

Health Governance and Managing Challenges Towards Achieving Universal Health Coverage in India

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Abstract : *Providing good health is the priority of decision makers for developing and developed countries. In this regard state intervention in health is universal to all countries. Right after independence the Indian state formulated several health policies to make health accessible and affordable to all which has led to improvements in health indicators. In spite of the progress in terms of health indicators the Indian health system can be characterized as a highly commercialized healthcare system owing to abysmally low government spending on health with failing public health facilities, scarcity in health workforce and infrastructure and increasing out of the pocket expenditure by households on health.*

The objective of this paper is to discuss the problems of the Indian health system and look into the concept of health governance and experiences of some Asian countries in order to achieve 'Good Health at Low Cost'.

Keywords : public health, healthcare, health governance, community, participation, preventive, health resources, equity, inclusiveness, affordability

Introduction : India's health policies since independence have aimed at making healthcare affordable and equitable. The Report of Health Survey and Development Committee, 1946, popularly known as the Bhore Committee Report aimed at developing a country where "no individual should fail to secure

adequate medical care, curative and preventive because of inability to pay for it". In 2010, the Planning Commission constituted the High level Expert Group (HLEG) which reiterated the aim of achieving Universal Health Coverage (UHC) for providing affordable healthcare to all citizens. The HLEG's definition of UHC is, "Ensuring equitable access for all Indian citizens resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) as well as public health services addressing wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services"(HLEG 2011: 3). Making health equitable and at the same time accessible has been reiterated in almost all policy documents from the Bhore Report of 1946 to The National Health Policy (NHP), 2017. The recent NHP, 2017 reiterated the objective of achieving universal health coverage and improving public health care system.

Health In India After Independence : The constitution of World Health Organization (WHO), 1948 defined health as "a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity" (WHOa). Therefore in the broader sense, the concept of health comprises of public health and healthcare which are not identical. The domain of public health is largely preventive and promotive while curative care is what we understand as healthcare. Curative care is not the only criteria for maintaining the health and wellbeing of the population. The health of the population is determined by several criteria which include environmental, biological, socio-economic factors, information technology and availability and utilization of health services. The high burden of disease and death in any country can be tackled with the help of an effective public health system which is cost effective than any curative care. Thus public health is a holistic approach to develop and improve the determinants of health for a healthy living. It requires adequate food and nutrition for the masses, drinking water and hygienic environment, mother and child care initiatives which focuses on the preventive and promotive aspects of health. To prevent diseases rather than curing them is the most effective approach in maintaining the health of the population. By adopting these conditions it reduces

a population's exposure to disease and therefore is an essential part of country's development infrastructure. Experiences show that unless these preconditions are fulfilled the morbidity pattern does not change and incidence of communicable diseases increases.

Good health of the population is required for economic and social development. Providing access to good health has been the concern for developing and developed countries across the globe. Addressing the policy of health in a political system is determined by the relative role of the state and the market in the production and distribution of healthcare services. The proportion of state intervention and market functioning in healthcare varies across countries but some types of state intervention in provision of healthcare is universal (Tuohy and Glied 2012).

Right from independence the Indian state has been highly interventionist in nearly all spheres except for the provision of public health which is not rooted in the Indian political culture (Mehta 2003). Public health in India has been "one of the most neglected aspects of development in India" (Dreze and Sen 2002). The expansion of democratic institutions in India was a crucial factor which contributed to the degeneration of public health. The Emergency had provided the impetus and by the 1980s had made the electorate more vigilant about their rights. The decision makers had understood that in a democratic establishment specialized curative/clinical services had a larger appeal towards the electorate rather than funding public goods (such as drinking water, sanitation etc.). Hence public funds for health and education in India have been funnelled towards tertiary rather than primary levels. Experiences showed that the non-democratic countries of East Asia were more successful in improving health outcomes because their limited resources were focused on building public health measures rather than on providing advanced curative services (Dasgupta 2005). The democratic state had failed miserably in improving health of the population and with the rise of the disease burden the focus on health was inclined towards curative services rather than on preventive services. In the next few decades the discourse and the reality of the health situation in India came to be shaped by four major factors which are major impediments towards achieving UHC. They are an incomplete epidemiological transition, a limited demographic transition, the evolving pressure of social determinants of health and rising concern about equity and access to

healthcare cutting across economic, caste, gender and rural urban barriers (Sen 2012).

