International Journal of Psychosocial Rehabilitation, Vol. 24, Issue 08, 2020
ISSN: 1475-7192

Universal Health Coverage: A Factor for Sustainable Development

[1]Roselin Francis, [2]Dr. Theresa Nithila Vincent

ABSTRACT--*The first time World Health Organization pinned Universal Health Coverage as a focal point was in the year 2010 in their World Health Report. Since then UHC has been a heated topic of discussion among researchers, academicians, industry experts and the governments across the globe including India (Greer & Mendez, 2015). According to the World Health Statistics of 2017, there are seven factors that have been taken into account in order to monitor health for Sustainable Development Goals (SDGs). One of these seven factors is Universal Health Coverage (World Health Statistics, 2017)*

Keywords--*Universal Health Coverage, Health Insurance, HLEG, Health Insurance Schemes*

I. INTRODUCTION

Health Insurance in India is as old as Arthashastraand Manusmriti(Vedic Literature). Health Insurance existed in India since a very long time but not in the form we know it today. It existed since the ancient times in the form of offerings/sacrifices to God with an expectation of good health and well-being in return. It was also practiced in a custom wherein people used to fund physicians in times of good health as an expression of gratitude and in return receive free treatment from the physicians when the disease actually hits (Vedic Literature). Today, however, we recognize health insurance as a systematically run business in the Insurance Sector of India. Health Insurance was officially instituted in the year 1923 with the inception of Workmen's Compensation Act.

One system which has been quite a popular topic of discussion in the past one decade is the system of Universal Health Coverage. In India, researchers and industry experts have raised the idea of implementing this system in the Indian healthcare, as a response to which certain actions were taken by the Government of India starting from the year 2010 by setting up a High Level Expert Group instituted by the Planning Commission to work towards the same.

The first time World Health Organization pinned UHC as a focal point was in the year 2010 in their World Health Report. Since then UHC has been a heated topic of discussion among researchers, academicians, industry experts and the governments across the globe including India (Greer & Mendez, 2015). According to the World Health Statistics of 2017, there are seven factors that have been taken into account in order to monitor health for Sustainable Development Goals (SDGs). One of these seven factors is Universal Health Coverage (World Health Statistics, 2017). The World Health Organization on 7th April 2018 (World Health Day) pushed the idea of UHC for its member countries. The WHO has suggested that all the countries adopt UHC for sustainable development and to improve the overall healthcare in the country (World Health Statistics, 2017).

[1] *MPhil Research Scholar, CHRIST (DTB) University, Hosur Road, Bangalore, India ,roselin.francis@yahoo.in*

[2] *Professor, CHRIST (DTB) University, Hosur Road, Bangalore, India ,nithila.vincent@christuniversity.in*

Received: 21 Dec 2019 | Revised: 18 Jan 2020 | Accepted: 05 Feb 2020

Statement of problem: UHC, in the form of scheme, began its journey in India through the Universal Health Insurance Scheme (UHIS) in 2003. Following which, many schemes have been introduced in order to facilitate healthcare financing in India. For example, Rashtriya Swastha Bima Yojana, Aam Aadmi Bima Yojana, Janashree Bima Yojana, National Rural Health Mission, National Urban Health Mission, Ayushman Bharat and so on.

However, the problem that lies here is that when compared with the total population of India, very less population is covered under these government schemes. UHC, as a system, aims at obtaining a nation-wide penetration, whereas, currently very less of our total population is covered under these schemes. In order to drive healthcare towards UHC, having a scheme-level approach is not enough; a well-structured system-level approach must be taken which is expected to be more compatible with the goal of attaining a nationwide system like UHC (Kutzin, 2013).

This paper aims at identifying the reasons for such sub-optimal implementation of UHC in India. Nevertheless, mere penetration of health insurance is not enough. Along with quantity of coverage and penetration, quality must also be taken care of (Kruk, 2013). Improved drug distribution, motivated healthcare providers, well-functioning medical equipments, interpersonal skills of staff etc. are a few among the qualitative factors that require attention as well.

II. UNIVERSAL HEALTH COVERAGE:

UHC or Universal Health Coverage is a system under which an entire populace is covered under insurance. The most essential factor of UHC is the equation where higher the number of policyholders Gireeshan et al., **(**2016),, wider is the risk sharing which in turn reduces the amount of premium payment from its policyholders on an individual level, if the UHC system is private in nature. If the UHC system is driven by the government, the responsibility of public health vests with the government and the financial burden is on the state.

