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Towards achievement of universal health care in India by 2020: a call to action

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To sustain the positive economic trajectory that India has had during the past decade, and to honour the fundamental right of all citizens to adequate health care, the health of all Indian people has to be given the highest priority in public policy. We propose the creation of the Integrated National Health System in India through provision of universal health insurance, establishment of autonomous organisations to enable accountable and evidence-based good-quality health-care practices and development of appropriately trained human resources, the restructuring of health governance to make it coordinated and decentralised, and legislation of health entitlement for all Indian people. The key characteristics of our proposal are to strengthen the public health system as the primary provider of promotive, preventive, and curative health services in India, to improve quality and reduce the out-of-pocket expenditure on health care through a well regulated integration of the private sector within the national health-care system. Dialogue and consensus building among the stakeholders in the government, civil society, and private sector are the next steps to formalise the actions needed and to monitor their achievement. In our call to action, we propose that India must achieve health care for all by 2020.

Introduction

Why reform India's health-care system?

The *Lancet* Series about India draws attention to the challenges affecting the health-care system of the world's second most populous country.^{1–11} With the impressive economic growth in India during the past two decades, the political commitment towards the social sector has increased but has not yet resulted in commensurate investments and health gains. Although substantial achievements have occurred in the improvement of

population health in India in the 60 years since independence as shown by the doubling of life expectancy during this period, the health outcomes remain inadequate when India is compared with other countries that were at similar economic stages of development at the time of independence; preventable disease burden remains high; health care is far from equitable, accountable, or affordable; government health expenditure is very low and has risen only slightly during the past decade; and most spending on health care is paid out of pocket and is rising in cost. Thus, catastrophic health-care expenditures are a major cause of household debt for families on low and middle incomes; indeed, costs of health care are now a leading cause of poverty in India. The country's health system ranks as one of the most heavily dependent on out-of-pocket expenditure and private health care in the world. However, progress has occurred in the past 5 years with new commitments by central and state governments to correct some of these inequities and gaps in health care. The health system in India needs to be reconfigured if these commitments are to provide optimum benefits to the people.

The evidence presented in this Series shows the co-existence of substantial burdens of infectious diseases,¹ reproductive and child health problems,² nutritional deficiencies,² chronic diseases,³ and injuries.³ India still has unacceptably high infant, child, and maternal mortality rates, and high numbers of premature deaths that are attributable to chronic diseases. The burdens of disability are further worsened by unrecognised and inadequately treated mental illness and the increasing toll of intentional and unintentional injuries. Several adverse social determinants together corrode the health of vulnerable populations, whereas behavioural risk factors like smoking, oral tobacco consumption, and binge

Key messages

We propose the following targets to be achieved by 2020 through the creation of the Integrated National Health System with three overarching goals: ensure the reach and quality of health services to all in India; reduce the financial burden of health care on individuals; and empower people to take care of their health and hold the health-care system accountable.

Service delivery

- The entire population should be covered by an entitlement package of health care with financing from a combination of public, employer, and private sources. Full range of relevant diseases need to be included in the entitlement package of health services with cost-effective interventions that include health promotion and disease prevention.
- All health practitioners and facilities in the public and private sectors have to be registered with the Integrated National Health System.

Health financing

- Public spending on health should be increased from 1% to 6% of the gross domestic product, and 15% of tax revenues—including new taxes on tobacco products, alcohol, and food with little nutritional value—should be earmarked for this purpose.
- Reduce the proportion of out-of-pocket spending from 80% to 20% of the total health expenditure.
- Increase spending on health research to 8% of the health budget.

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drinking of alcohol account for much death and disability. These burdens of ill health are inequitably distributed across geographical, social, gender, income, and educational strata, with substantial differences in health indicators between and within the different states in India. Caste, class, and gender are key factors that affect not just the occurrence of disease and ill health but also the likely outcomes. Individuals who are poor bear a disproportionate burden of death and disability. The threats to the health of the people of India are being further compounded by the rising risks posed by distal determinants—ie, unequal economic growth, unplanned urbanisation, water and sanitation crises, inequitable global trade, unhealthy trade policies, and climate change. We do recognise that multisectoral actions need to be initiated to favourably change the distal determinants to promote health and prevent disease, and hope that these will receive detailed deliberation in subsequent reports and action. This Series focuses on issues that need to be addressed to achieve a health-care system that ensures health care for all in India. Specific action within the health system can begin even while the more distal determinants are being addressed.

