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Role of Private Healthcare in Universal Health Care

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1. Introduction

The spirit of 'Health for all' has been at the core of designing of India's Public Health System. Going back to 1946 and Bhore Committee's report [1] and Alma Ata Declaration, 1978 [2] formed the foundation of the first National Health Policy 1983 [3]. The Committee recommended a health system for delivering comprehensive preventive and curative allopathic services through a rural-focused multi-tier government financed system for all irrespective their ability to pay. Subsequent to that the National Health Policy (1983) emphasized the goal of comprehensive primary healthcare services relevant to the needs of the community and their priorities. We, unfortunately, not only fell too short of achieving the goals but were unable to mobilize enough public funds to meet the needs. Investment in Health System stayed lower than 1% of GDP for a long time and in 2005 with National Rural Health Mission commissioning an increase to 1.4% was envisaged. Several environmental factors changed after 1990s with privatization, liberalization, and globalization. Private sector participation in medical-- nursing-paramedical education and hospitals grew very rapidly in the last three decades. Parallelly the Public Health System suffered from chronic under financing, low level of regulation, almost absent political prioritization and continued focus on disease specific programmes further pushed the communities to access private healthcare which boomed.

The progress on several morbidity and mortality indicators improved but we were not able to realize the goals of 'Health for all by 2000'. The government's resources and capacity to meet the growing healthcare needs were not sufficient. National Health Policy 2002 welcomed the participation of the private sector in all areas of health activities – primary, secondary and tertiary healthcare services but recommended a regulatory and accreditation for clinical practice. This opened new avenues to bring in private participation through social insurance and PPP models.

Push for India's healthcare achievements further got integrated with Millennium Development Goals and our own planning cycles (12th Plan 2012-2017). We did make fair to good progress on the eight Millennium Development Goals (MDGs) but to need to meet newer benchmarks. For e. g. the latest Sample Registration System (SRS) data indicating the Maternal Mortality Ratio (MMR – number of maternal deaths per 1, 00, 000 live births) has dropped from 167 to 130 (from 2011-13 period to 2014-16). Regional and state wise results vary and the fact remains that the rate of reduction even best performing states like Kerala and Tamil Nadu is slow [4]. 12th Plan sought to make provision of safe and healthy environment to communities, universal access to basic health services, medicines and regularly evaluating the health system. Use of communication, behavior change and participatory governance were recommended to make people more health conscious [5]

Universal Health Coverage:

The impetus for all countries to consolidate the public health advances and health system reforms came from identifying the 'Universal Health Coverage' at the 65thWorld Health Assembly held at Geneva. In October 2010, India's Planning Commission constituted the 'High Level Expert Group (HLEG) which submitted a report on UHC in November 2011 [6]. The three dimensions framework forms the basis for all nations to work towards UHC (Figure 1). India can learn from many neighbouring countries such as China, South Korea and Thailand to gear up for UHC [7] A critical analysis of India's ground reality regarding health financing, health infrastructure, health services norms, skilled resources, access to medicines and vaccines, management and institutional reforms, and community participation has led some to question if UHC for India by 2022 is 'Utopian' [8]. A strong political commitment to health as a social goal, upholding strong values of equity, political participation and community involvement go a long way in ensuring health for all. India has to garner strong political will to recognize UHC as a social, political goal and a basic human right [9].

