# Universal Health Coverage in India

## A Long and Winding Road

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India's steps towards universal health coverage began in the early years after Independence but they faltered because of various factors, including resource constraints. The context has vastly changed since then but the need remains as urgent as it always was. This overview to the special issue on the report of the High Level Expert Group on Universal Health Coverage notes that the report takes into account the complex nature of the health situation in the country and puts forth an integrated blueprint for achieving UHC. There may be a few shortcomings, but if the interlinked proposals are implemented in a carefully planned manner, a long-delayed promise to the country's people could be largely fulfilled.

This paper owes a great deal to discussions within the HLEG, stakeholder consultations with a number of individuals and organisations and to the staff of the Public Health Foundation of India who functioned as the secretariat and staff for the HLEG. Any errors of fact or interpretation are mine.

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There is arguably no aspect of social policy more complex or controversial in today's world than how a country goes about assuring health for its people. Preventing avoidable physical or mental suffering, ameliorating what is unavoidable and doing so for everyone at a reasonable cost poses a challenge not only in poor developing countries, but also in some countries with the highest per capita incomes in the world. Some of this is because the shifting dynamics and consequences of demographic and epidemiological transitions make Universal Health Coverage (UHC) something of a moving target. The health needs of an ageing population or of a growing burden of non-communicable disease are very different from those of a young population with a high prevalence of infectious diseases. Even if one excludes the US, which is widely recognised as having one of the world's most iniquitous health systems, there are high-income countries in Europe that have done well in the past but are now struggling to meet growing healthcare needs. The UK with its lauded National Health Service under stress is only one example.

Another major challenge is the sheer complexity of financing and managing preventive, promotive, curative and rehabilitative care; of proactively addressing the social determinants of health; of assuring quality in the public sector; of harnessing the initiative and resources of the private sector while ensuring effective regulatory systems; and of ensuring equity of access to services across social and economic divides. That health includes elements of private and public goods (as defined by economists), which opens up the possibility of combining public and private provisioning, does not make the task of health policy and management any easier.

The silver lining in all this is provided by continuing evidence of the possibility of "good health at low cost" (GHLC) in a variety of sociopolitical settings and in a number of low-income contexts (Balabanova, McKee and Mills 2011). As far back as 1985, the original good health at low cost report had shown that a combination of political commitment to health as a worthy social goal, strong societal values of equity, political participation and community involvement, high investments in primary care, widespread education, especially of women, and inter-sectoral linkages had remarkable effects on health in low-income settings such as China, Sri Lanka and Kerala (Halstead, Walsh and Warren 1985). Twenty-five years on, there are newer examples such as Thailand, Kyrgyzstan and Tamil Nadu, where these factors have been complemented by an intelligent use of research and monitoring and stronger management inputs. By no means have all the health problems in these cases been solved, but what these examples do mean is that it is possible even in today's more complex health scene to start on a path towards good health for all.

Of particular interest for India is that two of the GHLC examples are Indian states. While Kerala's better than average performance in health, education and other social development indicators has long been attributed to non-replicable historical and political factors, it is difficult to dismiss the lessons of Tamil Nadu in the same way. Certainly, Tamil Nadu has had its own social reform movements, but the state's recent experience also provides clear policy, legal and management lessons that other states and the central government can follow.

### Ups and Downs of UHC in India

If an extraterrestrial were to land in India and attempt to understand health provisioning in the country by reading through policy and programme plans, it would be convinced that Indians are a remarkably healthy lot. By the standard criteria, India has had, on paper at least, a universal

health system since very soon after Independence. From the Bhore Committee of 1946 on, there have been a series of committees – Sokhey Sub-Committee (1948), Mudaliar Committee (1962), Chaddha Committee (1963), Kartar Singh Committee (1974), Srivastava Committee (1975), Indian Council of Medical Research-Indian Council of Social Science Research (ICMR-ICSSR) Joint Panel (1980) – that have focused on different aspects of the issue, and together resulted in the three-tier system of health centres in the public sector for primary, secondary and tertiary care. These have been complemented by two enunciations of the National Health Policy (1983 and 2002), a National Population Policy (2000), the Report of the National Commission on Macroeconomics and Health (2005) and, most recently, the High Level Expert Group (HLEG) on Universal Health Coverage (HLEG 2011).

