ACCELERATING UNIVERSAL HEALTH COVERAGE

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Government has announced two important interventions to provide health to all at their door step. First, is through creation of Health and Wellness Centres (H&WC) that "will bring healthcare system closer to the homes of people" and second "a flagship National Health Protection Scheme(NHPS) to cover over 10 crore poor and vulnerable families providing coverage up to five lakh rupees per family per year for secondary and tertiary care hospitalization"

One of the important objectives of National Health Policy 2017 is to reinforce trust in public healthcare system and influence operation and growth of private healthcare industry as well as medical technologies in alignment with public health goals. As per Census 2011, the majority of population lives in rural area, and primary health care is essential health care which should be available and accessible to all equally without any regional and geographical discrimination. Right to Health is a basic human right which is protected by Article 21 of the Constitution of India. Thus, primary responsibility of the Government is to create good quality health care systems which take & care of overall well-being of the people especially marginalized and poor regardless of their socio-economic background and paying capacity.

The Government of India in order to lay down the road map to provide preventive and promotive health care services and universal access to good quality health care presented the new National Health Policy(NHP), in March 2017. The primary aim of the National Health Policy, 2017, is to inform, clarify, strengthen and prioritize the role of the Government in shaping health service systems in all its dimensions such as investment in health, organization and financing of healthcare services, prevention of diseases and promotion of good health through cross sectoral action, access to technologies, developing human resources, encouraging medical pluralism, building the knowledge base required for better health, financial protection strategies and regulation and progressive assurance for health. The policy emphasizes reorienting and strengthening the Public Health Institutions across the country, so as to provide universal access to free drugs, diagnostics and other essential healthcare. Some of the important features related to primary health care towards the Universal Health Coverage are:

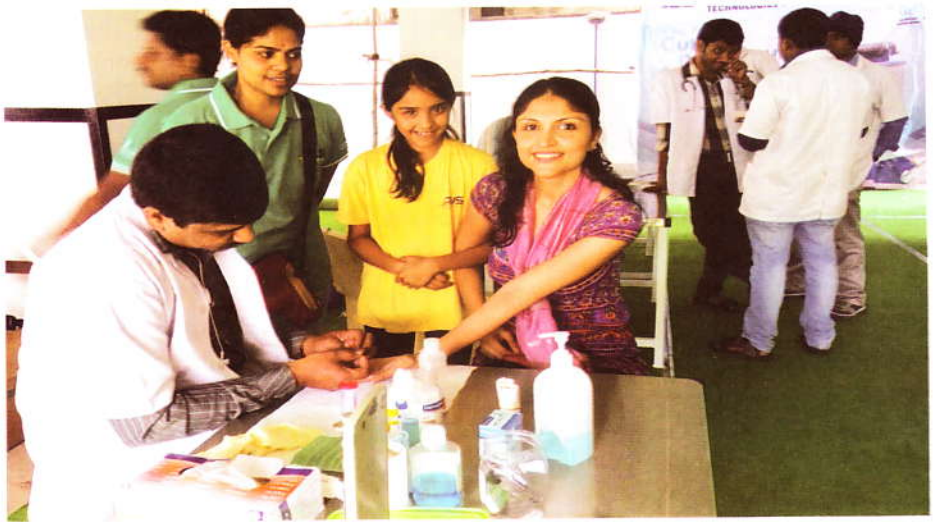
- The Policy seeks to reach everyone in a comprehensive integrated way to move towards wellness. It aims at achieving universal health coverage and delivering quality health care services to all at an affordable cost.
- This Policy looks at problems and solutions holistically with private sector as strategic partners. It seeks to promote quality of care, focus is on emerging diseases and investment in promotive and preventive health care. The Policy recommends prioritizing the role of the Government in shaping health service systems in all its dimensions. The roadmap of the new NHP is predicated on public spending and provisioning of a public healthcare system that is comprehensive, integrated and accessible to all.
- The NHP, 2017 advocates a positive and proactive engagement with the private sector for critical gap filling towards achieving national goals. It envisages private sector collaboration for strategic purchasing, capacity building, skill development programmes, awareness generation, developing sustainable networks for community to strengthen mental health services, and disaster management. The policy also advocates financial and non-incentives for encouraging the private sector participation.
- The policy proposes raising public health expenditure to 2.5% of the GDP in a time bound manner. It also envisages providing larger package of assured comprehensive primary health care through the Health and Wellness Centers'. It denotes important change from very selective to comprehensive primary health care package which includes geriatric health care, palliative care and rehabilitative care services. The policy assigns specific quantitative targets aimed at reduction

