

# Health System Reforms for Universal Health Coverage: Insights from Select Emerging Market Countries

Sandhya Venkateswaran, Madhurima Nundy, Alok Kumar Singh and Pankhuri Bhatt



## 1. Introduction

The Alma-Ata Declaration on Primary Health Care in 1978, endorsed by countries across the world, failed to reach the desired goal of ‘Health for All by 2000’. In the early 2000s, varied political, economic, and social contexts led to the initiation of health-sector reforms aimed at consolidating fragmented health systems towards universal and equitable coverage. The year 2010 saw the global endorsement of the idea of universal health coverage (UHC) that had its roots in the Alma-Ata declaration.

Universal health coverage is now included in the global development agenda under the Sustainable Development Goals (SDGs) of 2015. The idea of

UHC, as envisaged globally, is that all individuals should receive comprehensive health services—preventive, promotive, curative, palliative, and rehabilitative—when they need them and where they need them, without suffering financial hardship. It embodies within it, the ideas of equitable, quality, and responsive health services. Though UHC goals are common to all, they are interpreted and adapted in different ways due to the diversity in the socio-economic, political, epidemiological, and demographic contexts and the varied opportunities and challenges faced by health systems across countries. The pathways and trajectories that countries follow are informed by these contexts, hence there is no standard solution

to achieving UHC. There are convergences and divergences across countries in terms of dilemmas and policy experimentations. Some of these include aspects relating to health-care costs, epidemiological transitions, advancement in information technology, and regional inequities. Rising health-care costs and high out-of-pocket expenditure (OOPE) have led to public discontentment. Demographic and epidemiological changes necessitate countries to adapt to changing needs of the population. Advances in medical and information technology need integration with delivery systems. Regional disparities have led to inequities in access to health care. Globalisation has increased interconnectedness and the consequent rise of infectious diseases, underlining the need to build stronger and more resilient health systems.

This policy brief synthesises insights, relating to key challenges faced in achieving UHC, from six emerging country case studies—Brazil, China, Indonesia, Mexico, Thailand, and Turkey—with varying contexts in their journey towards UHC. These countries were selected for their comparability to India in terms of economic level, State structure, the share of informal employment, type of health system, and burden of disease. Individual country papers reviewed and analysed the developments and reforms in health systems over the past decades in the respective country contexts (Venkateswaran & Singh, 2022a and 2022b; Nundy & Venkateswaran, 2022; Nundy & Bhatt, 2022a and 2022b; Singh & Venkateswaran, 2022;). This brief draws out some important insights for India and similar countries aiming to move towards UHC, keeping in mind the challenges faced by these countries.

Unpacking UHC implies the **availability** of all health services to enable **accessibility**, **affordability**, and **acceptability** of services for all people. Building on these elements, and with a view to the particular challenges faced by several countries, the following focus areas emerge: 1) gaps in the provisioning of health services alongside challenges of fragmentation in services; 2) accessibility through responsive financing systems; 3) affordability through financial risk protection and effective demand-side financing; and 4) acceptability through quality sought by regulatory systems, especially in the context of mixed health systems. These elements then become the focus of this brief.

## 2. Synthesis of Insights from Select Countries

### 2.1 Addressing Gaps in Provisioning

**Inequitable distribution of health services (infrastructure, deployment of supplies, medicines, technology, and human resources) across and within sub-national territories, and across rural-urban geographies are a common feature in several lower- and middle-income countries. Such inequitable distribution of services leads to inequities even when universal financial protection for health services is provided for.**

A key goal of UHC is to ensure comprehensive availability and equitable delivery of services near communities. In the absence of provisioning reforms that do not ensure the availability of services, financing reforms—which have been popular across countries—will unlikely lead to UHC. Countries have had different experiences with supply-side reforms and those with a combined focus on provisioning and financing, such as Thailand and Turkey, have been more successful in moving towards UHC. Countries that witnessed a limited focus on the supply of services witnessed slow progress on UHC.

Thailand has had a strong primary health-care system spread across the country before the universal financial reforms were introduced in the early 2000s. This was due to a strong movement by the Rural Doctors' Society (Nundy & Bhatt, 2022b). The combination of strong provisioning along with financial reforms, led to the success of their health systems. Turkey employed crucial measures to not only boost the supply of both physical and human capital but also ensured the effective use of infrastructure by applying strategic purchasing (Venkateswaran & Singh, 2022b).

Mexico, China, and Indonesia were less successful in their progress toward UHC due to their limited supply-side focus, despite financial protection. The Seguro Popular reforms in Mexico, aimed at financial protection, did not take into consideration inadequacies in infrastructure and human resources and this was one of the reasons Seguro Popular met with limited success in providing services to the

population covered (Singh & Venkateswaran, 2022). Similarly, China realised that reduction in OOPe was not possible only through financial reforms but needed simultaneous focus on supply-side issues. China went through the process of course correction by addressing inadequacies in primary-level services and its links with higher levels of care. In Indonesia, while the primary health-care infrastructure was well-developed there were challenges in the deployment and distribution of human resources (Nundy & Venkateswaran, 2022).

Gaps in human resources and their inequitable distribution have been a key challenge for several countries. Turkey addressed this by increasing the salary of physicians working in primary health centres (PHCs); elevating general practitioners to family physicians and bringing in compulsory services for newly qualified doctors for up to two years in a government facility. Brazil and China attempted to augment human resources, especially at the primary level, by expanding medical colleges. Students from rural backgrounds were paid a stipend to join and also incentivised through scholarships. Brazil established medical facilities in less developed regions, with the commitment to hire local students with incentives so that they could be subsumed within the same structure in the long term. Despite the incentivisation, addressing the human resources gap in hard to access, rural or remote areas has been difficult. Structural issues due to low salaries have led to doctors undertaking 'dual' practice, and preferring to work in urban areas where they can simultaneously practice in the private sector as well. The dual practice also played a significant role in the unequal distribution of doctors in Indonesia and Mexico. Abolition of dual practice by increasing the salaries of government doctors could enable the retention of human resources for public hospitals, as seen in Turkey. Brazil also focused on the development of Family Health Teams comprising community health workers (per 4,000 population) to service the poorest regions, which contributed to the reduction of reliance on specialists.

