THE ROUTE TO UNIVERSAL HEALTH COVERAGE: LESSONS FROM ENGLAND, THAILAND AND BRAZIL

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INTRODUCTION

The Planning Commission's High Level Expert Group (HLEG) on Universal health coverage (UHC) defines it as "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, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative) as well as public health services addressing the 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" (The High Level Expert Group Report on Universal Health Coverage for India, 2011). Simply put it would mean an access to affordable quality health care for all.

Affordable quality healthcare in India is a tall order when 90% of the population are employed in informal sectors and 27% of rural and 13% of urban population live Below Poverty Line (Press Note on Poverty Estimates, 2011-12, 2013). It has one of the largest public health delivery systems offering primary, secondary and tertiary levels of care at highly subsidized costs. Public Expenditure on health in India is only 1.3% of its GDP, which is one of the lowest in the world. Myriad studies have pointed out to a lack of infrastructure and drugs; shortage of space and toilets, large distances to health centres, discourteous staff and corruption in the public health systems. The above factors combined with liberal policies resulted in the flourishing of expensive private health care systems. Evidence also points to the fact that most Indians prefer availing treatment at private facilities despite the higher cost associated, due to the lack of quality care in public facilities.

Public Expenditure on health in India is only 1.3% of its GDP, which is one of the lowest in the world

In India, out of pocket expenditure (OOP) is the norm (86.4%) when it comes to health care expenditure. A recent EY report, estimates the average cost of tertiary care procedures including bypass surgery, angioplasty, neurosurgery, oncology radiation and surgery, renal and liver transplants in the range of Rs.2,00,000 to Rs.4,00,000, which is more than the annual average household income of all Indians[1]. Costs of outpatient expenditures too are high especially in cases of chronic diseases like diabetes or high blood pressure. Data from a study based on the NSSO's 61st Consumer Expenditure Survey (CSE) showed that the bulk of OOP is spent on drugs (72%), which constituted 82% of outpatient expenditure as compared to 42% of inpatient expenses. It also showed that if OOP payments were removed from either outpatient services or medicines, the number of people pushed to below poverty line reduced significantly (Shahrawat & Rao, 2012). Catastrophic Health Expenditure (CHE) is among the top 3 reasons pushing people to poverty (Wagstaff, 2005), meaning that the number of people who are vulnerable will also include those who are categorized as just above the poverty line. In the face of CHE, the poor cannot cut back on their already low expenses (Wagstaff, 2005). Frequently, they go without treatment or borrow from local money lenders at high interest rates pushing them further into poverty. It is estimated that about 6% (18 million) of the urban population in India has become impoverished due to medical expenditure (Chowdhury, 2014).

Providing coverage for health care is not a new concept in India. Government employees are covered under various schemes like the Central Government Health Scheme (CGHS), the ESIS schemes for railway employees, etc. These schemes are fairly generous in their coverage and provide outpatient as well as inpatient service coverage. These schemes have been criticized as they are plagued

[1] *http://www.livemint.com/Politics/IP9JaS-fF3W5r5wAKgI6MnM/Medical-costs-at-private-hospitals-higher-than-most-house-hol.html?utm_source=copy*

with problems of inadequate care, staff and resources; and an absence of a gate-keeper mechanism to prevent specialist consultations without referrals (Ellis, Alam, & Gupta, 2000). There is also the dual problem of moral hazard[2] and adverse selection[3] due to a lack of user fee in case of the insured and low morale compounded by low salary in case of the health staff employed. More recently, financial protection schemes have been introduced by the central and state governments. The Rashtriya Swasthya Bima Yojana (RSBY) was introduced by the central government in 2008 to provide financial protection to the BPL population. It provides inpatient coverage for a family of five with a cap of Rs.30,000 per policy year. The state governments negotiate with private insurance companies and fix a premium which covers mainly secondary level inpatient treatments, hospital stay, medicines and laboratory & diagnostic facilities for the patient during the course of the hospital procedure. The beneficiary only pays Rs.30 at enrolment while the remaining premium is paid by the central and the state government in the ratio of 75:25. Although the scheme has potential, it has been criticized for its low cap and its inability to cover outpatient services, drugs and diagnostics. The Centre for Budget and Policy Studies' (CBPS) study on the first two rounds of RSBY showed that the insurance companies were the biggest benefiters from low utilization rates of the scheme in Karnataka (Aiyar et al., 2013). There have also been reports of private hospitals making money through false claims and contracted insurance companies have delayed issuing the RSBY cards in order to reduce the number of claims (Oxfam, 2013).

