ANALYSIS OF THE FLAGSHIP HEALTH MODEL OF GNCTD:

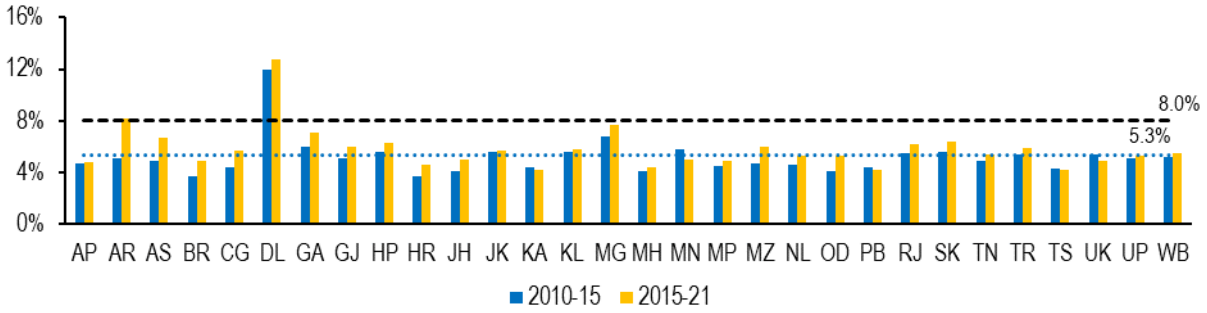
MOHALLA CLINIC

When one goes into understanding the governance in the National Capital, health and education will always be stars of the show. Being a metropolitan city with almost a 2 crore population, it requires high-level critical analysis and public policy framework to wisely and economically allocate and spend the funds. What is even more striking is that, at the helm of the governance at the National Capital, we have unconventional individuals designing health and education schemes. As the Deputy CM, Manish Sisodia mentioned in his Keynote address at the Harvard Kennedy School of Government, "Policymaking is not a rocket science, it requires honest intent to find honest solutions."

The most interesting aspect of healthcare planning in Delhi is that it is the vision of an architecture-turned-politician who, in the past few years has exponentially revamped the public healthcare system in Delhi. Architectures can imagine, design and implement accurate and precise ideas. They have observational skills that tell them how a common man would desire his house. These are policies that are designed based on how a common man takes action in terms of health care and what he would expect as an outcome from his actions. This is the reason why policymaking especially in developing countries is a two-way process, the positive actions on both sides of the table matter.

The flagship model by the Delhi Government has revolutionized how we look at governance. In a one-liner, it is how the Delhi CM, Arvind Kejriwal states after his stupendous victory in the 2015 polls, "People have proven that Kejriwal model of governance is better... and in our model, a common man is at the centre." The "common man" is where the government should begin. The idea is to give to those who give you. The allocation of the Delhi Government budget, year after year, with extensive percentages assigned to the education, health and transport sectors, has undoubtedly shown that public welfare lies at the summit of policymaking. Looking at the data one can see that Delhi attributes the highest to the health sector of all the states in India.

State	Abbreviation	State	Abbreviation	State	Abbreviation
Andhra Pradesh	AP	Jharkhand	JH	Odisha	OD
Arunachal Pradesh	AR	Jammu and Kashmir	JK	Punjab	PB
Assam	AS	Karnataka	KA	Rajasthan	RJ
Bihar	BR	Kerala	KL	Sikkim	SK
Chhattisgarh	CG	Meghalaya	MG	Tamil Nadu	TN
Delhi	DL	Maharashtra	MH	Tripura	TR
Goa	GA	Madhya Pradesh	MP	Telangana	TS
Gujarat	GJ	Manipur	MN	Uttarakhand	UK
Himachal Pradesh	HP	Mizoram	MZ	Uttar Pradesh	UP
Haryana	HR	Nagaland	NL	West Bengal	WB



In its' INR 69,000 crore "Desh Bhakti" Budget for 2021-22, the AAP government has allocated INR 9,934 crores to the health sector, which would include, 100 more new Mohalla clinics for women, INR 1,293 crores are allocated to revamp health facilities for COVID-19 management and INR 50 crores has been distributed to the Aam Aadmi Nishulk COVID Vaccine Yojana wherein they aim to expand the capacity of the number of doses administered in the NCT from 45000 per day to 60000 per day. It is also to be noted that the AAP government economics is measurable but not replicable. With their extensive welfare spending in the past years, they were successful to achieve a fiscal surplus in 2017-18 of INR 113 crores along with this the public debt to GSDP (Gross State Domestic Product) ratio had decreased from 7.23% to 4.89% from 2014-15 to 2017-18. However, now even if the government faces a Gross Fiscal Deficit as a ratio of GSDP at 0.5% but it is relatively better than the rest of the states. This deficit, as well, is expected due to the economic slowdown due to waves of infections and subsequent lockdown, demand slowdown and higher expenditure.

