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A Review of Recent Developments and Future Challenges in the Implementation of Universal Health Coverage Policy Framework in Some Countries

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ABSTRACT

Global attention has recently converged on the need for countries to achieve universal health coverage (UHC), which aims to guarantee that all persons are able to access needed and effective healthcare without facing financial ruin by using services. In the attempt to move towards UHC, several low- and middle-income countries are developing more sustainable revenue sources, expanding pooling arrangements and employing more efficient and sustainable purchasing strategies. Their experiences represent a growing evidence of the application of mandatory (social), private and community-based health insurance in low- and middle-income countries and their potential contribution to UHC. UHC reforms are an inherently political process, and public health advocates will need to do more to promote not only the health benefits of public health interventions but also the economic and political benefits too. Crucially, as UHC continues to be championed and rolled out globally, all people working in global health need to reinforce the importance of including the full scope of public health in health system reforms; only then can the full potential of UHC be realized—a true reduction in health inequities. However, implementation of a UHC is not an easy phenomenon, rather it needs proper design of a good health insurance system by integrating both the public and private health care providers. The influence of good governance and a sustainable health financing system is fundamental to establish UHC in the developing countries. This review Paper encompasses recent developments and future challenges in the implementation of Universal Health Coverage Policy framework in some countries.

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Introduction

Global attention has recently converged on the need for countries to achieve universal health coverage (UHC), which aims to guarantee that all persons are able to access needed and effective healthcare without facing financial ruin by using services. In the attempt to move towards UHC, several low- and middle-income countries are developing more sustainable revenue sources, expanding pooling arrangements and employing more efficient and sustainable purchasing strategies. Their experiences represent a growing evidence of the application of mandatory (social), private and community-based health insurance in low- and middle-income countries and their potential contribution to UHC [1,2].

The evidence from some countries suggests that strong political support, effective programmes, supportive context, robust public accountability mechanisms and strong technical capacity are vital to developing and implementing effective UHC-related proposals. Yet WHO has clearly stated that additional insights into policy processes in different policy contexts in low and middle-income settings are needed. The definition of UHC from The world health report 2010, quoted in the introduction, embodies one of the ultimate goals of health systems – financial protection–as well as intermediate objectives associated with improved health system performance: that all people obtain the health services they need (i.e. equity in service use relative to need) and that these services are of sufficient quality to be effective. The first aspect of UHC defined above (use of needed services of good quality) corresponds closely to the concept of effective coverage, i.e. the probability that an individual will get an intervention that they need and experience better health as a result [3,4]. This concept can be disaggregated into the following elements:

- Reducing the gap in a country's population between the need for services and the use of those services, which implies that: (i) all persons who need an intervention are aware of their need; and (ii) all persons who are aware of their need are able to use the services that they require;
- Ensuring that services are of sufficient quality to increase

the likelihood that they will improve (or promote, maintain, restore, etc., depending on the nature of the intervention) the health of those who use them.

