

Review Article

A Narrative Review on Universal Health Coverage-Concepts, Policy Implications and Path Ahead for India

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Abstract

Introduction: UHC addresses the concept of health in all its dimensions and not merely a response to illness. The deficiencies in the healthcare system of India cannot be bridged by additional investment, increasing manpower, adoption of technology or establishing regulatory institutes.

Methods: ‘PubMed’ database and Google search engines were used for searching the relevant articles. This review includes 12 studies and other relevant literature which address the determinants of UHC and its impact on the healthcare system in India.

Body: The emphasis of UHC is on the coverage of health services and financial protection. In India, the public health sector suffers from shortfalls in management, manpower issues and poor accountability, whereas the private health sector is unregulated and contributes to the increasing health expenditure. UHC will be advantageous to the rural and urban poor including the unorganized sector workers by improving access to health care and preventing financial impoverishment. The rich class in-turn pay a higher proportion of their income towards supporting provision of healthcare, and derive benefit from this system which has predictable quality and assured outreach.

Conclusion: The concept of UHC enables health systems in adopting sustainable financing mechanisms and ensures population wide coverage with efficient delivery of a wide range of healthcare services. In view of the current Covid-19 pandemic and the need to address future pandemics, we need to build resilient health systems as well as hasten the implementation of UHC.

Keywords: Universal health coverage; Insurance coverage; Health policy; Health equity; Healthcare financing

[3], as the health system is primarily dependent on out-of-pocket expenditure and accessing healthcare from private providers.

Introduction

Reforms in the health sector should focus on making healthcare available and affordable to the socially and economically marginalized groups. Universal Health Coverage (UHC) has been adopted as UN Sustainable Development Goal Target 3.8 [1]. UHC is relevant to every Country, as the health priority across the Globe includes equity in the utilization of health services, quality of service and financial protection of the community. The goal is to provide the whole population with a range of essential health services covering 100% of their healthcare needs, and ensuring they receive these services without incurring health expenditure which is >10% of the monthly household expenditure [2]. The cost of healthcare is one of the leading causes of poverty in India

WHO’s goal of ‘Health for all’ is reflected in the concept of ‘Universal coverage’. In India the financial risk protection is only 17.9%, and prevention and treatment coverage for select health conditions is 83.5% [4]. To achieve its intended objectives, National Health Policy 2017 envisages increasing the public health expenditure to 2.5% of the GDP by 2025 and state sector health spending to >8% of their budget by 2020 [4]. The landmark Bore Committee Report during 1946 envisaged the concept of UHC for India [4]. Other pre-requisites for the delivery of UHC include availability of skilled workforce, adequate healthcare infrastructure and access to affordable drugs and technologies [5]. Some of the determinants of disease occurrence and likely outcomes include factors such as gender, caste, socioeconomic class and regions across the Country.

The three main indicators within the UHC framework include:

- Coverage: How many beneficiaries are receiving the needed health services?
- Financial risk protection: Due to out-of-pocket payments, will people lack access to health services or be impoverished?
- Equity: Whether access to health services is equitably distributed across population groups?

In the Indian context, until recently there has been lack of political commitment in recognizing health as an essential component of human development. This led to low investment, lack of sound process for policy formulation and inappropriate health program implementation, which in-turn results in inadequate delivery of health care by the public sector. UHC is not merely an aspirational goal but an entitled provision [5]. It ceases to be a system of health insurance but conceptually is an assurance of health care. UHC addresses the concept of health in all its dimensions and not merely a response to illness. Its emphasis is on prevention and primary health care.

Objectives: 1) To review the objectives of UHC with regard to coverage of health services and financial protection, 2) To address the deficiencies of the healthcare system in India and align the solutions as per the framework of UHC.

