Strengthening Health Systems: lessons from developing nation

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Health System in India

Weak health systems are ailing the ability of the countries to achieve sustainable health outcomes. In the current context of global climate, food and fuel crisis, weak health outcomes are also irreversibly linked to non-attainment of non-health related MDGs. The situation is more precarious for developing countries, which are also equal signatories to UN Declaration of Human Rights that guarantees health as a human right. Even after over 6 decades of this commitment, some of the key indicators on health outputs raise basic question on what ails the health systems in even fast developing economies like India.

While design of any health system is bound to be equitable if it recognizes the right to highest attainable standard of health for all its citizens, the challenges are also on the demographic and other development parameters. The design of India's health system had to cater to 1.2 billion populations, almost three quarters of which are in rural areas with poor infrastructure availability. Parts of India have a topology that makes access difficult and travel time-consuming. Nearly 400 million people in India live on less than 1.25 USD (PPP) per day[1], and 44% of all children are malnourished[2] and 42% children are underweight[3]. Some of other major failing health indicators are the IMR is 47 per 1000 live birth, MMR of 212 per 1,00,000 live births with under – 5 Mortality being 66 per 1000 live births. It is also seen that the birth by the skilled personnel is 47% whereas the fully immunized children is just 66%[4].

Despite the catastrophic display of health indicators, the size of the health care sector grew rapidly from US$22bn during 2004–05 to US$60bn during 2011–12[5]. Further, social health indicators have also displayed marked improvement. In line with this, life expectancy at birth went up from 32 years during the independence era to 65.4 years in 2011. It is noteworthy that the improvement in life span between 2005 and 2011 has been much sharper than that recorded from 1990 to 2005. Though a remarkable growth has been seen in the last decade or two, in comparison to countries with similar development rate, India's key indicators have remained low. Large regional and geographic disparity amid states makes it difficult of implement healthcare programs.

'Health' is a state subject in India, whereas the policies and guidelines are formulated at the Federal level. The multiplicity of regulations at the federal and state level, leads to perplexity and hindrance in the governance and operations of health systems. Larger matters of concern, having national consequences such as population control, prevention of food adulteration, medical education, quality control of drugs manufacturing, are conjointly governed by both federal and state government.

The muddled amalgamation of different nodal agencies to tackle the strategy and implementation matters is paradox India has been living with. Insignificant public spending merely over a percent of GDP, leaves the private sector to serve the underserved needs of the country.

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[1] The World Bank Data on Poverty Gap at $1.25 a day (PPP) (%) from 2010, available at: http://data.worldbank.org/indicator/SI.POV.GAPS/countries, accessed on April15, 2018
[2] India at a glance", World Bank, available at: http://devdata.worldbank.org/AAG/ind_aag.pdf, accessed on April 18th, 2018
[3] WHO Report, 2011
[4] ibid
[5] "Public health care expenditure as a % of GDP," World Bank website, www.data.worldbank.org/indicator, accessed 1 April 2014.

Besides the entire nations condition and the inter state disparity, a thorough analysis needs to be varied parameters for conniving the status of healthcare system in any nations. Therefore this analysis draws impetus on the domains of Access to the Basic Healthcare Services, Access to the Basic Healthcare Services, Lack of Infrastructure and Access to Medicines and Healthcare financing system.

Access to the Basic Healthcare Services

Rural health infrastructure has been significantly strengthened, enhancing accessibility to healthcare services for the rural population. While the number of public health care facilities marginally increased between 2007 and 2011, the capability of such setups was stepped up significantly. The number of community health centers (CHCs) was increased by 19%, while the number of primary health centers (PHC) and sub-centers (SC) were increased by 7% and 2%, respectively.

Availability of Human resources

Shortage in the number and quality of human resources employed in the health care sector remaining to be an area of concern. Nevertheless, the government has initiated several steps in this direction that could potentially spell some relief. The government has set up medical, dental, nursing and AYUSH colleges in the last three to four years. This has resulted in an increase (34%) in the number of first year MBBS admissions. While 48 medical colleges were set up in the last four years, another 200 institutes need to be opened in the coming decade.[6] As per the global norm of 23-24 health-workers (Doctors, nurses and auxiliary nurses & midwives) per 10,000 population, India has 13/ 10,000 population which are also even these are mal-distributed, as about 80% of Doctors, 75% of Dispensaries and 60% of Hospitals are located in Urban Areas. It can also be seen in the ratio of Qualified Physicians in the 11.3/10,000 – Urban Areas and 1.9/10,000 – Rural Areas[7], giving rise to Urban – Rural disparity, the disparity also exists in the varied terrains of India, as the availability is extremely low in the north and north – eastern states. Indeed India has been classified the WHO as facing a global health workforce crisis.

