UNIVERSAL HEALTH COVERAGE AN SOCIAL DETERMINANTS:A POLICY ANALYSIS

A Dissertation Submitted In Partial Fulfillment Of The Requirements for The Award Of

Post Graduate Program In Hospital And Health Management

By

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May, 2013

May, 2013

Certificate of Internship Completion

Date:.....

TO WHOM IT MAY CONCERN

This is to certify that Dr. Aditya kumar (PT) has successfully completed his 3 months internship in our organization (PSI, India) from January 24, 2013 to April 24, 2013. During this intern he has worked on **Universal Health Coverage and Social Determinants of Health: A Policy Analysis** under the guidance of me and my team at population services international, India.

We wish him good luck for his future assignments.

(Signature)
_____ (Name) (Kalipada Roy)
National Research Manager
_____ Designation

Certificate of Approval

The following dissertation titled "**UNIVERSAL HEALTH COVERAGE AND SOCIAL DETERMINANTS :A POLICY ANALYSIS**" 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.

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This is to certify that **Dr. Aditya kumar (PT),** 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 "**Universal Health Coverage and Social Determinants of Health: A Policy Analysis**" in partial fulfillment of the requirements for the award of the **Post-Graduate Diploma in Health and Hospital Management**.

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AREA OF DISSERTATION: Universal health coverage and social determinants of health: A policy analysis

ATTENDANCE: Good

OBJECTIVES ACHIEVED: To a greater extend, but needs to tighten in report and connect discussion & recommendation w.r.to ~~research~~ findings.

DELIVERABLES: & OK

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UNIVERSAL HEALTH COVERAGE AN SOCIAL DETERMINANTS:A POLICY ANALYSIS

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. According to high level expert group (HLEG), 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."

Social determinants are the main factors, which determines the success of universal health coverage. In Indian context, social determinants of Indian population project a great need of universal health coverage to deal with equity and inequality. So this study tries to determine the social determinants of health of Indian population keeping the frame work of CSDH in mind. As the study tries to explore the social determinants of Indian population, it also tries to find out the gaps in policy implementation regarding universal health coverage considering the social determinants of health. This gap analysis will bring us in a position to recommend some measures to be taken to fill the gap of universal health coverage policy implementation.

ACKNOWLEDGEMENT

I am wholeheartedly grateful to Dr Nayanjeet for giving me opportunity to carry out my internship at population services international India for period of three months in the research department. It is my honour to have worked under Mr. kaliprosad 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 all the colleagues of research department of PSI who provided me constant support and valuable guidance.

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PART – 1

INTERNSHP REPORT

1. ORGANIZATIONAL PROFILE

ABOUT POPULATION SERVICES INTERNATIONAL INDIA:

Population services international is a registered Indian society dedicated to the improvement of public health in India. PSI India's mission is to empower the people of India to lead healthy lives. over the past twenty years, PSI has collaborated with the GOI and a number of donors to harnesses the vitality of the private sector to address health problems of the low-income and vulnerable populations using social marketing to achieve positive behaviour change by promoting ideas, products and services conducive to better health. PSI focuses on strategic partnerships and fostering of private sector partnerships to address a wide range of public health issues including reproductive health, maternal and child survival, tuberculosis, water, sanitation, hygiene, HIV/AIDS and non communicable diseases such as tobacco and diabetes

In 1988, PSI began a small operation in India and currently has more than 850 staff members across 22 states. PSI's mission is to empower the people of India to lead healthy lives by addressing priority public health challenges in India using social marketing, social franchising and behaviour change communication techniques.

Mission

PSI India's mission is to ***"empower people of India to lead healthy lives"***

Vision

In early 2008 PSI India, developed and adopted a five year strategic plan and by 2012 we are committed to accomplish the following:

100% increase in DALYS;

HIV and family health projects contribute equally (50% each) to total annual DALYS;

At least 40% of all product sales are rural;

Significant increases in healthy behaviours for priority target groups in select states.

Values

Core values which define our work are:

People: Our staff is our most important asset and we are committed to their continuous professional growth. we respect our partners and the people we serve.

Partnership: We embrace the value of partnerships and actively seek opportunities to collaborate with the goi and other stakeholders.

Results: We focus on bottom line health impact. we strive to improve every level of our operations by continually increasing our efficiencies and deploying innovative and cost-effective approaches.

Professionalism: We hold ourselves to high levels of quality, integrity, honesty and transparency in our work.

Chak de PSI/i: We are one PSI/i team! our whole is greater than the sum of our parts.

Functions :

Behavioural Research Communication

PSI has evolved evidence-based systems and processes to design, implement and evaluate effective behaviour change communication campaigns. by identifying and focusing on key determinants that affect particular behaviours among target groups, we ensure that the communication has the desired impact. PSI has implemented large scale communication programs using mass media, mid-media and interpersonal communication with proven success.

PSI's communications activities are evidence-based. we conduct qualitative and quantitative research to understand the target groups and measure the impact of campaigns. this ensures the most cost effective approach to effect behaviour change and achieve maximum health impact within a given budget. all messaging is pre-tested before use to make sure it is well-understood and sensitive to the needs of the target groups

PSI is a good partner - we conduct campaigns with local partners, including local NGO's and private sector companies. this improves their capacity in communications

PSI uses a diverse media mix – we have one of the largest and best run mid-media (street theater) communications programs in the country, with the capacity to reach lakhs of the target group on a monthly basis. this medium is especially strong at reaching rural areas, which are "media dark", and highly targeted groups. we have also produced many successful mass media campaigns, including television, radio, outdoor, and print executions. PSI is also known for producing interactive and creative communication support materials, such as interactive games and contests, used in interpersonal communications campaigns. all communications materials are carefully pre-tested before use

Research

PSI strongly believes in evidence based decision making in its entire functioning. this implies that research and various program teams work closely during the entire project cycle; right from studying the epidemiology to prioritize geographies and target population, to identification of behaviours that put the population to risk and in identifying the determinants of risky behaviour to monitoring of the change in various log frame indicators and evaluating the impact of PSI's interventions

