Chapter 1

INTRODUCTION

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"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition."

- WHO Constitution (1946)

1.1. The Foundation:

The World Health Organization (WHO), from its inception, has visualized health as a fundamental right for every human being. The relevance of good health is not limited to the micro or individual level only. At the macro level, it appears that population health and national income are closely associated. Thus, the economic development calls for human development. UNDP's (United Nations Development Programme) new and holistic approach for measuring human development has also given much emphasis on health while measuring growth. With regards to international development, it is a globally accepted fact that the positive correlation between health and per capita income reflects a causal link between income and health. As the income increases, the capacity to consume a wide range of products and services (like better nutrition, safe drinking water, sanitation, good quality healthcare services) also improves, promoting better health. But Bloom & Canning (2000) has identified that a causal link running the other way-from health to income can also partly explain the health-income relationship. They stated that poor health is not only a consequence of low income, but it is one of its fundamental causes as well. Similarly, Wagstaff (2002) also have pointed out that poverty and healthcare access share a cyclical relationship; poverty induces ill health, and the ill-health sustains the state of poverty. Though health is not the only factor that influences economic growth, it is definitely among the most potent ones.

The economic effect of population health is witnessed in both individual and macroeconomic level, passing on that effect to the economic development of the Nation as well. So, upholding the health standards of the population has been a concern globally in recent times. As a result, different international organizations like WHO, the United Nations (UN), the World Bank have been emphasizing, promoting, and providing assistance to improve the health security of the population from all aspects.

In the year 1946, the WHO constitution declared health as a fundamental human right. Two years later, the Universal Declaration of Human Rights included the right to health in Article 25, and the international law also supported the notion in the 1966 International Covenant on Economic, Social, and Cultural Rights. Following the trend, several countries also accepted health as a right in their constitutions. All these just modernized the significance of health at the global stage. But before all these, the importance of good health has been continuously promoted for centuries across the world. The teachings of several religions and cultural traditions from around the world hold lessons on maintaining healthy lives in its core. With the recognition on the international platform, now health and healthcare have drawn a lot of attention at several fonts like human development, economic growth, societal welfare, and social justice.

In the journey of general improvement of health and healthcare mechanism, the Declaration of Alma Ata was a chief milestone in the field of public health. In the post-colonial era, many newly-independent developing countries started emphasizing on providing high-standard healthcare, education, and other essential services to its population to strengthen their people, both socially and economically. Despite the different initiatives to establish hospitals, medical and nursing schools, an urban-rural disparity in accessing healthcare services came to notice, predominantly in the rural areas. As a result of it, there wasn't any significant improvement in the health conditions of the people; conditions have rather worsened at certain places. At different times, cultural beliefs of people also restricted them from availing these healthcare services despite having access; most of the population rather relied on traditional healers (Benyoussef & Christian, 1977; Bennett, 1979). In the 1960s-70s, to address the issue, some countries like China, Tanzania, Sudan, Venezuela came up with comprehensive healthcare programs to specifically deliver primary healthcare services to rural populations. This new approach raised questions on the existing healthcare systems, its healthcare delivery process and the role of medical professionals. Influenced by these new successful practices from around the world, the WHO also acknowledged the rising need for major structural reforms in the healthcare delivery systems of the developing countries. The Declaration of Alma Ata was the result of these paradigmatic shift in perspectives in the field of public health.

All the WHO member countries combinedly approved the Declaration of Alma Ata at the International Conference on Primary Health Care (PHC) at Alma-Ata in the

former Kazak Soviet Republic in September 1978.[1] This declaration also restated that health (defined by the WHO constitution) as a fundamental human right for every human being. According to the Declaration, "The existing gross inequality in the health status of the people particularly between developed and developing countries, as well as within countries is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries." And access to Primary Health Care (PHC) model is an effective way for all the countries to eradicate this inequity in health across and within the nations with comprehensive, universal, equitable, and affordable healthcare. As per it, a considerable sum of health for all was achievable by 2000 through adequate utilization of resources; hence goals and targets were set accordingly. The PHC model got criticized immensely for being an unrealistic, expensive plan with unachievable goals of total population coverage. Although for several reasons failed to achieve health for all by the end of 2000 (Tarimo & Webster, 1994), there is strong evidence that the PHC model was responsible for a significant and steady improvement in many health indicators (Hill, et al., 2000; WHO, 2012; Rutstein, 2000), demonstrating the strong potential of the PHC model. Though the PHC model couldn't deliver on its promises, it paved the way for universal healthcare and coverage. The 2019 Global Monitoring Report (WHO, 2019) even termed the PHC as the "programmatic engine" for the UHC.

By the mid-1990s, WHO review confirmed that it wouldn't be possible to achieve the goal of health for all by 2000. The World Health Report (2000) officially marked the end of the PHC model as a means for ensuring healthcare for all. In the meanwhile, the 191 UN member states signed the eight Millennium Development Goals[2] in September

[1] International Conference on Primary Health Care (1978), Declaration of Alma-Ata. *WHO chronicle*, *32*(11), 428–430

[2] By signing the Millennium Declaration, world leaders committed to combating poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. The Eight Millennium Development Goals are:

- to eradicate extreme poverty and hunger;
- to achieve universal primary education;
- to promote gender equality and empower women;
- to reduce child mortality;
- to improve maternal health;
- to combat HIV/AIDS, malaria, and other diseases;

2000, with focus on child mortality, maternal health, epidemics like HIV/AIDS, malaria, and other diseases; the aim was to achieve these goals by 2015 (WHO, 2000). Only powerful interventions and funds to acquire them can't deliver better health outcomes in the long run. An efficient healthcare delivery system is equally essential in this matter. In the absence of an adequate delivery system, operational efficiency gets compromised, affecting the outcomes. By the end of the year 2005, the sluggish progress towards the MDGs raised warnings about the healthcare systems in action, and it was evident from reviews that inadequate investment in the fundamental healthcare system, comprising of infrastructure, services, and manpower, hindered the pace of the progress. Review report showed that reforming focused on strengthening the national capacity of the health system was the best strategy for overall growth in the health sector (Chan, 2017).

The World Health Report (2008) on Primary Health Care rigorously assessed how the countries across the world organized, financed, and delivered healthcare to its people and found striking disparities in access to care, health outcomes, and what people had to pay for care. The report revealed that most of the health systems had failed to deliver fair access to care, invest resources wisely, and meet the needs and expectations of people. The comparative assessment between countries from the same economic level had unveiled that the countries with healthcare systems based on primary health care had achieved better health outcomes for the same amount of investment. That made the experts realized that the revival of primary health care was the best and most affordable way forward at such a critical point of time. The World Health Report drew several conclusions based on past experiences and evidence. Thorough assessments confirmed that,

- Community participation can play a substantial role in the improvement of the health system, especially in reducing neonatal and maternal death counts.
- In the absence of quality care, the increase in access to healthcare can't improve mortality.
- It is possible to deliver healthcare services in an integrated and comprehensive manner.

The financial crisis, in the year 2008, also added to the crisis in healthcare; post-crisis, the academicians and experts finally admitted that primary health care is the best

- to ensure environmental sustainability; and
- to develop a global partnership for development.

and most efficient way for service delivery. Amidst these positive evaluations, considering all the aspects of healthcare, several supporters proposed that the universal health coverage, the main essence of the PHC model, would be a better corrective policy. The World Health Assembly, 2005 had initially endorsed the idea of UHC, but the transition towards this strategy gained its momentum in the year 2010.