Despite different attempts made by countries, such as incentivising medical students/doctors and the creation of new teams of community health workers, inequity in the distribution of human resources remains a challenge due to several reasons including

differential personal and professional opportunities across rural and urban areas, and aspiration for the increase in income. Even though both Turkey and Brazil incentivised doctors to work in rural areas, inequities persisted due to the comparatively higher demand for urban areas.

## 2.2 Fragmented Health-Care Services

**Fragmented health-care services—with a lack of integration between preventive, promotive, and curative services, and weak referral systems—are a common feature of health systems in low- and lower-middle-income countries. This leads to direct access to secondary- or tertiary-care facilities, resulting in an undue burden on hospitals and undermining the ability to address diseases in a timely, rational, and cost-effective manner. Such lack of integration also results in a lower priority being accorded to the provision of preventive and promotive services.**

A central focus of UHC is on strengthening primary health services and integrating preventive, promotive, and curative services at the primary level. This ensures attention to the preventive and curative, limited burden on curative services, and timely and more effective attention to diseases. This can happen through gatekeeping by primary level health-service providers, who provide referrals to secondary and tertiary care and can help in keeping the system rational, and cost-efficient with equitable and adequate services for those seeking care.

To rationalise the flow of patients, countries have had a renewed focus on building and strengthening primary care services under UHC, typically through enrolling and registering community members under one family physician who is paid on a capitation basis. This has meant diverting the flow of patients from hospitals to primary-level services. The physician becomes the first point of contact for a person. A Family Medicine Unit (FMU) as in the case of Turkey, or a primary health unit has a team of personnel working with the family physician, including preventive and promotive services. Depending on the condition, the physician takes a call on whether to refer the individual to a higher institution or not.

Restructuring delivery has been undertaken by introducing the Family Medicine Programme in Turkey, the District Health System in Thailand, the Family Health Programme in Brazil, and introduction of the Family Physician model in China. In Turkey, the FMUs have been operational since 2005 and have helped reduce the burden on higher-level facilities through door-to-door services that enabled the handling of a large proportion of issues at the lower level of care. Turkey established more than 20,000 FMUs by 2013, to deliver door-to-door services (Venkateswaran & Singh, 2022b). In Thailand, the district health system (DHS) administers primary health-care, through an integrated primary health-care system with health-care units at the primary-care level able to resolve multiple problems due to a strong supply of workforce and other provisions (Nundy & Bhatt, 2022b). Brazil created a dedicated Central agency tasked with strengthening and monitoring primary health-care services and created a family health strategy programme with an adequate health workforce.

In order to keep people from directly accessing higher-level facilities, disincentives have been introduced in terms of higher co-payments for those who jump the referral in China. Patients who can afford to jump the queue and are willing to pay the penalty, access secondary or tertiary level institutions directly. Despite disincentives, curbing the flow of patients accessing hospitals directly has been difficult due to path-dependency issues (the persistence of previous processes because of resistance to change), in countries where citizens have long accessed hospitals as the first point of contact. The referral linkages have not been easy to introduce or re-introduce in cases where they have been broken. This has been largely due to loose gatekeeping, but also due to the commercial nature of hospitals at the secondary and tertiary levels. This is seen in China, Indonesia, and Turkey.

In China, for example, public hospitals behave commercially and have been unable to form successful linkages with health facilities below them (Nundy & Venkateswaran, 2022). In Turkey, gatekeeping (by primary level health-service providers, providing referrals to secondary and tertiary care) had to be removed due to citizens'

protests. Turkey then addressed the burden on the secondary and tertiary health-care system by: 1) introducing co-payment mechanisms if patients bypassed PHCs for primary health-care; and 2) by enrolling beneficiaries to a particular FMU who could not go to other FMUs within six months of enrolment (Venkateswaran & Singh, 2022b). Door-to-door services by FMUs in Turkey were one of the biggest reasons for reducing the burden on higher-level institutions. In Indonesia, the referral system faces numerous impediments including lengthy waiting time at the primary level, limited knowledge about gatekeeping, and lack of commitment from service providers (Nundy & Bhatt, 2022a). Those who are not insured, access health services directly at the hospitals and pay OOP. These patients are privileged over others who are insured, creating inequities at the point of delivery.

For strengthening primary-level care, not only are greater fund flows required at the primary level but also the flow of human resources to strengthen the primary-level cadre through training and their equitable distribution. As discussed in the previous section, reforms have been introduced in medical education to fill the need for a larger workforce at the primary level but these are long-term policies. For immediate reform, incentives to providers through performance-based remunerations have been tried. In Brazil, the performance-based payment system, with targeted incentives to improve services in remote areas, not only increased PHC coverage and enhanced quality but also addressed inequities in the distribution of health resources (Venkateswaran & Singh, 2022a).

In summary, gatekeeping, strong referral systems, and the strengthening of primary health services are important reforms in the context of UHC for integrated, equitable, and rational services. Restructuring service delivery through citizen enrolment under a family physician and the capitation payment system has been a common reform that has contributed to a balanced focus on preventive, promotive, and curative services. Path dependencies, however, often make such transitions challenging where behavioural shifts are required, and differential mechanisms and outcomes are visible across countries.

## 2.3 Challenges of an Input Financing System

Some countries have a dominant supply-side financing system, based on line-item financing. Such a system brings in rigidity, is not always responsive to the needs of the population, is inefficient, and makes it difficult to seek accountability in outcomes.