Although the Indian economy had high growth rates in recent years (9.4% in 2005–06 and 9.6% in 2006–07, with a consistent 7.0% growth rate even during the period of global economic slow down), according to the Human Development Index India is ranked 134 among 182 countries.¹² India's economic transformation does not seem to have produced tangible improvements in the health of the nation, and the recognition that improvement in health contributes to accelerated economic growth has not led to adequate investment in or improved the efficiency of health care. The people of India are exposed to a huge variation in health-care services, from one extreme in which the best possible care is provided to a small proportion of the population who can afford to pay for these services (now increasingly accessed by people from other countries as a result of medical tourism) to the other extreme in which even basic or essential services and technologies are lacking for a large proportion of the Indian people who are poor and living in rural and urban areas.

Several reasons exist why the health indicators for India have lagged behind those of many other developing countries, including some that are poorer. Immediately after independence, Indian health policy was affected by an egalitarian ethos that placed the main responsibility for provision of health care to all citizens on the government. However, lack of political commitment in recognising health as an essential component of human development, shown by consistently low investment, badly formulated policies, and inadequate implementation of programmes, led to inadequate delivery of health care by the public sector. The views of local civil society were not considered in a systematic manner during centralised planning, and neither was civil society substantially engaged in the

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Human resources for health

- Establish the Indian Health Service with guidelines developed through an autonomous National Council for Human Resources in Health.
- An updated training curriculum should be fully in place for medical and allied professions that is relevant to the situation in India.
- Establish suitable incentive structures to retain health providers in underserved areas.

Health information system

- Have in place a comprehensive health information and surveillance system that covers all major diseases, health-system issues, and key social determinants, which also facilitates assessment of public health interventions.
- Establish adequate research capacity in India to investigate and report key issues that affect the health system and policy for further improvements.
- Have in place a fully functional autonomous council that compiles and synthesises relevant information to develop guidelines for evidence-based health care and its assessment.

Drugs and technology

- Implement a national network of pharmacies for generic low-cost drugs for the entire population.
- Establish mechanisms for bulk purchase of patented drugs to make them available at low cost.
- Have in place mechanisms to check and control the use of perverse incentives by pharmaceutical and biotechnology companies for health-care providers.

Governance

- Have in place mechanisms to make functional the components of the National Health Bill 2009.
- Have a system in place that requires all middle and senior functionaries in public health to have relevant training in public health.
- Ensure devolution of responsibility for health care to district management systems along with accountability mechanisms and explicit community participation.

Consensus building

- To formalise the mechanisms to achieve universal health care in India and to discuss the implementation of the recommended actions, a national debate involving all stakeholders in India including government, civil society, health professions, private sector, academia, and the media is needed.

implementation of the programmes. The private sector, already dominant at the time of independence, grew in an uncoordinated manner, to become the default option in many cases. In an unregulated environment, neither the private sector nor the public sector provided an assurance of quality or access. The recent change towards a liberal market has resulted in a further redefinition of the role of the government, even in the health sector. The increasing dependence on the private sector, in addition to very weak regulation and corruption, has led to a huge increase in health-care costs with the result that out-of-pocket payments are now one of the leading causes of direct debt and poverty in India.⁴

Even though there has been a small increase in the governmental allocations for health in the past few years, the proportions remain very low compared with nearly all the other developing countries. However, even these low

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funds are often underused or inefficiently used by some states. The inadequate absorption capacity of state health-care systems is largely attributable to a deficiency in public health and managerial expertise. Until the advent of the National Rural Health Mission, states did not have the freedom that was provided by flexible funding. This dichotomy, wherein the central government has the mandate and the money for launching national health programmes, whereas the states have the primary responsibility for the implementation of these programmes and the delivery of a wide range of other health-care services, has led to a serious disconnection between planning and implementation. Lack of dependable and affordable primary health care for rural populations and the people living in urban areas who are poor, in many states, has been the main manifestation of the absence of a connection. The National Rural Health Mission is a huge initiative that seeks to correct this imbalance in rural areas. It is soon to be transformed into the National Health Mission, with addition of programme components that are related to urban health.

Human resources for health too have been severely deficient, particularly in rural areas. Shortfalls in training, inequities in distribution, and migration of staff to other countries have worsened these deficiencies. A doctor-centred approach to health care has led to a systematic underproduction, undervaluation, and underuse of public health professionals, nurses, and community health workers. The quest to use high-tech, specialist-delivered, and hospital-based medical care, with little regard for primary health care or evidence-based practices has worsened the huge health inequities and increased the costs of health care.

These findings help account for the underperformance of India's health-care system. Although central and state governments have taken several ambitious and welcome steps to correct some of these problems, we argue that the time has come for the health-care system to be radically reconfigured, along with attention to the social determinants of health, if India's health indicators are to rapidly improve and the health inequities are to be substantially reduced.

