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Finding healthcare solution for India: A comparative study with USA and UK

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ABSTRACT

Healthcare standard is one of the fundamental indicators of the growth of a nation and a basic requisite for leading a healthy life with dignity and yet it has not been recognized under the right to life in the Constitution of India. In such circumstance the two functions; health care providers and health insurers play a pivotal role. At large, cost of basic health care and insurance to afford health care remains either overlooked or unaffordable for the majority of the population, that is evident from the minimum penetration that the health insurance has achieved in India. The present study attempted to probe into the reason why India remains dismal in terms of providing its citizen a universal health care system and achieving maximum penetration in terms of health insurance. The study begins with a review of the prevalent health care models around the world and the geographies that have successfully implemented universal health care system. An introspect is also made to find whether such best practices can be implemented in the Indian context to put universal health care system in practice. The study concludes with a suggestion that; yes universal health care system is possible in India provided three essential stakeholders start functioning parallelly in coordination with each other under the vigilance of a single regulator.

Keywords*: Economics, Insurance, Universal healthcare*

1. INTRODUCTION

Health care is a basic need of every human being and with the progress in medical science, the expectations of the healthcare industry are increasing day by day. While new innovations are emerging into the human treatment mechanism, quality health care is becoming costly and hence out of reach of the common people in a developing country like India. Considering good health care as fundamental rights of the citizens, few developed countries have tried with various models to cover all citizens under the umbrella of insurance with a concept of maximum benefit with minimum premium. While the implementing methods were different customized to the need of the respective country, the results and effectiveness were also varied. India is different in terms of geography, the volume of populations with diversities, the selection of any method has to be carefully selected. The study is a discussion on the various health care models available in the world and introspect into the advantages and disadvantages of universal health care systems of the United Kingdom and the United States of America and tried to find out a possible solution that best fit to the Indian demography.

1.1 Healthcare Models around the world

There are four main models of healthcare, based upon the source of their funding namely Beveridge Model, Bismarck Model, National Health Insurance and Out of Pocket Expense Model.

Beveridge Model

In the Beveridge 'public' model, funding is based mainly on taxation and is characterized by a centrally organized National Health Service where the services are provided by mainly public health providers (hospitals, community doctors, etc.). In this model, healthcare budgets compete with other spending priorities. The countries using this model are the UK, Italy, Spain, Sweden, Denmark, Norway, Finland and Canada. [1]

Bismarck Model

The Bismarck model uses an insurance system and is usually financed jointly by employers and employees through payroll deduction. Unlike with the US insurance industry, Bismarck-type health insurance plans do not make a profit and must include all citizens. Doctors and hospitals tend to be private in Bismarck countries. This model is found in Germany, France, Belgium, the Netherlands, Japan, and Switzerland [2].

National Health Insurance Model

The National Health Insurance model has elements of both the Beveridge and Bismarck models. It uses private-sector providers, but payment comes from a government-run insurance program that all citizens fund through a premium or tax. These universal insurance programs tend to be less expensive and have lower administrative costs than American-style for-profit insurance plans. National Health Insurance plans also control costs by limiting the medical services they pay for and/or requiring patients wait to be treated. The classic National Health Insurance system can be found in Canada.

Out of Pocket Expense Model

The final model, the out-of-pocket model, is what is found in the majority of the world. It is used in countries that are too poor or disorganized to provide any kind of national health care system. In these countries, those that have money and can pay for health care get it, and those that do not stay sick or die. In rural regions of Africa, India, China, and South America, hundreds of millions of people go their whole lives without ever seeing a doctor.

1.2 Implementation of these Models Around the world.

Health insurance in the USA

In the United States, health insurance is any program that helps pay for medical expenses, whether through privately purchased insurance, social insurance or a social welfare program funded by the government. Health insurance in the USA is a market maximized for-profit business with the public as well as private insurers. In the USA, average health expenditure per capita is more than $9000 which makes it the costliest health care model and spends more than spends more than 17% of its GDP in healthcare programs. Yet, the average life expectancy in the USA is 78 years which is less than all the OECD countries.[3] The healthcare programs are so tailored and distributed between the state and private insurers that they cover the children, elder as well the working class of people. This helps in providing health care to approximately 91% of the Americans as only 9% of the Americans are without any healthcare.

