MASTER OF PUBLIC HEALTH

A cooperative Program of

JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH
&
INDIAN INSTITUTE OF HEALTH MANAGEMENT RESEARCH

Capstone Project at IIHMR University

Jaipur, India

By

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2013-2015

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'Transition towards Universal Health Coverage in India'

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Under the guidance of

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TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr Geetanjali Kapoor, student of Master of Public Health (Program offered by Indian Institute of Health Management Research, Jaipur in cooperation with Johns Hopkins Bloomberg School of Public Health, Baltimore), has undergone Capstone training at 'Indian Institute of Health Management Research, Jaipur' on the topic 'Transition towards Universal Health Coverage in India' from 1st June 2014 to 19th September 2014.

She has successfully carried out the study designated to her during Capstone training and her approach to the study has been sincere, scientific and analytical.

The Capstone is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

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IIHMR, Jaipur

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CERTIFICATE BY SCHOLAR

This is to certify that the Capstone Project titled **'Transition towards Universal Health Coverage in India'**. and submitted by **Dr Geetanjali Kapoor**, Enrollment No 2, under the supervision of Professor Barun Kanjilal, for award of **Master of Public Health,** and carried out during the period from 1st June 2014 to 19th September 2014, embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institutions of higher learning.

Geetanjali Kapoor

Signature

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Reflection

Reviewing literature while working on my Capstone titled 'Transition towards Universal Health Coverage in India', immensely enhanced my knowledge on the deficiencies with the existing health systems in India. I understood the intricate linkages amongst Health Policy, Ethics and Human Rights; how societal inequalities manifest as health inequities; and the role of health policy in ironing out these deficiencies.

My work provides a glimpse on India's health performance for over five decades, and the hindering factors on its road to progress. Despite mega programs and projects, India rests on a weak framework which pulls it back, time and again, in achieving its targets. While many fronts need to be corrected, the priority must always be towards reducing the inability of an average Indian in accessing quality health care. The world talks about 'Universal Health Coverage' today instead of 'Health for All' and India too has joined the 'league'.

My report, brief yet lucid, has a strong emphasis on importance of breaching the unjust inequities that clash with the concept of 'Human Rights' and the need to rectify the same with healthy policies as the 'Universal Health Coverage'.

Abstract

The journey of the world's second most populated nation, on the road to improve the health of its people, has been not without its own challenges. India has invested in various programs and policies addressing basic health issues including poor maternal and child health, spread of communicable diseases, unsafe water, poor sanitation and lifestyle diseases. Intensive planning has gone into infrastructural up gradation and expansion of primary healthcare facilities. International declarations like the Alma Ata and Millennium Declaration have not only provided an external thrust to the ongoing health activities but also shed light on existing deficiencies in the health systems. India, like most other countries, failed to attain the lofty target of Health for All by 2000 AD. It also kept a slow pace while trying to attain the Millennium Development Goals of 2015. Existing gaps in availability, accessibility, affordability and quality of health care have resulted in poor health outcomes. With the realization that inequity continues to be pervasive in the Indian health systems, India has recently shifted its priorities towards achievement of Universal Health Coverage, as a building block for realizing Health for All. The underlying theme for Universal Health Coverage is 'equity', thereby implying that everyone must have a fair chance to access basic set of quality health services with financial protection.

The mid-2014 has also witnessed a change in India's leadership to a more people centric governance. It is a matter of time that shall unfold how India develops and implements the right strategies to ensure progress on the road to its new goal, Universal Health Coverage.

Contents

1. INTRODUCTION

1.1. Introduction

Achieving‘Universal Health Coverage’ is one of the current priorities on the Indian health agenda.[1,2]The concept has gained a fast momentum in recent times, with most of the western world having some form of Universal Health Coverage on the one hand, and the developing nations taking steps towards its achievement, on the other.[3] World Health Organization has defined Universal Health Coverage as “ensuring that all people can use promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship”.[4]Dr Margaret Chan, Director-General, World Health Organization stated, “[Universal Health Coverage is] is the most powerful unifying single concept that public health has to offer, because you can realize the dream and the aspiration of health for every person irrespective of what class you belong to, whether you are a woman, or whether you are poor”.[5(p879)]

Unfulfilled achievement of the Alma Ata ‘Health for All’ goal by 2000 AD brought to light various shortcomings of health-care delivery such as inverse care,impoverishing care, fragmented care, unsafe care and misdirected care.[6] According to the World Health Report2008,[6] refocusing of the health systems towards the lofty ‘Health for All’ goal implies essential primary health care reformscovering four areas namely universal health coverage, service delivery, leadership and public policy. Universal Health Coverage (UHC) reforms seeks to breach inequity in the health systems, which otherwise tend to gravitate naturally towards inequity.[6,7]Strategies adopted for ensuring an improved coverage in the poor and marginalizeddepends on underlying settings, specific for each country.[7] For India, UHC is a

new goal that has been adopted under the Twelfth Five Year Plan (2012-2017) with progress expected to be unfolding over the next few years.[1]

1.2. Objectives

1. To identify gaps between the expected and actual health outcomes, resulting from various national health initiatives adopted by the Indian government, since post- independence times through the 2000s.
2. To identify the challenges faced during implementation of the national health initiatives, targeted towards realization of 'Health for All' and 'Millennium Development Goals'.
3. To identify the circumstances that lead to adoption of the newer goal of achieving 'Universal Health Coverage' by the Government of India.

1.3. Outline

This is a review of changing focus of health goals for India from 'Health for All' in the 1980s and 1990s, towards UHC in 2012, owing to realization of inherent weaknesses with the health systems in the country as well as under the influence of global developments in public health. It also briefly describes the progress in the Indian health sector for the second half of the last century and for over a decade in the new millennium.

The progress has been discussed in 3 phases:

1. An older phase spanning the fifty three years of post-Independence (1947-2000)
2. A second phase coinciding with the Post Millennium Declaration period (2001-2011).
3. A third phase commencing with the Twelfth Five Year Plan (2012-2017) and adoption of the new health goal of Universal Health Coverage.

2. METHODOLOGY

Online databases such as PubMed and Science Direct were searched to identify origin of the concept of Right to Health, Health for All and Universal Health Coverage. Articles published in peer-reviewed journals, news clippings, technical briefs, World Health Reports, World Health Statistics, Five Year Plans (Health) of India, High Level Expert Group (HLEG) report on health and National Family Health Surveys (NFHS) publications have been good sources of information while writing this paper. Citing Medicine (NLM Style guide) has been referred for compiling the list of references.Key words used were Health for All, Indian Constitution,Universal Health Coverage, Human Rights, health indicators and health financing schemes.

