The Elders

Universal Health Coverage (UHC) in India

A call for greater political commitment and public financing

The Elders at their April 2018 Board Meeting in London.

The Elders are a group of independent leaders, brought together by Nelson Mandela in 2007, who use their collective experience and influence for peace, justice and human rights worldwide. The Acting Chair is Gro Harlem Brundtland, former Prime Minister of Norway and former Director-General of the World Health Organization. Ela Bhatt, Indian trade union activist and founder of the Self-Employed Women's Association (SEWA), was an active member of The Elders from 2007-16.

Mary Robinson, Desmond Tutu, Gro Harlem Brundtland and Ela Bhatt during an Elders visit to India in 2012. Photo: Tom Pietrasik / The-Elders

Front cover photo: Pippa Ranger/Department for International Development

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It is health that is real wealth and not pieces of gold and silver.

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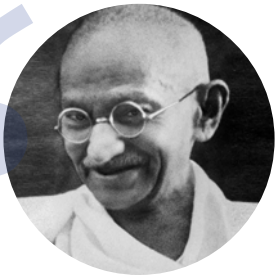

India urgently needs Universal Health Coverage

Universal Health Coverage (UHC) means that everybody receives the health services they need without suffering financial hardship. All United Nations member states have agreed to work towards UHC as part of the Sustainable Development Goals (SDGs).

India urgently needs UHC - around 600 million people fail to access the health services they need and 63 million Indians are living in poverty because of healthcare costs. As a result, India has the second lowest life expectancy in South Asia - almost eight years lower than in China. India also did not achieve either its child or maternal mortality targets under the Millennium Development Goals (MDGs).

This situation is not only damaging the health of the Indian people, it is also a significant impediment to further social development and economic growth.

The root cause of India's low health coverage is its **chronically low level of public health spending**, which has never exceeded 1% of GDP. In the absence of adequate public financing, households have had no choice but to pay for services directly themselves - often with disastrous consequences for family welfare.

The transition towards UHC involves increasing public health spending which has the effect of "crowding out" less efficient and more inequitable private out-of-pocket health spending. This has happened in many Asian countries (for example public financing has trebled in China and Thailand in the last 20 years) but is yet to take place in India.

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PUBLIC HEALTH SPENDING REPLACING OUT-OF-POCKET SPENDING IN ASIA

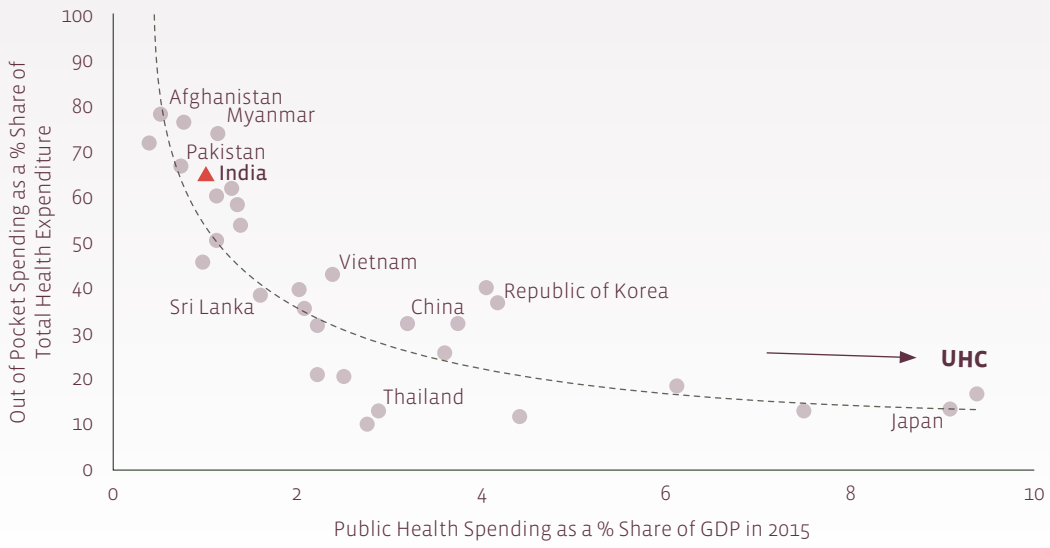


Photo: The White Ribbon Alliance

There are encouraging signs that the Indian Government has recognised the importance of better health for India's development and is taking action to improve services and increase financial protection – especially for the poor.

In March 2017, the Government published a National Health Policy which sets out a road map towards UHC. It has a strong emphasis on increasing levels of public financing (to 2.5% GDP by 2025) and allocating a large proportion of these resources towards primary care services.

The national "Ayushman Bharat" health reforms announced in the 2018 budget will implement the new policy and are built on two pillars: providing free primary care services through 150,000 health and wellness centres; and insuring 100 million households against hospital costs. We commend this strategy but strongly recommend that greater political commitment and public financing is given to the first pillar: providing free primary healthcare services.

We offer the following policy recommendations for key stakeholders to consider:

> All primary healthcare services should be available free at the point of delivery for all citizens.

1. **Increase public financing for health from 1.0% to 2.5% of GDP by 2021.** We believe India could allocate an additional 1.5% of GDP to public health financing in three years, based on comparable achievements in other large Asian countries. What is needed is genuine political will. Implementing this policy would generate an additional $39 billion of public financing for India's underfunded health system. If allocated efficiently, this could extend health coverage to the hundreds of millions of Indians currently paying out-of-pocket for their healthcare.

2. **Prioritise reaching full population coverage and meeting the needs of the poor and vulnerable.** Countries that prioritise reaching full population coverage quickly, rather than targeting sub-sections of the population, tend to perform better in terms of improved health outcomes and financial protection. The benefit of this approach is that it does not require complicated and expensive mechanisms to identify the poor. It is also vital to implement additional equity measures by skewing health benefits towards the needy, in particular women, children and the enormous vulnerable population living in the informal sector.

3. **Focus additional resources on primary care services.** To maximise the efficiency of its health spending, the Government needs to move swiftly to achieve full population coverage of a cost-effective benefit package of health services focusing on primary healthcare services. All primary healthcare services should be available free at the point of delivery for all citizens. Greater attention should also be given to inter-sectoral coordination in tackling issues relating to the social determinants of health in areas such as education, housing, transport, fiscal policy, water, sanitation, climate change and especially reducing air pollution.

4. **Guarantee universal access to free medicines and diagnostic services.** An immediate "quick-win" the Government could deliver to the Indian people would be to guarantee universal access to free essential medicines and diagnostic tests. Providing free medicines to everybody will be one of the best ways to reduce the financial burden of health services on the population. Such an initiative would also provide a major boost to India's generic medicines manufacturers. This would increase investment in one of India's most successful sectors, contribute towards economic growth and generate hundreds of thousands of new jobs.