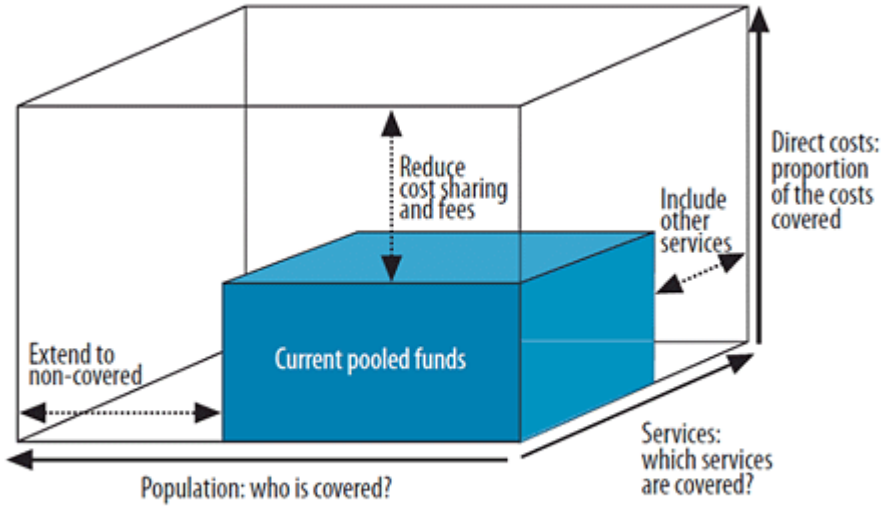


Figure 1: Three dimensions to consider when moving towards Universal Coverage

Karnataka State defined UHC at the time of announcing Arogya Karnataka [10] in 2017 to be implemented soon as "UHC is a scheme where everyone is covered for basic healthcare services regardless of their economic, social or cultural background. They will be entitled to affordable and quality services which will be paid for by the government through taxes and increased spending on public health. The system will be 'cashless' where patients will not be required to pay user fees for the services"

Universal Health Coverage (UHC)

Ensuring that "All people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship." This definition of UHC embodies three related objectives:

• **Equity in access to health services:** Those who need the services should receive them; services should not be available only to those who can pay for them.

• **Quality of health services:** Health services should be good enough to improve the health of those who receive services.

• **Financial risk protection:** The costs of health services should not put people at risk of financial hardship (WHO 2010).

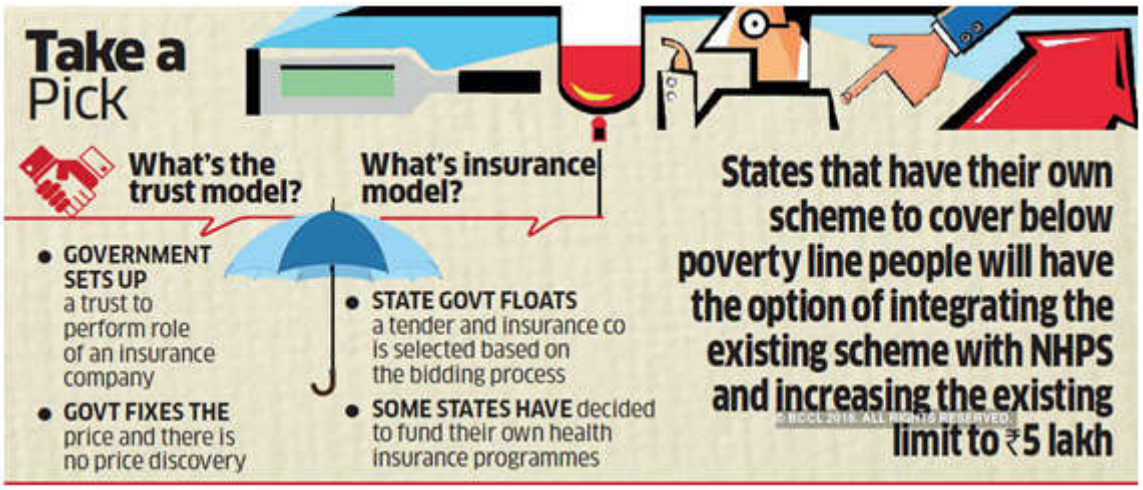
Reference: "Health Systems Financing: the path to universal coverage" World Health Report, 2010. Available at www.who.int

The International Finance Corporation (IFC) details five domains through which the private and public health sectors engage:

1) Policy and dialogue and the degree to which the private sector is included in discussions regarding health sector policies and practice;
2) Information and data exchange;
3) Regulation;
4) Financing, which includes funding and purchasing; and
5) Public provision of services.
(IFC 2011)

GoI has tried to engage with various stakeholders (though limited with private partners) in order to arrive at Ayushman Bharat. Engagement between public and private health sectors involves "deliberate, systematic collaboration of the government and the private health sector according to national health priorities, beyond individual interventions and programs. " (IFC 2011)

