

UID AND PUBLIC HEALTH

The Unique Identification (UID) project is a historic venture that seeks to provide a unique registration code to every Indian citizen. We surmise that the starting point would be to aggregate records from various population databases such as the census, the PDS system, voter identity systems, etc, while dealing with the challenge of duplication.

Existing data bases would probably still leave a large percentage of the population uncovered. Therefore every citizen must have a strong incentive or a “killer application” to go and get herself a UID, which one could think of as a demand side pull. The demand pull for this needs to be created de novo or fostered on existing platforms by the respective ministries. Helping various ministries visualise key applications that leverage existing government entitlement schemes such as the NREGA and PDS will (1) get their buy-in into the project (2) help them roll out mechanisms that generate the demand pull and (3) can inform a flexible and future-proof design for the UID database. It will also build excitement and material support from the ministries for the UID project even as it gets off the ground.

Health, and health related development schemes could offer a killer application for the UID. After years of neglect, public health in India is seeing a revolution both in terms of (1) greater commitment towards government financing of public and primary healthcare (2) pressure to meet the MDG goals (3) consequent creation of large supply platforms at national levels such as the NRHM, RSBY and complementary state level initiatives such as the Rajiv Arogyasri insurance scheme in Andhra Pradesh. In health there is a cumulative historic gap both in terms of demand and supply. The UID could further help catalyse a revolution in India's health outcomes.

What would be the public health associated payoff through the application of the UID?

Major challenges in public health today include (1) lack of detailed denominator (ie target population to be covered) focussed services delivery by the government's rural and urban healthcare systems at district and sub-district levels (2) poor tracking of health conditions by for example, the ICD-10 disease classification system and (3) lack of ability to roll out at scale, expansion of ambitious national health insurance schemes like the RSBY.

Thus for example, India's coverage of its annual birth cohort of 27 million children through childhood vaccinations has been stagnating at circa 55% for the most elementary bouquet of vaccines. Similarly antenatal check-up coverage of the roughly 27 million pregnant women is nationally about 52%, and only 47% of women deliver in institutions. While the first is a problem related to poor denominator tracking at the lowest level of the government's public health system by frontline health workers, the second additionally also poses a challenge of appropriately administering such demand side incentive schemes such as the JSY to increase institutional births.

Routine health information systems (including vital registration, cause of death identification, disease reporting) that capture and track the morbidity and mortality due to various disease

conditions are critical to improving public health outcomes including life expectancy. Currently infrequent national or state surveys are the major mode of capturing data on infectious disease conditions. However, chronic or lifestyle diseases are not captured in any meaningful way even through surveys. These pose new challenges for an already strained public health system. An integrated routine health system that can capture and track population level disease conditions by linking citizen ids with hospital or other medical facility records generated through facility visits can (1) inform the public health system of the prevalence of various routine disease conditions (2) help prepare the health system to respond to unforeseen epidemics. A partial example of (1) above can be seen under the Rajeev Arogyasri insurance scheme in Andhra Pradesh, but taking this to scale across the country will require coordination between the UID project, the Ministry of Health and the Ministry of Labour (see below).

The launch of the RSBY (Rashtriya Swasthya Bima Yojana) by the Ministry of Labour is a great example of a killer app waiting for a platform. Launched about fourteen months ago, it is intended to eventually provide in some form or other in partnership with states, the country's entire population with insurance coverage. Since launch only approximately 5.4 million individuals in some 370 districts of 18 states have been covered. RSBY does include the provision of a card and supports a putatively large but very simple field registration effort. Partnering with this scheme will (1) provide an additional and fresh, unlikely to be duplicated source of registrations for the UID and (2) more importantly, in conjunction with linkages to a routine health information system can improve public health in terms of efficiency and outcomes.