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ANALYSIS

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The Illusion of Universal Health Care: Medical Insurance as the Panacea

Madhurima Nundy
Assistant Director and Associate Fellow, Institute of Chinese Studies, Delhi
madhurima.nundy@gmail.com

The 1978 declaration on Primary Health Care (PHC) at Alma-Ata (presently Almaty), Kazakhstan was a watershed in the discourse on 'health for all' globally, giving value to equity, social justice and social determinants of health. All Member States of the World Health Organisation (WHO) were signatories to it. The idea of primary health care that was envisioned, went beyond strengthening primary level health services or access to medical care. Here, health was seen as central to socio-economic development and not only provision and financing of medical care to the population. The role of the community was central to this. Four decades since, 'health for all' is still elusive, remains unrealized and is open to multiple interpretations. Policies and programmes are packaged as being universal and comprehensive but are far removed from being so. In October 2018, forty years after the Almaty declaration, a global conference was called at Astana, Kazakhstan, to renew the political commitment to primary health care with governments, non-governmental organizations, professional organizations, academia and global health and development organizations. The renewed declaration is also seen as a precursor to a high-level meeting that will take place by the Member States of the United Nations on universal health coverage in 2019. But nothing significant has been reported as yet, about this declaration, its outcome and recommendations.

This analysis places the recent developments in health policy in India and China in the context of the departure from the principles and design that informed the PHC approach. Both the countries were engaged with the process and were signatories to this declaration. With the PHC declaration at the backdrop, this analysis will look at the discourse on universal health coverage in India and China that has evolved over the last decade in the context of reforms and how medical insurance has been seen as the panacea to achieve universal health 'coverage' instead, which is far removed from the primary health care approach.

Background

In many instances, Universal Health Care and Universal Health Coverage are used simultaneously and synonymously, though both hold very different meanings. There are different perspectives on the content and implementation of these approaches and in a neo-liberal context, the focus tends to become narrower. While the idea of primary health care still exists, it has changed meanings and has been adapted by countries based on their contexts (Bisht 2015).

The idea of universal health care emerged from the PHC approach, that in turn had emerged from positive health system outcomes in postcolonial socialist countries, with the state

playing a central role in provisioning of services. Given the different contexts – varying welfare and capitalist systems – the meaning of universal health care has changed over time. Universal health care does not emphasise on state's responsibility in health care and public provisioning of services as primary health care approach does. It merely proposes to ensure universal access to services through either public or private provisioning. So while UK, Canada, Germany, provide universal health care, given the different political contexts, the design and methods of implementing universal health care varies and is a mix within the spectrum of public and private financing and; public and private provisioning. In the past decade universal health coverage has gradually come to replace universal health care, alluding to the latter but restricting itself to access to medical care through insurance.

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India shifted its course from the vision of primary health care soon after 1978 citing lack of resources to invest in health, as did most countries during the time. The shift was seen in terms of moving away from a comprehensive paradigm where health was seen as a right to a more selective approach for reasons of being 'realistic and pragmatic', though the decisions were more political. There was implementation of selective programmes like family planning, maternal and child services and disease control programme with financial and technical support from multilateral organisations. With liberalisation in the 1990s, public investments in health further declined and the private sector received greater focus thus, leading to commercialisation of medical services. This resulted in opening health services to market mechanisms, experimenting with public-private partnerships, and changing governance structures. An important consequence of commercialisation was increased inequities in access to health services and a fragmented health service system.

As role of markets increased in health through the 1980s and 90s, primary health care remained in the realm of a utopia. In reality, markets expanded and accessibility to health and health services decreased. Experimentation with medical insurance began during this time and in recent years is projected to become one of the primary methods of financing to increase 'coverage'. Coverage in the present context has come to mean medical insurance for hospitalisation, for some selected services and procedures. Universal health care has hence, developed a new meaning and is replaced by universal health coverage. This has been observed in many countries around the world, more in middle-income and lower-income countries where accessible medical care has been distant.

While economic growth and health sector reforms were seen as an opportunity that would minimise inequities and improve access to resources, these reforms were guided by ideas of privatization and commercialization of health services that led to restructuring the role of the state and enlarging spaces for market forces within the health service systems. In both India and China these reforms resulted in tremendous inequities, regional disparities and have not been able to resolve the issue of access for all. China started addressing reforms to address universal health coverage in the early 2000s, much before India. But there are important lessons for India from the Chinese experience, since India has now ventured towards a universal health coverage model through medical insurance.

The Chinese Experience: What does insurance do to health services?