of disease prevalence/incidence, for health status and programme impact, health system performance and system strengthening. It seeks to strengthen the health, surveillance system and establish registries for diseases of public health importance, by 2020. It also seeks to align other policies for medical devices and equipment with public health goals.

- The broad principles of the NHP is centered on Professionalism, Integrity and Ethics, Equity, Affordability, Universality, Patient Centered & Quality of Care, Accountability and pluralism. It emphasized to ensure improved access and affordability of quality secondary and tertiary care services through a combination of public hospitals and strategic purchasing in healthcare deficit areas from accredited non-governmental healthcare providers, achieve significant reduction in out of pocket expenditure due to healthcare costs, reinforce trust in public healthcare system and influence operation and growth of private healthcare industry as well as medical technologies in alignment with public health goals.
- In order to leverage the pluralistic health care legacy, the policy recommends mainstreaming the Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH). Yoga would also be introduced much more widely in school and work places as part of promotion of good health. The policy supports voluntary service in rural and under-served areas on pro-bono basis by recognized healthcare professionals under a 'giving back to society' initiative.
- The policy advocates extensive deployment of digital tools for improving the efficiency and outcome of the healthcare system and proposes establishment of National Digital Health Authority (NDHA) to regulate, develop and deploy digital health across the continuum of care.

In order to attain these objectives, the country is aiming to create a vast network of public health system based on Public Private Partnership(PPP). In the Union Budget 2018-19, Government has announced two important interventions to provide health to all at their door step. First, is through creation of Health and Wellness Centres (H&WC) that "will bring healthcare system closer to the homes of people" and second "a flagship National Health Protection Scheme (NHPS) to cover over 10 crore poor and vulnerable families providing coverage up to five lakh rupees per family per year for secondary and tertiary care hospitalization" (PIB 2018).

To start with under the "Auyshman Bharat" programme the Prime Minister of India inaugurated first Health and Wellness Centre in Bijapur district of Chattisgarh on 14th April 2018. Under Auyshman Bharat programme it is planned to open such health and wellness centre in 115 Districts across the country. These districts will be those which are historically neglected and having worst health indicators. Also to motivate the state government these districts are not labeled as backward districts rather they will be known as "Aspirational" districts. The present government made target to have such 115 Health and Wellness Centre by 2022. These H&WC will provide treatment for non-communicable diseases, and disburse primary care to young mothers and children. Also it is decided to provide free essential drugs and diagnostic services and expected to provide comprehensive health care services through middle level skilled health professionals along with consultation with doctors of higher level. It is also aimed to deal with public health



issues and to work for preventive, promotive, curative and rehabilitative services for range of medical conditions/ailments. These medical conditions/ailments are; hypertension, diabetes, obstructive and respiratory diseases, oral, cervical and breast cancer, ENT, Ophthalmology. Also oral health, mental health, elderly care and emergency services will be provided at these centres. The provision of yoga services is also covered under this scheme, the space will be created for people to come and learn yoga practice under the guidance of learned instructors. As these centres will be functioning at the level of Sub Centre under Primary Health Centre continuous consultation with doctors is required to discuss individual cases (PIB 2018).

