Unpacking the discourse on universal health coverage in India

Arima Mishra Ph.D; Shreelata Rao Seshdari Ph.D

Abstract

Since the World Health Report 2010, universal health coverage has received increased policy attention worldwide. Though the goal of achieving universal health coverage has been widely acclaimed and is reinforced in several national and international forums, the contours of the debate have been disparate. Endorsing this global call, India like many other low and middle income countries, embarked on the path to achieve universal health coverage by proposing several health sector reforms. Though universal health coverage has received significant political attention in the country, there is a danger of limiting the debate to a question of financing and providing of medical services. We argue that the current debate about universal health coverage should draw critical attention to (re) prioritization of primary healthcare, health system governance, and health equity. We must keep health and its determinants in mind rather than medical care alone. Key words: universal health coverage, primary healthcare, governance, equity, India.

Introduction

Margaret Chen, in her address to the World Health Assembly in 2012, stated that universal health coverage is the single most powerful concept that public health has to offer. Following the resolution of the 58th World Health Assembly in 2005, Universal Health Coverage (hereafter referred to as UHC) has been acknowledged as the most important public health goal worldwide. Though this goal has been widely acclaimed and reinforced in several national and international forums, the contours of the debate are disparate. This commentary seeks to unpack the discourse on UHC in the context of India and argue that the recent attention given to achieving UHC needs to focus on "public" (population level) and "health" rather than on individualized medical care.

The call for UHC in India: An unfinished policy agenda?

Resonating with the global call, India has expressed its political commitment to achieve universal health coverage by 2020. The Government of India set up the High Level Expert Group (HLEG) in 2010 to develop a road map for operationalizing the UHC vision. The HLEG report has been heralded as a landmark document in health policy.[1] Evoking principles of equity and universality in healthcare, it has generated a vibrant political debate in India around the UHC vision.

In order to contextualize the current UHC discourse in India, it is pertinent to ask if UHC is really a new policy agenda. The World Health Report (2013)[2] traces the current expression of UHC as a descendant of the Alma Ata declaration on "Health for All." Both these movements, as the report notes, underscore the aspiration of "enjoyment of the highest attainable standard of health." A historical analysis of the current UHC debates in India is essential before any fresh recommendations on UHC are contemplated. The idea of UHC as a means of ensuring health for all was first expressed in India prior to the country's Independence. The Health Survey and Development Committee Report popularly known as the Bhore Committee Report (1946) has been considered as India's most comprehensive and detailed health policy and planning document.[3] The Bhore

Arima Mishra. Ph.D, School of Development, Azim Premji University, Bangalore, India
E-mail: arima.mishra@apu.edu.in
Shreelata Rao Seshadri, Ph.D
School of Development, Azim Premji University, Bangalore, India
E-mail: shreelata. seshadri@apu.edu.in
Submitted: 5/31/2014
Revised: 9/16/2014
Accepted: 6/13/2015

Conflict of interest: None

committee recommended a National Health Service to ensure universal health coverage through a comprehensive state run health service. More importantly, the National Health Service was designed to offer both curative and preventive services to individual patients and health promotion for the population as a whole. The Commission discussed the promotion of healthy environments at home, in the workplace, and beyond. Acknowledging rural-urban disparities, the Commission proposed a decentralized health structure which would place health services close to the people; this would ensure their maximum use by the community.

The spirit of the Bhore committee report and the consequent Alma Ata Declaration (1978) was reflected in the first Indian National Health Policy in 1983. Critiquing the curative model of healthcare, this policy reiterated the goal of providing universal, comprehensive primary healthcare services relevant to the actual needs and priorities of the community.[4] Despite its progressive intentions, the 1983 policy fell far short of realizing its stated goals. The liberalization of the economy in the early 1990s was accompanied by growth of the private sector with rare or ineffective regulations. Public investment in the health system was as low as 0.9% of the Gross Domestic Product until 2005 when it was raised to a meagre 1.4%. Thus, chronic underfinancing, the absence of political prioritization/leadership on the social sector including health, the continued focus on disease specific programs, and an unregulated, rapidly blossoming private sector meant that UHC remained an unrealized aspiration.

Opting for a strategy of providing selective primary healthcare – considered more affordable and feasible than comprehensive primary healthcare – India developed a large number of "vertical" disease control programs that are financed and managed from the central level; these also known as "Centrally Sponsored Schemes." These programs are directed at diseases of public health importance, including *inter alia* reproductive and child health, HIV/AIDS, tuberculosis, malaria, cataract blindness, and leprosy. They are managed, implemented, and monitored by complex organizational arrangements at central, state, district, and community levels.