Problems of inefficient spending, as experienced in many countries, have been addressed in recent years through the policy instrument of strategic purchasing. This includes the creation of a purchasing agency, identification of interventions and the best providers to purchase from, and contracting arrangements to pay for interventions. These are aimed at addressing inefficiencies, accountability, responsiveness, and effective allocation of health funds. Reaching agreements on costs, particularly with the private sector, is a complex political process involving multiple stakeholders, aimed at good governance, mitigating corrupt practices in purchasing, and allowing fair competition.

An autonomous central agency that acts as a strategic purchaser, has been created in several countries to get such processes in place. In most countries the period before their reforms included the Ministry of Health playing the role of both the provider and financier. Reforms entailed a split between the purchaser and provider within the government institutional framework. The Ministry of Health continued to be responsible for provisioning and another autonomous agency introduced within the government system acted as the purchaser. The latter pooled in funds and had the power to purchase services from both public and private providers. The segregation of roles through different institutions allowed the purchaser to demand greater accountability from the provider.

Brazil, Turkey, China, Indonesia, and Thailand created this split by creating an autonomous body focused on purchasing services. Turkey could implement it due to its centralised administration and greater State capacity to negotiate with multiple stakeholders. The purchaser institutionalised accountability mechanisms, such as performance criteria of working eight hours in the PHC aimed at curbing dual practice by public-sector doctors. This brought about significant improvements in the health outcomes of the community (Venkateswaran

& Singh, 2022b). Mexico failed to implement such a process, because the agreement related to purchasing by an autonomous purchaser, met with resistance from health associations (Singh & Venkateswaran, 2022).

The literature suggests that strategic negotiation with doctors and nurses associations and the incorporation of these stakeholders at the design level can be a critical variable. Mexico did not include these stakeholders at the design level. Instead, they sought their suggestions at the implementation stage (Singh & Venkateswaran, 2022). In the case of Indonesia, the role of the purchaser was undermined by unclear demarcations between the provider and the purchaser, diluting the focus on the ‘strategic’ part of purchasing (Nundy & Bhatt, 2022a). For instance, while the purchaser was responsible for monitoring provider performance and quality assurance, this responsibility was given to the Ministry of Health, which was involved in setting up processes and rates for provider payments. The purchaser—who was no longer responsible for monitoring provider performance and quality assurance—became a passive and administrative stakeholder, responsible only for processing claims and making provider payments (Nundy & Bhatt, 2022a). In China, tensions between the purchaser and provider made coordination and negotiations tough. The purchasing power that was traditionally held by the Ministry of Health had now gone to another agency, and this was a source of tension between the two, as the purchaser seemed to wield more power (Nundy & Venkateswaran, 2022).

In summary, strategic purchasing has been an effective tool for improving efficiencies, accountability, and responsiveness in financing. This entails the creation of an agency that plays the role of the strategic purchaser, in turn diluting the possible traditional role of a Ministry of Health. This divide could be used as a tool to make the system accountable, and leverage performance by providers to ensure quality and equitable services.

Not surprisingly, political economy plays a dominant role in the introduction and successful implementation of these reforms aimed at standardising pricing, improving accountability and quality of services. The engagement of key stakeholders in the design of such reforms, as well as increased satisfaction levels among the citizens, may go a long way in enabling these transitions.

## 2.4 Financial Protection

**Low-middle-income countries experience the challenge of high OOPe in health care and a regressive financing system. The lower-income quintiles spend a higher proportion of their income on health care than the upper-income quintiles. The upper quintiles have access to voluntary private health insurance which is not accessible to poor and low-income households due to high premium costs. This leads to low financial protection for out-patient and in-patient services for a large proportion of the population, despite government programmes in many countries designed to address this.**

To provide universal financial protection as a goal towards UHC, countries either provide financing for health services to their population through general taxation or through a mix of mandatory and voluntary insurance schemes, in order to reach universal coverage. Health insurance, a demand-side financing model, is one of the dominant tools used across countries for pooling risks through a pre-payment mechanism. Forms of demand-side financing vary across government-financed insurance, social health insurance, or voluntary insurance. The dominant model amongst these is the social insurance model, which includes mandatory contributions from employees and employers in the formal sector as pre-payment for health coverage. By its design, this model covers only those employed in the formal sector. High-income countries cover a high proportion of the population, due to the high levels of formal employment. Low and lower-middle-income countries, on the other hand, have a low proportion of the population in formal employment, where the poor and the large informal workforce are covered either through government subsidies, voluntary insurance schemes or not covered at all. Reforms towards greater financial protection and universal coverage have been focused on an expansion of the insurance model to the entire population, with one model being non-contributory and the other focused on differential contributions across population groups.

The motivation and architecture of health insurance emerge from the political and economic contexts and priorities of the government at a given point in time. For Southeast Asian countries, the financial

crisis of the late 1990s and the ensuing social turmoil and disruption became the inflection point for providing security and stability to the population through welfare measures in the early 2000s. For China, the rise of public discontentment with rising OOPe and the outbreak of the SARS epidemic became the point at which financing reforms were introduced in the early 2000s.

China, Mexico, Indonesia, Thailand, and Turkey expanded insurance to the population that was previously not covered or partially covered. In all cases except China, the poor did not need to contribute. China sought a minor contribution of 5–10 percent of the premium amount from the unorganised sector through door-to-door campaigning. Thailand and Turkey covered the population through a government-sponsored insurance scheme, with nil or minimal contributions. Mexico and Indonesia introduced a targeted insurance programme where the non-poor were required to make voluntary contributions.

Insurance helped cover a large percentage of the population in most of these countries (Table 1). Coverage became universal in China, Thailand, and Turkey through mandatory insurance schemes. Indonesia was able to expand coverage to over 80 percent but was unable to reach universal coverage, as the government kept insurance voluntary for the large informal sector. This led to resistance in the contribution of funds and enrolment, resulting in low financial protection for the informal sector and thereby inequitable coverage.

