

Developing a Truly Universal Indian Health System: The Problem of Replacing “Health for All” with “Universal Access to Health Care”

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India, like other countries in the developing world, is suffering from the seemingly paradoxical trends of high economic growth amongst a certain section of the population, coupled with extreme poverty and underdevelopment amongst others. This situation of extreme, obscene, and growing inequity is perhaps best characterized by the failure of these countries to achieve health goals such as lowering maternal mortality, infant mortality, and rates of malnutrition. “Health for All” indeed remains a distant dream.

Meanwhile there has been a shift in how this problem is described and approached. The positive slogan of “Health for All” is slowly being replaced by the goal of “Universal Access to Health Care.” At first sight these seem deceptively similar in intent and direction, but in fact they are fundamentally different.

The shift is clear if one contrasts key sections of the Alma Ata Declaration of 1978 with the positions articulated in the documents on “Health Systems Strengthening,” circulated by the WHO Secretariat at the 64th World Health Assembly in May, 2011. The Alma Ata declaration recommended that all governments “formulate national policies, strategies and plans of action to launch and sustain primary health care* as part of a comprehensive national health system.”¹ Today, however, the *leitmotif* in the reports by the WHO on universal access to health is the notion that: “*the emerging model for organizing health care is that of “integrated service delivery networks.”*”² It is argued that: “*these networks depend on linking up the diversity of public and private providers,*” and that: “*in pluralist, mixed health systems these policies, strategies and plans have to relate to the entire health sector and*

cannot be limited to ‘command-and-control’ plans for the public sector.”³ Further, governments are urged to “*take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government-inclusive stewardship.*”⁴

This shift—from promoting public health systems (public financing/public provisioning) as the main approach to providing universal access to health care to seeing the private sector as a major player and, indeed, a collaborator funded by public monies (public financing/private provisioning)—is problematic, illogical, and has many serious implications as experience is beginning to show in various parts of the world.

Restructuring Health Systems in India and the Lancet “Call for Action”

The discussions and debates summarized above have resonated amongst policy makers and civil society groups in India and resulted in a special issue of *The Lancet*⁵ that was released in January 2011 focusing on Universal Health Coverage in India.

There can be no two opinions that there is an urgent need to restructure India’s health system. While much of what is argued in the Lancet series is unexceptionable and indeed “timely and overdue” we are concerned about the ways in which the “Call for Action”⁶ in the Lancet series views Indian economic reforms as a cause for optimism and the way in which the Lancet—by divorcing health care financing from health care delivery—echoes the prevalent discourse on “Universal access to health care.” These formulations in the Lancet series are important to take note of as they have the potential to further strengthen the already dominant private medical sector, premise health care on technology

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* Note that the Alma Ata declaration meant primary health care to be a concept encompassing all levels of health promotion, prevention, and care in juxtaposition to the prevailing contemporary confusion that primary health care implies only primary level care

and cost intensive medicalized services, and entirely neglect the social and economic determinants of health.

Economic reforms in India: Opportunity or Part of the Problem?

In recent years there have been growing concerns that there is a mismatch between India's emergence as a global economic and technological power and the state of health care in the country. In 1990 India was ahead of both Nepal and Bangladesh with respect to child mortality. Two decades after "successful" neoliberal reforms, Indian children are less likely to survive five years after birth when compared to children in Nepal and Bangladesh. This calls into question certain assumptions that the apparent economic progress in India can be a launching pad for reforms that ensure better and more equitable access to health care. There is evidence that neoliberal reforms are actually part of the problem of inequitable access and not the solution. Policies to promote equity in health care services in the country, need to also consider the necessity to roll-back many of the consequences of neoliberal reforms, viz. reduced public expenditure on social sectors (accompanied by tax concessions provided to the corporate sector), dismantling of the public distribution system for food grains, reduced subsidies to the agricultural sector, and liberalization of trade and financial services that reduce the policy space available to the government to address the social and economic needs of large parts of the population.

The Lancet call treads dangerous territory by asserting that India's economic growth offers an opportunity to address the serious inequities in health rather than acknowledging that in many ways this economic growth is the basis of inequities in health. It is not only, as the call states, that "impressive economic growth in India ... has not yet resulted in commensurate investments and health gains."⁷ Rather, the current framework of economic growth is not designed to address the concerns of very large sections of the population for whom it has directly perpetuated the situation of ill health and inadequate health care. This position is not one of mere semantics. Any sustainable recommendation needs to be set in an honest and robust analysis of the causes of ill health in India. For example, the explanation (in the Lancet call) of what ails the health sector states that "Several adverse social determinants together corrode the health of vulnerable populations..."⁴ However, little mention is made of the severe, persistent, and near ubiquitous poverty that has characterized this era of

so-called economic growth in which 77% of Indians live on less than 20 Indian Rupees [about US\$ 0.40] a day.⁸

India's Health System: Privatized and Inadequate

Just as the call accepts the present framework of economic development as desirable and well established, it also accepts the value of integration of the private sector into a universal health system. To locate the discussion of the composition of a sustainable health care system in India in its proper context we need to understand the present health care system in the country.

India has had one of the most privatized health systems in the world for decades. In percent GDP terms, public expenditure on health care has stagnated at just 1% of GDP over the last two decades. This has resulted in huge out-of-pocket (OOP) expenditures being incurred to access health care. Estimates indicate that over 70% of health care costs are through such OOPs. Catastrophic expenditures on health care have been indicted as a reason for 39 million people being pushed below the poverty line yearly.⁹

The extremely low level of public expenditure has been responsible for an inadequately resourced public health system. In spite of the progress made through implementation of the National Rural Health Mission (NRHM) huge gaps continue to exist in infrastructure creation and human resource utilization and retention.¹⁰ For example, 68.6% of Primary Health Centres function with only one or no qualified doctor while 64.9% of Community health centres report that there is a shortfall of specialists.