History

Health insurance in the USA can be traced back to the sickness insurance funds that were prevalent in the early 20th century.[4] Prior to this period, the health care framework was rudimentary owing to archaic nature of health care and low medical aid cost. Since the medical aid cost was low, health insurance was rather unnecessary. However, the lower working class faced a potentially high cost of losing wages in the event of the death of the sole breadwinner of the family.[5] To combat these contingencies sickness funds were created and sponsored by the employer and unions. While many European nations made the sickness funds mandatory, the US did not follow suit as such an act was an intrusion into the business and states affair.[6] Commercial insurers deterred from providing insurance due to lack of data and knowledge necessary to calculate risk and price health insurance policies based on moral hazard and adverse selection. The advances in the medical science and the technology led to the rise in the medical cost. This was seen as a more serious problem that problem to individuals and families than the threat of lost wages that an illness could cause. This led to the increasing demand for the health care in the USA.

The private health insurance was a result of the great depression in the US when Baylor Hospital began allowing for 21 days of hospital stays per year to those who paid a 50-cent premium each month in 1929. This ‘‘prepayment’’ concept spread with encouragement from the American Hospital Association and paved way for private insurance. They were called blue cover plans.[7] Similar prepaid plans for physician services was created and offered to employees earning less than $3,000 for a fee of $1.70 per month. They enjoyed same statutory exemptions from taxes and insurance regulations which Blue cover plans enjoyed, and the affiliation of these plans was known as Blue Shield. Premiums for both Blue Cross and Blue Shield plans were charged based on community ratings so that subscribers paid roughly the same amount regardless of age, gender, or medical factors.[8] The large enrolment in these plans garnered the attention of the commercial insurers. The prospect of offering health insurance policies to groups of employees rather than individuals mitigated the risks of adverse selection and moral hazard that had previously kept commercial insurers from offering health insurance policies. Moreover, since commercial insurers would not operate as non-profit organizations, they used experience rating to charge premiums to groups rather than the community rating that was required for Blue Cross and Blue Shield plans.

Federal Public Plans

Due to the higher premium charges for old age group by the commercial insurer's government passed Medicare in 1965 as a federal program with uniform standards covering U.S. citizens automatically at age 65. Medicare consisted of two main parts upon its passage, Part A, which was a compulsory hospital insurance program that seniors were automatically enrolled into at age 65, and Part B, which provided supplemental insurance for physician services. Included with the Medicare bill was Medicaid, a means-tested program set-up to provide medical resources to the impoverished. Medicaid eligibility requirements and benefits were set by the states with the federal government solely providing minimum standards States received Medicaid payments from the federal government based on the state’s per-capita income relative to the national per-capita income.

Insurance Regulations in the United States

1. Patient Protection and Affordable Care Act

The Affordable care act or the Obama Care law significantly changed health care in the United States providing a cover to 95% of the legal population.[9] It made health care insurance mandatory for all the citizens failing to avail any form of cover results into a penalty in form of a federal tax return equal to the maximum of $695 per year or 2.5% of household income barring a few exceptions.[10] The act mandates that businesses with 50 or more employees and less than $50,000 in average annual wages will be required to offer their employee health insurance or pay a penalty. States must also set up health insurance exchange that will allow small businesses and individuals to pool their buying power and purchase health insurance.

