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UNIVERSAL HEALTH COVERAGE IN MEGHALAYA

Report of a capacity-building program for Meghalaya government health officials (26-27 June 2023, Shillong)



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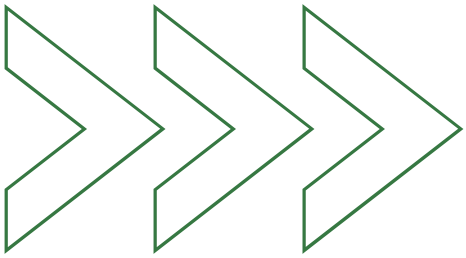
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Summary

Meghalaya is one of the few Indian states that has demonstrated extraordinary political and financial commitment towards promoting universal health coverage (UHC), and the first in India to extend it to its entire population.

The Meghalaya Health Policy, 2021 promises UHC to all its residents, with a special focus on preventive, promotive and public health. To ensure that curative care does not lead to catastrophic health expenditure, the state launched the Megha Health Insurance Scheme (MHIS) in 2012. Telemedicine facility was inaugurated in 2020, and drones are in use since 2021 to deliver medical supplies and receive diagnostic samples from remote areas under the Meghalaya Health Systems Strengthening Project (MHSSP).

Meghalaya's government health expenditure (as a % of general government expenditure) was India's highest in 2018-19 - becoming the only state to achieve the target of National Health Policy, 2017 to increase state health spending to more than 8% of the state budget by 2020. Its catastrophic health expenditure has been among the lowest in the country.

However, there are critical challenges to UHC that the state government needs to tackle to translate its commitment into improved, equitable health outcomes for its population. For instance, even after one decade of its launch, enrolment under MHIS stood at 55% of the eligible population. Birth and Aadhaar registrations are also low, limiting the capacity of unregistered population groups to benefit from public welfare schemes like the MHIS. While literacy rates are relatively high, higher educational attainment is among the lowest in the country. There are high levels of poverty as well as income and health inequalities. Although out-of-pocket health expenditures are not catastrophic, its health and nutrition outcomes definitely are. For instance, its child stunting level is India's highest, children with all basic vaccinations 2nd lowest, institutional births 2nd lowest, total fertility rate 2nd highest, child mortality rate 6th highest and maternal mortality ratio the 8th highest.

Meghalaya has a long way to go in terms of reducing health and socioeconomic inequities and improving health and nutritional outcomes for the population at large.

Preface

This report is based on desk research as well as group discussions and presentations at a capacity building program, "Analyzing and Accelerating Universal Health Coverage in Meghalaya", held on 26 and 27 June 2023 at Moreau Institute of Integral Training, Shillong.

The program was organized by Sambodhi Research and Communications (Noida), and commissioned by the Government of Meghalaya's Law Department, as part of a series of capacity building programs for Meghalaya government officials under the P A Sangma Fellowship for Legal and Policy Research.

This particular capacity building program was attended by 26 state government officials from the Directorate of Health Services, National Health Mission (NHM), MHIS, MHSSP, Meghalaya Institute of Mental Health and Neurological Science (MIMHANS) and Jhpiego.

I conceptualized, developed and conducted this capacity building program while I was a Deputy Vice President - Public Health Practices at Sambodhi. However, I conducted the desk research and developed the report subsequently.

This report was neither a requirement under the program, nor was it developed with any funding whatsoever. Meghalaya offered a very interesting case study of universal health coverage, both from an empirical and conceptual perspective, and I thought a report on its achievements and challenges would be a great first publication of UHC360. The report being based on group discussions and presentations also matches well with its objective of utilizing multi-stakeholder, multi-sectoral and multi-disciplinary collaborative methods for the identification of challenges and solutions to accelerate universal health coverage in low and middle income contexts like Meghalaya's.

I hope readers find our first report worthy and interesting.