Considering the growing population of India which seems to be beating China in the near future, UHC could turn out to be a scheme which not only covers every citizen of the country under health insurance but also helps defray medical expenses for those fallen ill. Health should be a matter of great concern as better health leads to better labour force contribution and higher performance which is why the World Health Organization has listed Universal Health Coverage as one of the seven Sustainable Development Goals (SDGs) in their Annual Report 2016. Even before, when WHO published its report on UHC financing, more than 70 countries across the globe took a step towards learning more about it and called up for technical help in framing models for their country (Kruk, 2013).

However, it must be noted that health financing is only a part of UHC. UHC is a multifaceted system (Kutzin, 2013). It involves finance, human resource, marketing, research & development, advertising, use of information technology, insurance education and many other facets.

Veritably, UHC is not an insurance scheme. Instead, it is a set of objectives laid down in order to channel health services to every citizen of the country (Kutzin, 2013). Undoubtedly, the major point of focus is health financing but it is not the only factor that needs attention Gireeshan et al., **(**2020),. There are a set of other objectives, varying from country to country, which go hand-in hand with health financing. Therefore, it is apt to say that UHC is not a health insurance scheme, it is a system!

Received: 21 Dec 2019 | Revised: 18 Jan 2020 | Accepted: 05 Feb 2020

1.1. UHC in India

Every country may have their own definitions of UHC where the core concept of UHC remains intact i.e. health insurance coverage for all. In the context of India, it implies that no Indian should lack access to healthcare due to financial incapacity and no Indian should undergo financial distress due to pending medical bills. In India, UHC has been a topic of concern among industrialists and professionals since around two decades. But referring the paper work suggests that India set on the journey towards Universal Health Care right after its independence in 1947. In 1946, Bhore Committee started off with setting up other sub committees like Sokhey Sub-Committee (1948) followed by the Mudaliar Committee (1963), Kartar Singh Committee in (1974) followed by the Srivastava Committee (1975) and the Indian Council of Medical Research-Indian Council of Social Science Research (ICMR-ICSSR) Joint panel (1980) that catered to conducting discussions on healthcare and healthcare financing in the country. Later the issues were brought forth in the National Health Policy of 1983 and 2002 followed by the Report released by the National Commission on Macroeconomics and Health (2005) (Sen, 2012).

In 2010, a High-Level Expert Group (HLEG) was instituted by the Planning Commission to work on the framework of Universal Health Coverage. The committee came up with recommendations in the succeeding year 2011 itself which were to be implemented in the 12th Five Year Plan of 2012-2017. But due to non-allocation of funds in the 2013-14 Budget, the recommendations got implemented only to a certain extent, majorly due to the upcoming elections (Singh & Outteridge, 2013).

However, ex-post, the Government of India gave considerate attention to UHC once the elections wound up in 2014 declaring a ruling party of authority. The Government of India came up with schemes like National Urban Health Mission in 2013 (a sub-scheme of National Health Mission NHM) to reach out to the rural and urban poor in the country (Singh & Outteridge, 2013). Even though these health plans may be looked up as the initial steps towards UHC, it is high time that a well-planned structure is proposed by the concerned authorities to persuade the government for more allocation of funds for UHC other than the model proposed by the HLEG in 2011 as it was one FYP ago! As far as proposing a model for UHC is concerned, there is no ideal model for the same, as different countries have had it in their own ideal ways. As a result, 58 countries got UHC effective in their health system by 2010 and proved that this scenario is not impossible after all (McKee, Balabanova, & Basu, 2012).

According to World Health Statistics 2000, India has one of the highest out-of-pocket expenses on healthcare and it holds true even today. Around 62% of expenses are out-of-pocket in India whereas when it comes to other countries like the USA it is around 20% and between 20%-25% in other BRICS nations (T. S. Vijayan, 2017).

On the road to attaining maximum population coverage, it is important not to be misled by the idea that wider the population coverage better is the state of healthcare in the country. The progress of UHC must not be calculated on the basis of the percentage of the population covered; it should be based on the 'equity' of service (Kutzin, 2013). Equity is another condition which should be assessed religiously. Unlike equality, equity means offering health services to citizens of this country without putting a sect of the population on stake for the sake of the rest. It implies that every individual must receive benefits as per the needs of the group they belong to and not on the basis of a uniform set of benefits for all.