Other schemes providing affordable tertiary care are also becoming popular. This includes schemes like the Yeshasvini scheme in Karnataka and the Rajeev Arogyashri in Andhra Pradesh. The Yeshasvini scheme was introduced by the Government of Karnataka in 2003. Members of all co-operative societies can be enrolled in the scheme. Each member pays Rs 210 and is covered for up to Rs 2 lakhs of treatment cost at empanelled private and public hospitals. Currently there are 37.51 lakh members and a total of 86000+ surgeries have been performed in 2013-2014[4]. The scheme has shown increase in health care utilization for surgical care among beneficiaries, although not so much for primary care especially among the lower income groups (Aggarwal, 2009). Another government sponsored scheme is the Vajpayee Aarogyashri Scheme (VAS) launched in 2009-10. It covers only the BPL population and the enrolment is free. Five members of a family can be enrolled on a family floater basis with no age limit. The scheme covers only tertiary care and currently covers 467 procedures under 7 main systemic categories. Since its inauguration in 2010, the number of beneficiaries utilizing VAS has increased from 4,095 in 2010-11 to 12,834 in 2012-13, which also coincides with the expansion of the scheme to cover the entire state. The role of private insurance in India is minimal and is limited mainly to those provided by private companies for their employees.

A study based on NSSO's 61st Consumer Expenditure Survey showed that in all central financial protection schemes available, government expenditures and benefits were the largest for the non-poor represented by the CGHS and became smaller with lesser benefits when expanded to the poor i.e. in RSBY (Gupta & Chowdhury, 2014). The schemes also focus mainly on the curative, hospital based approach as opposed to a preventive and primary care approach which could lead to decreases in health care expenditure in the long run.

This not only points to the disparities that exist in the current financial protection schemes but also to their inadequateness.

The road to making health care available and accessible to all is not an easy one given the diversity of issues faced in a developing country like India. Studying health care systems from other nations may help in building a system that can be tailored to Indian conditions.

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[2] *Adverse selection occurs when the insured deliberately hides certain pertinent information from the insurer resulting in loss to the insurer.*

[3] *Moral hazard is a situation in which the insured gets involved in a risky event knowing that he/she is protected against the risk which may result in cost to the insurer*

[4] *Source: http://sahakara.kar.gov.in/Yashasivini.html, accessed on 24.02.15*

LESSONS FROM OTHER UNIVERSAL HEALTH COVERAGE SYSTEMS

1. England's National Health Service

United Kingdom's (UK) National Health Service (NHS)[5] is in existence since 1948 and is based on the principle of equality where access to health care is based on need and not on a person's ability to pay. Hence a resident can access most health care services free of cost. The Basic health care package includes primary care, inpatient care and diagnostics free of cost. There is a fixed copayment[6] for drugs prescribed outpatient as well as a fixed payment for dentistry procedures which are all set at the national level. These copayments are relaxed in case of children under 16, women with children under age one, patients on cancer treatments and other specific chronic illnesses. Mental health services and some long term adult social care are also included within NHS.

Health Care Structure: All residents have to register with their local General Practitioner (GP) who serves as the entry point for health care. The GPs usually practice in groups and they are commissioned under a national contract as private contractors. They are paid according to the contract for services rendered as well as by performance based incentives. They serve as primary gate keepers to specialized care, thus preventing adverse selection. Specialists are all employed under NHS and most commonly practice at hospitals. Patients do not have choice in the pick of GP or specialist they get, though they may have their pick of hospitals. Most hospitals under NHS are public hospitals called NHS trusts and Foundation trusts. These are funded based on nationally set diagnosis related group rates for the services they provide. NHS also funds private sector care especially for mental health services, along with some routine elective surgery and diagnostics.