Panel 1: Reasons why the time is right for universal health care in India

- India's economic growth trajectory, in the past few years, has been much more rapid than that in any other country, except China, and has even withstood the recession reasonably well.
- India's greatest demographic asset is its young people (about 650 million people are younger than 30 years). However, the ability of these individuals to fully participate in the country's future is seriously undermined by the inability of the health-care system to address their needs.
- In two successive national elections, the rural population of India has asserted and given a political mandate for the government to prioritise its needs. This mandate and the continuing frequent reference to health care in electoral campaigns offer an opportunity for radical reforms. Indeed, all major political parties agree that India's health system is in need of reform.
- Diseases spread easily across borders, such as pandemic influenza A H1N1 and tuberculosis. Poor health systems and inadequate surveillance might result in India exporting and importing diseases, which could adversely affect trade and tourism.
- Global experience shows that universal health care is affordable and feasible provided there is sustained public finance and strong leadership. In turn, universal coverage generates political and financial commitment to improved health.
- Schemes for universal health care are being attempted in several states or through national initiatives, providing valuable experience on implementation.
- The technological strengths in India and the government's resolve to use these to overcome entrenched barriers in improving governance, exemplified by the Universal National Identity Card scheme, are potential enablers of effective health-care delivery.
- The health-care costs, although increasing, are still sufficiently low so as to allow major reforms at affordable cost. With delay, health-care costs will rise and make reforms more difficult and costly in the future.
- India's health progress is central to the achievement of the overall international development goals—eg, about a quarter of all child deaths in the world occur in India.
- India's aspirations as a global player and its rising international status with a free press and globalisation of information mean that the problems of India's health system will receive more scrutiny from domestic and international commentators.

Call to action

Access to appropriate, adequate, and affordable health care is the legitimate entitlement of every Indian citizen during his or her life. We therefore call for a radical transformation of the health-care system to promote equity, efficiency, effectiveness, and accountability in the delivery of health care at all stages through the establishment of the Integrated National Health System in which all major providers—ie, the public and the private sectors and the allopathic systems of medicine—are integrated. The Integrated National Health System should have three key goals: ensure the delivery and provision of good-quality health services to all Indian people; reduce the financial burden of health care on individuals; and empower people to take care of their health and hold the health-care system accountable. We call on the central and state governments of India to consider the provision of universal health care by 2020 a cardinal commitment and to implement the Integrated National Health System so as to achieve this objective.

We acknowledge that the broad recommendations contained in this call for action have been presented in one form or another by several expert committees of the government and civil society groups since India's independence. The Bhore Committee report of 1946,¹³ and more recently the Jan Swasthya Abhiyan, the Choosing Health report,¹⁴ and the Independent Commission on Health and Development report,¹⁵ as well as others have identified comprehensive primary health care as the highest priority, community-based approach as the key strategy, and equity as the core value that should guide the development of India's health system. Why should the government choose to respond to yet another call for action? We believe that the timing of our call is at a crucial point in India's history in which

a combination of factors and opportunities should compel the government to act (panel 1).

Of all the reasons, we believe the most crucial is the increase in the government's capacity to finance a universal health-care plan, created by the unprecedented economic growth in addition to the political consensus and public recognition of the importance of investment in health. The current global economic climate also offers an opportunity to refocus attention on the stewardship role of government, whose responsibility to protect the public interest, through provision of health care, adequate public financing, and effective regulation, is being reaffirmed. Policy makers in India are now more likely to be receptive to the demand that the state should be the guarantor and regulator of universal health care, which would be in recognition of the reality that presently most health-care provision is private. Several initiatives, ranging from major national programmes to state pilot projects, show an increasing commitment towards a strengthened public health sector. Panel 2 shows a few examples of such programmes in India. Although such initiatives are encouraging, many of them have limitations, not least of which is the lack of coordination between them and, ultimately, full collaboration. The time now is right for the government to move to one, comprehensive national framework for the provision of universal health care.

Because of the large presence of the private sector, assessment of its role in the delivery of health services is important and should be guided by principles of equity enhancement. Therefore, comprehensive health insurance that is financed through a combination of public, employer, and private sources, but which ensures provision of health care to all, including the individuals who are poor or disadvantaged, children, and elderly people, would be the way forward. However, the state needs to become the main provider of an increasing share of health services, particularly for rural and underserved communities, and would have to play the lead part in preventive and promotive work. Even with respect to the health services provided by the private and voluntary sectors, the state must act as a guarantor of universal health care by creating and overseeing an integrated health-insurance system that enables the achievement of the right to health for all people in India.

