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# TOWARDS UNIVERSAL HEALTH CARE: INDIA

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***Abstract***

*Five years into the SDG journey that started in September 2015, the world endures to make advancement on human development on many fronts. Poverty is declining at all poverty indicators, level of education has progressed, and there is reduction in child mortality. Most countries are witnessing economic growth and growing market demand over the past two decades. Economic growth and competent public taxation have also increased public revenue, contributing to increases in both private and public spending on health, with the health economy growing at a faster rate than economic growth. As a result, people's access to the health services continues to progress in all regions of the world and for all country income groups. India is also working in the direction of achieving the SDGs and rolled out world's biggest insurance scheme- PM-JAY, which is fully funded by government to provide primary health care to poor and deprived section of the society at affordable price. Government is also working in direction of improving the availability of resources and health infrastructure. This paper will included the significance of health, trends in health spending globally and in India, problems in health sectors and results achieved so far in context of India.*

***Keywords:*** *Universal Health Coverage (UHC), OOP, Public Health Expenditure, Health Financing, PM-JAY, Ayushman Bharat*



## Introduction

Health is considered as one of the significant factor in ascertaining the development level of a country. Apart from seeing per capita income or GDP rate for classification of a country as developed or underdeveloped, nowadays social factors like health, education and freedom level etc. are taken into account while ranking a country. Health inhabits a vital place in development and has been the content of debate by several development economists and organisations. Sen (1999) examined the relationship between development and health. He acknowledged that the primary goal of the process of development is to enhance the human health. In his book "Development as Freedom", Sen focused on capabilities to get better healthcare, education etc.

rather than just income level to ascertain development. The World Health Organisation (WHO) adopted their own constitution on 7 April 1948 and provided definition of health and supported the need for improving the healthcare services all over the globe and worked towards achieving Universal health coverage.

The health status of people is pertinent to the socio-economic development of a country for two main reasons. First, as a key factor for determining welfare level of the people (Sen, 1995) and second, improved health ranking of people indicates better school performance of students (Bartel and Taubman, 1979), more labour supply (Grossman and Benham, 1974) and higher economic productivity (Strauss and Thomas, 1998).

In the past few decades, there has been a reawakening of health as a fundamental right. United Nations (UN) in 1979 adopted health as integral part of socio-economic development and health is considered as end in itself, has become a major instrument of ascertaining the level of growth and development. In India, where poverty level is around 30 per cent (Tendulkar, 2009), the burden of financing the health expenditure is catastrophic in nature and forces many in to poverty and near poverty. Achieving Universal Health Care (UHC) is one of the targets undertaken while adopting the Sustainable Development Goals (SDGs) in 2015, to be achieved by the member nations of UN by 2030. In spite of so many efforts by the Indian government, health expenditure as a percentage of GDP is still hovering around 1.5 per cent.

India is a rich State and performing well considering the economic indicators. But the health system and infrastructure is not at par with other well performing countries of world. Several public health insurance and welfare schemes have been launched at centre and state level but still Approximately 70 per cent of health expenditure is paid Out-of-Pocket (OOP) which is obtained through borrowings, sale of assets etc.

**What is Universal Health Care (UHC)?**

Universal Health Care (UHC) means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care (WHO, 2018).

UHC allows every person to access the services that talk about the most significant causes of disease and death, and guarantees that the quality of those services is good enough to recover the health of the people who receive them.

Guarding people from the financial penalties of paying for health services out of their own pockets reduces the risk that people will be pushed into poverty because unexpected illness

