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Review Article

Health Management and Policy Section

Public and Private Healthcare System in Terms of both Quality and Cost: A Review

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ABSTRACT

A public healthcare system is one in which the Government governs and controls all healthcare services. It offers high-quality medical care to all citizens, regardless of their ability to pay. The benefits of public healthcare against the private healthcare system showed that the former reduces overall healthcare and administrative costs. It helps in standardising the services and creates a healthier workforce, prevents future costs, and guides the population to make better choices. In contrast, private healthcare maintains a business-driven culture and creates unfair competition for non profit organisations. It considers healthcare as a commodity rather than a right of every citizen and may use its considerable economic power to exert undue influence on healthcare policies. Countries with the best healthcare in the world provide free or universal healthcare. These countries regard healthcare as a social good rather than an economic good and provide universal care, which means that healthcare must be affordable and accessible to all the citizens. Considering the ethical issues in the for-profit healthcare system, as well as the drawback of private health insurers, it is advocated that health insurance must be administered by non profit healthcare providers.

Keywords: Non profit organisations, Private health insurance, Public health insurance, Universal healthcare system

INTRODUCTION

The most efficient strategy to achieve one of the Sustainable Development Goals (SDGs) is to ensure that all people have access to a basic standard of healthcare [1]. Public and private healthcare sectors are growing in the healthcare market. The responsibilities of each sector are determined primarily by more effective resource allocation, the uncertainty of how the healthcare market will respond to these institutions, and new management ideas [2-4]. The review of the relative benefits of the public versus private healthcare sector intends to address the question, "Who would offer healthcare services more efficiently in terms of quality of care and cost-effectiveness?" The proponents of the private healthcare system advocate its benefits as the duality of profit maximisation and efficiency. They consider that the competitive market model could improve efficiency, quality, consumer choice, responsiveness, transparency and responsibility. However, the empirical evidence shows a different result which cites the failures inherent in the healthcare market. Hollingsworth did a meta-analysis of 317 published papers on efficiency measures [5] and concluded that "public provision is potentially more efficient than private provision" [5-7]. According to Lee K et al., non profit hospitals in the United States are more efficient than for-profit hospitals [8].

The countries having the best healthcare are providing free or universal healthcare. Countries such as Sweden, New Zealand, Spain, Portugal, Japan, Italy, Ireland, Germany, France, Australia, Canada, South Korea, provide healthcare according to guidelines and standards, which affirm the principles of non profit public administration [9]. These countries consider healthcare as a social good than economic good and provide "Universal Care," which means healthcare must be affordable and accessible to all its residents [10].

Serious ethical criticisms of for-profit healthcare have been stated both within and outside the medical profession. For-profit healthcare exacerbates the problem of access to healthcare and creates unfair competition against non profit organisations. It regards healthcare as a commodity rather than a fundamental human right. It includes incentives and organisational controls that adversely affect the physician-patient relationship creating conflicts of interest that can diminish the quality of care. It undermines medical education and forms a medical-industrial complex that exert undue influence on public policy concerning healthcare and by using its great economic power [11].

It is a well-known fact that for-profit hospital boards maintain a business-driven culture. It must do so because it is held accountable to its shareholders. It does not always prioritise the quality of care over profitability [11]. To regulate healthcare systems, private health insurance markets are also expanding and consider its role as an alternative source of health financing and a means of increasing system capacity. However, it has a complex financing mechanism that affects and interacts with public systems [12]. It is essential to monitor and regulate private health insurance, especially in areas where resources are scarce and considering the recent economic downturn and rising healthcare needs. Therefore, policymakers must evaluate the current and potential role of private health insurance in the healthcare system, considering the complex interactions between private and public coverage, with the goals of health improvement, responsiveness and financial equity [12]. On the other hand, non profit healthcare organisations typically promote a service-driven culture and become more aggressive negotiators when managing expenses like managed care contracts [13]. The benefits and drawbacks of public and private health insurance are discussed in the [Table/Fig-1] [14-22].

Though most Organisation for Economic Co-operation and Development (OECD) countries have attained universal or nearly universal health coverage, the specific implementation varies from one nation to the other [23]. For example, the United Kingdom provides free healthcare through Government-owned public facilities, whereas Germany has a Government fund that pays for coverage from private doctors and hospitals [24]. Some of the most well-known healthcare systems in the world are discussed in the present review.

COUNTRIES OFFERING UNIVERSAL HEALTHCARE SYSTEMS

Many countries around the world provide free or universal healthcare [9]. This does not mean that every citizen or resident