Measuring effective coverage across all services and the entire health system is not feasible. To date, this has been done only in the case of individual health conditions and interventions, such as immunization coverage (e.g. a cross-country review) or hypertension control (e.g. in Kyrgyzstan); a specific set of interventions within one aspect of care, such as maternal and neonatal health interventions (e.g. in Nepal); or a wide but still limited set of interventions (e.g. in Mexico and China). Despite this difficulty with measurability, the concept of effective coverage is useful for orienting health policy. When combined with financial protection, it enables a more precise specification of UHC: it is system-wide effective coverage combined with universal financial protection [5,6]. Although the objectives embedded in UHC are distinct, UHC is a unified concept. From the perspective of any citizen or resident of a country, the problem boils down to this: Can I sleep well at night secure in the knowledge that if anything happens to me or a member of my family, good health services will be accessible and affordable, that is, obtainable without risk of a severe and long-term impact on my financial well-being? The extent to which the objectives of equity in the use of needed services of good quality with financial protection are realized is simultaneously determined at the person's point of contact with the health system. For example, if measures are introduced to reduce financial barriers to service use, we are likely to observe both increased utilization across the entire population and a reduced financial burden for those using care. Given the definition of UHC and its specification here, however, fully achieving UHC is impossible for any country. Even countries that succeed in attaining universal financial protection have shortfalls in effective coverage. Gaps will always exist because not all individuals in a society can be aware of all of their needs for services, new and more expensive diagnostic and therapeutic technologies continuously emerge, and the quality of care is not perfect in any country. Thus, strictly speaking, no country in the world has achieved universal coverage. Despite this, however, the aims of improving equity in the use of services, service quality and financial protection are widely shared. Thus, even if UHC can never be fully achieved, moving towards UHC is relevant to all countries [7,8]. It is justified from a health system performance perspective because it implies progress in attaining the goals of health systems: directly in terms of financial protection and indirectly on the goals of health and responsiveness via the intermediate objectives associated with effective coverage. Put another way, it is more useful to think of UHC as a direction rather than a destination. UHC is a set of objectives that health systems pursue; it is not a scheme or a particular set of arrangements in the health system. Keeping this distinction between policy objectives and policy instruments is essential for conceptual clarity and practical decision-making. Making progress towards UHC is not inherently synonymous with increasing the percentage of the population in an explicit insurance scheme. In some countries, such as Germany and Japan, insurance schemes are the instruments used to ensure financial access and financial protection for the entire population. Hence, the percentage of the population covered by insurance is a critical determinant of progress on UHC objectives in those countries. But in 1989, when the Republic of Korea achieved universal population coverage under its social health insurance system, most citizens were still at risk for very high and potentially catastrophic out-of-pocket payments because of the large and open-ended nature of cost sharing arrangements, particularly in a hospital setting [9-12].

After sharp criticism in the first decade of the twenty-first century that vertical global health programs were pushing the fragmentation of weak health systems, the concept of universal health coverage advanced to the top of the global health agenda. Universal health coverage has been described as "the single most powerful concept that public health has to offer" by World Health Organization director general Margaret Chan and presented as the third global health transition (after the demographic and epidemiologic transitions). Universal health coverage has been promoted as a solution that can strengthen health systems, raise revenue for health care, and improve social risk protection in low- and middle-income countries. Many emerging countries are now seeking to scale up national health care systems toward universal coverage. In particular, national health insurance, a demand-side model, is being advocated by the World Bank and other multilateral and donor organizations to replace the nominal national health service systems (supply-side model) that have commonly provided services to the poor in developing countries, which have arguably been unable to assure sufficient care and financial risk protection. Countries with national health services are increasingly converting their health systems to national health insurance models [13,14]. The Universal Health Coverage Forward Initiative and the Joint Learning Initiative have identified at least nine low-income and lower middle-income countries in Africa and Asia that have implemented national health insurance reforms designed to move toward universal health coverage. Ghana is perhaps the poorest country to attempt national health insurance. Chile, Colombia, and Mexico are middle-income countries with large and enduring informal sectors that have instituted national health insurance. Most East Asian tigers have adopted national health insurance systems in the context of rapid economic growth and shrinking informal sectors. Eastern and central European countries have switched from national health service model financed by general tax revenue and focused on salaried hospital-based specialists to a national health insurance model financed by payroll taxes with providers paid through fee-for-service. Other countries, such as Rwanda and Mali, are working to scale up health insurance from local community-based financing schemes to a national level. The development of universal health coverage systems in present-day high-income countries occurred over the course of more than a century [15,16]. For instance, Germany began scaling up social health insurance in 1883 and could only be said to have achieved universal health coverage in 1998. By contrast, Taiwan and Korea were able to scale up universal health coverage in less a decade rather than over the course of a century. What can be learned from the experiences of scaling up universal health coverage in low- and middle-income countries, and how do these experiences differ from those in high-income countries? What recommendations can policy makers and planners draw from the theoretical and practical literature on the politics of health reform in low- and middle income countries? [17,18].

