean task.

The vision to provide every citizen essential primary, secondary and tertiary care services that will be guaranteed by the central government under the national health package (NHP) which will give cover to all common conditions is welcome. The NHP will be based on the recommendations of experts who will determine the services taking into account resource availability as well as the healthcare needs of the country. Implementation, keeping in mind the ground realities in terms of urban-rural disparities, cultural beliefs and behaviour, and political differences in priorities between the central and state governments, will be a daunting task. The recommendation to earmark at least 70% of the expenditure for preventive, promotive and primary healthcare will be a very beneficial step for the population of the country. Creating specific purpose, quasi-governmental, autonomous agencies like the Tamil Nadu Medical Services Corporation which has been providing efficient service delivery at the state level can also be looked at as a possible model at the national level. Integrating all government-funded health insurance schemes into the UHC system along with the state-run insurance programmes is in the correct direction.

The healthcare services covered under the UHC are proposed to be available through public sector and contracted-in private facilities, including those provided by non-profit organisations. Two different options are proposed. The first option is to include the private providers in the UHC system and to see that they provide at least 75% of outpatient care and 50% of inpatient care on a standardised rate and a reimbursed mode. Such services will be offered cashless to the citizens. How this system can be monitored, regulated and quality assured irrespective of the location, caste, creed and economic status of the deserving is a question. The second option seems to be a facility which will provide only cashless services under the NHP and will be funded under the scheme. Integrating public hospitals and the private for-profit and not-for-profit hospitals to deliver a similar quality of care in our country will not be easy. What will happen if private healthcare providers who render 70% of the care, especially at the tertiary level, refuse to participate in the programme? This will leave the programme to be handled entirely by the public hospitals.

More than 60% of the inpatient services in India are now provided by the private sector, more so at the secondary and tertiary care levels. Many states to date do not have any legislation which would

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make it mandatory for private medical establishments to obtain a licence to function. The legislation that is in existence is outdated and irrelevant for contemporary conditions. The minimum standards needed in infrastructure, human resources, technology, the services to be rendered and the pricing of such services have to be addressed through legislation that would make them mandatory for all medical establishments. This has to be done across the country in a uniform manner. The government should come out with a legislation to make all such standardised hospitals in the private sector accept patients under the NHP and make it mandatory to allocate a certain percentage of beds for the programme. If viable packages are offered for private establishments then it will be possible to implement the NHP.

The need for country-specific technology from a viewpoint of cost, quality and efficacy is completely absent in the report. The use of medical technology of the western world at currently available costs will make medical care phenomenally expensive. We need to have technology which is relevant and serves the purpose in an objective manner, and costs need to be much lower than in the western world models. High-end gadgets with complicated mechanisms of handling may also not serve the purpose because we do not have the kind of quality power required to drive these sensitive equipment or biomedical engineers who can service them, leave alone professionals like nurses and paramedical staff who will be capable of handling these gadgets. Now, even the western world is looking for technology from the emerging markets that is cost-effective.

The dream of reducing out-of-pocket spending on health from around 67% today to around 33% by 2022 is a goal worth striving for. India is one among the developing countries where households spend a disproportionate share of their consumption expenditure on healthcare, with the government's contribution being minimal.

Almost 75% of expenditure is out of the pocket on drugs, which draws attention to the cost component and successive governments' failure to put in place a system of providing a solution in this direction and minimising the cost of essential drugs especially, through regulatory mechanisms. To date, the government does not have a clear policy of how to eliminate the middle man between the manufacturer and the buyer where much of the cost escalations take place. Simple solutions of propagating generic drugs, avoiding irrational combinations and setting up a system of ethical use of appropriate medicines by the medical fraternity have not been considered. The best example has been the vaccine industry where these negative trends have been growing rapidly. The vaccine market in India has become polluted because of the unethical practices of the entrepreneurs. The costs double when travelling from the manufacturer to the consumer. To overcome all this, all the vaccines needed in our country should be provided at no cost through the NHP.

India is a country of diverse cultural habits and beliefs. Health awareness and knowledge of public health, irrespective of the educational status of the population, need large investments and a special focus. Spending 70% of the budget of UHC on such activities and primary healthcare is acceptable. The role of public private partnerships, non-governmental and not-for-profit organisations and civil society can be very promising especially when corporatisation of healthcare can lead to artificial cost escalation and undesirable health practices. The emphasis on investing in the primary care network along with developing a community awareness of health and sanitation, holding the providers responsible for outcomes at the population level and developing networks with the secondary and tertiary facilities is in the right direction.

Health-Related Areas

Targeting investments in health education and promotion activities for women will yield constructive outcomes. UHC can be achieved only when sufficient and simultaneous attention is paid to at least the following health-related areas: (i) nutrition and food security, (ii) water and sanitation, (iii) social inclusion, and (iv) clean environment and housing.

Malnutrition and anaemia are rampant in India which makes the population susceptible to many medical conditions. To have an impact on the general well-being of women and children we need to address these primary problems. While problems of under-consumption and poor nutritional status continue to exist, increasingly problems of diet-related diseases are emerging as significant public health issues. Along with malnutrition, obesity, especially among the urban affluent, needs to be addressed with an appropriate emphasis on correct nutrition and adequate physical activity.

The World Health Organisation (WHO) has identified India as one of the nations that is going to have the largest of the lifestyle disorders in the near future. Already considered the diabetes capital of the world, India now appears headed towards gaining another dubious distinction – of becoming the lifestyle-related disease capital as well. Thirty-one per cent of urban Indians are estimated to be either overweight or obese. Interventions relating to lifestyle diseases, especially in urban populations, from the point of view of prevention, early detection and follow-up care are essential.