The Elders and Universal Health Coverage

The Elders believe that the SDGs, agreed by 193 countries at the United Nations in September 2015, offer the best route to an inclusive, just and successful development model that eliminates poverty and protects human dignity and wellbeing.

Health is a fundamental component of the SDGs. Improving health requires addressing the social determinants of health (including providing decent housing, clean air and water) and providing effective quality health services.

Achieving UHC is a key target within the health SDG. UHC means that everybody receives the health services they need without suffering financial hardship. The Elders, together with the World Health Organization (WHO) and the World Bank, believe that the best way to meet the overall health goal is to achieve UHC.

India urgently needs UHC. Currently, 63 million Indians are living in poverty because of healthcare costs.[1] India's path to progress will not be sustainable if its citizens continue to bear such an unaffordable burden.

This report provides an overview of India's health system and offers four key recommendations to help national and state leaders, policymakers and civil society groups come together and deliver a health policy that works for the whole country.

Key Recommendations

1. **Increase public financing for health to 2.5% of GDP by 2021**
2. **Focus on reaching full population coverage and prioritising the needs of the poor and vulnerable**
3. **Focus additional resources on primary healthcare services including vital public health services**
4. **Guarantee universal access to free essential medicines and diagnostic services**

Ban Ki-moon addresses The Elders' #HealthForAll event in New York in November 2017.
Photo: The Elders #WalkTogether

Why UHC matters for India

India currently faces a public health crisis. The country has the largest number of people without effective healthcare coverage in the world. WHO estimates average coverage of essential services is around 56% of the population[2] – meaning 600 million people fail to access the healthcare they need.

This is not only a damaging health risk to the individuals concerned and their communities, it is a significant impediment to further social development and economic growth.

Moreover, around two-thirds of health expenditures in India are made in the form of out-of-pocket payments (user fees), which is one of the highest rates in the world.

Photo: Ray Witlin / World Bank

UHC has two main components, both of which would help improve the health of the Indian people. Firstly, that everybody gets access to a comprehensive package of good quality health services, including services that promote health, prevent and treat illness and also care for people at the end of their lives. Secondly, that financial protection is guaranteed – that in using these services people are not forced into poverty, have to sell assets or cut back on vital expenditures in other areas.

> 600 million people fail to access the healthcare they need.

UHC in India would improve health outcomes (e.g. increase life expectancy and lower rates of child deaths) and reduce health inequalities between different groups in society. Improving access to effective health services would also make the Indian population less susceptible to the threat of epidemics of infectious diseases. This would strengthen health security in India and globally.

UHC is also a major driver of economic growth, with leading development economists showing that it can generate economic returns at least ten times the initial public investment.[3] It would also generate tens of millions of jobs in India including for healthcare professionals, support staff and people employed in manufacturing medicines.

In protecting people from impoverishing health costs UHC also improves life chances for disadvantaged groups and can therefore reduce inequalities in areas such as household wealth, gender, age, urban-rural divides and between ethnic groups. This can generate significant political benefits by strengthening social solidarity, lowering political tensions and helping build more harmonious societies. This has been demonstrated by both Japan and China in their recent development histories.

Where is India on the Road to Universal Health Coverage?

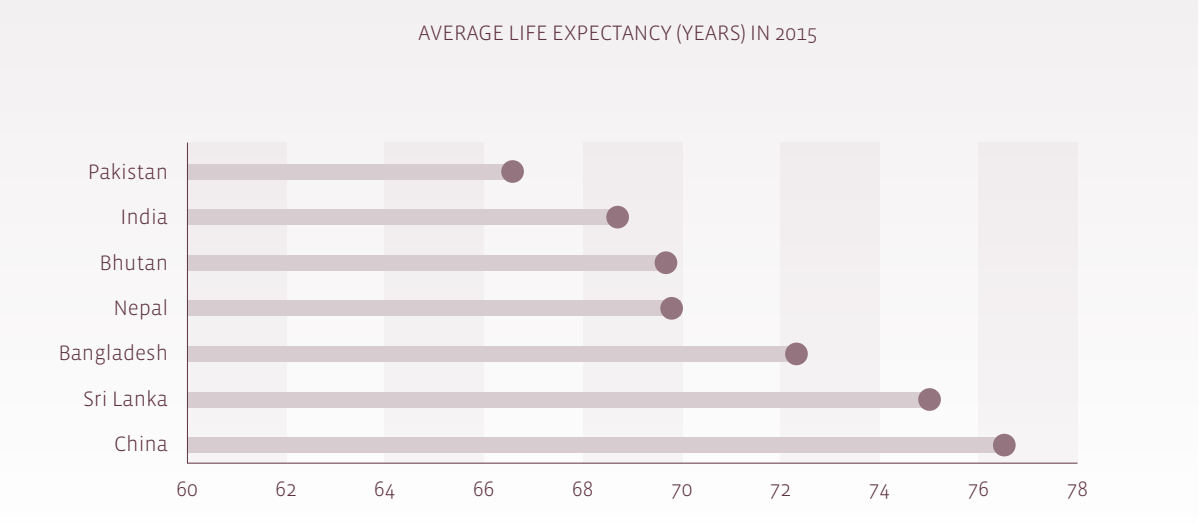
India has made good progress in recent decades against a range of key development indicators, most notably in achieving a sustained period of economic growth, which has seen its national income per capita quadruple since 2000.

It has also recorded some notable achievements in improving health indicators. For example, WHO declared India free of polio in 2014. The enormous efforts undertaken by the central and state governments to reach and sustain this **universal** health outcome demonstrate that India has the capability to attain UHC-related goals. The current Government has also made impressive progress in scaling up vital public health programmes in particular in areas such as water and sanitation, including constructing 60 million toilets.[4]

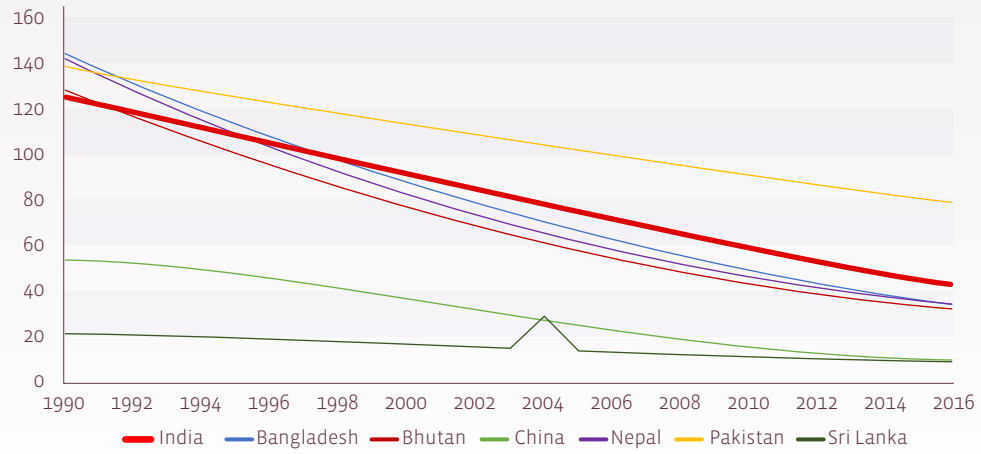
However, when assessing the rate of progress against a broad range of health outcome indicators, India's record has been disappointing.

