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Universal Health Coverage in India: Policy Priorities for the Central Government

MITA CHOUDHURY, *Associate Professor, National Institute of Public Finance and Policy, New Delhi, India. Email: mita.choudhury@nipfp.org.in*

Although "Health" is a State subject in India, the Central Government has an important role to play in India's drive towards Universal Health Coverage (UHC). Following the increasing recognition of the importance of UHC as part of social security policies of countries, the Government of India has initiated the first steps towards UHC in India. The 12th plan document lays out the objective of UHC in the following words: "each individual would have assured access to a defined essential range of medicines and treatment at an affordable price, which should be entirely free for a large percentage of the population."

Need to enhance Central Government transfers in poor performing States

Public spending on health in India is among the lowest in the world, and the need to increase the level of public spending has been repeatedly emphasized in various policy documents.[2] The levels of public spending are particularly low in most of the poor performing States of the country due to low fiscal capacities.[1] The low fiscal capacities partly arise from the inability of the Central Government to offset the fiscal disabilities of these States through vertical transfers.[1] Although these States spend a greater share of their total expenditure on health, in absolute terms, their level of per capita health spending remains low. Estimates show that about 65 per cent of additional requirement of health spending is needed in just the six poorly performing States.[1] Support of the Central Government needs to be enhanced in these States to ensure a minimum level of health services.

Need to enhance Central Government support for bridging gaps in the availability of trained health workers in poor performing States

Existing Central transfers through the National Rural Health Mission (NRHM) have been adversely affected by a critical resource constraint, *viz.* the inadequate availability of trained medical personnel. The size of the available health workforce in India is about a quarter of the WHO norms. Also, bulk of this workforce is concentrated in the better performing southern States of the country, resulting in acute shortages of manpower in the low performing States. Besides, around two-thirds of the existing health workers in these States are employed in the private sector in the urban areas, resulting in large vacancies in rural public facilities of the low performing States. Lack of trained health workers has translated into reduced effectiveness of NRHM spending on items like construction and equipment in health facilities. Similarly, although the *Janani Suraksha Yojana* has led to a significant increase in institutional deliveries, its benefits in terms of reducing neonatal and maternal mortality rates have been weak, as bulk of the deliveries are conducted by ANMs and nurses, who have limited training as skilled birth attendants.

The Central Government needs to step in to complement States' efforts to increase the availability of skilled medical personnel. The low availability of health workers in the poor performing States is partly a result of the skewed distribution of medical and nursing schools. About three-fourths of the total requirement of additional medical and nursing schools in the country, are in the seven low-performing States. Given the extent of shortage in the poorly performing States, and their limited fiscal capacities, States' own efforts in expansion of trained health manpower are likely to be inadequate. In successful countries like Thailand, expansion of health workers and ensuring their deployment in rural areas have played a key role in UHC.

Reliance on expansion of health insurance will increase cost and skew priorities

Insurance schemes to extend financial protection cannot address the primary cause of out-of-pocket spending (OOP) by households in India, and is likely to inflate costs. Nearly three-fourths of OOP spending by households is towards out-patient treatment, which is not addressed by the existing insurance schemes of the Government of India. In successful countries like Thailand, insurance services are largely provided through public health facilities, where moral hazard problems are likely to be lower, and include primary and preventive care. In contrast, RSBY rolled out by the Centre in India provides coverage only for hospitalisation (excludes primary and preventive care), and is largely implemented through private health providers. Moreover, in Thailand, restrictions on accessing secondary and tertiary health care without accessing primary care (except in cases of emergency) keep secondary and tertiary care costs under check. In India, in the absence of a well-functioning primary health system, expansion of insurance cover for hospitalisation will increase government spending towards relatively higher cost procedures. Evidence on the State-level health insurance scheme *Aarogyasri* does suggest that such an insurance can skew public spending away from primary and preventive care.[3]

Policy recommendations

In sum, there are three main policy lessons to draw. First, the Central government needs to increase the level of 'specific transfers' targeted towards health-sector in the poor performing States to enable them to increase spending on health. Secondly, the Central government should complement efforts of States in removing critical bottlenecks, the most important of which is the availability of trained medical personnel. Thirdly, financial protection through present form of health insurance schemes is likely to inflate costs and further skew public spending away from primary and preventive care. In view of this, provision of UHC should not be based on expansion of health insurance.

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