A Limiting Perspective on Universal Coverage

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The report of the High Level Expert Group on Universal Health Coverage for India reaffirms the principles of universality and equity in access to healthcare and the central role public services have to play in bringing this about. However, the HLEG pays inadequate attention to regulating the deeply entrenched private health sector, which is not only embedded within an intricate and interdependent web of power relations, but also has a marked influence on policy.

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The report of the High Level Expert Group (HLEG) on Universal Health Coverage (UHC) for India is a landmark document in health policy. Its most important contribution is that it reasserts the principles of universality and equity in access to healthcare. It also underlines the responsibility of the state, highlighting the central role that public services have to play in ensuring universal access to healthcare.

The principles that guide the report are commendable and worthy of support, especially in the context of glaring and rising inequalities in access to health services, both because of the atrophy of public services and the rising cost of private care. It rightly calls for increasing the financial outlay on public services, strengthening public systems and ensuring access to free medicines. The last is particularly relevant, given that medicines form the single largest component of out-of-pocket expenses on healthcare. The architecture suggested by the report for strengthening health systems understandably gives the public sector a central role. The private sector is only given a partnership role, with its services being "contracted in" at the secondary and tertiary levels.

There is no doubt that the public sector ought to be the focus of any such report on health services reform. However, it must be recognised that the private health sector is ubiquitous in India and plays an independent role at all levels of healthcare, even as it is increasingly "tied into" the public sector. This is reflected in the utilisation of health services both for outpatient and inpatient care. More than 80% of households in rural and urban areas access the private sector for outpatient care and the proportion turning to it for inpatient care is also on the rise. The growing reliance of individuals, including the poorest, and the public sector on the private health sector has resulted in a sharp rise in personal expenses.

Therefore, it is surprising that the report chooses to be silent about the growing role of the private sector in the various subsystems of health services. There is little analysis in the HLEG report of the private sector's influence on local, state and national health policies, while this recurrently figures in public policy debates and media reports. The private sector has consolidated and expanded its interests in provisioning, financing, drugs, technology, medical and nursing education, paramedical training and research over the last three decades. With consistent underfunding of the public sector, market forces have deeply entrenched themselves and are an important influence on healthcare policy and its formulation at the national and state levels.

Several independent reports and policy documents have highlighted the prominent role played by the "for-profit" sector and the need for regulating it. However, regulation is not merely a technical intervention; its design, implementation and effectiveness are determined by the structure and dynamics of the private health sector. It is quite apparent that the Indian private health sector is heterogeneous with multiple actors playing various roles in it. It is also varied in terms of the size of operations, volume of investment, links with international capital and access to political leadership, especially at the state and regional levels.

In countries where the private health sector is nascent, regulation is easier than where it is deeply entrenched. The absence of regulation, or weak regulation, in the early stages of the development of the private health sector in India has made reining it in now difficult, especially with powerful vested interests acquiring influence over policymaking. Though the challenge of regulating the private sector in Indian healthcare has emerged as a major public policy concern, the HLEG report is largely silent on this aspect.

Evidence from developed and developing countries shows that when commercial interests grow large enough to influence public health policy, their consolidation into powerful lobbies enables

them to block efforts aimed at regulating them as well as strengthening the public health system. The experience of the US shows how the pharmaceutical, medical equipment and insurance industries can coalesce and thwart health sector reform initiatives. The fate met by the Bill Clinton administration's proposal to reform the healthcare system and create a national health service is a case in point.

Commercial interests pose a serious challenge to universalising access to healthcare. This is because for-profit healthcare privileges individual responsibility and choice over social solidarity, which raises ethical dilemmas for designing a health service that is universal and equitable. It is inadequate to merely state the need for regulating the private health sector; the key questions are what must be done and how it must be done.

Regulation is often seen as a technical and administrative problem that can be addressed with adequate "political will". However, employing the lens of power to study the private health sector, one can delineate and analyse its complex architecture; the conflicts and alliances among its various actors and the nature of their influence on, and engagement with, political processes at the local, state, national and international levels. This helps identify the opportunities and constraints for "people-centred" regulation.

Given the range of institutions and actors in the private health sector, there is an intricate network of power relations within it as well as outside it. One can clearly discern a hierarchy in the distribution of power among the different actors and in their engagement with political processes.

The distribution and representation of power within the private health sector can be captured through levels of interest. These could be broadly classified into dominant, challenging and repressed interests (Tuohy 2003). The dominant interests are represented by the pharmaceutical, medical equipment and corporate hospital industries, Indian and foreign. The challenging interests include a diverse set of actors and institutions at the secondary level and the repressed interests comprise the heterogeneous informal sector at the primary level, which has the least power in the hierarchy. Given India's regional diversity, there is much variation in the alliances, conflicts and contradictions among these interests across states.

Dominant Interests

Over the last three decades, there has been greater visibility of corporate entities (pharmaceutical industries and hospitals) in the delivery of health services in India. They are seen as revenue earners for the economy and their interests are strongly articulated in policymaking. Indeed, this trend has encouraged the view that healthcare ought to be an internationally competitive industry, and such business interests have been incorporated into global trade agreements.

The corporate sector in health has been able to wrest public subsidies, consolidate operations and articulate its interests through forums such as the Confederation of Indian Industry (CII) and the Federation of Indian Chambers of Commerce and Industry (FICCI). It has access to the highest levels of the political leadership at the national and state levels and can even bypass the ministry of health on substantive issues.