Despite its impressive economic growth, India has the second lowest life expectancy in South Asia. Average life expectancy for people in India is now almost eight years lower than in China.[5]

Photo: Pippa Ranger/Department for International Development



INDIA'S CHILD MORTALITY FALLING - BUT SLOWER THAN ITS NEIGHBOURS



In 2015, India failed to reach either of the health MDGs relating to reductions in child and maternal mortality.[6] Child mortality rates have fallen in India since 1990, but as the graph above shows, India's rate of 46 deaths of children under five per 1,000 live births (latest comparable data), is the second highest in South Asia. Nepal, Bangladesh and Bhutan had worse child mortality figures than India in 1990, but all have now overtaken India and have achieved the child mortality MDG.

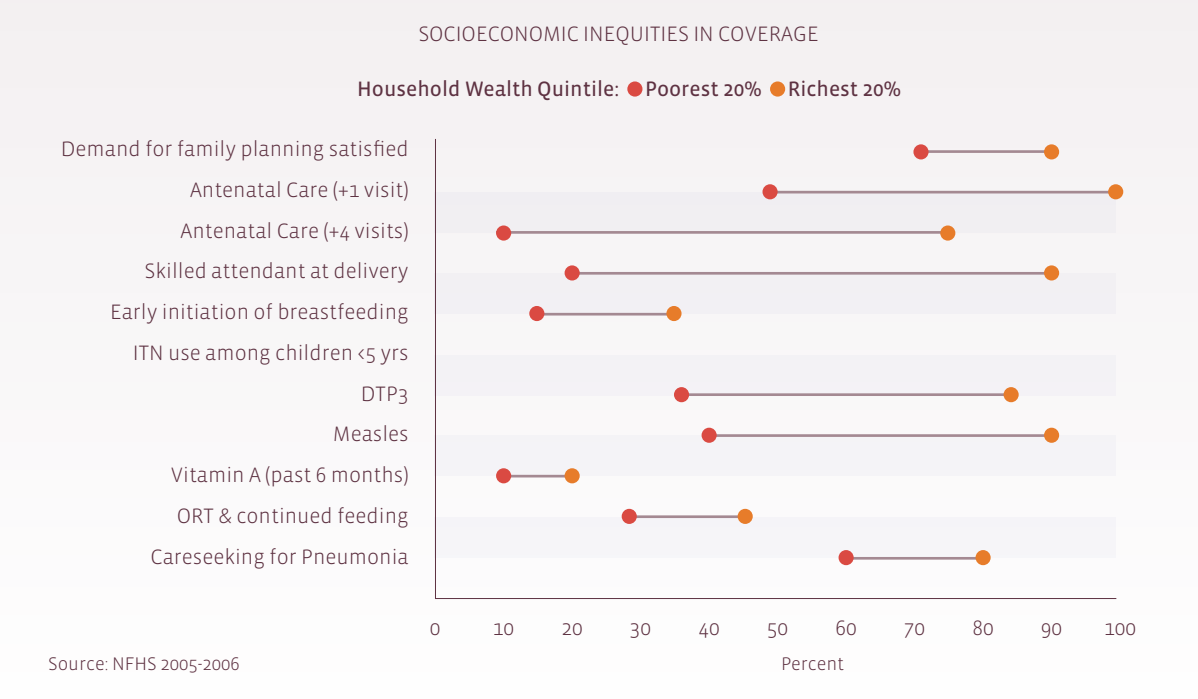
Health indicators for girls are particularly poor: in the 2000s, the risk of dying at an age of one to five years was more than 75% higher for Indian girls than for boys, which was partly due to high levels of female infanticide in some states.[7]

In a major international study recently published in the Lancet, using data from the Global Burden of Disease Survey and measuring progress against all the SDG health indicators, India ranked 127th of 188 countries.[8] This compared unfavourably with other "BRICS" countries that were ranked: Brazil (67th), China (74th), Russia (103rd) and South Africa (122nd). India's near neighbour Sri Lanka (which has been heralded as a "UHC success story" [9]) was ranked 70th.

These findings are consistent with the Global UHC Monitoring Report published by the World Health Organization and the World Bank in December 2017.[10] This showed that India had a UHC service coverage index of 56% compared to 76% in China and 75% in Thailand.[11]

More detailed studies indicate where key population groups are under-consuming vital health services. For example, a 2015 review of health coverage performance in India[12] noted that less than two-thirds (64%) of children aged 12-23 months were fully immunised against a standard range of infectious diseases. This national average hid huge variations across India's states: 92% of children in Goa were fully immunised, but only 33% in Nagaland. In India's largest state, Uttar Pradesh, less than half (47%) of children were fully immunised.

In addition to these regional inequalities, India's 2015 Countdown Report on its MDG performance[13] showed huge socio-economic inequities, with the poorest quintile consistently under-utilising key services compared to the richest 20% of the population.



Coverage levels are shown for the poorest 20% (red circles) and the richest 20% (orange circles). The longer the line between the two groups, the greater the inequality. These estimates may differ from other charts due to differences in data sources.

Photo: UNICEF India/2017/Prashanth Vishwanathan

India also performs poorly on the other dimension of UHC: financial protection.

In its World Health report of 2010,[14] WHO emphasised the importance of reducing financial barriers to health services, both to increase healthcare access and to reduce the incidence of households suffering financial hardship due to high health costs. Countries were encouraged to develop health financing systems built on pre-paid financing mechanisms that pooled contributions from across society, with richer households contributing more than the poor. In particular, countries were advised to move away from health financing systems dominated by out-of-pocket payments for services (user fees), which represented the most regressive health financing mechanism. This key policy objective was emphasised by both the Director-General of WHO, who said that "user fees punish the poor",[15] and the President of the World Bank, who called user fees "unjust and unnecessary".[16]

But repeated studies have shown that the Indian health financing system remains dominated by out-of-pocket spending, with people buying services, mostly curative, over the counter. In fact around two-thirds of health expenditures in India are made in the form of user fees, which is one of the highest rates in the world.

This financing system discourages poorer households from utilising needed services, and plunges millions of Indian people into poverty. 63 million people in India (4.8% of the population) are estimated to be living below the poverty line because they have had to pay high out-of-pocket payments for health services.[17]

In the last 20 years, successive national and state governments have tried to move away from out-of-pocket health financing by launching state-subsidised health insurance schemes targeted at people living below the poverty line (BPL). The most famous of these programmes is the nationally coordinated but state-run Rashtriya Swasthya Bima Yojana (RSBY). However, these schemes have not been effective in protecting the population against rising health costs and only account for 0.5% of total health expenditure in India.