Inequalities in accessing health on the basis of socio economic status, ethnicity persists within all countries irrespective of political regimes. Empirical evidence shows that there is no direct link to ill health from income inequality per se (Deaton 2003). The WHO Commission on Social Determinants of Health (CSDH) has documented that health inequities are a result of 'toxic combination of poor social policies and programmes, unfair economic arrangements and bad politics' (CSDH 2008). Large inequity in health and access to health services continue to exist in India along with interstate variations, between rural and urban areas and within communities. Interstate variations in availability of health services, utilisation of curative and preventive services and affordability of health services is high with Kerala having best health service development and health outcomes even at low levels of per capita income. Interstate variations of utilisation of public services shows higher private sector utilisation for states like Punjab, Haryana and Maharashtra even with relatively better infrastructure for public services. However states like Himachal Pradesh, West Bengal - Rajasthan and other north-eastern states there is a higher dependence on public sector (Baru et al 2010).

The next section of the paper looks into the challenges that define health system in India. India's healthcare challenges include low spending on health, unregulated private healthcare services, poor health indicators, out of the pocket expenditure on health by households, escalating costs of drugs and heavy burden of communicable and non-communicable diseases.

Challenges Towards Achieving Universal Health Coverage :

Low public spending on health

Over the years there has been growth in India's GDP and public revenue but the same could not be said with regard to health initiatives. Safe drinking water and sanitation is one of the most important concerns of any public health system as the consumption of polluted drinking water, open defecation and improper disposal of solid and liquid waste is the cause of several water-borne and vector borne diseases. Access to improved drinking water in rural areas is 89.3 percent

while improved sanitation facility in rural areas is just 36.7 percent (NFHS 4 2015-16). Expenditure on preventive care has been much low when compared to the expenditure on curative care. According to National Health Accounts 2013-14, preventive care just gets 9.6 percent of the total money that flows in India's healthcare system. The expenditure on preventive care is estimated at Rs. 40,627 crores (9.6 percent of Current Health Expenditure (CHE) i.e. Rs 326 per capita) while the expenditure on curative care is estimated at Rs. 38,477 crores (80.4 percent of CHE i.e. Rs 2,708 per capita). Public spending on health has been extremely low with only 29 percent of the total health expenditure, just 1 percent of GDP which has slightly improved from 2004-05 when the share of government spending was just 22 percent (NHA 2013-14). The world average of government health expenditure of the total health expenditure is 74.3 percent and even the average of Sub Saharan Africa is 35.1 percent. The most developed regions in the world accounts for above 50 percent of public health expenditure to total health expenditure North America (81.4 percent), Europe and Central Asia (77.7 percent) much higher than the Indian experience which is 25.4 percent (WDI 2016).

Out of the pocket spending on health

The decreasing public spending on health has increased reliance on private healthcare making India one of the most commercialized health care systems in the world. This makes healthcare unaffordable especially for those living below the poverty line because of the increasing cost of pathological tests, doctor's fees, medicines and hospital charges thereby increasing out of the pocket spending on healthcare by households. The cost of healthcare has become impoverishing than ever before as out of pocket expenditure on health is a major cause of hospital related indebtedness and specially for those living below the poverty line. In India out of the pocket health expenditure as percent of current health expenditure is 64.6 percent much higher than the world average and that of Sub Saharan Africa which stands at 18.6 percent and 36.7 percent respectively (WDI 2016). The link between out of the pocket expenditure and poverty is validated in the *National Health Policy 2015 Draft*, which claims that "increasing number of households facing catastrophic expenditures due to health costs have increased from 18 percent of households in 2011-12 as compared to 15 percent in 2004-05".