Universal Health Insurance Reform in Thailand

Prior to the introduction of the universal coverage (UC) scheme in 2001, around 30% of Thais were not covered by any medical insurance scheme. Following the launch of the scheme, Thailand almost achieved universal coverage for the entire population by early 2002. The UC scheme was a tax-funded health insurance scheme, targeting 47 million people who were not covered by the existing Civil Servant Medical Benefit Scheme (CSMBS) or Social Security Scheme (SSS). Financing the UC scheme through general tax revenues was a pragmatic approach as it was technically not feasible to finance universal coverage rapidly via membership contributions under existing schemes, considering the large size

of the informal agricultural sector in Thailand [19,20]. The UC scheme employed a capitation contract model that mandated registered members to seek care provided by designated providers, typically the District Health System (DHS) including district health centers and hospitals. Beneficiaries were entitled to free care at registered and contracted providers while it required a copayment of 30 baht (US$0.70) per visit or admission with exemption of some low-income populations, the elderly, children under 12, and etc. This fee was totally abolished in 2006. Beneficiaries were also required to seek care at a primary contractor first (a gatekeeper requirement). This ensured proper referral to secondary and tertiary care if needed. Those who bypassed the primary contractor were responsible for full payments for services received. No informal under-the-table payments have emerged so far, but this issue has to be continuously monitored in the future. The UC scheme provided a comprehensive benefit package including outpatient, inpatient and preventive health services, which attempted to be standardized across UC, CSMBS and SSS. As for payment methods, outpatient services were paid on a capitation basis while inpatient services were paid by global budgets and DRGs. Capitation has the advantage of cost containment as evident in SSS which pioneered the use of capitation in 1991 [20,21]. A Hospital Accreditation system, though voluntary, was introduced to ensure good quality of care provided by participating hospitals, by encouraging gradual quality improvement. It should be noted that the successful implementation of the UC scheme was based on the strength of health care infrastructure with wellfunctioning DHSs with extensive geographical coverage throughout the country, particularly in rural areas. This might be explained by the shifting of health budgets from urban to rural facilities resulting from a strong political commitment towards health equity. The proper functioning of DHSs would have been impossible without adequate medical professionals. This was strongly supported by the rule that new medical graduates undertake mandatory employment in rural health services for three years, notably in DHSs, as a response to the internal brain drain of well trained professionals from rural public hospitals to urban private hospitals. Community and village health volunteers and nurses also played a key role in primary care services, particularly in remote areas. The particular political environment supporting the progress of UC should not be neglected as well [22-24]. The rapid scaling up of the UC scheme in one year was largely due to the charismatic leadership of the Thai Rak Thai Party that won a landslide victory in the 2001 election (the party committed to various social obligations during the election campaigns).Since the introduction of the UC policy, the incidence of catastrophic health expenditures and impoverishment due to health care costs has decreased significantly, and service utilization has increased significantly, especially in DHSs. Evidence also indicates that increased service use favored the poor and that public subsidies benefited the poor more than the rich when compared to conditions before the implementation of UC. National health expenditures increased only marginally in subsequent years after UC in spite of the massive expansion of coverage under UC, breaking down the initial fears of possible fiscal ruin. However, the issue of financial viability needs to be continuously monitored by both health researchers and policy makers. While Thailand's UC reforms have admittedly made remarkable achievements and showed significant advances in controlling cost and improving health care access, criticisms remain that the capitation funding mechanism failed to address the issues of inequitable distribution of facilities and personnel as intended, leading to the persistence of regional disparities in health care provision and a continuing shortage of professionals in rural areas. Media criticism of declining quality of care occurred as well. Thus it has been argued by some that although Thailand may have universalized low-cost health care, it has not yet universalized best care [25-29].

