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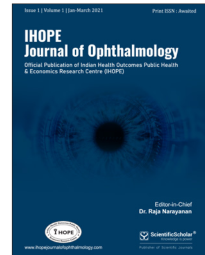
IHOPE Journal of Ophthalmology



Editorial

National health transformations

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Received : 15 September 2022
Accepted : 15 September 2022
Published : 23 September 2022

DOI
10.25259/IHOPEJO_25_2022

Quick Response Code:

Universal health care (UHC), where every citizen has access to quality, cost-effective health care, still has a long way to go. Providing quality health care and protecting people from healthcare-related financial burdens and catastrophes has been a continuous effort of modern civilizations. Starting from the Bismarck Model of social health insurance in the 19th century, the establishment of the National Health Service (NHS) after World War II, to the recent efforts toward Universal Health Coverage in India through its flagship initiative Pradhan Mantri Jan Arogya Yojana (PMJAY), is examples of health system transformations. These schemes and initiatives, despite the variations, have the characteristics of public financing for health care.

Most nations did not start with nationalized insurance systems. Great Britain established its NHS right after World War II, as a single-payer, single-provider system, the Beveridge model. This required a strong political will amid a realization that the government was failing in its commitment to its people's health. While widely promulgated as a model for many countries to follow, NHS as a universal model of national health care still needs to address many entrenched problems such as care rationing, efficiency, access, as well broadening patient choice.

In a comparative multi-country study across multiple parameters, including health equity, the UK was ranked 2nd, spending around 8% of its gross domestic product (GDP) on health care. In comparison, the USA fared poorly across all parameters, including quality of care, despite having the highest per capita expenditure on health as well as spending more than 17% of its GDP on health care. The key health indicators in the USA widely differ across socioeconomic classes, with those in the higher economic classes having access to the best care in the world. While the UK has the same health-care system for all its citizens, the US has a fragmented health system, from a single-payer-single-provider health system like the veteran's affairs system for the US Veterans to single-payer multiple provider systems such as Medicare and Medicaid for the seniors and underprivileged, multiple payers, and multiple providers as is seen in the private insurance markets and the enactment of the Affordable Care Act (ACA), with insurance exchanges. While the ACA was a major step to provide insurance options to all US citizens, issues of underinsurance and fragmented care delivery environments still need to be resolved. The recent US Supreme Court ruling on limiting women's reproductive rights has only served to erode health equity in the US.

In contrast to the macro challenges, the US faces around escalating costs, health equity, and access, the US scores highly on the management of diseases. The 5-year cancer survival rates are higher in the US than in the UK by 40%. The number of the US patients who received timely treatment for diabetes was more than 6 times that of the UK and twice that of Canada. Similarly, the percentage of the US seniors who received hip replacements within 6 months of diagnosis of need is more

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than 6 times that of the UK and twice that of Canada. The ratio of seniors with low income who were satisfied with the US health system was more than in any other country.

Cost, efficiency, and effectiveness remain major challenges in the US. The Biden administration has taken recent steps to address the cost of care challenges in the US. Till recently, Medicare did not have the power to negotiate drug prices. The Inflation Reduction Act, which President Biden signed into law on August 16, 2022, is likely to reduce prescription drug costs. Beginning in 2026, the federal government would have the authority to negotiate drug prices with manufacturers considering cost-effectiveness. There are certain limitations though on the number and type of drugs that can be negotiated. However, this is a bold step to reduce and manage the escalating care expenditures in the US.

The Canadian health system, which is a single-payer-multiple provider health model, has significantly lower costs with overall better health outcomes than many countries, including the US and the UK. Health insurance in Ontario is a publicly funded, state, National Health Insurance. Under the Canadian Health Act of 1984, the Health System is publicly administered, comprehensive, universal, portable across provinces, and accessible, without user fees and with free choice for patients. There can be no extra billing (balance billing). Primary care physicians serve as gatekeepers, and the state would pay lower fees to specialists for non-referred consultations. Canada also provides additional coverage to seniors, and children for health services that are not generally covered, such as vision care, medical equipment, podiatrists, and chiropractors. A centralized system of health insurance results in significantly lower administrative costs, compared to the cost of multiple systems such as in the United States.