"Around two thirds of health expenditures in India are made in the form of user fees, which is one of the highest rates in the world.

Photo: Simone D. McCourtie / World Bank

India's underperforming state health insurance schemes: not covering enough people or the right services

By September 2016, 41 million households (around 150 million people) had enrolled into state-run health insurance schemes providing households living below the poverty line with insurance coverage against inpatient hospital costs. Impressive as these numbers may appear at first glance, overall their performance has been disappointing:

- Population coverage remains low and schemes often fail to reach the poorest households. In 2016, The Times of India reported that 86% of the rural population and 82% of the urban population were still not covered under any scheme – public or private.
- RSBY schemes have provided no protection to the huge number of Indian people just above the poverty line, with hundreds of millions only marginally above this threshold.
- RSBY schemes are failing to protect their members from out of pocket health expenditures. In a 2016 evaluation it was found that RSBY membership "did not affect the likelihood of inpatient out-of-pocket spending, the level of inpatient out of pocket spending or catastrophic inpatient spending".[18] Studies show that 67% of out-of-pocket payments are for outpatient services and in particular for medicines and diagnostic services. The RSBY schemes have been failing to protect people from the largest cause of their medical impoverishment.
- These programmes distort the allocation of scarce health resources towards more costly hospital services and away from more cost-effective primary care services. Many hospitals maximise their income from RSBY members by conducting unnecessary and potentially harmful investigations and surgeries.

Poor access to medicines in the "pharmacy of the world"

Since Independence, one of the India's most successful industrial sectors has been pharmaceutical manufacturing. This employs 5 million people across the country directly, and 24 million indirectly.[19] It has also been a major contributor to the country's balance of payments.

India has become the world's leading manufacturer of generic medicines and has received international recognition for bringing affordable medicines to the world's poor. Indian companies and their leaders have been heralded by the global health community for enabling tens of millions of people in Sub-Saharan Africa to access life-saving HIV medicines.[20] In becoming the major global source of affordable medicines and vaccines, India is frequently referred to as the "pharmacy of the world".

It is therefore a tragic irony that India's own people have relatively poor access to effective medicines, due to its inefficient and inequitable health financing system, dominated by out-of-pocket spending. People should be entitled to access essential medicines free of charge throughout the public sector, but due to low government expenditures, frequently the required medicines are simply not available.

Faced with this situation, people needing essential medicines often have no choice but to purchase medicines over the counter in the private sector – often in poorly regulated drug shops. This places a huge financial burden on the population.

It has been calculated that around 70% of India's huge out-of-pocket (OOP) expenditure on health is spent on medicines.[21] With OOP accounting for around two-thirds of total health spending, roughly half of all Indian health spending is accounted for by people buying medicines over the counter.

There are also considerable health consequences associated with people buying medicines over the counter – in particular this is fuelling resistance to antibiotics which threatens India's health security.

Out-of-pocket health financing fuelling Anti-Microbial Resistance (AMR) in India

Most people who need healthcare lack medical knowledge about their conditions and which medicines would be most appropriate for their needs. They are therefore extremely vulnerable to drug suppliers selling them inappropriate and harmful medicines. In particular, there is a strong tendency for consumers to demand and pharmacies to supply antibiotics to people who do not need them.

This is one of the leading causes of the alarming rise in anti-microbial resistance (AMR) across the world. A recent paper in the Journal Lancet Infectious Diseases shows a high correlation between countries with high levels of out-of-pocket spending on medicines and countries reporting high levels of AMR.

The problem of AMR in India represents not only a threat to the health of its own people but also to global health security as drug-resistant pathogens cross international borders. Tackling this problem will require a series of health systems reforms, but one priority action ought to be to reduce the proportion of medicines consumed by the population involving out-of-pocket payments.

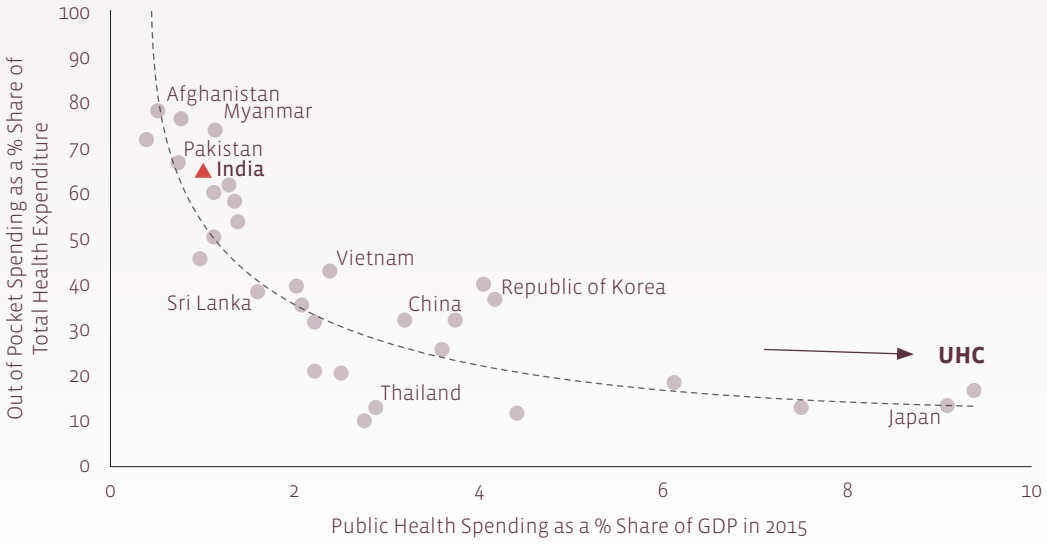
Inadequate public financing – the root cause of India's health problems

The root cause of India's low levels of health coverage (both in terms of service coverage and financial protection) is its **chronically low levels of public spending on health**. In the absence of adequate public financing and with healthcare demand increasing, households have had no choice but to pay for services directly themselves - often with disastrous consequences for their family's welfare.

The graph on page 14, shows that public health expenditure in 2015 accounted for around 1.0% of GDP or around $20 per capita. This level of public health spending is one of the lowest rates in Asia. Other large emerging economies in the region are spending considerably more: China is allocating 3.2% of its GDP on public health spending, Vietnam 2.4% and Thailand 2.9 %.

Queue of people at the Sawai Man Singh Hospital (SMS) Hospital in Rajasthan, India.
Photo: Asian Development Bank

PUBLIC HEALTH SPENDING REPLACING OUT-OF-POCKET SPENDING IN ASIA



The transition towards UHC in Asia, and indeed all countries, involves increasing public health spending which has the effect of "crowding out" less efficient and more inequitable private out-of-pocket health spending.[22]

There are also problems with how existing public health spending in India is allocated. Like the United States, the health system in India is providing poor value for money for its citizens because it is increasingly being dominated by expensive specialist hospital services over more cost-effective primary care services.