Variables	Public health insurance (Administered by the State or Federal Government)	Private health insurance (administered by the private sector)
Costs and affordability	It is Government-run insurance. Many people are participating in it. Healthcare cost is reduced [14].	The premiums are higher than those charged by public health insurance [15].
Insurance coverage	It provides more comprehensive and easier access to health insurance for all including people who are currently underserved by private health insurance coverage, particularly those who work for employers that do not provide health insurance as a benefit and people with pre-existing conditions who are not eligible for private health insurance coverage, are covered by public health insurance from the day they are born [14].	There are many conditions and treatments which private healthcare insurers do not cover for. Even a comprehensive policy may not cover every type of treatment or procedure. There are restrictions regarding previous medical conditions as most policies only cover short-term illnesses or injuries. Insurers may reject a patient's coverage if the patient fails to report a past illness. Patients must confirm which problems, illnesses, or diseases the insurance will cover before scheduling any treatment that would put them under stress [15].
Uniform health coverage for all citizens	It ensures that healthcare is accessible to everyone, irrespective of income. Whether it's doctor's appointments, emergency treatment, preventative care, or hospital stays, everybody has access to the same level of care [15,16]. If all have the same right to access healthcare, regardless of how they make their living, social division can be reduced.	Patients have access to different levels of care based on their insurance schemes [17].
Network and coverage limitations: Free choice of doctors and hospitals	It has no specific network of providers from which patients are forced to obtain healthcare services. Patients have complete freedom to select their doctors and hospitals. It has no coverage limitations and patients will get complete insurance coverage for their treatment.	It has a network of providers from which patients are obligated to obtain healthcare services if they are included in their service package. Sometimes the problem occurs if the private specialist lacks the expertise required to treat the condition, forcing the patient to rely on other expert doctors who are not covered by the insurer. Patients may or may not be reimbursed for such treatment received outside their network even after paying their heavy insurance premiums and are limited to receive treatment from doctors and facilities within their network [18].
Efficient administration	Administrative costs account for a significant portion of healthcare spending [19] however, it is significantly lower for public payer programs as the operating expenses are less under the public health insurance system, making it more effective in terms of administration and cost.	Since, there are so many types of policies offered by private health insurers, more administrative personnel are required for handling insurance related tasks such as filing and reviewing claims which significantly increases administrative effort and cost in private health insurance. In addition, many people are perplexed by the variety of health insurance plans offered by private companies and their coverage criteria. As a result, people may be unable to enroll in the best insurance plan and sometimes depending on the policy, they take out, they may not be covered for the treatment they require [20]. As well known, most health insurance plans do not cover elective procedures, beauty treatments, off-label medications or brand new technologies.
Uniform medical cost	There is a uniform acceptance of public health insurance in all the healthcare facilities irrespective of the treatment.	Patients having private health insurance need to ensure that the required treatment or procedures are covered under their policy during an Outpatient Department visit or hospital stay. If the patient's insurance is not accepted, the patient may be faced with a large medical bill [20].
Out of pocket costs	It covers all the costs of the patient's treatment or procedures. There is no need to pay any substantial amount as an excess. The patient will not face any bankruptcies due to medical bills or death due to lack of money or health insurance.	It covers a portion of the cost of the treatment or procedure. The patient is required to pay the remaining amount, which often leads to put a financial burden on them [20]. Also, patients need to pay more to get more comprehensive cover. Elderly patients and patients with any previous history of chronic illness also pay more for their health coverage. The premiums for all types of private health insurance are also dramatically rising putting financial stress on the common people making it out of reach for many people.
Effective policy implementation	It allows patients to get any kind of treatment regardless of cost.	It restricts patient's ability to select consultants and healthcare facilities [21], as well as make top-up payments to cover the difference between their insurance company's agreed-upon amount and the cost of their preferred private treatment.
The setting of prices for prescription drugs	The federal Government has the power to set the price for prescription drugs [22].	It has less negotiating power which leads to increased healthcare cost across the board.

[Table/Fig-1]: The benefits and drawbacks of public and private health insurance.

in each of these countries has access to free healthcare. Many of these countries' employers and individuals contribute to the cost of healthcare through contributions, cost sharing arrangements, copays and other related fees. These programs, however, are aimed at "Universal Care," which means making healthcare affordable and accessible for as many people as possible [10,23] which is not in the case of private health insurance.

Healthcare in Sweden

Sweden has one of the best universal public healthcare systems in the world and the 5th highest life expectancy in Europe, at 79.1 years for men and 83.2 years for women in 2010 [25,26]. The cost of healthcare is primarily funded by the Government through taxation [26]. Patients, on the other hand, pay about 3% of the cost directly [27]. Patients must pay a small copay for each doctor's visit. Exemptions are available for those under the age of 16 and those who qualify as vulnerable persons. Prescription drugs are not free, but they are very affordable. The total amount a patient pays for a year is capped, and if the prescription bill exceeds this amount, the Government pays the difference. Everything from wellness physicals to specialist appointments to emergency care is covered or heavily subsidised in Sweden. As a result, private healthcare is not widely used there [25], but it is gradually gaining popularity. Their main motivation is to reduce waiting times [25], which can be quite long in public hospitals. Expats who are permanent residents of Sweden or have a work permit in Sweden are eligible for public health insurance universal health coverage. Visitors from the European Union (EU) or European Economic Area (EEA) are also treated at the same rate as locals if they have a European Health Insurance Card (EHIC) [28].

Healthcare in the United Kingdom

The National Health Service (NHS) is one of the largest public healthcare systems in the world, responsible for all aspects of the United Kingdom's healthcare system, and founded on the principles of universality, free delivery, equity, and central funding [29]. The NHS now serves an average of one million people every 36 hours and is funded by taxes [30]. The NHS receives about 18% of each person's income tax, which equates to about 4.5% of the average person's income [31]. On a national scale, healthcare accounts for 12.8% of the UK's GDP by 2020 [32]. There are no copays, deductibles, or excesses for medical services in the United Kingdom because the NHS covers all aspects of medical services for free, including ambulance services, Emergency Department visits, preventative measures, and ongoing treatment programs such as chemotherapy [33]. Furthermore, the cost of prescription medication is very low at pharmacies, with most prescriptions costing only a few pounds.

Approximately, 12% of UK residents have private insurance [34]. Many people do so as part of their employee benefits package. Otherwise, anyone who is legally residing in the UK is eligible for free NHS healthcare [33].

Healthcare in New Zealand

New Zealand's healthcare system is an excellent universal public system in which all citizens have equal access to the same standard of care from an integrated preventative system [35]. New Zealand spends approximately 9% of its GDP on healthcare [36], and the system runs as a single-payer system. Most healthcare costs are borne by the Government through public taxation [37]. The healthcare system is either free or heavily subsidised for patients, depending on the service required. For children under the age of six, free medical services include standard diagnostic tests, immunisations, and prescription medication. Moreover, if the patient is referred by a general practitioner, the Government covers hospital and specialist care. Furthermore, people with low incomes are eligible for a Community Services Card (CSC), which reduces the cost of after-hours doctor visits and prescription medication costs [38]. All permanent residents of New Zealand who have been in the country for at least two years are eligible for public health insurance [39]. Australia and the United Kingdom have reciprocal healthcare agreements with New Zealand. These citizens can receive emergency healthcare in New Zealand at the same cost as locals. Everyone in New Zealand, including visitors, tourists, and expatriates, is entitled to free medical care in the event of an accident. This is known as the Accident Compensation Corporation (ACC) program in New Zealand [40].