**Early Challenges – Infrastructure and Vertical Programmes:** The Bhore Committee (1946) enunciated the principle that "nobody should be denied access to health services for his inability to pay" and that the focus should be on rural areas, with an emphasis on preventive measures and training of "social physicians". The early planners focused on the availability of resources for provision of a national public health service, in part because the private sector involved with western medicine was very small at that time.

The Sokhey Sub-Committee of the National Planning Committee (1948) recommended one community health worker for every 1,000 village population and reinforced the Bhore Committee's recommendations. Nonetheless the focus of the First and Second Five-Year Plans was on building infrastructure and launching vertical disease control programmes, though this challenged the idea of an integrated system. While the Mudaliar Committee (1962) focused on infrastructure and the need for more investment to ensure health workers at the primary level, the committees that followed focused mainly on the distribution of health workers.

**Alma Ata – Brave Words and Insufficient Resources:** After the Alma Ata Declaration in 1978, the ICMR-ICSSR Joint Panel (1980) stressed the need for a more integrated and comprehensive health system, and called on the government to formulate a national health policy. The result was the National Health Policy that was approved by Parliament in 1983. While the policy paid its respects to the Alma Ata vision of comprehensive preventive and curative care, insufficient investment meant that the programme provided only selective primary healthcare and its actual direction remained largely vertical. There were inadequate resources allocated for the building of human resources, a lack of decentralisation and unregulated expansion of the private sector (Duggal no date).

**Liberalisation and Privatisation:** With economic reforms, the early 1990s saw tax and other incentives being given for setting up private hospitals and clinics, which resulted in a rapid growth of the private health sector. The 1980s had already seen a steady erosion of drug price control in line with the policy climate of liberalisation after the mid-1980s. The number of drugs on the controlled list has fallen from more than 300 at its peak in the 1970s to around 30 at present. The second enunciation of the National Health Policy in 2002 began by acknowledging that 13 of the 17 goals of the previous policy had not been met. It had a number of critiques of the state of the health system – rural-urban disparities in health infrastructure; the limitations of a system centred on vertical programmes; the shortage of medical personnel, especially doctors; and the need to introduce legislation on minimum standards for medical establishments.

Recognising that financial constraints had played a key role, the new policy argued for raising government health spending to 2% of gross domestic product (GDP); aligning health goals more realistically to financial and administrative capacities; and increasing the role of the private sector, especially for those who could afford to pay. But while the government adopted the last two approaches by further incentivising the private health sector, including health insurance, and opening up a range of public-private partnerships (PPPs) in health, the proportion of GDP spent on health hardly changed. It has hovered around just a little more than 1% (centre and states combined), with most of the small recent increase coming from salary increases mandated by the Sixth Pay Commission. Some other aspects of the new policy such as the need for convergence of all health programmes, providing essential drugs with central government funding to kick-start the revival of primary care, increasing the availability of medical practitioners through a cadre of licensed medical practitioners (LMPs), and devolving power and responsibilities to panchayati raj institutions (PRIs) have been only partially implemented, if at all.

**Demand-side Financing:** With the establishment of the National Rural Health Mission (NRHM) in 2005, the focus shifted to the demand side, although supply-side attempts to improve infrastructure, build the capacity of health personnel, create a cadre of accredited social health activists (ASHAs)[1] and improve health management information systems (MIS) were also given attention. Cash transfers have been part of the country's anti-poverty programmes for decades, but it is only with the Janani Suraksha Yojana (JSY) that they have been linked to specific behaviour on such a scale.

To sum up, the idea of UHC and attempts to move towards it have been with us since the early years after Independence. However, three factors have acted as major constraints to its realisation – insufficient public investment, the absence of political prioritisation or leadership, and a push towards liberalisation and unregulated privatisation. While an increasing focus on the demand side is not bad in itself, there needs to be a much greater emphasis on strengthening the supply side if we are not to face a growing challenge of unmet demand and poor-quality services.

## Changing Context for UHC

Four major factors currently shape the discourse and the reality of the health situation in India. They are an incomplete epidemiological transition, a partial demographic transition, the evolving pressure of the social determinants of health and rising concerns about equity

and access along multiple dimensions – economic, caste, gender, rural-urban and across states.