Integrated National Health System

We propose the Integrated National Health System as an overarching strategy for the achievement of the broad goals set out previously. This system should provide free health care at the point of use—consisting of health promotion, disease prevention, and acute, emergency, and chronic care throughout the patient's life. Three guiding principles lie at the heart of our vision for the Integrated National Health System. First, the system should be financed through sources other than out-of-pocket costs, with an increasing share of tax-funded

Panel 2: Schemes to promote universal health care in India

The National Rural Health Mission was launched in 2005 as the strategic framework to strengthen the public health-care system. This scheme brought with it an influx of government funds that were aimed at increasing the outlays for public health from 0.9% of gross domestic product in 2005 to 2–3% by 2012. The National Rural Health Mission aims to revitalise the public sector in health by increasing funding, integration of vertical health and family welfare programmes, employment of female accredited social health activists in every village, decentralised health planning, community involvement in health services, strengthening of rural hospitals, providing untied funds to health facilities, and mainstreaming traditional systems of medicine into the public health system. It covers the entire country, with special focus on 18 states that have fairly poor infrastructure and demographic indicators. About 800 000 accredited social health activists have been selected and are being trained and assigned. The National Rural Health Mission is the most ambitious public health programme in India's history, with several unique components that distinguish it from previous national programmes; most notable is that it is centrally financed but implemented in the districts. An external mid-term assessment of this programme in 2009 has suggested substantial achievements and specialties that still need to be addressed.¹⁶

The Janani Suraksha Yojana launched in 2005 encourages women to deliver in government health facilities or accredited private facilities by providing financial incentives.¹⁷ This conditional cash transfer scheme has the largest number of beneficiaries for any such programme in the world, estimated to be 9.5 million women giving birth in 2010. This scheme is complemented by a public-partnership programme, initially started as the Chiranjeevi Yojana¹⁸ in Gujarat and now being tested in other states in which private obstetricians are paid to assist women who are poor with their deliveries. Another complementary programme is the Muthulakshmi Scheme in Tamil Nadu that provides financial support before and after the delivery period. Assessments of Janani Suraksha Yojana and Chiranjeevi Yojana have suggested beneficial outcomes and ideas for improvements.^{19–21}

The Rashtriya Swasthya Bima Yojana scheme was launched in 2007 by the Ministry of Labour and Employment to provide insurance coverage for treatment in hospital to families below the poverty line.²² Each eligible family is given a smart card that allows the members coverage up to a limit at either public or private hospitals at a nominal yearly fee that is paid by the beneficiary. 75% of the yearly insurance premium is contributed by the central government and 25% by the state governments.²² The scheme includes cashless care in hospital, coverage of pre-existing diseases, and transportation costs. The plan is that this scheme will cover the entire country by 2012–13.

The Jan Aushadhi programme is a public-private partnership, which aims to set up pharmacies in every district to provide quality generic drugs and surgical products at affordable prices 24 h a day. The first store opened under this programme was started in late 2008, and 44 stores were functioning throughout India by March, 2010. This programme, involving several stakeholders, has great promise because it aims to provide quality generic drugs at very low cost to individuals who might otherwise not be able to afford them.

insurance. Second, health care should be provided through the diverse providers who are already active in health care, with substantial strengthening of the public health-care delivery system and increasing integration of private providers and non-medical health practitioners in the system through a regulatory framework that defines responsibilities and requires accountability from all providers. Third, although the system supports a national vision with an emphasis on the removal of interstate

For more on the **National Rural Health Mission** see <http://mohfw.nic.in/NRHM.htm>

For more on **Jan Aushadhi** see <http://janaushadhi.gov.in/>

Panel 3: Proposed National Health Bill

The Constitution of India recognises the right to life and liberty of every individual. However, the government drafted the first National Health Bill in 2009,²³ six decades after India adopted its constitution, partly in response to civil society activism, with a view to “provide for protection and fulfilment of rights in relation to health and wellbeing, health equity and justice, including those related to all the underlying determinants of health as well as healthcare; and for achieving the goal of health for all; and for matters connected therewith or incidental thereto”.²³ The proposed health legislation goes beyond delivery of health-care services to endorsing health-care rights of every individual. It brings about a change towards a realisation that individuals have an equitable right to health and wellbeing. The draft of the proposed National Health Bill is different from all other health legislations because it is based on the understanding that health care and sound public health are public goods. It encompasses all the tenets of health and health care, including the determinants, and aspires to the goal of health for all. This proposed legislation delineates all rights of an individual with respect to health and health care, while regulating the services provided by health institutions and health-care providers through adequate health-care information and systems for redress. It gives emphasis to the Panchayati Raj institutions and local organisations. The bill addresses the needs of people in society who are marginalised and vulnerable through not just health care but by also addressing the determinants of health. It mandates an assessment of the effect on health of every proposed law, policy, programme, project, technology, or a potentially damaging activity, in relation to health, before decisions. The bill envisions protecting the right to affordable, inclusive, and portable health care that is accessible, available, acceptable, good quality, and delivered in a non-discriminatory way through transparent and accountable processes by government and private institutions.

differences due to variations in human and other resources, its implementation should be decentralised to districts and lower administrative divisions.

