Universal Access to Healthcare: Threats and Opportunities

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A close examination of the ongoing debates on universal access to healthcare, both in national and international fora, reveals a plurality of ideological perspectives and motivations on how universal access can be achieved. This statement, issued at the end of a recent meeting of "participant observers", brings their insights and concerns about universal access to healthcare.

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Universal access to healthcare (UAHC) seems to have become the current slogan for health services development, both internationally and within India. The Global Symposium on Health Systems Research organised by the World Health Organisation (WHO) in November 2010[1] with 25 other partners that included five health research networks as core partners and 18 funders such as the Rockefeller Foundation, Centre for Disease Control and Prevention (CDC), Atlanta, the United States and aid agencies of various governments, was focused on the theme "Science to Accelerate Universal Coverage".

In the past few years, international debates on universal healthcare have found echoes in academic and policy circles in India. Several Indian academics, policymakers and activists were involved since 2008 in preparing a special issue of *The Lancet* that was released in January 2011[2] focusing on universal health coverage in India. This issue was followed in late 2010 by the Planning Commission setting up a high level expert group on universal health coverage by 2020. Civil society and health activists in India have also been involved for several years in the right to healthcare campaign led by the Jan Swasthya Abhiyan and its member organisations. The Medico Friend Circle's discussions over the past two years on designing a model for UAHC for India culminated in its annual meet at Nagpur in January 2011.[3]

This evidently widespread concern regarding the need for universal access to health services is not only critical in view of the Draft National Health Bill 2009, but is also an opportunity to deal with the inadequacies and inequalities in conceptualising, provisioning and financing as well as with the irrationalities in practice of healthcare. The serious implications for the majority of India's citizens of these adverse conditions prevailing in the healthcare system call for urgent action with a long-term vision. However, the complexity of issues also demands carefully thought-out approaches and strategies. A close examination of the ongoing debates, both at the national and international fora, reveals a plurality of ideological perspectives and motivations that inform the idea of how universal access can be achieved. The signatories to this statement, all participants at a meeting organised by the Centre of Social Medicine and Community Health, Jawaharlal Nehru University, on 23 February 2011, express their serious concern about the tone and tenor of the current discussions on UAHC. Many of them have been participants in one or the other of these initiatives and discussions on UAHC at the above fora. They bring their insights and concerns to the analysis as "participant observers" and from their public health perspective on the issues.

Divergent understandings were evident at all the fora. Perspectives differed on both the definition and content of universal access to healthcare as well as on the optimal

mechanisms to achieve it. One approach focuses on achieving universal access by expanding the role of the commercial sector in financing and provisioning. A second approach is for universal access through public financing and private provisioning. A third approach argues for enhanced public spending with a central role for the state in provisioning. However, all these three dwell primarily on financing structures, with little by way of restructuring the over-medicalised and fragmented healthcare system, irrational use of medical technologies in it and the unethical practices that have become its bane in the country. A fourth approach proposes a central role on public financing and provisioning with a regulatory framework on the content of comprehensive services – defined on the basis of epidemiological priorities – including those of the private sector, and a vital role for the active agency of communities and civil society in planning, implementing and monitoring of healthcare. Thus, the outcomes of this debate on universal access and how it is to be achieved will depend a great deal upon the perspective with which related policy decisions are taken.

In our view, analysis of available evidence demands thinking of health services development for UAHC in India along the lines of the fourth approach if the ongoing shaping of the health system is to become effective in improving the health of the poor and underserved in the country, and in fact, to ensure quality healthcare for all. We articulate some concerns about the ongoing discussions on UAHC and then outline elements of a framework for UAHC based on the fourth approach.

Some Concerns

The discourse has been ahistorical, taking no lessons from the experience either of earlier initiatives at building a health service system that was meant to cater to all, "irrespective of their capacity to pay" and "with the tiller of the soil" as the centre point (Bhore Committee Report 1946), of why the primary health care approach of the 1970s was not seriously implemented and the obstacles to achieving Health for All by 2000, or the more recent initiatives at public health service strengthening (National Rural Health Mission 2005). The kind of strategies, systems design and measures for universal access being suggested at present in India and elsewhere are evidence of not drawing upon the analyses of past experience.

Led by "international health" perspectives emerging from the First World, even if the persons involved are of Third World origin, it has also avoided any examination of the political dimensions of health services development, both national and international. The ascendancy and domination of neo-liberal thinking that sees markets as bringing efficiency and promoting consumer choice and insurance as the mechanism for financing of healthcare seem to be dominating the discussion. This is without consideration of any comparative input-output analysis between the public and private sector services, or the differences in governance structures and user profiles. Financing and monitory efficiency has become the central issue to shape the services rather than people's health needs and the inequalities they face in accessing healthcare and achieving a reasonable health status. The approach is institution-focused as well as unquestioning of modern medicine and the contemporary over-medicalisation of health. Due to this conflation of health with medicine the social determinants of health are hardly addressed. Internationally-driven standards for quality of services impose a commodification of healthcare, ensuring a market for inessentials that get quickly rationalised without adequate examination for a specific social and economic context and their epidemiological advantage.

