How to Deliver Universal Health Coverage in India: An Empirical Review of Global evidence

A dissertation submitted in partial fulfillment of the requirements for the award of

Post-graduate Programme in Hospital & Health Management

By
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Under Guidance of:

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Certificate of Approval

The following dissertation titled " **How to Deliver Universal Health Coverage in India: An Empirical Review of Global evidence**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post-Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

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Certificate from Dissertation Advisory Committee

This is to certify that **Mr. Akhilendra Kumar Trivedi,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He is submitting this dissertation titled " **How to Deliver Universal Health Coverage in India: An Empirical Review of Global evidence**" in partial fulfillment of the requirements for the award of the **Post-Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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Dated: 9th May 2012

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Mr. Akhilendra Kumar Trivedi, student of International Institute of Health Management Research, New Delhi has successfully completed his internship in our organization from January 24, 2012 to May 1, 2012.

During this internship he has worked on preparation of background notes/minutes/reports on various health related subject under the guidance of Dr. Rakesh Sarwal, Adviser (Health) and his team.

Throughout the period of Internship his performance was satisfactory.

Arundhati Singh

(Arundhati Singh)

Acknowledgement

I am wholeheartedly grateful to Dr. Rakesh Sarwal for giving me opportunity to carry out my internship at Planning Commission of India for period of three months in the Health & Family Welfare Division. It is my honour to have worked under Dr. Sarwal during the dissertation. His constant support and encouragement has been a source of great inspiration for me. His critical appraisal and pertinent suggestions have been aid me in shaping this report. I am extremely obliged for his keen interest, constant support and guidance.

I would like to express my sincere regards and gratitude to Dr. Amandeep Singh for providing me constant support and valuable supervision. His important and decisive suggestions are extremely helpful in shaping this report.

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Akhilendra Kumar Trivedi

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Index

Internship Report

1. Organizational Profile

1.1About Planning Commission of India:

The Planning Commission was set up by a Resolution of the Government of India in March 1950 in pursuance of declared objectives of the Government to promote a rapid rise in the standard of living of the people by efficient exploitation of the resources of the country, increasing production and offering opportunities to all for employment in the service of the community. The Planning Commission was charged with the responsibility of making assessment of all resources of the country, augmenting deficient resources, formulating plans for the most effective and balanced utilisation of resources and determining priorities. Jawaharlal Nehru was the first Chairman of the Planning Commission.

The first Five-year Plan was launched in 1951 and two subsequent five-year plans were formulated till 1965, when there was a break because of the Indo-Pakistan Conflict. Two successive years of drought, devaluation of the currency, a general rise in prices and erosion of resources disrupted the planning process and after three Annual Plans between 1966 and 1969, the fourth Five-year plan was started in 1969.

The Eighth Plan could not take off in 1990 due to the fast changing political situation at the Centre and the years 1990-91 and 1991-92 were treated as Annual Plans. The Eighth Plan was finally launched in 1992 after the initiation of structural adjustment policies.

For the first eight Plans the emphasis was on a growing public sector with massive investments in basic and heavy industries, but since the launch of the Ninth Plan in 1997, the emphasis on the public sector has become less pronounced and the current thinking on planning in the country, in general, is that it should increasingly be of an indicative nature.

1.2. Functions

The 1950 resolution setting up the Planning Commission outlined its functions as to:

a. Make an assessment of the material, capital and human resources of the country, including technical personnel, and investigate the possibilities of augmenting such of these resources as are found to be deficient in relation to the nation's requirement;

b. Formulate a Plan for the most effective and balanced utilisation of country's resources;

c. On a determination of priorities, define the stages in which the Plan should be carried out and propose the allocation of resources for the due completion of each stage;

d. Indicate the factors which are tending to retard economic development, and determine the conditions which, in view of the current social and political situation, should be established for the successful execution of the Plan;

e. Determine the nature of the machinery which will be necessary for securing the successful implementation of each stage of the Plan in all its aspects;

f. Appraise from time to time the progress achieved in the execution of each stage of the Plan and recommend the adjustments of policy and measures that such appraisal may show to be necessary; and

g. Make such interim or ancillary recommendations as appear to it to be appropriate either for facilitating the discharge of the duties assigned to it, or on a consideration of prevailing economic conditions, current policies, measures and development programmes or on an examination of such specific problems as may be referred to it for advice by Central or State Governments.

1.3 Evolving Functions

From a highly centralised planning system, the Indian economy is gradually moving towards indicative planning where Planning Commission concerns itself with the building of a long term strategic vision of the future and decide on priorities of nation. It works out sectoral targets and provides promotional stimulus to the economy to grow in the desired direction.

Planning Commission plays an integrative role in the development of a holistic approach to the policy formulation in critical areas of human and economic development. In the social sector, schemes which require coordination and synthesis like rural health, drinking water, rural energy needs, literacy and environment protection have yet to be subjected to coordinated policy formulation. It has led to multiplicity of agencies. An integrated approach can lead to better results at much lower costs.

The emphasis of the Commission is on maximising the output by using our limited resources optimally. Instead of looking for mere increase in the plan outlays, the effort is to look for increases in the efficiency of utilisation of the allocations being made.

With the emergence of severe constraints on available budgetary resources, the resource allocation system between the States and Ministries of the Central Government is under strain. This requires the Planning Commission to play a mediatory and facilitating role, keeping in view the best interest of all concerned. It has to ensure smooth management of the change and help in creating a culture of high productivity and efficiency in the Government.

The key to efficient utilisation of resources lies in the creation of appropriate self-managed organisations at all levels. In this area, Planning Commission attempts to play a systems change role and provide consultancy within the Government for developing better systems. In order to spread the gains of experience more widely, Planning Commission also plays an information dissemination role.

1.4 Organization

The Prime Minister is the Chairman of the Planning Commission, which works under the overall guidance of the National Development Council. The Deputy Chairman and the full time Members of the Commission, as a composite body, provide advice and guidance to the subject Divisions for the formulation of Five Year Plans, Annual Plans, State Plans, Monitoring Plan Programmes, Projects and Schemes.

The Planning Commission functions through several Divisions, each headed by a Senior Officer. The Set up is:

1. **Chairman**
2. **Sh. Montek Singh Ahluwalia, Dy. Chairman**
3. **Shri Ashwani Kumar, Minister of State**
4. **Members**
    - **Shri B. K. Chaturvedi**
    - **Saumitra Chaudhuri**
    - **Dr.(Ms.) Syeda Hameed**
    - **Dr. Narendra Jadhav**
    - **Prof. Abhijit Sen**
    - **Dr. Mihir Shah**
    - **Dr. K. Kasturirangan**
    - **Sh. Arun Maira**
5. **Ms. Sindhushree Khullar, Secretary**
6. **Senior Officials**
7. **Grievance Officers**

1.5 Divisions in Planning Commission

1. Agriculture 2. Communication, IT& Information 3. Decentralized planning, Panchayati Raj and Special Area Programme (Including Western Ghat Secretariat) 4. Development Policy & Perspective Planning 5. Environment & Forests (Including Climate Change Cell) 6. Financial Resources 7. Health, Family Welfare & Nutrition 8. Housing and Urban Affairs (including Home Affairs Cell) 9. Human Resources Development 10. Industries 11. Infrastructure 12. International Economics 13. International Relations Cell 14. Labour, Employment & Manpower 15. Minerals	16. Minority Cell 17. Plan Coordination and Management 18. Power & Energy 19. Project Appraisal & Management 20. Rural Development 21. Science & Technology 22. Social Justice and Social Welfare 23. Socio-Economic Research 24. State Plans (Including Island Development Authority Cell) 25. Transport and Tourism 26. Village and Small Enterprises 27. Voluntary Action Cell 28. Water Resources Division 29. Women & Child Development 30. Programme Evaluation Organization

1.6 Area of engagement: The area of work is Health, Family Welfare And Nutrition Division, New Delhi which is responsible of making assessment of health related resources of the country, augmenting deficient resources, formulating plans for the most effective and balanced utilisation of resources and determining priorities.

1.6.1. About Health, Family Welfare and Nutrition Division:

The Division has following important functions: -

1. Evolving policy and strategy guidelines pertaining to:
    - Health & Family Welfare with a special reference to the flagship programme, the National Rural Health Mission (NRHM).
    - HIV/AIDS Control,
    - AYUSH
    - Health Research,
    - Nutrition
2. Drawing up short–medium-and long-term perspectives and goals for each of the above.
3. Monitoring changing trends in the health sector viz., epidemiological, demographic, social and managerial challenges.
4. Examining current policies, strategies and programmes in health and family welfare and nutrition sector, both in the States and in the Central sector and suggest appropriate modifications/mid course corrections.
5. Suggesting methods for improving access, affordability, accountability, efficiency and quality of services.
6. Evolving priorities for basic, clinical and operational research essential for improving health status of the population and achieving rapid population stabilization.
7. Looking into inter-sectoral issues and evolving appropriate policies and strategies for convergence of services so that the population benefits optimally from on-going programmes.
8. The Division represents the Planning Commission in:
    a. Various Committees of Ministry of Health & Family Welfare and Ministry of Women & Child Development.
    b. EFC/SFC pertaining to Ministry of Health & Family Welfare and Ministry of Women & Child Development.
    c. Scientific Advisory Groups of Indian Council of Medical Research, National Institute of Health & Family Welfare, Public Health Foundation of India, etc.
9. Expert Panels set up from time to time to advise the Planning Commission regarding the priorities and targets in the Plans and Programmes relating to Health and Nutrition

sector - the resources including human and material required, the training programmes to be initiated, standards of construction and equipment for health facilities and the development of health research etc.

