Indian Healthcare: The Malady of Political and Public Indifference

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Abstract

Health often fails to figure prominently on the political agenda of countries. The United States provides an example of how ineffective political will and public pressure can impede achievement of universal health care, creating distortions such as provider dominance in the health system and expensive, specialty-centric health care. In India, years of government under-investment in health and lacking civic engagement have paved the way for private sector dominance and undermining of community-based primary care, which could be exacerbated by the COVID-19 pandemic. Thailand's journey to universal health coverage offers lessons in political commitment and civic participation in health. Such lessons cannot always be emulated by others owing to path-dependent characteristics of systems. The COVID-19 pandemic, however, can be an opportunity to break path dependence and mobilize various quarters for lasting reforms in Indian healthcare.

Keywords: politics of health care, Indian health policy, US health care, universal health care, universal health coverage, Thailand UHC, COVID-19, primary health care.

Health ranks low on the political agenda of many countries. The health budget is often the first to come under the knife in times of economic downturn. But just as risk for disease sets in when personal health is neglected, indifference towards the health system sets the scene for public health problems to doom an otherwise promising economy. The Indian story is little different, and the ramifications of this have been starkly highlighted by the COVID-19 pandemic.

Provider Dominance in the United States

Unlike in Europe where health insurance was consumer-driven, health insurance in the US "was initiated by healthcare providers seeking a steady source of income" (Bodenheimer and Grumbach 2009: 8). The early health insurance schemes, for example *The Blue Cross* and *The Blue Shield*, were controlled by healthcare providers, allowing them to write generous reimbursement rules for their insurance programs [1]. It has also been noted that such generous reimbursement played a role in the success of large hospitals in post-World War 2 US, helping cement a hospital- and specialty-oriented healthcare culture [2].

Generous reimbursements and price inflation in healthcare didn't pose a problem until the 1970s, owing to steady economic growth. The years that followed witnessed a steady increase in the number of uninsured Americans and a number of measures directed at price control, such as managed care [3]. However, healthcare providers have repeatedly been able to undermine attempts at price control, and continue to wield tremendous power in health policy decisions.

It is common knowledge that such hegemony of private healthcare providers has been greatly responsible for the failure of universal health care to take off in the US, an exception among developed countries. The American Medical Association has been known to have derailed multiple attempts to institute a national health insurance in the US over the last century. While healthcare has been an area of passionate political and

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public discourse, traditional American values like individual freedom and consumerism have permitted little political will and public pressure towards ideas like private sector regulation, government intervention, and right to health. Predictably, the upper-hand of private providers has also meant that community-based primary health care remained unpopular in the US. Primary and preventive care arose as a challenge to specialty-oriented hospital care [4] in the 1970s and in reaction to the rampant price inflation that the latter entailed [3], but was soon pushed into a subservient position. Public opinion has rallied behind costly, increasingly specialized care despite its evident adverse impact. No wonder that the US health system became one of the costliest yet among the least efficient of all, and also the greenest pasture for doctors from across the globe.

The Deformity in Indian Healthcare

A public-private mix has characterized Indian healthcare since the beginning, however, it was after the 1980s that our health policy pronouncements started conveying a clear reliance on the private sector, particularly with respect to hospital care. This is against a background wherein the social sector (including health) managed to receive only the residual plan resources since independence [5]. Post the 1980s, the private health sector shifted its attention to lucrative tertiary healthcare, and backed by favourable economic policies, generous subsidies, and little regulation, evolved into one of the fastest growing sectors of the Indian economy.

Further, healthcare has traditionally lacked in effective public engagement, and there has been little public pressure to push health care reform to the top order of the political agenda. With the exception of some southern states like Kerala and Tamil Nadu, where civic activism in health flourished, the clout of the healthcare industry has gone unchallenged by the consumer. Instead, the impression that private hospital care is the 'gold-standard', which initially grasped the elite, has increasingly trickled into the commonest of citizens - downplaying the significance of community-based primary health care. There is incognizance both of the 'need' to demand and 'what' to demand.

All of this reflects in the current trend of prioritizing generous hospital insurance coverage over primary health care, through various state- and central government funded schemes. For example, the Health & Wellness centers conceived under the *Ayushman Bharat* Mission remain under-emphasized compared to the *Pradhan Mantri Jan Arogya Yojana*, the insurance component of the mission. With industry interests lying in tertiary care, there can be little fervour to invest heavily in primary health care (which can reduce demand for expensive tertiary care), despite gaping unfulfilled primary care needs. Here, the circumstances engendered by the COVID-19 pandemic become worrying. The pandemic is further likely to increase calls for prioritized strengthening of the hospital sector given that serious and critical cases consume disproportionate popular attention. This could eclipse the need of strengthening primary health care which is equally, if not more, crucial in case of pandemics.