As India is yet to develop robust health management information systems which can provide centralized linking of health data, the actual assessment of its health outcomes is largely determined by the available data sources. These include the Five Year Plan reports, Census, Sample Registration Systems (SRS) and NFHS, although they too are conflicting at times. For the purpose of this review, maternal and infant mortality indicators from NFHS and Five Year Plans (Health) have been considered as measures of population health, quality of public health services and drawing various justifications and comparisons.

3. HEALTH – STATE SUBJECT IN INDIA

The year 1947 was a turning point in the history of India, as the country attained independence from the British colonial rule. The Indian Constitution was framed after an exhaustive review of the contemporary literature and previous legislations. Unfortunately, the 'Right to Healthcare' is not spelt as a 'Fundamental Right' in the Indian Constitution,[8] thereby weakening the Indian citizen's claim on 'Health'. Central and state governments, the Indian parliament and state legislatures have a prime duty towards improvement of public health. State governments also have autonomy in decision making on health related issues since 'Health' is a 'State' subject in the Indian constitution.[8] The Planning Commission of India was the coveted institution since 1950 for formulation of the national Five Year Plans for all sectors of growth and development for India, until recently.[9]

4. PROGRESS IN THE INDIAN HEALTH SECTOR DURING POST-INDEPENDENCE UPTIL 2000 AD (1947- 2000)

The initial few Five Year Plans for health sector during the period 1950s to 1970s, primarily focused on improving maternal-child health, population stabilization, infrastructural development and expansion, national communicable disease control programs and human resource development for improvement in public health.[10,11] India launched its Family Planning program[12] in the early 1950s, the first developing country to do so, and in 1975 established the Integrated Child Development Services (ICDS) program, the world's largest early child development program[13,14]under the Ministry of Women and Child Development. The Expanded Program of Immunization which was started in 1978, was modified to the

'Universal Immunization Program' in 1985 with an objective to increase coverage and reduce mortality against the six vaccine preventable diseases by 1990.[15]

4.1. Alma Ata Declaration and 'Health for All'

The year 1978 has been etched in the history of Public Health with the 'Alma Ata Declaration' guiding nations to strengthen their primary health care in order to achieve 'Health for All' by 2000 AD.[16] It was indeed a major international influence which saw restructuring of India's rural health infrastructure, revision in criteria of manpower for different health facilities, capacity building of multi-purpose health workers, re orientation of medical education and popularization of traditional systems of medicine.[11] Village health committees, institutes of local self-government, voluntary and non-governmental organizations were promoted for strengthening grass root level collaborations. In 1996, various child health programs such as the Oral Rehydration Therapy (ORT) program, the Universal Immunization Program and the Child Survival and Safe Motherhood Program were integrated with the Reproductive and Child Health Program.[17]

4.2. Health outcomes for the period 1947-2000

The efforts undertaken by the Indian government between 1947 until 2000, resulted in an overall improvement in health indicators as reflected in declining cases of malaria, filaria and leprosy cases; lowering of infant and crude mortality rates and a rise in life expectancy.[18] A major achievement that complemented the ongoing disease control efforts was the eradication of Small Pox from India in 1977.[19] Table 4.1 provides a brief illustration of the changing trends in the important health indices for the period 1950-2000.[18]

Table 4.1

Changing trends in Health indices for period 1947-2000[18]

Health Indices	1951	1981	2000
Infant mortality rate (per 1000 live births)	146	110	70
Crude birth rate (per 1000 mid-year population)	40.8	33.9	26.1
Crude death rate (per 1000 mid-year population)	25	12.5	8.7
Life expectancy	36.7	54	64.6
Malaria cases (in millions)	75	2.7	2.2
Leprosy cases (per 10,000 population)	38.1	57.3	3.74
Doctors (allopathic)	61,800	2,68,700	5,03,900
Nursing personnel	18,054	1,43,887	7,37,000
Dispensaries & Hospitals	9209	23,555	43,322
Subcenters, Primary health centres, Community health centers	725	57,363	1,63,181
Beds	1,17,198	5,69,495	8,70,161

Source: Tenth Five Year Plan (2002-2007) for India (Reference no 18)

Unfortunately, success of various health initiatives was not at par with the intensive efforts put in by the Indian government and like most LMICs, India failed to achieve 'Health for all' goal by 2000 AD. According to the National Health Policy 2002,[20]the reach and quality of public health services was below the desirable standard and the annual per capita public health expenditure was also inadequate. Survey reports such as the NFHS which are conducted nation-wide on representative household samples, as a collaborative project between International Institute of Population Sciences (Mumbai, India), ORC Macro, Maryland and the East West Center, Hawaii, provided valuable information on various health outcomes.

Table 4.2

Differentials in Infant Mortality Rates and Under 5 Mortality Rates, over selected socio-economic, demographic and residential characteristics[21,22,23]

	Infant Mortality Rate	Under 5 Mortality Rate
Socio-economic characteristics		
Level of mothers education		
Illiterate	69.7	94.7
10-11 years complete	36.5	40.0
Religion		
Hindu	58.5	76.0
Muslim	52.4	70.0
Christian	41.7	52.8
Wealth Index		
Lowest	70.4	100.5
Highest	29.2	33.8
Demographic characteristics		
Birth Order		
Birth order 1	64.1	74.8
Birth order 4-6	61.9	85.6
Mother's age		
<20	76.5	95
20-29	50.4	65.5
30-39	56.4	80.6
40-49	72.1	106.7
Residence		
Rural	62.2	82.0
Urban	41.5	51.7
Total	57.0	74.3

Source: NFHS-3 (2005-2006) Survey Report (Reference no. 21,22,23)
(Information is for 5 year period preceding the survey)

According to NFHS-3 2005-2006 survey, for the 5 year period preceding the survey (and hence prior to NRHM efforts), Infant and Under 5 Mortality rates showed differentials across socio-economic, demographic and residential characteristics.[21,22,23]Progress towards achieving safe motherhood goals for India as a whole, revealed that only 15 percent of mothers had received all recommended types of antenatal care, 38 percent of deliveries took place in a health facility and 47 percent of deliveries were assisted by health

personnel.[24]Concerns such as availability of providers, distance from health facility, need for transportation and cost of services were the common problems for women while accessing health care.[25] Worse still, the national average on vaccination coverage rate for all basic childhood vaccinations was less than 50 percent.[26]

The survey also revealed presence of socioeconomic, demographic and geographic differentials for a variety of other health indicators such as access and utilization of health care services, service coverage, health seeking behavior, nutritional disorders and the prevalence of tuberculosis and HIV.[27] The southern and western Indian states consistently performed better on most health indices than the rest of the country.[1,24,27]Variable performance of the health indicators across socioeconomic, demographic and geographic characteristics brings to light probable gaps in service coverage and service utilization across societies and residence. A mismatch between 'the need for services' and 'access to services' implied an inequitable situation.[7]

5. PROGRESS IN THE INDIAN HEALTH SECTOR DURING THE POST-MILLENNIUM DECLARATION PERIOD (2001-2011)

With the turn of the century, United Nations Millennium Declaration[28] established eight Millennium Development Goals (MDGs), to eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and tuberculosis, and ensure environmental sustainability. Specific indicators were utilized in order to monitor country progress with effect from 1990 and towards achievement of stated targets by 2015.

