REVIEW ARTICLE

# The Quest for Universal Health Coverage in India: Lessons from Peer Countries

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*Published online on 26th October 2015*

## ABSTRACT

India is a signatory to the 65th World Health Assembly resolution that calls for developing health system that ensures universal health coverage (UHC) for its citizens. Though the health system in India is governed by the philosophy of making health services available and accessible to all irrespective of their ability to pay, existing health system challenges calls for rethinking and re-strategizing the path to UHC. This paper compares India's progress to UHC with three countries known to have made excellent progress towards UHC in their own unique way - China, South Korea and Thailand. This paper concludes that the increased public funding in healthcare, regulating cost and improving efficiency of private sector health services, universal coverage of population with financial protection, and access to a comprehensive service package to all insured are measures that have the potential to reduce catastrophic health expenditure and hence a way forward for India to progress towards UHC.

**Key Words:** Universal Health Coverage, Health Insurance, Social Protection, Health Expenditure, India

*Cite this article as:* Sharma R, Saha S. The Quest for Universal Health Coverage in India: Lessons from Peer Countries. Journal of Health Systems. 2015 Oct 26;1(1):6–12

## Introduction

India is a signatory to the 65th World Health Assembly resolution that calls for developing health system that universal health coverage (UHC) for its citizens. The UHC framework encompasses three dimensions i.e. increased number of services made available to the maximum possible population at affordable cost.[1] The concept in practical terms means that no one in the country should be deprived of accessing quality assured preventive and curative healthcare services due to their inability to pay for such services.

When sick, while the patient is already loosing health, they need assistance to recover. In such a situation, if required health services are not available or available but not good in quality or available but expensive to afford, it causes distress to the patients. In such circumstances where people continue to fall sick, but are unable to access the system due to various systemic challenges, it may cause prolonged sickness and disease burden in the country. In addition it also causes financial burden to the household. For example, around 39 million (30.6 million in rural and 8.4 million in urban areas, respectively). Indians fell into poverty as a result of out-of-pocket (OOP) expenditures in 2004-05.[2]

The solution could be two-fold: 1) the country must make available a healthcare system that is capable of providing quality services to its majority population; and 2) the country establishes mechanisms that ensures people's access to this healthcare system irrespective of their paying capacity.

While the focus of this paper is to analyse the health system's context in India in relation to UHC, the paper also draws lessons from three countries known to be successful in making progress towards UHC – China, Thailand and South Korea.

The first section of this paper illustrates India's context in the light of two solutions suggested above. The second section presents the case studies of the three countries. The later sections discuss and conclude with some lessons drawn for India to enable its journey to UHC.

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## India's Journey to UHC

### *Indian Healthcare Set-up*

The core principle of UHC i.e. "Universalism" is not new to India. The Bhore committee was set up by the Government of India (then British India) in 1943 to investigate and recommend improvements to the Indian Public Health

system focussed on the principle that 'nobody should be denied access to health services for his/her inability to pay' and that the focus should be on rural areas.[3]

So since 1940's, this led to the establishment of an extensive network of healthcare infrastructure comprising of health sub-centers, Primary Health Centers (PHCs) and Community Health Centers (CHCs) in rural areas, and multi-specialty hospitals in urban areas funded by the government.[4] But from the 1980's, the idea of government as a major health service provider underwent transition due to the inadequacies of the public system to meet public demands. Further, persistent low public spending on health focussed mostly towards hospital-based care resulted in utilization of public health facilities only by about 20% for outpatient services and 45% for inpatient care.[5] The World Bank data shows that India's public spending on health is among the lowest with Sri Lanka spending 1.8 percent, China spending 2.3 percent and industrialized economies such as USA, UK, Spain and Germany spending between 6.5 – 8 percent of their Gross Domestic product (GDP) on health care.[6]