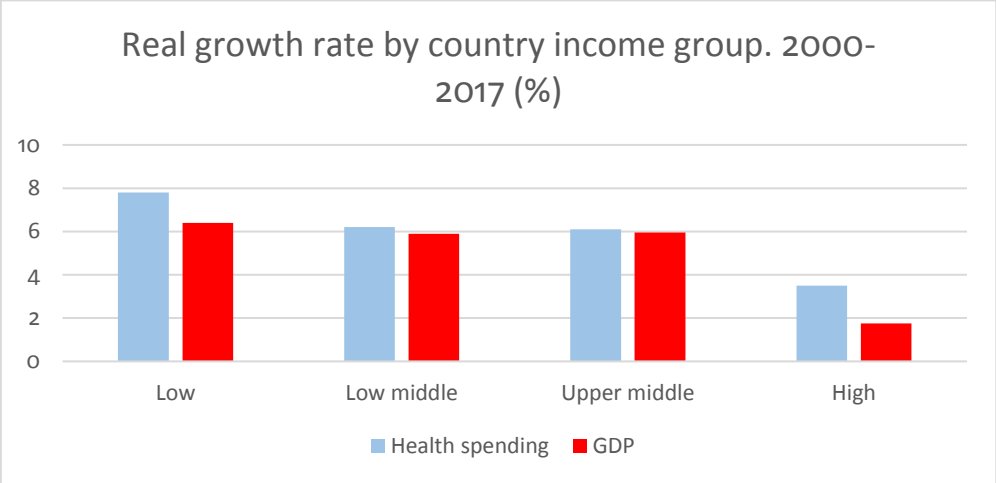
requires them to use up their life savings, sell assets, or borrow – destroying their future and often those of their children (WHO, 2018). Countries that progress in the direction of UHC will make progress towards the other health-related problems, and towards the other national objectives. Good health allows children to learn and adults to earn, helps people escape from poverty, and provides the basis for long-term economic development.

**Global Health Spending and trends: A comparison**

According to WHO report **"Global Spending on Health: A world in transition"** published in 2018, the global health spending was rising rapidly to USD 7.8 trillion in 2017 which was approx. 10 per cent of GDP and USD 1080 per capita out of which, 60 per cent was public and 40 per cent private. The external funding source represented meagre 0.2 per cent of total health spending.

The health sector was growing faster than the global GDP between 2000 and 2017, global health spending in real terms grew by 3.9 per cent annually and on the other hand, global GDP grew by 3.0 percent. Health spending in low income countries was higher than the global average and grew by 7.8 per cent annually between and 2000 and 2017 while the economy grew by 6.4 per cent. The middle income countries witnessed 6 per cent a year growth in health spending while the high income countries recorded an average annual growth rate of 3.5 per cent (Figure 1).