Good health practices such as physical exercises, yoga and pranayama, if encouraged and inculcated as a natural way of life along with a stress on the right kind of nutrition (discouraging junk food, food with low fibre content and high in dead calories) are needed. Mass education focusing on reduction of salt intake and certain kinds of fats and excessive sugar is also important. Campaigns enlightening the negative effects of tobacco, *gutka* and alcohol have to be taken seriously not only at the grass-root level but also at the policy level.

Immunisation

Owing to the large reproductively active population it is vital that investments in maternal and neonatal care are planned for, as this is likely to last for several more decades because of the sheer size of the population. Immunisation especially because India is a tropical country has phenomenal benefits if vaccine preventable diseases are taken care of. If the universal imunisation programme is expanded to include the injectible polio, pneumococcal, HIB and typhoid vaccines, and made available to every child in the country, it will lead to significant reduction in childhood

morbidity. It will lead to a significant reduction in hospital bed occupancy.

Screening for certain conditions, such as cervical, breast and prostate cancers, and for disorders like diabetes and hypertension will reduce morbidity and the need for tertiary care services.

In the information technology (IT) era, synergies can materialise through telemedicine, area-specific disease mapping, dissemination of health-related education, and by harnessing the medical database of the population. IT does have a great potential to improve the quality, safety, and efficiency of healthcare delivery

Raising the quality of healthcare professionals, be it the community level workers, nursing cadre, paramedical staff or doctors, calls for a paradigm shift in training templates and monitoring and evaluation of their competence at periodic intervals. It is vital that the gaps are identified in the performance of basic healthcare workers in providing healthcare services so as to plan for interventions to improve performances.

Vertical linkage from the subcentre upwards has not been addressed so far because of multiple reasons like the absence of road networks, the unavailability of transport mechanisms and thus, appropriate referrals are not taking place. With the advent of the 108 facility through a public-private partnership, a few states have been able to address this crucial linkage in healthcare to some extent. If this can be replicated in all states with certain modifications, it will lead to better outcomes.

Medical Colleges

An uneven establishment of medical colleges ranging from one medical college for a population of 1.5 million to a medical college for a population of 11.5 million in certain states of the country calls for immediate rectification. As rightly mentioned in the HLEG report an estimated 187 new medical colleges have to be started to address the gap in human resources. This, if done on a war footing so as to see that every district in the country has at least one medical college which, in turn, will generate medical professionals, not only of doctors but in allied services such as nursing and other paramedical staff, will address the health needs of each region. If the existing district hospitals are adequately equipped, suitably staffed and linked to medical colleges then their effectiveness will improve. This, supplemented by contracting-in of regulated private hospitals, should be able to meet the health needs of more than 95% of the population in the districts. The remaining can be referred to regional tertiary care centres.

The recommendation by the HLEG of a three-year bachelor rural healthcare degree programme that will create rural healthcare practitioners is a dream given the negativism created by the medical fraternity across the country and the class difference it is going to create in the population. When the user fee system was implemented in certain states it led to a drop in the access of the vulnerable population to basic healthcare, which should make us abandon this system and instead turn to revenue collection through a tax-based system which makes every individual mandatorily contribute according to the tax bracket in which she is situated.

The difference between rural and urban indicators of health status and the wide interstate disparity in health status are both well known. With the dearth of doctors in the Indian health sector, it is important to innovate on strategies so as to incorporate the paramedical staff in delivering care and thus minimise the role of doctors in primary healthcare. This will result in better outcomes. Making the rural practice compulsory for every medical graduate for a certain period also will fulfil this shortcoming. The paramedical team at the PHC level should be expanded and empowered; and the right infrastructure provided along with the required equipment and drugs. Bringing in more accountability along with demand creation through awareness and involvement of the local community and stakeholders will make it a perfect model which will work as a template across all regions, thus narrowing the rural/urban divide.

Conclusions

To sum up,

(1) Certain directions in the HLEG report are bold and will, if acted on, have a great impact. (2) The implementation strategy has not been clearly defined. (3) Increasing government health spend as a percentage of GDP from the present 1% to 2.5% will make a significant difference only if the model of delivery is made accountable and, transparent, and the right kind of monitory mechanisms are put in place. (4) Increasing human resources in health sector on a war footing, not compromising on the quality of professionals from such institutions, minimising the rural-urban, and the regional differences in distribution of medical colleges across the country will increase the standard of healthcare delivery multifold. (5) The stakeholders' roles in delivery of care and monitoring mechanisms have not been elaborated in the HLEG report. (6) Using generic drugs and having a tight control on pricing will minimise healthcare costs. (7) Low cost technology in medical industry should be encouraged; this will indirectly have an impact on tertiary care costs where technology costs are high. (8) Eliminating insurance in healthcare other than for universal healthcare will be the ideal situation. (9) Emphasising upgradation of medical knowledge regularly and inculcating ethical practices through proper practice guidelines and protocol-driven care will also add to better outcomes especially in tertiary care facilities. (10) If the national health entitlement card is going to ensure cashless transaction anywhere in the country, a dramatic impact on the health of the most vulnerable – the nomadic class (migrant population working in unorganised sector) – will be seen. (11) The HLEG report is devoid of any disruptive innovations, with reference to accountability, quality of care and outcomes.

In a diverse country like ours, we need the public sector, NGOs and not-for-profit organisations, PPP models and the corporates to address health needs. The public sector hospitals should mainly address the issues of primary and secondary care and improve access, quality and accountability. The not-for-profits, NGOs and PPPs should play a role in health awareness, capacity building, monitoring and evaluation and create islands of excellence in healthcare. The corporate sector should mainly focus on the critical care with international quality standardised care and research at a cost that most of the population should be able to afford.