UK's healthcare system has undergone a systematic change to make it more decentralized. As part this new system, all GPs and the hospitals are all contracted under the local Clinical Commissioning Groups (CCG) that have been set up in 2012-13.These CCGs come under the National Commissioning Board (NHS England) which will act independent of the Ministry of Health and gradually take over all its charges including budgetary control of NHS.

Finances: The NHS is financed mainly by general taxation (76%) along with 18% coming out of payroll tax. It also gets additional contributions from co-payments. It spends 9.6% of its GDP on health, of which 86% is being spent on NHS alone (International Profiles of Health Care Systems, 2012). Most private expenditure is on outpatient drugs and on private hospital care which is being financed by private insurance. 11% of the population has private insurance which are part of work related benefits. The office of national statistics published that from 1997 to 2009 the average annual expenditure on healthcare in the UK grew by 8% but since the economic downturn the average annual expenditure though increasing was only at 1.6% from 2009 to 2011[7].

Age specific mortality rates have consistently decreased since 1963 to 2013 which can be attributed to the NHS[8]. The commonwealth report ranked U.K's healthcare system the highest among 11 developed countries. It was first in the categories for quality of care, access to care although it ranked low along with the U.S. on health indicators i.e. infant mortality rates, life expectancy and mortality rate amenable to healthcare[9].

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[5] *The National Health System in the United Kingdom is jointly called as the NHS although each of the 4 countries Northern Ireland, Scotland, Wales & England operates a National Health Service independent of each other. In this review we focus on the NHS in England.*

[6] *An amount fixed by the NHS to be paid on each visit for availing dentistry services, buying prescription drugs, spectacles & contact lenses and for wigs & fabric supports.*

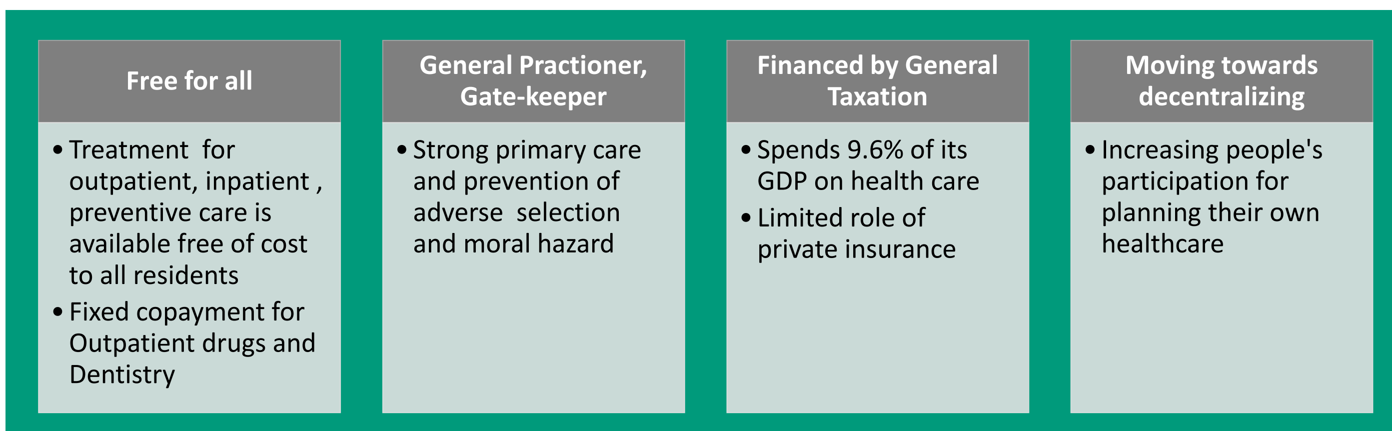
[7] *http://www.ons.gov.uk/ons/rel/psa/expenditure-on-healthcare-in-the-uk/2012/info-healthcare-spending.html*

[8] *http://www.ons.gov.uk/ons/rel/vsob1/death-reg-sum-tables/2013/sty-mortality-rates-by-age.html*

[9] *http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror*

NHS provides us proof that a strong public health system can provide the platform for allowing equal access to health care for all.

