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Debates around UHC in India

Vineet Kumar*

M.A. Economics, Ambedkar University, Delhi

Abstract – One such Global effort, after the Alma Ata Declaration of 1978 which "called for the building of health systems that would provide comprehensive care, would be integrated, organized to promote equity, and would be driven by community needs", is the emphasis on Universal Health Coverage (Sengupta, 2013). The World Health Organization Director General Margret Chan has claimed it to be "the most powerful concept that Public Health has to offer". The World Health Report of 2010 defines it to be 'an approach to finance health expenditure' that serves to contain, reduce and finally eliminate out of pocket expenditure. It is usually explained using a cube whose length, breadth and height represent who to cover, how many services to be covered and how much of the total expenditure to be covered respectively. Rapid growth on all these three axes is considered to be the goal of public health policy. According to Oxfam, "WHO has been explicit that countries should prioritize four key actions to finance UHC: reduce out-of-pocket payments, maximize mandatory pre-payment, establish large risk pools, and use general government revenue to cover those who cannot afford to contribute" (Oxfam Briefing Paper, 2013).

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I) INTRODUCTION

If you tell any random guy walking on the road in India that there are countries where you do not have to pay money to see a doctor no matter how serious the illness or how expensive the treatment, there are quite high chances that you will leave him amused and exasperated. We might have borrowed our jeans, I-phones, sandwiches or even TV shows from such countries but their health systems (especially like the NHS of UK) and more importantly the financial stability that comes along with most of them still eludes us. And it is not as if efforts were not made at national or international level to make health care accessible, affordable and equitable but with nearly 70 % of the total expenditure on health being out of pocket expenditure and a mere 1% of GDP being spent by Government on Health 'catastrophic health expenditures' are still the norm for millions of Indian households.

This innocuous and noble policy goal is not as simple as it may seem at the outset if one ventures beyond the definition to implementation and actual policy design. Or, as a matter of fact, even the definition itself is debatable with certain ambiguities like pooling the funds but not the services or keeping the 'depth' of services to be covered vague remaining contentious. There seems to be a raging storm in the tea cup that we seek to discuss in this paper. In what follows we discuss all these debated aspects of UHC. **Section II** discusses the debate around the very genesis or the fundamental premise of UHC. It traces the metamorphosis of the concept and the political economy of several developments leading up to UHC that make this seemingly neutral and harmless concept seem a bit biased and threatening. The debate on the two ways of financing UHC in the Indian context, viz. taxes or insurance premiums is the subject matter of **Section III**. Next, **Section IV** has some arguments on not just limiting the scope of UHC to financing health care but extending it to build comprehensive and integrated Health Systems that promote synergies. **Section V** lends some perspective on how to analyze international experience, especially claims of exact replications of certain policies without having any regard to the historical evolution of the policy in its source country and the distinct socio-economic environment in the country of destination. Finally, **Section VI** has some concluding remarks.

II) A NOBLE INITIATIVE OR A NEO-LIBERAL 'TROJAN HORSE'

From its modest and open ended beginnings, the concept of UHC has acquired a certain amount of rigidity in terms of its overall structure. Initially, it was mooted just as a mechanism to finance health with the provisioning of Health Care left to the Government, Private Sector or a combination of both. Even financing was mainly structured around pre payments, via taxes or premiums or a combination of both, that preserved financial stability and reduced drastic 00P. This flexibility has undergone a metamorphosis over the years and the resultant systems that have come up or are being prescribed show much more rigidity. The focus is on State financing (collected via taxation/premium receipts or paid as a contribution in Social Health Insurances) and **private provisioning** leading to pooling of funds for a "Basic Package" of Health Care services that reduce OOP.

This predominance of Private Provisioning is not merely accidental but has a historical context to it. The Structural Adjustment Programs of 1980s and early 1990s prescribed for 'bailouts' to Latin American and some Asian countries under aegis of World Bank and IMF lead to an overall reduction in the Government expenditure which included expenditure on Health care. This coincided with several initiates to Private Capital (easy land acquisition and tax concessions in India) to make certain headways into the Health care 'market'. Both these developments together meant a crumbling State infrastructure in Health Care and a booming Private Sector. Also, this is the genesis of the high Out of Pocket expenditure that becomes the main target of UHC approach in the ensuing years. Therefore, the dominance of private sector as a provider of care and the resulting high OOP expenditure is not heavenly ordained but an outcome of conscious policy decisions in the years gone by.