Political Will and Public Pressure

Two areas of inadequacy are apparent from the above examples. These are weak or ineffective political will and public pressure towards equitable, universal health care. Let us now consider an example from the opposite end of the spectrum, in Thailand. Thailand, despite a legacy of monarchy and having seen more military coups than any other country, has registered exemplary political responsiveness and civic engagement in health. This appears surprising when we consider the US and India, which happen to be two of the world's most celebrated democracies.

Thailand embarked steadily on its journey to expand health care coverage since the mid-1970s, incrementally covering the poor, the near poor, formal sector employees, the children and elderly, until finally achieving universal population coverage in 2002. Among the key actors in this process were civil society organizations (CSO). Student leaders who fought against the military rule in the early 1970s created the Rural Doctor Society in 1978, and spread across political parties, CSOs, and the bureaucracy [6]. They helped mobilize political commitment, public demand, and a formidable evidence base for making universal health coverage (UHC) possible. With the promulgation of the 16th constitution in 1997, UHC became a social movement with widespread public support and a populist program for the first election under the new constitution [7]. Civic groups have been consistently active in policy formulation, implementation, and assessment. They were instrumental in drafting the National Health Security Bill, the success of which earned them seats in the National Health Security Board. CSOs also participated actively in the framing of the National Health Act, 2006, and constituted one-third membership of the National Health Commission [6].

Thaiprayoon and Wibulpolprasert (2008, 2017) discuss the "triangle that moves the mountain" comprising creation of relevant knowledge, political involve-

ment, and social movement, which made UHC possible in Thailand [6,7]. Political commitment to UHC, apart from civic engagement, has been a crucial factor. In the 1980s, this lead to dedicated expansion of rural public health infrastructure and health worker cadres, greatly expanding access to basic health services in the community [7]. Private healthcare has had a minor role, and a strong foundation of public health facilities has primarily made UHC possible. Further, political commitment reflected in rolling out UHC defying concerns of financial unsustainability expressed by the World Bank, and subsequently covering high-cost interventions under the universal coverage scheme [6,7].

What makes lessons in political will and public engagement difficult, and possibly even impossible, to apply quickly across contexts? Much has been talked about these in India, but what is often overlooked is that they follow path-dependent trajectories. Amrith (2009) has discussed how, in states like Kerala and Tamil Nadu, public health reform rode on the backs of a long tradition of civic activism and a political culture of social reform. Widespread awareness about health being a right, and public health becoming an issue of political competition, drove improvements in healthcare [8]. The larger part of the nation which has traditionally lacked these traits finds it hard to mobilize different quarters for better public health. Also, the development paradigm of health services pursued over time greatly influences both public and political preferences and the range of available choices. This happens, for example, through inculcating a taste for certain kinds of services over others, creating strong interest groups which resist change, or progressively embedding a set of conditions inconducive to, or disparate with, a proposed reform. All these tend to constrain the scope of reform. The dominant legacy of the private sector in India making things awkward for universal health care can be a case in point.

Way Forward

However, while path dependence repels change, the pandemic can be a rare opportunity at path transformation. Such events in history have often acted as 'violent shocks' capable of rearranging power structures and pushing major reforms that would otherwise have been unimaginable. Certainly, there is no merit in over-estimating the capability of the pandemic in this case, but there is also no doubt that it has considerably invigorated the discourse on the fault-lines of Indian healthcare and prompted certain far-reaching, albeit temporary, measures - both of which were elusive before. For example, in the early days of the pandemic, a few calls to nationalize all private hospitals had surfaced, and given that the pandemic could be long-drawn-out, they could very possibly reappear in the future. Exorbitant treatment bills at many private hospitals prompted states like Maharashtra and Delhi to cap treatment charges. It is important to identify this opportune opening and marshal concerted action from all quarters towards bringing about lasting changes in healthcare. Owing to the pandemic, public sensitization on the need of healthcare reform will be at the zenith, which can facilitate efforts of the civil society at mobilizing public pressure. Improving healthcare can be more of a populist policy now than ever before in the country, and political will for reform can expect to encounter the least-possible amount of resistance and find the highest-possible level of popular support.

Policymakers, however, will need to repudiate perverse incentives to prioritize hospital care over primary care, of which there could be more than usual owing to the pandemic. This can be particularly challenging since both public demand and industry interests can be aligned in this direction. If left unchecked, this will only reinforce the old trajectory of expensive, inefficient, and inequitable health care, while leaving us underprepared for a future pandemic.

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