We recognise that this prescription is ambitious, and one that must undergo nationwide consultation, discussion, debate, and analysis to transform it into a plan that is acceptable to all major stakeholders. We note, however, that our prescription is in agreement with the planned Indian National Health Bill (panel 3). Although we have taken into consideration the models that were used in other countries to achieve similar goals, the basis of our proposals are the realities of India’s pluralistic health-care system and unique health-care demands (panel 4).

We propose five crucial actions that are needed to achieve the strategies summarised in panel 4. Many of these build on initiatives already implemented, particularly the National Rural Health Mission, or which are being considered by the government.

First, an insurance fund that is sufficient for provision of health care for all the people in India is a necessity. This fund would have to include financing from public, employer, and private sources. How best this combination is made effective to include health-care coverage of individuals who are poor or disadvantaged, children, and elderly people would need to be decided during a discussion with the key stakeholders in India. Private insurance markets are likely to increase in size, but must be tightly regulated to avoid the problems of moral

hazards and adverse selection. Public expenditure on health care has to rise from 1% to 6% of the gross domestic product by 2020. Additional revenues for health expenditure should be mobilised through raised taxes on all tobacco products (cigarettes, bidis, and chewable tobacco), alcohol (including locally brewed alcohols), and foods of low nutritional value. The revenues will also have other health benefits through a reduction in the use of these products. For the individual, health care at the point of care should be cash-free and easily accessible, but monitored to restrict the risk of abuse. The huge size and complexity of India mean that effective health insurance and coverage for everyone will progress initially more in some states than in others. However, the ultimate goal is to scale up coverage to all Indian people in all states.

Second, we call for the establishment of an autonomous council that can help with the generation of evidence to guide practices for health care in the Integrated National Health System and to monitor their implementation. Only evidence-based interventions should be financed through this system. A strong regulatory framework should also be developed to define and monitor the standards of health care. Audits, of both government and private health-care facilities, should be done periodically to ensure adherence to guidelines. Corruption throughout the health system must be rooted out through transparency in health-care transactions, and punitive action should be taken against offenders. The council should develop centres of excellence in health system and policy research with the explicit goals of encouraging innovative solutions for addressing India’s health issues. This council should also help with the professional development of all central and state professional organisations to reduce their dependence on pharmaceutical and biotechnology companies. The council should oversee a national health surveillance and information system to ensure that key health status and health-system indicators are collected reliably, collated meaningfully, and synthesised in a manner that allows the performance of the health-care system to be monitored, assessed, and improved.

Third, the development of a policy for the promotion of national human resources for health is urgently needed. It should include the creation of the Indian National Health Service cadre, which consists of not only medical professionals but also non-medical professionals who have been trained in public health. The proposed National Council for Human Resources in Health²⁵ could help with meeting the health-care system’s human-resource needs at an affordable cost and ensure that they are equitably distributed. We support the implementation of national standard-setting exit examinations, replacing highly variable local or state examinations. New human-resource health institutions, such as medical, nursing, or allied health colleges, have to be approved on a priority basis only in

Panel 4: Goals and key strategies for the Integrated National Health System

Service delivery*

Goal

- Integrate private and public health-care delivery systems

Strategies

- All health-care institutions and practitioners should be required to register with a national health regulatory agency and make this information available on the internet
- Define a rational mix of public and private health-care services to enhance complementarities, and invest in further development of public health-care services including health promotion and prevention services

Financing*

Goal

- Create a universal health-care fund and reduce the cost of health care

Strategies

- Increase the proportion of gross domestic product as public health expenditure
- Merge all existing health insurance funds (eg, Rashtriya Swasthya Bima Yojna, Arogyasri) with this fund
- Apply heavy taxes on harmful products such as tobacco products, alcohol, and foods of low nutritional value, and allocate most revenue to health care
- Define the costs of all essential and emergency health-care interventions, and finance a package of care that is based on diseases that should be prioritised and cost-effective interventions
- Negotiate prices with providers, including caps, for different services on the basis of the cost of the care packages
- Invest in health promotion and early recognition of disease

Human resources*

Goal

- Increase the numbers, diversity, and distribution of human health resources

Strategies

- Establish an autonomous organisation to govern the supply of a full range of health workers, from accredited social health activists to doctors to health administrators
- Strengthen the role of community health workers with clearly defined skills, adequate remuneration, and career paths
- Encourage postings in rural or other underserved areas through increased salaries and other incentives such as provision of education to children

- Establish the Indian Health Service for careers in government health care
- All senior personnel in the Ministry of Health should be required to have public health training
- Promote the creation of medical and nursing colleges in underserved districts

