Political Challenges to Universal Access to Healthcare

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While welcoming the report of the High Level Expert Group on Universal Health Coverage for India for its comprehensive vision and many well-conceived recommendations, this article focuses on the conditions needed for its promise to bear fruit. Towards this, it explores the political dimension, which comprises the forces and interests that come into play to shape and reconfigure administrative policy and its implementation.

We are grateful to Anand Zachariah and Susie Tharu for their insightful comments on the report. In particular, Zachariah's inputs on medical colleges as apex tertiary medical care institutions in districts and Tharu's stress on the importance of practice need mention. (See Zachariah et al 2010 for a conceptual background).

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The report of the High Level Expert Group (HLEG) on Universal Health Coverage (UHC) for India is to be welcomed for its comprehensive vision of healthcare. After the neo-liberal proposals on selective primary health care articulated by Walsh and Warren (1979) doubted if providing comprehensive healthcare in a third world country was a feasible goal and the World Bank's *Investing in Health* report (1993) put forth an influential model incorporating that view, the HLEG report reaffirms the goal of UHC. This is an important development, which shows that India is at a political and economic stage that no longer needs to repeat the minimalist solutions of selective primary health care – diphtheria-pertussis-tetanus (DPT) immunisation, tetanus toxoid to pregnant women, breastfeeding, chloroquine for malaria and oral rehydration solution (ORS) for diarrhoea. It is indeed worth pausing and pondering over the significance of this moment.

Many of the recommendations (and there are many) in the HLEG report are well-conceived – elimination of cost to the patient; funding through taxation; elimination of insurance; making medical colleges the apex tertiary care providers to the health system at the district level; putting the pharmaceutical industry under the control of the Ministry of Health and Family Welfare, and so on. The single question we would like to address is: What are the conditions under which the report's promise will bear fruit?

To answer this, we explore a dimension that is peculiarly invisible in the report, the political. By the term "political" we mean the different forces and interests that come into play to shape and reconfigure administrative policy and its implementation. Generally speaking, there are two levels at which the proposals of the HLEG report will be reshaped – the local and the international.

Local Architecture

Any programme to implement a developmental policy in this country, for instance, universal primary education, the Integrated Child Development Services (ICDS), mid-day meals, the National Rural Health Mission (NRHM), and so on, is practically reconfigured to align with the logic of political forces and possibilities at the local level. Top-down planning initiatives always trickle down without disturbing the power hierarchy along paths of least resistance. Such measures do not result in substantive benefits to the people targeted and also suppress critical questions from the ground level.

The current distribution of 300 calories a day under the ICDS consists of a nearly inedible powdered mixture, which is conceived by the powers-that-be as a dole to recipients habitually imagined as objects of charity. If the programme had been forged through an active political consensus with the dalits

and other castes, it would have resulted in a far more substantial diet, including milk and eggs. This has been the case in Tamil Nadu for more than two decades. Characteristically, the packaging of these "nutritive" powders generates superprofits for businessmen in the loop.

Similarly, from the 1970s onwards, countless teachers on government school rolls ran businesses in towns, captured the textbook industry and opened tutorial institutes and colleges. In short, they did everything except teach, presenting themselves once a month to collect salaries. The alternative configurations that have emerged over time to utilise the money made available by policy to both education and the ICDS remain very stable, deeply rooted and protected.

To cite a different example, the NRHM has a regulation that pregnant women should deliver in institutions to prevent maternal mortalities. This has resulted in confusion regarding the roles of the *dais* (traditional birth attendants) and auxiliary nurses and midwives (ANMs), who played crucial roles at the village and subcentre levels. As a result of this directive, deliveries are turned away from health sub-centres. Preventing mortalities implies the availability of an anaesthetist, facilities for a caesarean section and blood for transfusion in case of an emergency. These are available at district hospitals. There is predictably an unmanageable rush at these institutions and women are sent home three to 12 hours after delivery. Cash incentives to compensate for the increased cost of institutional deliveries without strengthening the system only exacerbates the problem.