The state-wise data given by the Reserve Bank of India is as follows:

(Per cent)

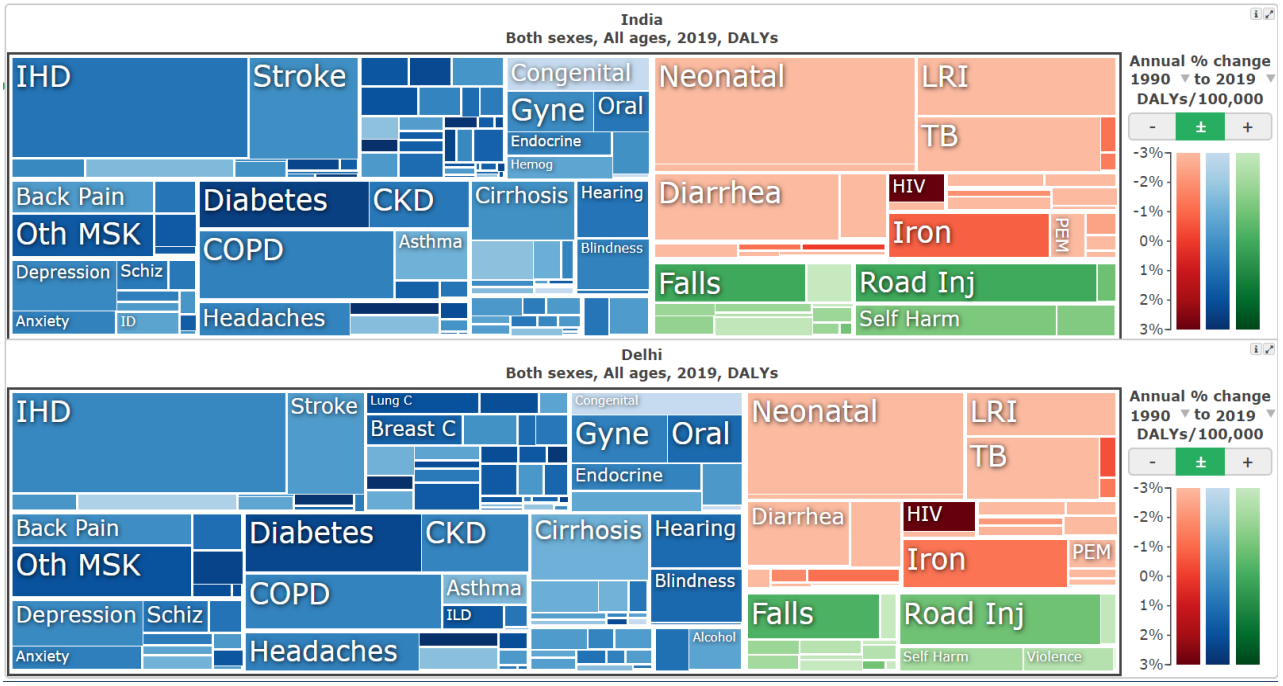
	State	2017-18			2018-19			2019-20 (RE)			2020-21 (BE)		
		RD/ GSDP	GFD/ GSDP	PD/ GSDP	RD/ GSDP	GFD/ GSDP	PD/ GSDP	RD/ GSDP	GFD/ GSDP	PD/ GSDP	RD/ GSDP	GFD/ GSDP	PD/ GSDP
	1	2	3	4	5	6	7	8	9	10	11	12	13
1	Andhra Pradesh	2.0	4.1	2.3	1.6	4.1	2.3	2.7	4.2	2.5	1.7	4.4	2.6
2	Arunachal Pradesh	-12.8	1.4	-0.7	-15.3	8.0	5.9	-12.8	3.1	0.8	-21.3	2.4	0.1
3	Assam	0.5	3.3	2.1	-2.1	1.5	0.3	-0.2	6.1	4.7	-2.3	2.4	0.9
4	Bihar	-3.2	3.1	1.1	-1.3	2.6	0.7	3.0	9.5	7.7	-2.8	2.9	1.1
5	Chhattisgarh	-1.2	2.5	1.4	-0.2	2.7	1.5	2.9	6.4	4.9	-0.7	3.2	1.6
6	Goa	-0.7	2.3	0.5	-0.5	2.5	0.6	-0.3	5.0	3.1	-0.4	5.3	3.3
7	Gujarat	-0.4	1.6	0.2	-0.2	1.8	0.4	-0.1	1.6	0.3	0.0	1.8	0.5
8	Haryana	1.6	2.9	1.1	1.5	3.0	1.1	1.8	2.8	0.9	1.6	2.7	0.8
9	Himachal Pradesh	-0.2	2.8	0.1	-1.0	2.3	-0.3	2.4	6.4	3.7	0.4	4.0	1.3
10	Jharkhand	-0.7	4.4	2.7	-2.0	2.1	0.5	-2.0	2.4	0.8	-0.5	2.2	0.7
11	Karnataka	-0.3	2.3	1.3	0.0	2.5	1.5	0.0	2.3	1.2	0.0	2.6	1.3
12	Kerala	2.4	3.8	1.7	2.2	3.4	1.3	2.0	3.0	0.9	1.6	3.0	1.0
13	Madhya Pradesh	-0.6	3.1	1.6	-1.1	2.7	1.1	0.3	3.6	2.1	1.8	5.0	3.3
14	Maharashtra	-0.1	1.0	-0.4	-0.5	0.9	-0.4	1.1	2.7	1.5	0.3	1.7	0.6
15	Manipur	-4.2	1.3	-0.9	-2.9	3.3	1.2	-0.9	8.5	6.8	-5.6	3.8	2.2
16	Meghalaya	-2.9	0.5	-1.5	1.6	6.1	4.1	-2.0	3.6	1.6	-2.3	3.8	1.7
17	Mizoram	-9.1	1.7	-0.1	-7.9	1.8	-0.1	2.8	10.4	8.7	-3.3	2.3	0.7
18	Nagaland	-3.4	1.8	-0.9	-1.9	4.0	1.1	1.9	8.0	5.1	-3.0	4.0	1.1
19	Odisha	-3.0	2.1	1.0	-2.9	2.1	0.9	-1.2	3.4	2.2	-1.6	3.0	1.8
20	Punjab	2.0	2.7	-0.6	2.5	3.1	0.0	2.2	3.0	-0.1	1.2	2.9	0.0
21	Rajasthan	2.2	3.0	0.7	3.1	3.7	1.4	2.7	3.2	0.8	1.1	3.0	0.7
22	Sikkim	-4.1	1.8	0.4	-2.4	2.2	0.7	-0.2	3.7	2.1	-1.7	2.8	1.3
23	Tamil Nadu	1.5	2.7	0.9	1.4	2.9	1.1	1.4	3.0	1.3	1.0	2.8	1.1
24	Telangana	-0.5	3.5	2.1	-0.5	3.1	1.7	0.0	2.3	0.8	-0.4	3.0	1.7
25	Tripura	0.7	4.7	2.7	-0.3	2.7	0.6	3.8	6.5	4.4	0.4	3.5	1.4
26	Uttar Pradesh	-0.9	1.9	-0.1	-1.7	2.1	0.2	-1.5	2.8	0.9	-1.4	2.7	0.8
27	Uttarakhand	0.9	3.6	1.8	0.4	3.0	1.2	0.0	2.5	0.6	0.0	2.6	0.6
28	West Bengal	1.0	3.0	0.1	1.0	3.1	0.4	0.5	2.7	0.2	0.0	2.2	-0.1
29	Jammu and Kashmir	-5.5	2.0	-1.4	3.1	8.5	5.1	-4.4	7.1	5.0	-12.8	5.3	1.7
30	NCT Delhi	-0.7	0.0	-0.4	-0.8	-0.3	-0.7	-1.1	-0.1	-0.4	-0.8	0.5	0.2
31	Puducherry	-0.6	0.6	-1.5	0.0	0.8	-1.1	-0.3	0.8	-1.0	1.0	1.8	0.2
All States and UTs		0.1	2.4	0.7	0.1	2.4	0.8	0.7	3.2	1.5	0.0	2.8	1.1

