World Health Day Theme 2018

Universal Health Coverage: everyone, everywhere what it means to Present India?

"Only Swasth Bharat can be a Samriddha Bharat. India cannot realize its demographic dividend without its citizens being healthy," said the Union Finance Minister while announcing the budget for 2018-19.

What is Universal Health Coverage?

"Universal coverage" refers to a scenario where everyone is covered for basic healthcare services. This is a scheme, under which all Indian citizens, regardless of their economic, social or cultural backgrounds will have the right to affordable, accountable and appropriate health services of assured quality defined in a published package of services and benefits. It is also a supplemental system of financing to protect people from increasing medical expenses.

The **High-Level Expert** Group (HLEG) on **Universal Health Coverage** (UHC) was constituted by the Planning **Commission** of India in October 2010 to formulate framework for implementing UHC, gave the definition of UHC for Indian citizens. "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."

History of Universal Health Coverage across the world:

The World Health Organization (WHO) Health Assembly set the target of "Health for All" in May 1977. These were to be achieved by the end of 2000. Subsequently, in 2000, the Millennium Development Goals were formulated by the UN with the target for achievement set for 2015. This was followed by the Sustainable Development Goals, set by the UN in 2016, to be achieved by 2030 by all member countries. **Universal health coverage** is the **goal** that all people receive the essential **health** services that they need, without being exposed to financial hardship, and is central to the **health**-related targets of the **Sustainable Development Goals**.

The concept of UHC began to evolve in Europe with reforms introduced by Bismarck in Germany in the 19th century. The Beveridge Report ushered in British reforms in the 1940's leading to the introduction of the National Health Service (NHS) by Aneurin Bevan in 1948. Since then, universal access to affordable healthcare has become a widely shared aspiration across the globe. Over the last decade many low and middle income countries have advanced along the path. Mexico announced 100% coverage in 2012 while China and South Africa expect to do so in 2012. Many Latin American, several Asian and some African nations are reconfiguring their health systems to achieve UHC soon. The World Health Report of 2012 documents and endorses this global movement.

This World Health Day 2018, the WHO is pushing for UHC across many countries. It is a well-established fact now, that countries that invest in UHC make a sound investment in their human capital. In recent decades, UHC has emerged as a key strategy to make progress towards other health-related and broader development goals. Access to essential quality care and financial protection not only enhances people's health and life expectancy, it also protects countries from epidemics, reduces poverty and the risk of hunger, creates jobs, drives economic growth and enhances gender equality. As WHO Director-General has said "No one should have to choose between death and financial hardship. No one should have to choose between buying medicine and buying food."

India's Current Scenario of Health inequity:

- Largest number of underweight children (42% under 5 yrs);
- Current infant mortality rate of 47 per 1000 live births;
- Maternal mortality ratio presently 212 per 100 000 live births; Challenge to meet national goals of 27 per 1000 (IMR) or 100 per 100 000 (MMR) by 2017.
- Rising burden of Non-Communicable Diseases.

Aggregate national indicators do not highlight the huge disparities which exist across the states and districts of India. Even in the first month of life, a newborn runs a five-fold higher risk of death if born

in Odisha as compared to Kerala. Across almost every health indicator, health inequity is starkly evident in the country. Rural, less educated and poorer sections of our population including Dalits have a worse health status than more affluent, higher educated, urban and upper castegroups. Women too are worse off in health status and access to healthcare.

The National Sample Survey Organization (NSSO) reported in 2006 that financial barriers limited access to healthcare for large numbers of rural as well urban residents. Catastrophic health expenditure and distress financing are common problems encountered by many families. This hazard is not confined to the poor but also affects vulnerable sections of the middle class. Unaffordable healthcare expenditure pushes a third of the hospitalized patients into poverty. Though India's health indicators have made some improvements over the last decade, it is still lagging when compared to other countries similar to it in progress and per capita Gross Domestic Product (GDP).

Why is health system reform needed?

- 18% of all episodes in rural areas and 10% in urban areas received nohealth care at all
- 12% of people living in rural areas and 1% in urban areas had no accessto a health facility
- 28% of rural residents and 20% of urban residents had no funds for healthcare
- Over 40% of hospitalized persons had to borrow money or sell assets to pay for their care
- Over 35% of hospitalized persons fell below the poverty line because of hospital expenses
- Over 2.2% of the population may be impoverished because of hospital expenses
- The majority of the citizens who did not access the health system were from the lowest income quintiles

Low priority to public spending on health in India lead to out of pocket expenditure

According to WHO (2009), India's public financing of health was only 1.2% of the GDP. India spends a very low amount on public funding of healthcare, leaving a very large fraction of the per capita total expenditure to be borne as a burden by the citizen. So long as public funding on health does not increase, as a percentage of the GDP, out-of-pocket private expenditure on health will remain very high and continue to characterize India's health system as regressive and highly inequitable. India is among the countries with an unacceptably high level of out-of-pocket expenditure (OOP).