Methods

‘PubMed’ database and Google search engines were used for searching the relevant articles. Search terms with Boolean operators used include ‘Universal Health Coverage’; ‘community health insurance’. The results of this search yields research articles which contextually provide details of the relevant concepts. The criterion used for reviewing these articles includes their relevance to the defined review question, which includes the concepts associated with universal health coverage, policy implications and path ahead for India. These studies were reviewed for their description of universal health coverage, policy issues influencing its delivery and programmatic implications in the Indian context. This review includes 12 studies and other relevant literature which address the determinants of UHC and its impact on the healthcare system in India.

Body

Ten principles guiding the formulation of UHC in India [5]:



Figure 1: Ten Principles guiding the formulation of UHC in India.

i) Universality: The system for UHC should cover all sections of the Indian population including the lower socio-economic classes, marginalized and hard-to-reach groups. This principle is a social need, as a large section of our population including the middle class, lack access to affordable and quality healthcare. Even the high income groups will benefit from this efficient and equitable health system.

ii) Equity: UHC will improvise the disparity in exposure and vulnerability to diseases, including access to health services among the disadvantaged groups in the community. This can be achieved by equitable spread of health care facilities and services, and availability of timely transportation for the underserved areas. Certain sections of the population will need unique health services which could be ensured as ‘vertical equity’ in the UHC framework.

iii) Empowerment: UHC will promote empowerment of communities towards making better health choices. This includes avoiding risk factors through behavior change initiatives, supportive supervision of community health workers, community monitoring of health services and community support for drawing attention to local health concerns.

iv) Comprehensiveness of care: This includes provisioning competent healthcare providers who will function from appropriate infrastructure, with rationing of adequate logistic support including essential medicines, functional equipment, laboratory supplies, other medical needs and transportation facilities. The framework will make provision for the maximum range of necessary medical services.

v) Non-exclusion and non-discrimination: Caste, class, religion, language, sexual orientation or social background will not impact the provision of services under this scheme. Pre-existing health conditions (HIV/AIDS) or requirement of special category of health service (occupational illness) will not preclude

the accessibility of health services under UHC.

vi) Financial protection: The scheme operates in a manner such that any individual irrespective of their financial ability should receive emergency or essential health care. Such financial protection includes cashless service at the point of service provision. In the Indian context, UHC needs to be financed by increasing the tax-based public financing as we have a low proportion of formal sector employees. Evidence indicates that UHC cannot be achieved through voluntary contribution or small group insurance schemes.

vii) Protection of patient's rights, appropriate care, patient's choice: Services are delivered in concurrence to the universally accepted standards for patient care and rights. This includes right to confidentiality and privacy, right to emergency medical care, right to information, right to informed consent, right to second opinion, right to choose between treatment options including refusal of treatment.

viii) Portability and continuity of care: Continuity of care is assured for migrant workers, beneficiaries who change employers or become unemployed, and those with any health insurance coverage. The scheme facilitates seamless care during inter-agency referral, including assistance for transportation of the patient.

ix) Consolidated and strengthened public health provisioning: UHC system creates a platform for integrating public facilities such as Employee State Insurance scheme (ESIS) hospitals, facilities associated with public agencies like Railways, as well as regulating the private providers. The quality of care rendered at such facilities will be evaluated through a medical audit done as per the defined standards.

x) Accountability, transparency and participation: General information regarding the functioning of the system will be available in the public domain, and certain specific information will be provisioned through the Right to information act. The scheme will operationalize grievance redressal mechanisms. The effectiveness of the health system will be periodically reviewed through participatory monitoring by stakeholders viz. civil society organizations, public health officials, community representatives and health rights groups.

Financial risk protection

The primary strategy of Policy makers towards achieving UHC includes Publicly Financed Health Insurance Schemes (PFHIS) for the low-income population. Evidence shows that after PFHIS were implemented, there has been no reduction in the out-of-pocket expenditure among the enrolled households. The cornerstone of financing UHC includes pre-payment from sources of taxation and pooling of such revenue for purchasing healthcare services on behalf of the entire population. In this regard, the ambitious AB-PMJAY (Ayushman Bharat Pradhan Mantri Jan

Arogya Yojana) scheme was launched in India during 2018. This National health protection scheme will cover ~500 million beneficiaries, providing coverage up to INR 500,000 per family per year for secondary and tertiary care hospitalization [6].