1.1.1. High-Level Expert Group UHC Model

A High-Level Expert Group (HLEG) was instituted by the Planning Commission of India in the year 2011. This group constituted of 15 members from various backgrounds of academic and industry expertise. The HLEG Report was created by referring many research articles and government as well as non-governmental reports. Lot of statistical data was collected from well-established authentic sources. Both Quantitative and Qualitative method was used in preparing the HLEG Report in order to derive conclusions and recommendations for effective implementation of Universal Health Coverage in India. National and International consultants contributed to the making of this extensive piece of work.

As discussed earlier, UHC is not just a scheme, it is a system which encompasses many aspects of healthcare. Therefore, the High Level Expert Group also made recommendations on six major aspects. They are:

Recommendation 1 Health Financing and Financial Protection

Recommendation 2 Health Service Norms

Recommendation 3 Human Resources for Health

Recommendation 4 Community Participation and Citizen Engagement

Recommendation 5 Access to Medicines, Vaccines and Technology

Recommendation 6 Management and Institutional Reform

III. OBJECTIVES:

1. To study the implementation levels of key recommendations proposed by the HLEG for UHC in India.
2. To recommend suggestions for achieving maximum UHC in India

IV. DESIGN/METHODOLOGY:

1. Type of paper-Descriptive

2. Source of Data-Secondary

- Journal articles
- Government Website
- WHO Reports
- Conference Proceedings

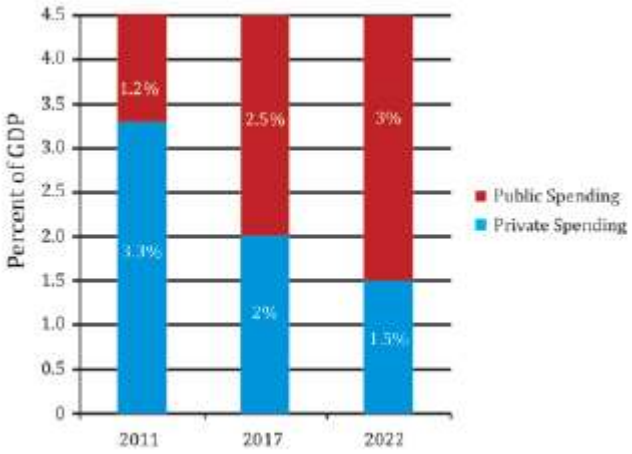
3. Type of Analysis-Qualitative: The research revolves around a universal concept. As a result, majority of the resources referred are government reports and documents. Content analysis is done on the accumulated government publications relating to healthcare and related aspects. Diligent reading has been done in order to evaluate past trends in healthcare and compare it with the current scenario referring the latest sources available. Dependence of primary data is nil as the scope of research is census in nature.

3. Key Recommendations of the High Level Expert Group for UHC in India

Recommendation 1. Health Financing and Financial Protection

Recommendation 1.1. Increase government expenditure on health from 1.2% of GDP to 2.5% of GDP by the end of 12th Five Year Plan

The percentage of GDP spent on health in the year 2011 was 1.2%. It was projected that the share be raised



from 1.2% to 2.5% in 2017 and 3% in 2022.

Figure 1. Projected share of public and private health spending in India

As per the last updated National Health Accounts 2017, the government health spending is 1.13% of GDP while the target set was 2.5% by the end of the 12th Five Year Plan i.e., 2017. (Mishra, Nath, Kumar, & Ved, 2017)

Rationale backing non-execution: As per the National Health Accounts 2018, India has still not arrived at the state to contribute more than 2% of its GDP towards healthcare. As a result, 64.7% of expenditure on health is still out-of-pocket and the rest is through Union Government (Non-Employee), Union Government (Employee), State Government (Non-Employee), State Government (Employee), Urban Local Bodies, Rural Local Bodies, Social health insurance schemes, Government Financed Health Insurance, Employer-Based Insurance (Private Group Health Insurance), Other Primary Coverage Schemes (Private Individual Health insurance), Community-Based Insurance, Non Profit Institutions Serving Households (NPISH), Resident Foreign Agencies Schemes and Enterprises (Mishra, Nath, Kumar, & Ved, 2017).