Within India itself, in the recent past, some states have been heralded as success stories because they have invested in their public health systems and especially in primary care. But as the case study to the right on Kerala shows, without sustained **political commitment** to increase public financing, coverage can slip if private voluntary financing is allowed to become more dominant.

A female eye care worker (right) supports mothers in the Mumbai community where she lives.
Photo: Shilpa Vinod Bhatte / Community Eye Health Journal

Kerala – A former star performer now regaining momentum towards UHC

In the post-independence period up until the mid-1980s Kerala achieved impressive health outcomes. It had low levels of mortality and higher rates of life expectancy and literacy than most other states in India. These achievements were in part attributed to a policy of public sector support for the welfare system (health and education) and a strong focus on primary healthcare.

But towards the end of the twentieth century, Kerala saw a shift away from public sector healthcare provision and the growth of an increasingly unregulated private sector. From 1990 to 2002, state expenditure on healthcare (as a proportion of GDP) decreased by 35% and Kerala was increasingly dominated by a private sector of variable quality, with access dependent on ability to pay. Households paid for 83.7% of healthcare expenditure which constituted approximately 7% of their total household expenditure (compared to a 5% average across India). Survey data between 1994 and 2005 showed a 100% increase in the number of families impoverished by catastrophic healthcare payments.

Growing concern over the cost of healthcare and its impact on poverty has seen health climb up the political agenda in Kerala. Over the last ten years, the State government has increased the public contribution to healthcare and this has begun to reduce out-of-pocket payments. Since 2008, Kerala has been implementing an adapted version of the RSBY which by 2013-14 was covering 85% of below poverty line workers (BPL) and their families. Kerala was also the first Indian State to incorporate the goal of UHC in its draft 2013 health policy and to plan UHC pilots.

India's overall progress towards UHC has been disappointing, but variations in state-level health outcomes reflect the fact that some states have been making faster progress than others. This shows that reforms can deliver better health outcomes in India, and if states learn from each other there is scope to improve the country's overall performance.

> If states learn from each other, there is scope to improve the country's overall performance.

Ayushman Bharat: a new dawn for UHC in India?

There are encouraging signs that the Indian Government has recognised the importance of better health for India's development and is taking action to improve services and increase financial protection – especially for the poor.

In March 2017, the Government published a National Health Policy which sets out a road map towards UHC. It has a strong emphasis on increasing levels of public financing (to 2.5% GDP by 2025) and allocating a large proportion of these resources towards primary healthcare services. These recommendations are similar to the key proposals of the 2011 Report of the High Level Expert Group on UHC that were incorporated into the five year plan of the previous government.[23] It is encouraging that there appears to be a cross-party consensus on the need to double public health financing in India to kick-start the country's UHC transition.

> We are concerned that Ayushman Bharat is unbalanced and too skewed towards costly inpatient care.

The goal of the 2017 National Health Policy is to "achieve the highest possible level of good health and well-being for all Indians through a preventive and promotive healthcare orientation in all developmental policies, and to achieve universal access to good quality healthcare services without anyone having to face financial hardship". This would be accomplished by pursuing four main policy objectives:

- Focussing on preventive and promotive health interventions
- Providing universal access to affordable primary healthcare
- Establishing better regulatory mechanisms and quality control
- Strengthening vital health systems in areas such as financing, human resources, infrastructure, medicines and building public-private partnerships

In effect the new national policy sets out a strategy to reach the health SDG through tackling the social determinants of health and achieving UHC. **We commend this vision for India's National Health Policy.**

To implement the new National Health Policy, the Indian Finance Minister announced major national health reforms, called the Ayushman Bharat, in his 2018 budget. This represents India's current UHC strategy and is built on two main pillars: refurbishing and strengthening 150,000 health and wellness centres to provide universal free primary healthcare services; and providing 100 million households (around half a billion people) with free state-financed health insurance for inpatient hospital care, in both public and private health facilities. This insurance scheme, called the National Health Protection Scheme (NHPS) will be financed jointly between the central government and Indian states on a 60:40 basis.

The Finance Minister also announced an increase in the health budget by 12%. However, taking into account economic growth, inflation and population increases, real per capita public health spending as a share of GDP has hardly changed. **India is therefore not yet on a trajectory to meet the Government's own target of 2.5% GDP public health spending by 2025.**

The Government's new commitment to improve health access is to be welcomed. But we are concerned that Ayushman Bharat is unbalanced and too skewed towards costly inpatient care. Greater focus should be given to the free primary healthcare services provided at Health and Wellness centres and integrating these with services covered by the NHPS. Also, it would appear that the NHPS is repeating the design flaw of the RSBYs in not protecting people from outpatient costs, including medicines, which make up 70% of India's out-of-pocket expenditure.

From the experiences of successful UHC reforms round the world, the Government would be better advised to invest the bulk of its additional public health funding in providing comprehensive, free primary care services to the entire population. This would be a more efficient and equitable route to UHC in India.

Key Recommendations

i. Increase public financing for health from 1.0% to 2.5% of GDP by 2021

If India is to improve access to essential health services for its 1.3 billion people, it is vital that it changes the composition of its health financing system to rely less on private out-of-pocket spending and more on **compulsory public financing.**

This has been the trend across the world: as countries become richer they spend more on health, and the proportion of public health spending relative to private spending increases too.[24] The transition to a predominantly publicly-financed system often occurs relatively quickly and is regarded as the birth of a nation's UHC system, as occurred in the United Kingdom in 1948, Japan in 1961, Canada in 1966, South Korea in 1977, Brazil in 1988 and Thailand in 2002.

The only wealthy country not to make the transition is the United States (US), which despite spending an astonishing 18% of its GDP on health, has failed to reach UHC. Today, 28.2 million Americans under the age of 65[25] still do not have effective health coverage and medical costs represent the biggest cause of personal bankruptcy. Furthermore, many health indicators in the US are inferior to those of less wealthy countries which spend far less on their health systems.

Unless the Indian Government takes action and implements significant health financing reforms, India could evolve into a US-style health system dominated by private insurance companies funding expensive hospital services catering mostly for the better-off, leaving a high proportion of the population still without adequate health coverage.

To avoid this happening, India should follow in the direction of other countries in Asia (China, Japan, Thailand, Malaysia, Taiwan, Sri Lanka and Turkey) and switch to a predominantly public health financing system where the healthy and wealthy in society subsidise services for the sick and the poor.

Evidence from other Asian countries like China (see box on page 18), which managed to increase health insurance coverage from less than 50% in 2005 to 95% by 2011,[26] shows that India could make rapid progress towards UHC in the next five years with a combination of increased political commitment, higher levels of public financing and a series of health systems reforms.