Figure 1: Features of National Health Service, England



2. Thailand's Universal Coverage Scheme

Thailand's model for achieving UHC gains importance because as a middle income country, it has been able to provide universal coverage by successfully keeping costs low. Before introduction of the Universal Coverage Scheme the Thai government had introduced the community based financing schemes in 1983 and the Voluntary Health Insurance cards from 1991 to include the informal sector to purchase a basic health package that provided primary care facilities to families of five for a fixed subsidized premium per year of 500 baht to which the government added 500 baht. Being a voluntary scheme with no pre-conditions, it faced adverse selection and moral hazard problems with the chronically ill choosing it more often than not. The scheme could recover costs from areas of high usage but it was low for hospitals especially in areas of low coverage as the utilization in these areas was higher (Pannarunothai, Srithamrongsawat, Kongpan, & Thumvanna, 2000). The scheme also has high cost of coverage for covering only 14% of the population and also required frequent campaigns for purchase of the cards. In the end, Thailand scrapped the Voluntary health cards and adopted the policy of Universal Health Coverage, based on which the Universal Coverage Scheme was introduced in 2001.

Universal Health Coverage: Thailand's insurance system consists of three parts – (1)the Civil Servants Medical Benefit Scheme (CSMBS) since 1980, (2) the Social Security Scheme (SSS) for the private employees with more than one employee since 1990, (3) Universal Coverage Scheme (UCS) for the poor and those not covered under the others. It started with a 30 baht for 30 diseases policy meaning the beneficiary had to pay 30 baht as co-payment with every visit (this copayment was removed in 2006).

Health Care Structure: The Public sector under the Ministry of Public Health (MOPH) has an extensive network of hospitals and these providers are the main providers in the rural areas. 90% of the hospitals participating in the scheme are public facilities. The Public facilities accounted for all 77% of outpatient visits and 81% of hospitalizations in 2009 (Hanvoravongchai, 2013). Private providers provide 38% of the health care services, claiming utilization of 23% in outpatient visits and 19% in inpatient visits. These are funded by the 3 schemes as well as by private insurance and out of pocket payments.

Finances: Public expenditure on Health amounts to 3% of its GDP[10]. Nearly 48 million people have been covered under UCS in 2011[11]. The providers are paid annually based on age adjusted capitation rates depending on the patient inflow at their facilities for outpatients.

[10] *http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS*

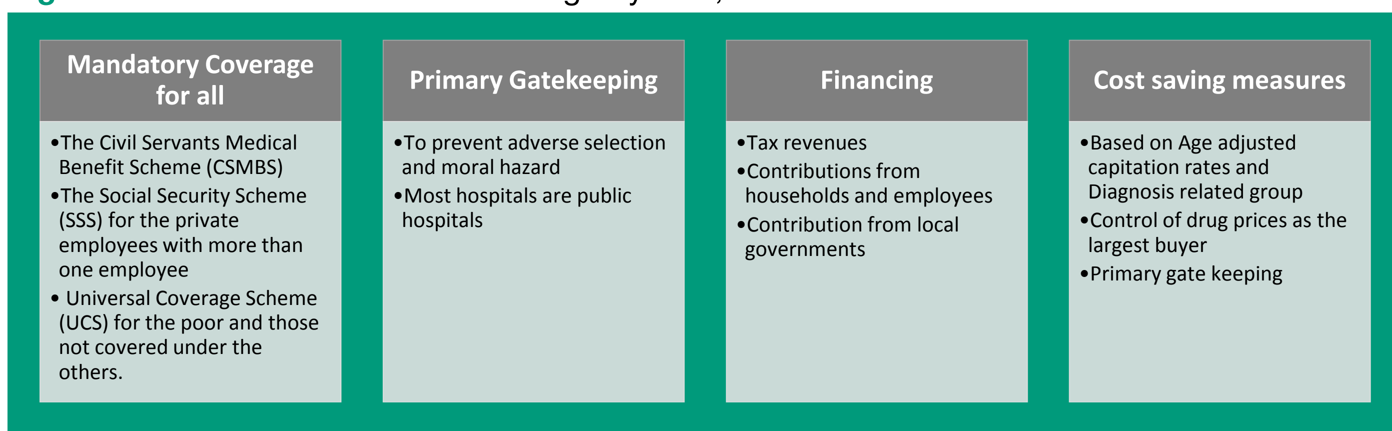
[11] *National Health Security Office(NHSO) Report, 2011*

For inpatient care, costs are calculated based on diagnosis related group (DRG) payments adjusted to global budgets. This meant that reimbursement value for one unit depended on the total units accumulated by all providers in the system. Therefore if there were more units in total across all providers, the reimbursement value for a single DRG-adjusted weight got reduced. The National Health Security Office[12] (NHSO) has also successfully brought down the cost of drugs and services due to their monopoly as the largest purchaser. It also encourages the use of generic drugs and bargains for the best prices for costly equipment and procedures. Primary gate keeping also prevented adverse selection and brought down costs further.