**Figure 1: Health spending is growing faster than GDP**



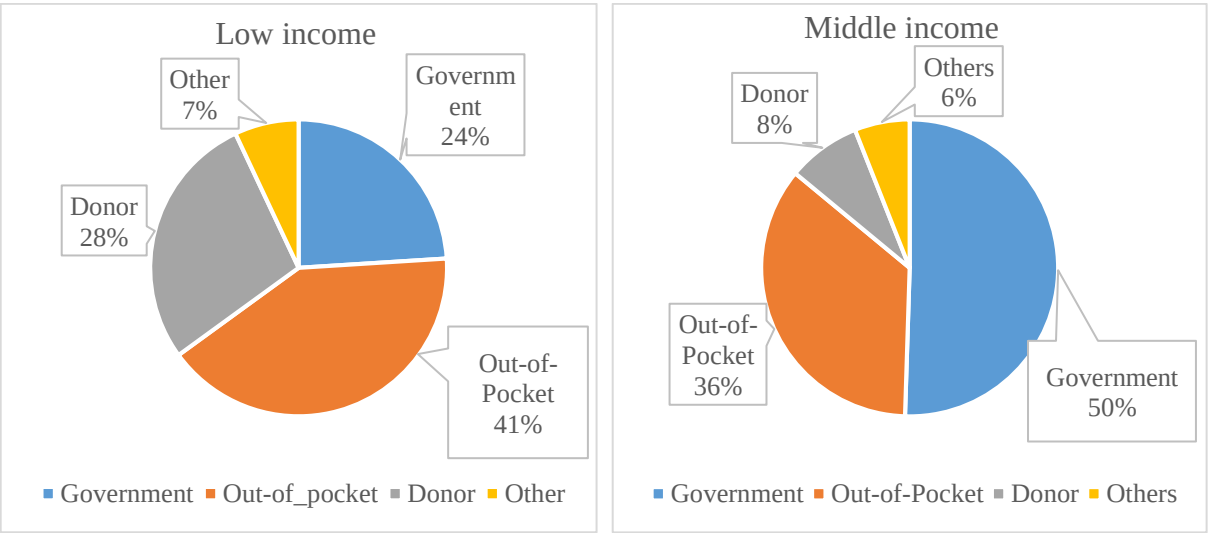

Source: Report: "Global Spending on Health: A World in Transition", WHO, 2018

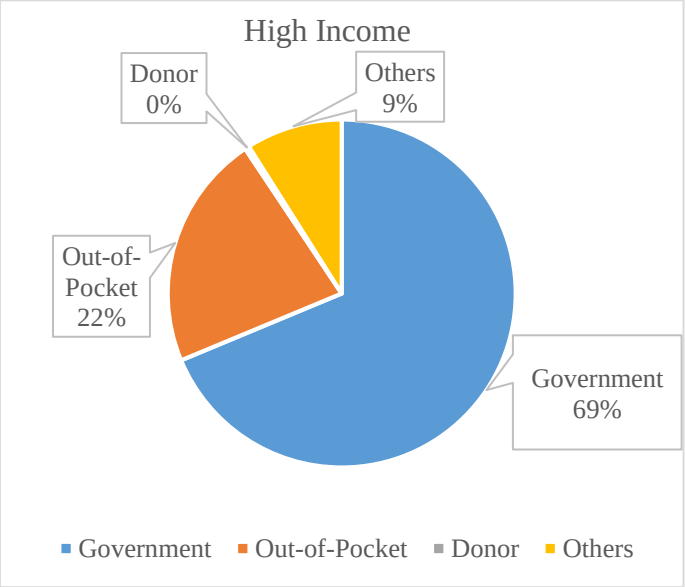
The Health spending in high income countries stood at 81 per cent in 2017 as compared to 87 per cent in 2000, still represents the major portion of global spending just covering 16 per cent of the population. After 2000, low income and upper middle income countries have steadily

improved their portion in global spending. Low income countries like India and China have moved to higher income groups and it led to increase in health spending. In 2000, 40 per cent of the population lived in low income countries, but it had reduced below 10 per cent by 2017. The major spending rise was in upper middle income countries like china (with a huge population joining the group), whereas the spending share of all other income group declined. Despite increase in health spending in low income and middle income nations as a share of GDP, still there exist inequalities across countries. As per WHO Health expenditure report 2019, in low income countries, health spending was only USD 41 per head in 2017, whereas USD 2937 per head in high income countries. This wide gap of more than 70 times is due to difference in wealth. North America, Western Europe and Oceania spend the highest on health spending and West, Central and East Africa the lowest, followed by South Asia. Generally the rich nations spend more on health but there is large dissimilarities in outlay amongst countries of identical income level. Also the government sources dominated the sources of financing the health expenditure. Government spending on health was estimated 60 per cent of global health spending in 2017 as compared to 56 per cent in 2000.

Due to economic growth, Out-of-Pocket (OOP) health expenditure per head increased globally between 2000 and 2017 but it is slower than spending by government. OOP spending is still the largest source of financing health in low income countries whereas in middle and high income countries, government spending surpassed the OOP expenditure (Figure 2 and table 1).

**Figure 2: Source of financing the health expenditure in low, middle and high income countries**






Source: "Global Spending on Health: A World in Transition", WHO, 2018

**Table 1: Key health expenditure indicator for 2017, by income groups**

| | **Low (n =30)** | **Lower midlle (n = 45)** | **Upper middle (n = 54)** | **High (n = 58)** | **Global (n = 187)** |
|---|---|---|---|---|---|
| Health spending (% of GDP) | 6.3% | 5.3% | 6.6% | 7.8% | 6.6% |
| Health spending per capita (USD) | 41 | 130 | 471 | 2937 | 1085 |
| Government spending per capita (USD) | 10 | 60 | 277 | 2021 | 723 |
| Donar spending (% of health spending) | 29% | 12% | 4.1% | -- | -- |
| Out-of-pocket (% of health spending) | 41% | 39% | 32% | 22% | 32% |
| Out-of-Pocket spending per capita (USD) | 18 | 46 | 132 | 565 | 228 |

Source: Report: "Global Spending on Health: A World in Transition", WHO, 2018

From the table 1, health spending as a share of GDP is highest in high income countries and government spending on health is highest as compared to low income countries. Out-of-Pocket spending on health as a percentage of total expenditure is highest in low income countries i.e. 41 per cent but in absolute terms OOP health spending per head is lowest i.e. USD 18 as compared to USD 565 in high income countries.