At the state level, public health services are provided by an extensive network of primary, secondary, and tertiary health facilities, each with its own service guidelines and staffing pattern. Despite such an elaborate organizational structure, most public health facilities suffer from severe resource constraints and fail to deliver quality healthcare. To add to this multi-level hierarchical public health service structure, there is a large private sector in health, which is both unregulated and extremely varied. It includes traditional healers dispensing homegrown remedies, practitioners of traditional Indian Systems of Medicine, pharmacists, doctors in solo practice, nursing homes, and highly sophisticated tertiary care centers. Eighty percent of outpatient care is provided by the private sector; this means high out of pocket expenditure for the poor and marginalized.

Despite some health gains in the recent past with regard to reductions in maternal and child mortality as well as improvements in life expectancy, health outcomes in India continue to belie the achievements of its consistent 6% economic growth in the past decade. Not only is India lagging behind many countries at comparable levels of GDP per capita, it is also clear now that several of the Millennium Development Goals for health will not be achieved (with the current Infant Mortality Rate and Maternal Mortality Ratio at 47/1000 and 212/100,000 respectively as against the targets of 28/1000 and 109/100,000 by 2005).[5] There are significant regional and inter-state differences within the country; substantial differences in health outcomes based on gender and socio-economic class remain. For example, the infant mortality rate was 82 per 1000 live births in the poorest wealth quintile and 34 per 1000 live births in the richest wealth quintile in 2005–06. Further, the mortality rate in children younger than 5 years who are born to mothers with no education compared with those with more than 5 years of education was 106/1000 live births and 49/1000 live births, respectively, during period from 1995–96 to 2005–06.[6] In terms of inter-state differences, maternal mortality ratio is as high as 390 in the state of Assam while southern states like Kerala and Tamil Nadu have 87 and 92 respectively.[7]

Hence, the discussion of UHC in India is very timely given the dismal situation of poor access to affordable services, poor quality of care, and inequity in health status. But how does this call aim to revive the unrealized agenda of universal comprehensive health reflected in the Bhore Committee Report (1946) and the Alma Ata Declaration (which India like many other countries wholeheartedly endorsed in 1978)?

Health for All to Universal Health Coverage

Despite an apparent continuity between the Alma Ata declaration and the current UHC call, these seem different on some fundamental grounds.[8] The differences pertain as much to the role of the state vis-a-vis the private sector in financing and provisioning of healthcare as to the notion of public health itself. Although set within an economic climate of neo-liberal reforms, exponential growth of a private sector in health and widening disparities in healthcare, the UHC discourse focuses only on redressing financial hardship in obtaining healthcare. Catastrophic expenditure in healthcare has thus been the entry point for the recent UHC agenda.

The WHO identifies three key dimensions of coverage: population, services, and cost. This has led to a lot of discussion around provision of a "package" of services through expansions in insurance coverage. As stated above, catastrophic expenditure has been a hard reality in India and there is no denying the fact that high out of pocket expenditure is an important deterrent to accessing quality healthcare. UHC seeks to check this unwarranted financial catastrophe. Yet reducing UHC to financing healthcare is only part of the story and at best an unhealthy one. There is plenty of evidence to show the pitfalls of responding to high healthcare costs through expanding insurance coverage via schemes like the Rashtriya Swasthya Bima Yojana (RSBY, introduced in 2008).[9-11] Such schemes have received greater support in the 12th Five Year Plan including the current Draft National Health Policy (2015).[12]

The HLEG in its report has rightly cautioned against relying on insurance schemes as way to implement UHC; there is a danger of fragmenting healthcare through underinvestment in primary care, preventive care, health promotion, and rehabilitative care while fostering the institutions of secondary and tertiary care. Other dangers of course include the indirect growth of private sector healthcare delivery using public financing. In a setting where the large, heterogeneous private health sector is mostly unregulated, such schemes would ironically promote the very set of problems which they try to redress: high cost of care and variations in quality. The insurance model of UHC initiatives rests on the fundamental principle of separating financing and provisioning (public finance with private provisioning of healthcare) and the privileging of coverage at secondary and tertiary levels for specific ailments.[8] These principles set it apart from the Alma Ata discourse on Health for All which was premised on the principles of a robust public health system (in financing and provisioning) and comprehensive primary healthcare.