RE: Revised Estimates. BE: Budget Estimates. RD: Revenue Deficit. GFD: Gross Fiscal Deficit. PD: Primary Deficit.
GSDP: Gross State Domestic Product.
Note: Negative (-) sign in deficit indicators indicates surplus.

This clearly shows that the Delhi governance and administration model under the AAP government is based on welfare spending with fiscal prudence, this is specifically something that should be a key strategy for the pro-growth policy framework in India. Seeing this, many allegations came forward to attack their “freebies” strategies alleging that it was a populist agenda, however one can see that it is the result of the efficient allocation of resources. Seeing a good amount of health expenditure, Mohalla Clinics is the key health policy to combat primary health issues. The Aam Aadmi Mohalla Clinics (AAMC) is the primary healthcare provider in the three-tier healthcare provision model in Delhi, with the Mohalla Clinics at the bottom of the pyramid and the Super Speciality Hospital at the top of the pyramid. This pyramid in Delhi was earlier inverted however with the establishment of the Mohalla Clinic, the pyramid has been reversed and set systematically. The Mohalla Clinics have been set up with the purpose to reduce the footfall at the government super speciality hospitals. It is also set up with the purpose to reduce the out-of-pocket expenditure on health, which is very high in India, wherein in the AAMC, the government provides free medical consultation, diagnostic facilities, and medicines at absolutely no cost to people of the community. Having been located in the deep locations of underserved and marginalized communities, the Mohalla Clinics have strategic importance to provide free and efficient medical services to every household in unauthorised colonies or ghettos in Delhi. All the medical prescriptions from most of the Mohalla Clinics around the city are recorded on the digital platform for future reference and data collection. The clinics have several pros which outweigh the cons. As our respected Health Minister, Satyendra Jain states that these primary health care services are not free, they are paid out of the government fund, received through the taxes collected from the citizens. This is exactly why the scheme is successful and applaudable, as it gives to those who give.