Liberalisation of healthcare sector in India invited private players participation as part of health sector reforms since 1980s. This no way means that the private sector did not exist in some or the other form all this while. But the impetus given to private sector's participation, especially multinationals in Indian healthcare system since 1980's is the reason that today the private sector has become the dominant healthcare provider in India.[2] This privatization has grown from five to ten percent during 1940s to 82 percent of outpatient visit; 52 percent of inpatient expenditure; and 40 percent of births in private institutions by 2005.[7] Profit motive of private sector, a weak regulatory structure to monitor private practice, and poor social health protection lead to a situation of high health care cost in India, mostly met through OOP spending at point of care.[8] Inefficient control of drug prices, weak procurement and distribution mechanisms, over-prescription of medications, and a poor risk-pooling system exacerbate inequitable access to affordable and effective drugs.[9,10]

Thus the current healthcare system is ailing with problems such as - 1) low public spending on health resulting in poor state of affairs in public healthcare institutions;[11] 2) complexity of emerging diseases and disorders that may escalate demand for healthcare services;[12,13] and 3) privatisation of healthcare services in an unregulated atmosphere that is leading to high OOP expenditure by people on health.[5,14] Such a scenario explains that while the "demand for services" and the "availability of services" exist, the access to these services may be limited due to their quality (mainly in case of public sector) and cost (mainly in case of private sector). The increased OOP expenditure on health may all the more be a problem for 22% Indian population classified as below poverty line and many others that constitute the middle class of India.[15]

As a solution, while increased public spending on health may improve the quality issues in public health settings, other initiatives e.g. regulating and monitoring private sector against its malpractices and escalated costs, and exploring various pre-payment and risk pooling mechanisms to financially protect people against OOP health expenditures can address both-quality and cost dimension of healthcare services in India. The following sub-section explains various mechanisms of financial protection available in India to improve people's access to healthcare services.

*Social health protection through insurance to improve access to health services*

Broadly the financial protection for people to access required healthcare services and avoid facing catastrophic healthcare expenditure on their overall lives could be of three types- i) fully funded by the governments using tax payer's money; ii) contributory in nature with portions contributed by government/employer and rest by the beneficiaries; and iii) totally self-funded by the beneficiaries. The principle behind all these is "risk and resource pooling". This means pre-payments by all those currently healthy but assuming a risk of illness anytime in the future.

India offers a mixed basket of health insurance schemes to its population- 1) the Central Government Health Scheme (CGHS) and the Employee's State Insurance Scheme (ESIS); 2) voluntary health insurance through private and public health insurance companies (including community-based health insurance); and 3) public-funded health insurance schemes.

The first type of social health protection is a contributory system for the civil servants and formal sector employees, and partially public funded. The CGHS and ESIS together cover only about five percent or 58.5 million of India's population.[16] The second type of social health protection, mainly through private insurers were promoted during the post liberalisation period in India to give high and middle income individuals an option to avail tertiary care health facilities.[17] These schemes are essentially voluntary in nature. In addition, community based health insurance schemes gave the option to avail primary and secondary health care. The third type of social health protection aims to cover people living below the poverty line by providing fully subsidised coverage to a limited set of secondary and tertiary in-patient care. In order to protect the poor households from high OOP payments, the government of India launched a social health protection scheme, called the Rashtriya Swasthya Bima Yojana (RSBY) in 2008. Population below the poverty line are eligible to enrol in the scheme for a registration fee of US$ 0.5 per family per annum. The family gets cashless coverage for treatment cost up to US$ 500 per annum in empanelled public and private hospitals.[18] While RSBY is nearly completely tax-funded, implementation is contracted at state level to

public and private insurance companies based on a tender process.[19] Several state governments also have initiated their own social health protection schemes to cover the poor against tertiary care expenses.[20]