**Table 2: Out-of-Pocket health expenditure per capita in USD and as percentage of current health expenditure (CHE)**

| | **Out-of-Pocket health expenditure per capita in USD and as percentage of current health expenditure (CHE)** | | | | | |
|---|---|---|---|---|---|---|
| | **2015** | | **2010** | | **2005** | |
| **Country** | **Per capita** | **(%)** | **Per capita** | **(%)** | **Per capita** | **(%)** |
| Bangladesh | 22.9 | 71.8 | 13.6 | 67.2 | 7.3 | 64.9 |
| Brazil | 220.8 | 28.3 | 262.0 | 29.3 | 137.5 | 35.8 |
| China | 137.8 | 32.4 | 76.6 | 38.5 | 41.7 | 55.7 |
| India | 41.2 | 65.1 | 29.5 | 65.2 | 20.3 | 73.1 |
| Norway | 1065.3 | 14.3 | 1182.6 | 15.0 | 933.4 | 16.7 |
| Pakistan | 25.3 | 66.5 | 18.7 | 70.4 | 14.7 | 71.0 |
| Russian Federation | 190.8 | 36.4 | 200.4 | 35.3 | 86.9 | 31.9 |
| Singapore | 719.4 | 36.7 | 616.6 | 47.5 | 431.6 | 50.0 |
| South Africa | 36.2 | 7.7 | 45.9 | 8.5 | 43.7 | 12.4 |
| Sri Lanka | 45.3 | 38.4 | 32.1 | 38.5 | 12.9 | 27.3 |
| UK and Northern Ireland | 644.4 | 14.8 | 322.4 | 9.7 | 305.0 | 10.1 |
| United States of America | 1057.0 | 11.1 | 967.9 | 12.2 | 893.9 | 13.9 |

Source: Global Health Observatory data (various years), WHO

From table 2, the per capita Out-of-Pocket Health expenditure (OOPHE) is consistently low but as a percentage of CHE, it is very high in under developing countries like India (65%), Bangladesh (71%) and Pakistan (66.5%) etc. The per capita OOPHE in India was USD 41.2 in 2015 as compared to USD 20.30 in 2005. In BRICS, India (USD 41.2) in per capita terms is just ahead of South Africa (USD 36.2), but OOPHE as percentage CHE is highest in India (65.10%).

Comparing India with Developed Nations like USA, UK and Norway, it is ascertained that the per capita OOPHE is very high in Developed countries but it is very low as a percentage of CHE. In Norway, OOPHE per capita is USD 1065 in 2015 which is very high as compared to

India (USD 41 in 2015), but as a percentage of CHE, it is just 14.3 per cent while is around 65 per cent in India. This high percentage of OOPHE as a share of CHE reflects low government spending in developing countries like India, Pakistan etc. which is recorded around 1-1.5 per cent of GDP and more burden on the poor people. This high percentage of OOPHE can be catastrophic in nature.

**India: Road to Universal Health Care (UHC)**

India is putting so much efforts to improve the health care infrastructure and services. The major initiative by government of India was taken in 2005, when National Rural Health Mission (NRHM) was launched to redesign the primary healthcare and report the unfulfilled needs of rural areas. The major objective of the mission was to create a fully functional, public owned, distributed health delivery system with inter-sectoral merger to provide accessible, affordable health care to the rural population that ensured corresponding developments in areas that effect health outcomes such as — sanitation, education, nutrition, drinking water, social and gender issues. Also the Indian Public Health Standards (IPHS) was published as a reference to do planning about the public healthcare facilities and infrastructure.

In 2013, government of India approved the framework of National Health Mission (NHM) with Rural Health and Urban Health missions as the two sub-missions. The National Health Mission (NHM) aims at attainment of universal access to health with major focus on reduction in child and maternal mortality, Prevention and control of communicable and non-communicable diseases. NHM worked towards improving the primary healthcare system, population control and demographic balance. The results of NHM are good but not at par with the set targets. The IMR has reduced to 37 in 2015, MMR has gone down to 167 per one lac live births in 2011-13, and TFR has reduced to 2.3 in 2014 and other health indicators also showed some improvements (PIB, Ministry of Health and Family Welfare, GOI, 2017).