Lack of Infrastructure and Access to Medicines

Inadequate health care infrastructure also pertains to exist in India besides the varied schemes coming into play, only 0.7 beds per 1,000 populations exist in comparison to the global norm of 2.9/`1,000. This can be especially seen in rural areas, making it largely unresponsive to local needs. Even assuming as we advance more towards day care less of hospitalized care, a minimal increase of beds from 0.86–2/1,000 by 2025 is essential.
Besides the infrastructure the availability of medicines is also very poor in India, besides the schemes and provision of free medicines for the in and out patient.

Table 1.1: Trends in access to medicines in India (%) from 1986-87 to 2004.

Period	Free Medicines	Partly Free	On Payment	Not Received
Inpatient				
1986-87	31.2	15	40.95	12.85
1995-96	12.29	13.15	67.75	6.8
2004	8.99	16.38	71.79	2.84
Outpatient				
1986-87	17.98	4.36	65.55	12.11
1995-96	7.21	2.71	79.32	10.76
2004	5.34	3.38	65.27	26.01

Source: Health data extracted from NSS Rounds 60, 52 and 42

[6] Medical Council of India, Dental Council of India, National Health Profile, Central Council of Indian Medicine, Department of AYUSH and Nursing Council of India
[7] WHO Report, 2011

Due to changes in the drugs pricing policy, which increased by 107% from 1980 – 93 drugs became costlier though India does produce generic drugs in large quantity and supplies to many countries in the world and we are considered the pharmacy in the South of the Globe. But considering the affordability within the country, the prices still remain high and a challenge.

Healthcare Financing System

This particular aspect remains to be the core problem of the Healthcare System in India, which can be explained by the table given below:

Table 1.2. Financing Structure for Healthcare in India

Countries	**Total Public spending as % GDP (Fiscal Capacity)**	**Total Expenditure on Health as % GDP**	**Public Expenditure on health as % of GDP**	**Per capita total expenditure on health (PPP $)**	**Per capita public expenditure on health (PPP $)**	**Proportion of out of pocket expenditure (%)**
India	33.6	4.2	**1.2**	132	42	78
Sri Lanka	24.5	4	1.8	193	87	54
China	22.3	4.6	2.3	309	155	61
Thailand	23.3	4.3	3.3	345	261	36

Source: WHO Database, 2009

It is evident that India's performance in comparison to the other Asian countries is very poor, besides within India itself, it can be seen that the total public spending is fairly high in comparison to other nation but this does not materialize in the improvement of the Healthcare Sector of India, as the public spending remains to be stagnant at 0.9% of GDP for the last decade.

India also fares poorly in the per capita expenditure $43 per person and with an extremely high out of pocket expenditure. Therefore, this brings to notice that efforts need to be made to enhance access to health care services, bridge inequity among states and facilitate changes to enhance availability of human resources in the health care domain. Central government has come up certain policies and schemes to overcome these challenges two of them have been briefly explained below:

Rashtriya Swasthya Bima Yojana (RSBY), which provides 'cash less' in-patient treatment for eligible beneficiaries through insurance, based system. The coverage of RSBY was initially limited to the BPL population but has been subsequently expanded to other categories. In planning for healthcare's structure for the future, it is desirable to move away from a 'fee-for-service' mechanism for the reasons outlined by the HLEG, to address the issue of fragmentation of services that works to the detriment of preventive and primary care and also to reduce the scope for fraud and induced demand.

Some of the strengths of this scheme are rapid enrolment and expanding coverage, portability across the nation, engaging both public & private providers for secondary care and quality improvement seen in the recent past. The effective use of IT for both for enrolment and follow up, along with the improved fraud detection systems. However, this scheme also has its weaknesses also as it only covers hospitalized secondary care, neglects preventive and promotive care. It is financially non – sustainable, if utilization rate is high e.g. – in Kerala last 3 years insurance provider are the 3rd party payer, though the government is providing in most of the money, escalating the cost each year otherwise becoming impossible because of the high claim ratios.