We believe India could find an additional 1.5% of GDP in public health financing in three years because this has been achieved in other large Asian countries (see page 18). What is needed is genuine political will. Implementing this specific policy would generate an additional $39 billion of public financing for India's underfunded health system. If allocated efficiently, this could rapidly extend health coverage to the hundreds of millions of Indians currently paying out-of-pocket for their healthcare.

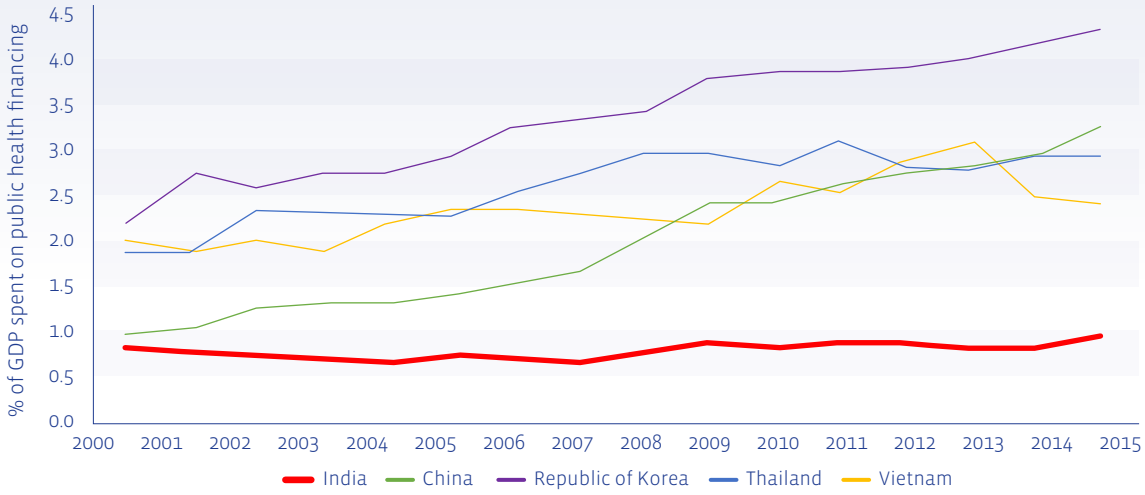
Health, including its financing, is a state issue in India. A high proportion of additional public resources are likely to be sourced at the state level, but in order to improve health equity across the country the national Government will need to channel additional central tax funding to poorer states.

In India, 93% of the population lives in informal sector households (where it is difficult to collect insurance contributions), so the bulk of additional public funding will need to be sourced from tax revenues. In order to increase the country's tax take, the Government may wish to consider increasing "sin taxes" on products harmful to health such as tobacco and alcohol. There could also be scope to re-allocate funds to health by reducing subsidies in other areas, for example cutting subsidies on fossil fuels which would also have environmental benefits.[27]

Public Health financing in Asia – India being left behind

The graph shows that at the start of the millennium in five large Asian countries, public health spending accounted for less than 2% of their respective national incomes. However, since then, and particularly in the last decade, there has been a dramatic increase in public health spending in Vietnam, Thailand, Republic of Korea and China - which are all heralded as UHC success stories. In India however, public health expenditure has hardly changed, and has never exceeded 1.0% GDP.

RISING PUBLIC HEALTH SPENDING AS A SHARE OF GDP SHOWS GREATER COMMITMENT TO UHC FROM INDIA'S COMPETITORS



In 2000, India and China both spent 1% of their GDP on public health financing. Whereas India still spends this much - China has more than trebled its share to 3.2% GDP and is now a global UHC success story.

Gro Harlem Brundtland and Ernesto Zedillo visit a health centre in Jakarta, Indonesia in November 2017.
Photo: Agoes Rudianto / The Elders

ii. Prioritise reaching full population coverage and meeting the needs of the poor and vulnerable

Recent analyses of successful UHC strategies show that countries that prioritise reaching full population coverage quickly, rather than targeting sub-sections of the population, tend to perform better in terms of improved health outcomes and financial protection. In these countries (for example Thailand (see page 20), Sri Lanka and Brazil) all members of society receive some services and financial protection, even if the service benefit package is modest, at least initially. As countries become wealthier they can then expand the benefit package to cover more services.

The main benefit of this approach is that it does not require complicated and expensive mechanisms to identify the poor, because there is a universal entitlement to coverage. Also, by explicitly including middle class beneficiaries from the outset, it does not stigmatise the poor and helps maintain the necessary political pressure to finance and govern the health sector adequately. In contrast, health schemes exclusively set up for the poor often degenerate into poor-quality health programmes.

It is also vital to implement additional equity measures by skewing health benefits towards the needy and health costs towards the rich. This is known as "progressive universalism" and is the UHC strategy recommended by the "Investing in Health" Commission established by The Lancet in 2013.[28]

India has an enormous informal economy, encompassing 93% of the population. These 1.2 billion vulnerable people need systems and services tailored to their needs and priorities, including occupational health and safety with health centres open according to their hours of work.

Given India's large health inequities, there is a clear need to prioritise the allocation of additional resources to meeting the needs of poor people, women, children and adolescents. Women are a particularly vulnerable group and with UHC expansion in India, not only will women become healthier, they will also be able to participate in the economy and contribute more to India's growth story. Currently, Indian women's workforce participation is very low and falling. One reason is that they are involved in unpaid care work and are often chronically sick themselves.

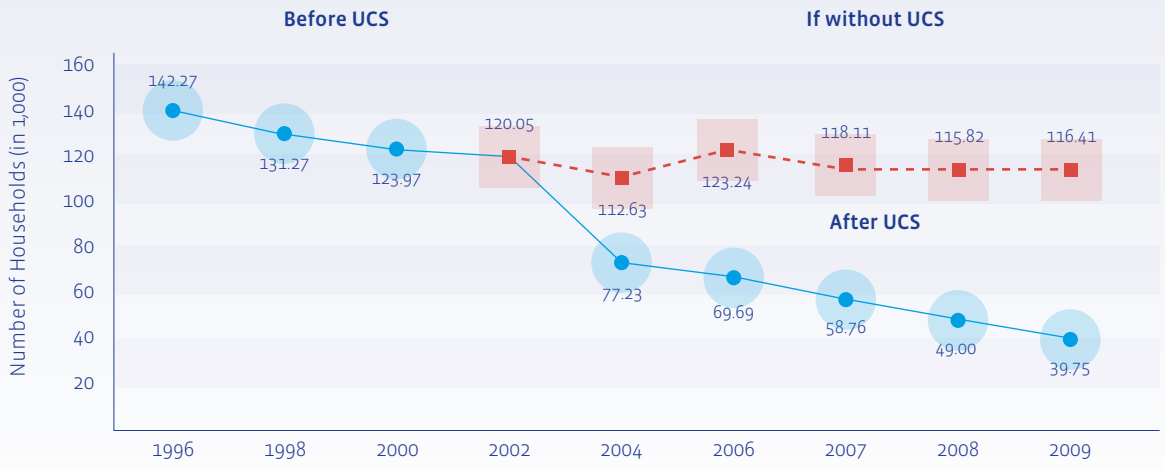
Gro Harlem Brundtland speaks to patients and staff at the Mae Tao Clinic, on the Thailand-Myanmar border in March 2014.
Photo: Kaung Htet / The Elders