PSI India has a highly qualified and motivated research team that works to provide timely and required inputs to each of the program teams viz. marketing, communication, medical support and implementing teams. there is a core research technical unit based at Delhi office which overall handles all research requirements across the country. PSI also boasts of a very strong backend support team based at its Washington dc office and a strong networking with other

researchers placed across different countries round the globe. PSI research team continuously strives to improve its research methodologies which are able to produce measurable results. PSI also plays an important role in capacity building by documenting all the research methodologies, standardizing them and sharing with at all possible platforms

Sales and Distribution

PSI uses existing commercial product distribution channels to make its high quality and affordable health products to its target audiences. PSI's sales and distribution network consists of product hubs, super-stockists, stockists and a team of highly motivated sales force which regularly visit retail outlets like – chemists, general stores, grocer's, pan shops to ensure that these outlet's stock our products

Social Franchising

PSI works closely with private providers – allopaths and indigenous systems of medicine, to involve them in improving access to and quality of service delivery for family planning, maternal health and STIs.

We work both on the supply and demand side to effectively harness the presence of private health care providers for public health issues. our supply side interventions, led by a team of medical services and training experts, include Mapping of providers and assessment of their training needs Design, development and delivery of appropriate training programs.
Training of support staff in counseling and infection prevention. Provision of high quality products at competitive prices. Supportive supervision and performance improvement plans Job aids and service delivery protocols and guidelines. Technical updates – meetings, newsletters and websites monitoring of quality of care and quality audits
Our demand side interventions include Branding and promotion of the network.
Signage's & client communication materials Demand generation and client mobilization activities. Organizing special event days.

Social marketing

In 1988, as part of govt. of India's multi-brand strategy, PSI launched Masti condoms in Uttar pradesh. since than we have expanded our product range and geographic reach. our products now cover - birth spacing; maternal health; HIV prevention and child survival.
PSI today is the largest social marketing organization with a product portfolio of 11 and 14 brands. our distribution covers 4100 towns and 72,000 villages in the country servicing over 700,000 retail outlets. the sales revenue from products was Rs. 16.94 crores in the calendar year 2008 PSI adopts standard marketing concepts and techniques like consumer research, segmentation, marketing mix (product, price, place and promotion) and strategic planning

Leadership

PSI India is a professionally managed NGO led by a group of highly talented, multi-disciplinary team. The day to day operations are led by the Managing Director, assisted by the Senior Management Team. We benefit greatly from our Governing Board, which consists of highly accomplished and eminent members.

Our Governing Board

Ms. Carol Squire

Carol Squire specializes in Strategic Mentoring, which involves facilitating management teams to clarify their strategic objectives and to find ways to break old patterns of organizational and individual behaviour in order to move their programs forward. She has over 25 years of international experience in social marketing and public health program management. Carol an independent consultant since 2005, now travels around the world leading workshops and consulting to social marketing organizations. She is member of PSI Board since 2005.

Mr. S. V. Sista

Known to his friends as 'Bobby', S.V. Sista is a doyen of the advertising industry in India. He is the founder and Executive Trustee of Population First – a communications initiative for a balanced, planned and stable population in India. One of the earliest proponents of Corporate Social Responsibility, he has been associated with a number of NGOs including Anga Karunya Kendra, Action Aid, Partners in Change. He has served in various capacities on the governing bodies of Advertising Agencies like Association of India (AAAI), Advertising Standards Council of India (ASCI), Audit Bureau of Circulations (ABC), guiding Indian advertising to consistently higher standards and advocating ethical business practices. He is one of the Founders of the Advertising Club, Bombay the largest Club of its kind in the world. He was awarded the ABBY Distinctive Recognition Award for his contribution to the Advertising Industry by the Ad Club, Mumbai, on 16th March, 2003. He has been on the board of PSI, since September 2005.

Mr. Shankar Ghose

Mr. Shankar Ghose is currently President of the Governing Body of Charkha Development Communication Network. Prior to joining Charkha, Mr Ghose was Executive Director of National Foundation for India. Shankar Ghose had a long and distinguished career in the corporate world having worked with multinationals like CALTEX (California Texas Oil Corporation) and Godfrey Philips, a Philips Morris subsidiary; public sector undertaking, the Maharashtra Agriculture & Fertilizer Promotion Company (MAFCO) and the well know Indian industrial group DCM- Shriram. Mr. Ghose is associated with a number of voluntary organization and committees of government and industry. He is a former member of the National Committee of the Confederation of Indian Industries (CII) on Population, Health

and Education and Chairman of the National Task Force on HIV/AIDS. He has been on the Managing and Executive Committees of the All India Management Association (AIMA) and the Delhi Management Association, member of the academic council of the Indian Institute of Mass Communication (IIMC), member of the Lok Seva Sanchar Parishad (LSSP) and Chairman of the Joint Steering Committee of the Public Service Communications Initiative (PSCI) of Doordarshan India. He was also one of the founding members of country's first mobile Home Palliative Care Initiative, CANSUPPORT, for poor, terminally ill cancer patients.

Mr. Kaushik Dutta

Mr. Kaushik Dutta, is a fellow member of the Institute of Chartered Accountants of India with over 20 years of experience. He is currently a member of the India Leadership Team of PriceWaterhouse Coopers and the national IFRS leader. Kaushik has been associated with a number of NGOs including Aga Khan Foundation, CARE, Catholic Relief Services, ChristianChildren's' Fund and Christian Medical College, Ludhiana. He has also worked with bi-lateral and multi-lateral agencies including European Union (Delegation of the European Commission), India Canada Environment Facility, UNICEF, World Food Program, World Health Organization, and Ministry of Health and Family Welfare, Government of India. He is a member of the Confederation of Indian Industries' (CII) Financial Group-Services and Reforms and also a member of CII's National Council on Corporate Governance. He is active in various professional forums and has prepared a number of research papers for the ICAI, ICWA, ICS on international reporting and governance issues. He is a visiting faculty at the Indian Institute of Management, Kolkatta and Lucknow and Delhi University. He writes frequently in the business columns of leading newspapers on governance and reporting issues.
Kaushik has participated in the Naresh Chandra Committee's deliberations for developing the norms of Corporate Governance in India. He has also worked with Conference Board of the U.S.A., the office of the Comptroller and Auditor General of India, CII, Asian Institute of Corporate Governance, Department of Public Enterprises etc., on governance matters for some of the top Boards of Directors of Indian companies.He has co-authored a book titled 'Corporate Governance: Myth to Reality' published by Lexis-Nexis Butterworths, which has been highly rated by the Global Forum of Corporate Governance, USA.