5.1. National Rural Health Mission

In order to expedite its progress toward achieving the Millennium Development Goals and improve the availability and accessibility of quality health care in rural areas, India launched the 'National Rural Health Mission' (NRHM) in April 2005. NRHM was a flagship program of the United Progressive Alliance government and a major investment for the Indian Public Health that built upon the failure of the previous health programs and initiatives. The Mission was envisaged for a seven year period from 2005 to 2012.[29] NRHM reflected the commitment of the Government of India to provide affordable health care services for the rural population. Gears shifted from a vertical disease specific program approach to program merging and resource pooling at national, state and district levels.

There was integration among various national disease control programs and of the ICDS with the Mid-day meal schemes. Capacity building of eligible local women as 'Accredited Social Health Activists' (ASHAs) to create awareness on importance of essential obstetric care, institutional deliveries, immunization and nutrition was an important component of NRHM.[30]There wasan emphasis on evidence based, integrated case management of common childhood illnesses through the Integrated Management of Neonatal and Childhood Illness (IMNCI) strategy; Home-Based Newborn Care (HBNC) was implemented in high focus states and Infant and Young Child Feeding practices were promoted.[31]Janani Suraksha Yojana (JSY) or Safe Motherhood Scheme, an incentive based and conditional cash transfer scheme was an important strategy to promote institutional deliveries for reduction of maternal and infant mortality. Availability of untied funds at primary health care levels, decentralization of power from state to local governments and mainstreaming of traditional Indian systems of medicine with the healthcare system were the other pillars of NRHM.[30]

5.2. Health performance and roadblocks for the period 2001-2011

Despite being a major health initiative, for NRHM to cater to rural population of the second most populous country and spread over states, many of which were larger than most world countries, was not without its own difficulties. The good news was that according to the MDG India Country Report[32] disease control efforts of Revised National Tuberculosis Control Program, National Vector Borne Disease Control Program and the National AIDS Control Programs had contributed to decline in morbidity and mortality during period 2000 - 2012 period. A landmark achievement in 2014 was the official certification to India by the WHO for its 'Polio Free' status, and also reaffirmed faith on the efforts of the community health and grass root level workers.

JSY schemes under the NRHM were successful in promoting institutional deliveries.[33,34] According to SRS Report of 2011,[35]MMR declined from 301 to 212 per 1 lac live births and IMR also dropped from 68 to 50 per 1000 live births during 2000- 2009 period (Table 5.1).

Table 5.1

Changing trends in Health indices towards attainment of MDGs[35]

Indicator	2000	2005	2009	MDG Target by 2015
MMR	301 (2001-2003)	254 (2004-2006)	212 (2007-2009)	109
IMR	68	58	50	28
U5MR	85	77	64	42

Source: SRS data- 2011

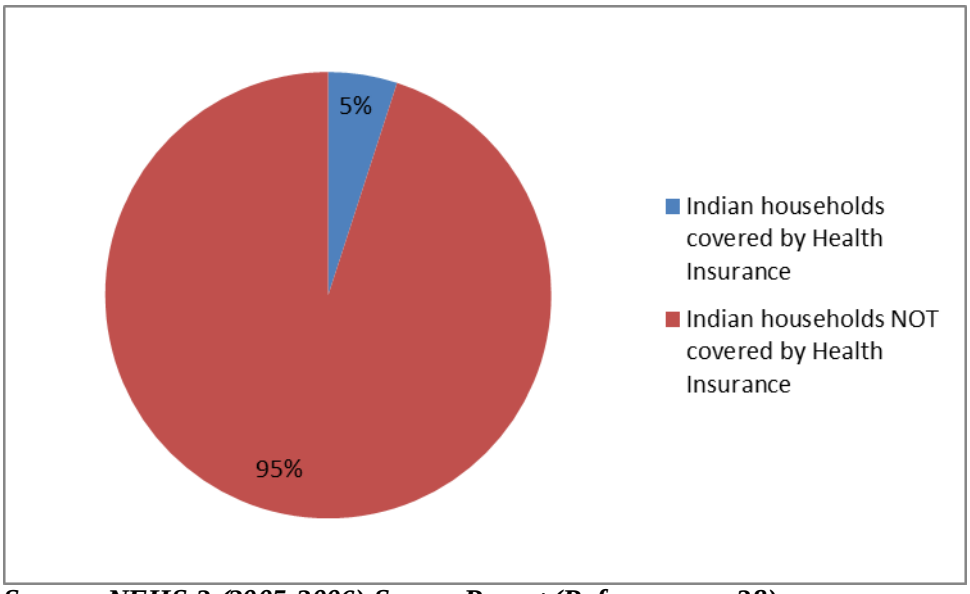
Yet, progress towards attainment of the desired country specific targets of the MDG 2015 goals was at a slow pace.[1] An MMR of 212 and IMR of 50, were way behind the MDG targets of 109 and 28 respectively.[1] According to the World Health Statistics 2010,[36] density of physicians and nursing personnel (including midwifery) for the period 2000-2009 was estimated at 6 and 13 per 10,000 population respectively, which were grossly low as compared to the developed countries. India also had a high number of unqualified medical practitioners or 'quacks' in the private health sector.[37] Ill-defined regulatory standards for public and private hospitals had encouraged corruption and malpractice in the health sector.[37]

Poor affordability of the health care services was another weakness in the Indian health system. Majority of Indians did not have a health insurance.[38] According to the third NFHS(2005-2006) report,[38]only about 5percent of Indian households (10 percent urban and 2 percent rural) were covered under health insurance (Figure 1). Since most Indian families were not protected by the existing health insurance schemes, the common Indian citizen had to choose between paying out of pocket or not accessing the healthcare.