Healthcare in Spain

Spain has a universal healthcare system and ranks 19th in Europe according to the 2018 Euro health consumer index [41]. The Spanish National Health System called Sistema Nacional de Salud (NHS) is mainly funded by taxes and runs through a public provider network. The health responsibilities have been moved to regional levels since 2002, resulting in 17 regional health ministries for the organisation and delivery of health services within their respective territories [42]. The Ministry of Health, Social Services, and equality oversees specific strategic areas and national health system performance monitoring. The NHS Interterritorial Council brings together national and regional health ministers. Its principal goal is to operate as a coordinator rather than a regulatory agency, to organise the national response to disease outbreaks, and to discuss the regional implications of new laws [42]. In addition to NHS, there are three alternative voluntary health insurance for Spanish citizens: substitutive voluntary health insurance, complementary voluntary health insurance, and supplementary voluntary health insurance. Substitutive voluntary health insurance is an alternative to statutory health insurance, available to people who choose not to participate in the public system or are not eligible for public health coverage, while complimentary health insurance offers full or partial coverage for services that are excluded or not fully covered by the statutory healthcare system. Supplementary health insurance is an option for those Spanish citizens who use the available universal healthcare but would like additional private insurance that may provide them with better or more suitable options and benefits [43].

Healthcare in Portugal

The quality of healthcare in Portugal is high and steadily improving. It consists of three components. The first is the National Health Service or NHS (in Portuguese: Servico Nacional de Saude or SNS), a form of subsidised state care for people who contribute to the social security system that was established in 1979 and is overseen by the Ministry of Health [44]. It is defined as national, universal, and free, and it covers the entirety of mainland Portugal. The second system, the health subsystem program, is a special social healthcare initiative provides medical care to members of specific professions or organisations such as police, military, and banking services. The ADSE (Assistência na Doença aos Servidores Civis do Estado) is the most important public health subsystem, covering over 1.3 million public servants. The third option is voluntary private healthcare [44]. The public NHS system in Portugal is funded through general taxation and is also subsidised by contributions from workers paying into the social security system [45]. It also covers people who are not employed, as well as dependent family members and retirees. The NHS services include everything from general practitioner's services and maternity care to hospital treatments and community medical programs [45]. Residents of Portugal are required to contribute a small portion of their medical expenses, including doctor and specialist visits, hospitalisation, and prescriptions. Around 20% of Portuguese residents have private health insurance to supplement their public health insurance, which includes dental and vision care. It can also be used to cover out-of-pocket expenses for patients. Portuguese citizens and permanent residents have access to the Portuguese public health system. Furthermore, European residents with a European Health Insurance Card have the same access to public services as Portuguese residents [45].

Healthcare in Japan

Japanese citizens have a higher life expectancy than the rest of the world, which could be attributed to the country's excellent healthcare system [46]. The system prioritizes preventative care over reactive care. The Japanese Medical System is based on universal healthcare, which is known as Social Health Insurance (SHI). The SHI applies to everyone who is employed full-time with a medium or large company [47]. Approximately 5% is deducted from salaries to pay for SHI, and employers match this cost. Those who do not qualify for SHI are covered by the Japan National Health Insurance (NHI) plan. Self employed individuals, such as expatriates and digital nomads, are eligible for the NHI plan. It also applies to those who work for small businesses and the unemployed. Their income determines the amount they pay into the NHI. In general, 70% of the costs of medical appointments, hospital visits, and even prescriptions are paid by the Government and patients only pay the remaining 30% of healthcare costs. However, this ratio may shift in favour of the patient depending on the patient's income level. For-profit organisations are not permitted to operate hospitals and clinics in Japan, except for hospitals established by for-profit companies for their employees [48]. The SHI covers 98.3% of the population, while the Public Social Assistance Program covers the remaining 1.7%. Also, 70% of the population holds secondary, voluntary private health insurance, which plays only a supplementary or complementary role in covering the copayments or non covered costs [48].

Healthcare in Italy

The Italian National Health Service (Servizio Sanitario Nazionale, or SSN) is the country's public health system, and it is based on the principles of universal coverage, solidarity, human dignity, and health [49]. The Italian healthcare system is ranked second in the world in 2000, just behind the French healthcare system, according to the World Health Organisation (WHO) [50,51]. The health insurance system in Italy is extremely affordable. Inpatient care, primary care, and doctor's visits are all free of charge [52]. Diagnostic procedures and prescription medication, on the other hand, have a copay. Copays can be as much as 30% of the total cost. Vulnerable people, such as the elderly, pregnant women, and children, are exempt from these copay costs. The free appointments and low copays are the results of Italy's tax funded public health system. The system is primarily supported by a payroll tax system. The system is also supported by federal and regional general taxation, such as income taxes and value added taxes on goods and services. The Ministry of Health provides funding to various

regions of Italy. The funding allocated to each region is determined by a formula that considers previous spending and other factors. The funds are then allocated to the local health authority by the regions [53]. This system keeps the cost of health insurance in Italy low. In general, the public health system and medical care are excellent, with almost all patient costs covered. The system emphasises both preventative and curative care. The SSN does not allow people to opt-out of the system and seek solely private treatment hence, substitute insurance is not available, however, complementary and supplementary private health insurance, on the other hand, play a minor role in the healthcare system, accounting for less than 1% of total spending in 2014. Private health insurance is divided into two categories: corporate, which covers employees and their families, and noncorporate, which is purchased by individuals for themselves or their families [52,54]. In addition to citizens and legal foreign residents, European Union citizens with a European Health Insurance Card can also use the SSN's services.

Healthcare in Ireland

The national medical system in Ireland is governed by the 2004 Health Act, which established the Irish Health Service Executive to provide medical and social services [55]. Almost 40% of the population receives free medical care, while the rest receives heavily subsidised services through the public system or choose private insurance coverage. The Irish public healthcare system is funded by taxes and is available to all legal residents [56]. Depending on their income,

- Approximately 37% of the population has access to completely free public services through the Medical Card System, also known as Category 1 care, which includes all doctor visits, hospital care, tests, and medication. There is also the General Practitioner (GP) visit card, which is available to those who are just above the eligibility threshold for a medical card and provides free general practitioner visits but does not include the other benefits that come with a medical card.
- Furthermore, people who are not eligible for the medical card or the GP visit card are still a part of the universal healthcare system, which is referred to as category 2 care, and are entitled to discounted public hospital treatments and prescription drugs, but must pay the full cost of GP and other primary care services [57].

There are some services and programs available, if anyone proactively signs up for them. For example, the Drugs Payment Scheme limits the amount spent on prescription drugs, the long-term Illness Scheme covers the costs of a long term condition and the Maternity and Infant Care Scheme provides medical care to expectant and new mothers and babies [58].