The need of the hour is political commitment towards consistently making substantial public investments in healthcare. Between 2000 and 2017, the Indian Government's expenditure on health as a proportion of GDP grew from 0.83% to 0.96% [2]. The current investment in health sector is ~1.2% of the Gross Domestic Product (GDP), which converts to USD 18 (INR 1350) per capita. The expenditure on public health is ~30% of the total health expenditure [7]. It is imperative to strengthen the coverage of primary healthcare. WHO has set the benchmark of a minimum of 445 healthcare personnel per 100,000 population, where-in India had only 169 Physicians, Nurses and midwives (including AYUSH doctors but excluding Auxiliary Nurse Midwives) [2] during the year 2016. When compared with rural areas of India, urban areas have 4 times more the number of health workers per 10,000 population. In rural areas, 42% of health workers identifying themselves as 'allopathic doctors' tend to have no medical training relative to 15% of workers in the urban areas [5]. The bias in health financing is reflected by the allocation made to urban allopathic services (~30% of public health expenditure) when compared with <12% for the rural centers [5].

The concept of health financing for UHC includes reforms in collection, pooling, benefit design and purchasing [8], which should in-turn improve the objectives ideally measured at the population or system level. When the financial burden for health service usage is reduced for the community, there is a likelihood of increased utilization by the population and reduced financial burden for those using healthcare. Reddy KS, et al opine that public spending on health should be increased from 1% to 6% of the gross domestic product [3]. This will enable reducing the proportion of out-of-pocket expenditure from 80% to 20%. The authors also opined that the investment on health research should be increased to 8% of the health budget [3]. Research will provide evidence for health policy reforms, innovation in relevant treatments and products, and solutions for UHC. High level expert group recommends an increase in the public procurement of medicines from ~0.1% to 0.5% of GDP. This will contribute to the financial protection of households by ensuring universal access to essential drugs and reducing the burden of private out of pocket expenditure [5].

Equity

The inequities in the Indian healthcare scenario could be attributed to the lack of regard for primary healthcare including evidence based practices, and disregard for the social determinants of health. Factors such as social class, gender, religion, caste, urban/rural residence and personal background determine access to healthcare and quality of services received by the community.

UHC should facilitate healthcare across the genders, through the course of lifetime, and create mechanisms for increased access to the full range of health services. The response of public sector system to the needs of the community has been poor, and UHC has the potential to reconfigure the norms of healthcare by ensuring universal reach, quality and accessibility of healthcare services. The focus of UHC system includes investing in primary care networks, and holding the Providers accountable for wellness outcomes at the population level. This aim super cedes the existing focus of present insurance schemes on hospital networks and their disregard for primary care services.

The Health and Wellness centers to be re-developed as a result of AB-PMJAY are envisaged to provide outpatient care, medicine and diagnostic charges at no cost, and the benefit package should consider including the travel allowance and wage loss compensation. Such primary care facilities should be the point-of-entry for accessing care, and referral linkages should be established with secondary and tertiary Providers for ensuring continuum of care. Healthcare should include the needs of special groups such as elderly on long-term medication support, children with special needs, victims of road traffic accidents and people requiring long-term rehabilitation. Although the design of this scheme extends beyond the poor families to the marginalized households, persisting challenges which will continue to affect the implementation of the scheme include skewed distribution of public/private hospitals and qualified healthcare providers, high cost of medicines, non-coverage of ambulatory care and lack of awareness among enrollees regarding the empanelled hospitals and eligible conditions.