Multiple countries, both developed and developing (Denmark, Japan, Brazil, Turkey, etc.), have demonstrated that UHC can be achieved despite much lower *per capita* health expenditure. These systems serve to inform us about lessons to incorporate in transforming India's health system.

India had a predominantly state health system for many decades after independence in 1947. The system design was excellent with Primary Health Centers, Community and District Health Centers, and Centers of Excellence at the national level. Most of the health care was provided through the government system till the early 1990s. Patients either paid nothing or minimal amount of fees for consultation and treatment. However, due to systemic underfunding in public health systems and poor quality of care, many private health-care providers entered the market to meet the demand for quality health care. However, these systems are targeted to the upper middle and affluent sections of India's society.

The past governments in India have focused on physician education and have ignored the need for increasing the supply and the quality of trained primary health workers and nurses. Public underfunding of health care is still a major problem. India spends only 2% of its GDP on health care and the quality of care provided by the health care institutes needs to dramatically improve. The establishment and the promulgation of health care institutional standards through the National Accreditation Board of Hospitals and Healthcare Providers have been a major step. However, major gaps remain in the systematic provision of health care based on national guidelines. Each institution is left to develop its own guidelines. A major impediment to improvement remains the lack of universally adopted care driven by Electronic Medical and Health Information Systems.

India needs to invest massively in its health systems, revive its existing facilities, expand them systematically around mandated standards for care delivery, technology adoption, transparency, and ethical care delivery, and move to digitally distributed care delivery models. Building a national health technology core will dramatically shift Indian health care toward a more quality-driven UHC model. Merging state health insurance programs and transforming India's traditional medicine system into an evidence-based system with accountability could dramatically address India's health workforce shortages.

PMJAY, launched by Prime Minister Modi in September 2018, is an excellent start to achieving the goal of UHC. It covers the bottom 40% of India's population. However, moving forward, taxpayers themselves should also be included in the coverage by a tax-funded program, so that the program is truly universal.

While health interventions in disease states have been covered in Health Benefit Packages (HBP), preventive health including screening which is extremely cost-effective should have adequate converge. For example, cancer screening and diabetes should be incentivized at the patient level. Individuals who undergo screening after the age of 40 years, for example, could be provided marginally higher benefits above the general coverage limit prevailing at that time. Incentive and partial control should be given to the patients on value perception. An example is co-pay, at least in the setting of health care in a private care setup. Co-pay is a strong gatekeeper to again consumption of low-value care. This consultation paper has alluded to unacceptable activities by healthcare providers. Co-pay also transfers some authority to patients for questioning less than expected service. Value-based care instead of only focusing on volume-based care is the way forward, coupled with incentives to increase quality, productivity, and improving access.

The consultation paper released by the National Health Authority of India is a promising policy document to improve the health system in India. The proposal of Health Financing and Technology Assessment (HeFTA) to improve

health care and reduce inequalities in health at national and state levels is commendable. The HeFTA unit will use a cost-effectiveness assessment of health technology to inform decisions regarding the inclusion and non-inclusion of interventions and procedures in the HBP. It will also make decisions on the pricing of new technologies for inclusion in the HBP and thereby allowing for the effective use of health budgets.

The transformation of India's healthcare system is finally seen as a national priority. Many critical initiatives have been taken to lay the foundation of a more equitable UHC model. However, a lot more needs to be done. While India learns from other countries' successes and failures, India must develop its system based on its own needs. The time has arrived for India to transform its healthcare system which will benefit every citizen.

This work was supported by the DBT Wellcome Trust India Alliance Clinical Research Centre Grant (grant number IA/CRC/19/1/610010) awarded to Dr. Raja Narayanan.

Acknowledgment

The authors acknowledge the help of Ms. Kriti Shukla, Research Associate at the Indian Institute of Public Health, Hyderabad, India.

How to cite this article: Narayanan R, Mehta M. National health transformations. IHOPE J Ophthalmol 2022;1:61-3.