The Second announcement was to launch a "flagship National Health Protection Scheme to cover over 10 crore poor and vulnerable families providing coverage up to 5 lakh rupees per family per year for secondary and tertiary care hospitalization". This initiative announced as important step towards "universal health coverage". The scheme will be provided to most socially and economically deprived people. A national health agency will be instituted under the scheme to oversee its implementation at the state-level. The identification of beneficiaries is to be done by consulting the 2011 round of the socio-economic caste census. In 2016, India had similar scheme Rashtriya Swasthya Bima Yojana (RSBY), which was covering an insurance of Rs.30,000 for a family comprising of at most five members. Out of the total expenditure for the scheme in the budget, the Central government pays 75% of the expense, while the rest is borne by the States. The RSBY, targeted at Below Poverty Line (BPL) families, and has been implemented in 15 States in India. Now under NHPS it is planned to cover over 10 crore poor and vulnerable families providing coverage up to 5 lakh rupees per family per year for secondary and tertiary care hospitalization(PIB 2018). The financial protection under this scheme is much broader than the earlier scheme which will provide coverage in case of hospitalization. The expenditure will be shared by Both 60% by the Center and 40% by the State and in North East Region it will be 90% by the Center and 10% by the State.

Rural Health Care: Services and Challenges

As per Census 2011, the total population of India is 121 crore, out of which the rural population is 83.3 crore (68.84%) and urban population is 37.7 crore (31.16%). It is evident that majority of population lives in rural areas. In context of rural health services, the challenge of government health care system is that there are many gaps in primary health services and the health care facilities are mainly urban centric. The differences in health status in urban and rural areas are based on various factors such as: availability, accessibility and affordability of health services, literacy and educational status, poverty, employment and source of livelihood, income and family size, food intake and nutritional status, gender disparity, housing, access to clean water and sanitation facilities, information and knowledge for health programmes etc. These factors have direct impact on health status of the rural population.

As far as health status of women and children on important indicators are concerned rural population is having greater need of health care services. As per the National Family Health Survey (NFHS) - 4 data, Infant Mortality Rate(IMR) deaths per 1,000 live births is 29 for urban areas and 46 for rural areas. Under five Mortality shows that in urban areas it is 34 deaths per 1,000 live births but in rural areas it is 56 deaths per 1, 000 live births. In case of trends in at least 4 antenatal care visits made by women of urban and rural areas in India, NFHS -4 data shows that in urban areas it is 66 % whereas, in rural areas it is 45% of last births in the past five years. If we look at institutional birth situation in urban areas it is 89% while in rural areas it is 75% . The data shows that there is increase in immunization trends from NFHS 3 stage to NFHS 4 stage but urban and rural divide is visible in Immunization trends. In urban areas it is noted upto 64% but in rural area it is 61 % as against to 62 % of the total status of India. This indicates to put more efforts to approach rural population in more strategic way. The data shows that children under 5 years who are underweight 29 % are in urban and 38% are in rural area, Men and Women who have comprehensive knowledge of HIV/AIDS 37 % in urban and 29% in rural and 28 % in urban and 17 % in rural area respectively. The Households using improved sanitation facility is 70.3% in urban areas in comparison to 36.7% in rural areas. A very important factor for good health is clean fuel for cooking, data shows Households using it is 80.6% in urban areas and only 24 % in rural areas(NFHS-4).

India doesn't have enough hospitals, doctors, nurses and health workers, and since health is a state subject, disparities and inequities in the quality of care and access to health varies widely not just between states but also between urban and rural areas. The WHO report, published in 2016, stated 31.4% of those calling themselves allopathic doctors were educated only up to Class 12 and 57.3% doctors did not have a medical qualification. "The lack of medical qualifications was particularly high in rural areas. The report brought out that whereas 58% of the doctors in urban areas had a medical degree, only 19% of those in rural areas had such a qualification Strengthening primary healthcare hasn't got the priority it needs and the patient use to reach hospitals after faith-healers, quacks and other unqualified practitioners fail to cure them. Setting up a building and buying equipment is not enough, you need trained doctors to provide care (Sharma S. 2017).