Recommendation 1.2 Under UHC, all the healthcare services must be rendered directly through central government or state governments and their authorized departments

Considering the national scheme- Ayushman Bharat- National Health Protection Scheme as a major milestone in the implementation of UHC in India, it is held that all the UHC oriented healthcare services are rendered through state government body known as State Health Agency (SHA) (www.india.gov.in National Portal of India).

*Rationale backing non-execution: Pr*ivate insurers in India have existed in India since over a century and considering the growing population, managing the healthcare system solely on the resources of the government is next to impossible. Therefore, it would be rather benefitting to include private insurers and other private healthcare bodies into the national healthcare system instead of isolating them. Hence, the wide and active existence of private healthcare bodies in India.

Recommendation 1.3 State wise allocation of funds for better implementation of schemes

HLEG recommended that other than the budget released centrally for schemes, state wise allocation be also done in order to facilitate better planning and execution as per the needs of different states. Flexible fund transfer from Central to State would lead to effective allocation of funds.

Rationale backing non-execution: As per the National Institute of Public Finance and Policy (Report on Central Transfers to States in India Rewarding Performance While Ensuring Equity), sectors of healthcare and education have the greatest trouble in transfer of funds. The major reason derived from the report is that in case of healthcare, poorer state of healthcare does not guarantee higher fund allocation. Rather, stronger bureaucracy encourages higher allocation. Because analysing the past trends in transfers and performances, it was observed that states with poorer health conditions have higher wastage of funds as there persists the problem of scarcity of other resources like human resource, information technology and so on and so forth (Rao M. G., 2015)

Recommendation 2 Health Service Norms

Recommendation 2.1 Development of a National Heath Package (NHP) that brings every citizen under its umbrella

As per the functioning of the current health insurance schemes, a scheme which covers every single citizen of the country is not yet developed. However, schemes like Rashtriya Swastha Bima Yojana RSBY, Employee State Insurance Scheme, Aam Aadmi Bima Yojana, Janashree Bima Yojana, Central Government Health Scheme, Ayushman Bharat National Health Protection Mission, are all catering to different sectors of the Indian population. UHC targeted penetration i.e., at least 90% of population penetration can be expected in the coming years.

Rationale backing non-execution: As India has wide gap between the rich and the poor, the lower class, middle class and upper class, other regional and communal disparities; developing a national scheme which caters to all sects under the principal of equity, is in itself a tough task. As a result, a system wherein various health schemes cater to various groups of people in the country is preferred and implemented even today.

Recommendation 2.2 Institution of National Health and Medical Facilities Accreditation Unit (NHMFAU)

It was recommended by the HLEG that a National Health and Medical Facilities Accreditation Unit be created in order to act as a regulatory and accreditation body that tracks the efficient usage of resources, quality and standard of healthcare offered to the citizens and provide support to the bodies functioning as healthcare providers. The NHMFAU however, has not been created as there is no trace of its existence in the National Health Portal of India.

Rationale backing non-execution: Research evidences that more focus has been given to establishing health insurance schemes and erecting health clinics/hospitals and less has been focused on evaluating the quality of healthcare. As preached usually, quantitative figures are more focused on for assessing improvement and growth than the qualitative factors.

Recommendation 2.3 Increase in availability of beds to 2 beds/1000 population

As per the Ministry of Health and Family Welfare, the count of hospital beds in India is 0.7 beds/1000 population as on November 2018, which is far below than the global average of 3.96 beds/1000 population (Central Bureua of Health Intelligence, 2018) and not in line with the recommendation of 2 beds/1000 population.

*Rationale backing non-execution:*As the population keeps exploding in the second most populous country in the world, maintaining supply of sufficient resources in par with the demand is rather a tough duty. As a

consequence, maintaining sufficient beds in hospitals, especially government hospitals, has proven to be one of the toughest tasks and has also been spoken about widely in media (Central Bureua of Health Intelligence, 2018).

Recommendation 3 Human Resources for Health

Recommendation 3.1 Establishment of National Council for Human Resources in Health (NCHRH)

On December 22nd, 2011, the National Council for Human Resources in Health (NCHRH) Bill was introduced by the Ministry of Health and Family Welfare in the Rajya Sabha. The NCHRH was proposed by the HLEG in order to evaluate and improve the quality of medical education in both undergraduate and postgraduate courses. However, the NCHRH Bill was rejected by the Parliamentary Standing Committee on Health and Family Welfare (Ministry of Health and Family Welfare, 2011). Hence, an umbrella body for supervising human resources in the medical education system could not get developed.