Infectious diseases were a leading cause of death and illness until well into the 20th century in the now high-income countries of the west. By the 1950s, however, these countries had gone through an epidemiological transition and the contribution of infectious diseases to mortality had declined markedly. In the US, for example, mortality due to infectious diseases fell from around 800 per 1,00,000 population in 1900 to low double-digit figures in 1950 (Armstrong, Conn and Pinner 1999). Much of this decline preceded the widespread availability of antibiotics and most vaccines and was attributable to such factors as better sanitation, water treatment, better nutrition, reduced crowding and family size, increased child spacing and the pasteurisation of milk, as well as the replacement of horse-drawn carriages by automobiles and trucks. Vaccines played a role in speeding up this decline once they became available.

In India, while some progress has been made towards addressing some of these broader social determinants such as pasteurisation and while there has been a significant decline in family size, the major problems of sanitation, inadequate and unsafe water and serious undernutrition and malnutrition still persist. As a consequence, infectious diseases contributed 38% of the total disease burden in 2005, according to the National Commission on Macroeconomics and Health, and maternal and perinatal ill health 12%. On the other hand, the burden of non-communicable diseases (NCDs) has grown to 33%, with injuries accounting for 17%. In epidemiological terms, the country thus faces a double burden – having to cope with rising cardiovascular problems and a diabetes explosion (including among poor people) without having finished with infectious diseases or maternal ill health. This is a major challenge because NCDs are far more expensive to handle and often require long-term or lifelong care, making far greater demands on scarce public and family health resources in terms of funds, personnel and facilities. By way of comparison, China had reduced its infectious diseases burden to less than 25% by 2000.

India also has a young population. In 2005, Indians under the age of 15 years accounted for 36% of the total against 20% in China. While economists have pointed to the benefits the demographic dividend could yield (Bloom, Canning and Sevilla 2003), this potential can only be realised if these young people are healthy, particularly young girls and women entering their reproductive years.

Most critical of all is the evidence of growing impoverishment due to healthcare costs and growing inequity in access during the period of economic reforms (Sen, Iyer and George 2002; Sen 2010). In the mid-1980s, before the economic reforms, the healthcare system in the country was already highly inequitable. More than 70% of health expenditure was out-of-pocket; there were large rural-urban differences in the availability of services; public services were poor in quality and uneven in reach; and there was a highly unregulated and unaccountable private sector. Nonetheless, public hospitals, even if of doubtful quality, were available to the poor and largely used by them, especially for inpatient care. In the mid-1980s, there were a number of drugs still left on the controlled list and a thriving market through reverse engineering made competitively priced and reasonably affordable drugs available.

## Post-Reform Policy Shift

What happened after the economic reforms began? Two policy shifts are important to an understanding of this – one, a very sharp reduction in the number of drugs on the controlled list, leading to significant increases in drug prices, and two, the introduction of user fees. While user fees in India may not (arguably) have had the kind of impact they have had on education and health in sub-Saharan Africa, what its introduction has done is create a two-tier system, which has had an important impact on services. In public hospitals, services have been separated into those for patients below and above the poverty line. Poor people are supposed to get services, including drugs free (though this rarely happens due to both under-the-table payments and non-availability of drugs). Those above the poverty line have been drawn in systematically during the reforms as a means – through user fees of different kinds – of ensuring that hospitals have some flexible money that they can use to pay for minor expenses, including maintenance and replacement. By and large, the medical profession and hospital administrators have been in favour of this because it gives them some income to meet urgent expenses, without having to wait for slow bureaucratic approvals.

The consequences of these policy shifts can be seen by analysing four key indicators of healthcare – untreated illness, the reasons for non-treatment, the shifting public-private mix and the cost of care – available from the National Sample Surveys (NSS) on morbidity and patterns of use of health services (42nd round, 1986-87; 52nd round, 1995-96; 60th round, 2004). Analysis shows that non-treatment of illness and discontinuation of treatment have gone up sharply in the last two decades, along with a serious increase in the role of financial reasons for non-treatment. This was related mainly to increases in drug prices and also possibly user charges. More than 70% of health expenses are out-of-pocket, and of these, over 70% are for drugs (HLEG 2011: 96). Current schemes for financial protection typically do not cover the cost of drugs, diagnostics or outpatient care. Significant gender gaps in treatment existed in the pre-reform period and these have persisted, modified in some instances by the phenomenon of "perverse catch up", particularly by the poorest men. Economic gradients of inequality in access to healthcare sharply worsened in the 1990s. As though this were not enough, public hospitals, which had long been the mainstay of the poor (despite their often poor quality of services), acquired a tilt towards the better off in rural areas by 2004. This was probably a consequence of the two-tier system that emerged during this period.