Universal health coverage in china

As the largest developing country in the world, China has been facing substantial challenges to serve its population of 1.3 billion with equitable, affordable and high-quality health services over the past several decades. The performances of the Chinese health system, and the reforms that have been implemented, have attracted broad and intense interest worldwide [30]. China's health system, once revered by other countries in the early decades after the founding of the People's Republic of China, has increasingly been criticized for its poor efficiency in health care delivery, inequity in utilization and access to health services, and cost escalation. Specifically, health care has become a leading and serious national concern. The general public has expressed its discontent with unaffordable access and medical impoverishment through thousands of organized protests throughout the country, receiving frequent media attention. With the failures of past reforms and the present policy goals of building a harmonious society, the Chinese government has recognized its responsibility to address these concerns and is launching a new wave of health system reform. The performance of the health insurance system, which dominates health care financing and payment in China, deserves greater attention in the current context. Through a number of difficult reforms and policy changes in the past decades, China's basic social medical insurance system, which includes the Urban Employee Basic Medical Insurance system (UEBMI), the New Rural Cooperative Medical System (NRCMS) and the Urban Resident Basic Medical Insurance system (URBMI), has been developed and is expanding rapidly. Although commercial medical insurance exists, it still accounts for a small proportion of the population covered and is purchased mainly by the upper echelon population at present. Under the new health plan announced in April 2009, the Chinese government promulgated the goal of achieving universal insurance coverage by the basic social medical insurance system by 2011 [31-33]. Although China's basic social medical insurance system nominally covers everyone across the country and is moving towards realization of the objective of universal insurance coverage, the performance of this system needs to be carefully considered and critically evaluated. On the basis of such an appraisal, the intrinsic strengths and weaknesses in institutional design and possible initiatives for further reform of the system can be identified. The experiences of health insurance system reform in other countries may also present useful insights for China's ongoing reform. As an example, Thailand has made impressive strides towards universal coverage, sparking considerable interest worldwide and potentially providing lessons for China. The success of universal coverage in Thailand is tightly associated with its specific political, economic and health system contexts. Copying Thailand's measures indiscriminately is unrealistic and unreasonable for China. Nevertheless, its experiences can still generate useful insights for China. From the perspective of equity and efficiency, there are several lessons that can be drawn [34,35]. Firstly, the gaps in the insurance coverage and health benefits across different schemes in China should be further reduced such that the equity in health care access across distinct social groups can be improved. In Thailand, the benefits across different schemes are approaching standardization in order to assure the objective of equity, although some disparities do exist. Also, the Thai experience demonstrates that, in transitional and developing countries with a large informal sector such as China and Thailand, employment-based social health insurance alone is unlikely to achieve the objective of universal coverage and equitable access. Tax-funded health financing should necessarily play a crucial and

complementary role. China's massive rural populations and urban unemployed residents pose particular concerns. Both the financing of NRCMS and URBMI rely heavily on government subsidies. Recognizing this, and with steady economic growth allowing further public policy initiatives, the Chinese government has increased subsidies for these needy sub-populations and committed to injecting 850 billion RMB (US$124 billion) into the health sector in the three years from 2009. The subsidies for URBMI and NRCMS are targeted to reach at least 120 RMB per capita by 2010 [36]. Indeed, China's surging economy, with an annual growth rate in GDP of around 9% from 1979 to 2006 and rising public revenues which increased from 11% of GDP in 1995 to 19% in 2004, afford the government unprecedented opportunity to increase investment in health care. But, as in Thailand, financial sustain-ability is still an important issue that cannot be neglected. It thus further stresses the importance of redressing the inefficiency in the current health delivery system in China. Meanwhile, to reduce the inequality in financing across regions, more central government spending should be directed to less-developed cities in the form of transfer payments, taking into account the actual fiscal conditions of local governments [37-39].

Secondly, the FFS payment system needs to be transformed. Current provider payment methods based on FFS give perverse incentives to providers and are not conducive to cost containment. In Thailand's UC scheme, capitation, DRGs and global budgets were introduced and played a vital role in cost control while the CSMBS scheme using FFS payment experienced a continuous increase in expenditures despite vast efforts made to rein in the trend. Implementing financing reforms without parallel measures to improve the efficiency of the delivery system, particularly the provider payment mechanisms, are unlikely to succeed. If the problems of cost escalation and inefficiency in China are not addressed, much of the additional funding injected into the insurance system as subsidies by governments will most probably end up as profits for providers [40-43]. Alternatives to China's current reliance on FFS include a mixed payment system like that adopted in Thailand, with capitation used for primary care and combining DRGs with global budgets used for inpatient care. China's explorations of reform in payment methods in some regions over the past decades can also serve as the basis and foundation for further changes. Given the potential problems of incentives for providers to undersupply services under prospective payment systems, it is crucial for insurers to enforce effective quality monitoring of providers' behavior as is carried out in Thailand. Pay for performance, emerging as an innovative and efficient payment mechanism in US and UK, should also be considered in combination with other prospective payment methods to improve quality of care [44-46].