2. Employee Retirement Income Security Act of 1974 (ERISA)

ERISA is a federal law enacted to protect the interests of employee benefit plan participants and their beneficiaries by making it mandatory for the employer to disclose financial and other information concerning the plan to beneficiaries along with establishing standards of conduct for plan fiduciaries and providing appropriate remedies and access to the federal courts. The major amendments to ERISA resulted in The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) that provides some employees and beneficiaries the right to continue their coverage under an employer-sponsored group health benefit plan for a limited time after the occurrence of certain events that would otherwise cause termination of such coverage, such as the loss of employment, and The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which prohibits a health benefit plan from refusing to cover an employee's pre-existing medical conditions in some circumstances.

2. RESEARCH GAP

The American healthcare system has come under criticism owing to the overwhelming expenditure incurred without providing quality healthcare because the current system is more consistent with the American political philosophy than socialized medicine and the citizens are made to pay not for the quality but for the quantity of the health services. This occurs due to the absence of any regulatory body that can assess the quality of the healthcare services. Moreover, it is a discombobulated, fragmented system which leads the Americans to pay very high administrative costs, and every program is disconnected. [11] It is mainly because when a person is young, his health services are provided by a private health insurer and when he grows old the healthcare services get funded by Federal run programs. When some segment of the society is insured by private insurers and the other by public insurers, then everyone does not get adequate coverage.

Health insurance in the UK

The government of the United Kingdom guarantees the right to health care access to all citizens through its program called the National Health Service. [12] The NHS is a market-minimized, national health service model and is the prominent means to obtain health care services in the United Kingdom.[13] It is made up of multiple subsystems broken down by each of the 4 countries and further into local organizations or ‘‘trusts.’’ The NHS, however, is essentially one system, one organization that provides health care access to the citizens and residents of the United Kingdom. This fully comprehensive system includes health care facilities and staff, technology and pharmaceuticals, financing, coverage, and delivery. [14] There is a growing private healthcare industry in the United Kingdom,[15] its 2 largest private insurers being AXA PPP Healthcare and BUPA.[16]

History of Health Insurance

The National Health Service (NHS) in the United Kingdom came into operation in 1948 following the provisions of the NHS Act of 1946. This Act was of crucial importance in establishing the post-Second WorldWar pattern of health service finance and provision in the United Kingdom. [17] The National Health Service (NHS) was founded in 1946 and is responsible for the public healthcare sector of the UK. Before this, healthcare in the UK was generally available only to the wealthy, unless one was able to obtain free treatment through charity or teaching hospitals. In 1911 David Lloyd George introduced the National Insurance Act, in which a small amount was deducted from an employee’s wage and in return they were entitled to free healthcare. However, this scheme only gave healthcare entitlement to employed individuals. After the Second World War, an endeavor was undertaken to launch a public healthcare system in which services were provided free at the point of need, services were financed from central taxation and everyone was eligible for care. A basic tripartite system was formed splitting the service into hospital services, primary care (General Practitioner’s) and Community Services. By 1974 concerns over problems caused by the separation of the three primary areas of care had grown, so a drastic reorganization effort was made which allowed local authorities to support all three areas of care. The Thatcher years saw a restructuring of the management system, and in 1990 the National Health Service and Community Care Act [18] was passed, which set up independent Trusts that managed hospital care. The quality of health care provided by the public and private providers is monitored and assessed by the Healthcare Commission, Commission for Social Care Inspection and the Mental Health Act Commission.

The net expenditure of NHS (resource plus capital, minus depreciation) has increased from £78.881 billion in 2006/07 [19] to £120.512 billion in 2016/17. [20] The planned expenditure for 2017/18 is £123.817bn and for 2018/19 is £126.269bn. Health expenditure (medical services, health research, and central and other health services) per capita in England has risen from £1,879 in 2011/12 to £2,106 in 2015/16. The NHS net deficit for the 2015/16 financial year was £1.851 billion (£599m underspend by commissioners and a £2.45bn deficit for trusts and foundation trusts) [21]. The provider deficit for the 2016/17 financial year has been confirmed at £791m. [22]

