Opinion Article

Universal Health Coverage- A case study of Indian Healthcare System during COVID-19 Pandemic

ABSTRACT

The present study aims to describe the Universal Health Coverage (UHC) within the Indian Healthcare System during the COVID-19 pandemic. The COVID-19 has exposed the vulnerability of the health systems across the world and India is no exception. The World Health Organization (WHO) has kept the definition of UHC very flexible and has left on the country which is implementing it as to how much population and which services should be included in the scheme. India already has launched its unique flagship program where it tries to protect its population against financial hardships related to healthcare. WHO has already put forth some barriers to achieve UHC and COVID-19 is putting more pressure on those barriers and thereby increasing the gap further to achieve UHC. On the other hand, it also poses some opportunities which had not been explored in the past. Health Systems Strengthening is path towards the achievement of UHC and due to COVID-19, India has touched upon all the six building blocks which are needed to strengthen our system towards the achievement of UHC. At the end, this paper also suggests that the government should include outpatient expenses into their scheme, and they should also concentrate towards building an adequate infrastructure in order to face future pandemics like COVID-19. It should also follow a systems thinking approach in order to approach the problem holistically.

1. INTRODUCTION

The COVID-19 pandemic has exposed the vulnerability of health systems, as countries around the world struggle to cope with this catastrophe. It has showed us the gaps in the healthcare systems across the world and shows the interdependence between health security and economic security. Countries that has a made progress towards UHC were better able to handle the shocks of the pandemic. According to the World Health Organization (WHO), Universal Health Coverage (UHC) is a fundamental health right of every individual. By understanding health systems, we can develop strategies for dealing with future pandemics, thus saving millions of lives. Globally, UHC operates on two principles. First, ensuring that everyone can access the services they need and secondly, that no one experiences financial hardship while accessing these services. All countries trying to achieve UHC should incorporate these two principles. The WHO also confirms that enjoying the highest attainable standard of health is a fundamental right and not a privilege.

2. METHODOLOGY

This article is based on secondary research which includes going through both the newspaper and journal articles.

3. WHO DEFINITION OF UHC

UHC has often been misunderstood as free access to all health services for everyone. Yet, each country might have its own roadmap for implementing UHC. Therefore, the services and population covered under UHC, depend on the country and the resources at its disposal. However, UHC does emphasize access to health services and right to information as the basic human right.

4. UNIQUE FLAGSHIP PROGRAM OF THE GOVERNMENT OF INDIA

Ayushman Bharat is the flagship program developed by the Government of India (GoI) to achieve the United Nations (UN) Sustainable Development Goal (SDG) 3: Good Health and Wellbeing. This program tries to address the issues of the healthcare system holistically by covering all the preventive, promotive and ambulatory care services at primary, secondary, and tertiary care levels. It is rolled out in two inter-related parts. The first component is Health and Wellness Centres (HWCs) which cover primary healthcare settings. The WHO has already highlighted the need to invest into Primary Health Centres (PHC). India's plan to develop 150,000 HWCs by transforming existing sub-centres and primary health centres shows us its investment in PHCs [1]. These facilities cover all essential services like child and maternal health services, non-communicable diseases, essential medicines, and diagnostic services. They also counsel communities on choosing healthy behaviours and making adjustments to reduce chronic disease risk factors.

The second component of this program is Pradhan Mantri Jan Arogya Yojana (PM-JAY), which mainly covers secondary and tertiary hospitalization care treatments for the bottom 40% of the population, equivalent to approximately 107.4 million poor and vulnerable families. It aims to provide a cover of 500,000 rupees per family on a floater basis. PM-JAY is also termed the world's largest insurance plan which is fully funded by the government. It has also tried to cover various ailments by developing around 1300 packages for the people [1]. These two components of the scheme try to cover all the parts of the healthcare delivery pyramid.

5. IMPEDIMENTS TO ACHIEVING UHC DURING COVID-19

The WHO has put forth three impediments to the achievement of UHC. The first one is availability of resources [2]. India faces a severe shortage in medical professionals. While the recommended doctor to patient ratio by the WHO is 1 per 1000, India only has 0.62 per 1000. COVID-19 further increases the pressure on our healthcare workers, according to a study done on Healthcare Worker's (HCW) in India during COVID-19 showed an increase in burnout amongst them during the pandemic. The doctors were 1.64 times more likely to suffer pandemic related burnout [3]. This clearly highlights the further stress COVID-19 is putting on the scarce resources.

The second barrier is dependence on direct payments, which includes OTC (Over The Counter) medicines and fees for consultations [2]. Though the plan attempts to protect people from catastrophic expenditures, which arise due to hospitalization, it does not cover outpatient (OPD) expenses. According to the health ministry's household health expenditure, half of the out of pocket expenditures comes from OPDs purchasing medicines and hospitalization which covers only one-third of the total out of pocket expenditure [4]. People are not able to access OPD services due to the fear of contacting the COVID-19 virus, thereby increasing morbidity and mortality due to non-COVID-19 cases. This will also increase the out-of pocket expenditure in non-COVID-19 cases therefore leading to an increase in private expenditure [5]. COVID-19 can therefore be coined as syndemic which is putting twice the amount of pressure on healthcare systems where there is an increase in expenditure due COVID-19 and non-COVID-19 related cases.