The main aim of the "World Health Report on Health system financing: the path to universal coverage" was to find out how to raise sufficient funds and remove financial barriers to healthcare access (WHO, 2010). It looked for ways to reduce waste and inefficiencies, instead of cutting down on spending. According to the report, all countries, irrespective of their development stage, can move towards universal health coverage. With adequate measures, nations can improve both service coverage and protection against financial risk against any level of healthcare expenses. Within two years, in 2012, the United Nations General Assembly adopted a resolution, with the consent of more than 90 countries from around the world, approving the goal of universal health coverage and gave it a high priority on the development agenda. In September 2015, before the adoption of the 2030 Agenda for Sustainable Development, the Economists' Declaration was launched with 267 signatories from 44 countries. The purpose was to prioritize a pro-poor pathway to universal health coverage as an essential pillar of development. Finally, on 25 September 2015, 193 countries of the UN General Assembly adopted the 2030 Development Agenda with the title: *Transforming our world: the 2030 Agenda for Sustainable Development*[3]. Out of the 17 goals, the Sustainable Development Goal (SDG) 3 focusing on ensuring healthy lives and promote wellbeing for all at all ages, holds the complete essence of Universal Health Coverage (UHC). The addition of a target

[3] The Sustainable Development Goals (SDGs) are a collection of 17 global goals designed to be a "blueprint to achieve a better and more sustainable future for all". The SDGs, set in 2015 by the United Nations General Assembly and intended to be achieved by the year 2030, are part of UN Resolution 70/1, the 2030 Agenda. The 17 broad and interdependent Sustainable Development Goals are: (1) No Poverty, (2) Zero Hunger, (3) Good Health and Well-being, (4) Quality Education, (5) Gender Equality, (6) Clean Water and Sanitation, (7) Affordable and Clean Energy, (8) Decent Work and Economic Growth, (9) Industry, Innovation and Infrastructure, (10) Reducing Inequality (11) Sustainable Cities and Communities, (12) Responsible Consumption and Production, (13) Climate Action, (14) Life Below Water, (15) Life On Land, (16) Peace, Justice, and Strong Institutions, (17) Partnerships for the Goals.

specifically for UHC under the Agenda for Sustainable Development has provided a unifying platform to deliver on every element of health, contributing to social cohesion and stability in every country (Chan, 2017).

1.2. Theoretical Framework

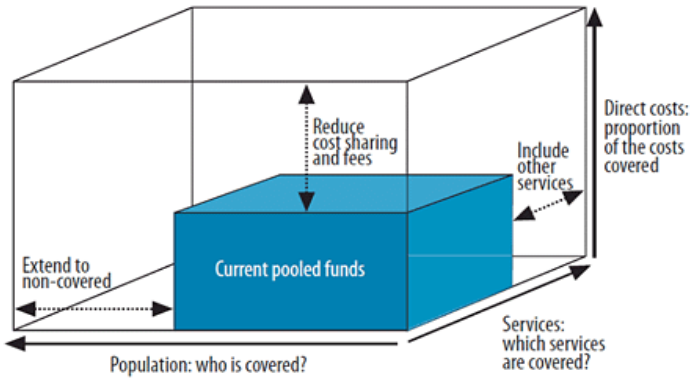
1.2.1. The Concepts of UHC, Health System, Healthcare Expenditure and Healthcare Financing

As per definition, the Universal Health Coverage (UHC) means all people have access to quality health services meeting their needs without exposing them to financial hardship while paying for them (WHO, 2013). There are three dimensions involved with the concept of UHC to encompass the complete coverage, i.e., population (who is covered), services (which services are covered and their quality), and cost (how much of the cost is covered) (WHO, 2010). The UHC cube (Fig 1) clearly illustrates the three dimensions of coverage, where the population axis represents the people in need of healthcare services, the services axis stands for the quality of healthcare services for major illnesses, needed by the population. The vertical axis of cost represents the total cost of delivering the needed healthcare services to the people. The "current pooled fund" (from Fig 1) for each of the countries determines the extent of services and population covered and the cost of these services shared by the pooled fund. Thus, attaining and maintaining UHC put every country's health system under substantial strain, especially at the time of economic emergencies. Hence, the prime focus of UHC is to ensure equity in access to and usage of services, quality of the services delivered, and financial security of the people in need of healthcare. Countries, to get closer to the goals of UHC, have to extend the coverage to more people, add more priority healthcare services of good quality, and also pay a more substantial share for the costs of such services from the pooled funds. But it is not possible to achieve in the absence of a well-functioning health system. The 58th World Health Assembly (2005) also emphasized the importance of the health financing system for better outcomes, and the Member states of WHO also committed to developing their health financing system in such a way that healthcare services became accessible without any financial hardships.

According to the World Health Report (2000), "a health system consists of all organizations, people and institutions producing actions whose primary intent is to promote, restore or maintain health." The health systems are not merely responsible for improving people's health, but also to protect them against the financial risks from the

costs of ailment. The main goals of a country's health system are to improve the health of their population, respond to the people's expectations, and ensure equity in the financial burden and financial protection from the costs of illness. And there are four fundamental functions that every health system has to perform to deliver on these goals, i.e., stewardship, resource generation, service delivery, and financing (Kutzin, 2013).

Figure 1: The Dimensions of the Universal Health Coverage Cube



Source: The World Health Report 2010 (Health System Financing: The Path to Universal Coverage)

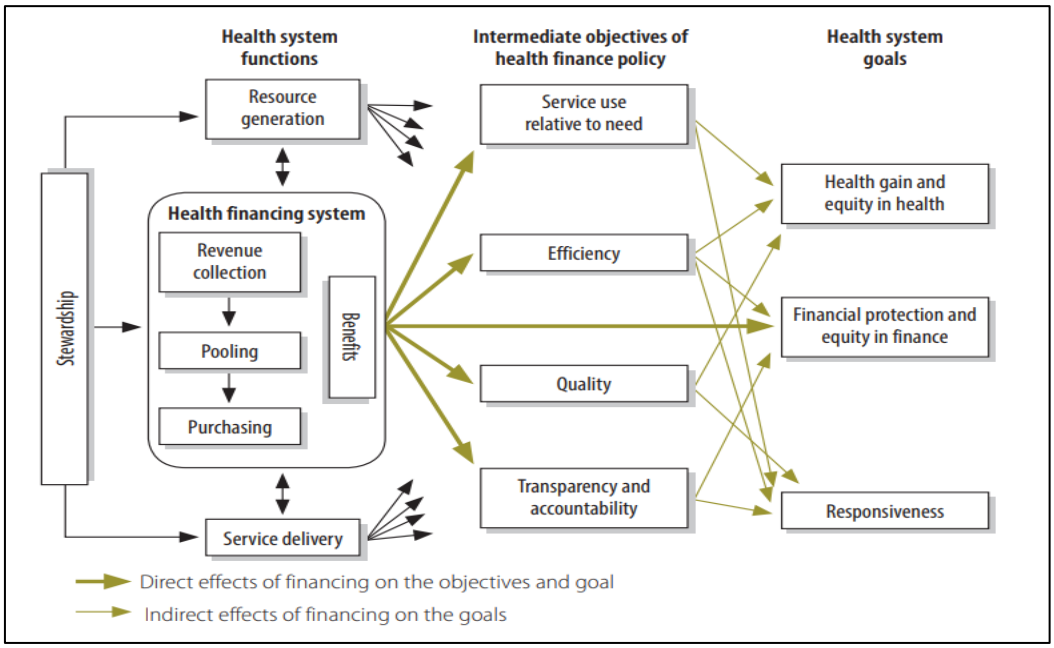
Financing for healthcare plays a great role in progressing towards universal health coverage, since carefully designed and implemented health financing policies aids in improving service coverage and financial protection. But health financing is not just an act of raising money for the health sector; it is concerned with how and when to raise the money, and how to utilize the accumulated sum of money. According to the WHO approach of health financing, this core function has three distinct sub-functions:

i. Revenue-raising*:* The health system raises the money from several sources of funds including government budgets, compulsory or voluntary prepaid insurance schemes, direct out-of-pocket payments by users, and external aids.
ii. Pooling: It is the process of accumulating the prepaid funds on behalf of some or all of the population for evenly distributing the financial risk associated with ill health.
iii. Purchasing: Here, the health system makes the payment or allocation of resources to health service providers for the healthcare services.