The scheme has been applauded by the former Secretary Generals of the United Nations Organisation Ban Ki-Moon and Kofi Anan and even the ex-Prime Minister Gro Harlem Brundtland for its inception and implementation. Universal Health Coverage (UHC) as explained by the World Bank and WHO is when "all people receive the health services they need without suffering financial hardship when paying for them". The UHC has been adopted under the Sustainable Development Goals (SDGs) in 2015 and is essential for the development of the country. When one reads the line, one can correlate it with the Mohalla Clinic model, it is precisely what the Universal Health Coverage envisions. What is even more applaudable here is that, that the AAP government policymaking targets the important parameters for per capita development. They focus on free and accessible healthcare, education, transport, etc. The government here believes that one cannot achieve development and growth goals by simply benefitting the handful, but it is when the entire population achieves a good standard of living including proper healthcare and education that the collective goal is achieved.

The most important aspect of the health system in the National Capital is that it is in coherence with the data on the Global Burden of Disease and the per-person burden in terms of Disability Adjusted Life Years (DALYs) data. As per the 2017 data given by The Lancet, more than a third of DALYs occurred due to non-communicable diseases such as diabetics, hypertension, etc., communicable diseases, maternal, perinatal and nutritional disorders. The diseases adding most to the DALYs around the world include ischaemic heart disease, perinatal conditions, chronic respiratory diseases, diarrhoea, respiratory infections, cancer, stroke, road traffic accidents, tuberculosis, and liver and alcohol-related conditions. Even when one looks at the Global Burden of disease chart for India in comparison to Delhi, it is seen that the health models and schemes are designed to circle these main indicators only. The GBD chart can be seen below.



It is observable that all policies and schemes implemented by the AAP government in the sphere of health are specific to these diseases e.g., Janani Suraksha Yojana, Janani Shishu Suraksha Karyakarm, Pradhan Mantri Surakshit Mantritva Abhiyan for pregnant women and infants, immunization schemes such as Mission Indradhanush Kawach, Child health programmes such as New Born Care corners, Kangaroo Mother care, Nutritional

Rehabilitation Centres, Intensified Diarrhoea Control Fortnight, National Iron+ Initiative for 6-10-year-old, SAANS (Social Awareness & Action To Neutralise Pneumonia Successfully) for childhood pneumonia, ICDS, Vector-Borne diseases programme specifically for dengue, malaria, chikungunya, National AIDS Control Programme under the Delhi State AIDS control society, an autonomous body, revised National TB Control Programme, Delhi State Health mission to combat communicable and non-communicable diseases with several programmes under them. These all schemes and policies form the basis for the conception of the idea for Mohalla Clinics, wherein the aim is to catch and treat the disease only at its initial stage and successfully decrease the propensity of increasing DALYs due to this.
It is also important to note here that healthcare policies such as the conception of Mohalla Clinics do not form in a night's time with a magic wand, it is researched, formulated and then implemented. It is also necessary to understand that the approach of the Mohalla Clinics, as per this analysis, is aiming to achieve Universal Health Coverage under the UNDP SDGs, such policies are usually not one of a kind, however, it is so in India specifically, but it has been used by a whole range of developed and developing economies successfully, wherein the community-centric approach has led to tremendous achievements. As citizens, it is important to understand the gravity of policies that the government undertakes, it's important to make sure that it is not experimental but tried-tested and successful. Hence, the NCT government draws the Mohalla Clinic concept from the healthcare system of the three countries, two developing economies namely, Brazil and Cuba and a free market developed economy, Singapore. The flagship Mohalla Clinic policy draws nuances from these systems and created a separate model under this paradigm. Before one dives into the comparison of the health care models, it is imperative to understand that health care in India, as per Constitutional duties, is a state duty with certain duties intersecting with central and certain duties assigned to the centre only, however, those duties to the centre are less ground-related.

Brazil is the largest country in the South American and Latin continent and like India, it is too the leading contender for the largest caseloads of the Covid-19 virus in the world. However, we must note that the health system in Brazil is still something to learn from. It is interesting to note that the duties in the Brazilian system are assigned systematically to three bodies Federal, State and Municipalities where the decentralised, universal public health is tax-funded and from the contributions of the above three bodies. There is private health insurance that a lot of citizens undertake and it is considered a tax deduction in their system. The Brazilian health system to achieve universal health coverage (UHC) is SUS (*Sistema Único de Saúde*) or Unified Health System, created in 1988. It includes the universal right to healthcare, decentralization of responsibilities and social participation of the three bodies, federal, state and municipalities. The SUS offers public health services including, preventive health care, primary health care, outpatient speciality care, hospital care, maternity care, mental health services, pharmaceuticals, physical therapy, dental and optometry care, medical equipment, hearing aids, home care, organ transplant, oncology services, renal dialysis, blood therapy and free access to HIV/AIDS medicines. Administration and delivery are dependent on the municipality as per the duty assigned to the body. However, the out-of-pocket expenditure is marginally high and affects the poor disproportionately. Something very similar to the Mohalla Clinic, is the Family Health Strategy, under the SUS, to promote primary health care. Now under this model in primary health care, is a family health team including one doctor, one nurse, one nurse assistant and up to 12 community health workers. These Family Health Teams work in the community in a specific geographic location and target almost 2000 to 4000 individual households per community. There are also dental specialists, nutritionists, psychologists, social workers, psychiatrists, pharmacists, speech and hearing therapists, gynaecologists/obstetricians, paediatricians, geriatricians, and other