The third barrier described is the inefficient and unequal use of resources [2]. Many states do not have appropriate facilities to cater to the needs of the people in their areas. Therefore, states empanel hospitals outside their state, which illustrates the inequitable distribution of resources between them [6]. COVID-19 further increases the pressure on the already overwhelmed health systems as only few hospitals out of the empanelled hospitals will be available for COVID-19 treatment. It has also been reported that 50% of the household expenditure on medicines is spent on unnecessary medication and diagnostic services [7] which shows inefficient use of resources. Isolated beds is one of the main requirements for the COVID-19 patients and there is a huge disparity amongst the states with this regard. The number of beds per 1000 persons in Andhra Pradesh, Madhya Pradesh and Tamil Nadu

are 0.43, 0.36 and 0.41 respectively which shows a comparatively better scenario when compared to states like Karnataka and Bihar which have a ratio of 0.02 and 0.02 respectively [8]. Issues like inequitable distribution of resources and inefficient use of resources further increases the burden of this pandemic inequitably amongst some of the states which are already worse off.

6. LESSONS LEARNED DUE TO COVID-19 PANDEMIC

COVID-19 possess a “window of opportunity” for the UHC which has not been taken seriously from a very long time. Health Systems Strengthening is a pathway towards the achievement of UHC, and this pandemic has touched upon all the six building blocks (Service Delivery; Healthcare Workforce; Information; Financing; Leadership/Governance; Medical Products, vaccines and technology) which were being ignored from a very long time. Due to this pandemic, there have been many innovations and uptakes which were previously not being taken in order to strengthen the healthcare system.

Service delivery was severely affected due to the pandemic. Many elective surgeries and visits were delayed in order to contain the disease. Telemedicine which was already present from a very long time has been appropriately embraced during this period. The government has launched e-sanjeevni OPD, a national teleconsultation service which has been made mandatory for healthcare providers. The Indian Medical Association is also issuing advisory against telemedicine consultation [9]. Therefore telemedicine is able to provide consultation to those who are in need of it and is also solving the problem of accessibility. People who do not have access to healthcare workers because of the concentration of doctors in urban areas, telemedicine also solves the problem of less workforce to some extent.

Several steps and innovations have been taken in order to combat the issue of doctor shortage during the COVID-19 pandemic. Telemedicine has been able to solve the problem of accessibility and saves our scarce workforce from the COVID-19 pandemic. During the initial phase of the pandemic there were discussions around including fifth-year medical students into the workforce in order to combat the shortage of doctors in India [10]. Though these measures are good in the short run, they do not solve the problem of scarcity of doctors. Consequently, the decision to open new medical colleges have been much appreciated, and in the last three years 47 medical colleges have been recognised [11]. These initiatives which were earlier not acknowledged as being important have been highlighted properly during this pandemic.

The new COVIN App developed by the Ministry of Health is another milestone in the area of mHealth. This app touches upon two of the six blocks which is Information and Medical Products, Vaccines and Technology. The app has been developed by the centre where it will track distribution, procurement, circulation and storage of vaccine. It will help authorities to access data in real time, and decide who has to receive a shot on based on priority and who has already received it [12]. COVIN App is one such example where technology came into place for vaccine rollout. There have been other technologies also which are into this space after COVID-19 pandemic has hit the Indian systems. Arogya Setu App, Rapid Testing kits, digital kiosks in villages for people who do not have access to mobile devices, etc., are some of the other technologies which have been embraced at the user end to combat this pandemic which were not previously embraced by the citizens.

In 2017, India came up with a National Health Policy which aims to establish public health cadre in all the states. Its progress has been limited due to lack of political will, absence of a public health cadre at the central level and opposition of clinicians who feel threatened by the shift in their administrative powers. COVID-19 highlights that there is a need for strong public health leadership and governance and thereby touching upon the leadership/governance block. A reliable system will help us track infectious diseases, and can also give early signs on disease outbreak [13]. Post this pandemic, this cadre will help us in planning healthcare resource allocation, set up laboratories for testing, and they will also keep an eye on the changing situation so that we can have early warning for any outbreak [14]. Thereby, a strong public health cadre is needed in all states and its importance has been highlighted through this pandemic.

Increased financing of healthcare in India does not need any explanation, as the Government spends only 1.2% of GDP which highlights the need for a considerable increase in the budget. Less spending by the Government leads to less infrastructure to deal with diseases. Thus, this leads to an increase

in infection rates. India itself has a very fragile healthcare system where states have unequal distribution of resources leading to some of the states being worse off. There have been talks in the parliament where the government is planning to increase the budget to 2.5% of the GDP in a phased manner[15]. Therefore, COVID-19 has highlighted the much-needed increase in healthcare budgets which was pending for a very long time.

7. CONCLUSION

Health has been called a human right, therefore, establishing UHC is necessary for every country to achieve this right for its citizens. What is included in UHC is entirely dependent on the specific services and population a country wants to include in its plan. Though India has made progress, the Government should also cover outpatient expenses which form an integral part of out of pocket expenses for the Indian population. The Indian Government lacks the infrastructure and medical staff necessary for the delivery of healthcare. To address this issue, India should try to build additional medical institutions with the aid of the private sector, so that medical staff can receive adequate training and the country can cater to the health needs of the area. These are the necessary steps which should be taken by the Government in order to strengthen our healthcare system from future shocks to the system like COVID-19.

These are some of the issues and lessons which are being posed by this pandemic. As these problems cannot be solved in silos, a systems thinking approach has to be followed. It centres around the dynamic interaction and integration of people, processes, and technology. Systems thinking helps us to identify critical relationships and connections which are often ignored or undervalued during an implementation process [16]. This approach will help us reform the healthcare delivery system as well as assist the healthcare organisations with decreasing complication and unexplained practice variation between the organisations.

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