Life expectancy for English men and women was 79.4 years and 83.1 years in the year 2003-05.[23] The health expenditure in the UK in 2016 was 9.75%. This compares to 17.21% in the USA, 11.27% in Germany. The expenditure per capita (using the purchasing power parity) for the UK was $4,192 in 2016. This can be compared to $9,892 in the USA, $5,551 in Germany.[24] At the end of April 2017, there were 3.783 million patients on the waiting list for treatment. 382,618 (10.1%) had been waiting for longer than 18 weeks, compared to 302,901 (8.4%) at the same point in 2016.[25] The number of patients waiting longer than a year for treatment declined from 20,097 in September 2011 to 214 in November 2013, before increasing again. In April 2017 the number stood at 1,573. Over the past three years, the number waiting more than 26 weeks has increased from 60,402 in April 2014 to 136,030 in April 2017.

2.1 Research Gap

This publicly funded system is currently under criticism owing to the huge incurred expenditure and the long waiting time for the patients before they can avail of the services. The financial position of NHS bodies overall has continued to decline which has resulted in indications that financial stress is having an impact on access to services and quality of care.[26] Moreover, the system

leaves citizen no choice to choose the physician or treatment that they want. In general, government-provided care is somehow not as good as private health care providers. In addition, the policy of universal health care scope is not as diverse or expanding as private insurance. The universal health care system is not rewarding from the point of view of nurses and doctors as the government employees as they receive low wages. Since the government runs the universal health care; there are bureaucracy hurdles and lots of red tapes which result in poor service and long-time wait [27].

Health Insurance in India

Health insurance is a form of general insurance that indemnifies against the economic losses suffered due to incurring medical expenses for the treatment of bodily injury, illness. It is a kind of financial protection that provides payment of benefits in case of sickness or injury.[28] Health insurance is defined as "a mechanism whereby the risks of incurring health care costs are spread over a group of individuals or households".[29] IRDA defines Health Insurance Business or health cover as effecting of contracts which provide sickness benefits or medical, surgical or hospital expenses benefits, whether in-patient or out-patient, on an indemnity, reimbursement, pre-paid or otherwise, including assured benefits and long-term health care.[30].

History

Health insurance found its root in the 19th century when benefit societies were founded to ensure the lives and health of their members. In India, it appeared with the launch of Mediclaim policies in November 1986 by the General Insurance Corporation. Post liberalization many policies have been floated in the market by the public as well as private sector. The primary types of health insurance in India consist of Social health insurance schemes (ESI, CGHS), which are statutory programmes that are financed mainly through wage based contributions that are proportionate to the income of the contributor and private health insurance schemes which are voluntary and the insurer collects the premium from the individuals who can afford to pay and then that money is invested to supplement the insurance fund. [31]

Community health insurance schemes are not for profit schemes that aim primarily at the informal sector and work by pooling of health risks and payment thereof. These schemes involve pre-payment and pooling of resources to cover the cost of health contingencies. [32] Government health insurance schemes are primarily focused on the poorest and the vulnerable sections of the community that cannot avail private health insurance facilities owing to the premium amount that sometimes exceed their annual household income. Under these schemes, the government provides subsidized premium directly to the insurer from the revenue generated from the taxes. Few GHI's are Rajiv Arogya Shri Scheme (RAS), Rashtriya Swasthya Bima Yojana (RSBY), and Universal Health Insurance Scheme (UHIS). Health care was a voluntary experience before independence [33]. The first recommendations for the improvement of health services in independent India were made by Bhore Committee Report. It was only after the independence that the Government of India laid considerable stress and put sustained efforts to provide primary health care system to its people. [34]

India's tryst with the health insurance programme dates back to late 1940's when subsidized health insurance programmes were rolled out for the civil servants and formal sector workers under Central government health schemes and Employee state insurance scheme respectively.[35] Post liberalization the healthcare insurance sector saw the entry of private players during early 2000. This development threw open the possibility for higher income group to avail better facilities from private tertiary care facilities.[36] Post detariffing the country has witnessed a plethora of new initiatives, both by central as well as the state government to improve healthcare facilities.[37] Yet, India fares among the worst in terms of spending on healthcare which currently stands at around one percent of the GDP.[38] Healthcare in India is market maximized which follows out of pocket expenses model.