Each of the three types of schemes has challenges of its own. The first type excludes people working in the informal sectors or not working at all, thus does not reach scale and hence defeats the ethos of equity and universality. The second are mostly voluntary in nature, thus limited in coverage. The third type, though aims to cover the poor, face the design issue of not covering outpatient care cost-a key contributor to catastrophic healthcare expenditure;[21] face the risk of disproportionate increase in tertiary rather than primary or secondary sector expenditure as they cater to expensive hospitalization treatment;[22] and many other operational challenges e.g. greater utilisation by those more socio-economically and politically powerful than otherwise,[23] poor and incomplete enrolment of those eligible,[24] and limited service utilisation due to limited awareness among beneficiaries.[25] Most health insurance schemes in India exclude out-patient care, a key driver to OOP expenditure.[16]

But apart from these design, implementation and management challenges, the major issue is that while, together, these schemes had only been able to cover an estimated 302 million people, or roughly one-fourth of India's population until 2010.[16] The key question is coverage for the remaining 930 million populations. So while the services are available in India, the existing mix of financial protection system is still unable to make the healthcare services accessible to the majority of its population - one of the key principles of achieving UHC. Thus there is a need to find ways to provide some kind of financial risk protection against increasing healthcare costs for the remaining 930 million people of India.

## Progress in Peer Countries

China, Thailand and South Korea have made vast progress in ensuring UHC. Before understanding various means and mechanisms adopted by the three countries to move towards UHC, it is important to understand their context in relation to India. **Table-1** presents some facts about these countries in relation to India, mainly around health expenditure.

Table 1. Inter-country comparison on some health related indicators

| Parameters | India | South Korea | China | Thailand |
|---|---|---|---|---|
| Income Category | Low-middle | High | Upper-middle | Upper-middle |
| Total Population in billion (2013) | 1.252 | 0.050 | 1.357 | 0.067 |
| GDP in trillion (US$) | 1.8 (2010-14) | 1.3 (2010-14) | 9.2 (2010-14) | 0.3 (2010-14) |
| Per capita GDP (current US$) | 1,497 | 25,977 | 6,807 | 5,779 |
| % Expenditure of GDP on health (2012) | 4 | 7.5 | 5.4 | 3.9 |
| Health expenditure-Public (% of total expenditure) (2010-14) | 33.1 | 54.4 | 56 | 76.4 |
| Health expenditure-OOP (% of total expenditure on health) (2012) | 57.6 | 36.1 | 34.3 | 13.1 |
| Per capita health expenditure (2010-14); (US Dollar) | 61 | 1703 | 322 | 215 |

Source: GDP data, Available from http://data.worldbank.org/indicator/NY.GDP.MKTP.CD/countries

### South Korea

*Country context:* South Korea or the Republic of Korea is a high income country with the population of 50.22 million in 2013. While the country has low employment rate in formal sector and majority of its population is self-employed, population in the country has experienced a shift to the formal sector in recent years.[26] In 2012, the country spent 7.5 percent of its GDP on health care. The share of public money in total health expenditure was 54.4 percent while the share of OOP in total health expenditure was estimated to be 36.1 percent during 2010-2014, the rest being other sources.

*Financial protection:* The Korean journey of health insurance started in 1977 when National Health Insurance (NHI) was made compulsory for workers in the formal sector. The scheme was extended to the entire population in 1989. Expansion was achieved gradually, covering employees of smaller firms to rural and urban residents through pilot programs. Korea adapted its model from Japan's national health insurance system.[27] The Korean scheme is based on three central principles – i) mandatory coverage, ii) payment of contribution on the basis of ability to pay, and iii) receipt of benefits according to need.[28] The first principle ensures universality and the latter two promote equity.