Government of India is now ready to roll out Ayushman Bharath in ten states and the following model is adopted [11] with the following features:



Healthcare financing in India: A quick reckoner

- Total Health Expenditure is 4% of GDP
- In 2016-2017 Public Health Expenditure is 1.4% of GDP
- This year Ministry of Health, GoI allocated Rs. 54, 600 Crores
- National Health Mission received Rs. 30, 130 Crores
- National Health Protection Scheme (NHPS) Rs 5 lakh per family per year will be provided for secondary and tertiary care hospitalization. It will cover over 10 crore poor and vulnerable families.
- NHPS will be partially delivered through nearly 1.5 lakh health and wellness centers that will provide comprehensive healthcare.
- Center –State contribution is that of 60:40 for the programme

"India has made several attempts to achieve UHC," says Dr P M Bhujang, President, Association of Hospitals. "In 2000, government came up with scheme called *Health for All*, which did not succeed and challenges remained. Many other schemes like ESIS, CGHS, RSBY, RGJAY or Mahatma Phule Yojana, though announced with good intention, did not meet their objectives, because of insufficient funding and type of illnesses to be treated were restricted. Recently, in 2018 Financial Budget, a new scheme AB-NHPM was announced to provide cover to 10 crore vulnerable families. The scheme is laudatory because of its intentions but raises a lot of questions on its future viability, like insurance companies agreeing to provide coverage of 5 lakhs per family at a premium so low, covering pre-existing diseases which is against the very basis of insurance, whether the hospitals will agree to treat patients at rates proposed by the scheme which is less than market rates, whether States would agree to participate, and fates of expensive treatment like chemotherapy, organ transplant, etc." [12] The consequences of the scheme can only be anticipated, however, learning from its own experience and that of others and constantly working towards improvement is the unassailable recipe of success.

The following section briefly discusses the structural challenges of India's health system as the country prepares itself to achieve UHC.

Structural Challenges of India's Health System:

Growth on the health sector front in India is at best a mixed bag. Even as India continues to struggle on many indicators on morbidity, mortality and malnutrition, the health sector is rapidly growing. We carry a disproportionate burden of the world's illnesses, the country accounts for 20% of the global burden of diseases with 17.5% world's population [13]. Over the 25 years, India's population increased by 450 million by 2016. Even though proportion of people living poverty has fallen by half, 'dual disease burden' marked by continuous rise in communicable diseases and spurt of non-communicable 'life style' diseases have rendered the system ineffective to meet the demands. Experience and evidence from countries across the world clearly shows that those with a strong Primary Healthcare System have better health outcomes, lower inequities of access/outcomes and lower costs of care.

Status of Primary Health Centers in India is well documented.15, 700 out of 25, 650 PHCs (61.2%) function with one doctor each and 1974 (7.69%) do not have even a single doctor.35.8% do not have a lab technician and 18.4% do not have a pharmacist [14]. PHCs cover a larger population size than that of global standard of 2000-3000 people. KPMG report estimated that 74% of the doctors provide services to a third of the urban population. Many states face the challenges of filling vacancies in the 'specialty care' in the public health where as private hospitals have excess capacities in urban areas. From Gujarat to West Bengal, the shortfall of specialists exceeds 80%. Recent attempt by Karnataka State to fill specialist vacancies by on-line bid system is a case in point.

Government initiatives in 'Public Health Cadre' with National Health Policy 2017 calling for multi-dimensional mainstreaming of AYUSH doctors and capacity building of non-MBBS like nurses and rural medical assistants to create mid-level service provider cadre would be a positive way forward for meeting the man-power needs of Primary Health Care. On the specialist side, plans to start DNB (Diplomate National Board) courses in district and municipality hospitals across the country are a welcome move.

Private Providers' Interests:

- Maintain and increase, and expand business
- Gain more favorable financing
- Achieve high quality of Professional Life
- Increase knowledge and skills.
- Even though they are much accused of commercial interests alone, no one should ignore the fact that many are interested to ensure that their patients get well.

On the health financing side, Indian public health stands highly disadvantaged. Government contributes about 29% of total health spend and world average healthcare outlay at 5.99% compared to India's a little over 1% of GDP. We have one of the lowest per capita health expenditure in the world. Our Government contributes to roughly 32 percent for insurance while UK spends 83.5 per cent [15].