The perspectives of the poor and underserved, the people that "universal access" is meant to benefit, are conspicuous by their almost complete absence. Approaches that view people as the sheet anchor of healthcare, as was envisaged by the Sokhey Committee of 1946, the community health workers (CHW) scheme launched by the 1977 Janata Party government, the Alma Ata Declaration, and Ivan Illich's ideas on the negative fallouts of medicalisation of societies (iatrogenesis) in the classic book, *Medical Nemesis*, find no place in most discussions. Similarly, marginalised have been other forms of knowledge about health, illness, prevention of disease and treatment; in the Indian context this includes the codified systems (Ayurvedic, Yoga, Unani, Siddha and Homeopathy – AYUSH), traditional health practitioners, traditional birth attendants, as well as home remedies and other folk practices. The impact of the medical industrial complex and the insurance industry that appears to be steering this initiative has been entirely ignored. Is this then a case of creating an "effective demand" with assured funds from the public exchequer for the private financial institutions through social insurance and the medical industry with its corporate interests? Insurance-based healthcare provisioning is known to add layers of expenditure and consume 15%-20% of the healthcare costs merely to run the insurance mechanism. Conditional cash transfers, even if they reach all those eligible to benefit from them, cannot cater to differential healthcare needs of families with varied morbidity rates and patterns, specifically in the context of the techno-centric healthcare provisioning. Therefore, even the financing mechanisms being offered to cover the poor and marginalised do not seem suited to the requirements of universal access and equity.

The experience of several middle and low income countries with social insurance mechanisms for ensuring universal access, such as in Brazil and Thailand, has demonstrated that it does not meet the objectives of universal access. These countries have, therefore, moved to direct tax-based financing of provisioning of services. The US experience of private insurance with targeted, publicly-funded social insurance and private provisioning shows how it drives up costs of care, raises issues of moral hazard, does not lead to comprehensive care and is exclusionary.

Proposed Paradigm

(1) Begin from the epidemiological needs of different regions and socio-economic subgroups, with priority to the needs of the most deprived. The current reality of the heavy burden of infectious diseases should be seen along with an emerging trend of non-communicable and chronic diseases, accidents, injuries and ageing of the population. The dominant biomedical model is widely recognised to have failed to cater adequately to the ill-health profile and even the developed countries are exploring alternative systems of medicine. Rampant and irrational use of medical technologies, with implications in the form of declining sex ratio, an epidemic of caesarean sections and hysterectomies, rising drug resistance for antibiotics, all pose the challenge of evolving innovative ways of prevention and treatment.

(2) Contextualise the healthcare needs in the real life conditions, such as related to employment, incomes, food security, environmental hazards, work conditions and housing, water and sanitation. These pertain to not only undertaking non-medical preventive health action, but also for their implications on the medical preventive and treatment regimens that would optimally work under such conditions.

(3) Take cognisance of the health-seeking behaviour and perceptions of people as relevant to planning for healthcare suited to their context. The prime concern should be removing the constraints faced by the marginalised majority to take actions for improving health, rather than relying on strategies of mass screening and compulsion or monetary incentives to accept medicalised solutions.

(4) With 90% of workers being in the informal sector and over 75% living at or below Rs 20 per day, epidemiologically rational comprehensive services must be provided free of charge in the entire public system in all states across the country. Not only the consultations, but also diagnostics and medicines must be provided free of charge.

(5) Expansion of infrastructure to improve population coverage by healthcare institutions in the public system is essential if universal access is to be assured. The responsibility of the State in the provision of quality services must be specified. The cost of this, as estimated by various public health experts is about Rs 2,000 per capita per year and totals to about 5-6% of gross domestic product.

(6) There is a need to rethink and augment the existing model and network of sub-centre, PHC, CHC and district hospital. Building upon the team approach envisaged in the PHC approach, we need to expand the team to ensure the appropriate skill mix for institutional and outreach services. The new model, while taking into consideration the existing structures, should not be bound to reproduce them with little or no variation. While getting informed by existing realities, it should plan for what is needed and ideal. The way to achieve the ideal would be to break it into feasible incremental objectives with change planned in a phased manner within a realistic timeframe. A strong political commitment is a necessary precondition for any of the efforts to succeed.

(7) The PHC approach of a primary level of services supported by secondary and tertiary levels has to form the framework for provisioning, where the primary level acts as a gatekeeper for the higher levels. The focus of expansion must, therefore, be from the primary to the tertiary and not in the reverse order of priority. However, PHC is not the primary level care and includes access to appropriate, quality, secondary and tertiary care.