The poor are therefore financially squeezed and experience difficulty in finding services they can afford, both public and private. The cost of care has

gone up significantly (Selvaraj and Karan 2009: 57). According to the NSS Office (2006), 28% of rural residents and 20% of urban residents had no funds for healthcare. More than 40% of them had to borrow money or sell assets to pay for their care, while more than 35% of them fell below the poverty line because of hospital expenses. More than 2.2% of the population may be impoverished because of hospital expenses and the majority of those who did not access the health system were from the lowest income quintiles. The rural-urban differences in health resources are stark, with 80% of doctors, 75% of dispensaries and 60% of hospitals being in urban areas. The towns and cities have 11.3 qualified physicians per 10,000 population against 1.9 in rural areas.

### Towards a Renewed Focus on UHC

It is clear from the above discussion that any policy movement towards UHC will have to address the questions of access and affordability. This in turn means addressing in a central way the questions of financing, the respective roles of the public and the private sectors and of PPPs, the cost and availability of drugs and diagnostics, and of health promotion and prevention of illness. It also requires meeting the challenges of quality, of accountability to citizens and governance and ensuring that people's right to health is effectively guaranteed.

(1) The HLEG[2] with Srinath Reddy as chairperson was set up by the Planning Commission in October 2010 with the following terms of reference (TORs).

(2) Develop a blueprint and investment plan for meeting the human resource requirements to achieve health for all by 2020.

(3) Rework the physical and financial norms needed to ensure quality, universal reach and access to healthcare services, particularly in underserved areas, and to indicate the relative role of private and public service providers in this context.

(4) Suggest critical management reforms to improve efficiency, effectiveness and accountability of the health delivery system.

(5) Develop guidelines for the constructive participation of communities, locally elected bodies, non-governmental organisations (NGOs), and the private for-profit and not-for-profit sectors in the delivery of healthcare.

(6) Propose reforms in policies related to the production, import, pricing, distribution and regulation of essential drugs, vaccines and other essential healthcare-related items for enhancing their availability and reducing costs to consumers.

Explore the role of health insurance systems that offer universal access to health services with high subsidy for the poor and a scope for building up additional levels of protection on a payment basis.

After discussion with the Planning Commission, there were some modifications made to the above TORs. The relative role of public and private providers was brought under TOR 3 on management reforms, which was further clarified to include regulation; the private for-profit sector was dropped from TOR 4 on community participation; TOR 6 was broadened to include financing more generally and not just the role of health insurance; and an additional section on the social determinants of health as well as a specific discussion of gender were added.

The HLEG held extensive discussions with a range of stakeholders – public, private, civil society, national and international – before finalising its report, which is now on the website of the Planning Commission (HLEG 2011). In addressing its TORs, the HLEG had to tackle some of the key weaknesses in the health delivery system, which included inadequate focus on public health, both preventive and promotive; the lack of public health regulation (including standard guidelines and their enforcement); large shortfalls in human resources and infrastructure, especially for rural areas; poor use of data and poor performance monitoring; inadequate attention to quality in health services; poor personnel management; weak management of logistics and supply chains; overly centralised financial management; and poor accountability to patients and communities. While a number of advances have been made under the NRHM, thanks to the National Health System Resource Centre, much more needs to be done. The next section discusses some of the key issues and the rationale for the HLEG's recommendations.

### Key Issues and HLEG Recommendations

The HLEG's definition of UHC is,

> 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 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, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services (HLEG 2011: 3).

The guiding principles for realising this vision of UHC are universality; equity; non-exclusion 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; and community participation. The goal is to ensure universal entitlement for every citizen to a National Health Package (NHP) of essential primary, secondary and tertiary healthcare services that will be funded by the government. This package has to be defined periodically by an expert group and can have state-specific variations.