The Indian pharmaceutical sector is a major exporter of drugs to several developing countries in south Asia and Africa. It has received a great deal of support from the government for consolidation and expansion in the last 30 years. The engagement of corporate hospitals with the central government health services (CGHS) system and their promotion by state-led insurance programmes such as Aarogyasri in Andhra Pradesh and Chiranjeevi in Gujarat are examples of public-private sector partnerships. There is a large market that can be tapped with such tie-ups. If the government chooses to leverage insurance as a means to universalising healthcare, the hospital, diagnostic and equipment industries would be willing partners.

The recent initiative taken by the Union Ministry for Human Resources Development for a US-India higher education dialogue, which proposes to set up academic partnerships in several areas, including health, is going to fundamentally alter the landscape of medical and nursing education in India. Several corporate hospitals have been engaged in pushing this agenda, advocating the need to train world-class professionals for the Indian and global markets.

Challenging Interests

The challenge to such dominant interests is posed by a diverse set of actors and institutions at the secondary level. These include nursing homes, medical, nursing and paramedical training institutions, diagnostic centres and pathology labs. They operate mostly at the state level and a section of them have alliances with dominant interests. For example, Aarogyasri in Andhra Pradesh has partnerships with several corporate hospitals, Apollo Hospital being one of them.

The uneven growth of healthcare provisioning and medical education across the country poses a challenge for a uniform regulatory policy. Recent data show that 40% of all private medical colleges are in Karnataka, Andhra Pradesh, Tamil Nadu, Kerala and Maharashtra. These medical colleges are mostly promoted by intermediate and backward castes in these states – Reddys and Kammas in Andhra Pradesh, Patils in Maharashtra, Chettiars and Mudaliars in Tamil Nadu and Vokkaligas and Lingayats in Karnataka. Medical colleges run by these dominant political groups have links with regional capital, non-resident Indian doctors and state-level politicians.

The powerful alliance between private medical colleges, nursing homes and government doctors poses a huge challenge to public policy and regulation. Regulatory bodies are fragmented and lobby to obstruct reform and regulation. Therefore, regulating the private health sector has to be the responsibility of the states with the centre providing broad guidelines.

Repressed Interests

In the hierarchy of power, the unregulated informal health sector has the least voice. There is enough evidence to show that more than 80% of the population is dependent on this sector for outpatient care. Studies have shown that the informal

sector provides treatment for a range of minor ailments and antenatal and delivery services. The urban and rural poor are dependent on it for the first level of care. Yet, the services provided by practitioners in the informal sector are often of variable quality and in some cases even dangerous.

The regulation of this sector is ridden with contradictions and conflicts of interest. The Indian Medical Association (IMA) has been consistently campaigning to ban quackery and abolish the informal sector, while the dominant professional view seems to be that the formal and informal private health sectors are two separate entities. However, evidence suggests that there are well-established links between the two. The formal private sector uses the informal sector for referrals, which is an important source of patients.[1]

The government has been ambivalent on the role and status of the informal sector. It has been included in the Revised National Tuberculosis Control Programme initiated in 1997 and in family planning and HIV/AIDS programmes. Some of the latter were promoted as public-private partnerships and they have built capacity among informal practitioners for case detection, holding and treatment. Apart from these initiatives, there has been little effort to regulate or improve the skill base of providers in this sector. A few non-governmental organisations (NGOs) have added to the skills of informal providers to deliver rational healthcare but these small-scale initiatives have not been expanded.

In my view, the proposed three-and-a-half-year bachelor of rural health care (BRHC) course could help to rationalise, legitimise and regulate the informal sector. With the IMA rejecting this proposal, one awaits the government's response on this matter. It would have been useful if there had been a strong recommendation in the HLEG report in favour of using the degree course as one of the instruments for rationalisation and regulation of the informal private sector and its incorporation into the formal private health sector.

The HLEG report has emphasised the abolition of user fees in hospitals and public health facilities and this is a welcome suggestion. Similarly its caution that healthcare must not be purchased by an independent agency for universalising it is also welcome. However, there are other issues such as private practice by government doctors, their close relationship with private hospitals and diagnostic centres and the contracting out of clinical and diagnostic facilities in government hospitals – all aspects that have transformed the mandated role of public hospitals. These have not been adequately addressed by the report and would require much more detailed attention.

Conclusions

The recommendations in the HLEG report provide an opportunity to revisit a range of issues and lend momentum to the move towards universal healthcare. The purpose of this paper has been to highlight the factors in favour and against regulating the private health sector by delineating the power relations within which it is embedded. It would be naïve to assume that the private health sector can be controlled through regulation alone, given the fragmented nature of regulatory institutions and the private sector itself. In addition, there is now an intricate and interdependent relationship among the public, private, formal and informal sectors in healthcare provisioning. Surely the HLEG would have been aware of this all too evident fact. It is, therefore, intriguing that its report has not adequately addressed this issue.

NOTE

1 A study on informal practitioners in Khammam district, Andhra Pradesh, shows how they refer cases to private hospitals and there is a well-established system of commissions for doing so (Narayana 2006). This has been documented in Mahboobnagar district as well (Baru and Dhaleta). Informal practitioners regularly refer patients from villages to diagnostic centres and hospitals and get paid commissions for this.

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