Coverage

UHC will be facilitated by monitoring the standards of healthcare provided in both public and private healthcare institutes. Periodical medical audits of such facilities will enable adherence to guidelines, including training of the existing personnel through supportive supervision. Transparency in healthcare systems will enable rooting out the existing corruption and malpractices, and punitive action against offenders will deter such attempts. By strengthening primary healthcare, UHC can reduce the morbidity of diseases and reduce the load on referral Institutes for complications arising from delayed detection. The public healthcare sector is plagued with manpower issues including lack of innovation and harmony with the organization. Recruitment initiatives for such positions should promote adequate incentives, progression through the career track and distinctive work environments. The creation of a cadre of Indian National Health Service in the Public sector, rather than general administrators, will enable public health personnel to plan and monitor health program implementation. Complex processes in healthcare need to be effectively managed using systems which will enable coordination of multiple resources

and diverse communities. Such management systems are crucial for coordinating the efforts of public and private sector towards the goal of UHC.

However, there is an increase in health expenditure in India due to the growth of the for-profit private healthcare sector. The nature of the private health sector in India has changed from individual practitioners operating from clinics and nursing homes, to an organized industry attracting huge investments [2]. Health facilities may not adopt the standard treatment guidelines and have weak accountability mechanisms. Their focus is on curative services than for preventive and promotive services. The Clinical Establishment Act 2010 does not seem to have a large impact on the regulation of the private health sector. Some of the health related goals are influenced by social determinants which arise outside of the health system. During the course of medical education, Providers lack orientation to these aspects including issues related to gender and equity. This contributes to the curative-treatment paradigm rather than a preventive healthcare approach.

Policy reforms in the past have focused on expanding the role of the private sector and public financed health insurance schemes for low-income households. The Government has provided incentives encouraging the private sector and has also entered into diverse Public-Private Partnerships (PPP). Evidence shows that PPPs have no significant population-level impact on expanding coverage to the impoverished population and could even raise the average out-of-pocket expenditure [2]. In the State of Karnataka, the PPP for primary healthcare 'Arogya bandhu scheme' was scrapped by the State Government during January 2016. The private entities managing the public sector were alleged with non-compliance to regulations, misappropriation of funds, lack of accountability, non-availability of qualified human resource and failure to provide quality service to the patients. The PPP for tertiary care in Raichur district, Karnataka, where-in the Government provided land, supply of utilities and financial aid to the private Institute was also abruptly terminated. The reasons include poor governance, lack of accountability and patient grievance redressal mechanisms. Also due to outsourcing in PPP, the contractual workforce tends to cope with poor working conditions including lower pay scales. PPP has possibly enabled expansion of the private sector but offers modest assurance in providing UHC. These strategies have not contributed to the progress towards UHC. Such experiences reinforce the need for a decentralized governance structure which responds to the local needs of the community. Empowered civil society groups will enable creating systems for accountability of healthcare.

Beyond the purview of health financing, other health system functions such as access to healthcare and supply of human resource have definitive influence on the goal of UHC. Kutzin J reports that increasing the equity in distribution of health expenditure results in improving both the equity in utilization of services as well as

the financial protection [8]. UHC related insurance scheme is expected to enable changes in the health system, unlike the private insurance scheme which exclusively benefits its subscribers. Many voluntary health insurance schemes tend to systematically exclude individuals with high risk of ill-health (smoking habit, hypertension, diabetes, HIV infection etc.). In many developing Countries, the private providers cater to the insured persons and the public sector facilities serve the under-resourced population. This leads to concentration of resources for the insured group, at the expense of those without coverage thus resulting in inequity of healthcare services.

Policy initiatives

Health policies and systems should not be enforced as a 'State subject', but as a concurrent subject of both the Central and State Governments. Effective implementation of UHC could be achieved through consensus among the Government, private sector, civil society and health professional associations. Citizen engagement should be promoted at the institutional level, which will promote community participation in health planning, implementation and review. This enables mechanisms being more responsive to the needs of the communities including local accountability. Involvement of formal and informal leaders will enable public decision making and improving the process of policy formulation. Operational deficits tend to exist in the current village level health and sanitation committees, due to low capacities and ambiguity of roles. These gaps should be addressed through training for strengthening capacities and establishing mechanisms for greater oversight by the community.