Mrs. Asha Das

Mrs. Das retired as Secretary to The Government of India, Ministry of Social Justice & Empowerment. She has significant experience and expertise in the social and human development sector having worked in the departments of social justice, women and child development, National Commission for Scheduled Cates and Scheduled Tribes She has represented India on the executive committees/boards of World Food Program, UN Commission on Narcotic Drugs, UN Commission on Crime Prevention and Criminal Justice. She was also special invitee on the Commonwealth Advisory Group on Alcoholism, UNICEF. She also has been associated with reviews, studies and consultations with

UNESCO, UNIFEM and ILO on issues of education, gender, HIV and Aids and migrant and child labour. She has been associated with the National Commission for Women as member of core committee, Special Rapporteur with the National Human Rights Commission on the issues concerning Disability, Women, Children and Trafficking and as an advisor to the National Abylimpics Association of India. Asha Das is also on the Governing Board of Guild of Service, Amar Jyoti Trust and Miranda House and Director on the board of India energy exchange and multi commodities exchange.

PRITPAL MARJARA, MANAGING DIRECTOR

Pritpal Marjara is the Managing Director of Population Service International in India. Mr. Marjara has over 15 years of diverse professional experience in social marketing, behaviour change communication, research and Information Technology. Mr.Marjara began his career as IT professional developing software programs. He started his career in development sector at PSI where he managed complex health programs in diverse geographical, social and cultural setting in India. He had progressive responsibilities, culminating the program leadership, within PSI's "Avahan" program with the Bill and Melinda Gates Foundation which involved the delivery of services in management and treatment sexually transmitted infections in the areas with high prevalence of HIV. Mr. Marjara holds a Master's degree in Information Technology. He speaks in English, Hindi, and Punjabi.

Mr. Brain Smith - Vice President and Regional Director, Asia and Eastern Europe

Brian Smith provides overall leadership to PSI's programs across Asia and Eastern Europe. With PSI since 1997, Brian has served as PSI's Country Representative in Rwanda and Mozambique, and as Director of Technical Services based in Washington, DC. He was a Peace Corps Volunteer in Botswana and Associate Peace Corps Director for Administration in Cameroon. Brian has an MA in English Literature from the University of Virginia and a Masters in Public Administration from Harvard's Kennedy School.

Senior Management Team

Pritpal Marjara, Managing Director

Pritpal Marjara is the Managing Director of Population Service International in India. Mr. Marjara has over 15 years of diverse professional experience in social marketing, behaviour change communication, research and Information Technology. Mr.Marjara began his career as IT professional developing software programs. He started his career in development sector at PSI where he managed complex health programs in diverse geographical, social and cultural setting in India. He had progressive responsibilities, culminating the program leadership, within PSI's "Avahan" program with the Bill and Melinda Gates Foundation which involved the delivery of services in management and treatment sexually transmitted infections in the areas with high prevalence of HIV. Mr. Marjara holds a Master's degree in Information Technology. He speaks in English, Hindi, and Punjabi.

Atul Kapoor, Senior Director Program

Atul leads Project Connect – a USAID supported program on building PPP models for HIV/AIDS & TB. Atul started his career in the private sector working in marketing and sales, moving onto project management and general management with organizations like Marico, Godrej Consumer, Dabur, Tata tele-services before moving to the development sector with PSI working on HIV/AIDS Programs. Atul has started and scaled up large scale projects both in India and overseas and has successfully managed large teams across different geographical areas across India, Bangladesh, Gulf, Egypt, South Africa & USA. Atul has a bachelor's degree in Pharmacy from the Birla Institute of Technology & Science, Pilani (BITS) and a post graduate in Management from Institute of Rural Management, Anand (IRMA)

Dr. Jyoti Vajpayee, Global Clinical Advisor

Dr. Jyoti Vajpayee, is an obstetrician/gynecologist and public health specialist with twenty five years of progressive professional experience working in the field of family planning, maternal and child health, reproductive health, HIV/AIDS and gender. Twelve years of progressive experience as manager, leader, program developer, strategic planner and technical advisor to multi donor funded large and small projects supported by USAID, DFID, Global Fund, BMGF, Packard and UNFPA. Experienced in program and financial management, supervision, grant making, subcontracting, collaborating with donors, local and international NGOs, national and state governments, professional bodies and academic institutions. Recognized for expertise in Quality assurance in service delivery, capacity building, training, skill transfer and health system strengthening. Exceptional entrepreneurial, fundraising, management, problem solving and team building skills. Effective in networking, developing strategic partnerships and resource mobilization. Member of FOGSI, IMA and Global Health Council. Working in PSI, India since September 2008 as Senior Technical Advisor. Prior to working with PSI worked with Engender Health as Country Representative.

Rup Kumar Sengupta – Senior Director Human Resources

Rup is an HR professional with over two decades experience, predominantly in the Hi-tech sector, with organizations like Siemens, Lucent, Huawei and C-DOT. After completing his post graduation in Industrial Relations and Personnel Management in '86, Rup started his career as HR Operations and Recruitment specialist which covered manpower planning to on-boarding, implementation of policies, procedures and ensuring statutory compliances. Rup has extensive experience in compensation & benefits, including designing salary grade structure, policies and procedures, performance management system and training & development including assessment of training needs, developing and rolling out training programs.
Rup is an accredited MBTI trainer from API, UK and have undergone several trainings like BHP & AHP from ISABS, Train the Trainer from Tata Management Training Centre and several modules on Compensation & Benefits from the Global Remuneration Organization, USA. Rup joined PSI in December 2008 and leads the human resource function.