The health financing system does not act alone for achieving the desired goals, but financing influences the objectives of the health system both directly and indirectly through the intermediate objectives. Financing has direct control over the health system's aim of attaining financial protection and equity in the financial burden for the population.

On the other hand, the financing establishes a plausible link between the remaining functions as well as the goals of health systems through the several intermediate objectives of health financing policies (Fig. 2).

Figure 2: Linkage between the Health system goals and health financing policy objectives



Source: Kutzin (2013)

Similarly, health financing policies are closely-knit with the three dimensions of UHC cube and monitoring of UHC progress. The framework derived by Kutzin (2013) clearly demonstrates the association of the three core health financing functions with the three prime goals of UHC: (1) minimizing the gap between need and usage of healthcare services, (2) enhancing the quality of care, and (3) raising financial protection, and the intermediate objectives as well. Although health financing reforms are not sufficient to bring in significant changes in the health system, it can directly influence each of the final UHC goals. In addition to that, the three intermediate UHC objectives: equity in resource distribution, efficiency, and transparency and accountability also promotes the progress towards the ultimate UHC goals, and health financing plays a vital role in accomplishing these objectives as well. With improved efficiency, for a certain level of funding, attainments will be more than usual irrespective of the constraints. Consequently, the health system will be more effective in elevating financial security and improving utilization as per needs. Likewise, there is evidence that with the rise (or decline) in health spending distribution, equity in both healthcare usage and financial protection advances (or worsens) (Shishkin & Jowett, 2012; Knaul, et al., 2012; Prakongsai,

Limwattananon, & Tangcharoensathien, 2009; Ataguba & McIntyre, 2012). Health financing clearly emphasizes on building awareness about people's entitlements, monitoring the fulfillment of them, and also very specific about maintaining transparency and accountability of the healthcare agencies. Transparency and accountability in the health system more likely to result in better utilization of available resources, which further aid in improving access, quality, and financial protection, as a whole.

The UHC goals and health financing are interrelated at several levels of the health system. The UHC goals and intermediate targets combinedly administer the progress for health financing systems. The health financing policies are designed and implemented in ways to achieve those specific goals only. In short, health financing has a pivotal role to play in the journey towards attaining universal health coverage for every country. Hence, the UN has also specifically emphasized for a substantial increase in health financing for strengthening the health systems in the SDG 3 targets.

1.2.2. Healthcare Systems based on the Financing Arrangements

All national health care systems are pluralistic in nature, which means they consist of a variety of schemes or subsystems (Cichon, et al., 1999). There are about 200 countries on our planet, and each country devises its own set of arrangements for meeting the three fundamental goals of a health care system: keeping people healthy, treating the sick, and protecting families against financial ruin from medical bills. Every country establishes its national health system in its political, social, and historical setting. But they have to keep on evolving to address the issues associated with demographic changes and epidemiological shifts. Different academicians have put forward different types of classification for the existing health systems across the world. Many academicians have used the various aspects of the health financing model (independently or mixed with some other components) as a criterion to classify different health systems across the globe. Some of these criteria for classification are

i. The source of financing: public, private for-profit, and private not-for-profit (Organisation for Economic Cooperation and Development, 2004; Thomson, Foubister, & Mossialos, 2009; Wendt, Frisina, & Rothgang, 2009)
ii. Obligation to Participate in the financing schemes: mandatory and voluntary (Organisation for Economic Cooperation and Development, 2004)
iii. Number of players involved in the financing model: single-player or multiple players) (Hussey & Anderson, 2003)

iv. Method of contributing to the systems: public (taxes and social insurance contributions) or private (private health insurance, medical savings accounts, and out-of-pocket payments) (Roemer, 1960; Organisation for Economic Cooperation and Development, 2004; Thomson, Foubister, & Mossialos, 2009)
v. Eligibility criteria for the financing schemes: citizenship, privilege, and poverty/vulnerability (Terris, 1979; Frenk & Donabedian, 1987)

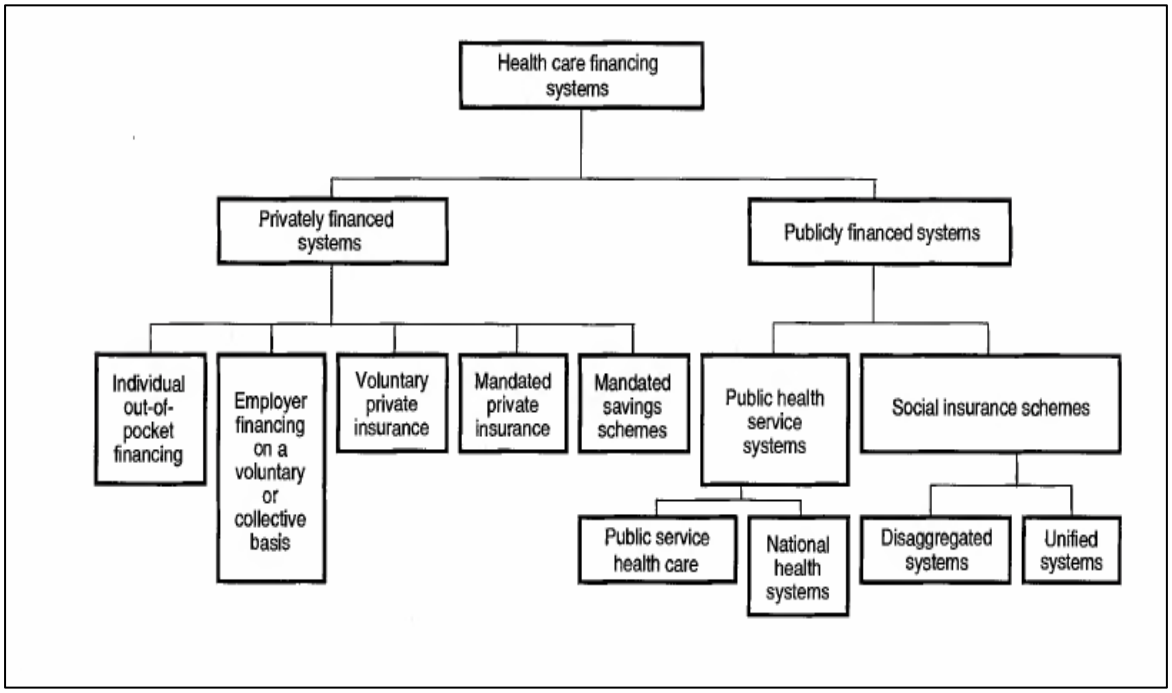
And as we know, the healthcare financing system is concerned with collecting funds from various sources, according to WHO (WHO Study Group, 1993), there are four sources of finance available for healthcare financing, and they are

i. Government Funding: Government financing is the expenses made in the health system at all levels of government (both central and local) along with the expenditures of public corporations.
ii. Private Financing: There are two types of private financing; direct or indirect. Direct payments include out-of-pocket payments/household expenses made in terms of user fees at government/private healthcare facilities, traditional-healers, or drugstores, as well as the contributions or prepayments to non-government schemes (community financing). On the other, indirect funding covers payments made by large private-sector employers and the health financing made by non-government organizations.
iii. Health Insurance: It is a mixed source of financing for future healthcare expenses through contributions (taxes/premiums) into a common fund or third party for all or specific healthcare services. These schemes often draw their contributions from employers, employees, and governments at times. Three principal types of health insurance are government or social insurance, private insurance, employer-based insurance.
iv. External Aid: External donors are important financing agents for healthcare financing, especially for developing and underdeveloped countries, where government funding is not sufficient to meet the various needs of the health sector. It contains institutional aids, foreign aids, or development loans.

According to Cichon et al. (1999), we can classify the healthcare system financing arrangements by their pattern of financing (public or private), delivery mode (private sector, public sector, or public/private mix), the scope of their benefits (full or partial) and their population coverage (full or partial). Using all the plausible combinations of these

criteria for classification, they have categorized a full range of health care financing options, including the main types of health care financing modes (Fig. 3). Each national health system across the globe is a unique combination of these categories and subcategories.