2.2 Research gap

WHO recognizes health as a human right and the common denominator for ensuring social well-being.[39] There is a positive correlation between economic growth with improved healthcare, but such a trend seems not applicable in India as despite having economic growth of 7%. For the capital to translate into positive healthcare, the healthcare should be given a priority in the budget. The healthcare budget for the financial year was abysmal, with budget allocation for health ministry for 2017-18 is Rs 47,352.51 crore in comparison to allocation in 2016-17 of Rs 37,061.55 crore, an increase of 27.76 percent from previous year.[40] Investing less than 1% of the GDP is grossly inadequate. Health is an important contribution to the GDP as the healthy population is more productive. Having abysmal healthcare is a huge loss to the GDP of the country as India loses more than 6% of its annual GDP due to premature deaths and preventable illness.[41] India has one of the lowest per capita healthcare expenditures in the world. It spends around $85 per capita on healthcare. Government contribution to insurance stands at roughly 32%, as opposed to 83.5% in the UK. [42]

The healthcare industry is growing at the compounded annual growth rate of 17% since 2003.[43] During 2015-16, the general and health insurance companies have issued around 1.18 crore health insurance policies covering 35.90 crore persons (2014-15: 28.8 crore).[44] India is a paradox of health care as India is the pharmacy of the world and with booming medical tourism fails to cater to the healthcare need of its own population.[45] Having a week public sector infrastructure, non-availability of cheaper drugs, the severe constraint of the health workforce and poorly financed health care along with a poor delivery mechanism for health care is the severe bottlenecks of Indian health care that prevent health system to provide appropriate and better health care.

Universal Health Cover

The universal health coverage means access to quality, effective and affordable health services for all without imposing a financial burden.[46] The greatest challenges that Indian health care system faces today are affordability, accessibility, and availability.[47] Availing all the attributes cumulatively leads to very high out of pocket medical expenses. Due to high out of pocket expense, more than 40 million Indians are pushed into poverty each year.[48] Indians met more than 62% of their health expenses from their

personal savings, called "out-of-pocket expenses", compared with 13.4% in the US, 10% in the UK and 54% in China.[49] The political and public health leadership has led innovative schemes and implemented the best of those into policies, and has made a substantial contribution for advancing population health but the state of health care in terms of affordability, accessibility and quality remains abysmal. The Modi led government has tried to bring radical reforms in the healthcare of the country with National Health Assurance Mission. [50] The scheme aims to provide universal coverage to every citizen to provide affordable and quality healthcare.

3. THE PROPOSED MODEL

The Health sector policy formulation, assessment and implementation owing to the gender disparity and complexly comprehensive stratification of society based on caste and creed, presents a daunting challenge. The further conflicts arise out of the moral hazard, adverse selection and non-availability of data. The policy formulation and implementation are a complex task, especially, in changing epidemiological, institutional, technological and political scenario. Published literature suggests that India's government-sponsored health insurance schemes have had a negligible impact on decreasing the incidence of inpatient catastrophic health expenditure. [51] Providing health coverage to 1.3 billion population when the public funding is abysmal 1.4% of GDP is a pie in the sky. The proposed model intends to provide the health coverage to every segment of the society irrespective of the caste, creed, sex, gender, religion. It may be necessary to pool various health insurance service providers to effectively use their services to ensure the healthcare of people. [52]

The concept of home-based treatment as against hospital-based treatment for the special category of the insured will help in reducing the cost of hospitals but will also result in the sustainable use of the resources as beddings can be made available to the patients that are terminally or critically ill or who need constant supervision of the specialist. This will further lead to the requirement of skills to sustain such arrangements, for instance, there will be an increased need for the skilled nurses who can take care of the patients at home. [53]