Healthcare in Germany

The German healthcare system is regarded as one of the best in the world. It's a universal, multipayer healthcare system funded by a statutory contribution system that ensures that everyone has access to free healthcare through health insurance funds [59]. There are two types of health insurance in Germany:

- Public Health Insurance: Gesetzliche Krankenversicherung (GKV)
- Private Health Insurance: Private Krankenversicherung (PKV)

Approximately 86% of the population is covered by statutory health insurance, which includes coverage for inpatient, outpatient, mental health, and prescription drug costs. The Government plays almost no role in delivering healthcare directly, whereas the administration is handled by non Governmental insurers known as sickness funds. These funds are financed by general wage contributions (14.6% of wages) and supplementary contributions (1% of wages, on average) by employers and employees. Copayments apply to inpatient services and drugs, and sickness funds offer a range of deductibles. The Germans who earn more than $68,000 can opt-out of SHI and switch to private health insurance, which is not subsidised by the Government [60].

Healthcare in France

The French healthcare system is based on the principle of universal healthcare and is known as the Protection Maladie Universale (PUMA) [61]. The public healthcare system is estimated to cover 96% of all French residents. In France, most of the hospitals are publicly owned and for non profit. Preventive healthcare is highly valued, and every patient is entitled to a comprehensive preventative physical every five years. Alternative healthcare methodologies are respected, and if a patient wishes to consult with an alternative practitioner for weight loss or smoking cessation assistance, the healthcare system will accommodate them. The French healthcare system costs a lot of money to run. Approximately 8% of salaries are automatically withheld to help fund the system. The system is funded by all citizens, and the rates that doctors and hospitals can charge are regulated by the state. Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES) is the Government agency responsible for accrediting health facilities, evaluating clinical practice and guidelines, and defining the interventions that are reimbursed by health insurance [62]. The total health expenditures accounted for 11.5% of GDP in 2017, with 77% of those spending being funded by the Government. The following are the terms of statutory health insurance financing i.e, employers pay 80% of the tax and employees pay the balance. Payroll taxes account for 53% of total funding. A 34% contribution comes from a national designated income tax. Tobacco and alcohol taxes, pharmaceutical sector taxes, and Voluntary Health Insurance (VHI) firms all provide 12% of funding. Subsidies from the state contribute to 1% of total funding. Coverage is compulsory and is provided to all the residents. A majority of voluntary health insurance is complementary, covering primarily copayments and balance billing, as well as vision and dental care, which are only minimally covered by SHI [61].

Healthcare in Australia

In Australia, public healthcare is provided through Medicare, a single-payer, universal healthcare program that covers all Australian citizens and permanent residents [63]. Medicare covers medical appointments, medications, and hospitalisation at a reduced or no cost [64]. The taxes cover the costs of healthcare. The Medicare Levy, which funds the public system, is paid by residents at a rate of 2% of their income [65]. As a result, most patients never pay medical fees at their appointments, and if they do, they can get reimbursed. Medicare pays for general physician visits, hospital visits, and 85% of specialist costs. It also subsidizes prescription medications, allowing them to be purchased at a reduced price. Medicare also pays for some costs associated with physiotherapy, community nursing programs, and basic dental care for children. However, expatriates in Australia, including workers and students, are paying for their healthcare through cash or private health insurance. People who are not eligible for Medicare benefits can apply for an exemption from paying the Medicare levy or a reduction in the amount they pay [66]. Healthcare in the country is also enhanced through Primary Health Networks (PHNs). There are 31 PHNs across the country that are in charge of assisting community health centres, hospitals, doctors, and nurses. PHNs also help to coordinate activities across the healthcare system and may provide more services, if the need arises in different regions [67].

Healthcare in Canada

Canada's healthcare system is unique in the world since it has a decentralized, universal, publicly funded health system known as Canadian Medicare, which is primarily funded and administered by the country's 13 provinces and territories [68]. Each has its own

insurance plan and receives per capita cash assistance from the federal Government [68]. The norms and standards are established by the federal Government, and they affirm five foundational principles: non profit public administration by a public authority, comprehensiveness, universality, portability, and accessibility [69]. Benefits and delivery methods differ. Medically essential hospital and physician services are, however, provided free of charge to all citizens and permanent residents. Provinces and territories provide some coverage for excluded services, such as outpatient prescription medicines and dental care. In 2017, overall health spending was anticipated to be 11.5% of GDP, with the public and private sectors accounting for roughly 70% and 30% of total health spending, respectively [68]. All medically essential hospital and physician services are covered by each patient's health insurance plan. Supplementary services, or those not covered by Canadian Medicare, are generally funded privately, either through patient fees or through employer based or private insurance. Provinces and territories are responsible for all of their own residents, based on their residency criteria. Taxes account for the majority of the patient revenue. The Canada Health Transfer, a federal program that pays healthcare for provinces and territories, provides almost a quarter of the funding (an estimated CAD 37 billion, or USD 29.4 billion in 2017 to 2018) [68].

Healthcare in South Korea

The healthcare systems of South Korea pursue universal healthcare, where everyone can access healthcare services with a minimal financial burden [70]. At the national level, the Ministry of Health and Welfare (MoHW) oversees health policy and planning [71]. The MoHW runs several specialty national hospitals where the private market fails to meet the needs of the population, such as the 17 Psychiatric Hospitals and three Tuberculosis Hospitals. However, private hospitals also play an important role in healthcare delivery [71] and the care provided in private clinics and hospitals is covered under the National Health Insurance (NHI) scheme. The NHI program is managed by the National Health Insurance Service (NHIS) and the care it covers is reviewed by the Health Insurance Review and Assessment Service (HIRA). Though the two organisations are separate from the Ministry, they remain under some indirect control of the MoHW. Health insurance coverage has gradually spread from large to medium and small companies, as well as from employees to self employed people. Coverage is provided through a statutory health insurance plan in which recipients pay a premium and cannot opt-out. A 20% co-payment is required for inpatient care, while the copayment for outpatient care varies from 30-60% depending on the provider. The Medical Aid Programme pays both the insurance premium and copayments for low-income people. In 2018, 97.2% of the population was covered by NHI, while 2.8% was covered by the Medical Aid Program [72].