specialists depending on the community-specific needs. The success of this system can be seen in such a way that, in 2019, 98% of municipalities opted for Family Health teams to provide primary care. Almost 43,000 family health teams and 26,000 oral teams provided services to 64% of the population. This expansion of primary health care has decreased hospital admission burden as they have a referral system. The entire system works on the pay-for-performance programme. Other than outpatient services and hospital speciality care, the system emphasises Mental Health care in the community and home-based care in form of residential therapeutic services, and integration of mental health teams with family health teams. This is still an untapped aspect in our system here in the National Capital Territory. They also preserve their word to provide the universal right to health to all vulnerable socio-economic groups and indigenous communities. Brazil too has an online medical platform for the digitization of medical records called the e-SUS. The government in Brazil promotes PPP to cut costs and contain expenses on expensive medical facilities, equipment and medicines. This is intersecting with the Mohalla Clinic model here.

Looking at Singapore, a high-income developed economy with extensive and successful health policy. Their path to achieve Universal Health Coverage includes a public insurance scheme, MediShield Life which covers large hospital bills and outpatient services, but most of the time it doesn't cover primary health care. Along with this, the government complements this system with a medical savings account called MediSave, deductible from the salary of the employees, which helps patients pay inpatient and outpatient services and cover out-of-pocket expenses for the individual as well as his/her family. Another attribute of this is, MediFund, which helps cover the out-of-pocket expense for even those who cannot cover theirs with the MediSave. This tier-based insurance scheme has proven to be highly successful and is in resonance with the aims and objectives of the UHC. Under this they have a plethora of policies, guiding the system and delivery. The premium in this MediLife insurance scheme is subsidized as per the income. Other than this, there are several other subsidies provided to make health more accessible and affordable. The insurance scheme covers, inpatient services, radiotherapies, bone marrow transplants, psychiatric hospital care, day-care surgeries, and other costly long-term expensive treatments. The government also tops budget surpluses into MediSave accounts and promotes their usage in this way amongst the citizens. Primary Care here, is provided through polyclinics and General Physicians (GP) wherein the latter work individually on a fee-for-service model. The appreciable part about their primary health care is that the government focuses even at the primary stage on the management of 20 chronic diseases. They have also incorporated the Primary care Network Model to integrate and coordinate the efforts of like-minded GPs to work on chronic disease management to address the needs of complex patients. Several other common services are quality checked and effective. An important aspect of the system is its differential model of subsidies for different income groups which helps to pave the way for income inequality and accessible quality medical care. To enhance the performance of the system, the government has taken steps to integrate the public institutions, by geographical areas. Steps were taken to strengthen partnerships across GPs and community care partners to add a more community-centric approach to the system. They too manage the electronic health records under "One Patient, One Health Record" and created a one-stop digitized health record system. All these aspects of digitization, primary care holistic integration and access to cheap and subsidized health services are all intersecting with our model here in Delhi. The health system in Singapore is perfectly competitive, with government regulation and control, wherein they are de-emphasizing profit maximization, to make quality health care accessible, affordable and easy. The entire system is homogenized in terms of the pay-for-performance model at all the health providers' stages, which is again similar to the Mohalla Clinics model

where doctors and staff are paid on a per-patient basis. The Singapore Government focuses on elderly health and their sustenance for which they even implemented the ElderFund in 2020 which will help in the provision of quality medical services at a very vulnerable life stage, this is something that our system could incorporate as well.

The Cuban Health System is rather an intriguing area that proves that equitable and judicious health can be achieved even under the communist regime. The undemocratic characteristics of the system still did far better in terms of healthcare providers than other developing and developed economies. This only tells us that, an effective healthcare system only requires a community-centric policy framework and good implementation. A revolutionary health care system in Cuba amplified back in 1959, when the Castro Family at the helm, implemented the “el servicio médico rural” or the Rural Medical Service to improve rural medical services. By 1990, almost 95 per cent population was availing of medical services under the government. But the striking part of their entire system is the social revolution in 1984, which changed the focus to community healthcare and prevention of disease. It was rather very surprising to see a restrictive economy taking steps similar to a free economy but doing better at it. They penetrated the tight-knit neighbourhoods with their community care centres rather than establishing hospitals in high socio-economic background settings, which already pose a very inaccessible picture for the poor. Their doctor-patient ratio stands at 7.59 per 1000 individuals (the highest in the world) precisely because the doctors and the community individuals were residing in the same area. This has led to a better harmonic and communal relationship with the doctors and medical staff. This is the same environment, sans the doctors residing in the same community, that the Mohalla Clinic instils in its programme. Primary care in Cuba is family-oriented which is why their system reaches every corner and can prevent diseases. While the other Caribbean countries struggle to fight diseases, they do comparatively far better. Even though the country is not a free market, innovation and education are far better in terms of even developed economies. This medical system has created an economic revolution wherein the health sector itself is financing its national economy. The government under its control manages to keep the growth in the medical field always on track and exponentially rising. The entire crux of their agenda is that they view society’s healthcare as a collective goal, dismantling the barriers which restrict equitable, accessible and affordable health for all.

