

India's Covid-19 Experience is a Renewed Call to Accelerate Progress on Universal Health Coverage

Rakesh Kumar¹ and Anchal Dhar²

Ministry of Health & Family Welfare, Government of India, India

***Corresponding author:** Rakesh Kumar, A former Joint Secretary of the Ministry of Health and Family Welfare, Government of India, and is currently serving as Chief Advisor to Population Services International, New Delhi, India. Email: drrakeshkumar92@hotmail.com

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The COVID-19 pandemic has left an indelible mark on India's living memory. It's second wave cast a dangerous spell with more than 3.50 lakh lives lost in this period alone [1]. 88% of all deaths comprised people in the age group 45 and above [2], often sole breadwinners in their families, unexpectedly leaving behind helpless, orphaned, vulnerable children to an uncertain future. Each one of us knows someone who never made it. The colossal face of human tragedy behind these statistics coupled with unsettling stories of people struggling for beds and gasping for breath will continue to haunt us for a long time. As a matter of fact, the pandemic has created a dual crisis, adversely affecting health and economy. At least 230 million Indians is said to have fallen below the poverty line during lockdowns [3].

As India begins to heal, we must all ask ourselves a question –How can India equip itself to never face such a dire situation ever again? It is in these times of trial and tribulation, accelerating progress on universal health coverage (UHC) with a primary health care focus is an idea whose time has come. Here's why.

Key facets of Universal Health Coverage (UHC)

UHC promises every individual access to quality healthcare, including promotive, preventive, curative, rehabilitative and palliative health services, without the cost of financial hardship. The global COVID-19 experience has proved the need to revisit the requisites consisting of Target 3.8 of the SDGs, UHC, in the most practical, workable sense. Moving towards UHC requires strengthening health systems. WHO's 2007 framework describes health systems in terms of six "building blocks"- service delivery, health workforce, health information systems, accessible essential medicines, health financing, and governance [4].

Responsiveness and efficacy of the building blocks of health systems can be significantly enhanced by answering three policy questions around UHC - who is covered (questioning the extent of population coverage), which services are covered

(questioning the extension of the program to services), what amount of costs are covered (questioning the overall financial design of the said program) [4].

UHC lessons from Asia-Pacific

Asia-Pacific region is home to 60% world's population. 263 million poor live in this region on \$1.90 per day and another 1.1 billion live on \$3.20 per day. The region contributes to 41% of Under-5 deaths, 44% maternal deaths, 56% newborn deaths, 60% stunting, and 2/3rd of Low-Birth-Weight babies. The region is rapidly urbanizing with highest migrant population. The region is characterized by low spending in public health; however, some countries have made gains towards UHC by increasing public health expenditure. These measures have stood them in good stead.

Success stories from our neighbors may serve us well in understanding what, and how their UHC focused health systems may have prepared them to battle the ongoing pandemic, better. Sri Lanka, for example, armored itself with an intricate network of health facilities along with free and equal public health care including COVID-19 at the point of health care delivery. It was the lack of financial barriers, guided by a comprehensive policy of public-private pooling of funds, that enabled the country to efficiently respond to the pandemic-induced challenges. The country has also spaced separate preventive and curative healthcare sectors, with new and improved expansions at the primary level [4]. Further, the constitution of a high-level task force, using an all-of-government and whole-of-society approach to regulate the distribution mechanism of essential commodities [4], combined with due emphasis on strict lockdowns and travel restrictions, created a conducive environment for carrying out the essential 3Ts- testing, tracing, and treatment.

The Republic of Korea managed to duck the scourge due to their existing universal, single-payer National Health Insurance Scheme which covers around 97% of its total population with the remaining 3% covered wholly with government subsidies. The lessons from 2015 MERS outbreak inspired the

country to push for an early and aggressive response against COVID-19 in 2020. On the other hand, in Thailand, a UHC program covering about 75% of its population had helped reduce out-of-pocket expenses to about 11% by 2017. With COVID-19 and related expenses covered under the national social security scheme, the country did well in mitigating the adverse health impact of the pandemic. Quick responses were catalyzed with ground-level volunteers to help prevent, detect, and report infected cases, minimizing local transmissions, raising awareness, and encouraging people to comply with disease control measures. Testing laboratories were ramped up along with a creation of an extended network for public and private hospitals.