As envisioned by the HLEG, a major thrust of the UHC will be prevention and promotion. It will be universal across all socio-economic groups; will be built on a combination of strengthened public services plus well-regulated contracted private providers; and will include cost containment through generic drugs and improved management, as well as mechanisms for accountability to citizens. It will be implemented through a tax-based system and will be cashless at the point of service. All patients will get the same services in the UHC system, with smart entitlement cards to facilitate both patient and service monitoring. In integrating both public and contracted-in private providers within a single system, it is necessary to move beyond ad hoc PPPs

towards a better regulated and managed system through new regulatory and other institutions (discussed later), and systematic capacity building in the public sector to design and manage contracts.

## Financing

India's public spending on health ranks among the lowest in the world (Table 1). As a consequence, out-of-pocket spending on health accounts for a very high proportion of total health expenditure, resulting in untreated illness due to financial reasons, and impoverishment. Opening up the sector to private health insurance in 1999 through the Insurance Regulatory and Development Authority (IRDA) Act has covered only a very small section of the well-to-do urban market. So there has been a proliferation of health insurance schemes funded by the State. The rapidly spreading national programme, the Rashtriya Swasthya Bima Yojana (RSBY), targets households below the poverty line. Other similar but more expensive schemes funded by different state governments in states such as Andhra Pradesh, Karnataka and Tamil Nadu are highly popular because they allow poor people who could never have dreamt of it before to access tertiary care at the most expensive private corporate hospitals at no or minimal cost to themselves. The most recent of these is Maharashtra's Andhra Pradesh-like scheme, the Rajiv Gandhi Jeevandayee Arogya Yojana, to which it has switched from RSBY.

**Table 1: Public Spending on Health** (2009)

| | Total Public Spending as % of GDP (Fiscal Capacity) | Public Spending on Health as % of Total Public Spending | Public Spending on Health as % of GDP |
|---|---|---|---|
| India | 33.6 | 4.1 | 1.4 |
| Sri Lanka | 24.5 | 7.3 | 1.8 |
| China | 22.3 | 10.3 | 2.3 |
| Thailand | 23.3 | 14.0 | 3.3 |

Source: HLEG (2011: 69).

There have been two kinds of critique of these insurance schemes, popular though they may be. The first is about their mechanics – that they are not truly inclusive in practice and have many implementation problems such as procedures that impede access to the poorest; that they allow fraud; and that there are exclusion and inclusion errors because of targeting (Sen 2011). A number of these problems can be handled through smart cards, better management and the use of information technology (IT). The second and more serious problem is that these schemes are partial to expensive secondary and tertiary care and against more financially viable preventive and primary care (Sen 2011). With no incentives for the latter and little capacity building at the lower levels, effective gatekeeping becomes well nigh impossible. In the medium term, these schemes become unviable very quickly because of the large reservoir of untreated illness; the targeting that works against risk pooling; and because all the incentives are in favour of more and expensive treatment for which the government has to foot a growing bill, as has been the experience of Andhra Pradesh.

The HLEG has therefore called for provision of universal financial protection and access to good healthcare without involving insurance companies or any independent agents to purchase healthcare services on behalf of the government. Independent agents fragment the nature of care being provided and, over time, such fragmentation leads to high healthcare costs and lower levels of wellness at the population level. Instead, the HLEG proposes general taxation as the principal source of healthcare financing, complemented by additional mandatory deductions from salaried individuals and taxpayers, either as a proportion of taxable income or as a proportion of salary. Government-funded health insurance schemes should be integrated into the UHC system and government expenditure on health should rise from the current 1.4% of GDP to at least 2.5% by the end of the 12th Plan, and to at least 3% of GDP by 2022. Public spending on generic drug procurement should rise to 0.5% of GDP from the current 0.1% and thus ensure availability of free essential medicines, following the successful Tamil Nadu model for medical supplies.

Even assuming the total spending on health remains at the current level of around 4.5% of GDP, the HLEG hopes there will be a sharp decline in the proportion of private out-of-pocket spending on health – from 67% today to 33% by 2020. There will be no sector-specific taxes for health financing. However, specific purpose transfers will equalise levels of per capita public spending on health by different states to offset general disability and mobilise resources to ensure all citizens are entitled to the same level of essential healthcare. States can have flexible and differential norms for financing recognising their physical and sociocultural diversities, but there will be no user fees for UHC services and this applies even to those who have the financial capacity to pay. Primary healthcare, including preventive/curative services at the primary level and health promotion targeted towards specific risk factors, should account for 70% of all government healthcare expenditure.