(8) We believe that, in a system for universal access to rational and quality healthcare, there is no scope for public-private partnerships (PPPS) without a clear definition of shared objectives, priorities and an effective regulatory mechanism in place. Otherwise, it only represents a siphoning off of public funds to the private sector with no commensurate benefit to the users. The private sector is known to escalate costs and engage in more irrational practice. We are of the firm view that the primary task is to strengthen the public service system. Putting in regulatory systems is a prerequisite to any form of PPP. The PPPS may be used in the short term and in a limited way where there is evidence that they will strengthen the public system's objectives. In the long term, what is rational to be included in secondary and tertiary care must inform both public and private services.

Human Resources

(9) Human resources for health cannot merely be governed by universal norms of population coverage, but need to be planned based on local epidemiological needs, on the optimal levels of healthcare required for them, and on the cost-effectiveness and safety of the measures to be taken. Their numbers, education and skill development must be commensurate with the tasks required of them. This will depend on the requirement for services as epidemiologically assessed, taking into account the optimal role of all levels of healthcare of all systems of health knowledge and practice – from home and community level care to institutional primary, secondary and tertiary levels.

(10) Population norms for institutional coverage must take into account the distance, time and expenditure required to reach them in different settings of terrain and development of transport and communication in different parts of the country.

(11) The use of indigenous systems of medicine and homeopathy must receive much greater attention, with documentation and research-based identification of their role in the overall healthcare system.

(12) The issues of rational and ethical healthcare practice by healthcare professionals need foregrounding and cannot be dealt with as mere side-issues relegated to some later point of time. In fact, any initiatives at PPPS must come only *after* effective measures have been taken to bring about this transformation of the professional providers.

(13) Attracting more doctors into the public system is possible through improved conditions of work, adequate facilities for rational care, and intake into medical college with consideration to social background of the doctors that is conducive to their entry and retention in the rural and public services. Monetary incentives and increasing the number of medical colleges will not be enough to get more doctors into the public system.

(14) There must be context-specific planning of health services development, with due consideration to social science insights about social inequalities, their impact on health, local needs and people's aspirations.

(15) Policy, planning and administrative structures such as of the Ministry of Health and Family Welfare and the Director General of Health Services need a detailed review so as to strengthen their capacities.

(16) The barriers to absorption of funds by the health services in the states must be examined and removed. Such barriers are not inherent characteristics of state systems and thereby do not justify the promotion of private sector services.

Cadre Structure

(17) There ought to be a fundamental reconstruction of the cadre structure for public health workers, with managerial physicians playing a pivotal role. The district health administration being the focal point of rural health services, may be headed by a managerial physician as the chief medical officer, with the superintendent of the district hospital under her/his charge. The current system of specialist-dominated CHCS at the block level needs review, possibly with a managerial physician being in charge of the entire health services in the block.

(18) Public health education and medical undergraduate education need to be revised in keeping with this perspective. The teaching of preventive and social medicine/community medicine within medical colleges needs to be rejuvenated rather than leaving it in isolation, while the emerging temples of public health garner support and resources.

(19) Decentralised planning and grievance mechanisms must be actively built and nurtured in order that this perspective is operationalised. Mechanisms for active participation of local elected bodies, democratically elected civil society members and direct deliberative involvement of communities will be required for a locally rooted health service.

(20) Rejuvenation of the key technical support institutions such as the All-India Institute of Hygiene and Public Health, National Institute of Health and Family Welfare, Indian Council of Medical Research and National Centre of Disease Control will provide an endogenous base for health policy and planning, relying upon the vast technical competence available in the country. As scientific bodies, there must be a complete transparency in their deliberative processes, regarding decision-making about health policies and programmes. Requirements of people's health within this perspective should determine whatever international collaborations are developed, and not some vested commercial or professional interests.

(21) An institution should be charged and capacitated specifically for setting up an endogenous mechanism of evaluation of health technologies for recommending their role in the country's healthcare, based on epidemiological rationality and appropriateness to context.

(22) A National Health Information and Evaluation System, starting from the village onwards, ought to become the nerve centre of the UAHC system. This will be necessary for our first three propositions, that of setting priorities based on the local epidemiological and health services context as well as people's perceptions. Thus, we come full circle in outlining the elements of the health system for universal access.

It is evident that the efforts underway fall short of these essential requirements. We hope a more grounded and contextually rooted approach to healthcare systems development will become possible in the near future as we engage in transparent public discussion on the issue.

NOTES

1 First Global Symposium on Health Systems Research: Science to Accelerate Universal Coverage, Montreux, Switzerland – http://www. hsr-symposium.org/.

2 *The Lancet* series (Vol 377, Issue 9765, 2010) – http://www.thelancet.com/series/india-towards -universal-health-coverage.

3 The MFC meet background papers – http://www.mfcindia. org/main/bgpapers/ bgpapers 2011/am/bgpapers2011am.html.