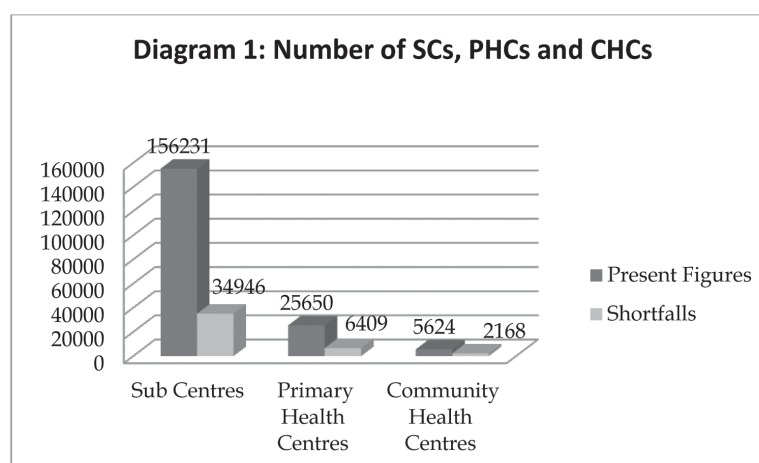
Medical expenditure which includes expenditure on medicines, fees paid for medical and para medical services, charges for diagnostic services, charges for operation and therapy has escalated in both private and public health care facilities. This can be substantiated by the fact that rural population spent on an average Rs.5636 for hospitalized treatment in public sector hospital and Rs.21726 in a private sector hospital. However in spite of the costs private institutions dominated rural (58 percent) and urban areas (68 percent). For non-hospitalized treatment of the total medical expenditure around 72 percent in rural and 68 percent in urban areas was made for purchasing 'medicine' (NSSO 2015a). For treating cancer average amount of Rs.24526 was spent in public hospital whereas more than three times i.e. Rs.78050 for the treatment in private hospital. An average of Rs. 5544 was spent per childbirth in rural area and Rs.11685 in urban area. However it may be noted that an average amount spent per childbirth as an in-patient of private hospital was more than nine times of that spent in public hospital for both rural and urban area (NSSO 2015b). Expenditure for delivery in public hospitals was Rs.1855 and Rs.17550 in private hospitals. The increased cost of delivery care is attributed to increased caesarean sections where the cost is six times higher than normal delivery (Jayakrishnan et al 2015). While accessing inpatient care since there is high level of expenditure people resort to various sources to meet the expenditure. Health expenditure related borrowing is reportedly 18 percent in urban areas and 25 percent in rural areas. To meet the burden of health care 68 percent of rural households primarily depended on their household savings whereas 75 percent the urban household relied on 'income/savings' (NSSO 2015b).

Inadequate public healthcare infrastructure

The Bhore Committee Report of 1946 recommended a three tier healthcare system with the primary health centres at the core of the health system to provide preventive and curative services (Report of the Health Survey and Development Committee 1946). This became the guiding principle on which the public healthcare system was developed in India to provide preventive and curative healthcare in rural and urban areas. The public healthcare system in rural India consists of the three tier system of Sub centres, Primary Health Centres,

Community Health Centres and First Referral Unit. There is a shortfall of 19 percent Sub Centres, 22 percent Primary Health Centres and 30 percent Community Health Centres (Diagram: 1). Primary Health Centre is the first contact point between the village community and the Medical Officer. There is also a severe dearth of doctors and para medical staff in the public healthcare system which is more acute in the primary care facilities in rural areas and urban slums. There are 7.8 percent PHCs without any doctor, 36.2 percent without a Lab Technician and 18.7 percent were without a pharmacist. There is also a staggering shortage of specialized medical care of surgeons, obstetricians and gynaecologists, physicians and paediatricians at the Community Health Centres. Although the specialist doctors at CHCs have increased from 3550 in 2005 to 4156 in 2017 there was a shortfall of 81.6 percent specialists at the CHCs as compared to the requirement for existing CHCs. This shortfall consists of 86.5 percent of Surgeons, 74.1 percent of obstetricians & gynaecologists, 84.6 percent of physicians and 81 percent of paediatricians were vacant (Rural healthcare system 2017).