Thirdly, the primary health care delivery system needs to be strengthened, buttressed by a proper referral system which includes a defined gatekeeper role for primary health care providers. As shown by Thailand's experience, the extensive geographical coverage of well functioning DHSs across the country greatly underpinned the effective implementation of the UC scheme, and the establishment of a proper referral mechanism improved the efficiency of the delivery system. Many countries, including the USA in its managed care plans, have found that having primary health care providers as gatekeepers to specialist services and hospital care is a useful cost containment approach, but it also depends on wellfunctioning primary health care facilities and effective regulation [45]. The infrastructure of primary health care facilities in China including urban community health centers, township health centers and village clinics, has lagged behind the flourishing development of general hospitals in the cities. This results in a lopsided allocation of health resources and inequitable health service utilization with most urban patients seeking initial care at secondary or tertiary hospitals even for minor ailments, due to mistrust of community health facilities, excessive reliance on hospital services and the lack of efficient referral regulations. The paucity of heath manpower is a tough problem to be tackled. The development of effective incentive mechanisms to encourage graduates to work at grassroots facilities is a priority issue. Thailand's mandatory rural postings for medical graduates, coupled with the vital role played by health volunteers and nurses, may present useful models for China's policy makers and academics. Considering the large disparities in income and facilities between urban and rural China, it will definitely be a challenging task for China in the future [47,48].

Finally, the low risk pooling level should be gradually raised. As discussed above, increasing the risk pooling level and the concomitant increase in the size of the risk pool will reinforce the risk sharing capacity and sustainability of the insurance scheme. It will also ease the issues associated with poor portability between different programs. With its large population and inadequate administrative capacity, it is impossible to achieve risk pooling at the national level as in Thailand in the short run, but incremental reform is possible. Practical and feasible measures should be taken to raise the risk pool of NRCMS from the current county level to the municipal level. Subsequently, risk pooling of all of these schemes should be raised to the provincial level and eventually the national level. This will take some time given the large differences in financing capacities across regions and the required development in administrative and technical capacity [49-52]. Further, establishing social pooling for outpatient services, as discussed previously, will also strengthen risk pooling. Finally, with the surging economy and urban-rural integration, fragmented medical insurance programs should be merged to shape a universal basic medical insurance system that can serve all the population with more homogenous coverage and benefits in the future, contributing to both the efficiency and equity of the system. Meanwhile, the expansion of risk pooling will not necessarily solve the problem of adverse selection in NRCMS and URBMI, given voluntary enrollment in these schemes. Although the enrollment rate in China's medical insurance system is around 90% according to recent statistics, the issue of adverse selection cannot be neglected. The high enrollment rate of NRCMS is to some extent driven by the mobilization of local rural officials, thus leading to relatively high administrative cost [53-55].

Universal health coverage in Africa

Achieving universal health coverage (UHC) has become a dominant global health policy preoccupation during the last decade, advocating ambitious healthcare coverage goals, increases in health funding and financial pooling mechanisms for social protection. As many commodity-dependent African economies are presently experiencing a marked slowdown and international assistance is becoming more volatile, there seems to be a growing divide between UHC principles and policy-makers' everyday concerns in the field. In order to keep inspiring health development in Africa, UHC thinking and international health support need to take into account the continent's non-linear growth pattern and the need to ensure that its health systems are resilient to external shocks. Drawing from past mistakes and from the continent's reaction to past crises, a number of macro, meso and micro policies can be identified to strengthen the UHC concept, and reconcile

its aspirations with Africa's current economic outlook [56,57].

For Africa, progress towards UHC involves ambitious goals for expanding access to a range of effective health services, a substantial increase in health expenditure, and establishing a greater reliance on prepayment and pooling mechanisms to finance healthcare. According to one set of calculations, achieving UHC requires countries to spend at least $86 per capita in 2012 dollars on healthcare, and a minimum of 5% of Gross Domestic Product (GDP). Clearly, expanding the 'fiscal space for health' will be key to the success of UHC. The global UHC movement is welcome and has helped to galvanise political will to tackle the problem of growing health inequities and the impoverishing effect of out-of-pocket health expenditures. It also helped refocus attention on the fragmented and inefficient architecture of domestic and international health financing, the unpredictability of foreign aid and the lack of regulation over the private health sector in low- and middle-income countries (LMICs) [58,59]. The concept of health insurance has become central to the promotion of UHC, in the belief that financial and risk pooling offers the best guarantee for cost-effective expenditure and protecting the most vulnerable from financial hardship. Public financing will need to play a critical role, and it has been argued that domestic taxation should be designed to both expand the fiscal space for health and pursue social justice objectives [59].