Ali Mehdi
Founder, UHC360

Acknowledgments

I would like to express my deepest gratitude to Sambodhi and Government of Meghalaya for providing me with the wonderful opportunity to conduct a capacity building program on universal health coverage as well as to all the fantastic participants who spared their valuable time to proactively participate in the program.

While I made a humble effort to enhance the participants' conceptual understanding of universal health coverage and promote a collaborative approach for the identification of challenges and solutions, they provided me with valuable insights regarding the status, challenges and potential solutions to accelerate universal health coverage in Meghalaya. The capacity building was mutual. This is how it should be as part of collaborative efforts.

I would like to particularly and profoundly thank Dr Rajib Nandi, Vice President of Capacity Building at Sambodhi, as well as his ever-smiling and ever-helpful associate, Mr Amartya Krishna Roy, for all their amazing support in organizing the required logistics for my travel and the smooth conduct of the program.

Introduction

Demonstrating extraordinary political and financial commitment for the promotion of universal health coverage (UHC), Meghalaya was India's first state to offer UHC to its entire population.

Meghalaya Health Policy, 2021 promises UHC to all its residents, with a special focus on preventive, promotive and public health.

To ensure that curative care does not incur catastrophic out-of-pocket health expenditure, the state launched the Megha Health Insurance Scheme (MHIS) in 2012. In its present version (MHIS-5), it provides an insurance cover of INR 530,000 per family per year, including an OPD cover of INR 30,000. However, enrolment stood at 55% under the MHIS even after a decade (Dutta et al 2022). The government plans to cover the entire state population in the next 2 years, the Chief Minister stated in his Budget 2023-24 speech.

According to National Family Health Survey, 2019-21 (NFHS-5), Rajasthan (88%) and Andhra Pradesh (80%) top the list of Indian states / UTs in terms of percentage of households with at least one member covered by a health scheme or health insurance. Meghalaya (69%) shared the 5th spot with Telangana.

Rajasthan's Mukhya Mantri Chiranjeevi Swasthya Bima Yojana, launched in 2021 for all state citizens, started with a cover of INR 500,000 - which was increased to INR 1,000,000 in 2022 and INR 2,500,000 in 2023. The better-off have to pay a premium of INR 850 per family per year. Within 10 months (May 2021 to February 2022), the scheme had covered 80% of the state population.

Andhra Pradesh's Dr YSR Aarogyasri Scheme, launched in 2007 as Aarogyasri, offers a cover of INR 500,000 per family per year to below poverty line (BPL) families. There are other eligibility criteria that are quite generous. The premium is paid by the state government for BPL families. It covered 14.2 million families as per the state's Socio-Economic Survey 2022-23.

Meghalaya was the only Indian state in 2018-19 to achieve the target of National Health Policy, 2017 to increase state health spending to more than 8% of the state budget by 2020.

Meghalaya's government health expenditure (GHE) as percentage of general government expenditure (GGE) was the highest in India during 2018-19. Its GHE as % of GGE as well as GSDP (Gross State Domestic Product) was India's third highest in 2019-20. Its GHE as % of GGE even exceeded the 10% mark in 2020-21. Its population with no health expenditure support and with catastrophic out-of-pocket health expenditure has been among the lowest nationally.

However, Meghalaya's high level of poverty and income inequality coupled with low levels of higher education are worrying from the standpoint of social determinants of health. No wonder its health and nutritional outcomes are among the worst in the country. We need to appreciate that SDG 3.8 on UHC is part of SDG 3 - 'ensure healthy lives and promote well-being for all at all ages'. We need to ensure that UHC leads to healthy lives and well-being for all.