In India, physicians per 1000 people stands at 0.8, nurses and mid wives at 2.1 and specialist surgeons at 6.8 much below the world average of 1.5, 3.4 and 30.5 respectively (WDI 2016). According to the National Health Profile, 2015, the number of Government Allopathic doctors and dental surgeons serving in India was 106415 and 5614 respectively. On an average, population served by Government Allopathic doctor was 11528 and by Government dental surgeons stand at 217448. Going by the same statistics, in India there were 20306 government hospitals (urban and rural) with 675779 beds. Average population served per hospital bed was 1833. According to NSS 71st Round this shortage has led to decline in use of public healthcare facilities. A steady decline in the use of government hospitals and a corresponding increase in the use of private sources is evident in the reports of the last three NSS rounds (52nd round – July 1995 to June 1996, 60th round – Jan to June 2004 and 71st round – Jan to June 2014). In urban India, 32 percent of the population in 2014 visited public hospitals for inpatient care as against 43.1 percent in 2004 (NSSO 2015b).



Source: Rural Health Infrastructure 2017 available at [https://nrhm-mis.nic.in/RURAL%20HEALTH%20STATISTICS/\(A\)RHS%20-%202017/Rural%20Health%20Infrastructure.pdf](https://nrhm-mis.nic.in/RURAL%20HEALTH%20STATISTICS/(A)RHS%20-%202017/Rural%20Health%20Infrastructure.pdf)

Heavy burden of communicable and non-communicable diseases

Burden of diseases in India is at a critical juncture; still grappling with old diseases while new ones like HIV/AIDS have got added on to the disease profile. The success story so far has been the complete elimination of polio in India. Communicable diseases along with maternal and child health and nutrition contribute to 38 percent of the entire health burden (**NCD Policy brief: India, 2011**). Amongst the communicable disease, malaria occupies the top position although there has been a significant decline. However challenges persist because the disease is known for its re-emergence and outbreaks. Viral Encephalitis, Dengue and Chikungunya are rapidly increasing in the urban areas and there are no effective measures to address them. In tuberculosis the challenge is huge as on an average there are nearly 19 deaths per 100,000 population and the rising problems of multi-drug resistant tuberculosis. With regards to disease control in India huge importance is given in implementing vertical disease control programmes without any importance given to comprehensive environmental and socio-economic improvements. Moreover 75 percent of communicable diseases are not part of the current national programmes. The *National Health Policy 2015 Draft*, clearly states that 'where there are sub-critical human resource deployment, weak logistics and inadequate infrastructure, all national health programmes do badly'.

All around the globe as well as in India non-communicable disease (NCD) is gradually increasing owing to rapid urbanization accompanied by lifestyle changes and with low level of population awareness results in late detection and increased chances of morbidity and mortality (Reubiet al. 2016). Non-communicable diseases account for 62 percent of the total disease burden in India which mainly include cardiovascular diseases, injury, mental health, cancer, respiratory diseases and diabetes. Along with human resource and finance to deal with NCDs in India the paucity of good quality data is affecting NCD planning process (NCD Policy brief: India, 2011).

Achieving UHC seems a difficult task given the challenges that the health system face in India. The next section will look into the concept of health governance which has been adopted by several countries to provide 'Good Health at Low Cost'.

Health Governance : Way Forward For Achieving Universal Health Coverage

In India : The realization of UHC requires policy interventions that can increase equitable access to healthcare utilisation. To be able to fulfil this goal requires not only infrastructure, medicines and medical products, health information, human resources in health and health financing but above all governance in health which is relevant to these components in order to coordinate the interactions between them. WHO states that strengthening health governance can help countries move towards UHC as a goal. WHO defines governance in health sector as 'wide range of steering and rule-making related functions carried out by governments/decisions makers as they seek to achieve national health policy objectives that are conducive to universal health coverage' WHO further describes that beyond the formal health system governance means collaborating with other sectors including the private sector and civil society, to promote and maintain population health in a participatory and inclusive manner (WHO b).