The goal of UHC should still apply in times of economic slowdown. If anything, there is even more of a need to ensure universal access to essential healthcare in times of economic crisis. But policies must incorporate the realities of non-linear economic growth and potential economic contraction. While solutions to Africa's political and macroeconomic instability are important, they lie beyond the scope of this commentary [59]. And while we recognise the fact that the impact of the regional economic crisis will be uneven across the continent, we argue that past experiences point to the general need to consider a certain set of health sector-specific policies. At a macro level, efforts must be made to keep expanding the fiscal space for health in both low-income and middle-income African countries. Crises also often present unexpected windows of opportunity to access extra resources for health, reform health systems, adopt unusually bold actions and take on ingrained special interests for the greater good. Because of the increased leverage of international funds during an economic crisis, donors could be more effective in negotiating earmarked windfalls from natural resources for social sectors, increased budget allocations for the health sector, reforms to make them more progressive introducing health-related levies and mobilising extra international assistance. At the regional governance level, the establishment of Africa's Centres for Disease Control and Prevention is another example of how to improve the continent's capacity to identify its own epidemiological issues and solutions to strengthen its health systems [60-62]. At the meso (sector-wide) level, learning from the deleterious consequences of the Structural Adjustment Programmes in the 1980s, counter cyclical measures should be brought in to mitigate the effects of the crisis on population health and health systems, and provide social protection for low-income and vulnerable groups. This is likely to be more feasible for those middle-income countries with wider fiscal space; as shown in Cuba, investments made at decentralised and district level of health administration and local health communities have the potential to boost system resilience.The introduction of National Health Insurance schemes should be piloted in phases to ensure the programmes are resilient to economic downturn, only to be scaled up in the following expansionary phases [61,63]. During economic contractions, recurrent expenditures (paying for salaries, drugs and basic maintenance) often take precedence over capital ones. However, African governments could still find ways to maximise resources and reduce costs by moving away from wasteful input-based to performance-based financing, reducing out-of-pocket financing for vulnerable populations by eliminating user fees, introducing solidarity funds and contracting out services. Private providers and private resources should be brought into the UHC equation to be regulated and harnessed to improve their quality and avoid dangerous distortions, but also as recognition of their importance as essential coping mechanisms that individuals and health systems fall back to when everything else fails. At the micro (health programme implementation) level, priority should be given to preventive primary services as well as to the procurement and distribution of basic drugs, and to retain key personnel; public health programmes and surveillance mechanisms should be strengthened against communicable diseases to avoid possible epidemics. Ensuring funding for salaries and basic drugs will have to take precedence over setting up complex pooling arrangements, as well as conducting minimum infrastructure and equipment maintenance interventions to avoid irreversible deterioration. The spread of recent technological advances such as mobile telephones and finance may create opportunities for the introduction of more cost-effective interventions such as telemedicine, thus strengthening the existing systems [35, 64-67].

Universal Health coverage reforms in India

Health sector needs in the context of India's diversity are so complex that it is rather impracticable to engage with all its stake holders. The Indian citizens deserve and desire an efficient and equitable health system which can help in providing UHC in India. UHC in India could only be achieved if the primary health care facilities receive a minimum of 70% of health spending, public spending on the purchase of medicines increase from 0.1% to 0.5% GDP, and all the health facilities in India are upgraded to match the Indian Public Health Standards. The health insurance programs currently available in India do not help in achieving these recommendations and only strengthen the private health infrastructure which mainly targets rich people. There are problems in sustainability of the health insurance programs because the mechanisms for financing the health system such as strong collecting systems are lacking in India [64,68].