But more than just having an insight into the health policies of these three countries, it's important to decipher what the international health community says. To break it down, the international health community here includes the World Health Organisation (WHO) as well as other prominent centres for health policies in different developed countries where important research and innovation form the basis of a lot of policies in other countries. One such prominent organisation is the Centres for Disease Control and Prevention, USA, which has gained prominence specifically during the COVID-19 pandemic. Defined in the 1946 Constitution of the World Health Organisation (WHO), *the Right to Health* is the enjoyment of the highest attainable standard of physical and mental health. Further, the Constitution states that attaining the highest standard of health is a *fundamental right* of a human being which should be provided without any discrimination on race, caste, religion, political opinions, or socio-economic conditions. It is essential to understand that the Right to Health includes a wide range of factors that are coherent to standard health, this includes, safe drinking water and food, sanitation, adequate nutrition, health-related education and environmental condition and gender equality. The right to health itself is inherent in the freedoms, such as freedom from non-consensual medical treatment, sterilization, torture, cruelty or forced experiments. The realization of the right to health is dependent and

contributes to other human rights including, the right to adequate and safe food and water, sanitation, freedom from discrimination, equality, access to a standard of living, benefit from scientific progress and innovation, and access to right information and participation. A developing nation such as India must accept and apply the above, as an integral and guiding point for our health policy. Right to Health thus forms the very base for Universal Health Coverage (UHC) which stands as the highlight of the SDGs. The main impediment to receiving quality health service is the cost incurred in achieving it. The UHC as the focus of the international community implies that all individuals must receive adequate health services without suffering any financial hardships. It would include health promotion, prevention, rehabilitation and palliative care during one's lifetime. The implementation of UHC-driven policies will help alleviate poverty as out-of-pocket expenses, either made through exhaustion of savings or selling of assets, hampering the future of the upcoming generation, pushes more individuals into the category of poor. UHC stands as the most important aspect of determining health policy, especially in the contemporary era.

As citizens of a developing nation, we need to understand the health policies of developed nations. Developing nations are often seen to be emulating the footsteps of developed nations but it is important to gain aspiration from the right source. The United States, however, rejoiced as a nation with one of the most advanced medical resources and dynamic innovation and research fails as a developed nation to provide necessary and affordable health services to its citizens. Health policies in the US are a mixed bag of public and private health care providers and insurers. The nation does not have a UHC policy. Almost 92% of the population has insurance, predominantly private insurance, leaving 8.5 % population uninsured. Under the public insurance scheme, there are namely two programs, Medicare and Medicaid, both of which were founded in 1965 under the Social Security Act. Medicare provided UHC to individuals above 65 years old and those below 65 years of age with end-stage renal disease are eligible to attain this benefit. Medicaid on the other hand gave the states the liberty to have federal funds to provide insurance to low-income families, people with disabilities and the blind. It is compulsory to opt for such insurance for low-income pregnant women. Medicaid also has an extended policy called the Children's Health Insurance Program, which to date covers 9.6 million children from low-income families. The game-changer to the health system was the Affordable Care Act of 2010, which extended the insurance schemes for individuals till 26 years old to be on their parents' insurance schemes. This also made American citizens undertake insurance, provided a free market for cheap and subsidised private insurance for low- and middle-income countries and expansion of Medicaid programs under the federal budget. The ACA, 2010 has helped expand coverage and helped drop the uninsured rate from 14% to 8.5%. Public health coverage is around 45% of total spending on health or 8% of the GDP. The Medicaid and Medicare program accounts for the largest fund absorber. Private health insurance accounts for two-thirds of the population (67%) and is widely used. Most (55%) private insurance is provided through employers only 11% is purchased by individuals. Seeing such dominance of private health insurance, the ACA, 2010 also began an online platform HealthCare.gov as a marketplace to purchase private insurance for dental and other services. Out-of-pocket expenditures by citizens account for nearly 10% of the total spending on health services. The average of the same for a single person in 2018 was around $1,846. Out-of-pocket spending is the maximum for dental care and prescription medicines in the US. The health record is recorded electronically and managed and maintained by the National Coordinator for Health Information Technology. Overall one can see with the highest spending on health by any nation in the world, with per-person spending by the government being almost $10,000, the health outcomes are poor and unsatisfactory in the US. This could be attributed to greater use

of medical technology which is both expensive and sometimes unnecessary in certain circumstances coupled with high prices of drugs and other equipment. Not only do they spend the highest amongst all developed nations, but they also have out-of-pocket expenditures similar to those with low spending on health. The US has a low life expectancy, high suicide rates, the highest burden of chronic diseases such as diabetes, hypertension, and cancer, and the highest rate of obesity among all developed nations. There are certain plus points to their policy such as the highest avoidable deaths, highest avoidable hospitalization due to diabetes or hypertension, great rate of vaccination and breast cancer detection, and the highest number of MRI scans and Hip Replacement surgeries among adults. Despite their poor outcomes in most spheres, they steal the show with their incredible research and innovation which just helps to cover a big gap existing in their system. But such policies require more inclusivity, to avoid marginalising communities that have no insurance. The pandemic showed even more importance of coverage, such that despite the best infrastructure and medication, the US showed terrible results during the pandemic. The health model of the US clearly shows the fall of a health system with a free market, despite using the best practices, results are not being achieved in the US.