Sanjeev Dham, Senior Director Program

Sanjeev has had a hugely successful career at PSI India. In the past 20 years he has taken on increasing responsibilities. He has successfully managed large scale operations; planned and executed innovative behaviour change communication strategies for birth spacing as well as HIV/AIDS programs; conceptualized and implemented a unique cost effective rural sales distribution model and effectively established a network of health providers in reproductive health area. Sanjeev has represented PSI at various national stakeholder forums. He has been instrumental in establishing operations in different states and has forged excellent relations with the state governments. Sanjeev has a Bachelor's degree in Commerce form Rajasthan University, Jaipur and a Diploma in Business Management from IFCA University, Dehradun. Sanjeev has also attended short term courses in sales and distribution, team management and effective leadership from IIM Kolkatta and on leadership in strategic health communication, Johns Hopkins University. He has co-authored a chapter on Emergency Contraception campaign in the book Social marketing for Public Health: Global Trends and Success stories being authored by Philip kotler, Nancy lee & Hong cheng.

REFLECTIONS FROM INTERNSHIP AT POPULATION SERVICES INTERNATIONAL (LEARNING AND EXPIERENCING)

Through out my dissertation i was involved into following tasks.

1. Started my work with Bloomberg project which is working in the line of tobacco control. I was asked to design a study to find out compliance of public places and tobacco retailers with COTPA act.
2. Post to conceptualization of study I was continuously involved in implementation of the study which included the role of training the investigators, coordinator and supervisor.
3. During report writing I was in continuous touch with the agencies sharing my comments to help them write the report and finally proof read the final report.
4. I was involved in an another study commencing on use of Utertonics/Misoprostol for management of PPH to decrease maternal mortality. I was instructed to do an extensive literature review on the status of Misoprostol with regard to policy, availability, perception of providers and users towards it, its market and its media coverage.
5. I was also assigned some daily basis tasks by my supervisor for documentation and proposal writing.

Personal learning:

As I started my career in this organisation, I can say that I have got a strong foundation, extensive exposure and great support from my colleagues and supervisor. Some of the key elements I have learnt in this organisation are interpersonal skills, spontaneity , delivering on time even in hectic schedule, time management, networking, coordination, organisational and work culture.

PART -2

DISSERTATION REPORT

UNIVERSAL HEALTH COVERAGE AND SOCIAL DETERMINANTS: A POLICY ANALYSIS

2.1 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. According to high level expert group (HLEG), 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."
Social determinants are the main factors, which determines the success of universal health coverage. In Indian context, social determinants of Indian population project a great need of universal health coverage to deal with equity and inequality. So this study tries to determine the social determinants of health of Indian population keeping the frame work of CSDH in mind. As the study tries to explore the social determinants of Indian population, it also tries to find out the gaps in policy implementation regarding universal health coverage considering the social determinants of health. This gap analysis will bring us in a position to recommend some measures to be taken to fill the gap of universal health coverage policy implementation.

2.2 ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CSDH	Commission on Social Determinants of Health
EAG	Empowered action group
HIV	Human immunodeficiency virus
HLEG	High level expert group
ICDS	Integrated child development services
JNNURM	Jawaharlal nehru national urban renewal mission
JSY	Janani surakhsha yojana
NGO	Non govermental organisation
NRHM	National rural health mission
OOP	Out of pocket
PDS	Public distribution system
RSBY	Rashtriya swasthya bima yojana
SDH	Social determinant of health
UHC	Universal health coverage
WHA	World health assembly
WHO	World health organisation

2.3 INTRODUCTION/BACKGROUND

“The most important asset of an individual is health”. “Health is wealth”. “A healthy mind lies in a healthy soul”. “A nation can be on the way of development only if its citizens are mentally and physically healthy.” These are some popular quotes we have been hearing since long time. But the main obstacle in providing a good healthy life style to any individual is the cost lying in it. This was thought by many intellects and health professionals across the globe and then they conceptualized a term called “universal health coverage”.

Its not new that different nations around the world are trying to get this word conceptualized. Evidences are there since late 1800 where health care was provided with subsidies by govt and other agencies. But the concept of universal healthy coverage has risen to the forefront of global health agenda in past few years as reflected by donor pledges, international declarations and high profile publications.(1) In Present time, 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.(3) Escalating health care costs, inadequate public spending, diverse social determinants 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.(4,5) 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.(6) 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. (7) 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.(8) 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. But India has its own constraints to attain status of universal health coverage considering its geographical pervasiveness, diverse population, socio economic determinants, health delivery system etc. Still efforts are going on to make this dream come true. High level expert group has given its contribution in proposing a model and has given its recommendations on UHC in India. Definition of universal health coverage in India according to HLEG is as follows:

Definition of universal health coverage :

"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."(2)

It is envisaged that universal health coverage in India shall be based on the following core principles which was highlighted in the HLEG report:

1. Universality Equity Comprehensiveness of care
2. Non-exclusion and non-discrimination
3. Financial protection
4. Quality and rationality of care protection of patients rights
5. Appropriate care, patient choice and portability and continuity of care. Consolidated and strengthened public health provisioning as a key component of UHC Accountability, transparency and participation

2.4 RATIONAL 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 a better health status of the population which can be built up by having proper policy framework and the implementation of the policy in a phased manner with set of goals and objectives. This study after extensive review of available literature on UHC, analysing existing gaps in implementation mechanism of policy on UHC, considering socio- economic determinants of population in India will propose a model and recommendations which could be applied in India for dream of successful universal health coverage.

2.5 OBJECTIVE:

To study the “policy environment regarding the universal health coverage” and “gaps in its implementation” focusing on social determinants in India

SPECIFIC OBJECTIVE:

1. Study of various social determinants of India in accordance with WHO framework.

2. Recommendation on kind of mechanism required to address the Indian policy on universal health coverage considering socio economic determinants of Indian population.