Insurance was not the only mechanism to increase coverage. Unlike other countries, Brazil increased coverage by implementing the Family Health Strategy Programme, funded through general taxation and based on family health teams that reached out to the population. The community outreach teams increased from 4,000 to over 40,000 between 1998 and 2019, increasing coverage to 75 percent (Venkateswaran, & Singh, 2022a). Brazil's economic and political context led to the focus on government-provided services, rather than insurance. Brazil's balance of payment crisis in 1982 impacted public expenditure on health, leading to greater reliance on the private sector since public facilities focused on preventive services. This created inequities with a predominance of the private sector in urban areas and related high costs. The ensuing

health reform movement caused by the economic and political upheaval, therefore, demanded a patient-centric system, with services delivered through government facilities (Venkateswaran, & Singh, 2022a).

**Table 1: Coverage of Population (Pre and Post-Reform)**

Country	Percentage of population covered		Percentage of population in the informal sector, pre-reform
	2000	2018	
China	20	98	61
Indonesia	<50	82	54
Thailand	70	100	71
Brazil	22.8	75	60
Turkey	69.8	98.8	50
Mexico	51	85	59

Source: Bağır, Küçükbayrak and Torun (2021); Coletto (2010); International Labour Organisation (2014 and 2014a); Li, Malik and Hu (2017); Singh and Venkateswaran (2022). Sparrow Budiya, Yumna, Warda, Suryahadi and Bedi (2017); Tangcharoensathien, Patcharanarumol, Kulthanmanusorn, Saengruang and Kosiyaporn (2019); Turkish Statistical Institute (2020); Venkateswaran and Singh (2022a).

**Table 2: Health Financing Indicators, 2000–2019**

Country	GDP per capita, PPP (constant 2017 international \$)		Annual GDP growth (%)		Public expense on health (% CHE)		Current health expense (% GDP)		Out-of-pocket expense (% CHE)	
	2000	2019	2000	2019	2000	2019	2000	2019	2000	2019
China	3,452	15,978	8	6	22	56	4.5	5.4	60	35
Indonesia	5,621	11,858	5	5	30	49	1.9	2.9	45	35
Thailand	9,792	18,004	4	2	55	72	3.1	3.8	34	9
Brazil	11,529	14,685	4	1	42	41	8.3	9.6	37	25
Turkey	15,223	28,150	7	1	62	78	4.6	4.3	29	17
Mexico	17,943	20,065	5	-0.2	45	49	4.4	5.4	52	42

CHE: current health expenditure; GDP: gross domestic product; PPP: purchasing power parity

Source: World Bank 2023.

## 2.5 Design of Demand-Side Financing

**Universal (or near universal) coverage has not always resulted in equity. The architecture of demand-side financing has driven the extent of equity in benefits.**

While demand-side financing has been deployed as a key tool for addressing financial risk protection and inequities in health access across many countries, its architecture has varied on many fronts. Key elements of architecture that influence the extent of equity achieved, include: 1) the extent of fragmentation of risk pools; 2) whether the focus of insurance has been on breadth, depth, or both; and 3) whether populations moving across formal and informal work have been integrated. A key common aspect across most countries has been significant government expenditure on health care, made possible by economic, social, and political motivations that led to the initiation of reforms (Table 2).

Even when countries merge insurance schemes under one autonomous agency or purchaser of services created by the government, pools can remain fragmented and benefits differ. Formal sector employees invariably have access to wider benefits than the poor and those in the informal sector, who have limited choices and shallower coverage. Standardised benefits, through merged pools, have witnessed the greatest equity and satisfied citizens.

Unlike most other countries that have fragmented risk pools, Turkey was successful in developing a large risk pool combining tax and progressive contributions, thus cross-subsidising the poor and near poor (Venkateswaran & Singh, 2022b). Turkey had five different insurance schemes before the reforms, covering different segments of the population and with different benefit packages. Except for the Green Card scheme aimed at the poor, the others were devised for those employed or capable of paying the premium themselves. The Green Card scheme lacked an effective system for identifying beneficiaries and accordingly, failed to cover the target population, leading to large OOPE. Besides this, informal-sector employees and poor households did not have access to greater benefits like active civil servants. The Health Transformation Plan, Turkey's health reform in the early 2000s, addressed this fragmentation by creating the Social Security Institution (SSI) in 2006. Five insurance schemes were integrated under the purview of the SSI. Benefits were standardised to enable all citizens to access both public and contracted private hospitals for any health condition. This contributed to the reduction of OOPE from 28 percent of total health expenditure in 2000 to 16 percent in 2020. The political and economic stability post-2000 enabled the new government to implement reform measures. Furthermore, political continuity through the retention of power by the same political party through the reform period enabled the government to bring about necessary legislative (General Health Insurance Act) and administrative initiatives (integration of insurance programmes under an umbrella institution).

Thailand too reduced its OOPE from 34.2 percent to 8.7 percent of total health expenditure between 2000 and 2020, by covering 75 percent of the population under the Universal Coverage System, while the rest were covered under social insurance schemes

(Nundy & Bhatt, 2022b). Interestingly, both Thailand and Turkey spent 3.8 and 4.3 percent of their GDP respectively on health (current health expenditure) in 2019, which is almost similar to what they were spending in 2000 and lower than other countries with high OOPE. But within this, the government spending on health increased from 55 to 72 percent of current health expenditure for Thailand, and from 61 to 79 percent for Turkey, between 2000 and 2020.

Country experience shows that the feasibility of merging risk pools depended on the politics across the stakeholders involved. In China, integrating the resident scheme (including the informal workers and unemployed) with that of the urban formal employees was not considered politically feasible (Nundy & Venkateswaran, 2022). The urban formal sector employees, with greater political clout, accessed better benefits than the resident schemes and protected their interests by resisting the merger of schemes and sharing resources.