McKee M, et al. identify five factors which enable the development of UHC: strength of organized labor, availability of resources, building shared identities, path dependency and windows of opportunity [9]. This study discuss the lack of strong labor movement in low and middle income countries unlike the industrialized nations, possibly due to the macroeconomic policy of foreign investment promising low-wage and union-free environment [9]. Evidence suggests a linkage between economic growth and expansion of coverage as the surplus tax revenue base is used to finance the public goods. Countries with a heterogenous ethnic and religious population tend to invest less in healthcare. The concept of path dependency exists when the present circumstances and past choices tend to shape the future path. Vested interests are ingrained in the existing healthcare system which is primarily reliant on private finances, and this could hamper the future role of public sector in the provision of healthcare including its finances. Socio-economic crisis including change of political leadership are triggering factors which are likely to provide windows of opportunity for progressing towards the goal of 'good health at low costs'. Sometimes, new health policies ironically evolve towards encouraging affordable individuals to purchase private insurance.

This is the result of limiting publicly funded benefit packages, which will lead to increase in the waiting time for insurance reimbursement and introduction of co-payments.

The declaration of Alma-ata during 1978 on the principle of universal primary health care was dissipated by the focus of UN health organizations and Rockefeller Foundation on varying priority interventions, which includes the quartet of: growth monitoring, oral rehydration, breast feeding and immunization. Although these interventions enabled gains in specific domains of health, the evolving epidemics of HIV and NCDs (non-communicable disease) however reflected the disparate needs of the population and health systems. The Millenium Development Goals adopted during 2000, provided the stimulus for expanding the health service provision in Low and Middle Income Countries (LMIC). There are various challenges for expanding primary health care service to the entire population, which includes political will to ensure that investment for public welfare is closely associated with the economic growth. On the contrary, the privatized health care delivery and finance will enable profits to the strong alliance of private insurance companies, pharmaceutical companies and medical associations.

Discussions on Universal health coverage are focused on clinical services targeted at individuals. In contrast with the clinical services, public health interventions generate different dynamics for evidence on informed policy making. This could contribute to the development of priority setting processes for UHC with focus on such interventions. Public interests need to be accounted as a deliberative process, which involves interactive learning among various stakeholders. This enables transparent decision making while using multiple criteria such as effectiveness, necessity and feasibility with relevance to social values [4]. WHO has advised Countries to consider using the three most essential criteria while setting priorities for UHC [10]: 'cost effectiveness', 'priority to the worse-off', and 'financial protection'.

Current pandemic scenario

Chi LY, et al. enumerate the Covid-19 related channels which could exacerbate the constraints on public health financing in LMICs: reducing Government revenues due to decline in GDP, reduction in support from external sources and additional health costs due to Covid response [11]. A reduction of domestic/international trade will result in declining revenues from consumption taxes (e.g.: Goods & Sales Tax). As economies of High Income Countries (HIC) dwindle, their support to LMIC for managing Covid pandemic will decline. This has influence on other health sectors such as the fight against HIV/AIDS, where-in half of the resources spent by LMIC comes from external sources. The Covid response including testing facilities, tracing systems, treatment costs and other logistics, demand exceptional allocation of budget. As the Covid-19 vaccination coverage is extended

beyond vulnerable age groups, the expenditure on meeting vaccination target will represent multiples of the Country's health budget.

In this context, a successful path to UHC in India includes sanctioning a realistic and affordable set of benefits and revising the same in accordance with recovery of the public finances. Given the disease burden of the existing pandemic and the related budget constraints, India should delist certain UHC related interventions which are currently not cost-effective. This crisis provides us an opportunity to reform the traditional ways of channeling aid and Provider payments for the provision of essential services. WHO's SCORE initiative comprehensively reviewed health data systems of LMICs and found important data gaps. We need to upgrade the systems for surveillance of health events towards tracking the progress of Covid vaccination campaigns and recording of deaths. The pandemic has provided us an opportunity to reform tax systems in ways which could benefit UHC.