The data provided by Rural Health Statistics(RHS) as on 31st March, 2017, revealed that there were 156231 Sub Centres (SCs), 25650 Primary Health Centres (PHCs) and 5624 Community Health Centres (CHCs) functioning in the country. While the Sub Centres, PHCs and CHCs have increased in number in 2016- 17, the current numbers are not sufficient to meet their population norm. The overall shortfall in the posts of HW(F) / ANM at SCs & PHCs was 5.6% of the total requirement, mainly due to shortfall in the States of Karnataka (4588), Tamil Nadu (2117), Gujarat (1615), Himachal Pradesh (835), Rajasthan (274), Tripura (360) Maharashtra (259) and Goa (43). Shortfall of allopathic doctors in PHCs was 11.8% of the total requirement for existing infrastructure. There was huge shortfall of surgeons (86.5%), obstetricians & gynaecologists (74.1%), physicians (84.6%) and paediatricians (81%). Overall, there was a shortfall of 81.6% specialists at the CHCs vis-a-vis the requirement for existing CHCs. While number of Sub Centres, PHCs and CHCs has increased during the year 2016- 17, the number of overall specialists at CHCs declined, though marginally from the position in 2015-16. Regarding the specialist doctors at CHCs , the number has been decreased marginally from 4192 in 2016 to 4151 in 2017. Major reduction has been noticed in the States of Madhya Pradesh (109), Gujarat (56), Jharkhand (47), Odisha (36) and Telangana (22).

The study conducted by Hazarika I.(2013) revealed that, while production of health workers has greatly expanded over the years at the cost of increased privatization of medical education in India. The rapid growth in the production of health workers such as doctors, dentists, nurses and midwives has not helped fill vacant positions in the public-health system. Further, the problems of imbalances in the distribution of these health personnel persist, with certain states remaining at a disadvantage. It revealed that mere increase in production capacity is unlikely to resolve the issues related to health-worker availability or distribution.

Golder S. (2017) on Universal Health Coverage stated that majority of Indian population lives in rural areas and only about 26 % doctors serve in this area. Also out of these majority are in the private sector, and it is beyond the reach of a large proportion of the population. "Bringing qualified health workers to rural, remote, and underserved areas is a daunting task. Huge level of international migration of qualified allopathic doctors and nurses further exacerbates the situation".

The study conducted on Rashtriya Swasthya Bima Yojana (RSBY) in Karnatka revealed that as per beneficiaries responses main factors to create barrier in utilization of services were, rejection from the hospitals, lack of awareness, and availability of fewer services. Acceptance by the hospital is one of the main factors that

is encouraging the service utilization. Further the research revealed that negative aspects include no reimbursement and no proper guidelines from State Government. Delay and uncertainty in the payment of claims by the insurance companies is the major reason informed by the hospitals for not providing treatment to the card holders

The Way Forward:

The majority of population lives in rural areas, and primary health care is essential health care which should be available and accessible to all equally without any regional and geographical discrimination. The Right to Health is a basic human rights which is protected by Article 21 of Constitution of India. Thus, it is primary responsibility of the Government to create good quality health care systems which take care of overall well being of the people especially marginalized and poor regardless of their socio economic background and paying capacity. Therefore it is quite important to look at the challenges so that timely actions can be taken on priority basis by assessing existing situation of health status of the people.

In the case of Health and Wellness Centre, the greater responsibility would be on middle level health professionals because they will be the first contact person. So, the challenge is to create this health care workforce in a time bound manner. These professionals should have minimum skills and relevant experience in health service sector who can understand medical complications from the medical and social perspectives. Another challenge is to consult the doctors continuously in each and every case which seems to be difficult keeping in view the infrastructural and manpower issues. It is assumed that these centres will "bring health care closer to home" but in absence of required manpower how we will achieve that objective, needs careful attention.

In case of National Health Protection Scheme, we have already witnessed that earlier insurance schemes not benefitted completely which were primarily meant for poor people. Therefore independent and transparent system should be in place to keep check on these insurance providers. More independent evaluation is required which can really suggests that whether such schemes are helping the poor people to access and avail quality health services in time and as per the individual health requirement. In such a situation to make protection scheme useful to poor and vulnerable sections of the society, the speedy implementation and strict instructions are required with targets to achieve in time bound manner. Also transparent systems needs to be set up for its regulation and to keep check on its progress and actual benefits for poor.

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