The context in which UHC emerged in Thailand had large public support, including the medical fraternity, led by a group of doctors (Rural Doctor Society) working towards designing UHC since the 1970s. The role of these doctors, former student leaders who fought against military leadership, has been significant in institutionalising UHC over the years. In the case of Turkey, citizen satisfaction with the government health system increased from 39.5 percent in 2003 to 67.1 percent in 2019. The more responsive the government health system, the more legitimacy it gave to the government, which got reflected in the retention of power by the political party. On the other hand, for Thailand, UHC became institutionalised under the populist party in 2002 and was sustained despite subsequent political upheavals.

Just how comprehensive services through insurance were, depending on the breadth of coverage and depth of benefits. Experience across countries varied in terms of focus across these two. Turkey and Thailand worked on expanding both the breadth and depth of services simultaneously, by increasing government funding (Venkateswaran & Singh, 2022b; Nundy & Bhatt, 2022b). A comprehensive benefits package resulted in effective financial risk protection, as reflected in the reduction in OOPE, low incidence of catastrophic health expenditure,



and impoverished households. China had universal coverage through insurance but the depth of benefits covered was shallow, especially among the informal sector and lower-income population (Nundy & Venkateswaran, 2022). The context of China in the early 2000s was conducive to universal coverage with shallow benefits; the country is now working on increasing benefits.

Indonesia, on the other hand, focused on depth (Nundy & Bhatt, 2022a). Benefits coverage was comprehensive for those covered, but coverage was not universal, with 80 percent of the population covered with deep benefits. In Indonesia, the informal sector was covered under a voluntary scheme, which did not make payments regularly. This led to adverse selection, where only those who needed health services would join, utilise the services and then leave the scheme. Comprehensive benefits in services with people moving in and out of coverage had financial implications and led to deficits (Nundy & Bhatt, 2022a). Making such schemes mandatory will likely address this.

Ensuring continuity of coverage, in the context of the flow of people from formal to informal employment, remained another challenge. In Thailand, citizens who got out of coverage through social health insurance due to a change in employment status were immediately enrolled in the Universal Coverage Scheme (UCS) for the informal sector or unemployed people (Nundy & Bhatt, 2022b). Mexico's Seguro Popular did not devise means to integrate people flowing out of formal employment into informal (Singh & Venkateswaran, 2022). The tripartite arrangement in Mexico—with contributions from the Centre, State, and beneficiaries—was expected to increase the available funds for Seguro Popular, but did not materialise as the majority of the eligible beneficiaries utilised the services free of cost without any contribution as per the design. The government expenditure on health as part of total health expenditure increased from 45.2 percent in 2000 to 52.2 percent in 2015, which was not adequate to add the unemployed population into Seguro Popular.

In summary, the extent of financial protection and equity has been driven by the aggregation of risk pools which increases citizen satisfaction through

uniform benefits and a demand-side financing architecture that focuses on both depth and breadth of coverage. These reforms require political commitment, which can enable increased public funds for health and the political management of long-term interests where citizen groups have enjoyed variable benefits.

## 2.6 The Challenges of Weak Regulation

**In several countries, the provider-payment mechanism is based on a fee-for-service (FFS) mechanism, whether insured or not. There is no cap on costs or bundling of payments, giving rise to irrational services by providers. In this scenario, despite insurance coverage many still incur high OOPe. The absence of strong regulation in provider fees constrains the containment of costs and OOPe.**

A gatekeeping function has been found to be an effective strategy in regulating both patient and provider behaviour. This also ensures a properly costed benefit package that is linked to payment mechanisms and defined service provision. The provider payment mechanism could be a form of contracted or regulated pay-for-performance arrangement that provides incentives to deliver the required services in an appropriate way.

Provider payment mechanisms also have an impact on the sustainability of insurance schemes. In Thailand and Turkey (Nundy & Bhatt, 2022b; Venkateswaran & Singh, 2022b), capitation payments for outpatient services and introducing diagnosis-related group (DRG) methods with a global budget (bundled) for in-patient services helped in containing costs and sustaining the programme, as against FFS in China, that charges separately for each service (unbundled) performed by health-care workers and increases and inflates the budget, hence unable to control health expenditure and reduce OOPe (Nundy & Venkateswaran, 2022). The Thailand experience shows a shift from supply-side to demand-side budgeting, limited discretionary budget allocation, and improved transparency and accountability to citizens (Nundy & Bhatt, 2022b).

## 2.7 Universal Health Care in Mixed Health Systems

Some countries have a mixed system of delivery with both public and private providers, often with a dominant private sector. The private sector is often heterogeneous with many small to medium-sized clinics, diagnostic centres, and hospitals, alongside a powerful corporate sector providing specialised services in the main urban cities. Such contexts are characterised by inequities in health delivery as a result of a high-cost private sector, functioning amidst weak regulatory structures, weak accountability, and delivering varied quality services.

Several of the countries under discussion have a dominant or growing private sector. Instead of allowing the creation of a two-tiered fragmented and inequitable system where private facilities are accessed by those who can afford them and public health-care services are left for the poor, countries have attempted to include the private sector within their reforms towards UHC. The adoption of financial protection to all led several governments to take on the role of the purchaser of services, with providers being either State-run health services or private health services. Through universal insurance coverage, the purchase of services by the government from the private health sector brings them into the purview of the mandate of UHC. Through this, the government also provided accreditation and regulated costs in the private sector. This was achieved through gatekeeping, standardised pricing, and reforms in provider-payment mechanisms as discussed before. Health-system architecture has been reformed to address regulation, through the creation of independent bodies specific to regulating the costs of drugs, diagnostics, and treatment.

There are challenges in regulating unnecessary services (including drugs, diagnostics, and procedures) by the private sector, which raises costs of care and OOP spending as co-payments. Resistance from the private sector to adhere to government mandates is common, but it is also important that government be sure-footed in its path toward UHC. The historical presence of the private sector with weak regulation, creates challenges in developing an effective and responsive system.