Achieving full population coverage in Thailand[29]

In 2000, 18.5 million people in Thailand (roughly 30% of the total population) were uninsured. The rest were covered by four different insurance schemes, including a government-subsidised scheme for the poor. In 2002, the new Prime Minister launched a universal coverage scheme, entitling all Thai people to a package of health services with only a modest 30 baht co-payment. Some high-cost services were excluded from coverage at the outset, but added later (e.g. anti-retroviral treatment in 2003 and renal replacement therapy in 2006). In 2006, the 30-baht payment was abolished – entitling the entire population to universal free health services.

These reforms have been heralded as one of the biggest UHC successes in recent history. Thailand achieved all its health-related MDGs by the early 2000s. Out-of-pocket health payments by households fell from 35% of health expenditure before 2002 to less than 15% in 2010. The number of households impoverished by health expenditure in a year fell from 120,000 in 2002 to 40,000 in 2009.

HEALTH COSTS AND HOUSEHOLD POVERTY IN THAILAND



Number of households falling below the poverty line per year due to health costs, before and after the introduction of the Universal Coverage Scheme in Thailand

> Countries that prioritise reaching full population coverage quickly, rather than targeting sub-sections of the population, tend to perform better in terms of improved health outcomes and financial protection.

iii. Focus additional resources on primary care services

To maximise the efficiency of its health spending, the Government needs to move swiftly to achieve full population coverage of a cost-effective benefit package of health services focusing on primary healthcare services.

To rebalance the Indian health system towards primary healthcare services, we recommend that national and state governments ring-fence a large proportion of additional public financing to these services. This would mean prioritising expenditure on the proposed 150,000 health and wellness centres in the new National Health Policy over the hospital-focussed National Health Protection Scheme (NHPS).

Given the labour-intensive nature of healthcare and the need to improve the quality of services, a large proportion of these additional resources will need to be allocated to improving human resources throughout the health system. In addition to recruiting and training additional doctors, nurses, midwives and other skilled health professionals, investing in millions of community health workers and public health cadres will be an efficient way to extend primary healthcare services. This will also create millions of new jobs in urban and rural areas which could significantly increase the participation of women in the workforce.

Greater attention should also be given to inter-sectoral coordination in tackling issues relating to the social determinants of health in areas such as education, housing, transport, fiscal policy, water, sanitation, climate change and especially reducing air pollution.

All primary healthcare services should be available free at the point of delivery for all citizens. This strategy has proved very effective in a number of Asian countries typically regarded as UHC success stories: Sri Lanka, Thailand and Malaysia. This is also the focus of the UHC reforms being rolled out by the Delhi State Government through Mohalla Clinics in the capital.

Photo: UNICEF India/2017/Ashutosh Sharma

Photo: Robert Yates

Delhi's Mohalla Clinics Proving People Will Use Free Public Primary Healthcare Services

In 2015, Delhi's State Government launched a series of ambitious health reforms to improve access to vital services and reduce the financial burden on households. First it introduced a programme to provide universal free medicines throughout the entire public health sector from health centres to tertiary hospitals. Then in July 2015, it launched an initiative to tackle the chronic under provision of accessible primary healthcare in Delhi by opening Mohalla (neighbourhood) Clinics in poorer areas of the city.

There are currently 164 Mohalla Clinics and the aim is to set up 1,000 clinics providing quality healthcare to all residents of Delhi free of cost. The package of services offered by the clinics includes consultations, first aid, diagnostic tests and screenings and essential medicines from an approved list. Clinics are staffed with a qualified doctor employed on a sessional basis and reimbursed at a rate of 30 Rupees per patient treated.

The 164 Mohalla Clinics currently operating have proved extremely popular with the population of Delhi, especially the poor, and by July 2018 had recorded over 7 million consultations. This is encouraging because it challenges the view that the Indian people have permanently abandoned publicly provided primary healthcare services.

We recommend that an independent evaluation is undertaken of the Mohalla Clinic programme to determine whether this could be a good model for other Indian States.

iv. Guarantee universal access to free medicines and diagnostic services

An immediate "quick-win" the Government could deliver to the Indian people would be to guarantee universal access to free essential medicines and diagnostic tests. Some states are already implementing this policy (for example Tamil Nadu, Rajasthan and Delhi) and it is proving very effective in encouraging people to return to the public health system. Such initiatives could also integrate traditional (AYUSH) systems of medicine which tend to be low cost and would encourage people to access integrated formal services.

Furthermore, providing free medicines to everybody will be one of the best ways to reduce the financial burden of health services on the population.

Such an initiative would also provide a major boost to India's generic medicines manufacturers. If just 20% of the additional 1.5% of GDP allocated to health is spent on medicines, this would increase the medicines market in India by $8 billion per year. This would increase investment in one of India's most successful sectors, contribute towards economic growth and generate hundreds of thousands of new jobs.

> If just 20% of the additional 1.5% of GDP allocated to health is spent on medicines, this would increase the medicines market in India by $8 billion per year.

Photo: Robert Yates

Access to Free medicines driving UHC reforms in Tamil Nadu and Rajasthan

Tamil Nadu has delivered impressive improvements in health indicators such as infant and maternal mortality and has one of the highest average life expectancies in the country for both men and women. Much of these improvements have been the result of non-discriminatory and universal social policies in public education, healthcare, social security and public amenities. In many cases the provision of essential services and amenities has not only been universal but also free.

In 1994, the Government set up the Tamil Nadu Medical Services Corporation which is responsible for the procurement, storage, distribution and regulation of drugs in the state. The aim of the programme has been the rational utilisation of generic medicines at a low cost and ensuring their availability to the poorest in the population. In contrast to other states where patients at a government facility are typically given a paper prescription and asked to buy their medications in the market, in Tamil Nadu's health centres the provision of free medicines is standard. This has significantly reduced the average cost per treatment of outpatient care in Tamil Nadu.

In Rajasthan, in order to address the problem of high OOP expenditure on medicines, the State Government of Rajasthan set up the Rajasthan Medical Services Corporation (RMSC) in 2011, which launched a universal Free Medicines Initiative in the same year. Following a similar procurement model to that of Tamil Nadu, the RMSC procures over 600 commonly used essential medicines directly from manufacturers and importers, and provides them free of cost to all patients visiting public health-care facilities in the state.