Linked Ministries:

1. Ministry of Health and Family Welfare,

2. Ministry of Women and Child Development.

2. Implementation tasks: Throughout my dissertation, I was directly engaged into the following tasks

1. To assist the internal supervisor in his day to day activities.

2. Preparation of the background notes of states for internal evaluation

3. Prepration of minutes of meetings.

4. Prepration of brief note on health related subject.

5. Give inputs in the Twelfth Five year Plan process for Health.

6. Reviewed various reports like HLEG Report, Steering Committee Report, etc in order to respond on the query from respective departments and officials.

7. Assisted in making the power point presentation.

Meetings And Workshop attended during the internship period are listed below:

- Attended Member level Discussions on Annual Plan 2012-13, Ministry of Health & family Welfare.
- Attended Workshop on the Promotion of innovation and their Scale-up in Social Sector
- Attended the two- day National Conference on Universal Health Coverage in India: Advancing the Agenda and Addressing the Challenges organized by the Public Health Foundation of India and the Health Economics Association of India at PHD House
- Attended the presentation on the Methods to Curb and Control malnutrition, Hunger, and Suicides before the Members of the Women and Child Development Division and Officials of Planning Commission presented by the Dr, Santilal Kothari, president, Academy of Nutrition Improvement

Reflections from internship Planning Commission of India, Health, Family Welfare & Nutrition Division:

An internship is a learning experience, during the entire period of internship, various phases gave various types of knowledge varying from soft skills, stress handling to technical advancements.

The exposure to the Planning Commission provides me the valuable knowledge regarding the planning, budgeting, and implementation of the various Health related Programmes running in the country. I feel fortunate to get involved in the preparation of the Health Chapter for the Twelfth Five Year Plan, the preparation process has been enhanced my knowledge regarding the various aspects of the health for example, budgeting, scheme description, etc to be very learning for me, during this entire process I have done lot of secondary research activities of the internal documents like Report of the Working Group on National Rural Health Mission (NRHM) for the Twelfth Five Year Plan (2012-2017), Report of the Working Group on Disease Burden for the 12th Five Year Plan, Report Of The Working Group On Tertiary Care Institutions For 12th Five Year Plan(2012-2017), Steering Committee on Health for the Twelfth Five-Year Plan (2012-2017), Fifth Common Review Mission Report 2011, High level Expert Group Committee Report on Universal health Coverage, Coverage Evaluation Survey 2009, District Level Household Survey-III, National Family Health Survey-III for evidence building of the chapter content..

No work is possible without coordination among the team members. Few of the tasks given required everyone's input and working as a team to finish the assigned tasks.

One of the most important lessons I have learned thus far is that flexibility is essential. As I was involved in two projects, shifting focus from one to another was little difficult, but multi tasking is the key here. There are days when you are working on an assignment and something very important comes up and you have to switch gears to focus your attention on that. You must be able to jump on that task and complete it with the best of your ability.

Also, I was open to criticism. Soaked up all the advice and critiques my seniors gave me. The guidance from the seniors helped me in completing the tasks as well as developing the required skills to perform well.

Dissertation Report

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CSMBS	Civil Servant Medical Benefit Scheme
DH-	District Hospital
DHS	District Health System
DR G	Diagnostic Related Group
EAG	Empowered Action Group
ESI	Employees' State Insurance
FFS	Fee-For-Service
HC	Health Centres
HIC	High Income Countries
HIV	Human immunodeficiency Virus
HLEG	High Level Expert Group
HMOs	Health Maintenance Organizations
IPAs	Independent Practice Associations
LMIC	Low and Middle Income Countries
MOH	Ministry of Health
NGO	Non-Governmental Organizations
NHP	National Health Package
NHS	National Health Service
NICE	National Institute of Health & Clinical Excellence
NRH	National Rural Health Mission
OOP	Out of Pocket Expenditure
PAB	Basic Health Package
PNHP	Physicians for a National Health Program
RKVY	Rashtriya Krishi Vikas Yojana
RTI	Right to Information
SHI	Social Health Insurance
SSS	Social Security Scheme
UC	Universal Coverage

UHC	Universal Health Coverage
UN	United Nations
VHI	Voluntary Health Insurance
WHA	World Health Assembly
WHO	World Health Organization

Abstract

Universal Health Coverage is defined as a system under which a specified package of benefits been provided to all members of a society with the end goal of providing financial risk protection, improved access to health services, and improved health outcomes i.e. it incorporates two complementary dimensions in addition to financial risk protection: the extent of population coverage and the extent of health service coverage.

Countries that have achieved the universal health-care coverage typically fall into two different groups, taxed-financed system and social insurance system.

Countries with predominantly tax-financed systems include China, Italy, New Zealand, Spain, Sri Lanka, United Kingdom, Switzerland and Thailand. Under this type of system, the predominant mode of collecting finances is through general revenue tax financing with government operation of publicly-financed health care services, which are made available to all citizens at free or at a minimal price. Countries with social insurance systems include Germany, Australia, Japan, and Republic of Korea. This type of system involves the use of mandatory social insurance as the mechanisms for collecting funds. Some other countries in the region also use a mixture of above two models as the main strategy for financing health services example Sweden, and France

In India, the inability of public funded health services to reach rural populations, people in the informal sector, poor infrastructure and weak political will has led to some implications to implement UHC so, the best way to implement the universal health care is to run pilots in at least one district of each state depending on availability of services, namely with public providers only, and a second model with public and empanelled private and NGO providers. In both models, each family should be able to opt for their ‘provider of choice’, the choice being exercised once a year and on the basis of the performance of the model, the best suited model is expanded.

I. Introduction:

Universal Health Coverage (UHC) as it is conceptualised today, refers to ensuring access, for all citizens of the country to appropriate promotive, preventive, curative and rehabilitative health services, at an affordable cost, so people do not suffer financial hardship while paying for them.[1,2] UHC is one mechanism of ensuring balanced development, where the economic growth of a nation is accompanied by an increases paralleled with increase in the health and well being of all persons. Globally, the agenda of UHC is currently taking centre stage in health policy. Governments as well as civil society, in developed as well as developing countries, are engaged in active debates over how best to achieve it. The concept of UHC, however, dates back in history. Article 25.1 of the 1948 Universal Declaration of Human Rights states, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care and necessary social services."[3] In 1966, member states of the International Covenant on Economic, Social and Cultural Rights recognised "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[4] The 1978 Alma-Ata declaration stands out as a landmark in the modern history of public health by promoting the vision of "health for all."[5]

State-led implementation of UHC dates back even further. Germany was the first country to make nationwide health insurance mandatory with the Health Insurance Bill of 1883, which laid the foundations for its current publicly, funded Social Health Insurance system which covers 88% of the population.[6] Britain followed Germany with the enactment of its National Insurance Act in 1911, replaced in 1948 by the National Health Service (NHS) catering to all legal residents, with supplementation from private insurance providers.[7] Following this, and in parallel with growing international endorsement of the aforementioned declarations, UHC was adopted by several countries.[8] Today, most high income countries (HICs) have some system of UHC, with the glaring exception of the United States, where 47 million people have no health coverage.[9]

Public demand, economic feasibility and political leadership have combined to move many low and middle-income countries (LMICs) towards adopting the goal of UHC. Countries like Brazil,[10] Thailand,[9] and Taiwan[11] have made considerable progress in the attainment of UHC through reforms introduced in the past 2-3 decades. Others like Kenya are in the process of introducing nation-wide social health insurance schemes which aim to grant all population groups access to comprehensive benefit packages of health services.[9] Clearly, India is not alone in its move towards UHC, and has much to learn from the experiences of other nations.

CURRENT SCENARIO: A GLOBAL MOVEMENT TOWARDS UHC

According to the International Labour Organisation, nearly 50 countries have attained universal coverage or near universal coverage in the world today. However, conspicuous gaps still exist in Asia, Africa and the Middle East.[12] Escalating health care costs, inadequate public spending, and weak health care delivery systems in low and middle income countries have been barriers to UHC. There is now a greater recognition of the need to configure health systems which ensure universal access to good health care, through adequate and sustainable financing mechanisms that permit population wide coverage and efficient delivery of a wide range of health services.[13, 14] The 2005 World Health Assembly (WHA) urged member states to pursue UHC, ensuring equitable distribution of quality health care infrastructure and human resources, based upon health-financing systems protecting against catastrophic health-care expenditure and impoverishment of individuals seeking care.[15] It also highlighted the importance of taking advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government stewardship.