India's share of GDP on health is low (Figure 5.2).[1,39] According to the Twelfth Five Year Plan (2012-2017),[1] India's public health expenditure on core health, as a percentage of the Gross Domestic Product (GDP), for the Tenth (2002-2007) and Eleventh (2007-2012) Five Year Plan, was 0.94 percent and 1.04 percent respectively. According to World Health Statistics 2014, for India, private expenditure was 69.5 percent of the total health expenditure, with over 80 percent being borne out of pocket (Figure 3 and 4).[39]

Fig 5.1

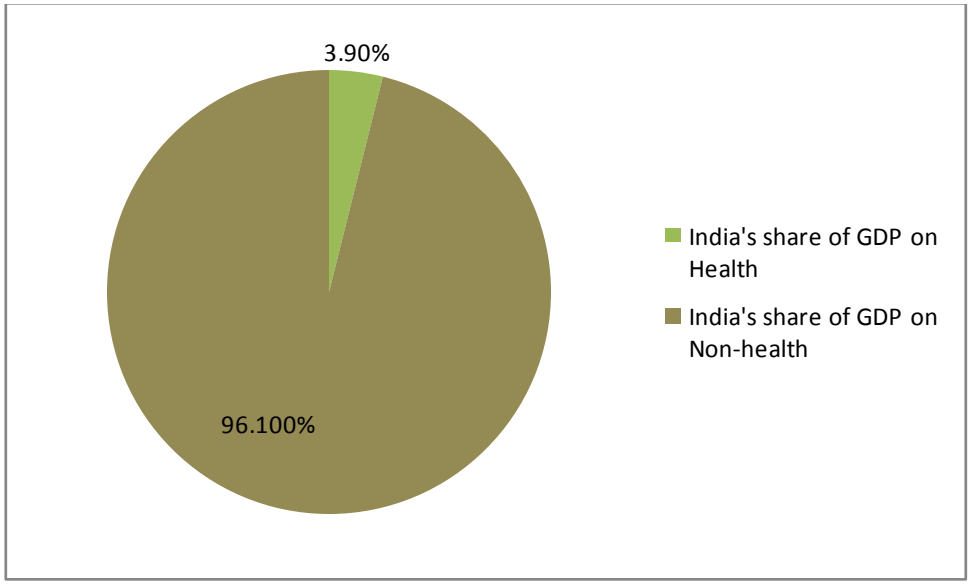
Health insurance coverage in Indian households[38]



Source: NFHS-3 (2005-2006) Survey Report (Reference no. 38)

Fig 5.2

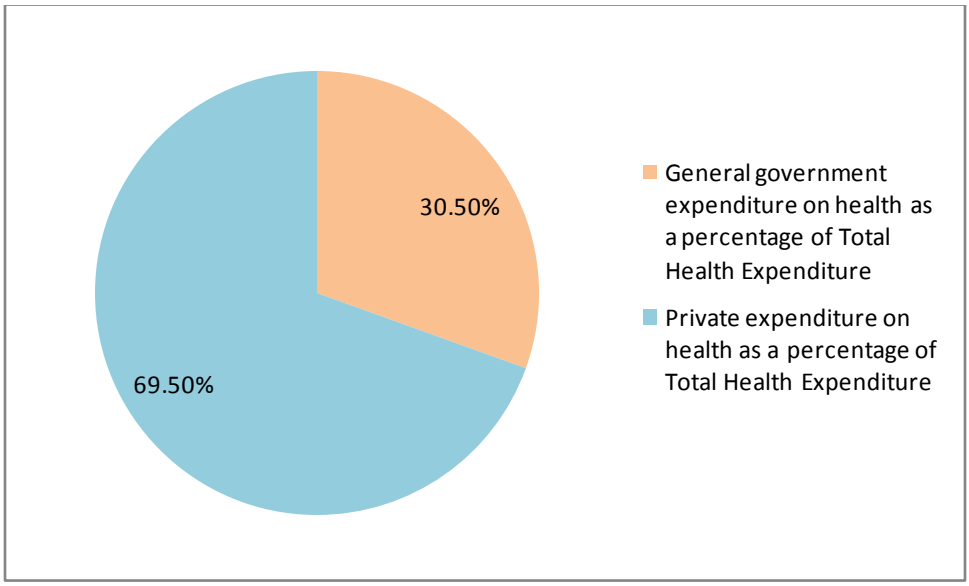
India's share of Gross Domestic Product on Health and Non-health[39]



Source: World Health Statistics(Reference no. 39)

Fig 5.3

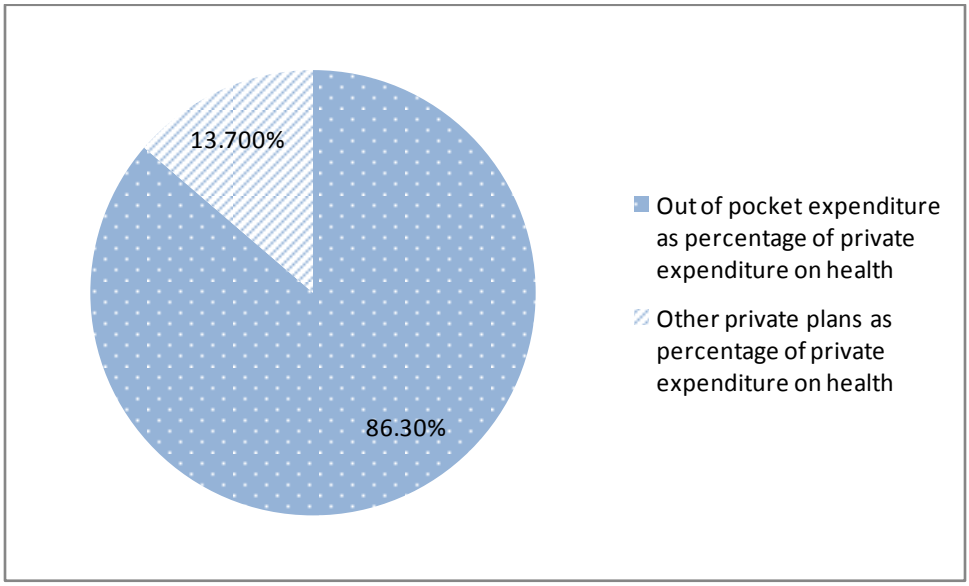
India's share of Gross Domestic Product on Health and Non-health[39]



Source: World Health Statistics (Reference no. 39)

Fig 5.4

Private expenditure on Health[39]



Source: World Health Statistics (Reference no. 39)

6. TWELFTH FIVE YEAR PLAN PERIOD AND ADOPTION OF UNIVERSAL HEALTH COVERAGE: A NEW DIRECTION TO HEALTH

Equity which implies that 'access to services' should be at par with the 'need for them', does not happen naturally.[7]Rather, health systems tend to gravitate towards inequities with superior health services getting better provided and utilized by the more well-off than the weaker sections.[6,7] That the health services in India were inequitable and 'access' was not at par with the 'need' was evident by the socioeconomic, demographic and geographic differentials which existed for various indicators such as mortality, morbidity, health seeking behavior, insurance coverage and service utilization.[21-24,26-27,29,40] An out of pocket expenditure of 86 percent[39] was undoubtedly a costly affair for an Indian without health insurance coverage.