Rationale backing non-execution: The Principal Secretary, Department of Health and Family Welfare, Government of Gujarat, suggested that considering state governments have a better know-how of the realities of their states' economic, social and educational conditions, it would not be appealing to let a National Council execute uniform planned structures in the field of education. Rather, it should be customized for every state. Besides, he pointed that the already existing committees and state councils must be improved instead of establishing a whole new National Council as the planning and setting up would be a more time consuming task than improving the already existing committees. Similarly, some other state governments expressed their dissatisfaction on the proposed bill along with the Dental Council of India, Indian Nursing Council and many other wings. (Ministry of Health and Family Welfare, Department-Related Parliamentary Standing Committee on Health And Family Welfare on Sixtieth Report on The National Commission For Human Resources for Health Bill, 2011) As a result, the bill was dissolved and the idea of instituting a National Council was never spoken about again.

Recommendation 3.2 Institution of Districts Health Knowledge Institutes (DHKIs)

Setting up of Districts Health Knowledge Institutes (DHKIs) was proposed for enhancement of the quality of training provided to the health workers in the district level. Providing bridge courses and training to locally recruited personnel for better delivery of health services to the local community. However, the DHKIs could not be set up as there is no such body functioning under the Ministry of Family and Health Welfare as per the data in the National Health Portal of India.

Rationale backing non-execution: Evidently, setting up of newer committees was considered unwise by many individuals/parties involved in the panel of authority as many believed that improving the already existing committees would be a wiser decision than to keep instituting newer committees (Ministry of Health and Family Welfare, Department-Related Parliamentary Standing Committee on Health And Family Welfare on Sixtieth Report on The National Commission For Human Resources for Health Bill, 2011)

Recommendation 3.3 Establishment of State Health Science Universities

Derived from the recommendations of the Bajaj Committee (1987), the HLEG suggested the establishment of State Health Science Universities. The State Health Science Universities aimed at introducing a uniform admission procedure, curriculum, training and assessment of all degrees across all the Indian states and union territories. The

SHSU failed to be established as per the data available on the National Health Portal of India. However, the Medical Council of India continues to be the umbrella body for regulation of medical education system in the country (Nadda, 2018).

Rationale backing non-execution: The State Health Science Universities did not get established, however, the Medical Council of India plays the role of monitoring medical education system in India and that fulfils the purpose regardless. It was skipped in order to halt the redundancy of authority and planning.

Recommendation 4 Community Participation and Citizen Engagement

Recommendation 4.1 Transformation of existing Village Health Committees like the Village Health Sanitation & Nutrition Committee (VHSNC) into participatory Health Councils

Through schemes like National Health Mission, committees like VHSNC and Accredited Social Health Activists (ASHA), Rogi Kalyan Samiti (RKS) and so have been established with a view of promoting community participation in the mission of improving healthcare in the country. The 10th Common Review Mission (CRM) Report 2016 demonstrates that the progress of both VHSNC and RKS is slow and irregular. The findings reflect that lack of commitment and effort was observed across all states of the country (Ministry of Health and Family Welfare, 10th Common Review Mission, 2016)

Recommendation 4.2 Enhancement of the role of Panchayati Raj Institutions (PRIs) in rural India

The 10th Common Review Mission has analysed the working of PRIs in various states and union territories of the country. As per the report, it is evident that the PRIs are engaged in enforcing community participation and citizen engagement in rural areas but need better planning and direction in order to smoothen the decentralized health system in the country. The report suggests that districts should frame 5 years' prospective plan to direct the PRIs towards community involvement (Ministry of Health and Family Welfare, 10th Common Review Mission, 2016)

Recommendation 4.3 Establishment of Rogi Sahayata Kendras (RSKs) in states and districts

In the year 2015, guidelines for Rogi Kalyan Samiti (RKS) was issued by the Ministry of Health and Family Welfare. The Rogi Kalyan Samiti (RKS) is the idea incorporated from the recommended Rogi Sahayata Kendras (RSKs). The RKS is a well-established working body of government for grievance redressal of health related issues in district and state levels (Ministry of Health and Family Welfare, Guidelines for Rogi Kalyan Samities in Public Health Facilities, 2015)**.**