Evaluation

Prinja S, et al. report a methodology towards computing a composite indicator for measuring the extent of UHC. The framework used was similar to the proposal by WHO and World Bank, where-in UHC was measured in terms of service coverage, financial risk protection and distributional aspects of service coverage [12]. Beyond the WHO framework, aspects of quality of care such as full effective antenatal care and curative care from a qualified healthcare provider were computed including the met need of curative care for non-communicable diseases. The authors [12] used robust statistical analysis (principal component analysis, geometric mean aggregation and regression methods) to generate weights, and such methods were validated using sensitivity analysis. Although the indicators estimated a wide range of preventive and curative services, lack of reliable data limited the inclusion of rehabilitation, palliation or long-term care coverage. Indicators related to structures, processes, health outcomes and patient experiences should be used for measuring the quality of care. The measurement matrix did not incorporate services related to the social determinants of health. Due to the high-unmet need for healthcare services in low-income Countries, poor households are perceived to be protected from financial risk as they do not spend out-of-pocket payment for accessing treatment. In this regard, extent of UHC should be measured in the context of both financial risk protection and service coverage. For measuring the financial risk protection, 2 indicators otherwise used to assess 'depth of poverty' need to be considered:

- i) worsening of the household's existing level of poverty due to out-of-pocket health payments,
- ii) 'mean catastrophic positive overshoot' – health related payment more than the threshold used to define catastrophic

health spending

Unweighted composite indicators for measuring UHC rely on good quality data. In this regard, India needs to strengthen the quality of routine Management Information System (MIS) or conduct reliable representative surveys. The alternative health financing mechanism such as social health insurance (occupational coverage) scheme holds the potential to improve financial protection and enhance healthcare utilization among the enrolled beneficiaries. However, it is unlikely that such benefits percolate to the rest of the population. The measurement of progress in a health financing scheme needs a systems approach, where-in the impact on equity in usage of health services and financial protection across the entire population takes precedence over the percent of population covered by the scheme [8].

Discussion

The concepts of transparency and accountability of health systems can be achieved when people understand the healthcare services they are entitled towards, and demand the same from healthcare institutions. Improving this aspect can contribute towards diminishing the gap between need for services and their utilization. In systems where lack of transparency exists due to informal payments, the mentioned aspect could contribute to improving the financial protection.

The National Health Mission (NHM) enabled strengthening both rural and urban public health infrastructure, human resource capacity and service delivery. To ensure that the health facilities across India are fully functional, public investments should focus on health infrastructure and human resources. India has to move away from the system of out-of-pocket payment at the point-of-service delivery for healthcare. Health services need to be financed by pre-payments, such as health insurance schemes or Government tax revenues. Health insurance schemes involve a payroll deduction for all salaried employees, matched by their employer's contribution. Self-employed persons need to pay fixed amounts as insurance premium, and the poor are subsidized or fully paid by the Government.

Government health services should enact innovative policies such as increasing investment in healthcare, recruiting manpower, financial and non-financial incentives for those working in remote areas, and compulsory rural service for one to two years for newly graduating Doctors, Nurses, Dentists and Pharmacists. Such mandatory service for health professionals should not be a means to conceal the Government's deficiency of developing health systems in rural areas. Tax based financing should be supplemented by a unique social health insurance scheme for employees of the formal sector. The range of healthcare services at the point of care should be comprehensive and made available at no cost, covering both inpatient and outpatient care including the cost of drugs.

Digital health is bringing healthcare within the reach of 70% of our population residing in urban and rural areas [2]. Other areas which need to be integrated include safe water supply, sanitation, nutrition and healthy lifestyle.

Gera R, et al. opine that unless the system provides adequate financial protection against health expenditure, the poverty alleviation programs in India cannot achieve their targets [7]. Progress on UHC in India includes repositioning the existing health systems, which is currently facilitated by the integration of SDG agenda in the NHP-2017 (National Health Policy) and NITI (National Institution for Transforming India) Aayog's Vision for Health 2032. Marten R, et al. in their review of progress to UHC in BRICS countries report the relevant issues: insufficient public spending, ensuring equity, managing the needs for logistic support and human resources, stewarding the mixed private and public health systems, managing the burden of diseases and addressing the social determinants of health [13].