Having made major health gains at the population level in a short period of time, China was one of the inspirations for the PHC approach in 1978. Ironically, the same year, China announced its open door policy and economic reforms leading to the restructuring of the rural economy and dismantling the financial and institutional structures for a range of social services.

In China, the policy shifts towards universal health coverage began in the late 1990s when medical insurance schemes were introduced and scaled up over a period of a decade and half. This policy shift occurred in the light of extreme inequities in access and high cost of medical care. It rolled out three insurance schemes in a span of seven years – for rural population, for urban employees and for urban residents respectively. China now claims to provide universal health coverage through its insurance schemes. There have been several hurdles and even by 2015 when the government declared that universal health coverage was attained, the provincial inequalities in access, depth of coverage, inequities across insurance schemes and focus on only curative services, left much to be desired. The inflationary impact of insurance schemes has raised cost of care and has questioned the financial viability of the scheme. The rise of chronic diseases and overdependence on drugs has tilted care towards tertiary hospitals. Since health services in rural areas were disrupted due to economic reforms in the 1980s, health institutions functioned as separate entities and had to raise their own funds. This led to overpricing and overuse of drugs and diagnostics. Insurance covers only part of the costs, and out-of-pocket expenditures remain the same if not higher in real terms. This occurred in China despite the fact that 85 per cent of their provisioning is with the public sector, though a highly commercialised one.

Realising the fault lines, China has gone back to strengthening its primary and preventive health services since 2015, to recreate the referral system that existed in the 1970s - upward movement of patients. But given the diverse rural and urban population, the government has had to give in to demands of the growing rich and middle class population. This has happened through investments in private hospitals and introducing partnerships with the private sector in public hospitals. This has led to a creation of a complex system with contradictory interests and complex designs. Medical insurance is there to stay and small corrections will continue to take place, but the struggle for universal health care will continue. Stories and anecdotes of suffering of patients and families are available across the digital media and these have intensified in the last decade (Wee 2018; Guo 2017).

Lessons for India

Given that China is way ahead than India in its health indicators, it still struggles to address issues of universal health care and coverage. What lessons could India learn from the Chinese experience and where should it tread with caution?

In India, there is a longstanding and ongoing debate between providing universal coverage through medical insurance or providing comprehensive health services by strengthening public health systems especially at the primary level. The High Level Committee in 2011 favoured strengthening public health services before introducing any kind of health insurance schemes at the national level. Given the current realities, the insurance schemes should be the last priority but the insurance path is exactly what the present government has prioritised as its policy towards health coverage.

Realising the fault lines, China has gone back to strengthening its primary and preventive health services since 2015

India has a more complex health service system than China, with both private and public provisioning – provisioning and utilisation is both tilted towards the private sector. Provisioning by the public sector is extremely weak. The private and corporate sector receive public subsidies to build their assets while public sector remains underfunded. The private sector also exists in places which are developed and there are several studies on questions of costs, irrational and unethical practices and quality of care in the private sector. With a weak public health system, a universal medical insurance scheme is bound to fail. There is enough evidence that has emerged from within India since the launch of state specific health insurance schemes and the Rashtriya Swasthya Bima Yojana (RSBY) that was launched in 2010 under the aegis of the National Rural Health Mission for only those below poverty line (Baru 2014; Nandi et al 2012; Hooda 2018; *PTI* 2018). These studies also show that the public funded health insurance schemes subsidise private

hospitals, helps them keep a steady flow of patients and helps in their growth and sustainability. The private hospitals in turn resort to irrational services in order to maximise their interests. Investing in public institutions instead would have a greater value.

These public insurance schemes were limited to providing coverage for medical services linked to hospitalisation. Significant expenditure occurs in seeking out-patient services that is not covered. The economically vulnerable spend more on out-patient services as a proportion of per capita consumption expenditure (Gupta et al. 2016). In insurance schemes like the RSBY that only cover hospitalisation, out-of-pocket expenditures for in-patient remained the same and in some cases more as the private providers who were empanelled in the scheme were overprescribing and performing irrational procedures. There was a high influx of hysterectomies and caesarean sections reported from across states where public health insurances were in place and this was just the tip of the iceberg.

These public insurance schemes were limited to providing coverage for medical services linked to hospitalisation. Significant expenditure occurs in seeking out-patient services that is not covered through insurance.