In the absence of regulation, the Mexican and Indonesian health systems, with a large network of private providers, were unable to successfully leverage private providers as part of their UHC reforms (Singh & Venkateswaran, 2022; Nundy & Bhatt, 2022a). The lack of regulation led to the disproportionate presence of such providers in urban areas, creating inequities in distribution compounded by the poor distribution of public facilities.

Turkey, on the other hand, introduced performance-linked payments to secondary and tertiary hospitals (Venkateswaran & Singh, 2022). This not only enhanced competition between public and private hospitals but regulated the costs of drugs and diagnostics, thereby controlling OOP. In Thailand and Turkey, there are annual negotiations on the pricing of services that have to be factored into the budget. However, a growing private sector, with increasing negotiating power brings into question the sustainability of financing to contain costs.

In Indonesia, despite government attempts at regulating the private sector through accreditation, licensing, and registration, weak implementation and monitoring led to weak accountability of the private providers (Nundy, & Bhatt, 2022a). Brazil too had a dominant private sector, with almost 70 percent of the total beds in the private sector in 1975, leading to greater utilisation of health services through private providers (Venkateswaran & Singh, 2022a). The large presence of private providers implied that when Brazil opted for a nationalised health service model, it had to rely on this private base. It did however establish institutions to regulate private expenditures. In Brazil, independent and professionally run regulatory bodies play a key role in controlling drugs, diagnosis, and treatment costs. Brazil's health reform movement (the Sanitarista movement) contributed to enabling this with strong participation from civil society, academic and municipal and State officers (Venkateswaran, & Singh, 2022a).

Regulation of the private sector is linked to the responsibilities of the purchaser as discussed before, which institutionalises accountability through strategic purchasing. In Thailand, private hospitals have to register annually with a medical registration agency. This agency regulates and sets rules and

standards of quality and safety. Accreditation guidelines are the same for public and private hospitals. Private facilities are contracted under the UCS and they are also involved in the governance of the UCS. Representatives from the sector serve on the board and on the quality control board of the public health service. Annual assessments of all hospital facilities are conducted empanelled under the UCS, by the purchasing agency responsible for the overall implementation of the insurance scheme.

Regulation of the private sector not only addresses the protection of patient rights and patient satisfaction but also ensures financial protection. Regulation of the private sector is also important for easing barriers to care coordination and integration of services. The private sector can be brought under the purview of UHC for better regulation via the financing mechanism of providing universal coverage through a dialogue on the goals and objectives of universal coverage. This could create some regulatory structures linked to accreditation, quality, accountability, and curbing irrational services. This of course could be leveraged successfully if coverage is universal, government is the purchaser, and providers are paid on outcomes.

## 2.8 Health Delivery in a Federal Structure

**In federal countries, health is often under the purview of State governance. Where Centre-State dynamics are marred with tensions, there are inequities in the distribution and availability of services. Both decentralisation and centralisation can be effective models for better-performing health systems for better outcomes. This would depend upon the political context of the countries.**

In the debate on centralisation and decentralisation of health services, experiences have differed across countries. Decentralisation, often viewed as an effective strategy for better access and outcomes, needs to be associated with greater autonomy and equitable distribution of healthcare resources. A prerequisite for effective decentralisation is effective capacity at the sub-national level. Differential capacity and inadequate attention from Central institutions to build capacity may increase disparities. Decentralisation has worked when the support from the Centre has been stronger, State capacities are

strengthened and there are funds devolved in an equitable manner across provinces/districts, with less developed provinces receiving more central support and resources.

The reforms in Brazil aimed to address prevailing inequities through decentralisation focused on: 1) the delegation of financial and administrative autonomy to municipalities; 2) the integration of health-care activities under the stewardship of the Ministry of Health; and 3) regulating the private sector (Venkateswaran & Singh, 2022a). Decentralised health-care was strengthened through the development of health-care networks organised on the basis of health regions, where planning and provisioning of health care were integrated, alongside extending support to lower capacity regions.

China and Indonesia both gave autonomy to provinces with fiscal decentralisation to reach UHC goals. Indonesia's experience shows that decentralisation created disparities across regions due to the weak capacities of disadvantaged regions and the Central government's lack of commitment toward these islands. Indonesia had a strong centralised government before decentralisation and there already existed patronage norms, nepotism, and related corruption (Nundy & Bhatt, 2022a). These practices continued after the reforms, which hindered accountability post-devolution of services. In China as well, decentralisation led to variations in the performance of health systems across provinces due to the absence of appropriate mechanisms to transfer and equalise payment (Nundy & Venkateswaran, 2022). As a result, there were inequities in accessing health-care services in poor provinces and rural areas.

Countries like Thailand and Mexico have gone back to re-centralising their systems of governance in the health sector, while Turkey has continued with a centralised system with a mandate of uniform UHC with fiscal decentralisation (Nundy & Bhatt 2022b; Singh & Venkateswaran 2022; Venkateswaran & Singh 2022b). Thailand and Turkey both had a strong political mandate of UHC and this commitment helped the reforms to become a success from the Central to the local levels. Mexico was unable to have a strong mandate and was unable to regulate and monitor health services through proper negotiations and dialogues with the private sector,

professional associations, and other stakeholders. It did not give much support to regions that were less developed with fewer capacities, hence reinforcing inequities.

In summary, what works for a country can be attributed to the different political contexts and

ensuing Centre-province dynamics that can ensure the balance of independence and supervision required over different elements of the health systems between levels of governance, but in the main, a Central government mandate and support for UHC has to be strong at the political level.