The HLEG recommends that total governmental funding should increase to at least 2.5% during the 12th plan period and to at least 3% during the 13th plan period, to advance the UHC programme. A recent cost modeling study, conducted by researchers from PGIMER at Chandigarh and the University of Toronto, estimates that the full range of services under UHC would require 3.8% of GDP. If these estimates are adjusted for the projected rise in India's GDP, the estimate provided by HLEG for the 13th Plan would be closely matched.

The Rashtriya Swasthya Bima Yojana (RSBY) was launched with a social objective of providing financial protection to unorganized workers, including migrant workers. It has benefited many persons who could access hospitalized care under the scheme. It was also successful in drawing upon the services of both public and private healthcare providers. Despite some success, the RSBY is limited by the fact that it only provides financial support during hospitalization for secondary care. Primary healthcare services as well as outpatient care are not supported. Hence recent evidence suggests that there is sometimes a paradoxical rise of OOP, as the add-on post-procedure costs may exceed the level of financial support provided during hospitalization. The framework of UHC must, therefore, accommodate outpatient care and provision of essential drugs within the ambit of public financing, as they contribute the highest fractions of OOP.

In a country like India, UHC has to be principal pathway for financing healthcare, because:

- Contributory social insurance will be difficult to collect from the largemajority of the population who are in the informal sector; payroll taxestoo will cover only a limited number.
- Private insurance is unaffordable for many and often discriminatesagainst those who have disease or are likely to develop it (i.e., those whoneed healthcare the most)
- Insurance schemes typically cover hospitalization for secondary ortertiary care and do not provide primary or outpatient care.

UHC delivery:

- UHC is delivered through primary health centres, subcentres, Taluka hospitals and District hospitals of Government sector.

- Private providers are co-opted to support the UHC system, through well designed *contracting – in* mechanisms which clearly define the services to be delivered and attach accountability.
- Networks of providers are created at the district level, to integrate primary, secondary and tertiary care services. While these can include both public and *contracted – in* private providers, the district health system manager.

Universal Health Coverage in India

- Universal Health Coverage in India as Ayushman Bharat is National Health Protection Scheme, which will cover over 10 crore poor and vulnerable families (approximately 50 crore beneficiaries) providing coverage upto 5 lakh rupees per family per year for secondary and tertiary care hospitalization. Ayushman Bharat - National Health Protection Mission will subsume the on-going centrally sponsored schemes - Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS).
- Benefits of the scheme are portable across the country and a beneficiary covered under the scheme will be allowed to take **cashless benefits** from any public/private empanelled hospitals.
- Ayushman Bharat - National Health Protection Mission will be an entitlement based scheme with entitlement decided on the basis of deprivation criteria in the Socio Economic and Caste Census (SECC) database of census 2011. According to this list, 10.74 crore families belonging to rural also urban areas are eligible to apply for this program.
- Every citizen will be issued an IT-enabled National Health Entitlement Card (NHEC) that will ensure cashless transactions of services.
- For giving policy directions and fostering coordination between Centre and States, it is proposed to set up Ayushman Bharat National Health Protection Mission Council (AB-NHPMC) at apex level Chaired by Union Health and Family Welfare Minister.
- States would need to have State Health Agency (SHA) to implement the scheme. It is ensured that the funds reach SHA on time, the transfer of funds from Central Government through Ayushman Bharat - National Health Protection Mission to State Health Agencies done regularly.
- In partnership with NITI Aayog, a robust, modular, scalable and interoperable IT platform will be made operational which will entail a paperless, cashless transaction.
- Ayushman Bharat - National Health Protection Mission will have major impact on reduction of Out of Pocket (OOP) expenditure on ground of: Increased benefit cover to nearly 40% of the population, (the poorest and the vulnerable) covering almost all secondary and many tertiary hospitalizations. (except a negative list) Coverage of 5 lakh for each family, with no restriction of family size.

Expenditure incurred:

The expenditure incurred in premium payment will be shared between Central and State Governments in specified ratio as per Ministry of Finance guidelines in vogue. The total expenditure will depend on actual market determined premium paid in States/ UTs where Ayushman Bharat - National Health Protection Mission will be implemented through insurance companies. In States/ UTs where the scheme will be implemented in Trust/ Society mode, the central share of funds will be provided based on actual expenditure or premium ceiling (whichever is lower) in the pre-determined ratio.

Premium: For this the beneficiaries will need to pay 1100-1200 INR on a yearly basis as a premium of the insurance.

How much is achieved?: Ayushman Bharat Yojana Registration Online has become operational also 18,000 centers have started their operations in different parts of India. As on November 2018, number of hospitals empanelled under AB-PMJAY is about 7,789 private hospitals treating patients under the scheme. The private hospitals are in the process of getting empanelled. So far, about 6, 340 government hospitals are providing treatment as they are empanelled by default. The need is to have at least 3,000 hospitals only in tier 2 and 3 cities, without which this scheme will not work. **Ayushman Bharat – Pradhan Mantri Jan Arogya Yojna (AB-PMJAY), benefitted at least 1.2 lakh people in the month following its launch on September 23, 2018.**

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