The semantics of "comprehensive primary healthcare" (covering all aspects of care responding to community needs and addressing social determinants of health) and "coverage" (provision of a defined package of services to the population) indicate differences in approaches to health planning itself (bottom-up/top-down). In this regard, it runs counter to the National Rural Health Mission (NRHM) agenda that sought to carry out "architectural corrections" in the public health system in rural areas. By revitalising the primary healthcare approach, the NRHM launched in 2005, sought to strengthen comprehensive primary healthcare through inter-sectoral actions, integration of earlier vertical health programs, and bringing the public (community) back into public health through recruitment of village level health workers, health and nutrition outreach sessions, village level health planning and community monitoring.[13] The UHC debate needs to be integrally linked with the NRHM and strengthen the political commitment to ensure healthcare that is comprehensive, integrated, and accessible to all.

Health for All is predicated on participation: of people, of communities, and of their political representatives at the local and state levels. This has been supported by the 73rd Amendment to the Constitution in India, and subsequently reinforced in the design and implementation of the NRHM. Health has long been peripheral on the political agenda in India. The UHC debate so far involves only the "Center" (the national level); but how this agenda fits into the political vision and priorities of different states in India is not yet clear. This is significant: the provision of health services in India's federal governance structure is the responsibility of individual states and without sufficient political will of these states, India would have difficulty achieving UHC. A goal like UHC cannot afford to rest in a top-down planning mode. In fact one of the major critiques of the HLEG report is its inadequate appreciation of the fundamental rift between top-down planning perspectives and demands of practical and functioning UHC services.[14-15] Continuing dialogue on the architecture and

operationalization of UHC with different states in India is imperative.

Equity lens in UHC

If UHC is about financing services to ensure universality in accessibility and affordability, how have inequalities in health been addressed in the current debates on UHC? Does ensuring universal coverage to health services translate in equity in population health?

Financial barriers are only one of several constraints that determine access to quality healthcare. Coverage as a term is inadequate to address issues of equity as it does not necessarily encompass universal access to health, Access is determined by factors such as physical accessibility, financial affordability, and acceptability. There are also broader social determinants of health, and healthcare is only one aspect of population health. Inequalities and their impact on access to healthcare need to be more sharply addressed in the structure of UHC.

Clearly, there are two distinct dimensions to inequality: the first has to do with the social determinants of health. Studies of inequalities in access to healthcare and healthcare outcomes, though widely acknowledged in public health, are spoken of more in terms of "associations" (caste, class, age, gender) that impact healthcare access and outcome. An analytical understanding of how such inequalities translate into inequitable access, vulnerability, and poor health outcomes is required. Such an understanding would then inform the design of mechanisms and processes through which health inequities could be addressed. In this regard, the World Health Report (2013) rightly underscores the importance of research in informing relevant paths to achieve universal health coverage. The goal is universal but the many solutions and paths to the goal need to be local.[2] The paths to UHC need to be cautiously nurtured to ensure that in the name of universality, it does not reinforce already existing inequalities.[16]

The HLEG both in its definition and in the report has devoted space to social determinants of health both in terms of structural locations (caste, class, gender) and as well to plea for broader investments in cross-sectoral domains like food, sanitation, water and housing. However like many other aspects of the report, modalities of implementation are far from clear. In order for social determinants of health to be central to the UHC discourse (thus addressing equity upfront), the UHC dialogue needs to go beyond the health sector alone to align itself with other campaigns on the right to food or water "to create a broad people's movement in the social sector."[8] The UHC debate in this context needs to be aligned with the comprehensive report of the WHO Commission on Social Determinants of Health (2008).[17] While inter-sectoral actions in health are the way forward, the health sector itself could do a lot to address social determinants of health including changes in clinical practice, advocacy, education and training, and employment conditions of health-sector workers.[18-20] In his recent plea for the inclusion of social determinants of health in the current universal health coverage debate and to address equity upfront, Marmot proposed using a monitoring framework for measurements of health and healthcare indicators by socio-economic status, age, geographical distribution or even education as markers of health inequity.[19] He cautioned that if a country is serious about not merely ensuring universal access to health services but equity in population health, it needs to work on the structural drivers of health inequity.