Healthcare in Qatar

Qatar has a rapidly developing healthcare system that has been ranked as the fifth best in the world and the first in the Middle East in 2019 Legatum Prosperity Index in terms of quality of care. It is the region's only country to rank among the top five in the annual prosperity index [73] and the Government has made significant investments in the country's public healthcare system with cutting-edge medical equipment, up-to-date facilities and highly-trained specialists. The Hamad Medical Corporation (HMC), a non profit organisation, directs Qatar's public medical facilities and has overseen major public hospitals in the country since 1979 [74]. It operates 12 public hospitals, community clinics, and the national ambulance service. The HMC has created an intricate and efficient network of clinics and hospitals which provide free treatment for Qataris and subsidised treatment for expatriates. Qatari residents can avail of the services through a Government issued health card. Expats can purchase the health card at a marginal cost of QAR100, while Qatari citizens receive it for QAR 50 [75]. With this card, emergency treatment is most often free in public hospitals, however, expatriates need to pay nominal charges for tests, consultation and inpatient care. Though Qatar's public healthcare system is excellent and subsidised, the country also has few private healthcare providers. However, these private hospitals are quite expensive and can be prohibitively high without medical coverage. Under a new healthcare law that goes into effect in May 2022, employers in Qatar are required to provide health insurance coverage for expatriates and their families [76]. The new insurance system is intended to help the healthcare sector by providing basic healthcare services to workers through care providers in Government and private health facilities [76]. Much more information will be available once it has been put into practice.

DISCUSSION

Although the Coronavirus Disease-2019 (COVID-19) pandemic hampered the availability and ability of health systems to deliver uninterrupted healthcare in many nations, several countries are already making progress toward Universal Health Coverage (UHC) [77]. Health systems in all countries must be strengthened to achieve universal health coverage. The importance of strong funding mechanisms cannot be ignored. The poor are often unable to access many of the services they want when they must pay the majority of the cost of healthcare out of their own pockets, and even the wealthy may face financial difficulties in the event of severe or long-term sickness [77]. The financial risks of diseases can be managed by pooling cash from mandatory financing sources like Government tax revenue [77].

Many Low and Middle Income Countries (LMICs) have also recently reformed their health systems to promote universal access to healthcare, improve the quality of health services, and increase equity in health financing [78,79]. Many such countries have set UHC as a goal for national healthcare reform [80]. According to the WHO, there are three fundamental, interrelated problems that prevent countries from achieving universal health coverage:

- The first one is resource availability, in which every Government must ensure that everyone has rapid access to any technology or intervention that can help them improve their health or live longer.
- The second is an over-reliance on direct payments when people need care, mostly for over-the-counter payments for medicines and fees for consultations and procedures. Millions of people are unable to receive healthcare because they are required to pay directly for services at the time of care and those who seek treatment may also face considerable financial difficulties and impoverishment.
- The third impediment to countries' progress toward universal coverage is inefficient and unequal resource allocation.

According to conservative estimates, roughly 20% to 40% of health resources are wasted. The ability of health systems to offer excellent services and improve healthcare would be considerably enhanced, if this waste could be reduced. Improved healthcare efficiency makes it easier for the ministry of health to obtain additional financing from the ministry of finance in most circumstances. To accomplish UHC, countries must raise enough revenues, minimise reliance on direct payments to finance services and increase efficiency and equity [80]. There are several ways for countries to raise money for health, including improving revenue collection efficiency, reprioritising Government budgets, and innovative financing, such as rich countries raising more funds for health in poor settings by increasing taxes on air tickets, foreign exchange transactions, tobacco, and other items, and development assistance for health, where the funding shortfall faced by low-income countries highlights the need for high-income countries to honour their commitments on Official Development Assistance (ODA) [80].

Though many of the world's top healthcare systems provide free or universal healthcare for the purpose of making healthcare affordable and accessible for all citizens [10], it also has certain drawbacks. The treatment of the sickest is paid for by the healthy. Chronic illnesses, mostly caused by lifestyle decisions, account for over 90% of healthcare costs. As a result, many people who live a healthy lifestyle feel burdened and unfairly taxed by others' poor decisions [81]. Patients who do not have to pay a charge may overuse emergency rooms and doctors. Wait times for elective operations also can be much longer because the Government generally focuses on providing basic and emergency healthcare [82]. The Government cost-cutting could also result in decreased care provision [83]. Moreover, healthcare spending accounts for a significant portion of Government spending [84]. The Government may limit services with a low possibility of success, such as rare disease drugs and expensive end-of-life care [85]. These disadvantages could easily be mitigated and overcome by excellent health governance, which could enhance the possibility of attaining the benefits of UHC.

Political stability and governance are important factors for developing a country especially for achieving universal health coverage. A cross-sectional study involving 118 countries found a significant association between political stability, governance status, and socio-demographic status with universal health service coverage [86]. A study by Fox AM and Reich MR, suggested that health service coverage could not be achieved without political negotiation and conflict settlement [87]. According to Bump J in 2010, UHC is intensely political since it requires consistent policies and programs to deliver quality health services to the entire population [88]. In addition, Kelsall T, demonstrated that effective public policy, adequate funding, and improved governance could accelerate advancements toward the UHC [89]. Also, the World Health Organisation's action plan affirmed that good governance is a prerequisite for UHC [90], and the World Bank Human Development Network reported that good governance leads to improved health outcomes and coverage [91]. According to a Chinese study, improving health governance greatly enhanced health service and health insurance coverage [92]. Another study by Yeoh EK et al., found that good governance contributes to progress toward UHC in the Asia-Pacific area [93]. Fryatt R et al., also stated that effective governance will help the success of UHC and that people are accountable inside the health system [94].

A study by Reich MR et al., classified LMICs into four different levels [95]. The first group consists of countries at the bottom of the UHC ladder, such as Bangladesh and Ethiopia, that are currently working to incorporate UHC into their national policies. The second group consists of nations such as Indonesia, Peru, and Vietnam, which have made tremendous progress toward universal health coverage but still have significant coverage gaps. The third group includes countries such as Brazil, Thailand, and Turkey, which have achieved several UHC policy objectives but are currently facing sustainability issues. Countries like France and Japan are in the fourth group, which have achieved universal health coverage but still need to make significant policy reforms to address demographic and epidemiological concerns such as aging populations and the rising prevalence of degenerative diseases [95].