Recommendation 5 Access to Medicines, Vaccines and Technology

Recommendation 5.1 Revise and expand the Essential Drugs List

As per the Department of Pharmaceuticals (GoI), the National Essential Drug List (NEDL) has expanded from 348 drugs in 2015 to 384 drugs in 2018. It was suggested that AYUSH medicines be included in the NEDL for enhancement of contribution of AYUSH doctors. However, AYUSH medicines are not veritably mentioned in the National Essential Drug List (Mukherjee, 2018).

Recommendation 5.2 Setting up national and state drug supply logistics corporations

The Central Medical Services Society (CMSS) was established in 2011 as a Central Procurement Agency (CPA) of the Department of Health and Family Welfare (DoHFW). The CMSS aims at delivering high precision tracking of health sector goods and services in order to ensure uninterrupted supply of the same. http://www.cmss.gov.in/

Recommendation 5.3 Revise India's FDI regulations

The HLEG recommended amendment of the FDI rates from 100% under automatic routes to less than 49% in order to retain the predominance of the Indian pharmaceutical companies and promote self-sufficiency in production of drugs. As per the annual report of 2017-18 of the Department of Pharmaceuticals, it is evident that the FDI rate under automatic route is stagnant at 100% (Department of Pharmaceuticals, 2018).

Rationale backing non-execution: The Indian Pharmacy is not self-sufficient as yet. There are certain medicines, drugs and equipments which are not developed nationally and hence require import from other medically advanced countries (Department of Pharmaceuticals, 2018).

Recommendation 6 Management and Institutional Reform

Recommendation 6.1 Creation of an All India Public Health Service Cadre (AIPHSC)

The purpose of creation of All India Public Health Service Cadre was to improve the connectivity of the state and national level health planning and appoint officers of professional expertise. The AIPHSC is akin to the civil services. As in the case of the Indian Administrative Services (IAS), the AIPHSC is to be looked at in the context of civil services wherein entrance exams are set for recruitment of highly qualified health professionals and further unified training at both state and central level in order to avoid patchy and sub-standard services (Rao, 2017). However, the AIPHSC, as a civil service, has not yet been planned and launched by the Government.

Rationale backing non-execution: Establishing Civil Services in healthcare requires huge deal of planning and funding. Consequently, the idea has taken a pause since its inception as focus is given more to the other aspects of healthcare such as insurance penetration, medicines, research and such others (Rao, 2017).

Recommendation 6.2 Create a national health IT network

The Ministry of Health and Family Welfare (Government of India) set up the National Health Portal as the authentic access point for any health related document and news for its stakeholders i.e. students, citizens, healthcare professionals and researchers. https://www.nhp.gov.in/

Recommendation 6.3 Increase in the health research budget

The overall budget allocation towards health research has increased in the past five years.

Table 1. Budget allocation towards health research from 2013-2018

Year	Budget Estimate (B.E) Rs. in Crore	Revised Estimate (RE) Rs. in Crore	Actual Expenditure Rs. in Crore
2013-14	40.00	5.35	4.95
2014-15	31.00	23.50	23.26
2015-16	30.50	16.00	13.99
2016-17	14.25	16.99	15.99
2017-18	20.00	30.00	18.12*

*includes proposal of release of 1.52cr which is in pipeline

Nevertheless, the quality of health research and expenditure on the same need to be tracked by the Department of Health Research (MoHFW, GoI) in order to ensure efficient and effective utilization of resources (Department of Health Research, 2017-18)

V. CONCLUSIONS AND SUGGESTIONS:

India has been marching towards UHC since the time of its independence in 1947. Yet it has not attained even fifty per cent of health coverage in the country. Government has been setting up many institutions as recommended by the High Level Expert Group in 2011 and lot of planning goes into establishing frameworks and schemes to cater to UHC in India. Yet, as per the government reports and conference proceedings, it is found that the poor states become poorer and the average states remain average.

As discussed in the paper, UHC is not a health insurance scheme. It is a health system which includes all the aspects like human resource, information technology, marketing, education, fund allocation and so on and so forth. Therefore, better mechanisms must be put to place in order to ensure effective implementation of frameworks.