Variable quality levels as well as unreliable services, low spend and several other challenges faced by public health has pushed people to rely increasingly on private sector for healthcare services.

Recent Developments in Our Health System:

Formation of NHM (merging NRHM and NUHM), National Health Policy-2017, Health Insurance/Finance related reforms, focus on NCDs and finally, India's commitment to Sustainable Development Goals and the recent National Health Protection Scheme (NHPS) have laying newer paths to achieving UHC. Ayushman Bharat Yojana/Programme [16] launched two major initiatives: 1. Establishment of Health& Wellness Center and 2. National Protection Scheme (See Box: Healthcare Financing in India – A Quick Reckoner).

The Lancet Commissions study 'Global health 2035: a world converging within a generation' based on an in-depth analysis of predicts a possibility of dramatic achievements in global health by 2035. Grand convergence around infectious diseases and RMNCH with major reductions in incidence and consequences of NCDs and injuries in a scenario of promising UHC would result such dramatic improvements in our life time [17]

Private health sector:

The private health sector is generally defined as all non-state providers, including for profit and not-for-profit entities. These include: hospitals, doctors, pharmacies, traditional healers, faith-based organizations, private health insurance mechanisms (including community-based and employer-sponsored voluntary insurance), as well as corporate philanthropic organizations created by the private sector for social responsibility (Harding 2009; IFC 2011)

Role of Private Partners:

The structural challenges to public health system (discussed above) and a number of driving factors (NHP 2002, NHP 2017 & others) and has made it clear that the role of private health sector cannot be ignored. Limited public healthcare facilities and poor service quality (often referred to as 'perceived quality levels' in public health circles) has led people to depend on private healthcare highly. Private sector includes a wide variety of partners. [18, 19] Since 2005, private sector has added most of the capacity in healthcare with nearly 58% of the hospitals and 29% of beds in hospitals and 81% of doctors [20]. At present, nearly 74% of the hospital beds are in the private sector.

A discussion convened by Save the Children and GSK as part of the first UN High Level Political Forum on Sustainable Development Goals held on 13th July 2016 clearly gave a message that '…. A mixed system can be highly effective; national governments must lead the way in providing a basic package of publicly funded healthcare services which can be supplemented and complemented by a well-monitored and incentivized private sector. The starting point for any government must first be to understand the balance within its own health system and then to use the understanding that exists from all healthcare stakeholders, public and private, to plan for the future. '

In 1986, the hospital sector was recognized as an industry, which enabled hospitals to raise capital from public financial institutions. In addition, customs duties on high-technology medical equipment were reduced. All these helped medical providers to expand as well as provide better quality of care. With liberalization, the participation of the civil society, namely, Non-governmental Organizations (not-for-profit) and other hospitals (including teaching hospitals) increased. Subcontracting of public health centers to NGOs and creation of innovative private initiatives came into existence.

Around 2005, opening up of health insurance sector to private providers, FDI in health insurance and hospital sector further gave impetus to growth of the private players. Successful PPP models emerged:

- Rashtriya Swasthya Bima Yojana (launched in 2008) enhanced coverage to BPL families;
- In Maharashtra a viable model between Municipal Corporation of Greater Mumbai (entrusted with services and infrastructure), the community (problem identification and monitoring the project), ICICI Center for Child Health and Nutrition (funding), the Center for International Health and Development (input design, evaluation and dissemination) and SNEHA (implementation and montoring).
- In Karnataka, PPP model for management of Primary Health Centers by Karuna Trust and other medical colleges with a 'contracting' model was found quite useful. This model is being replicated in other states also subsequently. The state of Karnataka reconsidered its decision in primary healthcare services (Arogyabandhu Scheme) but many other PPP models exist.
- 108 Emergency Services initiated in Hyderabad for the first time in the country around 2005 became one of the most successful PPP models in emergency and ambulance services. Almost all states have been implementing it and the model appears to have reached a maturity level making replication across various regions of the nation much easier.
- Diagnostic services 'contracting in' models as well as 'contracting out' have been quite successful. Availability

of trained clinicians and diagnostic equipment infrastructure in the private sector have added value to patient care.