CONCLUSION(S)

As countries move toward universal health coverage, private healthcare and private health insurance are also becoming more popular. In the private healthcare system, there are numerous ethical issues, including access to healthcare, unfair competition with non profits, viewing healthcare as a commodity, poor physician-patient relationships, reduced quality of care, diminished value of medical education, and undue influence on public policy regarding healthcare. Also, private health insurance may present significant equity challenges, potentially increasing healthcare spending. Complete coverage of public sector costs by private insurance may encourage moral hazard-induced utilisation. Hence, considering the ethical issues involved in a for-profit healthcare system and the drawbacks of private insurers, health insurance must be administered by non profit organisations.

REFERENCES

[1] United Nations. Goal 3: Ensure healthy lives and promote well-being for all at all ages [Internet]. United Nations Sustainable Development. 2018. Available from: https://www.un.org/sustainabledevelopment/health/.

[2] Arrow KJ. Uncertainty and the welfare economics of medical care. American Economic Review. 1963;53(5):941-73.

[3] Culyer AJ. The nature of the commodity 'health care' and its efficient allocation. Oxford Economic Papers. 1971;23(2):189-11.

[4] Hood C. A public management for all seasons? Public Administration. 1991;69:03-19.

[5] Hollingsworth B. The measurement of efficiency and productivity of health care delivery. Health Economics. 2008;17:1107-28.

[6] Hollingsworth B. Non-parametric and parametric applications measuring efficiency in health care. Health Care Management Science. 2003;6:203-18.

[7] Hollingsworth B, Dawson PJ, Maniadakis N. Efficiency measurement of health care: A review of nonparametric methods and applications. HCMS.1999;2:161-72.

[8] Lee K, Yang S, Choi M. The association between hospital ownership and technical efficiency in a managed care environment. J Med Syst. 2009;33:307-15.

[9] Foreign Countries with Universal Health Care [Internet]. Ny.gov. 2011. Available from: https://www.health.ny.gov/regulations/hcra/univ_hlth_care.htm.

[10] Martin D, Miller AP, Quesnel-Vallée A, Caron NR, Vissandjée B, Marchildon GP. Canada's universal health-care system: Achieving its potential. Lancet. 2018;391(10131):1718-35.

[11] Institute of Medicine (US) Committee on Implications of For-Profit Enterprise in Health Care; Gray BH, editor. For-Profit Enterprise in Health Care. Washington (DC): National Academies Press (US); 1986. Ethical Issues in For-Profit Health Care.

[12] Colombo F, Tapay N. Unclassified DELSA/ELSA/WD/HEA (2004)6. Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems [Internet]. 2004. Available from: https://www.oecd.org/els/health-systems/33698043.pdf.

[13] Institute of Medicine (US) Committee on Implications of For-Profit Enterprise in Health Care; Gray BH, editor. For-Profit Enterprise in Health Care. Washington (DC): National Academies Press (US); 1986. 1, Profits and Health Care: An Introduction to the Issues.

[14] Sonymol K, Shankar R. Healthcare cost reduction and health insurance policy improvement. Value in Health Regional Issues. 2022;29:93-99.

[15] Wray CM, Khare M, Keyhani S. Access to care, cost of care, and satisfaction with care among adults with private and public health insurance in the US. JAMA Network Open. 2021;4(6):e2110275-75.

[16] Cantarero-Prieto D, Pascual-Sáez M, Gonzalez-Prieto N. Effect of having private health insurance on the use of health care services: The case of Spain. BMC Health Services Research. 2017;17(1):716.

[17] Han X, Call KT, Pintor JK, Alarcon-Espinoza G, Simon AB. Reports of insurance-based discrimination in health care and its association with access to care. Am J Public Health. 2015;105(suppl 3):S517-25.

[18] Sun EC, Mello MM, Moshfegh J, Baker LC. Assessment of out-of-network billing for privately insured patients receiving care in in-network Hospitals. JAMA Internal Medicine. 2019;179(11):1543-50.

[19] Institute of Medicine (US) Roundtable on Evidence-Based Medicine; Yong PL, Saunders RS, Olsen LA, editors. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington (DC): National Academies Press (US); 2010. 4, Excess Administrative Costs.

[20] Australian Government Department of Health. What private health insurance covers [Internet]. Australian Government Department of Health. 2019. Available from:https://www.health.gov.au/health-topics/private-health-insurance/what-private-health-insurance-covers.

[21] Foubister T, Thomson S, Mossialos E, McGuire AL, Europe WHORO for, European Observatory on Health Systems and Policies. Private medical insurance in the United Kingdom [Internet]. apps.who.int. Copenhagen; 2006 [cited 2022 Jun 26]. Available from:https://apps.who.int/iris/handle/10665/107741

[22] Barber SL, Lorenzoni L, Ong P. Price setting and price regulation in health care: lessons for advancing Universal Health Coverage. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2019. Licence: CC BY-NC-SA 3.0 IGO.

[23] McKee M, Balabanova D, Basu S, Ricciardi W, Stuckler D. Universal health coverage: A quest for all countries but under threat in some. Value in Health. 2013;16(1, Supplement):S39-45.

[24] World Population Review. Countries with Universal Healthcare 2022 [Internet]. worldpopulationreview.com. 2022. Available from: https://worldpopulationreview.com/country-rankings/countries-with-universal-healthcare.

[25] Anell A, Glenngård A, Merkur S. Health systems in transition. Sweden Health system review [Internet]. 2012;14(5). Available from: https://www.euro.who.int/__data/assets/pdf_file/0008/164096/e96455.pdf.

[26] Rae D. Getting better value for money from Sweden's Healthcare System, OECD Economics Department Working Papers, No. 443. OECD Publishing, Paris [Internet]. 2005;(443). Available from: https://www.oecd-ilibrary.org/content/paper/082725005676.

[27] World Health Organization. Regional Office for Europe, European Observatory on Health Systems and Policies, Glenngard A, Hjalte F, Svensson M, Anell A, Bankauskaite V. Health systems in transition: Sweden. World Health Organization. Regional Office for Europe. 2005;7(4):128. https://apps.who.int/iris/handle/10665/107738.

[28] Sweden | Commonwealth Fund [Internet]. www.commonwealthfund.org. 2020. Available from: https://www.commonwealthfund.org/international-health-policy-center/countries/sweden

[29] Delamothe T. NHS at 60: Founding principles. BMJ. 2008;336:1216-18.