When it comes to utilizing limited resources strategically towards achieving UHC, Vietnam has made exemplary strides. With more than 87% people in Vietnam covered under national health insurance, it is the local community which has often played a crucial role in not just raising awareness but also in service delivery. With an emphasis on primary health care and with a collaborative participation of finance from public, private, not-for-profit sectors, and investments in digital technology, Vietnam has shown how best to optimize existing solutions. In its commitment to strengthen preventive care, they had been building emergency preparedness capabilities even before the pandemic [4]. They have also put the best foot forward in monitoring and evaluation of continual achievements. With fewer resources but sustained deployment of stringent containment measures with the help of military, private security services and grassroot NGOs, Vietnam proved that success comes from the strong will of the polity as well as of the community as a whole [4].

India can learn from other countries and turn its experience in battling the pandemic into a set of unique and historical opportunities.

Investing in UHC to build back better

Before COVID-19 hit, India had been making small but significant strides towards UHC. COVID-19 has adversely impacted UHC efforts with rising challenges such as insufficient funds, high OoPE, poor access, rising gender inequities, reduction in quality and efficiency of services. But there is a silver lining too. A hope for improved investment and speeding up of UHC implementation.

At this point, it would be important to highlight Astana Declaration's (2018) political commitment towards a sustainable primary healthcare (PHC) approach to UHC, given that millions of poor and vulnerable people across the globe are still deprived of essential primary healthcare. Expressing concern over the growing costs of healthcare over the years, the Declaration backed PHC as the most inclusive, effective, and efficient approach to addressing public health needs, and emphasized on preventive care to minimize burden on the existing infrastructure.

In pursuit of the commitment towards a sustainable PHC, India's Ayushman Bharat has managed to operationalize more

than 75,500 wellness centers at the primary level with a foot-fall of over 44.24 crore beneficiaries by April 2021 [4]. Health financing also saw a heartening 138% increase in the Union Budget, 2021-22, with an emphasis on the all-round approach with approximately Rs. 64,180 crores allocated to the Atmanirbhar Bharat Swasth Bharat Yojana to develop primary, secondary and tertiary healthcare systems [4].

Private sector contributes to more than 70% of the total 4.2% contribution towards health in national GDP. India must rope in private sector in its UHC campaign to improve access and increase coverage of health insurance as a measure for financial risk protection [4]. Creation of new Development Impact Bonds, alongside increasing scope for greater budgetary allocations to health can put UHC back on track.

Robust financing structures are key. Pooling funds from compulsory funding sources (such as government tax revenues) can spread the financial risks of illness across a population. While public funding is key to driving a UHC program in India, private sector emphasis will help pool funds, spread administrative costs, and improve accountability. As experience in countries like Sri Lanka and Indonesia shows, private funding can be merged with general taxation as well as social health insurance contributions to improve efficacy and expedite results. Measures to improve financial accountability should also be clubbed together with an improved system of monitoring and evaluation to measure and respond to the progress made.

Asia-Pacific experience shows that when both target populations, in terms of reaching the last mile, as well as the targeted range of benefits, are prioritized - results are more tangible. This includes improvements in existing social determinants of health, such as nutrition, environment, gender equality, water, sanitation, and hygiene. A multi-dimensional approach in conjunction with electorally important areas, including unemployment, pollution, among other social determinants, needs to be taken in overcoming challenges posed by the pandemic. Strengthening of social safety nets across verticals, for immigrants, the vulnerable, socially, and economically deprived is the need of the hour and must be facilitated as a part of the national development agenda in the next 3-4 years, including establishing service delivery systems for migrants and mobile population to prevent spread during the pandemic. It is important to save lives and livelihoods.

Tying back to the three questions around coverage, services and funds requires a strong political will. It remains at the core of fulfilling the UHC agenda. Health must be turned into an issue of the masses. Only then will any vision for UHC, manifest in reality.

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