The 2010 World Health Report builds upon the 2005 WHA recommendations and aims at assisting countries in quickly moving towards universal coverage.[16] The report highlights three basic requirements of universal health care: raising sufficient resources for health, reducing financial risks and barriers to care, and increasing efficient use of resources. Resource scarcities may be overcome through increased efficiency of revenue collection,

reprioritization of health budgets and innovative domestic funding mechanisms.[17] Ultimately, governments have a responsibility to ensure equitable access to all citizens and that all providers, public and private, operate appropriately and attend to patients' needs cost-effectively and efficiently.

Increased worldwide recognition of the importance of UHC, supported by growing political commitment across the world and the technical assistance of WHO and sister organizations, adds impetus to India's aspiration to attain UHC in the near future.

DEFINITION:

The High Level Expert Group on Universal Health Coverage in India[18], defined UHC as follows.

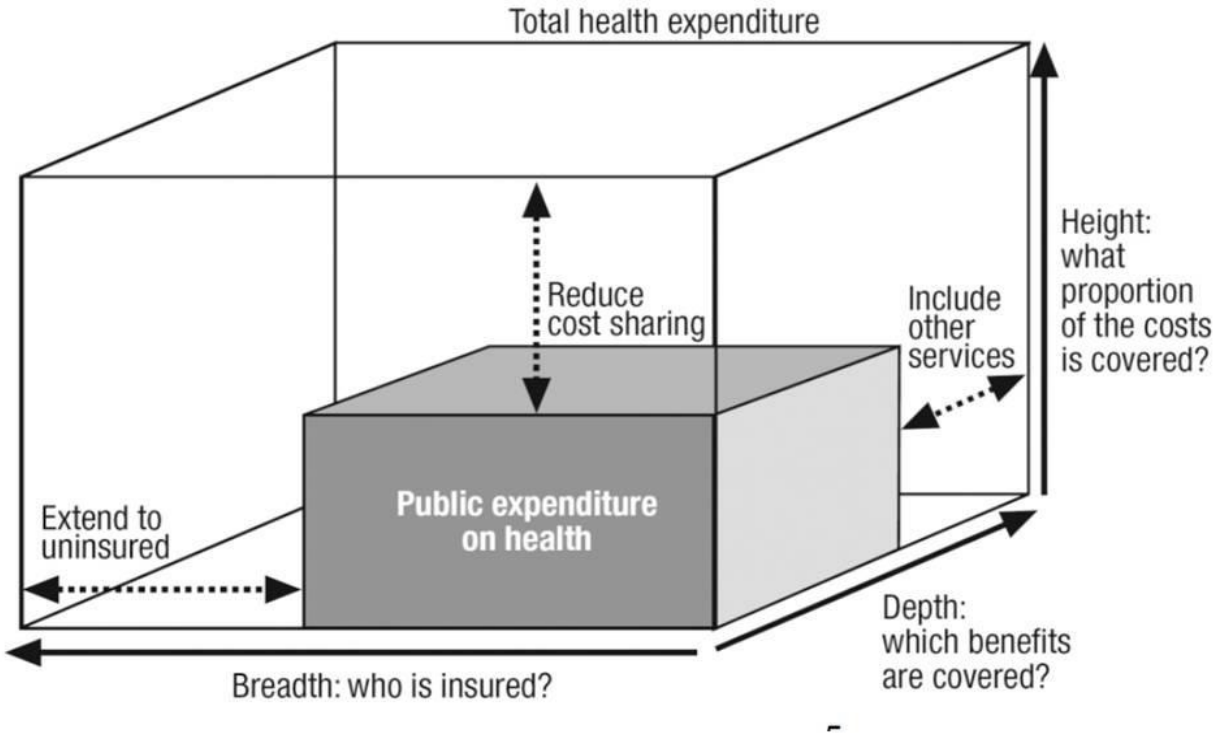
"Ensuring equitable access for all Indian citizens resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) delivered to individuals and populations, as well as services addressing wider determinants of health, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services."

PRINCIPLES

While discussing the principles of adopting and achieving Universal Health Coverage, it is imperative to consider the right to health as the key underlying theme. Right to health will enable health professionals to devise equitable policies and programmes that strengthen systems and place universal health coverage high on national and international public policy agendas. General Comment 14 of the UN Committee on Economic, Social and Cultural Rights gives its interpretation of Article 12 of the International Covenant on Economic, Social and Cultural rights and explains the right to highest attainable standard of health as encompassing an obligation by governments to provide medical care, access to safe drinking water, adequate sanitation, education, health related information and other underlying determinants of health. [19] It includes the right to be free from discrimination and involuntary

medical treatment while conferring entitlements like essential primary care and has a concern for disadvantaged populations, including those living in poverty. Thus, it builds a strong foundation for UHC.

Figure : Dimensions of Universal Health Care



Source: WHO 2008

Taking a rights based approach would require India to ensure recognition of the right to health in national law, set standards, establish institutional arrangements for the active and informed participation of stakeholders in policy making and implementation, ensure transparency, equity, equality and non discrimination and respect for cultural differences.[20]

Following from the above, it is envisaged that universal health coverage In India shall be sbased on the following core principles which was highlighted in the HLEG Report:

1. Universality

The system for UHC must be genuinely universal in its scope, covering all socio-economic classes and sections of the Indian population. Given that currently most sections of the population, ranging from the middle class to the rural and urban poor, lack access to quality affordable health care, such universality of the envisaged UHC system is an urgent social necessity. Universality is strongly linked with cross-subsidisation, social solidarity, and effective public voice for proper functioning of the system. It implies that the system is targeted at not only the poor but that its ambit also includes the relatively better off, so that they have an interest in building and benefiting from an efficient and equitable health system. Universality also implies that no one, including marginalised, hard-to-reach, mobile or traditionally discriminated groups would be excluded. The principle of universality recognises that programmes designed only for the poor are frequently weak in design and delivery, whereas systems which are inclusive of all sections of society have greater chances of success and sustainability. It also acknowledges that the relationship between health, income and social class is continuous and not a threshold relationship, requiring social protection across the board. Universal coverage approaches also generally require less administrative capacity and are more sustainable than targeted approaches.

2. Equity

Universality is integrally linked with equity; the envisaged UHC system must be based on the principle of equity, including the following dimensions:

Equity in access to services and benefits: A common range of services of adequate quality would be offered to all those covered by the scheme, in other words, there would be no hierarchies of entitlement within the scheme. The same set of health services, of comparable quality should be made available to all persons with similar medical need, irrespective of socio-economic status, ability to pay, social or personal background, on the basis of the principle of 'horizontal equity' (equal resources for equal needs). Urban-rural and geographic inequities would need to be overcome to the maximum extent possible, by ensuring more

equitable spread of health care facilities and services, as well as effective and timely transport services especially for remote and underserved areas.

Equity ensured by special measures to ensure coverage of sections with special needs: In any UHC system, universal, common provisions must be supplemented with special provisions for sections with special situations or needs. For example *adivasi* populations or persons living with HIV/AIDS would have, over and above health care needs common to all, certain special situations or needs for which additional programmes or measures would be needed to ensure 'vertical equity' (more resources for additional needs).

In a country beset with large-scale social and economic inequalities, the UHC system could act as a 'great equaliser', ensuring that, irrespective of their life conditions, everyone would enjoy a similar set of health services. Ensuring that all citizens have equal chances of being healthy requires urgent attention to the social determinants of health, which include sanitation, housing, and transport.

3. Comprehensiveness of care that is rational and of good quality:

Promotive, preventive, curative and rehabilitative services offered under UHC scheme at primary, secondary and tertiary levels should be comprehensive in scope and cover the broadest range of health conditions and illnesses possible within the resources that can be mobilised. Health care should include delivery of services by competent health care providers, along with infrastructure, equipment, essential medicines, laboratory investigations, medical supplies, implants and prostheses, as well as patient transport.

Even though some forms of tertiary treatment may not be included in the initial scheme, attempts will need to be made in the medium term to include the maximum range of medically necessary services.

4. Non-exclusion and non-discrimination

Universality implies that no person should be excluded from services or benefits on grounds of current or pre-existing illnesses and health conditions (e.g. congenital disorders, HIV/AIDS). Similarly, there should be no exclusion on the basis of special category of health

service required (e.g. maternity care, care for occupational illness or injury, mental health care).

No person may be excluded or discriminated against in the provision of services or benefits under the scheme on grounds of occupation, age, class, caste, gender, religion, language, region, sexual orientation or other social or personal background.

5. Financial protection

Equity in financing: Level of contributions by various socio-economic sections should be linked with their levels of income, as befits a progressive system involving significant cross subsidisation. A large proportion of the Indian population contributes substantially to the economy but receives incomes, which are at, or near subsistence levels; this fact must be recognized while deciding on contributions by various social sections. The scheme must be designed in a manner that no person should be excluded from services or benefits of the scheme due to their financial status or inability to pay. There should be no payment at the point of provision of all services under the scheme. The scheme should be designed, funded and operated in a manner that no person who needs essential or emergency health care is denied that service because of inability to make a personal payment.