Another important dimension of inequity are the disparities in service provision. Inequalities in the distribution of human resources (along with absolute shortage) have been a recurring problem in accessing quality healthcare in India. India currently has 6.5 doctors per 10000 people, less than half the global average of 14.2 per 10000 people. Regional inequalities are large and the distribution of personnel is uneven in India. States like Tamil Nadu, Karnataka, Delhi, and Goa have a much higher proportion of health personnel than states like Haryana, Bihar and Uttar Pradesh.[21] Though NRHM has sought to redress these to some extent, specifically in select states in the rural areas, UHC needs to further support these efforts by revisiting the quality of medical education, the development of better protocols and guidelines for service provision and care, and equipping personnel with the skills to provide care with an equity lens. Narayan and Narayan lament the HLEG's inadequate attention to practical concerns like incentivising health providers to work in disadvantaged areas, ensuring that continuing medical education supports the goal of UHC, and developing health promotion strategies to tackle health disparities.[14]

Emphasis on human resources needs to be given

a different dimension and focus: kinds of people, kinds of training, specific needs of different locations. Attention to these matters will lead to a more people-centred health system. Lack of such a vision shifts the focus of discussion to insurance and coverage rather than people *per se.* Without this discussion, UHC becomes simply an economic question of implementing financial and management solutions.[21] Cautioning on a similar global trend, Kutzin argues that discussions of financing mechanisms in UHC need to be centrally linked to health system objectives and goals, namely equity in health, equity in finance and responsiveness of the system to the entire population.[22] He rightly pleads for "getting the unit of analysis right" in the UHC debate. We must focus the debates on UHC on questions of population and health system, rather than on individual financing schemes to ensure coverage and utilization.

Health system governance

As is well known, the current state of public health in India is attributed to a large extent to poor governance of both the public and private health sectors. How the UHC debate addresses this issue is critical for retaining momentum and achieving its goal. Though the increasingly diverse private sector cannot be ignored and needs to be roped in to achieve this shared goal, it is important to work out effective mechanisms for an ideal mix of both public and private participation with well-defined accountability mechanisms and processes. A much more informed debate on what would work best in terms of practical mechanisms of public-private mix is required. What have been the experiences so far in the Public-Private Partnerships experiments? How are lessons from such experiments fed into the UHC debates? How could regulation and accountability be enhanced in the private sector considering that mainstream approaches to regulate private sector don't work? What could be alternative innovative mechanisms to regulate and govern the private sector? What have been the experiences of different states on private sector regulations? We need to understand the differences between public and private health sectors and the power dynamics within the private sector taking into account the huge diversity that is typical of this sector. However within these frameworks of difference, what fruitful partnerships can be created and how can they help each other? These questions need to be explored in a more constructive and collaborative manner. They require a much more intense and informed debate than that which has surfaced in the current UHC discourse. The strongest critique of the HLEG so far is its uncritical silence about the private sector which has fostered an increasingly powerful corporatization of healthcare with influence on health policies at the local, state, and national levels etc.[14,15,23] The reason for such concern lies in the fact that UHC discourse operates in the context of a deeply entrenched commercialized private sector in healthcare that privileges "individual responsibility and choice" over social solidarity raises ethical dilemmas for designing a health service that is universal and equitable."[22] The current and future directions of operationalizing UHC goal need to engage with the power dynamics of this sector as regulation is not a technical but rather a political question. In the absence of this discussion, current public-private partnership arrangements in healthcare will be fraught with malpractice and abuse of health financing mechanisms, over-medicalization of care, over-prescription of treatment services, and greater social exclusion of vulnerable communities. Evidence on some of the insurance programs has already indicated such trends.[9]

Conclusion

If UHC is serious about ensuring the rights of all Indian citizens to health, the predominant language of commerce and finance needs to embrace a "social logic" that focuses on the "public" and on "health."[24-25] It has long been acknowledged that a model that focuses on health without considering its social determinants is cost-intensive and not sustainable. It would be a missed opportunity if we restrict UHC to financial coverage and to curative healthcare alone. Though discussed in the context of India, this concern is expressed widely as part of the global movement on UHC.[26] UHC is a shared goal and the paths to achieve this goal traverse through continuing and intense dialogues among different stakeholders in the society: political parties, policy makers, research and academic community, civil society and community. Such multi-pronged dialogues are an imperative to construct a "progressive hegemony" around the concept of UHC.[15] Experiences of other countries show that a strong political commitment to health as a social goal, upholding strong values of equity, political

participation and community involvement, go a long way in ensuring health for all. India needs to fall back on these experiences to garner strong political will to recognize UHC as a social and political goal and a basic human right.