Though in different ways, these examples illustrate a failure of plan intentions. The issue here is not so much corruption (the favourite scapegoat) or even a lack of "merit" or competence, as the inability of planners to gauge reality on the ground and to convincingly communicate and negotiate with people who implement and use their programmes. Without processes carefully designed to overcome hurdles, plans fail. The HLEG report clearly acknowledges the importance of people's participation, but not adequately. It shows inadequate comprehension of the fundamental rift between planning perspectives in their current top-down form and the demands of a practical and functioning UHC service.

International and National Business Interests

It is clear that the impetus to set up UHC in India comes from big business and the state's agenda for growth. Quite tellingly, the World Bank and other international funding institutions like the Rockefeller Foundation have endorsed the Aarogyasri programme of healthcare for the poor in Andhra Pradesh (Shukla et al 2011). Indeed, it is commonly believed that the Planning Commission constituted the HLEG and gave it the responsibility to come up with a way to spend 2.5% of the gross domestic product (GDP) in the healthcare sector. This figure was presumably predetermined and this is the likely reason the report starts with the subject of finance (instead of ground-level considerations such as disease burden, health goals and system weaknesses). With assured Plan allocations and the high profile "success" of the Aarogyasri model, an insurance-based, expensive, tertiary care based universal healthcare system for India is likely.

Given this reality, and from the trends observable in the Aarogyasri programme, if the state does not have a role, it is almost certain that the healthcare system will be an exorbitant, interventionist, high technology tertiary care one. In this context, the HLEG report emphasises that public institutions have a key role to play. Unfortunately, many of these institutions have been reduced to agencies implementing donor-driven national programmes like family planning, the current drive for the introduction of newer vaccines, etc. As a way out, we feel that both the private and public sectors must be engaged, but configured in such a way that they act as checks on the unaccountability and rank opportunism of the private sector on the one hand, and the insensitive and unresponsive character of the public sector on the other. This will also facilitate the HLEG's agenda of pushing for broader investments in the social determinants of health such as food, sanitation and housing.

Historical Snapshots

An important factor in the success of different UHC systems in the world has been the circumstances in which they emerged. The UK's National Health Service and the Beveridge report that led to it followed the Great Depression and the second world war and it had the approval of both the Conservative and Labour parties. There was a desperate need to raise morale and work a way out of a national debt, estimated at about £3,300 million. It was this configuration of circumstances that held a shared appreciation of the health system in place, leading to its success.

In Brazil, the 1988 constitution marked the end of 20 years of military rule and the emergence of democracy (Buss and Gadelha 1996). This was preceded by the Eighth National Health Conference in 1986 attended by 5,000 participants, representing users, welfare organisations and public service personnel. The conference drafted the constitutional charter on health, which ultimately led to health and social security becoming constitutional principles. It was undoubtedly the fresh spirit of freedom and an overall commitment to the well-being and social security of the population that led to the country embarking on the path of successful healthcare for its people.

Thailand also set up its UHC system during a process of democratisation when new actors entered the political arena. The slogan used to mobilise people was "30 baht to treat all diseases" (1 baht is approximately 1.43 rupees; for an account see Khanna 2010-11). It is

surprising that the HLEG report misses this important dimension of a fresh start providing a stimulus to UHC in the many vignettes of healthcare successes across the world it provides. It narrates their stories as if putting a healthcare system in place was merely an administrative matter of bringing together logistics, planning and good intentions (though it does briefly mention political movements in the introduction to these studies).

Closer home, in Tamil Nadu, the success of the state healthcare system, which functions more effectively than most in the rest of the country, was attributed by a senior official to "greater enlightenment, efficient operation and personal commitment". All these may be traced to the history of Tamil Nadu's struggles over the last century with the problems of political representation, self-respect and brahmin domination. These movements and the emergence of the Dravida Munnetra Kazhagam (DMK) and its offshoots have led to a strong political will and administrative commitment to the plural subaltern population constituted of various castes, nationalities and historical circumstances. Though the English press tends to focus largely on corruption, the state has had successes in vital areas such as health, education and food.

What these examples teach us is that a political environment that allows for motivation, commitment and the active involvement of the people is essential for a healthcare system to succeed. Is it possible to construct a progressive hegemony around the concept of UHC? This is the question on which the success of the HLEG's proposals hinges.