To tackle secondary and tertiary level care, Rashtriya Swasthya Bima Yojana (RSBY) was already implemented at the national level in 2008, to provide protection to BPL families from economic obligations arising out of catastrophic health expenditure most of them involving hospitalisation. Few states like U.P. did not implement RSBY and rolled out state run health insurance schemes. The overall low budget and limited coverage of the scheme did not help the government to achieve positive results to provide affordable and accessible healthcare to all of its citizens especially the poor and vulnerable groups. So the RSBY along with NHM gave satisfactory results but unfulfilled targets.

India was committed to the Millennium Development Goals (MDGs) and under 11th plan, goals and targets were set according to the MDGs. But when the deadline to achieve Millennium Development Goals (MDGs) reached in 2015, a new set of inclusive and universal Sustainable Development Goals (SDGs) have been accepted by the UN general assembly as part of the post 2015 development agenda effective from January, 2016. The agenda of SDGs is to reduce and eliminate hunger, poverty and other deficiencies to deliver a life of dignity to all by 2030. India too, committed to fulfil the SDGs and healthcare to all is one of the prime goals (National Health Policy, 2017).

To achieve Universal Health Coverage (UHC) and better health to all, National Health Policy (NHP) was rolled out in 2017. The main objective of the National Health Policy is to inform, clarify, support and prioritize the role of government in determining the health systems in all its dimensions — from investment in healthcare services and infrastructure to promote good health and spreading awareness to achieve better health standards. Government of India is targeting each and every aspect related to health — life expectancy and healthy life, mortality rate, reduction in disease prevalence and its incidence.

The most ambitious flagship programme of government of India – Ayushman Bharat was launched in 2018 on the recommendation of National Health Policy 2017, to accomplish the vision of Universal Health Care (UHC). This initiative has been intended on the lines as to meet SDG and its underlining commitment of not leaving anyone behind. Ayushman Bharat is an effort to change from sectoral and segmented method of health service distribution to a inclusive need based health care service. Ayushman Bharat scheme framed to tackle primary, secondary and tertiary levels and embark on path breaking involvements to holistically report health problems concentrating on prevention, promotion and ambulatory care. This scheme is based on range of care approach, comprising of two inter-related components, which are—

1. **Health and Wellness Centres (HWCs)**

   In 2018, it was announced to create 1,50,000 Health and Wellness Centres (HWCs) by renovating current sub centres and Primary Health Centres (PHCs). The main purpose of these wellness centres is to supply Comprehensive Primary Health Care (CPHC) bringing health care nearer to the households covering both maternal and child health facilities and NCDs, as well as free vital drugs and diagnostic services. HWCs are envisioned to provide primary healthcare services to the entire population in a particular area.

2. **Pradhan Mantri Jan Arogya Yojana (PM-JAY)**

   Under this component of Ayushman Bharat scheme, health insurance cover of Rs. 5 lac per family per year for secondary and tertiary care hospitalisation to over 10.74 crores deprived and poor families which makes around 50 crore beneficiaries will be provided. The National Health Protection Scheme (NHPS) was renamed as PM-JAY on 23rd September, 2018. It was rolled out for bottom 40 per cent of poor population. The beneficiaries of this scheme are selected on the basis of deprivation and occupational criteria of Socio-Economic Caste Census 2011 for rural and urban areas respectively. PM-JAY also incorporated the Rashtriya Swasthiya Bima Yojana (RSBY) and covered the families that were covered under RSBY but were not present in the SECC 2011 Records. This scheme is totally funded by the government and implementation expenses is shared between central and state governments.