2.6 RESEARCH METHODOLOGY

STUDY DESIGN:

A qualitative descriptive study is proposed in which contextual review method will be used to identify the issues related to the service delivery of universal health coverage considering social determinants of India. The method of systematic review will also be used to gather evidences regarding service delivery on universal health coverage in which the articles focusing on the implementation of universal health coverage policy in various parts of country will be reviewed in Pubmed, Lancet, and other published scholarly papers.

SEARCH STRATEGY AND SELECTION CRITERIA:

we plan to search a wide range of sources, including academic literature, government reports, multilateral-agency reports, and commissioned reports, 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. search terms or key words to find these articles would be "universal health coverage", “social determinants” "health systems", "universality", "equity", "non-exclusion", "accountability", "financing", "regulation", "service delivery", "expenditures", "out of pocket", and "quality etc.

2.7 REVIEW FINDINGS:

The Commission on Social Determinants of Health (CSDH) was set up by the World Health Organization (WHO) to get to the heart of complexity of health. They were tasked to summarize the evidence on how the structure of societies, through myriad social interactions, norms and institutions, are affecting population health, and what governments and public health can do about it. To guide the Commission in its mammoth task, the WHO Secretariat conducted a review and summary of different frameworks for understanding the social determinants of health. This review was summarized and synthesized into a single conceptual framework for action on the social determinants of health which was proposed to and, largely, accepted by, the CSDH for orienting their work(9).

CSDH conceptual framework:

The CSDH framework shows how social, economic and political mechanisms give rise to a set of socioeconomic positions, where by populations are stratified according to income, education, occupation, gender, race/ethnicity and other factors; these socioeconomic positions in turn shape specific determinants of health status (intermediary determinants) reflective of people’s place within social hierarchies; based on their respective social status, individuals experience differences in exposure and vulnerability to health-compromising conditions. Illness can “feed back” on a given individual’s social position, e.g. by compromising employment opportunities and reducing income; certain epidemic diseases can similarly “feed back” to affect the
functioning of social, economic and political institutions.

“Context” is broadly defined to include all social and political mechanisms that generate, configure and maintain social hierarchies, including: the labour market; the educational system, political institutions and other cultural and societal values. Among the contextual factors that most powerfully affect health are the welfare state and its redistributive policies (or the absence of such policies). In the CSDH framework, structural mechanisms are those that generate stratification and social class divisions in the society and that define individual socioeconomic position within hierarchies of power, prestige and access to resources. Structural mechanisms are rooted in the key institutions and processes of the socioeconomic and political context.

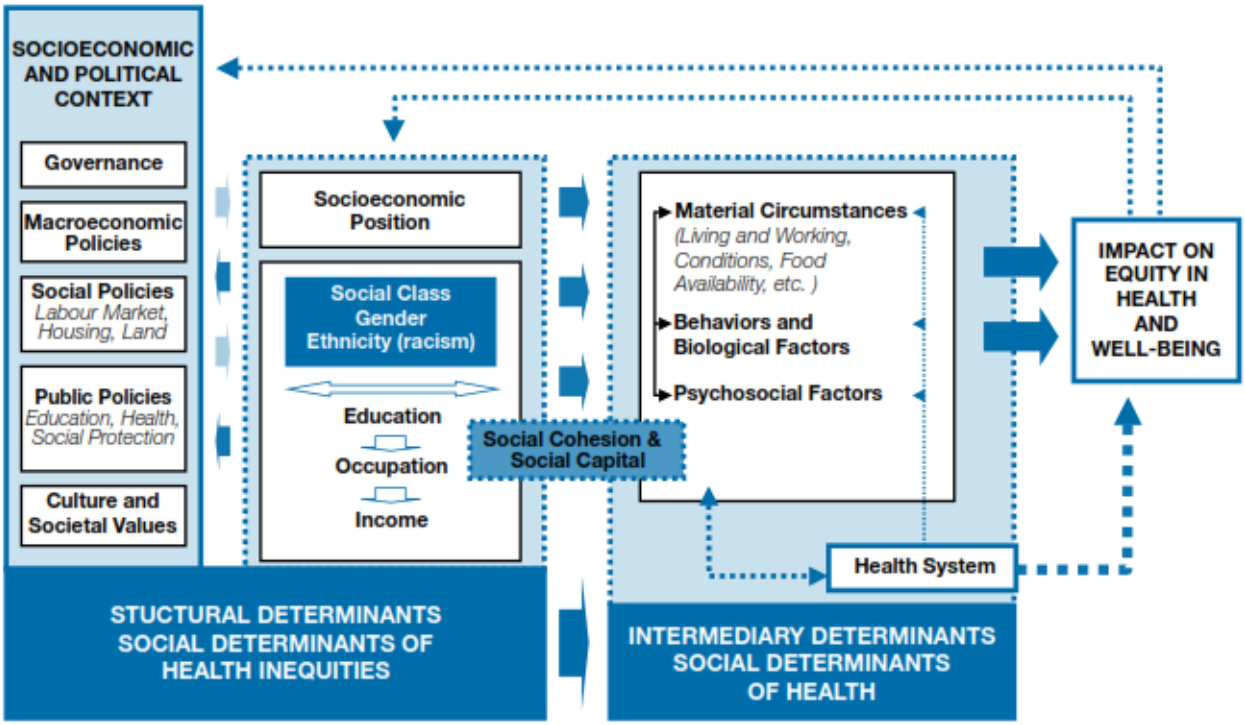
The most important structural stratifiers and their proxy indicators include: Income, Education, Occupation, Social Class, Gender, Race/ethnicity. Together, context, structural mechanisms and the resultant socioeconomic position of individuals are
“structural determinants” and in effect it is these determinants we refer to as the “social determinants of health inequities.” The underlying social determinants of health inequities operate through a set of intermediary determinants of health to shape health outcomes. The vocabulary of “structural determinants” and “intermediary determinants” underscores the causal priority of the structural factors. The main categories of intermediary determinants of health are: material circumstances;

psychosocial circumstances; behavioural and/or biological factors; and the health system itself as a social determinant.