Now, in a scenario so biased towards Private Provisioning, even if the UHC approach gives a choice between Private and Government Provisioning, the odds are that most systems will lean towards the former rather than the latter. This inertia of different countries to lean towards private provisioning is also in line with the overall hegemony of the Neo-liberal ideology over the state. The state has been reduced to a manager in the purchaser provider split between insurance companies and private providers with the sanctity of the quality and efficiency of the care provided by the latter remaining unquestioned. Such sanctity may fall flat against scrutiny but more importantly it provides the ideological backing for Private Capital to invade the hitherto unexplored yet highly profitable Health Care market. That this invasion has been a success is testified by the sprawling buildings of an Apollo or a Max hospital in Delhi, an increase in the number of Corporations working in Health Sector for 35 to 96 from 2001 to 2006 and the increase in Incomes of these enterprises from 8,510 million to 335,360 million rupees during the same period (Centre for Monitoring of Indian Economy data quoted in Mukhopadhyay, 2013). This blatant neglect of Government Health facilities for Private Health Care in spite of the several shortcomings of the latter has prompted some to call UHC nothing but a neo-liberal facade.

III) FINANCING UHC: TAXATION VERSUS INSURANCE PREMIUMS

Even before the provisioning debate could be initiated and even when the debates around what should or should not be included in the 'Basic Package' continue, there still remains a preliminary task of raising funds for UHC. There are disagreements here as well between those who support tax based funding to improve existing Government Health Care Infrastructure and those who intend to promote 'the insurance path'. The insurance path is simply pooling resource through premiums via the Employee- Employer contributions aided by the state in case of shortfalls or the state simply collecting the premiums and acting as the single payer to the insurance companies who are supposed to pay certain 'empanelled hospitals' in case of exigencies. The tax based funding, on the other hand, calls for increased tax collection by the Government that are either channelized directly into the existing health system or are devolved at lower levels for accountable and flexible utilization of the funds to Health sector.

The 'Insurance Path' has certain problems in the execution itself and also in terms of the health outcomes achieved especially for a developing country like India. The most startling of all the problems is the problem of regulation. The Government has to come up with a regulatory infrastructure for insurers as well as providers that regulates both their fee charged and services provided. In spite of the enormous administrative costs, there are still distortions in the provision, problems of 'physician induced demands', unethical practices and unnecessary increase in the application of expensive machinery which lead to rising costs of care and its uncertain quality. USA serves as the most apt example with worse health indicators when compared to other high income countries like Japan in spite of its higher per capita expenditure on health and higher percentage of total share of GDP going to Health Care (Dasgupta & Muralidharan, 2014). The problems of regulation is even more severe for India where the Government has not been to enforce upon the existing Private Hospitals the requirement of treat poor patients in lieu of the cheap land provided to them and also, the exact number of 'private practitioners' still remains an enigma leave alone the challenges of enforcing the regulations so enacted for them.

Funneling the increased funds via taxation to the existing health system has some added advantages. These include the inherent simplicity of utilizing an existing system in spite of its certain drawbacks which can be corrected using administrative changes like innovative monitoring mechanisms to tackle staff absenteeism. Also, since the existing system works well in certain states like Tamil Nadu, it can be made 'competitive and efficient' in other regions as well. Such a system would further lead to synergies in the form of focus on preventive care and social determinants of health which would otherwise be ignored in 'the insurance path'.

IV) WHERE TO STOP: JUST FINANCING OR COMPREHENSIVE 'PUBLIC HEALTH SYSTEM' DESIGNING

Ensuring increased financing for Health Care services is merely a starting point in the quest for improved overall health outcomes. But still a disproportionate amount of attention is solely devoted to the fund raising process or increasing the size of the risk pool. Important though that may be, it still is a small part of the larger 'whole.' This whole comprises of what is called the 'Health System'. This broadly includes "ensemble of all public and private organizations, institutions and resources mandated to improve,

maintain or restore health within the political and institutional framework of a given country" (Kutzin et al., 2013). It is this system as whole that must be directed towards the intermediate goals like improving coverage and increasing efficiency to the final goals like improving health outcomes and reducing out of pocket expenditure.