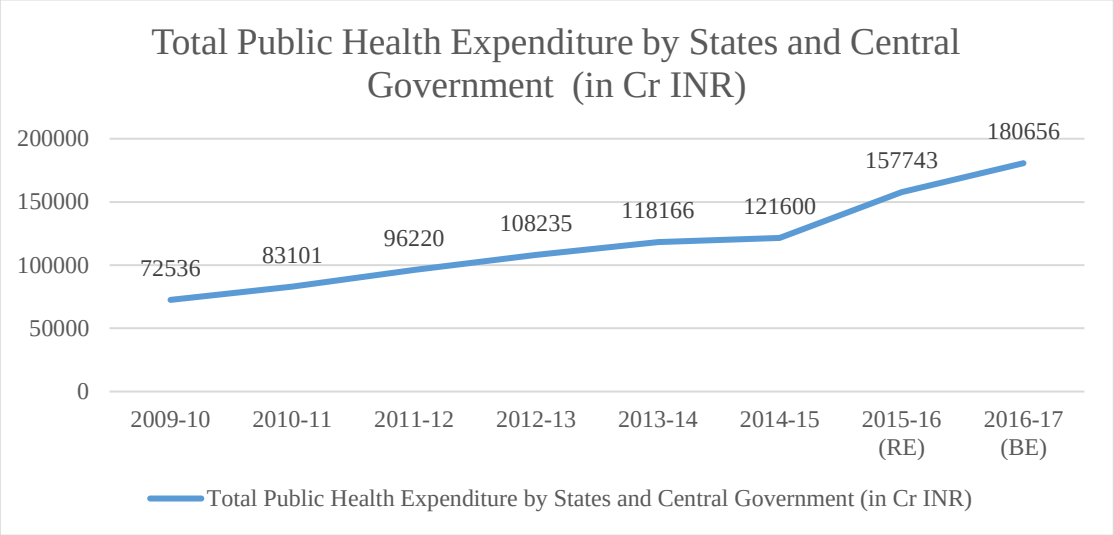
PM-JAY is considered as the world's largest health insurance scheme fully sponsored by the government. It is cashless scheme providing access to health care services at the point of service. As per the claims of the government, PM-JAY will help in reducing the catastrophic expenditure on hospitalizations which forces approx. 6 crore people into poverty every year and mitigate the monetary risk arising out of catastrophic health episodes.

**Success story so far**

The Lancet Commission predicted for India that a USD 1 investment in health would yield an increase of USD 10 in GDP by 2035. Over the past few years, India's health outlay has gone up substantially (Figure 3). But the increase in public outlay on health when considered as a percentage of GDP- remains stagnant and increased from 1.1 per cent to 1.4 per cent of GDP. The per capita income of India has increased to USD 6829 in 2018 from USD 2522 in 2000 as per the Human Development Report (HDR, 2018) of United National Development Programme. Also the HDI value improved to 0.647 (Rank – 129) in 2018 from 0.462 in 2000. There have been remarkable developments in health indicators such as life expectancy, infant mortality rate (IMR), Maternal Mortality Rate (MMR) etc. due to more focus on health by the government and international organisations in past one decade.

Malnutrition and stunting in children, is a major concern in India and it is also being addressed. As per the results of India Health Report: Nutrition (2015), the stunting rates for children under five reduced to 39 per cent from 48 per cent.

**Figure 3: Trends in India's Public Health Expenditure on Health**




Source: MOFHW, GOI, New Delhi, 2018

Note: Expenditure by the centre includes central ministries such as Ministry of Health, Defence, Railways, Labour and Employment, Science and Technology, Mines and Post.

Talking about the recent initiatives like NHP-2017, Ayushman Bharat (PM-JAY) schemes etc. under taken by government of India to provide universal health care to all, results are gradual but not remarkable, but in spite of these measures, the Out-of-Pocket (OOP) health expenditure is still high and the health infrastructure and services are in poor condition.

Public health expenditure as a percentage of GDP in India (1.4 percent) is extremely low as compared to the global average (6 percent). Further there is a huge inequality in the availability of healthcare services continue to occur in India. Developed states like Kerala, Maharashtra and Tamil Nadu have brought down their Birth Rate (BR), Death Rate (DR), Infant Mortality Rate (IMR), Total Fertility Rate (TFR) and Maternal Mortality Rate (MMR) to achieve the Millennium Development Goals (MDGs), while states like Assam, Bihar, Jharkhand etc. are still struggling with these issues (Table 4). In India, MMR stood at 254 in 2004-06 and 130 in 2014-16, which is a huge success. Assam recorded the highest MMR at 237 whereas, Kerala's MMR stood at 46 (Lowest) in 2016 as per NITI Aayog. Similarly, the TFR rate reduced to 2.3 in 2016 from 2.9 in 2004 (NITI Aayog). In many areas of health, India is performing well but still efficient Primary Health Care system targeting the masses is absent.