In an interview published in a national daily, Professor Amartya Sen, Noble Laureate and Professor of Economics and Philosophy at Harvard University stated,"Basically any self-respecting country has regarded this [health insurance coverage] to be a primary responsibility of the government".[41]Unfortunately, India is deficient in 'Right to healthcare' legislation and hence majority of the Indians do not have a financial risk protection from the government.[8,38] The consequences are grim as it leads to a choice between bearing the health cost out of one's pocket, or not seeking the treatment all together. As published in another national daily, Professor Devi Shetty, renowned cardiac surgeon and Chairman of Narayana Hrudayalaya, remarked,"Act [Right to Healthcare] is needed in healthcare services too which guarantees healthcare to even poor".[42]

Yet, until the same comes into being, the Indian government has moved on the path towards Universal Health Coverage in an attempt to improve access to health services and bridge the health inequities. The new goal also shows India's commitment to protect 'Health as a Fundamental Human Right', as enshrined in the WHO Constitution[43,44] and not letting it get denied based on the socioeconomic, demographic or residential characteristic of an individual.

6.1. Universal Health Coverage: A foundation to 'Health for All'

'Universal Health Coverage' is a step towards bridging the health inequities since it ensures that everyone has a fair access to essential and quality health services, along with financial protection. According to Rodin and Ferranti, [3] UHC may be better considered as the 'third global transition', after the first demographic transition and second epidemiological transition, which brought about improved sanitation and large scale control of communicable disease control respectively. Different countries have adopted different strategies to move towards UHC, based on their existing health systems and values.[3] According to Gwatkin et al,[7]in order to ensure a near realization of UHC,it is essential to improve 'coverage' in the poor instead of simply improving the 'population average coverage rate'.

World Health Report 2008 mentions thatUHC by itself cannot eliminate 'health inequities' and 'inequalities'[6,45] but it can certainly lay a framework for getting closer to equity and Health for All.[6]The report also states best practices while moving towards UHC include emphasis on pre-payment from the start, pooling of funds and combination of the multiple insurance schemes in the country. The World Health Report 2010 suggests exploring of various domestic options for financing health may include levies on profitable companies, currency transactions, tourism tax, excise tax on unhealthy food, sin tax and diaspora bonds.[47]

Efforts must also be made to reduce leading causes of 'inefficiency' such as 'wastage owing to medication' by use of generics and adherence to transparent logistic practices.[48] For India, it is as much essential to build professional regulatory and trust based bodies to check the growing healthcare malpractices.[37]

6.2. Initiation of Universal Health Coverage in India

Indian health planners and experts took their first official step toward 'Universal Health Coverage' by incorporating it as a long term objective within the current 12th Five Year Plan.[1] The High Level Expert Group (HLEG) on Health, a respected stakeholder for India's health planning, have defined 'Universal Health Coverage' as "Ensuring equitable access for all Indian citizens 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 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".[1]

6.3. Strategies for Universal Health Coverage in the Twelfth Five Year Plan

Considering the facts that more than 30percent of Indians live on less than $1 per day,[49] majority of Indians are uncovered by the existing health insurance schemes[38] and out of pocket expenditure are more than 60percent of total health expenditure,[3,39] strategies need to be worked out to ensure that health services are not denied to anyone on grounds of their inability to pay.

The Twelfth Five (2012-2017) Year Plan for Health envisages various key elements as part of the strategy towards achievement of UHC in India.[1]These include:

a. expansion and strengthening of a good quality, affordable and accessible public health sector to meet the health needs of rural as well as urban areas;
b. need for an increase in health sector expenditure by center and state governments by the end of 12th Five Year Plan;
c. redesigning of financial and managerial systems for more efficient utilization of resources and achieving better health outcomes as well as encouraging cooperation between public and private sectors by mechanisms such as contracting out while ensuring quality and transparency;
d. reforms in the current Rashtriya Swasthya Bima Yojana (RSBY) to cover entire population which is below poverty line and do away with "free-for-service" mechanism;
e. increase in health personnel by expansion of medical schools across especially in under-served states as well as extra recruitment of paramedical and community health workers;
f. holistic health systems approach instead of a vertical health programs approach to prevent duplication, redundancies and poor coordination;
g. promotion of essential and generic medicines as well as ensuring their universal availability free of cost,
h. regulatory frameworks in medical practice, public health, food and drugs to check on unethical practices and
i. coordinationof public and private health sectors as well as regulatory bodies to monitor quality of services being delivered.

6.4. Newer developments in 2014

Mid-2014 has also witnessed a change in India's leadership with the new Prime Minister, Mr. Narendra Modi, announcing plans to replace the Planning Commission with an institution with 'a new body, soul, thinking, direction and faith' and empowered with creative thinking, public-private partnership, optimum utilization of resources and youth power.[9] The new Health Minister, Dr Harsh Vardhan has promised transparency and e-governance as well as emphasized the government's commitment towards UHC by proposing an ambitious "Universal Health Assurance Scheme" resting on pillars of risk pooling across varied groups.[50] The Ministry of Health plans to launch India Newborn Action Plan (INAP) as well

as child health schemes to bring down stillborn deaths and reduce child mortality rate from 29/1000 to single digits.[51,52]

In order to resolve manpower crunch at the primary health centers and inaccessible areas, posting of postgraduate medical students to rural areas as well as recommendations from Ayurveda, Yoga, Unani,Siddha and Homoeopathy (AYUSH) expert group are being considered.[53] The new government has vowed to crackdown malpractice in India's $74 billion healthcare industry after recent reports of alleged kickback arrangements between diagnostic laboratories and doctors.[54] With the conversion of NRHM into National Health Mission (NHM), the scope of health services has increased to cover both rural and urban areas, and is a welcome step towards promotion of accessible and affordable health services in towns and cities.