6. Quality and rationality of care

Quality and rationality of care under the scheme would have to be ensured through regulation of all providers and their expected adherence to specified infrastructure, human power and process standards. Health services provided under the scheme should be delivered according to standard treatment guidelines, and be periodically audited. Along with medical quality of care, non-medical aspects of care and expectations of users (e.g. staff behaviour, hospital cleanliness, linen etc.) would need to be appropriately addressed. To ensure genuine universality, any differentials in quality of care between different facilities or geographic areas would need to be minimised.

7. Protection of patients rights, appropriate care, patient choice and Portability and

continuity of care

All services made available under the scheme would have to be delivered in accordance with universally accepted standards for patient and user rights including right to information, right to emergency medical care, right to confidentiality and privacy, right to informed consent, right to second opinion, right to choose between treatment options including right to refuse treatment, etc. Care would need to be delivered in a socially and culturally appropriate manner. Wherever relevant, patients should be allowed a certain degree of choice of providers, treatment systems and modes of treatment. The benefits and coverage under the UHC scheme should be available to any person or family moving across the country, without gaps in care. Migrant workers, those changing place of residence across states, districts or cities, beneficiaries of any health insurance programme and those who change employers or become unemployed should be assured continuity of care. Seamless care during referral from one agency to another, including patient transport, would have to be ensured.

8. Consolidated and strengthened public health provisioning as a key component of UHC

During the movement towards a system for UHC, public services for the provision of health care should be consolidated and significantly expanded, along with regulation and involvement non-public providers. Under-utilised public facilities such as ESI hospitals, or currently segregated facilities associated with public agencies like Railways could be appropriately linked with the UHC system, expanding the range of public providers available under the scheme. Provision of promotive and preventive services would need to occur through expansion of outreach of primary health care in rural areas and introduction of primary health services especially in urban areas. Increased finances, strengthening and significant expansion of public provision would need to be combined with measures to ensure and audit the quality of care according to defined standards. Community-based monitoring should be promoted to ensure responsive services and to create the demand for more efficient management of resources within the public health system.

9. Accountability, transparency and participation

The entire UHC scheme, including its authorities and various levels of providers, would have to be accountable to individual users, the general public, and community representatives. General information concerning the functioning of the system should be available in the public domain, and all specific information including that relating to public and non-public providers should be accessible under RTI provisions. Appropriate complaint and grievance redressal mechanisms should be operationalized to enable any person aggrieved under the system to seek redressal.

The regulatory framework for the UHC system at all levels should assign roles, functions and powers to both public authorities and multi-stakeholder civilin bodies, allowing for participatory regulation. Participatory bodies (analogous to various levels of Health Councils in Brazil) would include representation of relevant stakeholders including public health officials, public and non-public health care providers, elected representatives, civil society organisations, trade unions, consumer and health rights groups, and organisations / associations of health care employees. This regulation would be combined with participatory or community based monitoring and periodic reviews of the system to ensure its accountability, effectiveness and responsiveness.

II. Rationale of the Study:

Beveridge Report (1942), Alma-Ata Declaration (1978), World Health Assembly (2005), WHA58.33 Sustainable health financing, universal coverage & social health Insurance (2005)&World Federation of Public Health Associations (2007) each of these involved "people," "services," and "needs," where people should get free or affordable medical and health services according to their needs. But still in India the high out of pocket expenditure on health depicts that the most of the population is forced to buy health services at a very high cost because of lack of governance of health related policy and rules. No provision of services to the common people in spite of various health programmes and National Health Policy.

So, there is a need of Universal Health Coverage in India which means that all medical services should be available at low cost or no cost, or refer to a system that will provide all these benefits equitably to all the citizens of the country to achieve health status of the population which can be build up by having proper policy framework and the implementation of the policy in a phased manner with set of goals and objectives.

III. Objective:

To find out the appropriate service delivery system of Universal Health Coverage in India.

Specific Objective:

- Study of various model exist in the other countries to find out the suitable model regarding Indian context
- What kind of mechanism is required for the India centric model of Universal health Coverage?

IV. Research Methodology:

Study Design

The Qualitative study has been done in which Contextual review method is used to identify the issue related to the service delivery of Universal Health Coverage in India and in the assessment of the research question. The method of systematic review been used to gather evidence regarding service delivery of the Universal Health Coverage in India in which the articles regarding the implementation of Universal Health Coverage in various country and the health system of various country has been reviewed in PubMed, Lancet, and other published scholarly papers.

Search strategy and selection criteria

We searched a wide range of sources, including academic literature, government reports, multilateral-agency reports, and commissioned reports(The Steering Committee Report, 2012 of Planning Commission of India, High Level Expert Group Report on the Universal Health Coverage in India), reports relating to inequalities, inequities, health, and health systems in the Indian context that were published in English. Search terms included “universal health coverage”, “models of universal health coverage in various countries”, “health systems”, “universality”, “equity”, “non-exclusion”, “accountability”, “financing”, “regulation”, “service delivery”, “expenditures”, “out of pocket”, and “quality etc.

V. Review Findings:

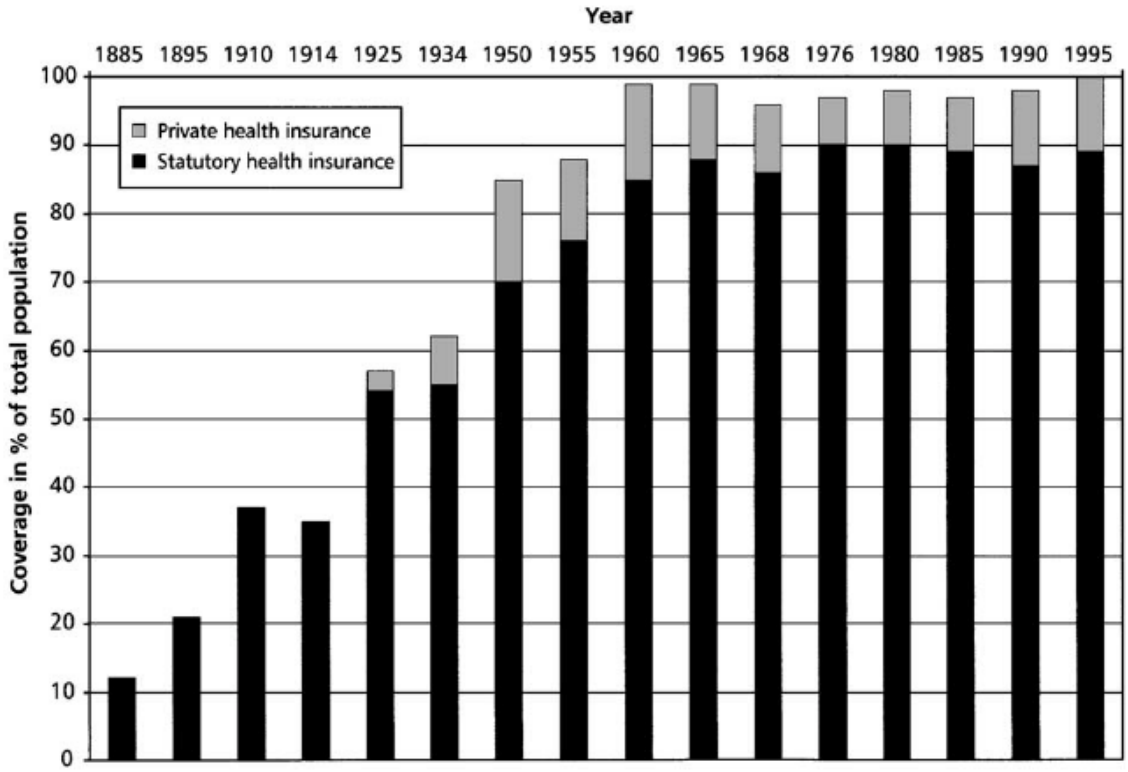
UHC System Models I

Bismarck and Germany's Social Health Insurance System, 1883

The 1883 launch of Germany's Social Health Insurance (SHI) system[21] is a landmark approach towards Universal health care model. SHI is an important model for financing health care. Under SHI, all members of a group contribute to an insurance fund that offers defined benefits. The group's members pool risk and provide a steady stream of revenue, often via a portion of their wages.

Bismarck's innovation in 1883 was to establish several so-called "sickness funds" that had mandatory enrolment and defined benefits. These funds covered members nationally, but have limitations.[22] Under Bismarck's leadership, the German government took a fundamental step toward UHC. Its actions solidified the previously vague principle of government involvement in private health by specifying a mechanism to guarantee financing and define benefits, which would be delivered through existing public and private facilities. Over the course of roughly a century, this SHI system evolved to provide universal health coverage. Germany slowly expanded the system in two directions. Mandatory enrolment was extended piecemeal to include more and more employment categories. Germany achieved universal health coverage through this series of extensions to minimum benefit packages and expansions of the enrolled population after 105 years after Bismarck's first sickness fund laws[23] . Bärnighausen and Sauerborn have quantified this long-term progressive increase in the proportion of the German population covered by public and private insurance. Their graph is reproduced below as

Figure 1: German Population Enrolled in Heath Insurance (%) 1885–1995



Source: Bärnighausen and Sauerborn, 2002.