Information*

Goal

- Promote evidence-based health-care practices

Strategies

- Establish an autonomous organisation to set guidelines for care practices in the Integrated National Health System
- Monitor and regulate the use of practices that are not based on evidence
- Strengthen capacities of health and non-health policy makers to recognise the importance of this approach
- Increase resources for priority health research
- Implement and act on the findings of district and national health surveillance and information systems, and encourage assessments

Drugs and technology*

Goal

- Promote rational use of drugs and technology

Strategies

- Promote use of generic drugs through a wide network of pharmacies for generic drugs, with at least one in each block
- Ban incentives by pharmaceutical and medical technology companies to practitioners or consumer groups
- Negotiate bulk purchasing for patented drugs
- Make the best use of information technology that is being developed for the health system

Governance*

Goal

- Create a decentralised governance structure that responds to local needs and is accountable

Strategies

- Create systems for accountability of local health-care services to fully empowered civil society groups
- Provide flexibility and expertise in districts and subdistricts to plan local health-care management plans
- Monitor and promote equity, efficiency, effectiveness, and accountability in the health-care system

*Building blocks in the WHO health system framework.²⁴

districts that are underserved or lacking such institutions. Recruitment and retention of health personnel in the public health-care sector needs to be aided by a system of well thought out incentives that involve remuneration, career track progression, and supportive work environments. The Indian National Health Service, with clear career pathways from primary care through to the health secretary position in the

government, might offer a pathway to attract and retain talented professionals within the public health system.

Fourth, we call for the collaboration of all health-related ministries or departments with the Ministry of Health and Family Welfare, notably those dealing with women and child development, and with water and sanitation. Although many health programmes might be designed nationally and the Integrated National Health System

would also provide a national pool of human resources for health, the administration of health care must be completely decentralised through a district-based model, with further devolution of some functions to blocks. Allocation of financial resources in accordance with district plans, accompanied by flexible spending and accountability mechanisms, will greatly help with such a district model of health administration. Planning and programme management in districts should be supported by systems for integrated surveillance of disease and risk factors, management of electronic information about health, and monitoring and assessment that will enable disaggregated data reporting, analysis, and response planning in the districts. Mechanisms to engage the civil society in a meaningful way would be the key to the success of decentralised governance. Public health personnel, rather than generalist administrators, need to

be in charge of health programmes. The remarkable progress shown in the past few decades by Tamil Nadu in improving health services and health indicators has been attributed to the presence of a district public health cadre with managerial responsibilities.²⁶ Other states like Andhra Pradesh have also announced their intent to create such cadres.

Fifth, we call for the creation of specific entitlements for health, using evidence and creating political support, which sustains these entitlements. An example is the small entitlement package for the next 1% of gross domestic product for public expenditure as suggested by the Choosing Health report¹⁴ that was based on merging available evidence with fairness. The options need to be discussed by relevant stakeholders in India to agree on the appropriate entitlement packages. The Indian National Health Bill (panel 3), being considered by the Government

	2012	2015	2020
Service delivery			
Implement the entitlement package of health-care services	Agree on the composition and implementation details for an entitlement package of health-care services	60% of population covered by the entitlement package	100% of population covered by the entitlement package
Register qualified health-care practitioners and facilities in the public and private sectors, including allopathic and Indian systems of medicine, with the Integrated National Health System	Establish a workable system to achieve this registration	60% of practitioners and facilities registered	100% of practitioners and facilities registered
Financing			
Increase public expenditure on health per person and proportion of tax revenues for health	Increase to 2% of gross domestic product and earmark 9% of tax revenues	Increase to 4% of gross domestic product and earmark 11% of tax revenues	Increase to 6% of gross domestic product and earmark 15% of tax revenues
Reduce proportion of private out-of-pocket expenditure on health	Reduce to 65%	Reduce to 40%	Reduce to 20%
Human resources			
Improve numbers, quality, and distribution of human resources for health	Have in place a fully functional National Council for Human Resources in Health with targets set for numbers and quality of personnel needed	Effectively implement the mechanisms needed to meet the targets set by the National Council for Human Resources in Health, including the Indian Health Service and revised training curricula for health professions that are relevant to India	Achieve targets set by the National Council for Human Resources in Health for 2020
Information			
Promote evidence-based practices and assessment of public health interventions	Establish an autonomous Council on Evidence Based Healthcare	Establish an effective health information and surveillance system covering priority diseases and health-system issues including capacity for programme assessment	Increase to a comprehensive health information and surveillance system that covers all major diseases, health-system issues, and key social determinants
Increase expenditure on health research in priority topics	Complete assessment of which neglected topics need more research	Increase funding for health research to 5% of total health budget	Increase funding for health research to 8% of total health budget
Drugs			
Reduce cost of drugs	Implement a national network of generic low-cost pharmacies to cover 40% of the population	Implement a national network of generic low-cost pharmacies to cover 70% of population	Implement a national network of generic low-cost pharmacies to cover 100% of population
Governance			
Enact appropriate legislation and adopt socioeconomic policies that support health goals	Enact the National Health Bill	Articulate and implement an integrated social determinants framework for health	Make all macroeconomic policies subject to an assessment of health effects
Require public health training for public health functionaries	Establish compulsory training and knowledge-enhancing programmes for public health functionaries	Make completion of public health training mandatory for senior positions in public health governance	All directors of health services and district health officers should have had public health training
Decentralise health planning	Implement health planning and management systems in districts	Implement health information systems and community accountability systems in districts	Ensure devolution of responsibility for health care to district management systems