Speaking of health equity, vast health and nutritional inequalities are another challenge for Meghalaya. According to NFHS-5 -

- Institutional deliveries ranged from 90% in West Garo Hills to 42% in South West Khasi Hills.
- While 87% children (12-23 months) had all basic vaccinations in South Garo Hills, this number was 48% in North Garo Hills.
- Total fertility rate was 1.6 in urban and 3.3 in rural Meghalaya, 0.8 among Hindus, 1.4 among Muslims, 3.2 among Christians.
- Stunting among children (0-59 months) was 30% in South Garo Hills and 59% in West Khasi Hills, 36% among Hindus and 51% among Muslims.
- Child mortality rate was 0 in urban and 9.3 in rural Meghalaya.
- Multidimensional poverty headcount ratio ranged from 32% in rural to 8% in urban Meghalaya, 53% in West Khasi Hills to 8% in West Garo Hills.

Indicator	Value	Time (Source)	National position
Basic indicators			
Projected population (millions)	3.3	30 June 2023 (1)	
Population with Aadhaar card	72%		2nd lowest
Rural households	78%	2019-21 (2)	
Institutional births	58%		2nd lowest
Birth registration (children <5 years of age)	82%		5th lowest
Death registration	54%		7th lowest
Medically certified deaths (as % of total registered deaths)	24%	2020 (3)	17th highest
Educational status			
Literacy rate among women aged 15-49 years	88%	2019-21 (2)	7th highest
Literacy rate among men aged 15-49 years	83%		10th lowest
Females ≥6 years of age with ≥12 years of schooling	13.4%		8th lowest
Males ≥6 years of age with ≥12 years of schooling	14.1%		Lowest
Economic status			
Government health expenditure (GHE) as % of general government expenditure	9.1%	2018-19 (9)	Highest
	8.9%	2019-20 (4)	3rd highest
	10.3%	2020-21 (10)	
GHE as % of Gross State Domestic Product (GSDP)	2.7%	2019-20 (4)	3rd highest
Incidence of catastrophic out-of-pocket health expenditure (exceeding 10% of household consumption expenditure)	1.2%	2004 (5)	3rd lowest
	1.1%	2018 (5)	4th lowest
Population with no health expenditure support (rural)	44.7%	2017-18 (11)	7th lowest
Population with no health expenditure support (urban)	52.5%		5th lowest
Gini co-efficient (income inequality)	0.25	2019-21 (2)	2nd highest
Health and nutritional status			
Multidimensional poverty headcount ratio	28%	2019-21 (6)	3rd highest
Total fertility rate	2.9	2019-21 (2)	2nd highest
Maternal mortality ratio	163	2019 (7)	8th highest
Life expectancy at birth (years)	69.8	2017 (8)	20th highest
Children aged 12-23 months with all basic vaccinations	64%	2019-21 (2)	2nd lowest
Children aged 0-59 months who are stunted	47%		Highest

Sources: 1 - UIDAI (2023); 2 - NFHS-5 (2022); 3 - RGI (2022); 4 - NHATS (2023); 5 - Mohanty (2020); 6 - NITI Aayog (2023); 7 - GBD (2021); 8 - India State-Level Disease Burden Initiative Air Pollution Collaborators (2019); 9 - XV Finance Commission (2020); 10 - PRS (2023); 11 - NHP (2022).

Beyond and before the socioeconomic, there are much more basic challenges to UHC (geographical, demographic, infrastructural and institutional) that Meghalaya needs to address on a priority basis.

Being mountainous with poor roads has led to limited health care availability and accessibility in rural and remote regions.

As remedial measures, the Government of Meghalaya launched telemedicine in 2020, and initiated the use of drones in 2021 to deliver medicines, vaccines, etc. as well as receive diagnostic samples from remote regions as part of the World Bank-funded Meghalaya Health Systems Strengthening Project (MHSSP).

Despite its population being predominantly rural, there has been a strong urban bias in the availability of private health facilities in the state. Close to 90% of them are in the state capital, Shillong, "impeding the realization of UHC," argues a paper co-authored by Meghalaya's Principal Health Secretary (Dutta et al 2022: 8-9).