Things have not been so dark in the recent past; wherein there has been a determination from the Government of India to redress **National Rural Health Mission** (NRHM) launched in 2005, and began rolling out in 2007. In its 1st phase (2007- 12) the main focus was on Maternal & Child Health, ASHA's, Janani Suraksha Yojna[8], infrastructure strengthening, increased fund flow to States with flexible funding mechanism and Decentralized planning.

Alongside the Central Level reforms there are phenomenal number of state level programs, covering poor people, having higher coverage, wherein the RSBY covers $600 per family per year; these go up to $3000 per family per year. Covering hospitalized tertiary care, with high proportion of state health budget diverted towards it. Example Andhra Pradesh and Tamil Nadu.

Besides the public sector, the private insurance markets have also seen their share of failure in the healthcare domain. Insurance coverage remains low with financial protection available for only hospitalization and not for outpatient care. The medical insurance sector remains weak and fragmented as less than 1 in 10 families have this coverage. The benefits of traditional insurance coverage are reaped by a privileged few and mostly to those working in the organized sector, where employer provides that coverage.

India is a federal polity; state governments are primarily responsible for funding and delivery of health services bearing close to 2/3rd of the total government health expenditure and the centre accounts the remaining third. Beside, there exists a large inter – state differential in public spending. Current schemes for Financial Protection mostly do not cover outpatient care, Drugs and Lab Diagnostics, which collectively contribute to the larger part of out of pocket expenditure.

About 18% of all episodes in rural areas and 10 % in urban areas received no healthcare at all. 12% of people living in the rural area and 1% in urban areas had no access to healthcare facility. 28% of rural residents and 20% of urban residents had no funds for healthcare. Over 40% of hospitalized persons have to borrow money or sell assets to pay for their healthcare. Over 35% of hospitalized persons fall below the poverty line because of hospital expenses. Over 2.2% of the population may be impoverished because of hospital expenses.[9]

Thus, there is a dire need for healthcare reforms. The ideal health system would have a good linkage between primary – secondary and tertiary care services, that doesn't exist as the current focus remains on the secondary care and tertiary care.

Developing Nations Case Studies

Presently it can be seen that many countries have a strong ideological flavor to the reform process, which is aligned to economic growth and demographic changes and backed by a fervent political will. While relative intensities may vary, developed and developing countries face similar challenges and turn to common potential levers to address them. Developed countries are grappling with spiraling per capita health spend and constrained supply infrastructure given the rapidly aging population, which contributes significantly to health care costs but only marginally to health financing. Developing countries are struggling to implement Universal Health Coverage (UHC) and provide financial protection amid rising disease burden, sustained population growth in addition to financial constraints associated with health having to compete with other elements of social agenda.

[8] Promoting Institutional Delivery
[9] NSS 2004, reported in 2006

International experience strongly suggests that there is no unified approach to delivering a successful UHC program. All countries need to make trade-offs, priorities need to be constantly revised in terms of from whom and how resources will be raised, on whom and for what will the resources be utilized and the proportion of total health care costs. The current new wave of UHC, with many nations studying how to institute government- funded programs of health care. While many countries subscribe to the objective of UHC there is a great deal of variety in how this objective is achieved. Many countries have adopted a tax-financed model, while others have adopted an insurance-based model. Some countries deliver care through salaried public providers; others have adopted capitation as the preferred model for payment for outpatient care, and fee-for-service for in-patient care. Many developing nations have experienced sustained economic growth of late, which made UHC financially feasible for the first time. Spurred by economic success, the citizenry of many low- and middle- income countries increasingly made strong demands for an improved health system. Governments, in an effort to meet those demands, made political commitments to achieving universal coverage and have, in some cases, formalized UHC legislation in their respective constitutions. In charting their respective paths towards universal health, many developing countries placed special emphasis on reaching the rural and urban poor as part of their larger effort to ensure that coverage is truly universal for all population sectors.

Key learning's from UHC designs and implementation from a diverse set of countries across different economies have been encapsulates. There were 12 countries models were studied on the basis of Benefits, Source of Funding, Provider Payment, Institutional Structure, Service Delivery and varied related factors, assessing dimensions and challenges associated with design and implementation of UHC. From which only two countries have been chosen based on references from global literature of World Bank classification of countries by income. (Low-income economies and lower-middle income economies), with the aim of looking at developing nations. This will provide a broad overview of health financing tools, policies, and trends with focus on current and anticipated challenges and potential levers being used to address them.