UHC System Models II

The Beveridge Report and the British National Health Service

The British National Health Service (NHS) was founded in 1948, which offer all medically indicated services to any resident without payment at the point of service. As in Germany, the means by which health care was delivered—by private physicians and public hospitals—predated the establishment of a national health system.[24] In its moment of creation, the NHS contained innovations primarily related to its financing model.

Beveridge laid out broad principles of social protection (Annexure I) and directly precipitated the establishment of the NHS.[25] Authority for the whole scheme would be nationalized, and to provide protection from health-related poverty, all medical care would be free.[26] Although politicians resisted initially, these principles were adopted largely unaltered and the NHS was established in 1948[27]

UHC Model III

The National Health Insurance Model

The National Health Insurance (NHI) Model has elements of both Beveridge and Bismarck. . Like the Bismarck Model, it is insurance-based; like Beveridge, it is single payer. It uses private-sector providers, but payment comes from a government-run insurance program that every citizen pays into. Since there's no need for marketing, no financial motive to deny claims and no profit, these universal insurance programs tend to be cheaper and much simpler administratively than American-style for-profit insurance.

Because the government is the sole payer, it can exert tremendous bargaining influence on the prices of medical services and drugs. NHI countries generally control costs by limiting the services they will pay for and by limiting the availability of certain services, thus creating the lengthy waits for non-acute secondary care. The classic NHI system is found in Canada, but some newly industrialized countries like Taiwan and South Korea, for example have also adopted the NHI model

UHC System Types:

Single Payer: "The government provides insurance for all residents (or citizens) and pays all health care expenses except for copays and coinsurance. Providers may be public, private, or a combination of both"[28]. Single-payer health insurance collects all medical fees, and then pays for all services, through a "single" government (or government-related) source. In wealthy nations, this kind of publicly managed insurance is typically extended to all citizens and legal residents. Examples include the United Kingdom's National Health Service, Australia's Medicare and Taiwan's National Health Insurance.[29]

Two-Tier: "The government provides or mandates catastrophic or minimum insurance coverage for all residents (or citizens), while allowing the purchase of additional voluntary insurance or fee-for-service care when desired. In Singapore all residents receive a catastrophic policy from the government coupled with a health savings account that they use to pay for routine care. In other countries like Ireland and Israel, the government provides a core policy which the majority of the population supplements with private insurance".[30]

Insurance Mandate: "The government mandates that all citizens purchase insurance, whether from private, public, or non-profit insurers. In some cases the insurer list is quite restrictive, while in others a healthy private market for insurance is simply regulated and standardized by the government. In this kind of system insurers are barred from rejecting sick individuals, and individuals are required to purchase insurance, in order to prevent typical health care market failures from arising."

Review of existing UHC system in different countries:

1. Australia[31]

In Australia the public, taxation-funded national health insurance scheme, Medicare, provides universal access to subsidized medical services, subsidized pharmaceuticals, and free hospital treatment as a public patient. People can also take out private health insurance to complement the public scheme, in order to cover or partially cover the financial costs of hospital treatment as private patients, to enable quicker access to elective surgery as a private patient, and to cover or partially cover dental and other allied health services

2. Canada[32]

In Canada under Universal health Coverage, most of the physicians are in private practices and are remunerated on a fee-for-service basis, though an increasing number receive alternative forms of public payment such as capitation, salary, pay-for-performance, and blended funding. Physicians are not allowed to charge patients more than what they receive under the fee schedule negotiated with the provincial or territorial health insurance plan. Hospital-based physicians generally are not hospital employees and are paid fee-for-service. Physicians in community clinics are salaried. The Health Council of Canada was set up by the federal and provincial governments (except Québec and Alberta) as an intergovernmental, nonprofit organization to monitor and report on progress with the federal/provincial/territorial health strategies to improve the quality, effectiveness and sustainability of the health care system

3. Thailand[33]

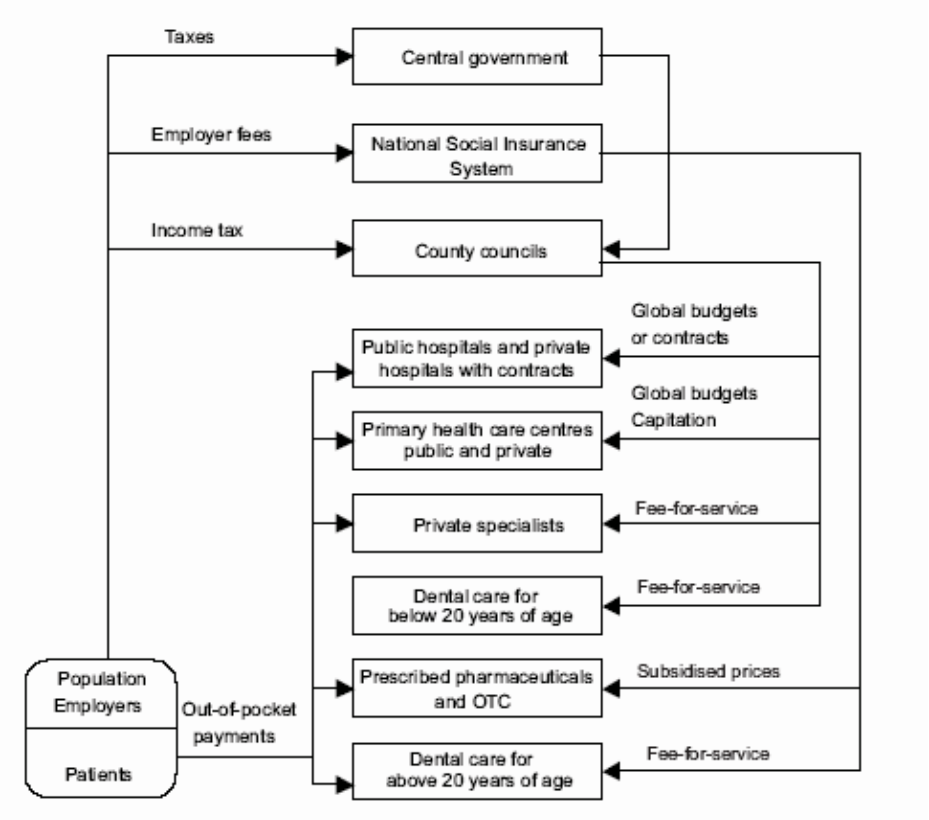
Universal Coverage (UC) beneficiaries have access to free ambulatory care at registered primary-care contractor networks, which is normally a district health system (DHS), consisting of sub-district health centres—(HC) and district hospitals (DH), with a nominal payment, 30 Baht, equivalent to US$ 0.7 per visit (with exemption for previous LIC holders) (Tangcharoensathien and Jongudomsuk, 2004; Towse et al., 2004). UC members are entitled to free hospital admissions, with hospitals paid from global budgets based on Diagnostic-

Related Groups (DRG). Beneficiaries under CSMBS (Civil Servant Medical Benefit Scheme) have access to free ambulatory and admission services, with free choice of providers that are paid by Fee-For-Service (FFS). SSS (Social Security Scheme), beneficiaries are also entitled to free ambulatory and admission services but only at registered hospitals that are paid by capitation. All three public schemes are financed from public resources.

4. Sweden

Swedish healthcare is financed by government taxes, employer-paid national social insurance, out-of-pocket user fees, and private insurance. Public expenditures accounted for 85.2% of healthcare services, while 14.8% of expenditures were private (WHO 2004d). Physicians "at public hospitals are employed and salaried by the county councils. Their income depends on neither the number of patients treated nor on the volume of their work" [34]

Since the 1970 Seven Crown Reform, Swedes visiting a physician have been charged a user fee The fee serves to reduce overuse and abuse of the inexpensive Swedish healthcare system, while allowing low- income persons access to care (the old system required up-front payment followed by reimbursement). The fees represent 2% of total healthcare expenditures.[35] A maximum annual co-payment is established, after which an individual receives a *frikort* card, providing free care for the next twelve months (Parker 1998).The flowchart showing the mechanism of service delivery under UHC in Sweden:



Source: European Observatory on Health Care Systems, 2001

5. France[36]

Health care coverage in France is universal. All residents are entitled to publicly financed health care through Statutory Health Insurance (SHI). It covers the entire population, it does not cover 100 percent of expenditures; 92 percent of the population have access to voluntary health insurance (VHI) either through their employers or via means-tested vouchers (CMU complémentaire, or CMU-C).