Beyond financing, the HLEG recommendations can be seen under the broad categories of tools, methods, and institutions.

## Tools

A major recommendation is introducing a specialised state-level health systems management cadre and all-India and state-level public health service cadres to strengthen the management of the UHC system and to also give greater attention to public health. This would draw from and extend the successes of the Tamil Nadu example.

Another key recommendation is developing an IT-enriched system with a specialised body that will oversee adoption of health information systems and define standards of meaningful use of resources and health management systems infrastructure; oversee information documentation, use and exchange between healthcare centres; ensure clinical interoperability of information to enable seamless transition of patient data between healthcare facilities; and define and promote standards of patient privacy and ethical use of patient data. A health system portal will strengthen the use of IT for better performance by both public and private service providers.

## Methods

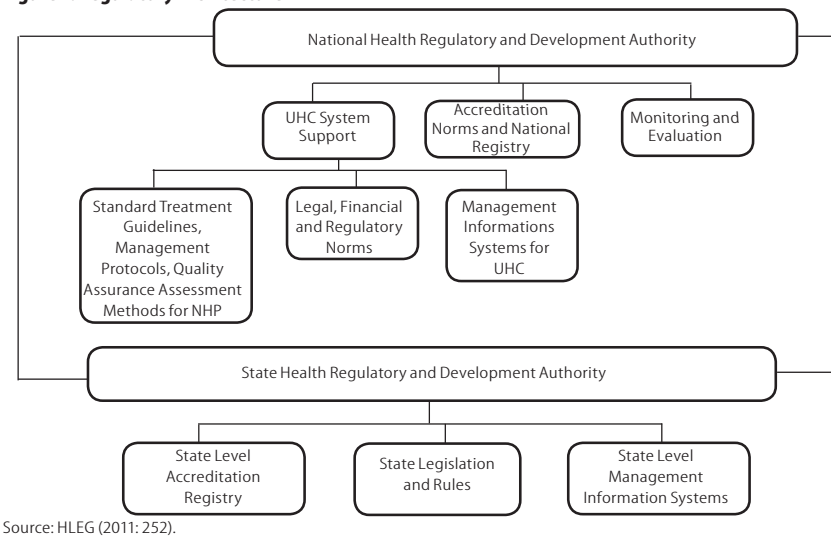
The UHC system should provide essential and standard health services as part of the entitlement for every citizen at different levels of healthcare delivery; ensure more equitable and improved access to

functional beds for guaranteeing secondary and tertiary care; and ensure adherence to and compliance with quality assurance in healthcare provision at all levels of service delivery. At least 15% allocation of the public funding for health should go to drugs; the government must procure all essential drugs list (EDL) medicines; and ensure quality generic drugs are distributed through district-level warehouses. There should be an autonomous procurement agency for drugs, vaccines and diagnostics, and an empanelled laboratory for quality assurance; as well as the enactment of transparency in tendering legislation at the state level.

The government should ensure adequate numbers of trained healthcare providers and technical healthcare workers at different levels, giving priority to the provision of primary healthcare. More specifically, the number of ASHAs should rise from one per 1,000 population to two per 1,000 population in rural and tribal areas; and a three-year bachelor of rural health care (BRHC) degree programme of rural healthcare practitioners should be introduced for recruitment and placement at sub-centres. The UHC system should focus on improving human resource management and institute effective supportive supervision mechanisms at the block, district, state and national levels to complement healthcare service providers. It should enhance the quality of human resources for health education and training by introducing competency-based, health system-connected curricula and continuous education. It should invest in additional educational institutions to produce and train the requisite health workforce and institute a dedicated training system for community health workers. And it should set up district health knowledge institutes (DHKIs); and establish a National Council for Human Resources in Health (NCHRH).

One of the most complex areas for the HLEG to reach agreement on was how to contract in private-sector providers. Different countries that have made significant advances towards UHC, such as Sri Lanka, Thailand and Brazil, have all recognised that the private health sector has considerable resources and potential but needs to be carefully harnessed and managed through effective regulatory institutions and mechanisms. There were different opinions, particularly on the question of whether private providers within the UHC system should be allowed to provide anything other than UHC-mandated services, given the problematic experience with PPPs in health and with incentivised private providers who do not meet the terms of their grants of cheap land or tax-free status. In the end, the HLEG left it to the states to choose between two options.