In developing the health governance framework several key issues need to be addressed. This includes the role of the state vs. the market which is an important aspect because for low and middle income countries the most crucial task for health policy makers is agreeing to an appropriate sense of balance between governments direct intervention in health affairs on one hand and the application of free market principles on other. Secondly, role of the health ministries vs. other

state ministries is another key issue because health system governance requires a holistic approach to health like providing clean water, sanitation food and nutrition and not confines itself only to the provision of health services. Thirdly, several actors in governance like the communities, civil society and the private providers influence health system governance within countries. Therefore good governance in health is determined by the extent to which the state executives value the experience of these stake holders. Fourthly health system governance should be resilient enough and respond to the changing demographic and epidemiologic profiles of the population i.e. they should be able to ascertain static vs. dynamic health system. Lastly, it is important to delineate the boundaries between health reforms vs. human rights based approach to health. Following the World Health Organization's (WHO) domains of stewardship; Pan American Health Organization's (PAHO) essential public health functions; World Bank's six basic aspects of governance; and United Nations Development Programme (UNDP) principles of good governance on health ten principles on health governance have been identified which are : strategic vision, participation and consensus orientation, rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence and information, and ethics. (Siddiqi S et al.2008).

A comparative study across few countries highlighted the importance of good governance in health in countries can promote good health and also at low cost. The study dismissed the idea that economic growth is a sufficient driver of development which promotes good health of the population. The study revealed that many low income countries had achieved vast improvements in health similar to those seen in developed countries with only modest growth in income. The social and political factors which contribute to good health include political and historical commitment to health as a social goal, strong societal value of equity, political participation and community involvement in health, high level investment in primary health care and other community based services, widespread education for women and intersect oral linkages for health (Balabanov et al. 2011).

In India an important challenge is low government spending on health which aggravates the problem of out of the pocket expenditure by households which leads to low financial protection and access to care (Quintussi et al 2015). The

problem worsens for poor people in the poorer states of India who pay significantly more to avail hospitalization in public health centres than those in developed states (Dash and Mohanty 2019). The most pertinent question is what the government is spending and what has been the impact of the spending and what are the future prospects. A study on this question "What a country should spend on healthcare" (Saved off, 2007) tells that increasing government spending on health should be based on the analysis what the government wants to achieve with its spending and how much will it cost to achieve the stated goals. Given India's federal structure and the division on the subject of health it is an important factor to consider. The trend shows that primary health care is largely funded by the centre whereas the states finance secondary and tertiary care except for national institutions. The political economy of government financing on health needs planning which has to be matched by centre and states (Berman and Ahuja 2008). This is one of the ten principles on governance on health i.e. strategic vision which is required for good health.

In several developing countries like India health is not delivered to all segments of the people because of the shortage of healthcare infrastructure and health workforce. This can be tackled by training health workers from the community with focus on public health and healthcare and subsequently several communicable and non-communicable diseases can also be prevented. Community Health Workers play a pivotal role in applying their deep understanding of local population needs on certain aspects of local health delivery (Lehman and Sanders 2007). Improving community based services is an important component of good governance which has also been a reason for developing good health in several countries. Training village health communicators and public health nurses and introducing new types of public health workers has also been emphasized by Thailand for maintaining primary care infrastructure supported by community efforts. In Thailand community health workers and auxiliary staff visiting communities have been able to communicate the idea of contraception which has subsequently reduced fertility (Balabanov et al. 2011). Bangladesh Rural Advancement Committee (BRAC) is driven by the principle of community participation involves large scale deployment of trained Community Health Workers (CHWs) There are two types community health workers one with minimum of 10 years of training known as Swasthya Kormi (SK) and