2. Challenges to Overcome

The debates on various issues should be considered in the UHC context and role of private providers:

- **Price Regulation in Healthcare** – ***Access vs Affordability:*** The rising costs of healthcare and excess charging by private sector has been a highly contentious issue. And rightly so. Recent conflicts regarding Karnataka Private Medical Establishment Amendments Act (2017) [21] and the latest policy draft for regulating private providers in Delhi [22]. No one can deny that rising healthcare costs, catastrophic healthcare events, high variance in prices in private sector, ever rising out of pocket expenses and poverty levels are a major challenge to UHC. At the same time, a large population continues to be denied access due to poor availability of hospitalization, specialists and drugs. Therefore, access and coverage have to be guaranteed first.

  Even if the pricing regulation is justified, the costing of healthcare services is very unclear and hence the basis of price caps would be far from reality. Some healthcare professionals argue that price regulations are often driven by bureaucrats and hence not balanced. Chennai based Cardiologist Dr. Mathew Samuel Kalarickal says that the current price policies on stents would restrict the new developments to come to India. Manufacturing companies would gradually phase out top-of-the-line stents due to the price restrictions. Further, such price restrictions do not always necessarily bring down the overall package prices drastically down. Price lists of procedures (rates proposed under Ayushman Bharat) appears to be much lower and impact the operations of hospitals in smaller towns where providers cater to mostly low income groups. In cities, large players and chain of hospitals could rationalize costs vs prices (higher income groups charging could cover for losses incurred by serving low income groups under the schemes) and may not come under huge losses. Also, all secondary care is to be taken up by public hospitals and again in small towns, the private providers in the segment take the hit. Strategic purchase of services from Tier 2 and Tier 3 cities (rural/semi-urban areas) and pricing is a very critical area to be addressed.

- **Financial Protection**-Health insurance penetration stands close to 25% in general (including all central, state government, private and social insurance schemes). Therefore, India has one of the highest out-of-pocket expenses of nearly 61%. Comparing this with other countries, for e. g. China has 34% and 11% in US. An example of Government scheme is that of how Rajiv Arogya Shree scheme improved the poor's access to in-patient care, but efficiency and investing money into tertiary care alone is not sufficient to improve financial protection. A large part of the out-of-pocket payments come from medicines and out-patient services [23]. The present Ayushman Bharath addresses the health and wellness issues by strengthening PHCs by upgrading them as 'Health and Wellness Centers', its implementation and impact is still a long way to be seen from now. Another case in point for effective monitoring is that of PPP model in Andhra Pradesh, under the State Government Health Insurance Scheme, reports indicated a sharp increase in some medical surgeries prescribed by the private hospitals. NFHS – 4 [24] showed that health insurance coverage sharply increased reaching 28.7% households in 2014-15 compared to 4.8% ten years back. Interestingly, insurance penetration is more in rural India than urban. Data showed that 29% of households in rural areas have at least one person covered by health scheme or health insurance compared to 28.2% in urban areas. Nearly 63% of the rural and 70% of the urban population use private healthcare.

- **Quality Regulation –** Monitoring of quality among both public and private is not only highly contentious but almost negligible. Private healthcare in India is highly fragmented and bringing everyone under monitoring and scrutiny is a tall order. NABH is voluntary at this stage and has come up with very good standards for healthcare services. Implementation and accreditation is expensive in time and money terms for most small players. And external quality assurance mechanisms in itself does not guarantee an on-going quality improvements. A major shifts needs to come from the providers too in terms of strong internal quality management systems, clinical governance and good management practices.

  NABH provides a great opportunity for healthcare organizations to establish standards, procedures and improve reliability of service operations. Accreditation is most useful to all stakeholders of a hospital, benefiting patients the most. For a hospital, it stimulates continuous improvement in governance, operations, and functions (clinical and administrative). A sense of ownership and clinical excellence is instilled among staff. Accreditation is voluntary in nature and in the competitive market, hospitals are getting increasingly interested in demonstrating their quality of service delivery. Presently, nearly 600-700 hospitals are accredited which form a small percent of hospitals in India (there are about 79, 000 hospitals in private and public sector in the country). As on 2017 about 119 hospitals (out of 4000 hospitals) across Karnataka have NABH recognition.