Despite these evidences, in September, 2018, *Ayushman Bharat* National Health Protection Scheme (ABNHPS) was launched in India, claiming to be one of the largest health programme in the world. ABNHPS essentially includes two components – one is the creation of 1,50,000 health wellness centres (HWC) and the other is the Pradhan Mantri Jan Arogya Yojana (PMJAY) - literally 'Prime Minister's Health Insurance for All', for those below poverty line, to begin with. The PMJAY proposes to cover 100 million families and provide hospitalisation coverage of up to Rs. 500 thousand. While this is being given the name of universal health coverage, it is a far cry from the primary health care approach. PMJAY follows a similar model as the RSBY, in a much higher scale. While RSBY provided coverage of Rs. 30,000 per family in a year, PMJAY promises to provide a coverage of Rs. 500 thousand per family per year. How the government plans to generate resources for this is still being speculated (Srivastava 2018).

In January 2019, the National Health Authority (NHA) was set up to replace the earlier National Health Agency to directly oversee the PMJAY. The NHA will be responsible for implementing the PMJAY and will have the autonomy to handle day-day-operations as well as decide on premium amounts and purchase services from the private sector. Interestingly, in a recent development, the NHA CEO wrote to the Health Secretary, stating that a significant step in the success of the PMJAY would be to integrate both the components of the *Ayushman Bharat* – the HWCs and the insurance programme (PMJAY). This would lead to the eventual progression towards universal health coverage. The CEO, Dr. Indu Bhushan writes, "The staff of HWCs should create beneficiary awareness at the grass-root level about both legs of Ayushman Bharat i.e. HWC and PMJAY. This also needs to be supplemented by branding of PMJAY at HWCs to create a cost-effective information, education and communication at the field level… All HWCs must have the capability to determine the eligibility of beneficiary under PMJAY and should have the capability to issue PMJAY e-cards to beneficiaries" (Ghosh 2019).

This integration was exactly what was lacking when the insurance schemes were introduced in China in the late 1990s. It is only in 2015 that the Chinese policy makers realised that the primary health services needed strengthening and had to be integrated with the insurance schemes in order for the insurance to be effective.

Conclusion

Globally, medical insurance has been seen as the panacea for universal health care and coverage. There has been a clear move from a national health service kind of system that emerged in a welfare context post Second World War in Britain or a comprehensive health system that viewed health as a right in a socialist paradigm in the Chinese context, in the late 1940s. India had adopted the public welfare

model during the post-independence period but it was weakly developed through the subsequent decades. This led to a mixed economy in health services and gradually the private sector gained prominence in terms of numbers and distribution. Increased commercialisation led to medicalization and cost escalation. Globally, evidence has shown that cost escalation is inevitable when the private sector or commercial interests are involved, even if the state does the price-fixing for procedures and other services linked to medical care. A weak public health structure, especially at the primary level, will be unable to sustain an insurance based financing and address the issues of access and equity. In the case of China, the commercial behaviour of the public hospital has created a similar situation where they have to generate revenues. Both countries have a serious issue of underfunding of public health services system, especially health services at the primary level, though China is way ahead than India in terms of integration of services.

The neo-liberal mandate in India has given the market a greater role. There are clear divisions between people who view health as a right and those who view health as an investment and consumption. There is also a clear distinction between health as a right and health services as a right. The former is what the PHC approach was about and the latter integrates preventive, curative and promotive services. In both cases the state plays a critical role in funding and prioritising services based on population needs. But coverage through insurance is even narrower to these two – this includes only coverage for medical care when hospitalised and is a targeted approach for below poverty line people rather than universal - who decides who gets covered and how.

The Bhore Committee, that was set up in 1943 by the Viceroy of British India to assess the health conditions of the Indian population to come up with a blueprint for health service development, had expressed doubts about any kind of insurance mechanisms in the health sector. Even then, the Committee debated on the role of social insurance and argued that priority should be given to building a strong public health services before bringing introducing insurance schemes. (Baru, R. 2019). India is still grappling with the similar challenges.

The People's Health Movement, a global network of health activists, civil society organisations have critiqued the associations made between primary health care and universal health coverage. They comment that, *"Primary healthcare is broader and indeed subsumes universal health coverage, which is, in many countries, being implemented by private health insurance companies and aggravating health inequalities."* Universal health coverage also trivialises the idea of primary and universal health care.

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Universal health coverage, as imagined in the present times, is nothing but a techno-managerial fix to a much more complex problem. For a country like India, where out-of-pocket payment constitutes a large proportion of expenditure, universal health coverage will have a limited outcome even when universally implemented. The discourse should be on why we are substituting universal and comprehensive approach to health for a medical insurance scheme. ■

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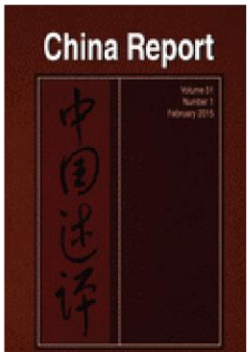

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