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REVERSING HEALTH SECTOR NEGLECT WITH A REFORM AGENDA

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Two countries which lead in the COVID-19 cases tally in the world today, namely the United States (first) and India (third), are also the ones where the need for health-care reform post COVID-19 has been most keenly felt. This is due to the lack of effective universal health coverage (UHC) in these countries, which has broadened concerns beyond the frontiers of an epidemic response into the larger domain of access, equity, and quality in health care.

This lack of UHC has a long legacy in both these countries, which they owe to multiple long-standing factors and historical reasons that have put a damper on the UHC agenda. This long legacy has two important and inter-related implications when it comes to health-care reform. First, certain entrenched characteristics of these health systems that have accrued over decades tend to dictate the terms of further evolution and lead to a number of compromises. Second, the long legacy itself comprises a path-dependent trajectory that precludes far-reaching health-care reform.

The US Affordable Care Act (ACA) can be an example of the first implication. It envisaged a number of overarching measures to expand health insurance and improve access, including Medicaid expansion, essential health benefits, and discouraging risk selection in insurance. However, the foundational aspects of U.S. health care, such as a fragmented private insurance landscape and a love for expensive specialised care, could hardly be altered due to their entrenched nature. The ACA reforms were thus superimposed on such largely non-negotiable elements, which in turn constrained the nature and scope of those reforms. It is little wonder that the ACA has been not very successful on multiple fronts, such as ensuring access commensurate with insurance levels, and checking the rise of premiums and out-of-pocket costs. A similar set of entrenched and non-negotiable fundamentals, including weak public and pervasive private health care, will also impact health-care reform in India.

The government has looked poised to employ Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PM-JAY) health insurance as the tool for achieving UHC, and such calls have only grown stronger in the context of the COVID-19 pandemic. Plans are reportedly under way to extend coverage to the non-poor population under AB-PM-JAY, which currently covers the bottom 40% of the population. Taking the health insurance route to UHC driven by private players, rather than strengthening the public provisioning of health care, is reflective of the non-negotiability of private health care in India. This could have several unwanted consequences, which merits attention.

Stark maldistribution of health-care facilities (almost two-thirds of corporate hospitals concentrated in major cities) and low budgetary appropriations for insurance could mean that universal insurance does not translate to universal access to services, much akin to what was seen under the ACA in the U.S. Thus far, insurance-based incentives to drive private players into the rural countryside have been largely unsuccessful, and experience suggests that the public sector could be the only effective alternative. Further, the Indian story has traditionally been one of aiming high with little homework. Envisaging universal health insurance without enough regulatory robustness to handle everything from malpractices to monopolistic tendencies is a case in point. This could have major cost, equity, and quality implications. For example, shouldn't there be a potent 'Clinical Establishments Act' before embarking on a universal scheme involving large-scale public-private collaboration?

A similar argument can be made about the National Digital Health Mission (NDHM) conceived by the Centre. Integration and improved management of patient and health facility information are very welcome. However, in the absence of robust ground-level documentation practices and its prerequisites, it would do little more than helping some private players and adding to administrative complexity and costs like the electronic health records did under the US ACA.

One possible advantage for India over the U.S. could be a relative ease of integrating fragmented schemes into a unified system. The AB-PM-JAY has this ability, but it would require mobilising sufficient and sustained political consensus.

The second implication concerns path-dependent resistance to reform. The bigger and deeper the reform, the more the resistance. Covering the remaining population under the AB-PM-JAY presents massive fiscal and design challenges. Turning it into a contributory scheme based on premium collections would be a costly and daunting undertaking, given the huge informal sector and possible adverse selection problems. Meeting requirements through general revenue financing would greatly strain the exchequer and looks very unlikely especially in the immediate aftermath of the pandemic. In either case, an effective roll-out of UHC would require a robust regulatory and administrative architecture, entailing huge administrative expenses and technical capabilities. Harmonising benefits and entitlements among various beneficiary groups, and a formalisation and consolidation of practices in a likely situation of covering outpatient care, are formidable additional challenges. While these would need to be pursued incrementally, the question arises as to how to push such a thoroughgoing reform agenda, especially against a backdrop of decades of frail capacities and neglect of the health sector.

While upheavals offer windows for pushing reform, as Johnson notes, “the weight of past and pre-existing paths strongly constrain and limit the impact of the most radical ruptures”. We cannot afford to be complacent and think that the pandemic will automatically change the Indian health-care landscape. This is particularly important since a protracted presence of the pandemic in the country could undermine its gravity and the perceived urgency for major reform. It will require mobilising concerted action from all quarters. Civil society would need to utilise this opening to generate widespread public consensus and pressure for health-care reform. The fact that States with higher per-capita public spending on health have fared better against COVID-19 can be invoked to back the reform argument. At the same time, politics would need to recognise the unprecedented populist significance of health and marshal enough will to negotiate organised opposition to change.

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