7. SUMMARY AND CONCLUSION

India has had a long journey over the last six decades building its health sector in order to cater to the growing demands of its people. Efforts for strengthening the primary health care, improving maternal and child health services, merging of vertical health schemes, re-structuring of health programs and capacity building efforts of the health work force have been underway since long. As an active participant of various international forums, India has kept abreast with the contemporary world concepts and consistently made efforts to improve the health of its people. It has shown commitment to the ratified treaties and declarations including the Alma Ata Declaration of 1978 and the Millennium Declaration of 2000.

India has had an overall improvement in health indicators and successfully eradicated small pox, dracunculiasis and poliomyelitis. Yet, the progress has been slow towards attainment of

its various health targets for 2000 and 2015.[1,31-33,35] India continues to battle inequities[21-24,26-27,29,40] which are pervasive in its health system.

The new health goal of Universal Health Coverage comes as a ray of hope for over 1 billion Indian citizens. It's a hope in the ability to financially sustain oneself during an unexpected illness, seek care and trust the quality of service being provided. Although UHC can neither eliminate 'health inequities' nor ensure 'Health for All', it certainly helps to breach the inequities, thereby paving a path towards 'Health for All'.

Achieving a state near to Universal Health Coverage for India would mean experimentation with varied options, new evidence from health systems research, innovative financing, and cross country learning. Health planners have a task of immense responsibility while adopting the correct strategies based on feasibility and applicability in the Indian scenario. Success on the road ahead, for the second most populated country, India, shall not come easy and but would surely mean a source of huge learning for many low and middle income countries.

8. FUTURE DIRECTION

India's drive towards UHC opens up new discussions, field of experiments and avenues. The role of Health Systems Policy Research (HSPR), as a barometer to understand current gaps and warning signals within the existing systems, is invaluable and requires strengthening across state levels.[55] Scientific evidence must guide the health policy makers and planners during decision making as much as the underlying social context of the country. India has many things to its advantage such as a long history of research, turning point studies, innumerable 'yojanas' and the more recent polio legacy.

UHC needs a high social and political commitment and the recent change in national governance, brings about optimism during another journey towards a new goal. It is a matter of time that will unfold how India successfully delivers 'Universal Health Coverage' for its citizens, that largely comprises of poor Indian farmers and marginalized sections of society.

MATRIX

	Phase 1 1947-2000	Phase 2 2001-2011	Phase 3 Starting 2012
National health initiatives	1951 National Family Planning Program 1960s National Disease Control Programs 1975 ICDS 1977 National Family Welfare Program 1978 EPI 1985 Universal Immunization Program 1992 Child survival safe motherhood program 1997 Reproductive child health program RNTCP -DOTS	2003-2004 NVBDCP 2005 NRHM Integrated comprehensive primary health care JSY initiative ASHAs Strengthening of disease control programs AYUSH Capacity building of PRI Decentralization and intersectoral coordination Improvement in social determinants NCD control 2007 NACP-IV 2008 RSBY	Universal health coverage
Major international declarations	1978 Alma Ata Declaration and Health for All	2000 Millennium Declaration	
Achievements	Improvement in health indicators but slow pace of attaining the expected health targets for 2000 AD	Improvement in health indicators but slow pace towards attainment of the MDG targets of 2015 AD	
Challenges	Inverse care Impoverishing care Fragmented care Unsafe care Misdirected care	Availability issues Accessibility issues Affordability issues Acceptability issues Quality issues	

REFERENCES

1. Planning Commission, Government of India. Twelfth Five Year Plan (2012-2017): Social Sectors [Internet]. Vol. III, New Delhi: Sage Publications; 2013 [cited 2014 July 22]. Chapter 20, Health; p. 1-46. Available from: http://planningcommission.gov.in/plans/planrel/12thplan/pdf/12fyp_vol3.pdf

2. Reddy KS, Patel V, Jha P, Paul VK, Kumar AK, Dandona L. Towards achievement of universal health care in India by 2020: a call to action. The Lancet [Internet]. 2011[cited 2014 Jul 12]: 377(9767), 760-768. Available from: http://cghr.org/wordpress/wp-content/uploads/Towards-achievement-of-universal-health-care-in-India-by-2020-a-call-to-action-2011.pdf

3. Rodin J, de Ferranti D. Universal health coverage: the third global health transition? The Lancet [Internet]. 2012 [cited 2014 Jul 1]: 380(9845), 861-862. Available from: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61340-3/fulltext

4. World Health Organization. What is universal coverage? [Internet]. World Health Organization [cited 2014 Jun 6]. Available from: http://www.who.int/health_financing/universal_coverage_definition/en/.

5. Holmes D. Margaret Chan: committed to universal health coverage. The Lancet [Internet]. 2012 [cited 2014 Jul 7]; 380(9845):879. Available from: http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673612614937.pdf

6. World Health report 2008: Primary health care: Now more than ever [Internet]. World Health Organization; c2008 [cited 2014 June 30]. Introduction and Overview; p. xi-xx. Available from: http://www.who.int/whr/2008/whr08_en.pdf

7. Gwatkin DR, Bhuiya A, Victora CG. Making health systems more equitable. The Lancet [Internet]. 2004[cited 2014 Sep 10]; 364(9441): 1273-1280. Available from: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(04)17145-6/fulltext

8. Ministry of Law and Justice, Government of India. The Constitution of India [Internet]. 2007 Dec 1[cited 2014 June 25]. Available from: http://lawmin.nic.in/coi/coiason29july08.pdf

9. Mehra P. Move to scrap Planning Commission raises Constitutional questions. The Hindu [Internet]. 2014 Aug 17 [cited 2014 September 12]; News. Available from: http://www.thehindu.com/news/national/move-to-scrap-planning-commission-raises-constitutional-questions/article6324619.ece

10. Planning Commission, Government of India. First Five Year Plan (1951-1956) [Internet]. [1951?] [cited 2014 Jul 15]. Available from: http://planningcommission.nic.in/plans/planrel/fiveyr/1st/1planch32.html

11. Planning Commission, Government of India. Sixth Five Year Plan (1980-1985) [Internet]. 1980 [cited 2014 Jul 15]. Available from: http://planningcommission.gov.in/plans/planrel/fiveyr/index6.html

12. Visaria L, Jejeebhoy S, Merrick T. From family planning to reproductive health: challenges facing India. International Family Planning Perspectives. 1999 [cited 2014 Jul 15]; S44-S49.