- **Trust deficit –**In general, private sector is reluctant to work with the public sector. The following factors are related to it:

1) Distrust of government with respect to paying the private sector in a timely manner and delivering the contractual agreements.
2) Concern that government will create burdensome and unfair regulations that constrain/control private sector operations
3) Competition with the Government and
4) Belief that the government inherently distrusts the for-profit (commercial) sector's motives in the delivery of health care [25]

It is not only that trust deficit between public and private sectors exist in India, the community does not trust both.

The trust deficit among all partners in achieving UHC is not a very conducing environment for major reforms and regulations. Engaging all partners and community is very crucial to achieve 'health and wellness among people. '

PPP Model for delivering healthcare to BPL and poor families is a noble cause for a country like India. Private partners both NGOs and for-profit and have taken partnered in providing primary, secondary and tertiary care. Even though NITI Ayog's proposal to rope in private healthcare providers to diagnose and treat certain non-communicable diseases is good considering the very high prevalence of life style diseases among Indians, lack of clarity will be detrimental to its success. Some of the failures in the past indicate that the models have not attained maturity level. Unfortunately, a number of controversies have come up in the recent past such as a district hospital being contracted out to UAE Company, scrapping of Arogya Bandhu scheme, delays in reimbursements to Private Hospitals for treatments under various social insurance schemes and subsequent freezing of services by hospitals.

Major challenges in PPP [26] model is well understood which include: Trust deficit between Public and Private partners, misappropriation of funds by private partners in PHC contracts, lack of clarity in contracting/service level agreements, very low rates approved for hospitals for various procedures under schemes, hidden costs in terms of extra billing to the patients on grounds of 'additional care', inadequate monitoring and professional approach. All agencies involved have to put the interest of the poor patients as 'top priority' and develop effective mechanisms to deliver healthcare to the needy.

As discussed earlier, NHP – 2017 has given a fillip

- To serve all vulnerable populations (gender, poverty, caste, disability, social exclusion, geographic barriers)
- Inter sectoral coordination – align with Swacch Bharat (Safe water sanitation)
- Encourages Private participation and PPP

NGO Sector in health is having a growing presence. About 3 million NGOs are registered (0.7 traced out!) – National Accounts Division of Central Statistics Office, GoI with Rural-Urban distribution of 60: 40.92% Health NGOs in India (top four states – AP, Maharashtra, Rajasthan and TN). Their role in UHC is highly crucial as they have community presence in remote, underserved and rural areas. Majority of the NGOs carry out activities with Health awareness accounting most of it (75.1%), Surgical/diagnostic camps (17.5 and 22.4%), Less in Immunization and ANC/PNC (3 and 3.9%) and Blood Donation (47.1%). In 2013-14 INR 10, 091 crore health expenditure was incurred by the NGO sector amounting to 2% of total health expenditure (0.09% in GDP terms). Health NGOs take up preventive care, curative care, health system support services and implementation of newly conceived programmes by the Government. Single purpose grant received by NGOs is in the area of HIV/AIDs, TB Control, Tribal Focus, Health System Management, Dengue and Malaria, RMNCH and Disability [27].

CSR in Healthcare: Study of India's top companies for sustainability and CSR shows that the top 200 companies spend around Rs 1369 crores on healthcare and wellness. About 24% of the total spend on CSR is focused on healthcare. However, much of the spend tends to be focused on health camps and building hospitals or donating to hospitals for upkeep of facilities. Health camps tend to have a short-term orientation and are number driven. Setting up and running hospitals are often poorly targeted [28]. Companies Act 2013, Section 135 Schedule VII has suggested companies to include various activities related to poverty reduction, social/women issues, health and other social aspects. From 1st of April 2014 companies have to take up CSR reporting in their governing board and CSR department is to be formed as a parallel structure in the company.