Again, largely as a consequence of grossly inadequate public expenditure on health care, the private sector has grown enormously. In spite of some sporadic attempts, the private sector remains largely unregulated. Costs in the private sector have also grown enormously over time (at current prices, OOP expenditures on medical care have grown two and half times between 1993-94 and 2004-200),¹¹ with little attention paid to the standardization of the quality of care. The private sector is undergoing a transformation with large corporate run hospital chains forming an important segment of private care, especially in urban areas.[†] In contrast, there is

[†] For a detailed discussion on the transformation of the private medical sector in India and the increasing presence of huge corporate controlled hospital chains, see: Chakravarti, Indira, Corporate Presence in the Health Care Sector in India, Social Medicine, Volume 5, Number 4, 2010.

a huge pool of untrained and unqualified private providers who are often the only source of medical care in rural areas. While public systems remain under-resourced, the private sector (especially the large and organized corporate controlled private sector) benefits from indirect subsidies it receives from the Government in the form of tax breaks, land made available at almost no cost, and a pool of human resources trained in public funded institutions.¹²

Initiatives for “Universal Health Coverage” in India

Recent initiatives in India, launched to universalize health coverage, are premised on a structure that separates health financing from health provisioning. These mark an important shift in the fundamental nature of health financing. Until recently public investment on health care (however inadequate) was almost entirely tax-based and financed a public health system. The new schemes, on the other hand, are what are called ‘social health insurance’ schemes. They finance care that is accessed through accredited private facilities. However, unlike most countries with social health insurance schemes (this include large parts of Europe, Brazil, Chile, Thailand, Malaysia, China, etc.), financing in India is almost entirely from tax-based revenue. In contrast, social health insurance schemes in many other parts of the world pool finances from public sources and from contributions made by employers and beneficiaries. Extension of such a mechanism in India is not a feasible option because only 7% of the work-force is employed in the formal sector (where it is possible to obtain contributions from employers and workers). Consequently, current Indian social health insurance schemes are financed in the same way as the public sector. The difference lies in the fact that the provisioning of health services may now be shifted almost entirely to the private sector.

The rollout of the new social health insurance schemes has been significant. The three largest are Rashtriya Swasthya Bima Yojana (RSBY: National Health Insurance Scheme, launched by the central government) and two state-run programs: Aarogyasri (Andhra Pradesh) and Kalaigarnar (Tamilnadu). These three programs now cover over one-fifth of India’s population (247 million). They allow beneficiaries to access care in accredited facilities which may be in the private or public sector. In practice an overwhelming majority of the accredited facilities are in the private sector; almost all providers of hospital care under the Kalaigarnar scheme and 80 per cent under the Aarogyasri scheme are in the

private sector. This assumes special significance when we examine the data regarding hospitalization costs (per annum) for beneficiaries of the different SHIs. While the mean hospitalization expenses of the private health insurance sector was Indian Rupees 19,637 (US\$ 370) per annum in 2009-10, it was Rs.33,720 (US\$ 630) and Rs.25,000 (US\$ 470) respectively for the Kalaigarnar and CGHS schemes. This is indirect evidence that private providers not only benefit from these schemes by securing a “captive” market, they also over-charge (with the possible complicity of the administrators of the SHI schemes).¹³

Such a trend is likely to have long term consequences. Most importantly, any increase in public expenditures would not build or strengthen the public health system but would further strengthen the private sector (especially the large tertiary care sector that increasingly is constituted by corporate run hospital chains) which already accounts for more than 70 percent of health care in India.

Clearly, the public-private mix of the “integrated health services” model does not factor in the growing power of large private hospital chains that can overpower public health systems. Recent attempts to impose legally binding commitments on private organizations to provide health care for poor people exemplify this power imbalance.¹⁴ The corporate-led private sector in India cannot be controlled by integration. It should be made to compete against a well resourced and managed public system that is run with public funds. While harnessing capacity in the private sector can be a short-term measure to fill gaps in availability of public health infrastructure, it cannot substitute for a publicly funded and managed health-care system.

Conclusions

Proposals in the Lancet series for restructuring India’s health system, as well as current programs being rolled out in India, constitute an ideological continuity. They attempt to build upon the present neoliberal economic philosophy that, in fact, informs all public policy making. Behind the smokescreen of “universal access” lies an endeavor to further secure the role and investments of the organized private sector and to abandon the goal of providing a dominant and decisive role to the public health system. The proposed reforms are clearly directed at promoting cost and technology intensive tertiary care and do not address the broader social determinants of health.

While we have focused on India to better understand the present rhetoric regarding health systems

strengthening, we would strongly suggest that there is a case for a much larger scrutiny of the dynamics of the recent shift in emphasis from “Health for All” to “Universal Access to Health Care.” We would further suggest that the shift is not an innocent concession to pragmatic thinking based on the argument that the present approach is merely an acceptance of the role that the private sector already plays in providing health care. Rather, there appears to be a clear attempt to undermine public health systems and to privilege the role of private medical care. It is unfortunate that such a shift is being supported by the WHO as well, and there appears to be an uncritical acceptance of this shift in many quarters—including in sections of well meaning civil society actors.

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