- Material circumstances include factors such as housing and neighborhood quality, consumption potential (e.g. the financial means to buy healthy food, warm clothing, etc.), and the physical work environment.
- Psychosocial circumstances include psychosocial stressors, stressful living circumstances and relationships, and social support and coping styles (or the lack thereof).
- Behavioural and biological factors include nutrition, physical activity, tobacco consumption andalcohol consumption, which are distributed differently among different social groups. Biological factors also include genetic factors.

The CSDH framework departs from many previous models by conceptualizing the health system itself as a social determinant of health (SDH). The role of the health system becomes particularly relevant through the issue of access, which incorporates differences in exposure and vulnerability, and through intersectoral action led from within the health sector. The health system plays an important role in mediating the differential consequences of illness in people's lives.

Figure – 1: CSDH frame work of social determinants



CSDH framework in turn, includes:

1. The socio-political context;
2. structural determinants and socioeconomic position;
3. Intermediary determinants.

First element of CSDH frame work: **The socio-political context**

Although explaining socio political context is beyond the scope of this paper, but broadly it includes six major points:
(1) **Governance** in the broadest sense and its processes, including definition of needs, patterns of discrimination, civil society participation and accountability/transparency in public administration;
(2) **Macroeconomic policy,** including fiscal, monetary, balance of payments and trade policies and underlying labour market structures;
(3) **Social policies** affecting factors such as labour, social welfare, land and housing distribution;
(4) **Public policy** in other relevant areas such as education, medical care, water and sanitation;
(5) **Culture and societal values;**
(6) **Epidemiological conditions,** particularly in the case of major epidemics such as HIV/AIDS, which exert a powerful influence on social structures and must be factored into global and national policy setting.

Second element of CSDH: Structural determinants and socio economic position

The CSDH framework posits that *structural determinants* are those that generate or reinforce social stratification in the society and that define individual socioeconomic position. These mechanisms configure the health opportunities of social groups based on their placement within hierarchies of power, prestige and access to resources (economic status). There is a close interplay between structural determinants and socio economic positions. Some of the major socio economic variables identified are income, education, occupation, social class, gender, race/ethnicity. Also socio political factors such as, Governance patterns; macroeconomic policies; social policies; and public policies in other relevant sectors act as modifiers or buffers influencing the effects of socioeconomic position on health outcomes and well-being among social groups. The positive significance of this linkage is that it is possible to address the effects of the structural determinants of health inequities through purposive action on socio political features, particularly the policy dimension.

Third element of CSDH: intermediary determinants

The intermediary determinants basically consists of Factors such as material circumstances; psychosocial circumstances; behavioural and/or biological factors; and the health system itself. The social determinants of health inequities are causally antecedent to these intermediary determinants.

1. Material circumstances include determinants linked to the physical environment, such as housing (relating to both the dwelling itself and its location), consumption potential, i.e. the financial means to buy healthy food, warm clothing, etc., and the physical working and neighbourhood environments.
2. Psychological circumstances includes psychosocial stressors (for example, negative life events and job strain), stressful living circumstances (e.g. high debt) and (lack of) social support, coping styles, etc.
3. Behavioural and/or biological factors includes smoking, diet, alcohol consumption and lack of physical exercise, which again can be either health protecting and enhancing (like exercise) or health damaging (cigarette smoking and obesity); in between biological factors genetics factors, age and sex distribution are also included. The healthsystem should be viewed as an intermediary determinant as this is closely related to models for the organization of personal and non-personal health service delivery. The health system can directly address differences in exposure and vulnerability not only by improving equitable access to care, but also in the promotion of intersectoral action to improve health status.

SOCIAL DETERMINANTS PERSPECTIVE FOR UNIVERSAL HEALTH COVERAGE IN INDIA CONTEXT

Now given the CSDH frame work of social determinants, in Indian context there is great need for action on social determinants emerges from the recognition that there are huge differentials among and between classes and castes, gender gaps and wide regional variations in both disease burden and response by the health system and others concerned with development.

a) Nutrition and Food Security

One fourth of the world's hungry are Indians. As per the WHO's standards, 40% of Indian children under the age of 3 are underweight, 45% are stunted and 23% have wasting (see Annexure 2). Malnutrition itself is the result of several other determinants that have extended and extenuating lifetime impact on the health and wellbeing of women and their children(10) Even economically developed states - Gujarat, Maharashtra, Andhra Pradesh and Karnataka – have high levels of food insecurity(11). As per the New Delhi Birth Cohort, the population attributable risk of being underweight is 28% for 6 month olds, as compared to 18% among 5 year olds - clearly the concentration of nutrition-related morbidity follows a reverse age gradient, rendering the youngest most vulnerable.(12) The focus of India's current nutrition programmes has become supplementary nutrition and preschool education for 4-6 year olds, belying the need to focus adequately on the first 2 years of a child's life – critical to prevent under-nutrition and its sequelae(12). Nutrition is a social determinant of health and is itself influenced by many other social determinants. Vertical programmes will, therefore, not provide complete or lasting solutions.

b) Water and Sanitation

This is well known fact now that there is strong correlation in quality of water, sanitation practices and health. A study in five Indian states found a negative correlation between the

provision of household toilets and community level prevalence of communicable diseases including cholera, typhoid/enteric disease,
diarrhoea/vomiting, hepatitis, nematodal infections as well as malaria and dengue(13).
A 2002 Planning Commission report expressed alarm over the 'rather extensive presence' of fluoride and arsenic in Indian drinking water, which is associated with a number of cancers (of the skin, lungs, kidneys, and bladder)(14). Another major finding is that use of improved facilities is strongly correlated with sanitation related knowledge and hygiene-promotive attitudes ultimately leading to better health(13,15).

c) Social Exclusion

Gender inequality is a persistent and worsening phenomenon in India(16). In rural India, women are three times more likely than men to go without treatment for long-term ailments, a trend that persists even amongst the non-poor. When treatment is sought, significantly smaller sums of money are spent on treatment of women than on men(17). Other factors such as Caste and social stratification in India determine health, education, employment, social, and economic outcomes (18).

d) Work (In) Security, Occupational Health and Disasters

Globalisation and the concomitant casualisation of labour have resulted in the growth of informal economies that account for 93% of the Indian workforce. Migrant workers are among the poorest and most exploited, performing low level, unskilled and hazardous work. This population faces significant disease burdens including musculoskeletal injuries, chronic obstructive lung diseases, toxic chemical exposure and poisoning and noise-induced hearing loss(19).