The public health insurance scheme covers hospital care, ambulatory care, and prescription drugs. It provides minimal coverage of outpatient vision and dental care. The coverage of health care costs accounts for 85 percent of SHI expenditure. The remaining 15 percent goes toward cash benefits in the form of daily allowances for maternity, sickness, or occupational accident leave and disability pensions. Medical goods and services qualifying for coverage by the health insurance system include following services which are: Hospital care and treatment in public or private institutions providing health care, rehabilitation, or physiotherapy; Outpatient care provided by general practitioners, specialists, dentists, and midwives; Diagnostic services and care prescribed by doctors and carried out by laboratories

and paramedical professionals (nurses, physiotherapists, speech therapists, etc.); Pharmaceutical products, medical appliances, and prostheses prescribed and included in the positive lists of products eligible for reimbursement; prescribed health care–related transport.

6. Switzerland

In Switzerland, entire population is insured either in one of the three types of managed care organization: health maintenance organizations (HMOs), independent practice associations (IPAs), and fee-for-service plans with gatekeeping provisions. There are two types of HMOs: staff models, in which physicians are employees, and group models, in which a physician group owns the HMO and is paid on a per capita basis. An IPA consists of a network of general practitioners who contract with an insurer and function as gatekeepers; payment is usually on a fee-for-service basis, although a few IPAs are capitated. Patients who use an in-network general practitioner often pay lower cost-sharing. HMOs are more likely to achieve savings, with estimated cost reductions ranging from 20 percent to 37 percent (Beck et al. 2006; Lehmann and Zweifel, 2004). IPAs show much smaller savings, usually in those organizations those capitate physicians.

7. United Kingdom[37]

Coverage is universal. All those "ordinarily resident" in England are entitled to health care that is largely free at the point of use under National Health System (NHS). NHS is divided into two sections: primary and secondary care

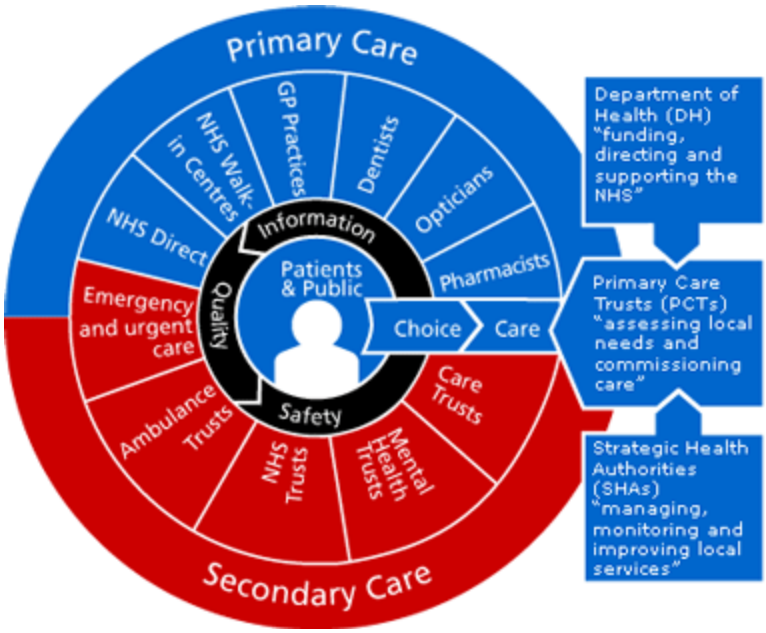


Figure: Structure of NHS

Primary Care: Primary care is the first point of contact for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists.

Secondary care: Secondary care is known as acute healthcare and can be either elective care or emergency care. Elective care means planned specialist medical care or surgery, usually following referral from a primary or community health professional such as a GP.

Primary care trusts: Primary care trusts (PCTs) are in charge of primary care and have a major role around commissioning secondary care, providing community care services. They are central to the NHS and control 80% of the NHS budget. The 2011-12 PCT recurrent revenue allocations represent £85 billion, which is an average of £1,615 per head.

As they are local organisations, they understand what members of their community need, so they can make sure that the organisations providing health and social care services are working effectively. The PCTs oversee 39,409 GPs and 22,800 NHS dentists. For more information about PCTs see authorities and trusts.

Acute trusts: There are 170 acute NHS trusts and 58 mental health NHS trusts, which oversee 1,600 NHS hospitals and specialist care centres. Foundation trusts are a new type of NHS hospital of which there are 129 across England.

Ambulance trusts: Emergency vehicles are provided by the NHS ambulance services trusts. There are 11 ambulance trusts in England. The Scottish, Welsh and Northern Ireland ambulance services provide cover for those countries.

Care trusts: NHS care trusts provide care in both health and social fields. There are few care trusts and they are based mainly in England. There are none in Scotland and the Scottish NHS has no plans to introduce them.

Mental health trusts: NHS mental health services trusts provide mental health care in England and are overseen by the local PCT.

NICE: There are also agencies controlled by the NHS. These include the National Institute for Health and Clinical Excellence (NICE).

8. Germany[38]

In Germany government funded Social Health Insurance (SHI) is compulsory for citizens with annual incomes up to €48,00 under the UHC, patients are free to choose their physicians including specialists, and physicians have the obligation to treat insured patients. They may, however, exercise discretion in cases of geographically unacceptable home visits (unless no other physician is available or in an emergency), prior patient refusals to comply with treatment, physician-patient conflicts, and practice overload. *The reform of 2004 introduced the "family-physician centered" insurance plan as an option for the insured. Physicians are entitled to proper compensation under Art. 12 (professional independence) and Art. 4 (protection of property) of the Constitution, and under SGB V, Art. 72(2) (physicians must be compensated "adequately" to ensure the sufficient, appropriate delivery of health care in accordance with the generally joint interpretation by the sickness fund and physician associations, the BSG has ruled that physician compensation must provide*

sufficient incentives for physicians to become licensed to practice within the universal health care system

9. South Korea[39]

All people in South Korea are eligible for coverage under the National Health Insurance Program. In 2006, the total number of covered people was over 47 million, which is about 96.3% of the total population. *The insured are divided into two groups: employee insured and self-employed insured. The "employee insured" category includes the insured person's spouse, descendants, brothers or sisters, and direct lineal ascendants*. Insured employees pay 5.08% of their average salary in contribution payments. Contribution rates change every year. The insured individual is required to pay a certain portion of the health care costs. The co-payments differ according to the level and type of medical care institution (Table 2).

Table 2:Co-payment system

Classification	The portion of health care costs
Inpatient	**10–20% of total treatment cost**
Outpatient	
Tertiary care	**Per-visit consultation fee+50% of treatment cost**
General hospital)	**50% of (treatment cost +Per-visit consultation fee)**
Hospital)	**40% of (treatment cost +Per-visit consultation fee)**
Clinic	**30% of treatment cost**
Pharmacy	**30% of total cost**

(Source: National Health Insurance Corporation)

10. New Zealand[40]

All New Zealand residents have universal access to a broad range of health and disability services with substantive government funding drawn from general taxes. Public hospital

services are free, but patients are required to make copayments for primary care medical services. New Zealand has a mix of public and private hospitals, but public hospitals, providing all emergency and intensive care services. Private insurance exist which is used to cover cost-sharing requirements, elective surgery in private hospitals, and specialist outpatient consultations.

11. Italy[41]

Italy, as other developed European countries, has a national health service (NHS) that in principle offers universal health care and coverage through a prepaid compulsory health insurance that is managed by the central government, which is responsible for both funding and supplying services to the population (McCarthy, 1992). The only prerequisite is the enrollment in the national system and the choice of a general practitioner who is responsible for primary care and referrals to other levels of care (i.e., hospitals). Few years ago most of the medical services provided were free, or small copayments were requested at the point of use for specific procedures and prescriptions. Recently, in the context of the efforts to control the rising costs while maintaining universal coverage, the impact of copayment has increased for diagnostics and for medicines only.

12. **Brazil[42]**

In the year 1988 health services became universal and equitable for all citizens of the Brazil according to the constitution with the establishment of the Unified Health Service (*Sistema Único de Saúde*, SUS). Prior to this time, the health system were two tiered with a social security model for formal employees in the private sector, and a public sector funded by government budgets for the rest of the population, more than 75% of Brazil's population relies exclusively on public health care for coverage. Covering some 97 million of Brazil's rural poor, the Family Health Programme is a central part of the Unified Health System, and employs teams of community health care.

Under the SUS, every citizen is entitled to health care services free at the point of use provided by public and private facilities. The financing of health care under the SUS initially comprised of (in addition to government budgets) mandatory contributions tied to gross revenues and net profits from companies.