An evaluation of the Free Medicine Initiative conducted in 2013 found that the median availability of drugs at primary health centres, community health centres, and district hospitals was 70%, 67%, and 85% respectively. Additionally, a significant increase in utilisation of public health services was observed after the introduction of the initiative.

Photo: UNICEF India/2018/Prashanth Vishwanathan

Conclusions: Health and Development Benefits of UHC for India

India's health system is failing its people – around 600 million people are not accessing the health services they need and 63 million are living in poverty because of health costs. More people lack health coverage in India than in any other country on earth. Without action this situation will deteriorate as the burden of non-communicable diseases and demand for healthcare increases.

With people routinely paying for medicines in unregulated drug shops, anti-microbial resistance is rising in India. This poses a threat to both national and global health security. Extending health coverage in India should not just be a national priority; it should be a priority for the whole global health community.

The root cause of India's health woes is its chronically low levels of public spending on health. At around 1% of GDP this is approximately one-third of the level of Thailand's and China's public health spend. Most Indians are forced to buy services from private providers and in particular from expensive, profit-maximising hospitals. Primary care services are woefully underfunded and often simply not available.

With its increasing focus on insuring people against the costs of staying in private hospitals, India risks creating an inefficient and inequitable US-style health system.

The Government's recent announcements, through the 2017 National Health Policy and the 2018 budget, to prioritise health reforms are to be welcomed. In particular the commitment to double public health spending to 2.5% GDP should provide much-needed resources to kick-start India's journey towards UHC.

How these funds are allocated will be of crucial importance. We believe they would be better spent on providing universal free primary care services, rather than increasing access to costly inpatient care in private hospitals. Of the two major announcements in the 2018 budget, we urge that a much greater priority be given to rapidly scaling up access to the proposed 150,000 health and wellness centres.

In the "pharmacy of the world", the Indian Government should be able to provide all its people with universal access to free generic medicines and medical supplies.

If the national and state governments prioritise providing universal free primary healthcare services, the benefits for the Indian people will be huge. This strategy would improve health outcomes (e.g. increase life expectancy), reduce health inequalities and improve health security against infectious disease. It would also bring economic benefits by accelerating growth, creating jobs, reducing health-related impoverishment, and increasing domestic consumption (as shown by China).

The Elders agree with the Director-General of WHO that UHC represents the best strategy to deliver health for all and the SDG.[30] We are convinced that with the necessary political will and public financing India can make UHC a reality and ensure a better, healthier future for all Indian people and future generations.

If the national and state governments prioritise providing universal free primary healthcare services, the benefits for the Indian people will be huge.

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Acknowledgements

The Elders are grateful to the members of the Advisory Council, whose support and advice allows them to carry out their work. Further information is available on The Elders' website.

The Elders would also like to thank all the individuals and organisations consulted for their valued assistance in preparing and reviewing this report.

Photo: UNICEF India/2017/Prashanth Vishwanathan

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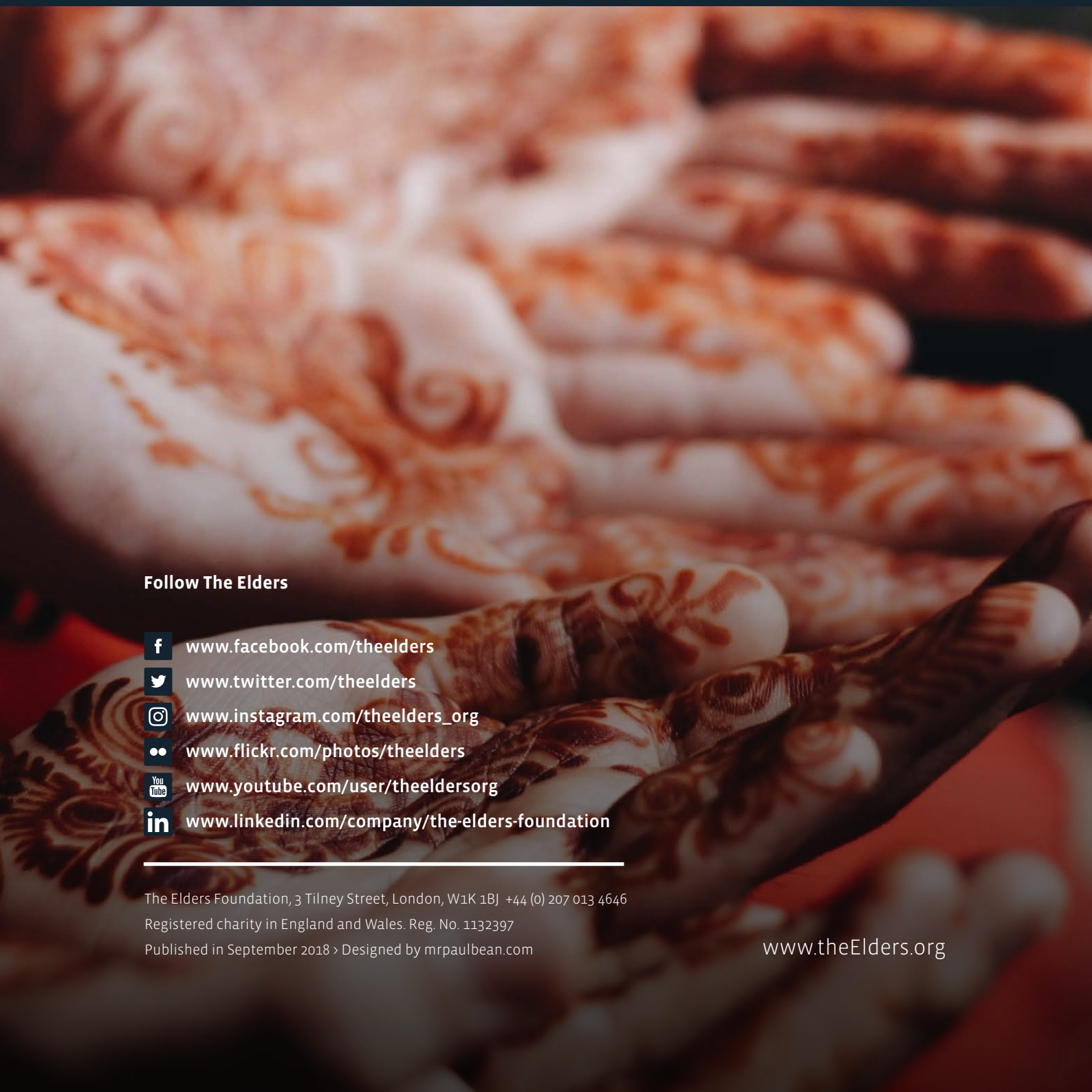

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Published in September 2018 › Designed by mrpaulbean.com

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