India has a very low public health spending with only 0.94% of the GDP. The government contribution of the total health spending is only 22% with 78% of private health spending. Every year around 39 million people are impoverished because of catastrophic health expenditure. 74% of OOP spending was on outpatient care and only 26% on inpatient care. Public health care in India is free of cost in most cases or charges a minimal service charge. However, the quality of services in the public health system is very poor, and people are unsatisfied. A majority of the people use private health services for their health care needs. Around 20%-28% of diseases in India are untreated because of the lack of financial protection. Around 30%-47% of inpatient care in India was financed by the sale of property and loans [68,69]. There are difficulties in the expansion of insurance coverage in India because only 7% of the workforce is in the organized sector. India does not currently have UHC. The 12th five-year plan (2012-17) of the Government of India (GOI) tries to achieve UHC. GOI created a High Level Expert Group (HLEG) in 2010, which prepared a report for the achievement of UHC in India by 2022. The health insurance system in India is only rudimentary and available to only few groups of advantaged individuals. In India, the unmet need for healthcare is very high with the people having the highest need having the least access to health care. In India, the IMR among

the poorest wealth quintile is around 82 per 1000 live births, while the IMR among the richest quintile is only 34 per 1000 live births. Women in the richest quintile are more than six times more likely to have an institutional delivery compared to poorer women. These statistics show there are wide disparities between the rich and poor in access to healthcare. The approaches to achieve UHC in India currently target poor people [35,70-73].

Universal Health coverage in Indian context is defined as; "Ensuring equitable access for all Indian Citizens, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the Government being the guarantor and enabler, although not necessarily the only provider, of health and related services". It is a concept, which implies, the absence of geographic, financial, organizational, sociocultural and gende based barriers to care. The concept of Universal Health Coverage (UHC) arose out of a global concern for high levels of out of pocket expenditure for health care in many low- and middle-income countries (LMIC) [72-75]. UHC has the prime objective of "ensuring that everyone within a country can access the health services they need, which should be of efficient quality to be effective and providing all with financial protection from the costs of using health services". Core to the design of UHC is the health financing system and how it engages with the mechanisms for provision of healthcare. Progress towards UHC requires strengthened health system functioning and a focus on equity. Despite this broad vision, at country level, UHC has often focused on the establishment of state funded insurance schemes and stopped short of addressing the health systems strengthening or equity aspects of UHC. The path to universal health coverage involves important policy choices and inevitable trade-offs [75,76]. The pooled funds – which can be contributed from a variety of sources, such as general government budgets, compulsory insurance contributions (payroll taxes), and household and/or employer prepayments for voluntary health insurance - are organized, used and allocated, impacts greatly the direction and progress of reforms towards achieving universal coverage. Even where funding is largely prepaid and pooled, there occurs need for tradeoffs between the proportions of the populations to be covered, the range of services to be made available and the proportion of the total costs to be met. Pooled funds can be employed to extend coverage to those citizens who previously were not covered, to services that previously were not covered or to reduce the direct payments needed for each service. These dimensions of coverage reflect a set of policy choices about benefits and their rationing that are among the important decisions facing countries in their reform of health financing systems towards achieving universal coverage. Ayushman Bharat Program is a balanced program, which combines provision of comprehensive primary healthcare and secondary and tertiary care hospitalization. Although ABP would help India make rapid strides towards UHC, this program alone would not be enough and needs to be additionally supplemented by rapid scale-up and convergence of ongoing schemes and programs, and taking a few additional measures. The Ayushman Bharat Program (ABP) can prove as an effective and bigger initiative than simply delivering health services and rather provide a platform to prepare India for making health coverage universal in India. The patterns of utilization and differential Out-of-pocket health expenditures across public and private sectors under publicly financed health insurance warrant further investigation, so as to inform strategies that make best use of scarce public resources and deliver on the promise of equity under Universal Health Coverage [76-79].

Conclusion

Universal Health Coverage (UHC) is driving the global health agenda; it is embedded in the Sustainable Development Goals (SDGs). UHC reforms are an inherently political process, and public health advocates will need to do more to promote not only the health benefits of public health interventions but also the economic and political benefits too. Crucially, as UHC continues to be championed and rolled out globally, all people working in global health need to reinforce the importance of including the full scope of public health in health system reforms; only then can the full potential of UHC be realized—a true reduction in health inequities. However, implementation of a UHC is not an easy phenomenon, rather it needs proper design of a good health insurance system by integrating both the public and private health care providers. The influence of good governance and a sustainable health financing system is fundamental to establish UHC in the developing countries.

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