Figure 3: Categories of Healthcare Financing Systems



Source: Modeling in Health-Care Finance: A compendium of quantitative techniques for healthcare financing

The publicly financed healthcare systems are the backbone of every country's health financing setup, following two approaches *public health service approach* (including national health service and public service health systems), and the social health insurance approach. In the first approach, the public sector plays the role of financing agent and healthcare provider, while in the alternate method, government is responsible for financing, but may or may not be the provider of the services. On the other hand, private funding of healthcare takes either of two modes: direct purchases and co-payments for purchases. It covers out-of-pocket payments on healthcare, private insurances (mandatory as well as voluntary, and employer-based), and the mandated saving schemes.

Although the health systems vary from one country to another, their aims are the same for all. Every nation establishes its national health system in its political, social, and historical setting. But they have to keep on evolving to address the issues associated with

demographic changes and epidemiological shifts, and health financing plays a pivotal role in the entire process.

1.2.3. Healthcare Expenditure & Its Components

The existing health systems across the globe are continuously evolving in response to several factors like advancement in the field of medical (technology and knowledge), changes in health policy priorities to meet shifting disease and demographic patterns, new organizational methods, and more complex financing mechanisms. Each of the health systems needs to ensure good health alongside financial protection. So, it is quite essential to keep track of the amount of money spent by a country on healthcare across multiple streams. Based on past expenditure records, health administrators can revise the planning and allocations of resources throughout the system to further improve the system in terms of efficiency and accountability. So, to determine the dynamic financing needs of a country for healthcare needs, a proper accounting norm in a universally comparable form is a necessity at present times. Thus, WHO introduced the concept of "National Health Account" (NHA) using the System of Health Accounts (SHA)[4]. According to it, health accounts provide a systematic description of the financial flows related to the usage of healthcare goods and services and a standard for classifying health expenditures according to the three axes of consumption, provision, and financing. The health accounts include all health expenditures regardless of how or who funded or purchased or provided the healthcare goods/service. The standard types of health expenditures, defined according to the NHA guidelines (National Health Systems Resource Centre, 2016), are:

i. Total Health Expenditure (THE): THE constitutes current and capital expenditures incurred by Government and Private Sources including External funds
ii. Current Health Expenditures: It is only the recurrent expenditures for healthcare purposes net of all capital expenditures (however, SHA 2011 Framework disaggregated both capital and current expenses)

[4] The System of Health Accounts (SHA) provides a framework for a family of interrelated tables for standard reporting of health expenditure and the financing. The aim behind writing the SHA is to provide a framework for international data collections and as a possible model for redesigning and complementing National Health Accounts to aid policy-makers. WHO first developed the SHA in the year 2000, and in 2011 it got revised further.

iii. Government Health Expenditure (GHE): It constitutes the spending under all schemes funded and managed by Union, State, and Local Governments, including quasi-governmental organizations and external aids, channeled through Government organizations

iv. External/Donor Funding for health: This constitutes all funding accessible to the country by aids from donors

v. Out of Pocket Expenditures (OOPE): The SHA 2011 framework has defined the out-of-pocket (OOP) payments as the payments made by an individual/household at the point of service directly in case social protection or insurance scheme either does not cover or partially cover the cost of the health good/service. It includes expenditure on inpatient care, outpatient care, family planning, immunization, drugs, diagnostics, medical non-durables, therapeutic appliances from various healthcare institutions.

vi. Household Health Expenditure: Household health expenditures are the expenditures incurred by houses on health care and include out of pocket expenditures and prepayments against public and private financing schemes. Household health expenditures are either direct expenditures (OOPE) or indirect expenditures (health insurance contributions or premiums). Although the individuals are the end- users of the available healthcare services, as per the SHA 2011 guidelines for expenditure estimation purposes, households are the basic unit of consumption, cluster of several users. As an institutional entity, they are even considered as the financing agent for the household's OOPE or otherwise known as a financing scheme.

These segregated healthcare expenditures help in understanding the health systems from the expenditures perspectives and assist in finding the answers to three primary questions (OECD; eurostat; WHO, 2011): (a) What kinds of health care goods and services are consumed (b) Which health care providers deliver these goods and services, and (c) which financing scheme pays for these goods and services. THE (as a percentage of GDP) designates health spending relative to the country's economic development, while THE per capita symbolizes the health expenditure per person in the country. The current health expenditure, as a percent of THE, indicates the operational expenses on healthcare that influence the health outcomes of the population in a particular year. OOPE depicts the extent of financial protection available for families against the

costs of healthcare services. Household health expenses, as a percent of THE, indicate the dependence of the households on their income and savings to meet the healthcare needs. With the low level of GHE, the dependency on houses out-of-pocket grows higher.

Preparation of NHA is a lengthy, time-consuming process, and maintaining data quality can also be challenging (Price, et al., 2016) at times. Still, over the past decades, systematic reporting of NHA has assisted in understanding the gap between demand and supply in the health sector from the expenditure standpoint. But it has made one thing clear that in the journey towards achieving the UHC, estimation of various healthcare expenditures can unveil significant insights about the progress against the ultimate goals, especially the extent of the financial burden prevailing on the people. Ensuring financial protection from healthcare risk is one of the fundamental goals of UHC. Although NHA provides the overall scenarios across the countries, it doesn't address the diversity within the regions. The systematic estimation of health expenses at different sub-levels is more likely to provide more definite and detailed updates on the issue, and policymakers, academicians can look into its prospects.

1.3. India: Health and Healthcare System

India is one of the world's oldest civilizations, located in the south-eastern region of Asia. It is a democratic and republic country with 28 states and 8 number of union territories.[5] After China, India is the second-most populous country in the world, roughly covering one-sixth of the world's population, and by area, it is the world's seventh-largest country. With thousands of ethnic groups and hundreds of languages, the country's population is highly diverse. In the past few decades, India has transformed from a traditional agrarian economy to an industrialized economy and emerged as one of the fastest-growing economies in the world.

According to the 2011 Census, 68.8 percent of the total population live in rural areas, and 31.2 percent are from urban areas. The overall literacy rate in the country is 74.0 percent (rural: 68.9 percent, urban: 84.9 percent), with an extensive gender-based disparity. The male literacy rate is 82.14 percent, while the female literacy rate is 65.46 percent. The difference in the female literacy rate is remarkably high between urban (79.9 percent) and rural (58.7 percent) areas. The Human Development Index (HDI) value

[5] https://knowindia.gov.in/states-uts/

(UNDP, 2018) of 0.647 has put India in the medium human development category with a rank of 129 out of 189 countries and territories. Since 1990, India has improved its HDI value by 50 percent, with significant improvements in each of the HDI indicators.

The British ruled over India for around 200 years from the mid-eighteenth century till 1947. During this period, the British authority approved and implemented some successful initiatives for developing the public health laws and systems. The epidemic of plague India, in the year 1896 led to urgent and significant actions to improve public health. One of the leading transitions was the 1919 Montague–Chelmsford constitutional reforms. This reform introduced self-governing institutions into the administrative system, and the autonomy transferred from the central government to the states. It steered the decentralization of health administration and the creation of primary public health organizations in all the states in the year 1921–1922. There was more independence in operations post the Government of India Act 1935.

The Bhore Committee Report of 1946, based on a survey of health conditions and organizations, was the foundation for most of the planning and measures adopted by the country from post-independence to date. The report contained short and long-term recommendations to improve health services in the country. The first government of Independent India accepted the proposals of the committee in 1952. Indeed, the government didn't implement most of the recommendations immediately, but it worked as a trigger for all future reforms. The committee recommended a three-tiered health-care system to provide preventive and curative health care in rural and urban areas through placing health workers on government payrolls and limit the need for private practitioners. It is the fundamental principle of the current public health-care system of the country. The aim of doing so was to ensure access to primary care to everyone, irrespective of the individual's socioeconomic conditions. However, due to the public health system's inability to provide access to quality care (Peters, Rao, & Fryatt, 203), private health-care systems also evolved simultaneously through a steady and gradual extension of services.