According to such an approach increased funds are not as important per say as is their allocation among different layers; primary, secondary & tertiary. Reallocating the expenditure towards Primary Health Care could lead could metaphorically be a 'nip in the bid' and reduce both expenditures and pressure of the higher levels of care along with achieving better health outcomes. Such expenditure must be monitored via improved data collection systems and combined with enhanced accountability and delegation of decision making to the community level. Another facet of resource allocation is increasing the 'absorption capacity' which is often taken as an excuse to not devolve additional funds to health care.

Another important component of the 'Health System' is the inputs used in the provisioning of health care. This includes both physical capital and human capital. To achieve UHC both the inputs must be augmented simultaneously especially in a country like India. The PHC and CHC infrastructure must attract sustained attention and funds after the initial though limited success of NRHM. Drug procurement by the state is the pressing need of the hour since a major constituent of the out of pocket expenditure is on drugs. The human resource in health in India needs to be augmented in several qualitative and quantitative ways like formalizing the nature of work for the ASHAs and the ANMs and increasing the number of doctors by adding a supplement 3year course or bringing the hitherto unregistered care providers under the some sort of formal net by training them.

Another important aspect of the Health system design is the shift from 'vertically schemes' and a clear cut demarcation of area of operation between the centre and the states to a well-integrated system based on referrals. Such a system of referrals integrates the health care into one single whole and utilizes all levels of care efficiently and judiciously. All that is listed above could only materialize if the focus of the debate is not merely on flow of funds but on the design of a comprehensive health system focusing on provisioning, inputs used, government stewardship and strategic incentives (Kutzin et al., 2013).

V) INTERPRETING INTERNATIONAL EXPERIENCES

Before implementing and adapting any international experience on UHC to domestic health systems it is essential to locate their distinct socio-historical context, prevailing societal nuances and their enormous diversity in terms of application and outcomes. As far western Europe is concerned, the evolution of UHC from the Bismarck Model of 1886 onwards proceeded in response to the growing working class movements and its intended purpose was to stabilize incomes rather than to guarantee each citizen a Right to Health. Right from the very beginning it was marred with two internal contradictions namely; solidarity in financing versus private appropriation of these funds and interest of the individual providers versus interests of the society at large. The state continually balanced these contradictory tendencies in the past is now finding it increasingly difficult to do so due to the increased bargaining power of Capital post the arrival of Neo-liberalism (Sengupta, 2013). These countries are facing their own challenges in terms of increasing proportion of elderly people and rising costs which must serve as a reality check for those who recommend models similar to these developing countries simply on the basis that such models are being implemented in the developed countries.

Experiences of developing countries must also be enumerated carefully be drawing lesson for replication. For example, before attributing favorable health outcomes in Thailand to the 2002 National Insurance Bill the preceding Decade of Health Centre Development Policy (1986-1996) must be duly stated as it because of this massive infrastructure creation especially in Rural Health Care that when the demand for health services increased post 2002 it could be taken care off at reasonable costs (Sengupta, 2013). Similarly, a close scrutiny of the Mexican insurance based program 'Seguro Popular' reported 'no effect on self-reported health indicators and did not report change in general patterns of service use' (Moreno-Serra and Smith 2011). This must be combined with the fact that measuring improvements along the different dimensions of UHC itself is difficult and often controversial. Especially in country like India where the cost of care data by NSSO is too scarce and sporadic while data for service coverage is available of only a few services like reproductive and child care (Sunderaraman et al., 2014). Experiences, coming from either developed or developing countries cannot be taken at their face value while designing domestic Health Systems.

VI) CONCLUSIONS

Universal Health Coverage is a tempting idea to begin with but must not be restricted in its scope to merely financing health care. Also, the Health Care System must be looked at as an integrated whole rather than an aggregation of several disjointed units of care provisioning. A well-functioning referral system will be central to such an approach. The idea that Private sector is bound to be efficient and qualitatively superior must not be accepted as orthodoxy. Further, International experiences must not be quoted out of context for the convenience of supporting one argument or the other. Each experience must be located in its historical context and nuances. Finally and most importantly, the debate around Universal Health Coverage must be taken outside the expert

domains to the dining tables discussions. Health Care has to be central to our entire democratic discourse and from surgical strikes on terrorists to surgical strikes on black money the next surgical strike should be on 'out of pocket expenditure'. Even electoral politics should be centered on issues and not on personalities. From 'Har har Modi, Ghar Ghar Modi' it's time for 'Har Har Healthy, Ghar Ghar Healthy'.

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Corresponding Author

Vineet Kumar*

M.A. Economics, Ambedkar University, Delhi