Another country that has always been quoted as an inspiration for the US health model, is the Canada Health Model. This model has been everyone's favourite in the US and is a key demand by US citizens during the elections. Canadian health care is decentralised, universal and publicly funded. It is one of those healthcare systems that are free from discrimination and work on egalitarian principles. In Canada, a higher-income individual getting better access to health care than a lower- or middle-income individual is a sin, however, this could be seen as a normal practice in the US. The star of the Canadian Health care system is Canadian Medicare, which is being administered by its 10 provinces and three territories. Medicare is taxation based, publicly funded and completely free at the point of service. Total spending on health care in Canada is approximately 11.5 % of its GDP in 2017 wherein public spending acquired a 70% share and private funding acquired a 30% share of spending. Public insurance covers 100% of the insured population, private insurance is rather complimentary insurance for those services which are not covered under Medicare such as dental and vision services, outpatient drugs, rehabilitation and private hospital rooms. Medicare provides first-dollar coverage of physician and diagnostic services, inpatient prescription drugs as well as other hospital services. It also extensively includes immunization as an inherent part of its program. Out-of-pocket expenditures, mainly incurred for dental, vision and long-term home care, accounted for only 15% of the total spending which is significantly less than the US, while the total spending as a percentage of GDP for Canada is less than the US. Drug prices are highly negotiated and capped to reduce out-of-pocket expenditures. Despite such a robust system of UHC-driven policies, the system lacks in certain aspects. The Canadian healthcare system is known for long waiting lines, red-tapism, substandard quality of health services, absence of a nationwide electronic record system for health data, and the disparity in healthcare services especially towards the indigenous community. While steps are being taken to make amends, the system still stands an edge above even the US healthcare system, thus giving Canadians an even bigger reason to be proud of it. Canadian Medicare is a system to be idolised and further studied upon.

If there is a nation where a free market for insurance companies has succeeded in providing UHC for all its citizens then it's the German healthcare system. Health insurance in Germany is a must for its citizens. It is one of those countries which are applauded for an equitable and fair health care system with standard services. The government-funded health insurance in Germany is called Statutory Health Insurance (SHI) which provides inpatient, outpatient,

mental health and drug prescription coverage. It serves almost 86% of the population in Germany. SHI finances bills through its sickness funds which are financed via wage contributions of 14.6% and a supplementary wage contribution of 1% which are funded by both employer and worker. Those individuals earning more than $68,000 can opt out of SHI to go for better and widely covering private insurance schemes. The government provides long-term care insurance (LTCI) for long-term health services. The system in Germany is administered by the federal and state government, while also giving decision-making powers to self-regulated and private entities. The total healthcare spending in Germany accounted for 11.5% of the GDP wherein 74% was publicly funded with 55% going towards SHI, in 2017. There were 109 sickness funds till 2019, which are formed through wage contributions, via a centrally pooled health fund called *Gesundheitsfonds,* which allocates funds accounting for age, sex, morbidity burden and 80 chronic diseases. Private health insurance accounts for 8.4 per cent of the total spending this includes insurance bought by those who opt out of SHI and supplementary insurance schemes bought by the citizens. A total of 8.65 million individuals in 2017 had bought substitute insurance schemes from for-profit companies. Out-of-pocket expenditures accounted for 13.5% of the total spending on health care in 2017 which was mainly attributed to nursing care expenses, pharmaceuticals or medical aid.
Otherwise, the physicians are not permitted to charge above a limited fee which would be covered under the SHI. While the system has its reporting agency, the key highlight is the German Health Monitor, *Gesundheitsmonitor,* which assesses and measures the quality of health care, dispensation of information and performance and experiences of citizens. They also have electronic health chips for pan Germany collection of health records, showing their basic information with insurance details and prescriptions. With proper associations such as the Federal Association of Sickness Funds, they can negotiate and cap the prices for drugs and equipment with the pharmaceuticals. The health system of Germany has a list of pros that are even shadowing the cons, such that they are not even debated or deliberated as of yet. It is one of the finest and most systematic models in any country, covering all the characteristics of UHC. This model too becomes the pivotal inspiration for many nations.

One of the most prominent health systems in the world is the National Health Service of the United Kingdom. It draws its string back to World War II post when the government in the UK decided that health is an integral part of government expenditure like constructing roads and therefore should be entirely publicly funded. With such a structure, the system is famously called “socialized medicine” and is a highly demanded form of the system by citizens of many nations. It however became a contentious topic during Brexit for the possibility of being affected as a trade agreement, but such debates are being denied by the government as of yet. Every resident in the UK is covered under NHS for free public health care which is funded through general taxation. With a relatively low share of expenditure on health care as compared to other developed nations at 9.5% only, the UK has far better-reaching health outcomes. Out of the 9.5% expenditure, 76.4% is accounted for NHS which is mainly through general taxation. On the other hand, private health insurance accounts for 3.3% of the total health expenditure, with only 10.6 % of the population opting for voluntary private insurance schemes. Public services account for 100% insured individuals under the NHS providing services ranging from preventive, immunization, check-ups, screening, inpatient and outpatient hospital services, inpatient and outpatient drug prescription, maternity services, physician services to even dental, vision, mental health, rehabilitation, palliative care, hearing aid, wheelchair, home nurses, long term care. With such a wide array of services, the majority of the market falls under the ambit of the NHS policy. Services are free at the point of use, but out-of-pocket expenditures are only for a few General Practioner services which are not covered under the NHS. Overall the out-of-pocket