Aadhaar registration in the state is second lowest in the country. There are wide differentials in Aadhaar registration by district - from 100% in South West Garo Hills to 35% in West Khasi Hills (June 2023). During 2019-21, it was only 28% in rural Meghalaya vis-a-vis 51% in urban Meghalaya and 89% in rural India (NFHS-5).

Aadhaar is mandatory to enrol for the MHIS as it is linked with the Central government's principal UHC scheme, Ayushman Bharat. Given migrant influx from neighboring Bangladesh, MHIS officials specially insist on Aadhaar to establish citizenship and eligibility.

Not just Aadhaar, Meghalaya's birth and death registration levels are also among the lowest in the country. Low death registration means low level of institutional care at the time of death, leading to high levels of preventable mortality as well as scant data about causes of death, which is critical for the evidence-based design, monitoring and evaluation of health policies and programs.

Addressing the institutional disconnect - reflected in low levels of Aadhaar, birth and death registrations as well as institutional deliveries - should be a priority for expansion of UHC in the state.

UHC challenges, solutions, good practices - Participants' views

This section features some of the key challenges, solutions and good practices of UHC in Meghalaya, identified by participants of the capacity building program in Shillong through group discussions and presentations.

CHALLENGE 1

Primary health care (PHC) network needs strengthening.

Solutions

1) Knee-jerk reaction to problems should give way to more sustainable solutions.

2) MHSSP should cover the entire state. At the moment, it is being piloted in 2 districts.

3) Invest in the most important resource – the Human Resources for Health, especially in terms of recruitment, training and retention.

4) Leverage information technology to enhance efficiency.

5) Health records need to be digitized so that doctors have access to patient history.

6) Two-way referral system needs to be strengthened.

7) There should be continuous, built-in monitoring and evaluation to assess where we stand vis-a-vis our challenges and to ensure that we are moving towards our goals.

8) There should be information sharing between various health centres so that there is mutual learning in terms of challenges faced and solutions developed and adopted.

Good practices

1) PHC in Meghalaya has a strong health promotion and disease prevention focus.

2) Centralized procurement through Meghalaya Medical Drugs & Services Limited (MMDSL) as per essential drugs list (EDL) has reduced duplication. Supply is being done directly to health facilities. Software being used is producing data for analysis.

3) To tackle the challenge of remote access, the state is using telemedicine and drone delivery of drugs and diagnostic samples.

4) Wastewater surveillance of Covid-19 is ongoing to identify potential early warning signals and be prepared for any health emergencies.

CHALLENGE 2

There is limited multisectoral coordination.

Solution

There should be a forum where related entities can share problems as well as solutions. At the moment, problems are raised to concerned departments, but we don't know the status of action, while follow-up is never done.

CHALLENGE 3

There is widespread public hesitancy to get identification documents. Absence of them prevents access to government benefits like the MHIS.

Solutions

1) Studies should be conducted on reasons and behavioural change strategies.

2) Conduct impact assessment of ongoing awareness programs.

3) Make it easy to get identification.

4) Strengthen civil registration system (CRS) in the state.

5) Village Health Councils can play a central role in strengthening registration systems - they can maintain the CRS in their localities - and in liaising with officials. This will lead to greater acceptance of institutional registrations in the population.

CHALLENGE 4

Lack of assessment of health challenges and inequities and roadmap for tackling them.

Solutions

1) Develop assessment checklists with selected indicators.

2) Get regular data on these indicators from facilities and share with stakeholders.

3) There should be collaborative mapping of vulnerable populations to tackle health inequalities.

4) Develop roadmaps to tackle health challenges and inequities in collaboration with stakeholders, especially local communities.

CHALLENGE 5

There are few collaborative partnerships with the non- and for-profit sector, etc.

Solutions

1) There should be awareness at various levels about the possibilities for collaborations.

2) There should be need-based partnerships with various stakeholders.

3) Develop Standard Operating Procedures (SOPs) and financing models for collaborations.

4) There should be outreach to different stakeholders for dissemination purposes.

5) Different stakeholders should also be able to propose collaborations.