The UCS is financed mainly by tax-revenues. According to a paper on Health financing in Thailand, 2/3rd of the health expenditure was done by the central government, 4% by the local government and the remaining was direct contribution from households and private firms. Of this central government expenditure in 2008, the UCS consumed 25%, followed by CSMBS at 16% and 7% for SSS.

Thailand obtained Universal coverage by 2002, a process that took about 50 years starting with the CSMBS. From Thailand's experiences it can be learned that a mandatory coverage is more effective than voluntary coverage in obtaining universality. It has also been stressed in literature that sustained political commitment is essential in achieving sustained support for improvement and expansion of the program.

Figure 2: Features of Universal Coverage System, Thailand



3. Unified Health System, Sistema Único de Saúde (SUS)

Brazil's SUS was introduced in 1988 to decentralize management of healthcare and increase provision of health services. There was a need to shift from the curative-hospital based approach to preventive primary care. Its major component therefore was the primary care strategy which consisted mainly of the Family Health Strategy. The important feature in Brazil's strategy is that Brazil did not actively seek vulnerable or low income populations but concentrated on improving primary care by allowing more access or services in areas with more need (Dmytraczenko & Couttolenc, 2013). In 1995 as part of the family health approach, Brazil introduced the Community Health Agents Program (CHAP)It also defined a comprehensive package of services and basic drugs, alongside launching specific programs for the vulnerable populations. The shift to better healthcare was also helped by increased availability to water, sanitation facilities, electricity with a decrease in inequalities due to poverty and illiteracy (1995-2010)(Barreto et al., 2014).

Health Care Structure under SUS: Brazil's health care system is a mixed health system with both public and private healthcare. 70% of the Brazilian population uses mainly or only SUS for its health care

[12] *An autonomous organization that is responsible for the registration of beneficiaries and service providers, and pays the claims according to the regulations set out by the National Health Security Board.*

needs. In 1995, they also introduced the Community Health Agents Program (CHAP) which consisted of Family Health Teams (FHT). This is a multi disciplinary team that consisted of 6-10 members including a physician, a nurse, a nursing assistant, community health workers and sometimes even a dentist. A team is responsible for anywhere between 1000 to 4000 households. They serve as the entry point into the health system and it's their responsibility to register every family and monitor their health status. In addition to providing primary care and curative services they also provide referrals. Primary health care is the responsibility of the municipality governments which offer most of the primary services. Here 65% of the Outpatient care and 35% of Inpatient care is publicly provided and funded.

Secondary care is publicly funded but privately provided and accounts for 25% of outpatient consultations and 27% inpatient care. A privately financed and provided subsystem, which accounts for 25 percent of medical consultations and 38 percent of inpatient care; most of these services are funded through private insurance schemes. General hospital care is mostly supplied by the private sector, under a contract with SUS (51 percent of hospital beds and 27 percent of inpatient admissions) or under private financing (14 percent of beds and 38 percent of admissions). The private sector also provides specialized care and diagnosis. However expensive tertiary care (like organ transplant) is funded mainly by SUS and a few private hospitals (Dmytraczenko & Couttolenc, 2013). The Health care system in Brazil however suffers from poor integration in primary, secondary and tertiary services. This is due to a poor co-ordination between the public and private sectors and an ineffective gate-keeping mechanism. Although there are referral management units and referral guidelines, these have not been well enforced.