**Table 3: Health-Sector Reforms Across the Six Countries**

Country	Brazil	China	Indonesia	Mexico	Thailand	Turkey
<b>Type of Insurance</b>	Not an insurance-based system; health services provided by Govt	Two schemes – for urban (formal), and urban and rural (informal)	Universal National Health Insurance with different pools for formal, informal, and the poor	Combination of Govt-provided services and insurance	Different insurance schemes for different population groups	Universal tax-funded health insurance model
<b>Breadth of Coverage</b>	Designed to be universal; effective coverage of 75%	Universal coverage	Designed to be universal: 82% covered	Formal sector (49% of population) covered; Govt provided services cover the rest	Universal coverage	Universal coverage
<b>Depth of Coverage</b>	Comprehensive, including preventive and curative	Moving towards inclusion of all levels of care, preventive and curative	Comprehensive, curative services (not preventive)	Comprehensive coverage, including preventive and curative	Comprehensive coverage, including preventive and curative	Comprehensive coverage, including preventive and curative care
<b>Single or Multiple Risk-Pools</b>	Single tax-funded pool	Multiple and fragmented risk pools for different groups. Mandatory for all. No cross-subsidisation	Multiple risk pools: mandatory for formal, voluntary for informal employees, and subsidies for poor. No cross-subsidisation	Multiple risk pools for formal sector, tax-funded for rest	Multiple and mandatory risk pools for Govt officers; for formal sector employees; and rest; no cross-subsidisation	Single risk pool under umbrella organisation, and cross subsidisation for poor
<b>Public and Private Providers</b>	Primary - Mainly Govt; secondary and tertiary-PPP mode	> 80% Providers are public at all levels of care	For primary, many private modern and traditional practitioners; 63% private hospitals; many at secondary and tertiary level empanelled within the NHI	Private clinics provide 85% primary care; Govt facilities mainly provide secondary and tertiary care	Some primary facilities and most private hospitals empanelled under UCS	Govt is the main provider at all levels of care
<b>Purchasing and Provider Payment Mechanism</b>	Pay for performance at PHC level and PPP facilities; line-item budgeting for public hospitals	Fee-for-service reimbursements, but moving towards DRG for in-patient, and capitation for out-patient services	Primary care funded through capitation; in-patient payments done through DRG methods	Input budgeting dominant payment model across all public providers	Mix of fee-for-service and capitation for out-patient services; DRG and global budgeting for in-patient services, depending on insurance scheme	Combination of global budgeting and performance-based supplementary payment at public hospitals and PHCs

Country	Brazil	China	Indonesia	Mexico	Thailand	Turkey
<b>Governance</b>	Regulation of private sector, including pharmaceutical, through quasi-autonomous institutions	Single agency manages and regulates insurance schemes, and purchases services	Single agency merges all insurance schemes, and regulates health-care services	General health law governs health regulation and health-service provision	Single agency manages and regulates schemes and acts as purchaser	Quasi-autonomous agency regulates drug prices and Ministry of Health regulates private establishments
<b>Incentive to Workforce</b>	Scholarships to students from deprived regions	Subsidisation of tuition fees, especially for those from rural areas	Incentives in rural areas and regulations to limit dual practice by doctors	Better remuneration than in private sector for, doctors employed in Govt facilities	Rural workforce recruited to work in districts; scholarships to students willing to work in remote areas	Increased salary to family physicians working in deprived regions
<b>Gatekeeping</b>	No gatekeeping; strengthening PHCs, reduced burden on higher facilities	Gatekeeping piloted by introducing family doctor model	Gatekeeping was part of overall reforms, but not implemented effectively	No gatekeeping	Effective gatekeeping	No formal gatekeeping system; strengthening PHCs, with result-based financing, reduced burden of secondary and tertiary care
<b>Challenges</b>	Dual practice and line item budgeting in public hospitals, strengthening private sector	Commercial nature of public hospitals creates over-dependence on them; inequitable insurance schemes offer diverse benefits	Dual practice by doctors; over-dependence on hospitals; low voluntary contributions by informal workers; ineffective regulation of private sector; Inequity in human resources distribution	Existence of dual practice; large private sector with ineffective regulation	Ineffective regulation of private sector; inequities in human resources distribution and across insurance schemes	Absence of referral system

Source: Venkateswaran and Singh (2022a, 2022b); Nundy and Venkateswaran (2022); Nundy and Bhatt (2022a, 2022b); Singh and Venkateswaran (2022).

### 3. What are the implications for India

India has the same UHC goals as other countries, and many of the challenges discussed above resonate with the Indian context. While there are insights emerging from the experience of other countries, their adoption or adaptation will depend on the specific socio-economic, political, epidemiological, and demographic context in India. Thus, there is no defined or standard solution to achieving UHC, but the charting of a broad pathway, which has to be navigated through India's own socio-economic and political canvas.

Despite improvements, financial risk on account of health expenditures remains high in India. At 10 percent of the population, the organised sector in India is small, with health coverage through insurance. A large section of the unorganised sector remains without any health coverage and pays OOPE to access health services. India has introduced demand-side financing through health insurance provided by the government, and based on global experience, India could do well to focus on how this can be strengthened. Increasing coverage requires an increase in public expenditure on health, and global experience has underlined the various triggers that motivated this. While the Asian financial crisis and the SARS outbreak are contextual examples that motivated financial reforms in different countries, the question for India is what might incentivise such shifts in the country.

While universal coverage is important, its mere provision is not enough. Health financing in India is extremely fragmented,<sup>1</sup> undermining the potential for efficiency, equity, and accountability that large consolidated risk pools can bring. Consolidation of different risk pools could help India move towards effective and equitable coverage.

Even though India has for long focused on a supply-driven system, its health infrastructure, health workforce, drugs, and other medical supplies remain inadequate and unevenly distributed. Until the health system is strengthened and supply-side gaps addressed, it is unlikely that insurance coverage in itself will provide meaningful access to health. Country experience suggests that despite initiatives aimed at the equitable distribution of

human resources, this has remained a challenge in most countries, and effective pathways are not obvious. What is clear however is that India needs to increase public expenditure on health to: fill infrastructure gaps, incentivise the health workforce, and implement reforms that rely less on specialists.