expenditures account for only 15% of the total spending which is too precisely for long-term care needs. Safety nets are provided by the government to provide co-payments for drug prescriptions for lower-income families, children below 15 years of age and senior citizens above 65 years of age, pregnant women, full-time students between 16-18 years of age and individuals with long-term disabilities or cancer. The Care Quality Commission is responsible for assessing and measuring the quality parameters for health and regulates all health-related social care. All health records are completely computerized, from immunization to even dental records are nationwide electronic. The aim of the government in this segment is to become paperless and convert all reporting electronically. The government has a responsibility to provide health services free from any discrimination, in this regard, they aim to promote and dispense equitable health care to all irrespective of any disability, age, socio-economic background, ethnicity or gender. What steps are taken till now to ensure the above is still contentious as they seem to be simply covering the issues, while not solving them? The health system of the UK irrespective of anything is one of the most systematic, socialized, equitable and affordable as compared to the other developed nations. It covers the basics of the UHC and broadly falling the Right to Health paradigm. It clears the affordability, accessibility and availability criteria set by the international community.

Another interesting perspective that is paving its way into different educational and research centres across the world, is the concept of “One Health”. It is a collaborative, multisectoral and transdisciplinary approach functioning at the local, regional, national and global levels, to attain standard health for plants, animals, humans and the environment around them. It focuses on the essence of interconnections among plants, animals and humans on a health spectrum. It takes into account the expansion of human civilization, climate change, deforestation, and movement across international boundaries thus leading to the spread of diseases, more intimate contact with plants and animals leading to the transfer of pathogens, viruses, and most importantly disruption of habitats. It takes into account zoonotic diseases such as Ebola, COVID-19, Lyme disease, etc. which are endangering food security and food safety, spreading diseases and contaminating the environment. The One Health approach requires public intervention, collaborating professionals of human health, animal health and environment activists and scientists, to communicate and cooperate to achieve better outcomes for humans, plants and animals and their environment. This approach is a new take on health policy and will take a centre stage in the upcoming years, considering the level of globalisation and expansion in terms of innovation and research. The addition of attributes of this concept will help create a more comprehensive and sustainable health policy.

The point of this comparative analysis is that point out that the Mohalla Clinics draws inspiration from their respective national health structure. There are a few aspects in them that even the system here should incorporate in the future. But such a system shouldn’t be isolated to a state, each state under their jurisdiction must apply such a community-centric approach such that everyone could be on the path of Universal Health Coverage (UHC) consistent with the axioms of the SDGs. The flagship policy of Mohalla Clinics has a lot of potential. It is to be understood that as subjects of this policy, every policy has a gestation period even after conception. Policies cannot start showing tremendous results in a few years, it takes years, to fully adapt, explore, grow, absorb and reflect on every aspect. For several flagship policies even at the central government such as the MGNREGA is still receiving frequent praises and criticism, the jury for any policies is always out. The AAP government is still spending but still not spending fully, they still face underutilisation of the budget every year due to bottlenecks created in the administration by a different party at the centre and three other individual Municipality bodies. The budget allocation to the health, education and

transport sectors is high but it is not realised due to the politicisation of the administration in the Union Territory. The Mohalla Clinic has innumerable potential, with the capacity to create forward linkages such that there is proper analysis and efforts taken to improve the condition in the clinics. The sole step to amplify the health system would be to decentralize the health sector. The politicisation of the system is creating hurdles which we have seen in this pandemic in the NCT. The model right now needs to incorporate certain aspects which are needed for the comprehensive development of this model in the future. There needs to be a system to provide public healthcare even to undocumented individuals, and members of the transgender community, who are heavily marginalised and disproportionately treated due to a lack of visible social inclusion. These clinics are so strategically located that it possesses prospective attributes to incorporate and bust myths about mental health and create a space of safe and secure environment for patients of psychiatric care. These are all points that we saw were inherent in the system of the above developed and developing economies. They can be wellness centres that focus on holistic care wherein preventive measures must be inculcated. Chandrakant Pandav, a community medicine expert at the All-India Institute of Medical Sciences in New Delhi, told The Lancet medical journal regarding the Mohalla Clinics that "a serious limitation is a focus on curative care and neglect of preventive and promotive care." Incorporation of new and uprising research on Circadian Rhythm Sleep-Wake Disorder, Childhood Cancer detection, oncology research, Climate Change effects on health, etc., is imperative. Integration of these at the primary healthcare will help uplift the foundation of the Mohalla Clinics, this is also something we saw in the case of both Singapore and Cuba Health Systems. The Mohalla Clinics have undoubtedly solid policy standing, with immense potential to upgrade and develop to create a more systematic healthcare structure providing affordable, accessible and equitable medical services.

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