As per the data on government budgets, it is evident that fund allocation is done centrally for further transfer to states but they take a great deal of time to reach the states. The reason is due to improper details presented in budget requirement proposals presented by the states. One reason is because, even if funds are available, sufficient human resource and hospitals are not. And even if sufficient health professionals and hospitals exist, the quality standards are not decent. Another reason projected in the report by the National Institute of Public Finance and Policy in 2015 is that mere allocation of fund is not enough. The bureaucracy has to be strong and fair in order to execute the plans developed by the government.

Evidence suggests that the number of government institutions set up for health is very high starting from the central to the state to the district. Similarly in case of schemes, a scheme has its sub-scheme and a sub-sub-scheme which leads to creating confusion among the general population. There are many establishments set up by the government to cater to public, especially in the rural areas; yet, the quality of healthcare is not well maintained

Research reflects that in India, awareness is a major obstruction towards the path of Universal Health Coverage. Importance of healthcare and health related aspects are not incorporated into the general education system of the country. In order to create awareness among the citizens, campaigns must be conducted even more rigourously and social media must be made a tool for seeding the idea of UHC into the minds of the citizens.

Analysis conducted by the National Institute of Public Finance and Policy in 2015 shows that the two sectors which are greatly lagging behind in India are Education and Health. It is a matter of great concern as these two sectors are the most important ones as they cater to the basic needs of a human. Under health as well, health education needs a new landscape. The number of medical colleges for under grad and post grad courses are not enough considering the rising population of the country. As suggested by the HLEG, establishment of State Health Universities must be done in order to maintain a unified system of admissions, training, high quality education and recruitments in the country so that migration of Indian health professionals to other countries may come down and retention of human resource is made possible in the country.

Determination and strong will at the centre is not enough. The Central Government needs to delegate that determination and strong will to the state and district level governments through rigourous and strong frameworks. Through community participation, as in case of ASHA workers and anganwadi workers in collaboration with the Panchayati Raj Institutions (PRIs), the penetration and execution of healthcare services will get better over time.

Strictly interpreted, there is no country in the world that can ever achieve complete universal coverage (Kutzin, 2013). But the thriving is towards achieving the maximum coverage practically possible. It is only by incorporating all the aspects into one UHC system i.e. health financing, health service norms, human resources for health, community participation & citizen engagement, access to medicines, technology, and management institutional reforms; that the healthcare landscape of India can be altered.

REFERENCES

1. Bang, A., Chatterjee, M., Dasgupta, J., Garg, A., Jain, Y., Kumar, A. S., et al. (2011). High Level Expert Group Report on Universal Health Coverage for Inda. New Delhi: Public Health Foundation of India.
2. Bhattacharjya, A. S., & Sapra, P. K. (2008). Health Insurance in China and India: Segmented Roles for Public & Private Financing. Health Affairs, 1005-1015.
3. Central Bureua of Health Intelligence. (2018). National Health Profile. New Delhi, India: India Offset Press.
4. D., B., D., C., & J., S. (2003). The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change. RAND Corporation.
5. Department of Health and Family Welfare. (2017). Report no.99: Demands for Grants 2017-18 (Demand No. 42). New Delh, India.
6. Department of Health Research. (2017-18). Annual Report. New Delhi: Ministry of Health and Family Welfare.
7. Department of Pharmaceuticals. (2018). Annual Report 2017-18. New Delhi, India: Ministry of Chemicals & Fertilizers.
8. [8]Gomez, E., & Watt, N. (2013). McKee M. Global Health in Foreign Policy-and Foreign Policy in Health: Evidence from the BRICS. Health Policy Plan.
9. Greer, S. L., & Mendez, C. A. (2015). Universal Health Coverage: A Political Struggle and Governance Challenge. American Journal of Public Health.
10. alstead, Walsh, S. J., & Warren, K. (n.d.). Good Health at Low Cost. New York: Rockfeller Foundation.