Challenges of each country towards reaching UHC [13]:

- **Brazil:** A major concern is the restricted health financing of the Government. The expansion of the private sector could be attributed to the tax subsidies accorded, and the Health Ministry is redressing the regional inequalities by solving the shortages of manpower and infrastructure. The cost of medical expenditure is addressed by upgrading the technological infrastructure of public healthcare sector
- **Russia:** Some healthcare services in public facilities are chargeable, and the challenge is to combine this reality of private health financing with free healthcare provision. Increasing public financing will enable modernizing the systems, thus contributing to efficiency as well as reforming the guarantee of health services
- **India:** Aspects regarding limitations of the public sector, regulation of private sector and primary care approach to the service delivery mechanism has been discussed in the narrative. Another issue which plagues the delivery of UHC includes the shortage of medical supplies and equipment, and manpower including skilled personnel and paramedics
- **China:** Hospital governance should be reformed for effective action to control the use of expensive medicines and oversupply of laboratory/diagnostic tests. A strong regulatory system will enable controlling of costs, which remains a challenge
- **South Africa:** Governance and accountability mechanisms are needed to regulate the pooled funds, which will enable the creation of a robust primary health foundation and effective Provider payment mechanisms. Although such a renewed system will provide a broad range of healthcare services, an eternal impediment includes the shortage of human resources.

The major barriers to UHC in the Indian context include engaging the powerful private health sector and the low level of public investment in healthcare. The UHC based health system should efficiently regulate the complex and dynamic nature of the private healthcare sector. The market competition and choices generated therewith should be used as tools to enhance the quality of care and reduction of cost. The pluralistic UHC driven healthcare system should enable the engagement of multiple stakeholders, as the social determinants of health influence the equitable distribution of healthcare.

Unlike our experience with the Rashtriya Swasthya Bima Yojana (RSBY) scheme, it is critical for the AB-PMJAY to ensure the gatekeeping function of the insurance regulators. This enables addressing the moral hazard between the supply and demand sides, which is the hallmark of insurance-driven schemes [4]. The synergy between AB-PMJAY and the Health and Wellness Centers would ensure a complimentary enterprise between the secondary and tertiary care services covered by the former and the comprehensive primary care provided by the latter. Additional investment, hiring of manpower, better technology and regulatory institutions by themselves cannot bridge the gaps in the healthcare delivery system of India.

Conclusion

Investment in healthcare is perceived as a drain of resources rather than an outlay, unlike with labor which will drive the economic growth. Progress towards UHC involves working through the health systems, and not just the financial investments. The means towards achieving UHC objectives include a direction driven approach than a destination one. In this regard, certain intermediate objectives include improving efficiency of healthcare services, equity in the distribution of resources and accountability. The specification of UHC includes system wide effective health coverage along with universal financial protection. This includes building advocacy for the health needs of the community. The objectives of UHC need to be evaluated not at the individual but at the population level. The way forward is to develop a comprehensive integrated health insurance service which is financed through a combination of public sector funds, occupational coverage and private sources for ensuring provision of health care for all, including vulnerable individuals such as from poor or rural background, children and elderly age group. In view of the current Covid-19 pandemic and the need to address future pandemics, we need to build resilient health systems as well as hasten the implementation of UHC.

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Authors Contributions

VR conceptualized the information and built the draft manuscript. SS proof-read the manuscript and drafted the sections on 'Current pandemic scenario' and 'Challenges faced by various Countries'. RN provided critical insights and approved the final version of the manuscript.

Key messages:

- The three main indicators within the UHC framework include: coverage, financial risk protection and equity. UHC is not merely an aspirational goal but an entitled provision,
- Extent of UHC should be measured in the context of both financial risk protection and service coverage,
- Progress towards UHC involves working through the health systems, and not just the financial investments.
- A successful path to UHC in India includes sanctioning a realistic and affordable set of benefits, and revising the same in accordance with recovery of the public finances

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