13. Sri Lanka[43]

Sri Lanka achieved universal health coverage while its per capita GDP was still below US$500 annually by relying on tax-financed and government-operated health services. All in-patient, out-patient, and community health services are free to all Sri Lankans, without any user charges since 1951. Sri Lanka's health system is public hospital-dominated

The Indian perspective: Contextualising UHC

Although India has made measurable progress in public health since independence, the achievements so far lagged behind the country's planned goals and have failed to keep pace with the country's economic growth. Despite considerable declines in child malnutrition rates over the past few decades,[44] India continues to have the highest number of malnourished children in the world today.[45] Maternal health has also shown sluggish improvement– India has an unenviably high maternal mortality rate.[46]

According to several analysts, the onus for this lies, to a great extent, on the country's health system, which has been plagued with decades of inadequacy in financing, governance and management.[47, 48] Although all forms of health financing exist in the country, most of its health expenditure is supported by private spending, primarily Out of Pocket (OOP), with public funds constituting an insufficient amount. Despite several government initiatives in social protection, such as the Employees' State Insurance Scheme and the Central Government Health Scheme, less than 6% of the population was till recently, is covered by some form of health insurance.[12] Efforts have been made in the past few years to provide equitable health care to Indians, such as the National Rural Health Mission, the Janani Suraksha Yojana and the Rashtriya Swasthya Bima Yojana. However these by themselves cannot accomplish UHC.[49] The lack of an efficient and accountable public health sector has led to the burgeoning of a highly variable, unregulated private sector which, while providing a major fraction of the country's health services, has also driven up catastrophic health expenditure and poverty caused by it. This, coupled public sector deficiencies such as management shortfalls, paucity of human resources and poor accountability, has resulted in a health system that is unable, at present, to cater to the needs of the entire population.[47,48]

This situation, however, is not uniform across India: some states, such as Tamil Nadu and Kerala, have model health systems, while others, in particular the "Empowered Action Group" states (EAG) of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttarakhand and Uttar Pradesh, are not performing well.[48] The differences are stark. For instance, for a girl born in rural Madhya Pradesh, the risk of dying before age 1 is around 6

times higher than that for a girl born in rural Tamil Nadu, and there is an 18 year difference in life expectancy between Madhya Pradesh (56 years) and Kerala (74 years).[50] Health actions need to be differentially prioritized and geared to meet the varying health needs in different parts of the country. In particular, active steps towards addressing the social determinants of health can begin to reverse the chronic underdevelopment that characterises the poor health performance of EAG states.

Universal health coverage in India has to have a flexible architecture to adequately deal with the regional diversity as well as differences in the health care needs of rural and urban areas in India. There are considerable gaps between rural and urban areas with respect to disease morbidity and mortality. While the combined problems of under-nutrition and inappropriate nutrition account for almost equal population proportions in rural (48%) as well as urban areas (49%), under nutrition is a dominant problem in the former while overweight-obesity accounts for half the burden of 'malnutrition' in the latter.[51] In addition to this, there is considerable inequity in human resources and infrastructure across geographical regions. For instance, urban areas have 4 times more health workers per 10,000 population than rural areas, and 42% of health workers identifying themselves as 'allopathic doctors' in rural areas have no medical training relative to 15% in urban areas.[52] Compounding this is the urbanbias in health financing, with almost 30% of public health expenditure (both from the centre and states) being allocated to urban allopathic services relative to less than 12% to rural ones. Universal Health Coverage in India thus has to be able to deal with the conditions and conditionalities of rural and urban areas respectively.

VI. Discussion:

Universal health coverage (UHC) has risen to the forefront of the global health agenda in the past few years, as reflected by donor pledges, international declarations, and high-profile publications The United States believes in individual freedoms, democratic government, and the free market economy, which, together with the protestant work ethic, keeps health insurance coverage tied to employment in the U.S. However, healthcare does not operate according to free market ideals

In much of the recent literature, UHC has been used as a banner under which to discuss the design and implementation of health systems, rather than to clarify the underlying conceptual meaning. Rob Yates has stated that "coverage" should mean the use of services and facilities rather than the mere existence of infrastructure. He has argued that eliminating user fees is an important element in reducing financial barriers that limit "coverage," in this sense.

From the review of the literature of the thirteen countries having Universal Health Coverage implemented except United Kingdom, Canada, Mexico and Thailand* all other countries have insurance based Universal Health care provisions in their provinces which is more evident by the Germany Model of Universal health Coverage in which first they cover the whole population under the insurance sector and then implement UHC system so that the system should have absorptive capacity to absorb the resources pumped while in case of India, our system do not have absorptive capacity and policy makers have no control over this#. Whereas the HLEG recommended that, do not use insurance companies or any other independent agents to purchase healthcare services on behalf of the government while Steering Committee[1] has different view on this, they recommended that two different sets of pilots can be run depending on availability of services, namely with public providers only,

*Mixed of three systems viz CSMBS (Civil Servant Medical Benefit Scheme) have access to free ,SSS (Social Security Scheme) and UC (Universal Coverage)

During the National Conference on the Universal health Coverage in India, Principle secretary of Health, Delhi has stated this

[1] Report of the Steering Committee on the 12th Five Year Plan constituted by the Planning Commission of India: available from: http://planningcommission.nic.in/aboutus/committee/strgrp12/str_health0203.pdf

and a second model with public and empanelled private and NGO providers. The States would have the flexibility to decide which model would suit their needs. Because pure insurance system in which service providers have an incentive to do unnecessary procedures because they are re-imbursed on a “fee for service” basis. This is leading to a cost explosion everywhere. What is proposed is a “managed care” system in which, because service providers are paid depending on the number of beneficiaries registered with them, they have no specific incentive to over prescribe procedures or to prolong hospitalisation. However, the problem in this system is the opposite; having received a total payment the service provider has an incentive to minimise cost by compromising the quality of service

On the matter of the direct provisioning of health services by the government, HLEG recommended that the purchase of additional services from contracted-in private providers. Private providers opting for inclusion in the UHC system would have to ensure that at least 75 per cent of out-patient care and 50 per cent of in-patient services are offered to citizens under the NHP. The second alternative entitles that institutions participating in UHC would commit to provide only the cashless services related to NHP and not provide any other services which would require private insurance coverage or out-of-pocket payment. The provisions proposed are stringent and would leave out most of the providers where as on these lines steering committee has recommended that two different sets of pilots can be run depending on availability of services, namely with public providers only, and a second model with public and empanelled private and NGO providers. In both models, each family should be able to opt for their ‘provider of choice’, the choice being exercised once a year. Since a part of the payment, at least, would be performance and health outcomes based, empanelled providers might decline the poor and not so healthy cases. However, this could be balanced by also allocating points for responsiveness to patients, as well as the class and other diversity of patients that a health provider is responsible for. In addition, to avoid cherry picking of patients, the empanelled provider should be mandated to accept whoever opts for it.

In Brazil, to improve efficiency in the decentralization process, the MOH started to substitute some supply-side payment mechanisms (such as fee-for- services and prospective payments) for block grants related to primary health care and public health. That is the case of the Basic Health Package (PAB), which transfers resources to states and municipalities based on a per-capita set of high cost-effective health measures. The MOH established performance, impact and coverage indicators to evaluate the achievement of goals in the sector. Similarly on these lines the Planning Commission is proposing a scheme on the lines of Rashtriya Krishi Vikas Yojana which incentivizes States through Additional Central Assistance for higher funding on health and achieving goals of strengthening their health systems. Beyond the larger policy goals and subject to achieving population health outcomes, States should be awarded the freedom to devise and implement health programs. RKVY type model looks to equalize health outcomes rather than spending across States.

A single-payer which is also called PNHP (Physicians for a National Health Program), non-for-profit, universal, comprehensive health care system would rely on a *single* public agency that would organize health care financing. At the same time, the delivery of health care would remain largely *private*, and patients would exercise a free choice of a provider or a health care facility. Note that such a system does *not* amount to "socialized medicine". The latter implies government *ownership* of health care delivery institutions. Rather, the universal health care system of the PNHP-type should be properly called as "social *insurance*" because the government's role would be that of a *payer* rather than an *owner* and an executive (Bodenheimer, 2005, p. 1431).

A single-payer system could also save lots of money spend in health care, according to a study by the D.C. based consulting firm Lewin, Inc. The study also found that a highly regulated "pay or play" system (in which employers either provide their workers with coverage or pay into a state insurance pool)

First priority should be expansion of the coverage of health care infrastructure to provide public health and prevention services. Regarding curative services, user fee model with appropriate measures to decrease financial catastrophic could be used.

Although it has a lot of arguments for financial sustainability to implement this financial model for universal coverage for health care, Thailand shows clearly that this financial model can be possible to implement. The difficulty is the uncertainty which occur during government budget preparation. A well design health care financial model to project future development of total health care expenditure is an appropriate tool for agreement between Ministry of Finance and social protection schemes.

The UCS and SSS have adopted capitation as a main provider payment mechanism. The capitation contract model is an effective long-term cost containment strategy. But the flat rate capitation payment is an incentive for providers to give limited services to those needing expensive care services, like senior citizens, and patients with chronic conditions. Age and other risk factors should be taken into account in calculating the capitation rate, to prevent selecting low risk beneficiaries for hospital registration, and their bias in service provision. Also, some selected high-cost, low-volume medical services and equipment should be paid by other payment mechanism which more performance-based approach than capitation. In addition, keeping and close monitoring of their quality of care must be diligently enforced.

Each historical case demonstrates how critical public sector action was to achieving universal health coverage. In Sweden, the government role evolved from subsidizing sickness funds to enforcing strict regulations and later mandating participation. In Japan, too, the government role expanded beyond public health measures toward mandating health insurance participation and even directly managing a major insurance fund. In Chile, the role of government in health care was fiercely contested yet ultimately expanded through direct provision for the working class and later by mandating health insurance coverage in a mixed public private system. In Malaysia, colonial policies prior to independence were relatively marginal compared to the concerted effort to achieve universal health coverage after independence through a system of direct public provision.