Good practice (emerging)

Voluntary blood donation pilot with Terumo Blood and Cell Technologies, India Office.

CHALLENGE 6

Communities are resistant to behavioural change programs of Village Health Sanitation and Nutrition Committees (VHSNCs).

Solutions

1) Hold consultative workshops after awareness programs for impact assessment.

2) There should be a Jan Arogya Samiti (JAS) - part of comprehensive primary health care (CPHC) under Ayushman Bharat – at every sub-centre. JAS should hold monthly meetings with ASHAs.

3) There should be more involvement of men in JAS for greater social acceptability.

4) There should be a bottoms-up approach to health needs assessment, planning, etc.

5) JAS should be encouraged to pool resources from various sources for greater local involvement and ownership.

CHALLENGE 7

There is inadequate health financing vis-a-vis population's economic status.

Solutions

1) Strengthen health promotion, disease prevention, public health, quality of care and monitoring and evaluation systems to make the best use of limited resources.

2) Food availability, safety and quality should be strengthened to address malnutrition.

3) There should be more untied funds to encourage local resource planning as per local health needs.

4) Potable water should be made available.

CHALLENGE 8

There is inadequate strategic planning and priority-setting vis-à-vis the continuum of care (promotive, preventive and curative care, etc.).

Solutions

1) Quality has to be prioritized in everything.

2) Communities should be involved in priority-setting. They should take ownership of their health ultimately.

CHALLENGE 9

There is limited financial awareness in health system staff.

Solutions

1) Studies, surveys and consultative workshops should be conducted before deciding on the health budget.

2) There should be enhanced data use for health planning purposes.

3) Doctors and other health staff should be involved in developing National Health Mission (NHM) State Program Implementation Plans (PIPs).

CHALLENGE 10

There is limited cost-effectiveness analysis of health interventions. IQVIA did a study on MHIS cost-effectiveness, but it is not up to the mark.

Solution

Develop a culture of accountability, monitoring and evaluation in the health staff.

OTHER CHALLENGES

Given limited time, groups were not able to brainstorm solutions for all the challenges that they had identified. Below is a list of such challenges.

11) Lack of adequate, well-trained and skilled health workforce

12) Limited access to technology

13) Limited availability of essential medicines, equipment and infrastructure

14) Challenges related to health information systems

Lack of properly classified data - data systems not talking to each other (fragmentation) - data analysis and use is a major issue - bi-directional flow of data is missing (bottom-top-bottom) – lack of data sharing with health facilities and communities after analysis (centralized data repository and universal access to cleaned up data is missing) - lack of adequate training of health staff in data handling – as a result of these data challenges, accountability at various levels of the health system is missing

15) Challenges related to mental health

Limited awareness, social stigma and discrimination - beliefs and cultural practices - lack of daycare centers and special schools for children

Next steps

Where do we go from here?

UHC has to be work in progress - until the SDG 3 goal of healthy lives and well-being for all is achieved. Below are 4 steps that Meghalaya needs to take in the near term for improved health outcomes and equity.

01

Meghalaya UHC Collaborative

A formal UHC collaborative of global and national experts and stakeholders and a Secretariat should be set up. Its primary role should be to identify multi-sectoral / -disciplinary challenges and solutions to accelerate UHC in Meghalaya.

02

Health needs assessment

UHC means everyone has access to the health services they need. However, no agency or government does any health needs assessment for UHC. Meghalaya should do it on priority and regular basis for a needs-based approach to UHC.

03

Priority-setting for UHC

Needs are unlimited, but resources are limited. How do we make the best use of available resources? Which and whose needs should be prioritized? Ethical and economic studies as well as stakeholder and expert consultations are required.

04

Population approaches to UHC

The Meghalaya Health Policy, 2021 aptly emphasizes public as well as preventive and promotive health. Meghalaya should consider how to leverage them together with curative, palliative and rehabilitative care within the broader UHC framework.

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