Based on this, a summary of the UHC models in the selected countries has been outlined to derive imperative for the design and implementation of the UHC system in India. Therefore the chosen countries are as follows:

Economic Status	**Country Chosen**
Low – Income Economy	Bangladesh
Low – Middle – Income Economy	Sri Lanka

<u>Bangladesh</u>

The government of Bangladesh aspires to achieve "health for all" through its Revitalized Primary Health Care initiative but it does not have a full-fledged UHC system as yet. Currently health care services are available from both the public and private sectors, although the public sector mainly handles in-patient and preventive care while the private sector is largely used for out-patient care. In answer to the growing demands of its population, the government is using pilot projects to explore the possibility of a comprehensive health insurance system. While public coverage is high for a few essential public health interventions, particularly immunizations, financial protection is very limited for secondary and tertiary care.

Today less than 1% of the population is covered by formal insurance, and high out-of-pocket costs push countless citizens into poverty annually.[10] In part due to 90% vaccine coverage since 1995,[11] however, Bangladesh has seen steadily improving health indicators over the last few decades, including a marked increase in life expectancy at birth and a decline in infant, maternal, and child mortality rates. These averages hide the inequalities that nevertheless persist between different social groups and geographical regions.

The government appears increasingly committed to improving health outcomes, which is very evident from the recent health indicators, such as the Life expectancy has improved from 40 years in 1960 to 64 years in 2005. Vastly improved immunization coverage, from less than 10% in the 1980s to 90% since 1995, has led to substantial gains in child health and a decline in total fertility rate from 6.3 in the 1970s to 2.7 in 2007.[12]

Though certain challenges stillpersist, including lack of skilled birth attendants, which has prevented any improvement in the percentage of underweight children in Bangladesh, which has stood at 45%since the mid-1990s. Bangladesh faces severe drug, facility, and physician shortages. There is a current shortfall of 60,000 physicians, which will only increase as the population grows. Shortages are particularly acute in rural areas. Because of resource shortages and poor care quality, only 25% of the population uses the publicly funded health care system. Bangladesh has burgeoning private for-profit and not-for-profit health sectors. Disparities in access to health services, particularly antenatal care; treatment for acute respiratory infection, malnutrition, and anemia during pregnancy; and complete vaccinations for children are widening.

Sri Lanka

Sri Lanka achieved universal health coverage by relying on tax-financed and government-operated health services, while its per capita GDP was still below US$500 annually.[13] In 2005, total expenditure on health in Sri Lanka accounted for 4.2 % of GDP and neared Rs.100 billion (US$1 billion).
Government spending accounts for 46% and private financing— mostly household out-of-pocket payments—covers the rest[14]. All in-patient, outpatient, and community health services are free to all Sri Lankans, with very few exceptions. Today roughly 96% of all childbirths occur in hospitals, and the country has close to 100% immunization coverage.[15]

Sri Lanka realized universal coverage by ensuring that the rural poor had access to hospital services and by removing financial and social barriers to care. Sri Lanka's health system is public hospital-dominated, and the government budget has prioritized establishing rural hospitals since the 1950s. The government financed the construction of a high-density but low-cost network of rural facilities to make sure that almost all citizens live within one or two kilometers of a clinic.

Sri Lanka's system successfully protects the poor from the catastrophic financial risk associated with illness—according to an EQUITAP study, only 0.3 % of households[16] in Sri Lanka drop below the international poverty due to health expenditure. In prioritizing access above all else, Sri Lanka's system encourages richer patients to choose private care, which opens up facilities for the poor and reduces the burden on the government.

[10] Coordinator, Timothy G. Evans. Centre of Excellence Timothy G. Evans, "Centre of Excellence on Universal Health Coverage," James P. Grant School of Public Health, BRAC University, http://www.bracuniversity.net/I&S/sph/centres_initiatives/uhc.htm, accessed February 14, 2018)
[11] World Health Organization, Health System in Bangladesh, 2008, http://www.whoban.org/health_system_bangladesh.html (accessed February 14, 2018).
[12] Anwar Islam, Bangladesh Health System in Transition: Selected Articles, Monograph Series (Dhaka, Bangladesh: James P. Grant School of Public Health, 2008).
[13] United Nations Publications, "Chapter IV: Towards Universal Health Care Coverage in the Asia-Pacific Region," United Nations Economic and Social Commission for Asia and the Pacific, http://www.unescap.org/esid/hds/pubs/2449/2449_ch4.pdf, accessed February 16, 2018).
[14] Ibid

15 Ibid

16 Review of National Commitments to Reducing Health Inequalities in Asia: Content Analysis of Policy Documents, http://www.equitap.org/publications/docs/EquitapWP11.pdf, accessed February 16, 2018.