References

1. The Planning Commission. High Level Expert Group on Universal Health Coverage. [Internet] New Delhi: Government of India. 2011. 323 p. Available from: http://planningcommission.nic.in/reports/genrep/rep_uhc0812.pdf
2. World Health Organization. World Health Report 2013: Research for universal health coverage. Geneva: WHO; 2013 [cited 2015 Oct 10] 146 p. Available from: http://apps.who.int/iris/bitstream/10665/85761/2/9789240690837_eng.pdf?ua=1
3. Health Survey and Development Committee. Report of the Health and Development Committee survey. Government of India. Calcutta: Government of India Press; 1946 [cited 2015 Oct 10] 232 p. Available from: http://sihfwrajasthan.com/Reports/bhore%20Committee%20Report%20VOL-1%20.pdf
4. Ministry of Health and Family Welfare. National Health Policy. New Delhi: Government of India, 1983
5. Office of the Registrar General, India. Sample Registration Bulletin 2012. New Delhi: Office of the Registrar General; 2013 [cited 2013 May 18] available from: http://censusindia.gov.in/vital_statistics/SRS_Bulletins/SRS_Bulletin-2010-2012.pdf
6. Balarajan, Y, Selvaraja, Subramanian, S.V. Healthcare and equity in India, The Lancet, Special Issue on Call for Action on Universal Health Coverage. 2011 377(9664):510-515
7. Office of the Registrar General. Special Bulletin on Maternal Mortality in India 2007-09. [Internet] New Delhi: Office of the Registrar General 2011. [cited 2013 May 18] 4 p. Available from: http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/Final-MMR%20Bulletin-2007-09_070711.pdf
8. Sengupta A. Universal healthcare in India: Making it public, making it a reality. Occasional Paper No. 19 [Internet] Ontario: Municipal Services Project; 2013 May [cited 2015 Oct 15]. 23 p. Available from: http://www.municipalservicesproject.org/sites/municipalservicesproject.org/files/publications/Sengupta_Universal_Health_Care_in_India_Making_it_Public_May2013.pdf
9. Shatrugna V, Shukla R, Srivatsan, R. Aarogyashri healthcare Model: Advantage private sector, Economic and Political Weekly. 2011 Dec XLVI (49):38-42.
10. Dasgupta M, Muraleedharan VR Universal health coverage: Reform of the Government system better than quality health insurance. Economic and Political Weekly. 2014 XLIX (35):29-32.
11. Sodhi C, Rabbani, A. Health service system in India: Is insurance the way forward? Economic and Political Weekly. 2014 XLIX (35):26-28.
12. Ministry of Health and Family Welfare. National Health Policy 2015 Draft. [Internet] New Delhi: Ministry of Health & Family Welfare; 2014 Dec; Available at: http://www.thehinducentre.com/multimedia/archive/02263/Draft_National_Hea_2263179a.pdf
13. Government of India (2005) The National Rural Health Mission – Mission Document available from: http://www.nird.org.in/brgf/doc/Rural%20HealthMission_Document.pdf
14. Narayan R, Narayan T. Editorial: Universal health coverage for India: Now is the time to move beyond rhetoric and get the action right. BMJ 2012:344:e2247
15. Srivastan R, Shatrugna V. Political Challenges to universal access to healthcare. Economic and Political Weekly. 2012 Feb. XLVII(8).
16. Gwatkin, DR, Alex E. Universal health coverage: Friend or foe of health equity. The Lancet. 2010 Jun, 377(9784):2160-2161.
17. Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva:World Health Organization. 2008.
18. Marmot, M. Universal health coverage and social determinants of health, The Lancet, 2013 Oct 382(9900):1227-1228.
19. Farmer, P., Nizeye, B. et al. Structural Violence and Clinical Medicine. PLoS Medicine 2006 3(10):1686-1691.
20. Wong ST, Browne AJ, Varcoe C, Lavoie J, Smye V, et al. Enhancing measurement of primary health care indicators using an equity lens: An ethnographic study. International Journal for Equity in Health. 2011 [cited 2014 Apr 20] 10(38). Available from: http://www.equityhealthj.com/content/10/1/38
21. Kollannur A. Editorial: Will India deliver on universal health coverage? British Medical Journal. 2013, 347:f5621.
22. Kutzin J. Health financing for universal health coverage and health system performance: Concepts and implications for policy, WHO Bulletin, 2013 91: 602-611.
23. Baru R. A limiting perspective on universal health coverage. Economic and Political Weekly. 2012 Feb XLVII(8).

24. Sengupta, A, Belanger Dumontier Health for All in India: Public, not "packaged", Global Health Check, 2013 available from: http://www.globalhealthcheck.org/?author=49.org/?p=1440

25. Sengupta A, Vandana P. Developing a truly universal Indian Health System: The problem of replacing "Health for All" to "Universal access to care". Social Medicine, 2011 6(2):69-72.

26. Latko B. et al. Comment: The growing movement for universal health coverage. [Intenet] The Lancet, 2010 Jun, 377, June 25 377(9784):2161-2163.