The enabling model

The increasing GDP growth has led to the decline in a number of people living below poverty line in India (the ability to spend Rs 47 per day in urban areas, Rs 32 per day in rural areas). [54] This population continues to rely on the under-financed and short-staffed public sector for its healthcare needs, as a result of which their healthcare needs remain unmet [55]. The number has fallen from 41.6% in 2004 to 16% in 2016. 224 million Indians still live below the poverty line [56]. This population accounts for approximately 16% of the total population. The existing health insurance scheme has failed to ease the burden of healthcare cost borne by its poorest families. The programme has not led any reduction in out of pocket expenditure by its 150 million beneficiaries. [57] An insurance cover of 30,000 is inadequate for a family of five. The cost of hospitalizing is increasing at the average rate of 11% yet the insurance amount has remained same in the scheme. Poor till pay for healthcare despite the RSBY due to low enrolment, inadequate insurance cover, and lack of coverage for outpatient. The cost of outpatient treatment, which the poor prefer over hospitalization, forms 65.3% of out-of-pocket expenditure in India, which is not covered by RSBY. [58] The scheme has covered only 36.3 million out of eligible 59 million households. [59] The proposed enabling model is aimed at eliminating poverty, along with generating skill-based employment thereby making the enrollee to be able to afford quality care without incurring out of pocket expenses in a phased manner. This model intends to reduce the dependency of the distressed segment of the society on the government-run health schemes by making then self-sufficient thereby leading to the universal health coverage so that public fiscal health spending can be channelized from providing quantity health care to 1.3 billion people to quality healthcare to 1.3 billion people. The aim is to achieve universal coverage with maximum penetration with the adequacy of the healthcare services. The surplus fiscal public health care funds can be then utilized to generate skill-based employment, efficient health administration, increasing health awareness and education and developing public healthcare infrastructure in a phased manner. The ultimate objective of the enabling model is to increase the amount of cover of healthcare and transiting the distressed segment of the society to non-distressed segment of the society without relying upon public expenditure in a phased manner. The transition of the distressed segment into the non-distressed segment and the cover of 30,000 to the maximum coverage can be achieved into 3 phases.

3.1 The first phase

The first phase involves the time span of 3 years where the benefit of the scheme can be availed in its current form i.e. by subscribing to the scheme with the contribution of the nominal amount of 30 rupees. The benefit of the scheme will be applicable in its current form by providing a floater cover of Rs. 100,000 to the family of the beneficiary. However, add-on benefits can be availed by the beneficiary by subscribing to the better plans for the additional premium. The latter part of the scheme is voluntary at the option of the subscriber. Whereas the former part of the scheme shall be made mandatory. Implementing the latter part of the scheme will involve amending prevailing Rashtriya Swasthya Beema Yojna. In this phase, the state should make sustained efforts at generating and providing skill based employment to this distressed segment so that it can avail of the benefits in the second phase of the scheme. This can be done by channelizing funds of the existing healthcare schemes that are yielding no result in the development of healthcare infrastructure for the implementation of this model. This will serve a two-fold purpose. Firstly, the citizens will have the infrastructure necessary for the implementation of this scheme and secondly, it will generate employment for the distressed category. The state should strive to increase the annual income of the distressed segment in this phase so that better benefits and plans can be availed.

3.2 The Second Phase

The second phase of the enabling model will commence for the subscriber of the scheme after exhausting the benefits of the first phase. The second phase involves the repealing of the plans in the first phase where the premium subscription was for Rupee 30. The minimum subscription premium shall be raised from Rupee 30 to Rupee 100. This shall be done to be at par with the rising consumer pricing index and rising inflation as well as to provide better healthcare with increased cover. The cover offered under the

second phase will be a floater cover with the limit of Rupee 2 lac. However, it will be open to the beneficiary who is in the first phase to avail the benefits of the second phase or the third phase by subscribing to the plans with a higher premium. Failure to subscribe to the plans of the second phase will result in lapsing of the benefits under the scheme. This phase shall remain in operation for the period of 2 years. Any deficit in the incurred claim ratio at the end of the first year of this phase should be either used in the development of infrastructure, generating employment or should be set off for the second year of this phase to increase the cover. This five-year plan should be implemented in such a manner so that state funds should utilize extensively for the development of healthcare infrastructure and generating skill based as well as unskilled based employment.