**Figure 1: Regulatory Architecture**




Source: HLEG (2011: 252).

Option 1: Provide at least 75% outpatient and 50% inpatient care; the remainder can be provided on payment from individuals or insurance;

Option 2: Provide only the cashless services related to the UHC package and no other services that would require private insurance coverage or out-of-pocket payment.

The former option can only work without abuse if there is a strong system of regulatory oversight and surveillance. This is discussed in the section on institutions.

Community participation and citizen engagement should be strengthened by transforming the existing village health committees (or health and sanitation committees) into participatory health councils; by organising regular health assemblies; enhancing the role of elected representatives as well as PRIs (in rural areas) and local self-government bodies (in urban areas); strengthening the role of civil society and NGOs; and instituting a formal grievance redressal mechanism at the block level.

## Institutions

At the centre of the new regulatory architecture for health and for the mixed public-private UHC system will be a National Health Regulatory and Development Authority (NHRDA), statutorily empowered to regulate and monitor/audit both the public and the private sectors and ensure enforcement and redress (Figure 1). Though linked to the ministry of health and family welfare, the NHRDA will be an autonomous body. This authority will be supported at the state level by State Health Regulatory and Development Authorities (SHRDAs) with corresponding powers. The entry of states to the UHC system will be predicated on their setting up SHRDAs with powers determined uniformly across all states.

This NHRDA will be responsible, inter alia, for overseeing and enforcing contracts for public and private providers in the UHC system; accreditation of all health providers (actual contracting will be done by the health ministry/department or by an independent party); formulation of legal and regulatory norms for facilities, staff, scope, access, quality and rationality of services, and costs of care with clear norms for payment; standard treatment guidelines and management protocols for the NHP so as to control entry, quality, quantity and price development; enforcement of patients' charter of rights, including ethical standards and institution

of a grievance redress mechanism; evolving and ensuring adherence to standard protocols for treatment with the involvement of professional organisations; and establishing and ensuring a system of regular audit of prescriptions and inpatient records, death audit and other peer review processes.

Three units are envisioned under the NHRDA.

(i) A system support unit (SSU) responsible for developing standard treatment guidelines, management protocols and quality assurance methods for the UHC system. It should also be responsible for developing the legal, financial and regulatory norms as well as the MIS for the UHC system.

(ii) A health system evaluation unit (HSEU) responsible for independently evaluating the performance of both public and private health services at all levels.

(iii) A national health and medical facilities accreditation unit (NHMFAU) responsible for the mandatory accreditation of all allopathic and ayurveda, yoga and naturopathy, unani, siddha and homeopathy (AYUSH) healthcare providers in both the public and the private sectors as well as for all health and medical facilities. This accreditation facility housed within the NHRDA will define standards for healthcare facilities and help them adopt and use management technologies. A key function of this unit will be to ensure meaningful use of allocated resources and there will be a special focus on IT resources. There should be corresponding state-level data and accreditation agencies (state facilities accreditation unit) under the national FAU to oversee the operations and administrative protocols of healthcare facilities.

In addition to the above, the Drugs and Medical Devices Regulatory Authority will be strengthened and expanded in scope to include a development function so as to better regulate the pharmaceuticals and medical devices sectors. Last, but by no means the least, a National Health Promotion and Protection Trust (NHPPT) is envisioned to play a catalytic role in the promotion of a better health culture among people, health providers and policymakers through knowledge and information. Its task will be disseminating information on the health system and accountability mechanisms; examining and publicising the health implications of other sectors, including health impact assessments of the social determinants of health; and collaborating with international partners on information sharing related to the social determinants of health.

## Gaps and Risks

Two special chapters, "Social Determinants of Health" and "Gender and Health", went beyond the original mandate of the HLEG. While a beginning has been made, the discussion is far from over, given the central importance of these issues. In particular, a special effort is needed to produce a supplementary report that fully mainstreams gender into UHC. Another major gap is in the lack of attention to the problems of urban health. In addition to these, there are some important risks and concerns that need to be addressed.