1.3.1. Health Status: Key Health Indicators

Since the time of independence, along with economic development, the health indicators have witnessed improvements across different health status indicators. India has been able to achieve remarkable progress in reducing the Maternal Mortality Ratio (MMR). According to the latest reports, the MMR has decreased by 78 percent (from 556

in 1990 to 122 in 2017 per 100,000 live births). There is substantial improvement in the under-5 mortality rate as well. As per the SRS 2015-17, since 2012, the count of children under-five years of age dying in India has fallen by 37 percent. Accordingly, the number of under-5 death counts per 1000 live births dropped to 37 from 56. At the same time, with a 34 percent decline in infant deaths, the Infant Mortality Rate has also come down from 44 to 30. Similarly, the 29 percent drop in neonatal death counts pulled down the Neonatal Mortal Rate from 31 to 23 percent. From the National Sample Survey (75th round), it appears that only 54.7 percent (approx.) of estimated deliveries happen in a health institution in India, and the full immunization rate among children of 0-5 years of age is 59.2 percent.

India reported about a 16 percent surge in the number of cases of tuberculosis in the year 2018, and these newly reported TB cases (around 27 lakh cases) accounted for more than a quarter of the global TB burden (27%)[6]. The majority of these affected people belonged to the age group of 15-69 years, and 2/3rd were males. Moreover, as per estimation[7], by the end of 2017, an estimated 21.40 lakh people were living with HIV in India, and two-fifth of these HIV patients are female. Although HIV incidence per 1000 uninfected population has declined from 0.64 in 1995 to 0.07 in 2017, India recorded approximately 69.11 thousand AIDS-related deaths in 2017.[8] There were around 50 thousand HIV co-infection cases among TB patients as well. Simultaneously, the burden of NCD is rising rapidly, as NCD responsible for 53 percent of the total death-cases of the country. Both communicable and non-communicable diseases are still prime health issues for the country.

1.3.2. Healthcare System: Structure and Financing

There are three levels involved in the Indian health system: central, state, and local. In India, health has been provided a higher priority at the constitutional level. It is a matter of fact; Article 47 of Part IV of the Constitution of India has listed the duties of the state to raise the level of nutrition and the standard of living and to improve public health. Hence, each state is responsible for developing its own healthcare delivery system,

[6] India TB Report 2019 (Revised Annual TB Control Programme Annual Report) https://tbcindia.gov.in/WriteReadData/India%20TB%20Report%202019.pdf

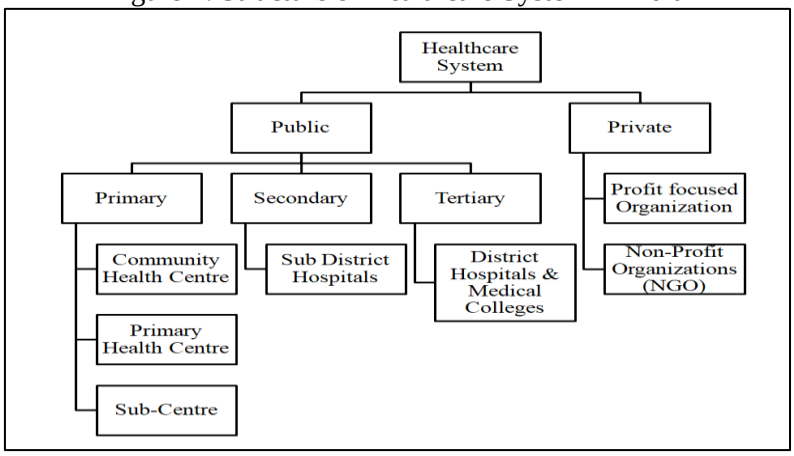
[7] India HIV Estimations 2017 Technical Report (http://naco.gov.in/sites/default/files/HIV%20Estimations%202017%20Report_1.pdf)

[8] UN AIDS Data 2017 (https://www.unaids.org/en/resources/documents/2017/2017_data_book)

independent of the center. The roles of the central government are to guide, support, and coordinate with the state government to strengthen the states' efforts. The central government needs to coordinate the different health activities and programs from every corner of the country. There are three main organizations associated with the health system at the national level:

a) Union Ministry of Health and Family Welfare: A member of the Council of Ministers (with a cabinet rank) responsible for all government programs regarding family planning composed of two departments: Department of Health and Family Welfare and the Department of Health Research.
b) Directorate General of Health Services: To provides technical advice to the union government on healthcare, medical education, and public health issues
c) Central Council of Health: To provide continuous guidance, maintain mutual understanding, and cooperation between the center and the states on different health matters

Figure 4: Structure of Healthcare System in India



Source: Compiled by the Author

Similarly, state-level health management comprises two organizations; the State Ministry of Health, headed by a minister at the state level, and the State Health Directorate, responsible for the technical advisories to the ministry on medicine and public health issues. The healthcare infrastructure in India consists of primary, secondary, and tertiary health care, provided by both public and private health care providers at each of these levels. In the public health system, there are community health centers (CHCs), Primary health centers (PHCs), and sub centers (SCs) at the primary level of health care. While for the secondary level of healthcare, there are sub-district hospitals, the tertiary level of health care includes the regional or central level institutions like the district

hospitals and medical colleges. In parallel to this, a strong private healthcare infrastructure also exists throughout the country to deliver all three levels of healthcare (Fig. 4).

As of March 2019, there are 152,794 SCs, 20,069 PHCs, and 5,685 CHCs in India covering both rural and urban areas. Available data shows not only that the infrastructure is insufficient for the present as per the target consumer but their shortage as well (Table 1) in both urban and rural areas. There is a shortfall in Sub-Centre (20%), Primary Health Centre (22%), and Community Health Centre (30%) with respect to the estimated requirements. Even the NFHS-4 reveals, when household members get sick, they are somewhat more likely to seek care in the private sector (51%) than the public sector (45%). More than half (55%) of households in India do not generally seek health care from the public sector for reasons like poor quality of care (48%), no government facility nearby (45%), and long waiting time at government facilities (41%). Even the state of human resources in the sector is not any better than the infrastructure. The availability of all kinds of personnel is very low compared to the large population (Table 2 & 3). Rural Health Statistics (GoI) reveals that there is still a substantial shortage of trained manpower in the health sector to deliver the various services in an efficient manner. Comparison between rural and urban has showed that 80 percent of the doctors are in the urban area serving on 28 percent of the total population (KPMG, 2016), showing a high shortage specifically in rural regions.

Table 1: Shortfall in Health-Care Infrastructure as per estimation of midyear population (As on 1st July 2019)

		Required	In Position	Shortfall	Shortfall (%)
Rural Areas	Sub Centre	189765	157411	43736	23
	Primary Health Centre	31074	24855	8764	28
	Community Health Centre	7756	5335	2865	37
Urban Areas	Primary Health Centre	9072	5190	4026	44.4

Source: Rural Health Statistics (GoI) 2019

Table 2: Shortfall in Human Resources in Rural Areas (as of March, 2019)

	Required	In Position	Vacant	Shortfall
Health Worker (Female)/ANM at SCs	157411	205228	13909	4424
Health Worker (Male) at SCs	157411	59348	29421	98063
Health Worker (Female)/ANM at PHCs	24855	28992	5478	6492
Health Assistants [Female] / LHV at PHCs	24855	13786	7442	11906
Health Assistant [Male] at PHCs	24855	13446	10839	14865
Doctors at PHCs	24855	29799	7715	1484