India's health system remains fragmented, with a disproportionately high focus on curative services. The absence of integration and discipline in use across different levels of care has impacted health-seeking behaviour, with citizens making their own choices on the first point of care. This has reduced the potential for a strong preventive and promotive system and led to the disproportionate use of secondary and tertiary services. The latter has implications for the effective control of disease and costs. Country experience shows the value of gatekeeping, but it also highlights the path dependencies involved. Introducing gatekeeping at the primary level in India will require significant cultural shifts in health-seeking behaviour, the pathways towards which need greater study.

India's supply-side financing system with line-item budgeting has been under discussion for a long, for its inability to effectively address contextual health challenges. Not only is such a system not able to address the differential health contexts and needs across states, but supply-focused financing limits the ability to optimise accountability, outcomes, and control costs. Purchasing of services is being increasingly introduced across India, but it is strategic purchasing, a key reform as evident from country experience, that will enable greater accountability. These shifts entail separating the purchaser from the provider and political economy aspects often play out in determining the success of such shifts. The strength of political commitment to health, the role played by the political regime, and the capacity of the administrative regime in bringing about such a separation, are key to success. Turkey, for example, could implement such shifts well due to its centralised administration and greater State capacity to negotiate with multiple stakeholders.

Weak regulation regimes in India have led to high prices and often unnecessary prescription of drugs, diagnostics, and irrational procedures. Strategic

<sup>1</sup> National and State contributory pools such as State voluntary health schemes, Employees' State Insurance Scheme (ESIS), Central Government Health Scheme (CGHS), Railroads, Defence, other government employee social health insurance (SHI), private employer coverage, private-owned commercial, public-owned commercial; National and State non-contributory such as National Health Mission (NHM), other Central health expenditure, Pradhan Mantri Jan Arogya Yojna (PMJAY), State public health expenditure; and out of pocket expenditure (OOPE).

purchasing offers the potential to improve the regulation of providers through negotiations on pricing, protocols, and other aspects. Country insights point to the value of engaging with varied providers and other stakeholders and mobilising their ownership, in the process of developing such strategic pathways.

India has had a mixed health-system for a long, with a dominant private sector. The experience across countries demonstrates the need to mobilise the private sector in the country's UHC strategy through a combination of strategic purchasing and a capitation-based system for primary care.

Finally, in India's federal structure, inequities across and within states remain high. Health is a State subject, but the role of the Centre is significant in policy formulation and in fiscal and administrative devolution. Greater devolution to the States focused on outcomes with a view to the differential needs and capacities across states, is needed.

In any of these reforms, much depends on the commitment to health at the highest political levels. Countries that have prioritised health have been more successful than others in bringing about shifts that require changing the status quo of decades. Both Thailand and Turkey for example, had a strong political commitment to UHC which was pivotal in bringing about reforms in a successful manner.

In Thailand, UHC became institutionalised under the populist party, Thai Rak Thai, in 2002 and was sustained despite subsequent political upheavals.

The role played by actors, external and internal to the system, has also been critical in creating the political mandate. Brazil's health reform movement (the Sanitarista movement) for example, which included civil society, academic, municipal, and State officers, was instrumental in the prioritisation of health reforms. The Rural Doctors Society in Thailand similarly, played a decisive role in Thailand's reforms towards UHC.

Political and economic stability enables governments to introduce reforms and legislative and administrative initiatives. The retention of reforms is often made possible by political continuity, and citizen satisfaction emerging from the reforms. Turkey has been a strong example of this. In the decade-and-a-half after the reforms, citizen satisfaction with health systems in Turkey increased considerably. As citizen satisfaction increased, so did the government's legitimacy. This enabled the government to retain power over a long period. India currently has a stable government. This offers the country the opportunity and window to initiate reforms that will be viewed by citizens to be responding to their health needs.

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## About the authors



**Sandhya Venkateswaran** is a Senior Fellow at CSEP and leads the Human Development work at CSEP, with a specific focus on Health Policy. Spanning a career over three decades, she has worked on a wide range of issues in the social sector spanning health, nutrition, gender, natural resources, urban development and others, and has authored books, multiple articles and other publications on varied social sector issues. Over the last 15 years her focus has been on policy issues, developing and leading the policy and advocacy portfolio in organisations such as the Bill and Melinda Gates foundation, Global Alliance for Improved Nutrition and CARE. She has worked with grassroots campaigns and civil society organisations, as well as with government and international organisations. She is currently a member of the Lancet Citizens Commission on Reimagining India's Health System.



**Madhurima Nundy** is a Fellow in Health and Human Development at the Centre for Social and Economic Progress, New Delhi. She holds a PhD in Public Health from the Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi. She completed her MPhil from the same centre. Previously she was Assistant Director and Fellow at the Institute of Chinese Studies (ICS), Delhi (2012-21); Senior Programme Coordinator at the Public Health Resource Network, New Delhi (2009-12). Among other experiences, she was a Technical Consultant with the National Commission on Macroeconomics and Health (2004-05) and a Research Associate at the Institute of Social Studies Trust (1999-2001). Her areas of interest include studying different health service systems, health policies and inequalities in health. She has several publications to her name.



**Alok Kumar Singh** is a Research Associate in the health vertical at CSEP. He has done his MPhil in Public Health from the Tata Institute of Social Sciences, Mumbai, and MA in Development Studies (specialization Public Policy) from Azim Premji University, Bengaluru. Prior to CSEP, he has worked as a researcher with the Abdul Latif Jameel Poverty Action Lab, National Centre for Biological Sciences – Tata Institute of Fundamental Research, and also as a manager with Reliance Industries Limited, Mumbai. His research interests include health systems strengthening, social epidemiology, and the interaction of biomedicine with other medical systems.



**Pankhuri Bhatt** has recently completed her master's in public policy from Jindal School of Government and Public Policy. Prior to it, she was a consultant at a law firm management consultancy. She is interested in public health, including health system strengthening, governance, health economics and financing. She is also interested in studying the developments in public health through the perspectives of gender and social inequalities.

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CSEP Research Foundation

6, Dr. Jose P. Rizal Marg, Chanakyapuri, New Delhi - 110021, India



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