[30] NHS England. The NHS belongs to the people: A call to action [Internet]. England.nhs.uk. 2013. Available from: https://www.england.nhs.uk/2013/07/call-to-action/.

[31] Chang J, Peysakhovich F, Wang W, Zhu J. The UK Health Care System [Internet]. 2012. Available from: http://assets.ce.columbia.edu/pdf/actu/actu-uk.pdf.

[32] Cooper J. Healthcare expenditure, UK Health Accounts provisional estimates - Office for National Statistics [Internet]. www.ons.gov.uk. 2021. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/healthcareexpenditureukhealthaccountsprovisionalestimates/2020.

[33] Tikkanen R, Osborn R, Mossialos E, Djordjevic A, Wharton GA. England | Commonwealth Fund [Internet]. www.commonwealthfund.org. 2020. Available from: https://www.commonwealthfund.org/international-health-policy-center/countries/england.

[34] Doyle Y, Bull A. Role of private sector in United Kingdom healthcare system. BMJ. 2000;321(7260):563-65.

[35] Ministry of health. Challenges and opportunities [Internet]. Ministry of Health NZ. 2016. Available from: https://www.health.govt.nz/new-zealand-health-system/new-zealand-health-strategy-future-direction/challenges-and-opportunities.

[36] Organisation for Economic Co-operation and Development, OECD Health Statistics, 2017. http://www.oecd.org/els/health-systems/health-data.htm.

[37] Tikkanen R, Osborn R, Mossialos E, Djordjevic A, Wharton GA. New Zealand | Commonwealth Fund [Internet]. www.commonwealthfund.org. 2020. Available from: https://www.commonwealthfund.org/international-health-policy-center/countries/new-zealand.

[38] Community Services Card [Internet]. Ministry of Health NZ. Available from: https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/community-services-card.

[39] Healthcare if you're in NZ on a work visa [Internet]. New Zealand Government. [cited 2022 Jun 26]. Available from: https://www.govt.nz/browse/health/public-health-services/healthcare-on-a-work-visa.

[40] Eligibility questions and answers for consumers [Internet]. Ministry of Health NZ. Available from: https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/eligibility-questions-and-answers-consumers.

[41] Euro Health Consumer Index 2018 [Internet]. Available from: https://healthpowerhouse.com/media/EHCI-2018/EHCI-2018-report.pdf.

[42] OECD/European Observatory on Health Systems and Policies (2017), Spain: Country Health Profile 2017, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, https://doi.org/10.1787/9789264283565-en.

[43] Mossialos EI, Dixon A, Figueras G, Kutzin J. Funding health care: Options for Europe. United Kingdom: Open University Press. 2002;129-31. ISBN 0-335-20924-26.

[44] Simões J, Augusto GF, Fronteira I, Hernández-Quevedo C. Portugal: Health system review. Health Systems in Transition. 2017;19(2):01-184.

[45] Barros PP, Machado SR, Simões Jde A. Portugal. Health system review. Health Syst Transit. 2011;13(4):01-156.

[46] Tsugane S. Why has Japan become the world's most long-lived country: Insights from a food and nutrition perspective. Eur J Clin Nutr. 2021;75:921-28. https://doi.org/10.1038/s41430-020-0677-75.

[47] Ikegami N. Japan: Achieving UHC by regulating payment. Global Health. 2019;15:72. https://doi.org/10.1186/s12992-019-0524-24.

[48] Matsuda R. Japan | Commonwealth Fund [Internet]. www.commonwealthfund.org. 2020. Available from: https://www.commonwealthfund.org/international-health-policy-center/countries/japan.

[49] Salute M della. Strengths of the Italian National Health Service [Internet]. www.salute.gov.it. Available from: https://www.salute.gov.it/portale/cureUE/dettaglioContenutiCureUE.jsp?lingua=english&id=3879&area=healcareUE&menu=vuoto.

[50] The World Health Organization's ranking of the world's health systems, by Rank. https://photius.com/rankings/healthranks.html.

[51] Tandon A, Murray CJL, Lauer JA, Evans DB. Measuring overall health system performance of 191 countries (PDF). GPE Discussion Paper Series no. 30. EIP/GPE/EQC. World Health Organization. 2000.

[52] Italy | Commonwealth Fund [Internet]. www.commonwealthfund.org. 2020. Available from: https://www.commonwealthfund.org/international-health-policy-center/countries/italy.

[53] Poscia A, Silenzi A, Ricciardi W. Italy. In: Rechel B, Maresso A, Sagan A, et al., editors. Organization and financing of public health services in Europe: Country reports [Internet]. Copenhagen (Denmark): European Observatory on Health Systems and Policies; 2018. (Health Policy Series, No. 49.) 5.

[54] Sagan A, Thomson S. Voluntary health insurance in Europe: Role and regulation [Internet]. Copenhagen (Denmark): European Observatory on Health Systems and Policies; 2016.

[55] Health Act. 2004. Irish Statute Book. Office of the Attorney General. https://www.irishstatutebook.ie/eli/2004/act/42/enacted/en/html.

[56] Connolly S, Wren MA. Universal health care in Ireland—What are the prospects for reform? Health Syst Reform. 2019;5(2):94-99.

[57] Johnston B, Thomas S, Burke S. Can people afford to pay for health care? New evidence on financial protection in Ireland. Copenhagen: WHO Regional Office for Europe; 2020. Licence: CCBY-NC-SA 3.0 IGO https://apps.who.int/iris/bitstream/handle/10665/332978/9789289055086-eng.pdf.

[58] HSE. Services. https://www.hse.ie/eng/services/list/.

[59] Blümel M, Spranger A, Achstetter K, Maresso A, Busse R. Germany: health system review. Health Syst Transit. 2020;22(6):01-272. PMID: 34232120.

[60] Tikkanen R, Osborn R, Mossialos E, Djordjevic A, Wharton G. Germany | commonwealth fund [Internet]. www.commonwealthfund.org. 2020. Available from: https://www.commonwealthfund.org/international-health-policy-center/countries/germany.

[61] Tikkanen R, Osborn R, Mossialos E, Djordjevic A, Wharton GA. France | Commonwealth Fund [Internet]. www.commonwealthfund.org. 2020. Available from: https://www.commonwealthfund.org/international-health-policy-center/countries/france.

[62] Quality and accreditation in healthcare services. A global review. Evidence and Information for Policy Department of Health Service Provision. World Health Organization. Geneva. 2003.