Table: Goals, targets, and timelines

of India, has to be quickly advanced for enactment by the parliament. The Food Security Act must be enacted too, after strengthening its provisions to ensure food security for the people below the poverty line and other vulnerable people in the population. Other laws that have already been enacted, and can directly or indirectly advance health, should be effectively implemented. Some of the examples of these laws are the Indian Tobacco Control Act (2003), Persons with Disabilities Act (1995), National Trust Act for Disabled Persons (1999), Protection of Women Against Domestic Violence Act (2005), and the Prevention of Food Adulteration Act (1954). An autonomous council to ensure evidence-based and accountable health care would monitor the enforcement of these legislations.

Conclusions

We propose some targets and timelines to map the milestones for the achievement of universal health care in the table. We chose not to include disease-specific targets, such as reduction in infant mortality rate, because we believe that these will be addressed implicitly if our broader recommendations for radical transformation of India's health-care system are realised. We have proposed targets for 2012, 2015, and 2020. We call on India to ensure the achievement of a truly universal health-care system by 2020.

Our call to action is ambitious, but also commensurate with India's aspiration to be a leading player on the global stage. We, the members of *The Lancet* India Group for Universal Healthcare, like many others in this country, believe India can and should move in this direction, and we are committed to working with the Indian Government and other stakeholders to design the implementation plan for the Integrated National Health System, monitor the progress towards agreed goals, and present a report to the nation every 2 years.

We emphasise the urgency with which all of the recommended actions need to be taken if the objective of universal health care is to be achieved by 2020. Restriction of actions in one or some specialties of health care will not suffice. Interventions to increase the available health services will help but will have only a small effect if interventions are also not undertaken to radically transform the health system. Without mechanisms for health financing, which make health care universally accessible, even improvements in the quality of health services will not be provided to many people in the population. Without action to achieve the major determinants of health for which the locus of control resides in other sectors, actions confined to the health-care sector will provide only incomplete benefits. All of these actions are unlikely to be initiated or successfully implemented in a sustainable manner if a broad-ranging societal consensus and non-partisan political commitment are lacking.

We therefore call for a national debate about these recommendations and invite all stakeholders in India—government, civil society, private sector, academia, and

the media—to engage in an active dialogue for making universal health care a shared national goal by 2020. Two recent events make the timing of this call especially opportune. One is the outlining of the health sector priorities by the Health Minister of India, several of which are synchronous with the action proposed in our call.²⁷ The other is the setting up of a High Level Expert Group on Universal Healthcare by the Planning Commission of India. The secretariat of this group would be at the Public Health Foundation of India, which would help to engage a variety of stakeholders in this call to action. The Public Health Foundation of India partnered with *The Lancet* in developing this Series, and offers to help a coalition of all stakeholders to encourage debate about these issues in the public domain. Public health experts and advocates from other countries are also welcome to join this debate because the underlying values for our call to action are universally applicable, the call to action is based on global evidence, and the results of what happens in India will have ramifications across the world.

Contributors

KSR, VP, and LD led the drafting of the report; KSR and LD led the response to reviewer comments and revisions of the report; PJ, VKP, and AKSK contributed to the writing of the report; all members of *The Lancet* India Group for Universal Healthcare contributed ideas for the report, reviewed the report, and agreed on the final version.

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Conflicts of interest

We declare that we have no conflicts of interests.

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References

- 1 John TJ, Dandona L, Sharma VP, Kakkar M. Continuing challenge of infectious diseases in India. *Lancet* 2011; published online Jan 12. DOI:10.1016/S0140-6736(10)61265-2.
- 2 Paul VK, Sachdev HS, Mavalankar D, et al. Reproductive health, and child health and nutrition in India: meeting the challenge. *Lancet* 2011; published online Jan 12. DOI:10.1016/S0140-6736(10)61492-4.