Only an extensive agreement across the chain of the implementing agencies that healthcare is an item of absolute priority will generate the organic commitment, supervision and diligence necessary to conducting its operations successfully. The absence of these today is not so much a mark of corruption, selfishness or incompetence as the mark of an elitist model of national development that has failed to carry the people (including administrative functionaries) with it. It is the insularity of elite political will obsessed with indices of rapid growth to the exclusion of the concerns of most of the people of India. Even in these circumstances, a progressive hegemony may not be impossible to construct. There are many examples of partial success in India, despite some of them having somewhat dubious credentials, such as family planning, universal primary education, oral polio vaccination and the Tamil Nadu health experience.

Progressive hegemony can never be simple government propaganda. We would agree broadly with the Medico Friends Circle position (MFC 2011-12) that the government needs to engage in negotiations with different groups of people so that their (even partially articulated) ideas, needs and constraints are woven into the broad picture. However, this would require the involvement of not just secular people's health assemblies and panchayati raj institutions, but also mainstream national and regional political parties (like the Congress, BJP, Shiv Sena, the Majlis-e-Ittehadul Muslimeen) and their local representatives. While it is indubitable that politicians are deeply corruptible, and invested in businesses (as was the late Y S Rajasekhara Reddy in Andhra Pradesh) they also have historically developed a degree of bilateral communication with and accountability to the people they represent. We should note that minorities and marginalised castes and tribal groups have to be important participants because they are structurally the most vulnerable in secular healthcare programmes. The political parties that address them would historically be attuned to their aspirations and felt needs.

A recommendation that stands out in the HLEG report is the one to establish medical colleges linked to district hospitals as apex tertiary units. We feel these should largely be government-run colleges, which establish standard practices in areas for tertiary care and support primary- and secondary-care initiatives (both government and private). The proposed three-year Bachelor of Rural Health Care course (HLEG 2011: 159) will strengthen the primary and secondary-care systems.

It is worth speculating on the several advantages medical colleges linked to district hospitals could have. One, since the college will be a government-run educational institution providing tertiary care, its economics need not be profit-oriented, thus offsetting a constraint in providing accessible, advanced medical care in the hinterland. Two, the increased availability of seats for medical education is likely to make the discipline less a target of artificial academic merit measured by entrance tests and more one of a genuine concern for healthcare. Three, medical courses will be less susceptible to the current laissez-faire curriculum policy where only the most advanced specialisations imbue value to an export-oriented medical education. This will create the possibility of a curriculum that is more responsive to actual health needs.

Four, depending on a district's case load of medical problems to teach students will exert a corrective influence on competence, understanding and inventiveness. This will also hopefully result in a research orientation that is responsive to the specific healthcare needs of the people of this country. Finally, with the medical college's support, the medical system will be able to penetrate rural areas in a way that other initiatives of the last two or three decades have not. On the whole, it may carry forward the promise of Aarogyasri programme with the necessary radical course correction.

REFERENCES

Buss, P and P Gadelha (1996): "Healthcare Systems in Transition: Brazil Part I: An Outline of Brazil's Healthcare Reforms", *Journal of Public Health Medicine,* (18) 3, pp 289-95.

HLEG (2011): "High Level Expert Group Report on Universal Health Coverage for India", Planning Commission of India, New Delhi.

Khanna, R (2010-11): "Universal Health Coverage in Thailand: What Lessons Can India Learn?", *MFC Bulletin*, 342-44, August 2010-January 2011.

MFC (2011-12): "Exploring a Road Map for Health Care for All/UAHC", *MFC Bulletin*, 348-50, August 2011-January 2012.

Shukla, R, V Shatrugna and R Srivatsan (2011): "Aarogyasri Healthcare Model: Advantage Private Sector", *Economic & Political Weekly*, 46 (49), pp 38-42.

Walsh, J A and K S Warren (1979): "Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries", *New England Journal of Medicine*, 301, pp 967-74.

World Bank (1993): *Investing in Health*, World Development Report 1993 (New York: Oxford University Press).

Zachariah, A, R Srivatsan, and S Tharu (2010): *Towards a Critical Medical Practice: Reflections on the Dilemmas of Medical Culture Today* (Hyderabad: Orient BlackSwan).