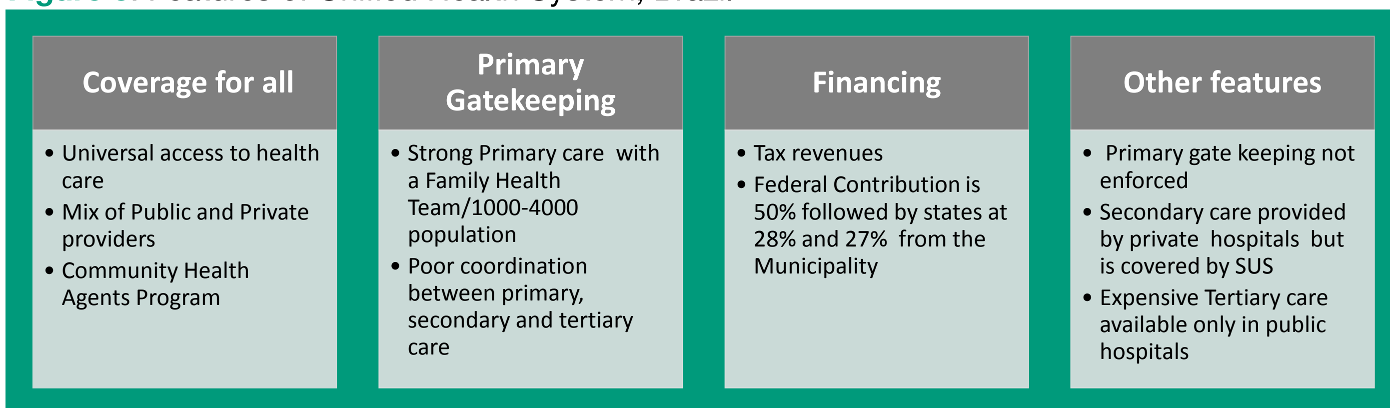
Finances: Public expenditure on health is 4.3% of its GDP[13]. SUS consists of less than 50% of total health expenditure, private insurance at 24% and out of pocket expenses at 31%. The highest contributor to SUS is through federal transfers at about 50% followed by the state and municipality contributions at 28% and 27% of their net revenues. The Federal transfers to the SUS are split into two types called the fixed per capita amount (PAB) and variable PAB. The fixed PAB is calculated based on the per capita score of the municipality which includes (per capita income, share of the population that is not extremely poor, percentage of people on private insurance and population density). Higher capita scores meant a lower fixed PAB. The variable PAB which gets a larger share of federal transfers depends on the number of Family Health Teams (FHT) in a municipality. In 2012, the variable PAB was US$ 3,500-US$ 5400 per FHT per month for 12 months while the fixed PAB came to US$ 9-US$11 per person (Dmytraczenko & Couttolenc, 2013).

SUS has improved health outcomes by reducing the facility based approach and decreased the number of costly hospitalisations. It has been commended for its strong primary care practices. However the system is fragmented and lacks co-ordination of care especially in the secondary and tertiary care levels. It has also seen a reduction in quality of care and an absence of clearer guidelines on inclusion /exclusion criteria. Due to a cap on the number of personnel that can be hired a growing number are being hired on a contractual basis. The SUS has reached a plateau in enrolment and there is a need to work on public-private options especially in urban areas with a large private representation. It has also been seen that one in five patients have to access hospitals outside their municipal area and therefore a need to improve capacity within municipalities or improve transportation options to provide easier access is seen (Paim, Travassos, Almeida, Bahia, & Macinko, 2011).

Brazil's healthcare system is an example of partnership between public and private health care providers with private providers being responsible for secondary level medical care and the government managing primary and tertiary level care. However, such partnerships are only feasible under strict regulations and primary gate-keeping.