[63] Australian Institute of Health and Welfare. Australia's Health 2018. https://www.aihw.gov.au/getmedia/7c42913d-295f-4bc9-9c24-4e44eff4a04a/aihw-aus-221.pdf.

[64] Department of Health, Australian Government. Medicare. https://www.health.gov.au/health-topics/medicare.

[65] Australian Taxation Office, Australian Government. Medicare levy. https://www.ato.gov.au/Individuals/Medicare-and-private-health-insurance/Medicare-levy/.

[66] Australian Taxation Office, Australian Government. Medicare levy exemption. https://www.ato.gov.au/Individuals/Medicare-and-private-health-insurance/Medicare-levy/medicare-levy-exemption/.

[67] Department of Health, Australian Government. Primary Health Networks. https://www.health.gov.au/initiatives-and-programs/phn.

[68] Allin S, Marchildon G, Peckham A. International healthcare profiles, Canada. The Commonwealth Fund. https://www.commonwealthfund.org/international-health-policy-center/countries/canada.

[69] Canada Health Act and its Principles. https://www.health.gov.bc.ca/library/publications/year/2007/conversation_on_health/PartII/PartII_HealthAct.pdf.

[70] Heo K, Jeong K, Lee D. A critical juncture in universal healthcare: Insights from South Korea's COVID-19 experience for the United Kingdom to consider. Humanit Soc Sci Commun. 2021;8:57. https://doi.org/10.1057/s41599-021-00731-y.

[71] Kwon S, Lee T, Kim C. Republic of Korea health system review. Health Systems in Transition 2015;5(4). http://apps.who.int/iris/bitstream/handle/10665/208215/9789290617105_eng.pdf;jsessionid=202657338B0BE096D2E7FC62E0117DC3?sequence=1.

[72] The public health system in Korea. https://www.oecd-ilibrary.org/sites/6e005d47-en/index.html?itemId=/content/component/6e005d47-en.

[73] Qatar's health system ranked 5th best globally. Gulf Times. https://www.gulf-times.com/story/624072/Qatar-s-health-system-ranked-5th-best-globally.

[74] Hamad Medical Corporation. https://en.wikipedia.org/wiki/Hamad_Medical_Corporation.

[75] Health Card. https://www.phcc.gov.qa/Patients-And-Clients/Health-Card.

[76] Health insurance mandatory for expats, visitors from April 2022. https://www.gulf-times.com/story/702739/Health-insurance-mandatory-for-expats-visitors-from-April-2022.

[77] World health Organization. Universal health coverage (UHC). https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

[78] Han W. Health care system reforms in developing countries. J Public Health Res. 2012;1(3):199-07.

[79] Otieno PO, Asiki G. Making Universal Health Coverage Effective in Low- and Middle-Income Countries: A Blueprint for Health Sector Reforms. In: Bacha U, Rozman U, Turk SS. editors. Healthcare Access - Regional Overviews [Internet]. London: IntechOpen; 2020 [cited 2022 Apr 13]. Available from: https://www.intechopen.com/chapters/71666 doi: 10.5772/intechopen.91414.

[80] World health organization (WHO). The World Health Report 2010: Health Systems Financing: The Path to Universal Coverage. World health organization (WHO) 2010. https://www.who.int/publications/i/item/9789241564021.

[81] Centers for Disease Control and Prevention. Health and Economic Costs of Chronic Diseases. https://www.cdc.gov/chronicdisease/about/costs/index.htm.

[82] Partnership for America's Health Care Future. CBO Confirms One-Size-Fits-All System Could 'Negatively Impact The Quality Of Care For Patients'. https://americashealthcarefuture.org/cbo-confirms-one-size-fits-all-system-could-negatively-impact-the-quality-of-care-for-patients/.

[83] American Medical Association. 2018 Medicare payment cuts for clinical testing. https://www.ama-assn.org/practice-management/medicare-medicaid/2018-medicare-payment-cuts-clinical-testing.

[84] The University of British Columbia. Evidence and Perspectives on Funding Healthcare in Canada. https://healthcarefunding.ca/key-issues/current-funding/.

[85] Duncan I, Ahmed T, Dove H, Maxwell TL. Medicare cost at end of life. Am J Hosp Palliat Care. 2019; 36(8):705-10.

[86] Ranabhat CL, Jakovljevic M, Dhimal M, Kim CB. Structural factors responsible for Universal health coverage in low- and middle-income countries: Results from 118 countries. Frontiers in Public Health. 2020;7:414. https://www.frontiersin.org/article/10.3389/fpubh.2019.00414.

[87] Fox AM, Reich MR. The politics of universal health coverage in low and middle-income countries: A framework for evaluation and action. J Health Politics Policy Law. 2015;40:1023-60.

[88] Bump J. The long road to Universal health coverage: A century of lessons for development strategy. Seattle, WA: Path 2010. https://www.formosapost.com/pdf/The-Long-Road-to-Universal-Health-Coverage.pdf.
[89] Kelsall T, Hart T, Laws E. Political Settlements and Pathways to Universal Health Coverage. London 2016. https://cdn.odi.org/media/documents/10382.pdf.
[90] World Health Organization. Health systems governance for universal health coverage action plan: Department of health systems governance and financing. World Health Organization. 2014. https://apps.who.int/iris/handle/10665/341159.
[91] Savedoff WD. Governance in the Health Sector: A Strategy for Measuring Determinants and Performance. Washington, DC: The World Bank; 2011. https://doi.org/10.1596/1813-9450-5655.
[92] Yuan B, Jian W, He L, Wang B, Balabanova D. The role of health system governance in strengthening the rural health insurance system in China. Int J Equity Health. 2017;16:44.
[93] Yeoh EK, Johnston C, Chau PYK, Kiang N, Tin P, Tang J. Governance functions to accelerate progress toward universal health coverage (UHC) in the Asia-Pacific Region. Health Systems Reform. 2019;5:48-58.
[94] Fryatt R, Bennett S, Soucat A. Health sector governance: Should we be investing more? BMJ Global Health. 2017;2:e000343.
[95] Reich MR, Harris J, Ikegami N, Maeda A, Cashin C, Araujo EC, et al. Moving towards universal health coverage: Lessons from 11 country studies. Lancet. 2016;387(10020):811-16.

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