Received: 21 Dec 2019 | Revised: 18 Jan 2020 | Accepted: 05 Feb 2020

11. Hsiao, W., Li, M., & Zhang, S. (2015). Universal Health Coverage: The Case of China. United Nations Research Institute for Social Development.
12. aul, R. (2019). Under Ayushan Bharat 6,85,000 people availed free health care in 100 days. Hindustan Times.
13. Kruk, M. E. (2013). Universal Health Coverage: A Policy Whose Time has come: It is both the right and the smart thing to do. British Medical Journal.
14. Kutzin, J. (2013). Health Financing for Universal Coverage and Health System Performance: Concepts and Implications for Policy. Bull World Health Organ, 602-611.
15. McKee, M., Balabanova, D., & Basu, S. (2012). Universal Health Coverage: A Quest for all Countries but Under Threat in Some. Value in Heath.
16. McKee, M., Marten, R., Balabanova, D., Watt, N., Huang, Y., Finch, A. P., et al. (2014). BRICS' Role in Global Health and the Promotion of Universal Health Coverage: the Debate Continues. Bull World Health Organ.
17. Ministry of Health and Family Welfare. (2011). Department-Related Parliamentary Standing Committee on Health And Family Welfare on Sixtieth Report on The National Commission For Human Resources for Health Bill. New Delhi: Rajya Sabha Secretariat.
18. Ministry of Health and Family Welfare. (2013). Survey Report & Recommendations of Clinical Establishents.
19. Ministry of Health and Family Welfare. (2015). Guidelines for Rogi Kalyan Samities in Public Health Facilities. New Delhi, India.
20. Ministry of Health and Family Welfare. (2016). 10th Common Review Mission. New Delhi, India: National Health Systems Resource Centre.
21. [21]Ministry of Rural Development. (2011). Socio-Economic Caste Census. Government of India.
22. [22]Mishra, C., Nath, P., Kumar, J. R., & Ved, R. R. (2017). National Health Accounts. New Delhi, India: NHSRC, Ministry of Health and Family Welfare.
23. Mukherjee, R. (2018). Essential List of Medicines to be Revised; Medial Devices and Consumables may be Included. The Times of India.
24. Dr Gireeshan Mg ,"Alcohol Sensing Alert With Engine Locking System"International Journal Of Psychosocial Rehabilitation,Vol. 24, Issue 06, 2020 Issn: 1475-7192
25. Nadda, J. P. (2018). The Indian Medical Council (Amendment) Bill. New Delhi, India.
26. National Health Policy. (2017). Ministry of Health and Family Welfare.
27. PRS Legislaive Research. (2018). Demand for Grants 2018-19 Analysis. PRS India.
28. Rao, K. S. (2017). Creating an Indian Medical Service Would Be Good for the Health Sector. In Do We Care: India's Health System.
29. Rao, M. G. (2015). Central Transfers to States in India Rewarding Performance While Ensuring Equity. New Delhi, India: National Institute of Public Finance and Policy.
30. Sen, G. (2012). Universal Health Coverage in India: A Long and Windng Road. Economic & Political Weekly, 45-52.
31. Sharma, E. K. (2019). Ayushman Bharat gets more exceution teeth, CEO hopes to iron out pending callenges in 2019. Business Today.

32. M G Gireeshan,"AUTOMATIC STEP-UP POWER FROM JUMBO URINE",IJPT| March-2016 | Vol. 8 | Issue No.1 | 11035-11037
33. Singh, S., & Outteridge, G. (2013). India's Proposed Universal Health Coverage Scheme- Implications for the Global Pharma Industry. Journal of Medical Marketing, 181-193.
34. Standing Committee on Health and Family Welfare. (2016-17). Report no. 99- Demands for Grants. New Delhi, India: Department of Health and Family Welfare.
35. T. S. Vijayan. (2017, December 18). 1oth Annual Health Insurance Conference. New Delhi: FICCI.
36. (n.d.). Vedic Literature.
37. Vega, J. (2013). Universal Health Coverage: the post -2015 development agenda. Lancet, 381:179-180.
38. World bank. (2014). World development Indicators, Health Systems.
39. World Health Organization. (2016). Health Expenditure Per Capita (US $).
40. World Health Report . (2018). World Health Day. World Health Day 2018.
41. World Health Statistics. (2017). World Health Statistics, Monitoring Health for SDGs. Geneva: WHO.
42. Yuan, B., Jian, W., He, L., Wang, B., & Balabanova, D. (2017). The Role of Health System Governance in Strenghthening the Rural health Insurance System in China. International Journal of Equity in Health.

Received: 21 Dec 2019 | Revised: 18 Jan 2020 | Accepted: 05 Feb 2020