Such mandatory and contributory social insurance in Korea means that formal sector employees will make contribution in their insurance scheme, equal to that made by the employer based on their wages and this will constitute their insurance cover. For the self-employed, the contribution is based on their income level, assets and property.[29] This necessitates the need to establish a reasonable contribution rate which was easy to administer. Contribution rate was calculated based on pilot projects among counties (administrative unit) in 1981, and then rolled out in 1988, based on findings from the experiment. The contribution was calculated based on a flat rate payment of US$1.5 per household, and a graded contribution determined by the resident autonomous committee based on the level of taxes paid, farm land owned, and the standard of living. This contribution mechanism was further refined based on four parameters, divided into two parts: basic contribution and

capacity-based contribution. The basic contribution was a per-household flat rate which was equally applicable to all households, and an amount obtained by multiplying the insure flat rate by the number of insured individuals in the household. The capacity-based contribution was further subdivided into two parts: an income-rated portion and a property-rated portion. However, the process of calculating contribution from the self-employed had its challenges, as context differs between rural and urban sector.[26] The NHI's revenues consist not only of contributions from the employed and self-employed, but also government subsidies, financed through general taxation. Thus the NHI fund has contributions from the employers, employees, self-employed and government subsidies.

*Challenges and solutions:* While today the financial protection against availing health services is universal in South Korea, even their system had its share of challenges in improving the efficiency of private health sector and reducing private healthcare costs. The highly privatised healthcare system under the fee-for-service creates a 'supplier-induced demand' with providers increasing volumes of services by inducing unnecessary health-care treatments for profits. There were instances of high rate of caesarean section, and Magnetic Resonance Imaging (MRI) scans.[26] For example, between 1985 and 1999 caesarean section rate increased from 5.6% to 43%. As a measure to regulate private sector, Korea has piloted a new system of Diagnostic Related Group (DRG) which standardized clinical practices. The scheme benefit package includes curative services, but also biannual health check and vaccination from public health centres.

The country has also introduced a capitation based outpatient treatment reimbursement mechanism.[30] For outpatient care, a graded co-payment system was adopted that encourages visits to physician clinics, rather than an expensive hospital outpatient centre.[29]

**China**

*Country context:* China is an upper middle income country with the population of 1.36 billion in 2013. This is roughly equally split between rural (48%) and urban (52%) population. The country spends 5.4 percent of its GDP on health which is 1.4 percent more than that of India. Of this, 56 percent is public and 34.3 percent is OOP expenditure. This means that China spends 23 percent more through public funds compared to India. People in China are experiencing economic, social, environmental, and disease burden transition.[31] The population is increasingly demanding access to health services and reductions in OOP health expenses. Per capita health expenditure in China is 261 US dollar more than that in India.

*Financial protection:* In 2003, the government of China started a New Rural Cooperative Medical Scheme (NRCMS)—a scheme financed mainly by the government, with small contributions from farmers and collectives, to cover medical costs. Through this scheme 95 percent of its farmers (0.812 billion) were covered as on June 2012.[32] Two other schemes were set up to cover the urban population: the Urban Resident Basic Health Insurance (URBHI) and Urban Employee Basic Health Insurance (UEBHI). Simultaneously, China established a Medical Financial Assistance system (MFA) for the poorest citizens, which covers medical care for more than 68·76 million people, including direct aid to severely disabled people, elderly patients, and seriously ill patients in low-income families.[32] With this expansion of population covered under insurance, the above schemes also greatly expanded the range of health services to the insured population.

*Challenges and solutions:* Changing demographic characteristics with rapid ageing population, weak disease surveillance system, ineffective cost control for medical care are some of the key challenges of the country's health system.[32] Without addressing the above problem, enhanced investment and range of social health protection schemes are unlikely to be effective in China's commitment for UHC by 2020. At the country level, the recent 12$^{th}$ five year plan focuses on optimal use of resources to curtail costs, increasing government investments and reducing OOP expenditure to less than 30 percent. Efforts need to be made to improve, regulate and standardise inpatient reimbursement plans and undertake broad outpatient pooling fund reimbursement to benefit more and more people.

**Thailand**

*Country context:* Thailand is widely cited as a one of the development success stories with remarkable progress in social and economic issues, moving from a low income country to an upper-middle income economy in 2011.[6] It is likely to meet most of the Millennium Development Goals (MDGs) on an aggregate basis. While Thailand's spends equal proportion of its GDP on health as by India, the contribution of public funds is 43.3 percent more than that of India. This means that the Thailand health system is highly public funded compared to countries such as India, China and South Korea.