3.3 The Third phase of the project

The third phase of the project will result in increasing the premium from Rupee 100 to 200 thereby increasing the cover from Rupee 2 lacs to Rupee 2.5 lacs and will commence from the date of exhaustion of the benefits of the second phase or exhaustion of the benefits of the plans with higher premium than prescribed under second phase, whichever is earlier. The benefits of the second phase stand terminated at the commencement of this phase. The beneficiary who has already availed the benefits of the second phase by opting the prescribed plan for the second phase or opting plan with a higher premium than prescribed in the second phase will no longer be able to enroll for the benefits of the third phase unless he subscribes to the higher premium. This phase will remain in operation for the period of 2 years with the option to the subscriber to subscribe to the plan with higher premium at the end of the first year. But in no case, the beneficiary would be allowed to opt for the plan with the lesser premium and coverage than prescribed for the second phase after availing the benefit of the plan with a premium higher than the prescribed premium for the second phase. The objective of this phase is to provide maximum coverage. Any deficit in the net incurred claim ratio at the end of the first year of this phase should be set off for the second year of this phase to increase the cover proportionately to the surplus amount due to the deficit in the net incurred claim ratio.

At the end of this phase, the beneficiary will be entitled to the minimum floater cover of at least Rupee 2.5 lacs and maximum cover will depend upon the premium subscribed. At the end of the third phase, we will be successful in eliminating distressed class by transitioning distressed segment into the non-distressed segment by making them self-sufficient and able to afford the desired plan and quality care.

Model for the non-distressed segment of the society

The current model of healthcare has failed abysmally in catering to the healthcare need of the Indians. The public funded model aimed by the current government in the backdrop of meager budget allocation for the healthcare in the coming year is not going to achieve universal health care. Universal health care cannot be achieved unless the individual is capable of recognizing and deciding for himself the healthcare services that he requires and the plans that suit him best. The tailor-made plans by the government that is provided to the society at large without recognizing the individual requirement will force the people for out of pocket expenditure thereby defeating the universal health coverage. The aim of this plan is to provide and make available a wide array of services, policies, and plans that an individual can choose from, at an affordable price without compromising the quality of the service. For understanding this model it becomes pertinent to understand the prevailing similar model of healthcare in few hospitals in India. For the purpose of this study, we take the example of Tata Memorial Service and CMC Vellore hospital.

Depending upon the financial capacity of the patient to pay for treating the patients fall under two categories namely General patients and Private patients. The general patients pay partly for the health care services whereas the private patients pay fully for the health care services. The general partly paying patients are further classified into three subcategories namely, C, NC, and BP. The patients belonging to subcategory Care partly charged i.e. they are charged 20% for investigation and consultation. The patients belonging to subcategory NC have to pay minimal charges for few services and they are not charged for investigation and consultation. The BP or Below Poverty Line category patients with annual income less than Rupee 1, 00,000 are provided cashless quality care under Rajeev Gandhi Yojana Scheme.[60]

In the event of hospitalization of a patient, the General patients of different gender are admitted in separate wards in Main Block of the premises whereas the private patients have a choice of semi-private room (2/3 patients in a room), private room (single occupancy), deluxe room (single occupancy). The general C category patients have to pay hospital deposit of Rupee 5,000, whereas NC category is not charged. The private patients availing semi-private, private, or deluxe rooms are required to pay Rupee 35,000, 50,000, 75,000 respectively. The medical procedures are costlier in the private category. [61]

The researcher argues for the implementation of the similar model throughout this country. For this model, the individuals above the poverty line will be classified into two categories. First category comprising individuals who can afford specialized and adequate healthcare and the second category comprising individuals who cannot afford specialized health cover or can afford inadequate specialized healthcare. The aim of this model is to provide adequate specialized healthcare to all irrespective of the affordability. The category that can afford adequate specialized healthcare will be called special or private category and the category that cannot afford adequate specialized health care will be termed as general category henceforth.