Because the wealthiest voluntarily opt out of the government health system, all public hospitals are able to accept all patients without restriction, and no referral system is enforced. Interestingly, however, most private doctors are typically government medical employees who are permitted to practice privately during their free time.

Thus, the crucial factors of erudition from Sri Lanka are the strong health infrastructure in rural areas, which encouraged usage of health services by the poor. Ever since 1951, when user charges were abolished, the poor have gradually become more familiar with health resources. Today utilization rates of government health facilities are actually higher among the poorest households than among the richest. Though the system is hospital-based, an expensive definition of what constitutes a hospital means that the focus on hospitals does not come at the expense of primary care. Sri Lanka has found that well-run government hospitals are actually an efficient way of delivering primary care. Sri Lanka's rates of in-patient admission and outpatient visits are comparable to OECD countries.

In offering a full range of services instead of a more restricted one, Sri Lanka's health system has prioritized risk protection over cost-effectiveness and has won public support and confidence. Sri Lanka's system is efficient in terms of high patient throughput—average bed-turnover rate is high and average length of stay is short—and high labor productivity. To contain costs, the health system bulk-purchases only generic drugs. A national formulary of drugs approves drugs for use in government hospitals.

The main challenge for the provision of health care services in Sri Lanka relates to the government's ability to continue to provide health services free at the point of delivery. The government cannot increase the budget without raising taxes substantially. Lack of funding prevents the adoption of certain modern medical methods, such as the management of chronic, non-communicable diseases. Through internal purchasing and investment decisions, the Ministry of Health implicitly rations care and deliberately restricts the availability of certain services it considers too expensive. For example, X-rays are not present in most lower-level facilities, and not every medicine is available in every hospital. Though patients can go to whatever hospital they choose and public transportation is cheap, most high-level facilities and services are available only in urban areas. As the rich increasingly turn to the private sector, this shift may undermine political support for a tax-financed government health system.

Conclusion

This report has encompassed existing conditions, the model proposed with the challenges it faces and the gaps that can be filled – in by roping in stakeholders. Awareness exists wherein by mere requirement of a new policy and regulatory framework furthermore increasing financing, health workers, and creating more opportunities for better technology all of this alone cannot overcome the deficiencies of the Indian Healthcare System. It has been understood that crucial importance needs to be given to social determinants of health, cross cutting issues of health (gender) and a culture managing new political ethics needs to be guiding through with assistance of both public and private sector.

Despite understanding the need of the hour, dynamics and heterogeneity of India, health being a state subject the real power lies in the hands of the state. The challenges of the complicated processes with legacy of earlier period, the intricacy of the present-day dynamics would help in moulding the future. Since a lot many developing countries have taken the initiative partially or completely towards achievement of Healthcare goals.

This has certainly motivated India, as it has a promising capacity of enormous resource, but the challenge remains in effective and efficient utilization of resources and management of the same in a more sustainable manner.

Ever since 2014 major developments have taken place in the healthcare sector. With the much awaited National Health Policy came out in 2017. It aims to achieve universal health coverage and delivering quality health care services to all at affordable cost, through a preventive and promotive health care orientation in all developmental policies. The very recent announcement of the National Health Protection Scheme (NHPS) or 'Modicare' which would cover 500 million people, the introduction of the world's largest government funded healthcare program of approximately US $179 million. With the new 1% health and education cess empowering the poor common man with specialized treatment with premiums at approximately US $16.47 per family, the Federal Government has set the stage by increasing the federal health budget by 11.5% for 2018-19.