**Table 4: Estimated Birth Rate, Death Rate and Infant Mortality Rate, 2017**

| | Birth Rate | | | Death Rate | | | Infant Mortality Rate (IMR) | | |
|---|---|---|---|---|---|---|---|---|---|
| **States** | **R** | **U** | **Total** | **R** | **U** | **Total** | **R** | **U** | **Total** |
| Haryana | 21.9 | 18.2 | 20.5 | 6.3 | 5.0 | 5.8 | 32 | 25 | 30 |
| Punjab | 15.5 | 14.1 | 14.9 | 7.7 | 6.0 | 7.0 | 22 | 19 | 21 |
| Himachal Pradesh | 16.3 | 10.3 | 15.8 | 6.8 | 4.0 | 6.6 | 23 | 15 | 22 |
| Bihar | 27.2 | 20.9 | 26.4 | 5.9 | 5.4 | 5.8 | 36 | 31 | 35 |
| Assam | 22.4 | 14.7 | 21.2 | 6.7 | 5.3 | 6.5 | 46 | 21 | 44 |
| Jharkhand | 24.2 | 18.2 | 22.7 | 5.8 | 4.6 | 5.5 | 30 | 24 | 29 |
| Kerala | 14.1 | 14.2 | 14.2 | 7.2 | 6.5 | 6.8 | 9 | 10 | 10 |
| Tamil Nadu | 15.0 | 14.9 | 14.9 | 7.6 | 5.9 | 6.7 | 19 | 14 | 16 |
| Karnataka | 18.2 | 16.1 | 17.4 | 7.6 | 4.9 | 6.5 | 27 | 22 | 25 |
| Maharashtra | 16.0 | 15.4 | 15.7 | 6.6 | 4.6 | 5.7 | 23 | 14 | 19 |
| Gujarat | 21.8 | 17.6 | 19.9 | 6.9 | 5.5 | 6.2 | 36 | 22 | 30 |
| Madhya Pradesh | 26.8 | 19.4 | 24.8 | 7.3 | 5.5 | 6.8 | 51 | 32 | 47 |

Source: Sample Registration Bulletin, volume 52 No.1, RGOI, 2018

Low public investment in health infrastructure and services has been a prime reason for poor service delivery and low utilisation rates. Around 86 per cent of the public sector expenditure is incurred on wages and salaries of staff and just 5 per cent is spend on services which leads to lack of service availability in the public health sector. Also, there is no strong mechanism to protect people from financial hardships arising due to catastrophic health outlays and impoverishments due to OOPHE. Previous studies data highlighted that 20 per cent of urban and 28 per cent rural families do not avail medical treatment because of financial constraints. Government is putting efforts in reducing such financial constraints and evolving policies to overcome these hindrances.

**Conclusion**

India in the field of health has taken a leap forward in past decade, but a long way to go. There are many problems to tackle to achieve the motive of Universal Health Care (UHC) and basic health care to all at affordable price. There is a need of restructuring the entire health system. To start with, increase in public investment in health sector is needed. Rise in public expenditure on health must be 4-5 per cent of the GDP as per the international experiences. National Health Policy (2017) suggested government to

increase health expenditure as percentage of GDP from existing 1.1 per cent to 2.5 per cent by the year 2025.

Increasing per capita spending will help in accessing public health facilities by the poorest section of the society and would be the key to achieve UHC. Resource availability (both human and material) must be strengthened first, then, overall community health services. Several interventions, both on demand and supply side, were introduced to expand the availability and consumption of services for formal delivery in public sector. Not only did it increase the coverage of service intensely but also reduced the OOP expenditures and provided financial risk protection.

The current state of the society in terms of health indicators, healthcare service provision, and catastrophic financial effects of OOP spending on health leaves a lot of room for enhancement. As UHC is a multidimensional paradigm, a single solution cannot be the answer to all problems. Not only the health system needs strengthening, better mechanisms than the currently existing ones need to be identified and urgently implemented to enhance equity and protect community from financial difficulties due to healthcare spending.

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