The general category can avail specialized health care at the prescribed minimum affordable premium in the general wards of the hospital after registering their name on the waiting list for the requisite health service. The inpatient facilities can be availed by the general patients as soon as the bed is available, or the required service is available. The coverage of the healthcare services will depend upon the plan that has been chosen by the beneficiary. If the availed healthcare services exceed the plan then the prescribed coinsurance kicks in above the exceeded limit. If an individual wants to avail the facility at the earliest instance by jumping the waitlisted queue for the non-emergency healthcare services, he will have to make the prescribed co-payment.

The special or private category will be required to pay a higher premium than the general category and the availability of the healthcare services on the will not be subject to the waiting list registration. However, they will be liable for prescribed deductible

before the health insurance starts covering the liability. It is to be noted that the healthcare services provided to the special and general class of patients will not differ in terms of quality and quantity. The special class of patients can avail the facility in semi-private, private or deluxe room depending upon the premium and co-pay.

The role of Supply Chain:

The healthcare model in India can be made affordable by an efficient supply chain model. Currently, supply chain expenses represent nearly 25% of pharm cost and more than 40% of medical device cost worldwide. This lead to expensive healthcare. Having a better supply chain model will result in reduced cost by shortening manufacturing lead time, slashing inventory levels across the value chain, and cutting product obsolescence. It can improve access, reducing drug and device shortage and delivering affordable healthcare and can transform safety, by making it harder for the counterfeit product to enter the supply chain and reducing the human and financial toll of medication error [62].

The existing regulatory framework will not be sufficient for the proposed method. There will be a need for comprehensive health cover care and protection legislation with the object of providing comprehensive and universal healthcare and protection by making the health care mandatory, affordable, accessible without compromising the quality. The provision should aim at making health insurance mandatory for everyone that should cover pre-existing conditions since the day of issuing healthcare policy.

4. CONCLUSION

The project commences with the analysis of various forms of health care models and there implementation around the world in various jurisdictions. The adoption of a particular model in the various jurisdiction is the result of the political and economic ideologies. The perusal of the various health care models was done with the aim to adopt the best practices prevalent in those jurisdictions. The analysis led to the inference that every health care model suffers from the structural deficiencies or capital deficiency owing to the whooping expenditure that is incurred by the state to implement such schemes. India is not in a position to adopt the model that is followed in UK and USA owing the deficiency in the budget that is allocated by the Indian government for the healthcare services in India. In the light of these circumstances, the applicability of any such model is possible.

Thus, this research paper proposes an alternate self-sufficient model which does not require the funding from the state as it has been seen in the past that government has failed to successfully implement health care policies due to the lack of budget. To fill these research gaps the proposed model suggests that to achieve maximum cover and provide universal health insurance with maximum penetration, the population should be divided into two categories namely Higher Income Group and Lower Income Group. The insured in the higher income group will have to pay a higher premium and can afford luxurious facilities in terms of the lodgings and stay where the insured belonging to the lower income group can avail the same treatment in the general ward of the same hospital at the lower premium. However, the aim is to provide same treatment and same health care services at an affordable premium. The model, if implemented, will eradicate out of expense model that has several disadvantages associated with it. It will bridge the gap between the difference in the healthcare services and affordability in the country. The ultimate goal is to provide universal quality health coverage that is affordable with a threefold strategy, 1. Planning the three stages with distress support and enabling. 2. Implementation in coordination with three stakeholders, 3. Regulating and monitoring system.

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