NITI Aayog, the revolutionised version of the pre-existing Planning Commission in India, in 2017 came out with the Three-Year Action Agenda, with ambitious proposals for policy changes, with possible actions by the states to complement the efforts of the Centre. Specific Health Goals have also been set as follows to Achieved by the Year 2020.[17]

1. Reduce Maternal Mortality Ratio to 120/100,000 live births (2013 estimate:167/100,000 live births[18])
2. Reduce Infant Mortality Rate to 30/1,000 live births (2013 estimate: 40/1,000 live births[19])
3. Reduce Under 5 Mortality Rate to 38/1,000 live births (2015 estimate: 48/1,000 live births[20])
4. Reduce the percentage of underweight children by 3 points per annum from NFHS-4
5. Reduce Total Fertility Rate to 2.1 (2013 estimate: 2.3[21])
6. Reduce incidence of TB to 130/100,000 (2015 estimate: 217/100,000[22])
7. Reduce incidence of Malaria (Annual Parasite Incidence) to less than 1/1,000 in 90% of districts (2016 estimate: 74% of districts have achieved an API of less than 1[23])
8. Eliminate Kala Azar (2015 estimate: 80% of endemic blocks have eliminated[24]) and Lymphatic Filariasis (2015 estimate: 87% of endemic districts have eliminated[25])
9. Reduce premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 1/4th of National Family Health Survey-4 (NFHS-4) levels
10. Reduce Out-of-Pocket Spending (OOPS) to 50% of the total health expenditure (2014 estimate: 62.4%[26])

The planning to increase the total share of expenditure on healthcare from 1.7% to 3.6% in coming year of 2019 -20. This increase would improve the health conditions and with alongside contribute directly to enhancing the social welfare of people and in developing human capital.

Consequently, after understanding the present Healthcare System in India and the analysis of the International Universal Health Coverage implementation models, and the proposed healthcare model in India following are some of the recommendations encompassing the financing and incentivizing models along with suggestive implementation models.

Planning Stage: To adopt a trilateral coverage model, covering three dimensions of the population (breadth), Services (Depth) and proportion of out of pocket spending (height) for the path forward. And the life cycle approach of "Womb to Tomb" mechanism, where all the services provided are free of cost in the Public Hospitals throughout this lifecycle approach could help tremendously.

17 http://niti.gov.in/writereaddata/files/coop/India_ActionAgenda.pdf
18 Press Information Bureau, "Achievements Under Millennium Development Goals", July 2015.
19 Press Information Bureau, "Achievements Under Millennium Development Goals", July 2015
20 20% of world's under-5 deaths occur in India", Times of India, September 2015.
21 Press Information Bureau, "Achievements Under Millennium Development Goals", July 2015.
22 http://data.worldbank.org/indicator/SH.TBS.INCD
23 http://www.who.int/features/2015/india-programme-end-malaria/en/
24 Press Information Bureau, "Steps taken towards elimination of Kala-Azar", March 2016.
25 NITI Aayog, Appraisal document of 12th Five Year Plan.
26 http://data.worldbank.org/indicator/SH.XPD.OOPC.TO.ZS

Financing Model: As discussed within the HLEG Report, the public funding needs to be increased. The expenditure on UHC should predominantly be financed by government sources through the general taxation and tax ratios mechanism. Determining the actual expenditure in the healthcare sector per person is also crucial and should be evaluated for estimating the required GDP figures than the subsidized cost. The choice of payment mechanism, provider payment model should have incentivized efficiency and clinical outcomes rather than focus on revenue generation.

Incentivizing Model: A mechanism could exist wherein the hospital in every district area is incentivized if they cater to citizens of that district, but at the same time they could be penalized for the citizen of a district catering to services from other district hospital, due to poor availability and quality of healthcare services provided.

Implementation Model: A body of knowledge, like centre of excellence should be created within the MoHFW, which would be responsible for creating awareness and disseminate the guidelines, which would be created by the learning of the lucratively operating state models. This would also guide the ministry guide the ministry in the funding mechanism and hiring institutes in carrying out pilots. The government should encourage the private sector to participate in specific focus areas to complement public health care provision. Public and private health care facilities should offer a complementary mix of health services with the Choice left to the patient. Well-designed centralized procurement of drugs/medical devices, use of generic generics and indigenous technology to reduce costs of treatment should be in place. The government should set up an independent agency (on the lines of National Accreditation Board for Hospitals & Healthcare Providers, which is an autonomous body on quality and accreditation in the country) to monitor the quality and efficiency of the health financing system.

Thus, a thorough inclusive and comprehensive strategy to achieve the Sustainable Development Goals, India Agenda 2020 Health goals targets or the much-awaited ‘Modicare’ program should be panned out and carried forth by political will. Therefore, it is essential each state should take an initiative to develop an intervention scheme addressing the challenges, improving the health outcomes by strengthening the management system and serving quality services to its citizen.