13. Kapil U. The Integrated Child Development Services (ICDS) Scheme: A Program for Holistic Development of Children in India. Indian Journal of Pediatrics [Internet]. 2002 [cited 2014 Jul 7]; 69 (7): 597-601. Available from: http://link.springer.com/article/10.1007/BF02722688#page-2

14. The Integrated Child Development Services (ICDS). UNICEF [Internet]. [cited 2014 Sep 2]; India. Available from: http://www.unicef.org/india/media_2640.htm

15. Madhavi Y. Vaccine Policy in India. PLoS Medicine [Internet]. 2005 May 31 [cited 2014 Aug 6]; 2(5): e127. Available from: http://www.plosmedicine.org/article/infopercent3Adoipercent2F10.1371percent2Fjournal.pmed.0020127#pmed-0020127-g003

16. Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, U.S.S.R., 6-12 September, 1978 [Internet]. Geneva: WHO; 1978 [cited 2014 Jun 4]. Available from: http://www.unicef.org/about/history/files/Alma_Ata_conference_1978_report.pdf

17. Vora KS, Mavalankar DV, Ramani KV, Upadhyaya M, Sharma B, Iyengar S, et al. Maternal health situation in India: a case study. J Health Popul Nutr [Internet]. 2009 Apr [cited 2014 July 4]; 27(2):184-201. Available from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2761784/

18. Planning Commission, Government of India. Tenth Five Year Plan: 2002-2007: Sector policies and programmes [Internet]. Vol. 2, [Delhi (India)]: [Publisher unknown]; 2002. Table 2.8.1, Time Trends (1951-2000) in Health Care; [cited 2014 Jul 18]. 81 p. Available from: http://planningcommission.nic.in/plans/planrel/fiveyr/10th/volume2/10th_vol2.pdf

19. Dutta M, Basu R. Lessons from smallpox eradication campaign in Bihar state and in India. Vaccine. 2011[cited 2014 Aug 20]; 29(11): 2005-2007.

20. Ministry of Health and Family Welfare, Government of India. National Health Policy 2002 [Internet]. 2002 [cited 2014 August 4]. Available from: http://mohfw.nic.in/showfile.php?lid=2325

21. International Institute for Population Sciences (IIPS) and Macro International, Maryland. National Family Health Survey (NFHS-3), 2005-2006: India: Volume I [Internet]. Mumbai: IIPS (India); 2007 Sep [cited 2014 Aug 12]. Table 7.2, Early childhood mortality rates by background characteristics; p. 182. Available from: http://pdf.usaid.gov/pdf_docs/PNADK385.pdf

22. International Institute for Population Sciences (IIPS) and Macro International, Maryland. National Family Health Survey (NFHS-3), 2005-2006: India: Volume I [Internet]. Mumbai: IIPS (India); 2007 Sep [cited 2014 Aug 12]. Table 7.3, Early childhood mortality rates by demographic characteristics; p. 185. Available from: http://pdf.usaid.gov/pdf_docs/PNADK385.pdf

23. International Institute for Population Sciences (IIPS) and Macro International, Maryland. National Family Health Survey (NFHS-3), 2005-2006: India: Volume I [Internet]. Mumbai: IIPS (India); 2007 Sep [cited 2014 Aug 12]. Table 7.1, Early childhood mortality rates; p. 180. Available from: http://pdf.usaid.gov/pdf_docs/PNADK385.pdf

24. International Institute for Population Sciences (IIPS) and Macro International, Maryland. National Family Health Survey (NFHS-3), 2005-2006: India: Volume I [Internet]. Mumbai: IIPS (India); 2007 Sep [cited 2014 Aug 12]. Table 8.22, Maternal care indicators by state; p. 220. Available from: http://pdf.usaid.gov/pdf_docs/PNADK385.pdf

25. International Institute for Population Sciences (IIPS) and Macro International, Maryland. National Family Health Survey (NFHS-3), 2005-2006: India: Volume I [Internet]. Mumbai: IIPS (India); 2007 Sep [cited 2014 Aug 12]. Table 8.9, Reason why mother did not receive antenatal care; p. 203. Available from: http://pdf.usaid.gov/pdf_docs/PNADK385.pdf

26. International Institute for Population Sciences (IIPS) and Macro International, Maryland. National Family Health Survey (NFHS-3), 2005-2006: India: Volume I [Internet]. Mumbai: IIPS (India); 2007 Sep [cited 2014 Aug 12]. Table 9.4, Vaccination by background characteristics; p. 229. Available from: http://pdf.usaid.gov/pdf_docs/PNADK385.pdf

27. International Institute for Population Sciences (IIPS) and Macro International, Maryland. National Family Health Survey (NFHS-3), 2005-2006: India: Volume I [Internet]. Mumbai: IIPS (India); 2007 Sep [cited 2014 Aug 12]. Available from: http://pdf.usaid.gov/pdf_docs/PNADK385.pdf

28. United Nations. United Nations Millennium Declaration, Resolution 55/2. 2000. [Internet]. 2000 Sep 18 [cited 2014 July 1]. Available from: http://www.un.org/millennium/declaration/ares552e.htm

29. Bajpai N, Sachs JD, Dholakia RH. Improving access, service delivery and efficiency of the public health system in rural India. Mid-term evaluation of the National Rural Health Mission. The Earth Institute at Columbia University. c2010[cited 2014 Sep 4].

30. National Rural Health Mission (2005-2012): Mission Document[Internet]. No date. [cited 2014 Jul 2]. Available from: http://www.nird.org.in/brgf/doc/Ruralpercent20HealthMission_Document.pdf

31. Nath A. India's progress toward achieving the millennium development goals. Indian journal of community medicine [Internet]. 2011 Apr-Jun [cited 2014 Aug 12];36 (2): 85-92. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3180952/.