- 3 Patel V, Chatterji S, Chisholm D, et al. Chronic diseases and injuries in India. *Lancet* 2011; published online Jan 12. DOI:10.1016/S0140-6736(10)61188-9.
- 4 Balarajan Y, Selvaraj S, Subramanian SV. Health care and equity in India. *Lancet* 2011; published online Jan 12. DOI:10.1016/S0140-6736(10)61894-6.
- 5 Rao M, Rao KD, Shiva Kumar AK, Chatterjee M, Sundararaman T. Human resources for health in India. *Lancet* 2011; published online Jan 12. DOI:10.1016/S0140-6736(10)61888-0.
- 6 Shiva Kumar AK, Chen LC, Choudhury M, et al. Financing health care for all: challenges and opportunities. *Lancet* 2011; published online Jan 12. DOI:10.1016/S0140-6736(10)61884-3.
- 7 Sen B. Securing the right to health for all in India. *Lancet* 2011; published online Jan 12. DOI:10.1016/S0140-6736(10)62182-4.
- 8 Raj A. Gender equity and universal health coverage in India. *Lancet* 2011; published online Jan 12. DOI:10.1016/S0140-6736(10)62112-5.
- 9 Grover A, Citro B. India: access to affordable drugs and the right to health. *Lancet* 2011; published online Jan 12. DOI:10.1016/S0140-6736(10)62042-9.
- 10 Sudarshan H, Prashanth NS. Good governance in health care: the Karnataka experience. *Lancet* 2011; published online Jan 12. DOI:10.1016/S0140-6736(10)62041-7.
- 11 Dandona L, Katoch VM, Dandona R. Research to achieve health care for all in India. *Lancet* 2011; published online Jan 12. DOI:10.1016/S0140-6736(10)62034-X.
- 12 UNDP. Human development report 2009. New York: United Nations Development Programme, 2009.
- 13 Report of the Health Survey and Development Committee (Bhore Committee). Delhi: Government of India; 1946. http://nihfw.org/NDC/DocumentationServices/Committee_and_commission.html (accessed July 9, 2010).
- 14 Jha P, Laxminarayan R. Choosing health: an entitlement for all Indians. Toronto: Centre for Global Health Research, 2009.
- 15 ICHDI. Report 2009. New Delhi: Independent Commission on Health and Development in India, 2009.
- 16 Bajpai N, Sach JD, Dholakia RH. Mid-term evaluation of the National Rural Health Mission. New York: Columbia University, 2009.
- 17 MoHFW. Janani Suraksha Yojana: guidelines for implementation. New Delhi: Ministry of Health and Family Welfare, Government of India; 2005. http://www.mohfw.nic.in/layout_09-06.pdf (accessed July 9, 2010).
- 18 Health and Family Welfare Department, Government of Gujarat. Chiranjeevi Yojana. http://gujhealth.gov.in/Chiranjeevi%20Yojana/M_index.htm (accessed July 9, 2010).
- 19 UNPF-India. Concurrent assessment of Janani Suraksha Yojana (JSY) in selected states. Delhi: United Nations Population Fund-India, 2009.
- 20 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. *Lancet* 2010; **375**: 2009–23.
- 21 Mavalankar D, Singh A, Patel SR, Desai A, Singh PV. Saving mothers and newborns through an innovative partnership with private sector obstetricians: Chiranjeevi scheme of Gujarat, India. *Int J Gynaecol Obstet* 2009; **107**: 271–76.
- 22 Ministry of Labour and Employment, Government of India. Rashtriya Swasthya Bima Yojna. <http://www.rsby.gov.in/> (accessed July 9, 2010).
- 23 MoHFW. The National Health Bill 2009: draft. New Delhi: Ministry of Health & Family Welfare, Government of India, 2009. www.mohfw.nic.in/nrhm/Draft_Health_Bill/General/Draft_National_Bill.pdf (accessed July 9, 2010).
- 24 WHO. Everybody's business: strengthening health systems to improve health outcomes. Geneva: World Health Organization, 2007.
- 25 MoHFW. The National Council for Human Resources in Health Draft Bill, 2009. New Delhi: Ministry of Health and Family Welfare, Government of India, 2009. http://mohfw.nic.in/Draft_Bill_-_The_National_Council_for_Human_Resources_for_Health_Bill_2009%20Part%202.doc (accessed July 9, 2010).
- 26 Das Gupta M, Desikachari BR, Somanathan DV, Padmanaban B. How to improve public health systems: lessons from Tamil Nadu. Washington DC: World Bank, 2009.
- 27 Press Information Bureau, Government of India. Azad outlines priorities for health sector. New Delhi: Ministry of Health & Family Welfare, Government of India, 2010. <http://pibmumbai.gov.in/scripts/detail.asp?releaseId=E2010PR1801> (accessed Oct 7, 2010).