However, it cannot be happen by change or political party agenda. It needs long term plan and continuous effort to go further step by step when windows of opportunities exist at points along the route of policy development. Health care infrastructure should be the first step before arrangement of health care financing for universal coverage. There is no single payment mechanism which is the best for every service. In Thailand there is a trend that the three large scheme move toward to similar payment mechanisms for similar services. They use fee-for-service method for specific services or equipments i.e. prosthetic heart value, which they would like to promote more usage. On the other hand, they use casemixed method i.e. to control inpatient cost. Quality improvement program and measurements to improve equity are the next step after achievement of the universal coverage.

Retrospection: Need of Political Convergence

Given the complex disease burdens, economic challenges and geographic diversity of the country, it must be recognized that there is no single path to achieve universal health coverage for India. While ensuring its population equitable access to the health and protecting the poor and vulnerable against catastrophic health care costs, India needs to determine for itself an appropriate balance between extending coverage to more people, offering more services, and/or covering more of the cost of care.

It is important to recognize the fact that in charting the India's course to universal coverage the barriers encountered are not only technical ones but also political. Even as the country establishes a vision for Universal Health and develops the mechanisms for financing and effectively implementing this initiative, there has to adequate political momentum to bring this about and the relevant buy-in from political actors at both the state and central levels.

In the course India of devising its own route to achieve this goal it is important to time the initiative at a stage in the country's political climate where policymakers in India are now be receptive to the demand that the state should be the guarantor and regulator of universal health care.[53] Several initiatives, ranging from major national programmes to state pilot projects, show an increasing commitment towards a strengthened public health sector. Several foundational efforts in the direction of universal health coverage have been forged in

recent years. Noteworthy among these is the National Rural Health Mission (NRHM), launched in 2005 to strengthen the public health-care system. This scheme brought with it an influx of government funds 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 revitalize 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, decentralized 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.

The NRHM and and the development of the proposed National Urban Health Mission, which has to respond to the rapid urbanization in India, are crucial steps to both ensuring universal access and health equity in the country. Other schemes that also speak to ensuring equity and affordability of health coverage include the Janani Suraksha Yojana, launched in 2005 which encourages women to deliver in government health facilities or accredited private facilities by providing financial incentives. 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. 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 and 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.

VII. Conclusion:

This new wave of universal health coverage, or UHC, has touched nearly 100 countries, all studying how to institute government-funded programs of health care. The main requirement to achieve Universal Health Coverage is the financial protection that however does not mean that achievement of UHC is linked to a country's GDP size. As noted by Laurie Garrett and others in a 2009 *Lancet* article, countries with low GDPs such as Costa Rica, Cuba, Gambia and Gabon attained more impressive prepaid coverage than countries with much higher GDPs. Indeed, countries that introduced nationwide health-insurance schemes are found not only in upper-middle and high-income economies, such as Brazil, Thailand and Taiwan, but also in low-income or lower-middle-income economies, including Bangladesh, Philippines and Sri Lanka.

Many of these economies, including Sri Lanka, Malaysia and Indonesia, and to a lesser extent, Brazil and Thailand, have adopted some key aspects of the Beveridge Model which funds UHC through a government service paid directly through tax revenue. Others, such as Taiwan, Mexico and Turkey, choose the national health insurance model under which payment comes from a government-run insurance program that covers every citizen. Still others, such as South Korea and Costa Rica, rely on compulsory social health insurance financed jointly by employers and employees through payroll reduction, or the Bismarck Model.

In most countries, though, UHC is pursued through a mixed model of funding. Chile, for example, finances UHC through a public social insurance fund that combines the Bismarck contribution model with tax-financed care under the Beveridge approach for those without income. In context of India, the best thing is to run pilots across the districts depending on availability of services, namely with public providers only, and a second model with public

and empanelled private and NGO providers. The States would have the flexibility to decide which model would suit their needs.

Political commitment and health-system capacity are equally critical in this process. According to Kwesi Eghan, a senior program associate for the nonprofit international health organization Management Sciences for Health, many African governments lack the political will to introduce UHC plans or the ability to develop innovative funding mechanisms to pay for them.

Of course, at issue is not just scalability, but sustainability as well. How to sustain existing programs instituted for achieving UHC is a major concern in low-income and lower-middle-income economies. In Rwanda, a nation with a successful UHC program, foreign donors contributed 53 percent of the country's total health expenditure. In Sri Lanka, another successful example, there is concern about the government's ability to continue to provide health services free at the point of delivery. So, the best suited mode of service delivery system to implement UHC in India is to do not levy any kind of user charges for the in-patient services and fee-for-service for the out-patient services as recommended in the Steering Committee Report of the Planning Commission of India. The health related services are provided by the public facilities only if possible but as it is also evident that we are not in a position to provide entitlement to each and every citizen regarding the rights of health services by the means of the public health facilities alone. And if we start system strengthening in each and every state then according to HLEG estimates it will take 10-12 years more to build a efficient health system, which is not a remarkable thing to go with. So, rather than doing system strengthening we should empanelled private provider to provide the Essential Health Package, likewise most of the countries are providing the universal access to health services by using a mix of Public only, public with contracted-in private/NGO providers, public and private/NGO providers which are enrolled by a State level para-government agency. One another benefit of using public-private mix type is that it should not only provide services to the people but also give a choice to the beneficiary to select from a panel of providers/networks. The element of choice is essential to build responsiveness in and satisfaction with services.

VIII. Recommendation:

- A mix of public health services with regulated, 'contracted in' services of those private providers and public provider has been used to provide Essential Health package to the citizens.
- Offer reasonable choice of providers to citizens between multiple public and private providers through the means of a nationally portable Health Entitlement (Smart) Card which can be used across public and contracted-in private providers without the need for using insurance led purchasing models or purchaser-provider splits. It admits that there is a serious concern how the Direct Provision System will "perform." But it maintains that various steps proposed in this report to improve the performance of the public health system, combined with the competitive pressure exerted on it by the contracted-in private sector, would take care of this problem.
- It is also recommended that every citizen should be guaranteed a minimal health care cover package which should be biased towards preventive and primary care to decrease the societal disease burden, which will decrease the need to utilize expensive tertiary care for preventable sickness, is welcome.
- That Public and Contracted-in Private Facilities should offer only UHC benefits to the population and would be entirely cash-less for all users to take away all incentives on their part for "induced" demand. They will not be permitted to offer any additional care using out-of-pocket expenditure or honour any private voluntary or community based insurance plans for providing supplementary healthcare either in the facility or after-hours in a "Private Practice". The "private providers should be 'contracted-in' on the basis of standardized rates and norms for service delivery and functioning rather than ad-hoc Public Private Partnerships (PPPs)". It maintains that such "contracting in" of the private sector through systematic and transparent processes would strengthen socialization of health care, expand pro-poor investment, and expand services in the health sector. Insurance Regulatory and Development Authority (IRDA) regulated Private Voluntary /

Community Based Health Insurance will continue to be available, but only at facilities that are not contracted-in to serve NHEC card holders.

- As regards access to essential medicines to it is estimated that around Rs. 30,000 crores annually (close to about 0.5% of GDP) would be needed to to stop rational supply quality generic drugs by enforcement of pooled public procurement for supply through public health system as well as through private chemists contracted-in into the UH System.

IX. Limitation

- The study is a review of the various literatures available on the web and reputed journals which contain some common element, so, duplication of some element in the study might be possible.
- Due to the shortage of time during the study period, limited article had been reviewed which gives us an overview of the status in the other country in a restricted way.

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Annexure I

Beveridge Report (1942)

"The first principle is that any proposals for the future, while they should use to the full the experience gathered in the past, should not be restricted by consideration of sectional interests established in the obtaining of that experience. Now, when the war is abolishing landmarks of every kind, is the opportunity for using experience in a clear field. A revolutionary moment in the world's history is a time for revolutions, not for patching.

"The second principle is that organization of social insurance should be treated as one part only of a comprehensive policy of social progress. Social insurance fully developed may provide income security; it is an attack upon Want. But Want is one only of five giants on the road of reconstruction and in some ways the easiest to attack. The others are Disease, Ignorance, Squalor and Idleness.

"The third principle is that social security must be achieved by co-operation between the State and the individual. The State should offer security for service and contribution. The State in organising security should not stifle incentive, opportunity, responsibility; in establishing a national minimum, it should leave room and encouragement for voluntary action by each individual to provide more than that minimum for himself and his family.

"The Plan for Social Security set out in this Report is built upon these principles. It uses experience but is not tied by experience. It is put forward as a limited contribution to a wider social policy, though as something that could be achieved now without waiting for the whole of that policy. It is, first and foremost, a plan of insurance - of giving in return for contributions benefits up to subsistence level, as of right and without means test, so that individuals may build freely upon it." From
http://www.sochealth.co.uk/history/beveridge.htm