AYUSH Doctors at PHCs	24855	13347	1807	-
AYUSH Doctors at CHCs	5335	3197	1089	2154
Dental Surgeon at PHCs	24855	1037	220	-
Dental Surgeon at CHCs	10670	1920	509	8456
Surgeons at CHCs in Rural Areas	5335	768	2572	4567
Obstetricians & Gynecologists at CHCs	5335	1351	2135	4002
Physicians at CHCs	5335	683	2190	4652
Pediatricians at CHCs	5335	1079	2255	4265
Total Specialists [Surgeons, OB&GY, Physicians & Pediatricians] at CHCs	21340	3881	9147	17459
General Duty Medical Officers (GDMOs) - Allopathic at CHCs	10670	15395	3747	1078
Radiographers at CHCs	5335	2419	1548	3148
Pharmacists at PHCs	24855	18975	3318	7220
Pharmacists at CHCs	5335	7229	1273	361
Laboratory Technicians at PHCs	24855	12462	3929	12638
Laboratory Technicians at CHCs	5335	6253	1160	605
Nursing Staff at PHCs	24855	30071	6126	5800
Nursing Staff at CHCs	37345	50905	7336	3978
ASHA (Accredited Social Health Activist)	895718	929893	-	-
Doctors at District Hospital	28545	24676	-	-
Doctors at Sub District/ Sub Divisional Hospital	22891	13750	-	-
Para Medical Staff at District Hospital	90969	85194	-	-
Para Medical Staff at Sub District/ Sub Divisional Hospital	52526	36909	-	-

Source: Rural Health Statistics (GoI) 2019

Table 3: Shortfall in Human Resources in Urban Areas (as of March, 2019)

	Required	In Position	Vacant	Shortfall
Health Worker (Female)/ANM at PHCs	25950	16820	2891	11498
Doctors at PHCs	5190	4457	954	867
Total Specialists [Surgeons, OB&GY, Physicians & Pediatricians] at CHCs	1400	1017	502	641
General Duty Medical Officers (GDMOs) - Allopathic at CHCs	700	713	243	172
Radiographers at CHCs	350	192	73	168
Pharmacists at PHCs	5190	3549	849	1260
Pharmacists at CHCs	350	468	62	56
Laboratory Technicians at PHCs	5190	1933	731	2642
Laboratory Technicians at CHCs	350	447	64	47
Nursing Staff at PHCs	5190	5938	1464	1154
Nursing Staff at CHCs	2450	4618	887	523

Source: Rural Health Statistics (GoI) 2019

Although health insurance is the globally accepted best alternative for financing healthcare, the role of health insurance is limited to a great extent within the Indian health system. IRDA reports show that only 33.04% of the population (i.e., 4375 lakh people) has health insurance scheme enrolment. The remaining 66.9% still exposed to the threat

of health risk. The National Family Health Survey 2015-16 (NFHS-4) reveals that across the country, only 29 percent of households have at least one usual member covered by health insurance or a health scheme (International Institute for Population Sciences and ICF, 2017). This number has increased by only 15 percent (approx.) in 10 years between NFHS-3 and NFHS-4. There have been several policy initiatives by the government to improve the delivery of affordable and good quality care to the people of the country. In 2005, the government of India initiated the National Rural Health Mission aiming to establish a fully functional, community-based healthcare delivery system for addressing the needs of the underserved rural areas, with specific emphasis on the Empowered Action Group (EAG) States as well as the North Eastern States. In 2009, *Rashtriya Swasthya Bima Yojana*, a national health insurance scheme, was initiated for people living below the poverty line with 75 percent financing from central and state funding of 25 percent. In the year 2012, the Cabinet approved the National Urban Health Mission (NUHM) to address the healthcare need of the urban population, especially the urban poor, by availing quality healthcare and reducing out-of-pocket expenses. In the year 2013, the Ministry merged both NRHM, NUHM under the banner of the National Health Mission (NHM). The aims of NHM include health system strengthening, improving the situation of communicable, non-communicable diseases, and improving reproductive, maternal, neonatal, child, and adolescent health.

Apart from this, since 1983, the central government periodically has been developing the National Health Policy (NHP) to define and redefine the future vision of the Indian health sector, to establish priorities, set short and long-term goals to deliver on its commitments. The first NHP got approved in the year 1953, updated again in 2002, and finally revised in 2017. The Ministry developed the NHP given the national commitments to achieve "health for all" by 2000. The basis for NHP 2002 was the MDGs, and, based on its progress, the health Ministry formulated the latest NHP 2017. The policy aims to acknowledge the pivotal importance of SDGs goals in the health sector.

Several government legislations emphasizing improving health situations in the country include the Water Act (1974) for prevention and control of pollution, the Cigarettes Regulation (Of Production, Supply, and Distribution) Act (1975), the Prevention of Food Adulteration (Amendment) Act (1976), and the Air (Prevention and Control of Pollution) Act (1981). Policy initiatives include the National Health Policy

(1983), National Nutritional Policy (1993), National Population Policy (2000), National Health Policy (2002), National AIDS Policy (2002), and National Urban Sanitation Policy (2008). Other government-initiated health programs include the introduction of multipurpose community health workers in 1973, elimination of smallpox in 1975, Integrated Child Development Services (1975), universal salt iodization (USI) efforts launched in 1992; Revised National Tuberculosis program with DOTS (1993), National Vector Borne Diseases Control Programme (2003), Integrated Diseases Surveillance Project (2004), NCD programme (2007), and many more.

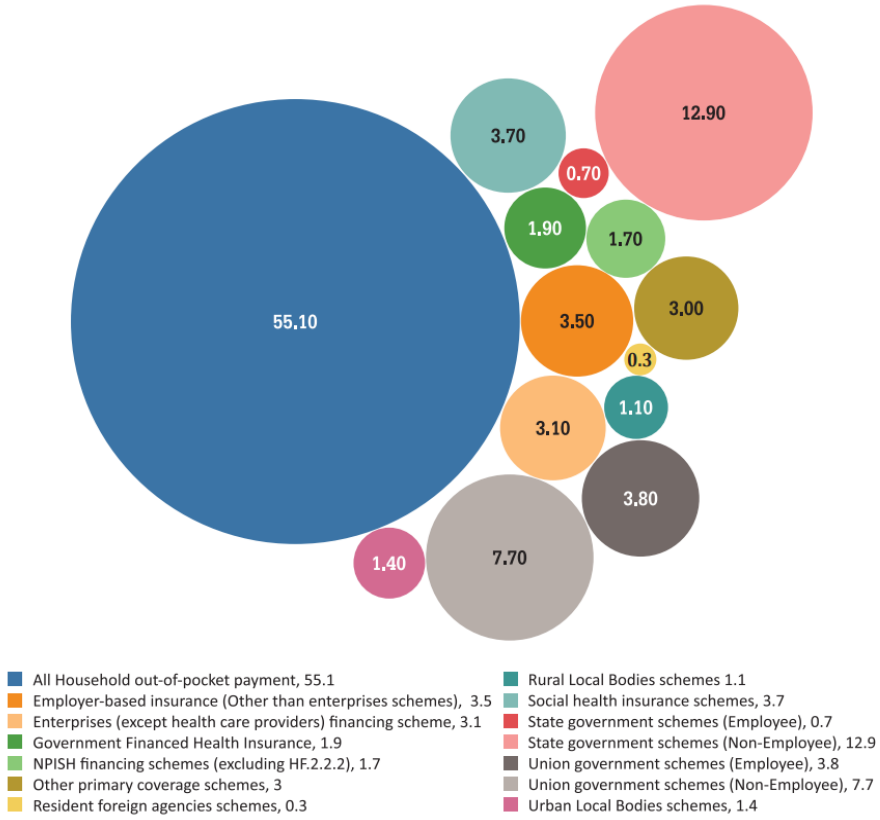
The *Ayushman Bharat (AB)* scheme, a result of the NHP 2017, is the latest addition to the government-funded policies, in the path towards achieving UHC in India. The AB scheme, launched in 2018, has two components: Health and Wellness Centers (HWCs) and Prime Minister's Health Protection Scheme/*Pradhan Mantri Jan Arogya Yojana* (PMJAY). Under this scheme, the government aims to set up 150,000 Health and Wellness Centers (HWCs) by 2022 for delivering universal and free Comprehensive Primary Health Care (CPHC) to all users, and around 21,000 are already operational. The CPHC covers preventive, promotive, curative, rehabilitative, and palliative care. On the other hand, the PMJAY scheme offers financial protection (cashless at the point of care and portable) to 500 million people for secondary and tertiary care, through joint financing by center and state at a ratio of 60:40.