First, the HLEG's report has come out at a time when the political pressure for populist solutions such as government-funded health insurance is very high. Schemes such as Rajiv Arogyashri and even RSBY are popular and proven vote-winners. They also have serious limitations, as discussed earlier, in terms of financial viability and skewing of health services towards secondary and tertiary care rather than prevention, promotion and primary care, besides doing little to improve the quality of services in the public sector. How and whether the government can figure out a way to integrate the best aspects of, say, RSBY into a more manageable system of the kind proposed by the HLEG is a serious issue.

Second, while the HLEG has identified some potential "quick wins" such as assuring generic drugs through the public system, it will be problematic if the government begins to cherry-pick those elements of the recommendations that are easy to implement or more politically palatable, ignoring the others. The elements of UHC spelt out are an integrated whole, and its complexity is a result of the nature of the problem itself. Its implementation will have to be time-phased and carefully planned as other countries such as Thailand and Brazil have done over at least a generation. But all its different elements are linked to each other and are essential.

Third, building public awareness and mobilising public debate on UHC are essential. The HLEG's report has received extensive and laudatory coverage in the print and other media but this will inevitably give way to other headlines. For the complex messages of UHC to generate a broader consensus and understanding, a sustained and systematic effort in a campaign mode is essential, and the time for that is now.

Fourth, one of the biggest challenges UHC faces is the serious shortage and highly unbalanced availability of health services personnel. The HLEG has supported the three-year rural degree for which the health ministry has been trying to gain traction and which has been opposed by some in the medical fraternity. Without a major breakthrough in this regard, it will be very difficult to realise UHC.

Fifth, the HLEG came into existence at a time (2010) when the global economy was still in the grip of a financial crisis but the Indian growth rate was respectable. Finances for UHC were not at that point seen as a major barrier and the need to significantly raise the share of public spending for health was recognised at the highest levels of government. That scenario has changed somewhat for the worse with a slip in the growth rate and the continuing European financial crisis. Sustaining the political momentum to raise government health spending to 2.5% of GDP by the end of the 12th Plan (without falling into the trap of unviable populist insurance schemes) is essential.

Sixth, a very serious matter for concern is the rapid erosion of what has been one of the country's major health resources – the production of affordable generic drugs for the Indian and other developing country markets. This has taken place through large-scale takeovers of major Indian generics producers by multinational pharmaceutical firms using the facility of 100% foreign direct investment (FDI), the decline of drug price control. Other factors include the closing down of public sector drugs and vaccines producers, as well as the enormous pressure being brought to bear on India by rich countries through bilateral trade agreements to go beyond

the trade-related aspects of intellectual property rights (TRIPS) agreements to adoption of TRIPS + and its much more stringent regime. The EU-India free trade agreement now in the final stages of negotiation is one such case and if the EU manages to force through TRIPS + conditions, it could seriously hamstring Indian generic drugs producers and result in a major blow for UHC in the country.

Finally, there are many powerful forces that would like the health system to move (or continue to move) in the direction of an unregulated and lucrative private market, including for service provision, health insurance and medical education. While the HLEG has clearly recognised an important role for the private sector in the provision of health services, it has insisted that a strong regulatory framework and architecture are essential, that ad hoc PPPs that bypass regulations must stop and that an effective process for building in accountability to the country's citizens is crucial.

Of course, there are strong supporters for UHC in the country. The Planning Commission's expert group on health for the 12th Plan has strongly endorsed the HLEG report, as have many others both nationally and internationally. What remains to be seen is whether civil society can mobilise, whether public enthusiasm can be generated and sustained and whether the government can move with consistency and focus towards fulfilling the long-delayed promise of UHC.

## NOTES

1 There is some question whether ASHAs should be considered as supporting the supply side or the demand side since their major function is to support women for institutional deliveries under the demand-side Janani Suraksha Yojana (JSY).

2 The members of the High Level Expert Group are K Srinath Reddy (Chairperson), Abhay Bang, Mirai Chatterjee, Jashodhra Dasgupta, Anu Garg, Yogesh Jain, A K Shiva Kumar, Nachiket Mor, Vinod Paul, P K Pradhan, M Govinda Rao, Gita Sen, N K Sethi (Convenor), Amarjeet Sinha and Leila Caleb Varkey.

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