*Financial protection, challenges and solutions:* Prior to 2002, the country had publicly financed health care, with a large benefits package given only to the poor. This approach meant that the non-poor had to finance their care either through OOP payments or private voluntary insurance.[33] Disadvantages of this system include a costly administrative arrangement to identify and protect the poor and to organize the collection of co-payments and premium from the non-poor.[34] In 2002, the government of Thailand passed the National Health Security Act with an aim to provide universal coverage for its population against health expenditure. The scheme originally known as "30 Baht Scheme", in line with the small co-payment charged for treatment, extended insurance coverage to 47 million or 70 percent of the population who were not formally insured earlier. This financial protection was entirely paid

out of government revenues.[33] To be enrolled in Universal Coverage Scheme (UCS) all members must register with a Contracting Unit for Primary care (CUP) and receive a card for care in their home area. The important dimension of Thailand's UCS scheme is that all registered beneficiaries are entitled to a comprehensive benefits package that includes both inpatient and outpatient care, curative (with some exclusions) and preventive healthcare focused on health promotion and disease prevention e.g., immunizations, annual physical check-ups, premarital counselling, antenatal care and family planning services.[35]

## Lessons for India

The country case study highlights the following lessons for India in terms of progress towards UHC.

*Increase public spending in health:* Recommendations of various expert groups to increase public spending on health in India finds additional support from the case studies of the three countries included in this paper. All the three countries have higher public spending and consequently lower OOP expenditure in health than India. In India, the increased public spending in health may not only improve the quality and hence access of the available public health services, this may also bring down the OOP expenditure that people make when they are forced to access the expensive private sector due to the inadequacies of public sector. Also, as followed in Korea, the increased public funding can be utilised to make some standard health insurance contribution by the government per household (excluding those below poverty line) where the remaining is contributed by the household based on their assets and paying capacity.

*"Free for some and contributory for others":* While social health protection is a key imperative to reduce high OOP health expenditure, the question is what form it should take in India: "free for some and contributory for others (India and China)", "contributory for all (Korea)" or "free for all" (Thailand)? While "free for all" public-financed health protection scheme is ideal, the model is impractical for India because of its large population working in the informal sector, thereby limiting its tax-base. Also the fact that 22 percent of Indian population is below poverty line hence with no capacity to contribute to health insurance, "contributory for all" model is not a practical solution. Hence in such a scenario, "free for some and contributory for the majority others" only seems to be the feasible solution for India to cover remaining 75 percent of its uninsured population. In this regard, the Korean experience provides lessons for expanding the compulsory and contributory health insurance scheme to all those not covered under publically financed schemes. A detail study of the Korean model for calculating the capacity based contribution by the beneficiaries and standard per household contribution by the government can provide pathways to implement such a system in India.

*Improve private sector efficiency and control cost:* Only making health insurance compulsory or ensuring that everyone has a financial cover to meet some of their healthcare costs does not bring down the healthcare expenditure in the country. Equally important is to bring down the cost of healthcare services under control. While evidence from India about malpractices followed by private sector to increase their profits by increasing health services cost is discussed in this paper, there are many lessons that India can learn from the three countries discussed here. The Korean innovation of standardizing clinical practices to reduce unnecessary drug and diagnostics cost; similar initiatives by China to regulate private sector; practices like capitation fee on inpatient care in Korea; and fee for comprehensive care package rather than fee for service initiatives in Korea and Thailand are some models India must study and adopt to make private sector more efficient with reduced cost of healthcare services.

*"Fee for comprehensive service package" than "fee for service":* Most schemes in India provide exclusive in-patient cover for tertiary care. The fee-for-service for providers of tertiary care is the reason for escalated costs of tertiary care and imbalance between primary secondary, and tertiary care services in India. Initiatives to cover outpatient care in India are limited. There are evidence that majority OOP expenditure is spent on medicines by both-in-patients and out-patients.[21] Thus financial covers for both in-patients and out-patients care are needed. Also there are debates in India that the health insurance models focus mainly on curative care and tend to leave limited public resources for preventive care. In the light of these facts, India has lessons to learn from the other three countries discussed in this paper e.g. comprehensive service benefit package with both preventive and curative care innovated in Korea and Thailand; and inclusion of out-patient care cost under insurance cover in Korea and China.