Table 4: Key health financing indicators for India across NHA rounds

Sl. No.	Indicator	NHA 2004-05	NHA 2013-14	NHA 2014-15	NHA 2015-16	NHA 2016-17	NHA 2016-17
1	Total Health Expenditure (THE) as percent of GDP	4.2	4	3.9	3.8	3.8	3.31
2	Total Health Expenditure (THE) Per capita (Rs.) at current price	1201	3638	3826	4116	4381	4297
3	Current Health Expenditures as percent of THE	98.9	93	93.4	93.7	92.8	88.5
4	Government Health Expenditure (GHE) percent of THE	22.5	28.6	29	30.6	32.4	40.8
5	Out of Pocket Expenditures (OOPE) as percent of THE	69.4	64.2	62.6	60.6	58.7	48.8
6	Social Security Expenditure on health as percent of THE	4.2	6	5.7	6.3	7.3	10.1
7	Private Health Insurance Expenditures as percent of THE	1.6	3.4	3.7	4.2	4.7	6.6

Source: Compiled by the Author

Figure 5: Current Health Expenditures (2017-18) by Financing Schemes 0(%)



Source: National Health Accounts Estimates for India 2016-17

Healthcare is one of the largest sectors of the country, which is likely to grow triple folds by 2022 to Rs. 8.6 trillion. But the country's health spending as per its economic advancement has not been up to the mark. The NHA rounds for India reveals that over time, the total health expenditures for the country have declined relative to India's growing GDP. But, in response to the rapid epidemiological and demographic transition, the per capita expenses on healthcare have increased by multi-folds. The current expenditures on healthcare purposes cover the majority of THE. There has been a nominal increment in government spending on healthcare, but it yet far from sufficient as the majority of the health expenses are still drawn out of people's own pockets. In India, several central and state-level policy interventions available solely focus on reducing the gap in healthcare financing, yet, the government health spending is merely 1.18 percent of the GDP ((National Health Systems Resource Centre, 2019). In India, most of the public funding for healthcare is usually from the state government budgets (about 80 percent), and the remaining comes from the Union government (12 percent) and local governments (8 percent). On the other hand, in the case of private financing, OOPE is responsible for

the lion's share, while insurance contributions form a rather small proportion, irrespective of the scheme type (Fig. 5).

Table 5: Country-wise Comparable Estimates of SDG 3 Indicators[9]

		Life expectancy at birth	Healthy Life Expectancy at birth	Maternal Mortality Ratio	Under 5 Mortality Rate	Neonatal Mortality Rate	New HIV Infections	TB Incidence	Malaria Incidence	Hepatitis B Prevalence	Probability of dying from major NCDs	UHC services coverage index
		2016	2016	2017	2018	2018	2018	2018	2018	2015	2016	2017
India		**68.8**	**59.3**	**145**	**37**	**23**	**-**	**199**	**5.3**	**0.51**	**23.3**	**55**
BRICS Countries	Brazil	75.1	66.0	60	14	8	-	45	5.1	0.07	16.6	79
	Russia	72.0	63.5	17	7	3	-	54	-	0.88	25.4	75
	China	76.4	68.7	29	9	4	-	61	0.0	0.93	17.0	79
	South Africa	63.6	55.7	119	34	11	4.94	520	1.7	1.74	26.2	69
Neighboring Countries	Bangladesh	72.7	63.3	173	30	17	0.01	221	0.7	1.38	21.6	45
	Nepal	70.2	61.3	186	32	20	0.03	151	0.4	0.31	21.8	48
	Sri-Lanka	75.3	66.8	36	7	4	0.01	64	-	0.64	17.4	66
	Myanmar	66.8	58.4	250	46	23	0.20	338	3.4	2.03	24.2	61
	Pakistan	66.5	57.7	140	59	42	0.11	265	3.4	2.75	24.7	45
	Bhutan	70.6	60.7	183	30	16	0.11	149	<0.1	0.81	23.3	62
Developed Countries	United States	78.6	68.5	19	7	4	-	3.0	-	0.04	14.6	84
	Germany	80.9	71.6	7	4	2	0.03	7.3	-	0.24	12.1	83
	Japan	84.2	74.8	5	2	1	0.01	14	-	1.95	8.4	83
	France	82.9	73.4	8	4	3	0.09	8.9	-	0.01	10.6	78
	United Kingdom	81.4	71.9	7	4	3	-	8.0	-	0.22	10.9	87
Global		**72.0**	**63.3**	**211**	**39**	**18**	**0.24**	**132**	**57.4**	**0.80**	**18.3**	**66**

Source: World Bank Data Bank[10]

In the last few decades, India has emerged as one of the fastest-growing economies in the world. In comparison to that, from the global viewpoint, the Indian health system is still lagging on several aspects, compared to the rest of the BRICS and other developed and developing countries. The World Health Statistics 2020 Report shows that the values of most of the SDG related health indicators for India somewhat better or similar to the overall global averages (WHO, 2019). But when compared with the health indicators for the different developed countries from around the world, it has been observed that a vast difference in health outcome scenarios (Table 5). Even among

[9] In Table 5, the "-" stands for missing values

[10] https://data.worldbank.org/ .

the BRICS countries, India's performance is the worst, in terms of most of these indicators. The UHC service coverage Index for India is the lowest among the BRICS, as well as the other considered developed countries. The comparison of India's indicator values with its neighboring countries reveals a mixed outcome. India stands somewhere in the middle of these countries based on its performance on different dimensions of SDG. India has been able to outperform Pakistan, Bangladesh, and Nepal in terms of service coverage, while Sri-Lanka, Myanmar, and Bhutan are still far ahead of India in this aspect. There is no doubt that India has been making incremental improvements in the different aspects of health over the last few decades. But the comparison of the country's progress with the rest of the world confirms that the pace at which India is moving forward is not fast enough to achieve the SDGs within the stipulated timeframe.

Table 6: Country-wise comparison of SGD Indicators on financing[11]

		Incidence of Catastrophic Health Expenses		Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)
		Population with household expenditures on health >10% of total household expenditure or income (%)	Population with household expenditures on health >25% of total household expenditure or income (%)	
		2010-2018	2010-2018	2017
India		**17.3**	**3.9**	**3.4**
BRICS Countries	Brazil	-	-	10.3
	Russia	4.9	0.6	8.8
	China	19.7	5.4	9.1
	South Africa	1.4	0.1	13.3
Neighboring Countries	Bangladesh	24.7	9.5	3.0
	Nepal	10.7	2.4	4.5
	Sri-Lanka	5.4	0.9	8.5
	Myanmar	14.4	2.8	3.5
	Pakistan	4.5	0.5	4.3
	Bhutan	1.8	0.4	7.9
Developed Countries	United States	4.8	0.8	22.5
	Germany	1.7	0.1	19.1
	Japan	4.4	0.6	23.6
	France	1.4	0.2	15.5
	United Kingdom	1.6	0.5	18.7
Global		**12.7**	**2.9**	**10.2**

Source: World Bank Data Bank[12]

[11] In Table 6, the "-" stands for missing values

[12] https://data.worldbank.org/ .