[13] *http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS*

Figure 3: Features of Unified Health System, Brazil



The role of Private Insurance

Private Insurance is not usually the principle method of health financing and needs to be strictly regulated to provide equity in health care. In most OECD countries today, with the exception of the U.S., private insurance provides supplementary coverage to predominantly publicly funded systems. In France, for example, 85% of the population purchases private policies to pay for co- payments; while in the Netherlands over 90% of the population purchases either principal or supplementary insurance plans. In countries like the U.S, where private insurance provides principal coverage through employment insurance, it generally faces significant restrictions (Sekhri & Savedoff, 2005). Separate Medicaid and Mediclaim policies have been set-up to provide health care to the vulnerable that is the poor and the elderly. Health care cost in the U.S. is among the highest in the world, making it virtually unaffordable without insurance. Although it is claimed to have promoted improvements in technology making the U.S. the destination for medical innovations, studies in the U.S. indicate that uninsured people tend to have worse health status than those insured and receive less medical care and less timely care. It was calculated that 'approximately 44,789 deaths among Americans aged 18 to 64 years in 2005 was associated with lack of health insurance' (Hadley, Holahan, Coughlin, & Miller, 2008; Wilper et al., 2009). This also gets reflected in the fact that the Infant Mortality Rates (IMR) in the U.S. is amongst the highest when compared with European countries (MacDorman & Mathews, 2009). Most recent literature agrees that private insurance can provide support to public health insurance schemes by providing supplementary insurance to those who can afford and thus reduce the financial burden on the state, but cannot be the only or primary source of health care delivery. What is clear is that there is no alternative, but to strengthen the public health delivery system where insurance can only be used as a supplementary means for providing universal health care.

CONCLUSIONS AND RECOMMENDATIONS

Strengthening the Public Health system: India already possesses a large primary health system network strengthened by the National Health Mission (NHM) along with its newly trained ASHAs. This provides the groundwork to improve the primary health care network which should go beyond immunization visits and pregnancy care. Like in the case of Brazil, an effective primary care will in the long run reduce hospitalizations leading to lesser expenditures. Spending on primary health centres by improving facilities as well as increasing the number of staff will ease the pressure of population on the PHCs. Improvement in infrastructure is slowly underway due to availability of untied funds via

NRHM. However, the locals in many cases have limited knowledge about its availability. The Village Health, Nutrition and Sanitation Committees (VHSNC) and the Rogi Kalyan Samitis which serve as the unit of monitoring and evaluation at the village level should be given the means to help bring about change in their respective villages realizing the role of decentralization.

Free care for all: Recognizing access to health as a fundamental human right, health care at every level should be offered free of cost. The government may consider financing the scheme through general taxes like in all the three countries. Like Thailand, they can bargain for lower cost of drugs and devise a system of payment to both private and public providers based on disease groups and patient load at the clinic. As in England, Thailand and Brazil, emphasis should be on improving primary and preventive care. This should be backed up by strong gate keeping mechanisms where specialist referrals are only possible after recommendation by a general physician.

Making Inclusion of Private providers more accountable: Private providers offer the necessary bridge for services in resource poor settings where the public sector is over burdened and hence not effective. India has many examples of private–public partnerships to improve access to health care, e.g. the Thayi Bhagya Yojana in Karnataka, Chiranjeevi Yojana in Gujarat or the Janani Suraksha Yojana at the national level. This is productive in both ways as people get access to quality care when required and also smaller private clinics prosper due to increase in clientele. However, it is also important to improve the public health care service in those areas so that there is a healthy competition

and unscrupulous practices are avoided (Oxfam, 2013). Also, in areas where both private and public resources are unavailable, efforts should be made to improve connectivity by means of transport and telemedicine.

Integration of current schemes: Karnataka state alone has three different health insurance schemes run by three different trusts/managements. Studying the three schemes and integrating them to include the whole state would be the first step towards achieving universal coverage. A single scheme providing primary, secondary and tertiary level of care to all citizens should be the final goal of the scheme. Studies should be undertaken on all schemes in each state to provide a basis for a new scheme that accounts for local factors as well. The central government may lay down guidelines for the scheme but the states should be given room to make their own additions.

Role of Private Insurance: Strict laws should be in place to govern private insurance companies. As a government scheme may not be able to provide coverage for all diseases or conditions, private insurances can be offered as an add-on to people who can afford it.

Continued political support and commitment: By far the most important factor towards promoting universal coverage for all is sustained political will and commitment. This is highly evident in Thailand, where successive changes in government did not hamper or stall the progress of Universal Health Coverage Scheme. This provides evidence that politicians rose beyond party lines to ensure the success of the scheme which was accepted as the right of every citizen. In India the lack of political commitment has been observed especially in the neglect of the public health care system (Srinivasan, 2005). The need of the hour is for the people's representatives to accept every Indian's right to quality health care and to look beyond the political lines of separation to make a commitment towards achieving health care for all.

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