NEED FOR UNIVERSAL HEALTH COVERAGE IN INDIA CONSIDERING SOCIAL DETERNMINANTS OF HEALTH

As the definition of universal health coverage given by HLEG states "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, quality health services (promotive, preventive, curative and rehabilitative) delivered to individuals and populations, as well as services addressing wider determinants of health." (20)So, Considering CSDH guidelines on social determinants, if the financially insecure, the socially excluded, or the politically marginalized lack access to health services or to any other social determinants affecting health, such as food, housing, or income security, the universality of health coverage is compromised. In other words, for health coverage to be universal, the drivers of health inequity - the social determinants - must be addressed(2). Different committees/agencies have advocated the acknowledgement and prioritization of social determinants towards approach to attain universal health. Some of them to name are Bhore report (21), Sokhey reports(22), 2010 Annual Report to the People on Health(23), and the draft National Health Bill(24).The Sokhey report focused on treatment as well prevention of disease by bringing about an environment and conditions of living which would prevent the germs of disease taking hold through an organised public service. The 2010 Annual Report is more specific, highlighting nutrition, access to safe drinking water, education, as well as poverty and marginalisation as key social determinants of health in India.

The Draft National Health Bill indicates that health interests will guide the creation of minimum standards for food/ nutrition, water, sanitation and housing, adding that an individual's right to the highest attainable standard of health cannot be impaired on grounds of social or economic status (including gender, religion, language and perceived or actual health status).

CONTEXTUALISING UHC CONSIDERING SOCIAL DETERMINANTS OF HEALTH

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(25), India continues to be among the highest number of malnourished children in the world today(26), maternal health has also shown sluggish improvement- India has an unenviable high maternal mortality rate(27).

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(2 8,29). Although forms of health financing exist in the country most of it 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 till recently, is covered by some form of health insurance(34). 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(30). 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(28,29)

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(29). The differences are stark. for instance, for a girl born in rural Madhya pradesh, the risk of dying before age 1 is around

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)(31). Health actions need to be differentially prioritized and geared to meet the varying health needs in different parts of the country and 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 focusing the various social determinants proposed by CSDH. 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(32). 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(33) 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 along with social determinants of rural and urban areas respectively.

2.8 DISCUSSION AND CONCLUSION

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 and socio economical status of population. Even as the country establishes a vision for universal health and develops the mechanisms for financing and effectively implementing this initiative, there has to be adequate political momentum to bring this about at state as well as central level and a synchronized intersectoral coordination to address the social determinants. HLEG in its report (2) has recommended to set up a dedicated Social Determinants Committee which would operate at the national, state and district level and would be responsible for following functions:

Review current status vis-a-vis convergence of all developmental programmes.

Examine and advise on convergence of developmental programmes to ensure implementation. This could be done in phases. For example, India could tackle the problem of malnutrition in rural areas through immediate convergence of ICDS, NRHM and the Public Distribution System (PDS). Specifically, this would involve clear outlining of roles, recognizing overlap and building synergies, especially at the point of contact with beneficiaries of these programmes.

Examine the feasibility of pooling and rationalising resources for maximising outcomes. For example, dovetailing of the National Urban Health Mission with Jawaharlal Nehru National Urban Renewal Mission (JNNURM) and other programmes for urban infrastructure of the Ministry of Housing and Urban Poverty Alleviation.

Review the progress of and remove operational hurdles against such amalgamation.

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(35). 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. 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 catering to some of the social determinants but not all. The NRHM 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. 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. Apart from these initiatives, if we focus on appropriate delivery system for universal heath coverage in India, it should be 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 packages. And these packages could be designed focusing different socio- economic determinants for different strata of population which could fit into their particular needs.

2.9 RECOMMENDATIONS:

1. A mix of public health services with regulated, 'contracted in' services of those private providers should be used to provide essential health package to the citizens. These collaborations may include pilot programmes. Impact on health and other indicators must be carefully assessed as a result of these collaborations. Based on the findings, the pilots may then be scaled up and/or adapted to different settings.

2. 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.

3. At the national level, a macro-policy initiative should be taken across ministries and government departments to catalyse action on the "WHO-recommended Health" in All Policies framework. This framework introduces health as a priority in the planning and implementation of ministries and departments involved with social determinants of health (such as chemicals, trade, agriculture/food, housing and transport, rural and urban development)

4. A surveillance system should be developed to map the nation's progress in closing gaps in health equity. Systems-level health equity surveillance will be coordinated with Health Systems Evaluation Units with disaggregated information up to at least the district level, and preferably up to the block level. This information will enable our health system for continuous correction and rectification of errors in implementation and other obstacles to achieve the goal of decreasing gaps in health equity.

5. A dedicated social determinant committee should be set up to operate on national, state and district level, Which would incorporate members from different developmental and social sector. The main responsibility of this committee would be to examine and advise on convergence of developmental programmes to ensure implementation in right manner for best results. This will serve the purpose of inter-sectoral coordination which is an important demand of the hour in giving holistic approach to the universal health coverage.

6. All the stake holders such as Multilaterals, national and local government, NGOs, the private sector, pharmaceutical industry, civil society and research and academic institutions should be made accountable and responsible, as all these institutions have roles to play in ensuring the success of achieving equity in health and indeed better health governance. This requires transparency, better leadership and partnerships within the health system, together with systematic assessment and analysis of health system governance.

7. Capacity building for public health system by increasing the investment substantially greater than present to strengthen the public health system.

2.10 LIMITATION:

1. 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.

2. 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.

2.11 REFERENCES

1. BBC News 2009; Garrett, Chowdhury et al. 2009.

2. k. srinath reddy, "high level expert group report on universal health coverage for India", 2011, http://planningcommission.nic.in/reports/genrep/rep_uhc0812.pdf.