Financing plays an influential role in elevating the health sector outcomes, and the data from Table 6 also validated this fact. It is evident from this information that the high government spending for healthcare purposes can yield better results like improvements in health conditions, reduced incidence of diseases (communicable, non-communicable), and extended financial protection. The developed and the BRICS countries have invested a significantly large amount of money for healthcare purposes, compared to India and its neighboring countries, and it has been observed that these investments contributed to the noticeable improvements in the health status of their population. Interestingly, India's government spending in the health sector is the least of its neighboring countries, as well as the global average. All types of countries, under-developed, developing, and developed, can witness financial hardship due to healthcare costs, but it the extent of such incidences that matters the most. With the least government spending in the sector, like its neighboring countries, India has also suffered from a severe rate of financial hazard from healthcare over the years.

1.3.3. The Issues:

For a country as diverse as India, developing and implementing health programs to fulfill the different needs of its population is quite challenging. The extensive socioeconomic setting calls for a flexible healthcare system. In the past decades, India has miserably failed in keeping up the health sector's progress with the country's economic advancements. India has been facing several challenges in its journey towards UHC and SDGs (NITI Aayog, 2019), such as:

(a) Healthcare Access: Aday and Andersen (1974) have defined access as entry into the healthcare system. It is all about enabling a patient in need to receive the proper care, from the right provider, at the right time, in the right place. Healthcare access stands for affordability, physical accessibility, and acceptability or quality of services (Gulliford, et al., 2002). The country's public health system has been struggling with issues like inefficient and shortage of well-equipped infrastructure and the lack of trained, efficient workforce for a very long time. Moreover, India's miserable rank of 145th among 195 countries in healthcare access and quality (HAQ Index) further substantiates the poor quality of Indian healthcare services (GBD 2016 Healthcare Access and Quality Collaborators, 2018).

(b) Affordability: Affordability is another prime issue for the country, with the prevalence of high out-of-pocket expenses and low financial protection. Due to the

insufficient spending on health by the government, the people have to bear most of the financial burden of healthcare. Although the public sector is availing healthcare services at a nominal rate, the country's private sector is still highly dominant. Despite the high cost of treatment, according to the people, healthcare in private facilities is more reliable in terms of quality of care than in public facilities, preferred by the majority, thus further surging the financial burden for the people.

(c) High OOP Health Expenses: With low levels of risk pooling and passive purchasing, healthcare financing in India is highly fragmented. The Governments spending on healthcare has been almost stagnant for a very long time. As per National Health Accounts 2016-17 (2019), combining both current and capital expenses, the total per capita spending on healthcare is Rs 4381. Here, the per capita government spending, including the capital expenditures, is Rs 1418 only, while households' OOP spending is almost double (Rs 2570 per capita). On the other hand, the households contribute about 68.1% (including insurance contributions) to the current expenditures, and OOPE is around 63.2%. Thus, most people have to pay out of their own pockets for the various healthcare services, and if their earnings are not enough, they mostly resort to formal and informal borrowings. Medical debt has been a major cause of poverty in India. As per a study by the Public Health Foundation of India, about 55 million Indians plunged into poverty in a single year due to patient- care costs (Selvaraj, Farooqui, & Karan, 2018). Prolonged underfunding of public sector health facilities and the rapid growth of private sector providers are prime causes of the rise in OOP health care costs for the past decades. (Selvaraj, Karan, Srivastava, Bhan, & Mukhopadhyay, 2022).

(d) Financial Security: Data shows that households having at least one member with health insurance rose sharply from 7.8% in January 2014 to 27.8% in January 2020 and again fell back to 24 percent in May 2020 and 21 percent in September 2020 (Agrawal, Ravi, & Sharma, 2021). Despite the rising trend, the country's health insurance uptake is still very low; only one out of five households have at least one member with health insurance enrolment. Presently, the share of government health insurance expenditure on current health expenditures is only 4.5%, and that of private health insurance is 4.7% only (National Health Systems Resource Centre, 2019) . It indicates that the financial burden is too high on the people, and at the same time, the financial protection scenario is too weak for them.

(e) Distress financing: distress financing is defined as a situation when a household is not able to pay for their OOP health expenses with their income/ savings, and they resort to alternatives such as borrowing, sale of assets, contribution from friends/relatives, etc., which have long term financial consequences (Dasgupta & Mukherjee, 2021). Due to high healthcare expenses, people have to may majority of their medical expenses out of their own pockets. Around 63 percent of the total health expenditure of the country is OOP health spendings only, and Indian households predominantly rely on their incomes or savings to pay for their OOP health expenses. But it has been found that often when situations are tough, they resort to other distressing measures (Joe, 2015; Kumar, Singh, James, McDougal, & Raj, 2020, Dilip & Duggal, 2002). In absence proper financial protection, such distress financing for OOP expenses is a matter of concern for developing countries like India, as such measures further threatens the financial security of the households at various levels.

(f) Regional Disparity: The "Healthy States Progressive India" report (NITI Aayog, 2019) revealed a vast level of disparities in overall performance in health exists across the states and UTs. According to the report, the difference in the estimated overall health index score between the best-performing state and the worst-performing state is more than two and a half times. This Health Index is a composite score incorporating 23 indicators covering three primary aspects of health sector performance: health outcomes, key input/processes, and governance and information. States and UTs are progressing at different paces towards the SDG 3 goals. Moreover, in the last few decades, the country's disease patterns have gradually shifted, and now non-communicable diseases (NCDs) and injuries contribute the highest to the overall disease burden (Indian Council of Medical Research, Public Health Foundation of India and Institute for Health Metrics and Evaluation, 2017). Despite that, many states are still struggling with the burden of communicable, maternal, neonatal, and nutritional diseases.

(g) Lack of Awareness: A large segment of the Indian population is still in the dark about several aspects of health and healthcare system and this lack of awareness has been hindering the country's health system from delivering its best. There is still a considerable gap detected in the peoples' understanding in the areas of child and adolescent health; food and nutrition; lifestyle aspects; geriatric morbidity and care; mental health; and complete knowledge of the various services availed by the governments. Diverse causes, like lack of focus on preventive care and patient counseling in the health delivery system,

lower public priority to health concerns, and weaker links between education and health, act as a barricade in achieving the broader goals.

With high out-of-pocket health expenses and inadequate financing for the health sector, the country will continue to underperform, despite having the required potential to perform better and deliver the best. To better address the issue, one must explore it at the root level. In such cases, a thorough examination of the current situation at the regional level can provide a better understanding of the actual needs and gaps in the entire system of financing. And that, in turn, can further help in setting the course of action for rectifying the issues.

1.4. Organization of the Study:

The issues discussed in the previous section (Section 1.3 c), one way or another, are responsible for the high OOP health expenses prevailing in the country. The issue of high OOP spending calls for dissecting every aspect associated with it. The study has been carried out to deliver detailed insights on the matter from the demand side. The entire work of the study has been documented in seven chapters. The illustration for each of these chapters are as follows:

(a) Chapter 1 – Introduction: This chapter provides the theoretical framework for UHC, the health system, and healthcare financing. It also provides a review of the Indian health system.

(b) Chapter 2 – Literature Review: This chapter contains the summary of the the current status of research in the area and the key findings, including both national and international work. The overview established the relevance and gap in the existing knowledge base and provided a rationale for the study.

(c) Chapter 3 - Research Methodology: This chapter illustrates the research methodology adopted for the study based on the identified problem statement, covering the research plan, sampling procedure, and statistical tools.

(d) Chapter 4 – Healthcare Expenditure and Financing Measures: This chapter attempted to quantify the OOP healthcare spending at the household level and identify the financing pattern adopted by the households based on the various financing measures reported.

(e) Chapter 5 – Impact of Healthcare Expenditure on Rural Households: This chapter described the repercussions of high out-of-pocket health expenses on the economic conditions at the household level.

(f) Chapter 6 – Healthcare Costs and Financial Protection: It contains the preliminary assessment of the role played by the different existing health insurance policies in delivering financial security against health risks in rural settings. It has also recorded people's outlook on a contributory health security scheme as an alternate health financing measure.

(g) Chapter 7 – Summary of Findings and Conclusion: The last chapter comprises a comprehensive summary of the findings from the study and its interpretations. It also includes some policy-specific suggestions based on these results to address the issue.

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