Role of Digital Health:

The market value of Health Information Technology is pegged at USD 1 billion and expected to grow one and half times by 2020. The disruptions in the sector is driven by technology innovations including IT, biomedical research, healthcare delivery models, population health, financing of healthcare, people and provider knowledge and expectations in addition to the epidemiological spectrum. Even though the cycle times for revenues and profits are longer, nearly 300 start-ups entered the market in HIT in 2015. Health apps from monitoring personal vitals to making diagnosis easier, real time data capture, point of care devices, trackers and remote monitoring and telemedicine are making in-roads to improving patient care. mHealth apps, appointment booking, wearables, telemedicine, data analytics, practice management, wellness and clinical decision systems were the most funded health technology areas from 2010-2015, in that order. Telemedicine market in the country is estimated to be over USD 32 million by 2020. Much of the digital health technologies will be driven by the private sector. The rural and urban divide in access to quality healthcare services would reduce over the years due to technology adoptions. "Medical infrastructure in India is concentrated in the urban areas while a substantial section of the population lives in rural areas with limited access to such facilities. Through the use of technology, this divide can be bridged. Consultation through mobile devices using video, images, and conference calls can help rural patients' access basic medical advice." Mobile users in India crossed the one billion mark in 2016 and in the years to come they will start using smart phones. This development along with improved internet and data usage will not only bridge the gap of rural-urban divide in healthcare access through technology but also support 'health education' of vulnerable groups in a big way.

Health IT would help improve a number of care processes such as patient diagnosis, data management, e-prescription, pathology lab management, scheduling of appointments, case analysis etc. Other hospital functions like marketing, HR, administration etc would also benefit with applications in enterprise resources planning software and hospital management information systems. Partnerships with private and public players are all ready to leverage the power of technology and CSR in technology based programmes are looking very attractive to large companies. However, with the growing usage of IT in healthcare, organizations have had to find a structured way to building capacity by

introducing the right skill sets amongst the aspiring health and hospital management professionals.

Electronic Medical/Health Records, cloud computing for data access and management, mobile and Internet of Things will impact care processes positively in various settings be it in outpatient, in-patient, emergency/ambulance, ICUs, critical care, robotic surgery and home healthcare services etc. When it comes to technology adoptions for healthcare in India 'sky is the limit' and there is excitement all around. Harnessing the power of technology to improve access to quality healthcare, reduce in-equities in access and affordability and achieving 'health for all' is a humongous task and private sector role is crucial.

3. Conclusions

The spirit of 'Health for all' has been at the core of designing of India's Public Health System. Historically, from Bhore Committee to National Health Policy of 1983, 2002 and 2017, Planning Commissions and now to Niti Ayog, India has approached public health through policy formulation and programme implementation. Further push to improve health of the population and commitment is through NRHM and NHM in recent years. Aligning with global health goals India was a signatory to MDGs and now SDGs.2010 saw HLEG on Universal Health Coverage give the much-needed push for coverage for population, services and financial investments and political commitment at a much higher level. Parallel to the growth and development of public health system India saw unprecedented growth of private healthcare from 1980 onwards. Liberalization, health policy push for public private partnerships, growth of medical education, medical technology, entrepreneurial nature of doctors, financing models, emergence of health insurance, healthcare needs of people and epidemiological spectrum among many other factors drove the private healthcare care sector to grow very fast.

Presently private hospitals and hospital beds outnumber public health system. Capacity, skilled professionals, technology, diagnostics, digital health etc. are available. A vast country like India cannot deliver 'Universal Health Coverage' by public health system alone. Private hospitals, PPP models, NGOs and CSR have a great role and responsibility to partner with the government system to achieve 'UHC' soon. Ayushman Bharat Programme is a very ambitious scheme on Health Protection and Wellness. The focus on RMNCH and NCDs along with preventive, promotive and curative care need to be synergized to achieve UHC. Road to UHC is not easy; price regulation, health financing, quality regulation, equity, reducing rural-urban divide in access/affordability, trust and engagement of private and public partners is critical for the success of UHC. Even though UHC by 2022 sounds utopian, UHC in our own life time is achievable. Thus, India needs good leadership and governance, development of infrastructure, a focus on primary care and a determination to build a healthy inclusive community. Providing UHC is an investment but its benefits to the nation are incomparable.

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