32. Millennium Development Goals. India Country Report 2014 [Internet]. Delhi: Ministry of Statistics and Program Implementation (India); 2014[cited 2014 Sep 4]. Available from: http://indiaenvironmentportal.org.in/files/file/mdg_2014percent20Indiapercent20countrypercent20report.pdf

33. Reddy H, Pradhan MR, Ghosh R, Khan AG. India's progress towards the Millennium Development Goals 4 and 5 on infant and maternal mortality. WHO South East Journal of

Public Health [Internet]. 2012 July–September [cited 2014 Aug14]; 1(3): 279-289. Available from : http://www.searo.who.int/publications/journals/seajph/issues/seajphv1i3_full.pdf

34. Lim SS, Dandona L, Hoisington JA, James SL, Hogan MC, Gakidou E. India's Janani Suraksha Yojana, a conditional cash transfer programme to increase births in health facilities: an impact evaluation. The Lancet [Internet]. 2010 Jun 5 [cited 2014 Aug 20]; 375(9730): 2009-23. Available from: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60744-1/abstract

35. Office of the Registrar General & Census Commissioner, India. A presentation on Maternal & Child Mortality and Total Fertility Rates: Office of Registrar General, India: 2011 Jul 7. [Internet]. Delhi: Ministry of Home Affairs (IN), Office of the Registrar General & Census Commissioner; 2011 July [cited 2014 Aug 2]. PowerPoint presentation available from : http://censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_release_070711.pdf

36. World Health Statistics 2010 [Internet]. Geneva: World Health Organization; c2010 [cited 2014 June 17]. Table 6, Health workforce, infrastructure and essential medicines; p. 118-119. Available from: http://www.who.int/gho/publications/world_health_statistics/EN_WHS10_Full.pdf

37. Bloom G, Kanjilal B, Peters DH. Regulating health care markets in China and India. Health Affairs [Internet]. 2008 [cited 2014 Aug 1]: 27(4); 952-963. Available from: http://content.healthaffairs.org/content/27/4/952.full.pdf+html

38. International Institute for Population Sciences (IIPS) and Macro International, Maryland. National Family Health Survey (NFHS-3), 2005-2006: India: Volume I [Internet]. Mumbai: IIPS (India); 2007 Sep [cited 2014 Aug 12]. Table 13.11, Health insurance coverage; p. 435. Available from: http://pdf.usaid.gov/pdf_docs/PNADK385.pdf

39. World Health Statistics 2014. Geneva: World Health Organization; c2014 [cited 2014 June 17]. Table 7, Health expenditure; p. 144-145.

40. World Health Statistics 2014. Geneva: World Health Organization; c2014 [cited 2014 June 17]. Table 8, Health inequities; p. 156-157.

41. Srinivasan R. Time for a 'Right to Healthcare'. The (India) Hindu [Internet]. 2013 Dec 18 [cited 2014 Aug 1]; Opinion: Interview. Available from: http://www.thehindu.com/opinion/interview/time-for-a-right-to-healthcare/article5470806.ece

42. 'Right to Healthcare is need of the hour'. The Times of India Health [Internet]. 2012 Aug 19. [cited 2012 Aug 1]; Jaipur (IN). Available from: http://timesofindia.indiatimes.com/city/jaipur/Right-to-Healthcare-is-need-of-the-hour/articleshow/15551549.cms

43. United Nations. Constitution of the World Health Organization. New York, 1946 [Internet]. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1625885/pdf/amjphnation00639-0074.pdf

44. Fact Sheet: The Right to Health [Internet]. WHO; [reviewed 2013 Nov; cited 2014 Aug7]. Available from: http://www.who.int/mediacentre/factsheets/fs323/en/

45. Gilson L,McIntyre D. Post-apartheid challenges: Household access and use of health care in South Africa.International Journal of Health Services [Internet]. 2007 [cited 2014 Aug 8]: 37(4): 673-691. Available from: http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,6,13;journal,28,175;linkingpublicationresults,1:300313,1

46. World Health report 2008: Primary health care: Now more than ever [Internet]. World Health Organization; c2008 [cited 2014 June 30]. Chapter 2, Advancing and sustaining universal health coverage; p. 23-38. Available from: http://www.who.int/whr/2008/whr08_en.pdf

47. World health report 2010: health systems financing: the path to universal coverage [Internet]. World Health Organization; c2010 [cited 2014 June 21]. Chapter 2 More money for Health. Available from: http://whqlibdoc.who.int/whr/2010/9789241564021_eng.pdf

48. World health report 2010: health systems financing: the path to universal coverage [Internet]. World Health Organization; c2010 [cited 2014 July 30]. Chapter 4 More health for the money. Available from: http://whqlibdoc.who.int/whr/2010/9789241564021_eng.pdf

49. World Health Statistics 2014. Geneva: World Health Organization; c2013. Table 9, Demographic and socioeconomic statistics; p. 169. [cited 2014 June 17].

50. Govt's ambitious health plan proposes insurance the poor, says Harsh Vardhan. Firstpost [Internet]. 2014 Aug 27 [cited 2014 September 17]; India News. Available from : http://www.firstpost.com/politics/govts-ambitious-health-plan-proposes-insurance-poor-says-harsh-vardhan-1685073.html

51. Action plan launched to check under-5 deaths. IBN Live [Internet]. 2014 Sep 18 [cited 2014 Sep 18]; India. Available from: http://ibnlive.in.com/news/action-plan-launched-to-check-under5-deaths/500068-3.html

52. Government to launch its most ambitious scheme to reduce infant mortality rate tomorrow. IBN Live [Internet]. 2014 Sep 17 [cited 2014 Sep 18]; India. Available from : http://ibnlive.in.com/news/government-to-launch-its-most-ambitious-scheme-to-reduce-infant-mortality-rate-tomorrow/499800-3.html

53. Ayush Mission, a significant step in history, says Harsh Vardhan. IBN Live [Internet]. 2014 Sep 16 [cited 2014 Sep 17]; Health. Available from: http://ibnlive.in.com/news/ayush-mission-a-significant-step-in-history-says-harsh-vardhan/499561-17.html

54. Centre reviews state hospitals to end widespread corruption. IBN Live [Internet]. 2014 Aug 23 [cited 2014 Sep 17]; India. Available from: http://ibnlive.in.com/news/centre-reviews-state-hospitals-to-end-widespread-corruption/493884-3.html

55. The Future of Health Policy & Systems Research in India: Knowledge for Systems Transformation [Press release]. Public Health Foundation of India; 2014 July [cited 2014 Aug 20]. Available from: http://phfi.org/images/home/hpsr_seminar_summary_final.pdf

ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda Yoga Unani Siddha and Homoeopathy
GDP	Gross Domestic Product
HBNC	Home Based Newborn Care
HIV	Human Immunodeficiency Virus
HLEG	High Level Expert Group
HSPR	Health Systems Policy Research
ICDS	Integrated Child Development Services
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
INAP	Integrated Newborn Action Plan
LMIC	Low and Middle Income Countries
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
NFHS	National Family Health Survey
NHM	National Health Mission
NRHM	National Rural Health Mission
ORC	Opinion Research Company
ORT	Oral Rehydration Therapy
RSBY	Rashtriya Swasthya Bima Yojana
SRS	Sample Registration Systems
U5MR	Under-5 Mortality Rate
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization

LIST OF TABLES

LIST OF FIGURES