community volunteers called Shastya Sebika (SS). The SKs provide antenatal and postnatal care; reproductive health services, especially adolescent health; and deliver health and nutrition education while SSs educate communities on preventive measures provide primary care and subsequently link them to referral services to higher tiers of healthcare if needed. The role of the CHWs has thereby been expanded shifting from vertical to integrated models of care and has enabled health workers to implement vertical programmes in a flexible manner which has been more appropriate for dealing with the local disease burden. The neighbouring countries of Pakistan and Nepal have also initiated community engagement and participation to improve healthcare in the form of Lady Health Workers (LHWs) and Female Community Health Volunteers (FCHVs) to provide family planning and primary healthcare services respectively. In Sri Lanka the Preventive Health Care Program comprises of medical officers of health units and public health midwives (PHM) nurses and other support staff who have been critical in reducing maternal mortality in Srilanka (Bhutta et al. 2018).

Community Health Workers can help not only to provide maternal health care and combat communicable disease burden by providing primary health care but can also be empowered to deal with the problem of non-communicable diseases. The guideline on NCD in India proposes community awareness and advises governments to disseminate NCD related communication messages at camps and local and public gatherings through community health workers and performing community based screening (Mondal and Van Belle 2018). For example in Kenya CHWs are being used to increase hypertension awareness, screening rates and provide knowledge on treatments. Through mobile phones and household visits CHW play an important role in ensuring that majority of patients with NCD receive medical follow up that they require(Jarvis et al 2016).

In the last decade India has initiated certain aspects of health governance for making health services available to the people. The flagship health programme the National Rural Health Mission (NRHM) launched in 2005; trained Community Health Workers across India and named them Accredited Social Health Activists (ASHA). ASHA has been successful in catering to a large section of the rural population for generating awareness about public health issues and maternal and child health. In 2007 Community Based Monitoring (CBM) was introduced as a part of NRHM to increase health sectors accountability through participation

of the community. Apart from providing health services by community health workers CBM is one of its kind initiatives where the state of public health services are tracked, recorded and reported as experienced by the people themselves. It also creates awareness what people are entitled to in order to monitor whether it is delivered (Shukla et al. 2011). The health system of Tamil Nadu has garnered praise because of its focus on health governance and has been able to create a health system that is able to deliver effective and equitable care. Tamil Nadu's achievement can be attributed to a mix of strong political commitment to health and a paradigmatic shift in public health policy which emphasised on intersectoral policies like improving literacy, increase public awareness on family planning and good nutrition. In Tamil Nadu village health nurses which are based at health subcentres provide home visits and inform women about antenatal and postnatal care and vaccinations thereby enhancing maternal healthcare (Balabanov et al. 2011). In another case trained CHWs employed by nongovernmental organisation Society for Education Action and Research in Community Health (SEARCH) in tribal regions of central India for the diagnosis and treatment of childhood pneumonia and common new-born illnesses have proved to be an effective measure and therefore later incorporated in National Rural Health Mission programme in 2011 (Bhutta et al. 2018). In Kerala a population based NCD prevalence study reveals that CHWs can play a powerful role in collecting data related to NCD prevalence and other vital information (Menon et al 2014).

Conclusion : The policy guidelines laid down in health documents from time to time have addressed the challenges that India's health system faces yet it lacks significantly in terms of implementation. Neighbouring countries like Bangladesh and Sri Lanka with similar economies have been able to perform much better than India in terms of several health indicators. These countries have shown that it is possible to achieve good health for the population with lower spending on healthcare but effective spending. Focusing on preventive measures rather on curative measures is an optimal solution to ease down the pressure building on the current healthcare system. Preventive measures like proper sanitation, increasing awareness through health education, vaccination help in curbing the disease burden. The outreach of the Swachh Bharat Mission needs to be maximised. Community participation for delivering health services has to be

supported by community based monitoring as an effective strategy throughout the country. Availability of food and safe drinking water are two areas where community monitoring can help. Ultimately health governance is about optimum utilisation of available resources in health, a mechanism for community empowerment thereby giving the people right to good health.

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