## Discussion

The four countries comparative case study shows various similarities in the means they have adopted to reach UHC. Korea, China and Thailand contribute more than 50 percent through public funds as part of their total health expenditure. In comparison, public spending on health is lowest in India among the four countries (43.3%, 23% and 21% less in India than Thailand, China and South Korea respectively). Consequently OOP spending on health in these countries are lower than that in India (21.5%, 23.3% and 44.5% less in Korea, China and Thailand respectively).

While 75 percent of Indian population is still uninsured, South Korea has adopted compulsory insurance model that covers its entire population, China's majorly public funded insurance schemes are close to covering its entire population and tax funded health insurance model of Thailand has also covered its full country population.

India has three major types of social health protection mechanism: contributory for central government employees and large industrial employees, public-funded for people living below poverty line, and voluntary insurance for the rest of its population. Korea follows a contributory model for all based on capability to pay. China also follows a contributory model but majorly funded through public funds. Thailand follows a fully government funded model.

It is also noted that the three countries (India, South Korea and China) are seen to be facing the problem of expensive private healthcare services that affects the overall healthcare costs in the country. Both-Korea and China are seen to be taking strong measures to regulate and standardise practices followed by private sector to be able to control cost and promote efficiency. Health planners in India have to gear up its stewardship to regulate activities of its private health sector.

Korea, China and Thailand are exploring innovating approaches to provide comprehensive service benefit package to people rather than insurance coverage for selective services. These countries are moving from a "fee for service" approach to capitation fee/reimbursements for comprehensive package.

Hence increased public funding in health, regulating cost and efficiency of services offered by private sector, near universal coverage of population with financial protection, access to comprehensive than selective service package to all insured are all measures that reduce OOP expenditure in health and are ways forward to progress in all three dimensions of UHC i.e. increased services available to maximum population irrespective of their paying capacity (financial protection).

## Conclusion

India is committed to UHC for its citizen. To realise this, India has existing public healthcare infrastructure and similarly vibrant private sector. While the country's public health system is falling short of meeting people's expectation in terms of quality, the private sector is out of reach for many due to its expensive services. Realizing the current state of each of these systems, efforts are needed to take maximum advantage of its strengths and minimize the weaknesses.

The public health system requires infusion of public funds to revitalize it in terms of human resources, infrastructure, real time health information system, drug cost, equipment, and supportive services. Such revamping of public health system is important for it to be able to win back people's trust and efficiently cater to people's health needs with minimum OOP cost. Though this should be the prime focus of India to ensure UHC to its citizen in the long run, the potential of the available private sector should also be harnessed with adequate strategies in the meantime.

Initiatives towards rationalisation and regulation of costs of various services offered by private sector and inclusion of basket of services e.g. inpatient and outpatient in an insurance package would make more sense for the government if it has to contribute in the financial protection for all its citizen to enable them to access to private healthcare services. Lessons from the other countries also show that deciding a capitation fee of a comprehensive package of services rather than fee for service makes it convenient for the government to administer, people to use, and also reduces OOP expenditure.

Finally, while a public funded health system to meet maximum of people's healthcare needs is ideal, a graded mandatory health insurance system where those who are below poverty line are covered through public funds and rest have to pay a contribution to join the scheme is the feasible option. Such a scheme with specific standard contribution by the government per household, if expanded to all, will ensure coverage for a range of essential services, and without causing financial distress. It is time for policy planners in India to develop a firm plan to walk the path, learning from experience of countries that have succeeded in moving forward to meet the goals of UHC.

**Conflict of Interest:** None declared

**Source of Funding:** None

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