3. international labour organisation. social health protection: an ilo strategy towards universal access to health care. *social security policy briefings; paper 1,* international labour office, social security department - geneva: ilo, 2008.

4. garrett l, chowdhury amr, pablos-méndez a. all for universal health coverage. *lancet,* 2009, 374(9697):1294-1299.

5. institute for health metrics and evaluation. financing global health report [internet]. 2009 available from: http://www.healthmetricsandevaluation.org/print/reports/2009/financing/financing global health report full ihme 0709.pdf

6. world health assembly w. sustainable health financing, universal coverage and social health insurance [internet]. 2005 available from: http://apps.who.int/gb/ebwha/pdf_files/wha58/wha58_33 en.pdf

7. who. the world health report - health systems financing: the path to universal coverage [internet]. 2010 available from: http://www.who.int/whr/2010/en/index.html

8. bennett s, ozawa s, rao kd. which path to universal health coverage? perspectives on the world health report 2010. *plos med,* 2010, 7(11):e1001001.

9. A Conceptual Framework For action on the Social determinants of health, social determinants of health discussion paper 2, WHO, Geneva, 2010.

10. Jose S, Navaneetham K. Social Infrastructure and Women's Undernutrition, Economic and Political Weekly. 2010: 45(13); 83-89.

11. United Nations World Food Programme, M. S. Swaminathan Research Foundation. Report on the State of Food Insecurity in Rural India. Chennai: Nagaraj and Company Private Limited; 2008.

12. Paul VK, Sachdev HS, Mavalankar D, et al. India: Towards Universal Health Coverage 2. Reproductive health, and child health and nutrition in India: meeting the challenge. Lancet 2011; published online Jan 12. DOI:10.1016/S01406736(10)61492-4.

13. Nath KJ, Chowdhury B. Impact of inadequate Sanitation and Poor level of Hygiene Perception and Practices on Community Health. Sulabh International Academy of

Environmental Sanitation/The World Health Organisation India [Internet] 2009. [cited 2011 March 2] Available from: http://www.whoIndia.org/LinkFiles/Sanitation_Impact_ of_Inadequate_Sanitation_and_Poor_Level_of_Hygiene_ Perception_and_Practices_on_Community_Health.pdf.

14. Planning Commission. Water Supply and Sanitation: A WHO-UNICEF Sponsored Study. New Delhi: Government of India, Planning Commission; 2002

15. Jalan J, Ravallion M. Does piped water reduce diarrhea for children in rural India? Journal of econometrics. 2003;112(1):153-173.

16. John ME. Census 2011: Governing Populations and the Girl Child. Economic and Political Weekly. 2011; XLVI(6): 10-12.

17. Iyer A, Sen G, George A. The dynamics of gender and class in access to health care: evidence from rural Karnataka, India. International Journal of Health Services. 2007; 37(3): 537554

18. Jacob, KS. Caste and inequalities in health. The Hindu (22/08/2009), [Internet] 2009. [cited 2010 December 29] Available from:http://www.thehindu.com/2009/08/22/ stories/2009082255540800.htm.

19. Joshi TK, Smith KR. Occupational health in India. Occup Med. 2002;(17)3: 371-89

20. See definition of Universal Health Coverage, Preamble of Report of High Level Expert Group on Universal Health Coverage 2011.

21. Government of India, [Bhore Commission] Report of the Health Survey and development Committee, 4 vols. New Delhi: Government of India; 1946.

22. National Planning Committee, National Health: [Sokhey] Report of the Sub-Committee. Bombay: National Planning Committee; 1947: 26-7.

23. Government of India/Ministry of Health and Family Welfare, Annual Report to the People on Health. New Delhi: Ministry of Health and Family Welfare. [Internet] (September) 2010 [cited 2010 December 28] Available at: http://mohfw.nic.in/Annual%20Report%20to%20the%20People%20 on%20Health%20_latest_08%20Nov%202010.pdf.

24. Ministry of Health and Family Welfare, The National Health Bill, 2009 (Working Draft) [Internet] 2009 [cited 2011 January 12] Available from: http://mohfw.nic.in/nrhm/ Draft_Health_Bill/General/Draft_National_Bill.pdf.

25. svedberg p. child malnutrition in India and china. 2020 focus brief on the world's poor and hungry people. 2007. washington, dc: ifpri.

26. grammaticas d. food warning for Indian children. 13 may 2008, bbc news, delhi. [internet]. 2008; available from: http://news.bbc.co.uk/2/hi/south_asia/7398750.stm

27. sinha k, "India: maternal mortality plummets, still highest in the world", one world south asia, 17 september, 2010. [internet] ; available from http://southasia.oneworld.net/todaysheadlines/India-maternal-mortality-plummets-still-highest-in-the-world

28. abbasi k. the world bank and world health: focus on south asia-ii: India and pakistan bmj. 1999 apr 24;318(7191):1132-5.

29. jha p, laxminarayan r. choosing health: an entitlement for all Indians. 2009, centre for global health research.

30. horton r, das p. Indian health: the path from crisis to progress. *lancet*, 2011, 377(9761):181-3

31. balarajan y, selvaraj s, subramanian s. health care and equity in India. lancet. 2011 jan 10.

32. arnold f, parasuraman s, arokiasamy p, kothari m. nutrition in India. national family health survey (nfhs-3), India, 2005-06. mumbai: international institute for population sciences; calverton, maryland, usa: icf macro [internet]. 2009 available from http://www.nfhsIndia.org/nutrition_report_for_website_18sep09.pdf

33. rao m, rao kd, kumar as, chatterjee m, sundararaman t. human resources for health in India. lancet. 2011 jan 10

34. International labour organisation. social health protection: an ilo strategy towards universal access to health care. *social security policy briefings; paper 1*, international labour office, social security department - geneva: ilo, 2008.

35. reddy ks, patel v, jha p, paul vk, shiva kumar ak, dandona. 2011 towards achievement of universal health care in India by 2020: a call to action. lancet; 377(9761):760-768