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Health Sector Reform at the COVID-19 Cross-roads: Public Goods or Health Markets – An Agenda for Health Systems Research

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Summary

The debate around approaches to health sector reform is one of the foundational questions around which the discipline of health policy and systems research has grown. In the immediate postwar period, health and health care were recognized as areas of market failure, requiring state action in the provision of free or subsidized services. In the eighties and nineties, due to both geopolitical and ideological reasons, this understanding changed, leading to a wave of market-based health sector reforms. An academic discourse built around neoliberal economics initiated, shaped, and legitimized these reforms. Faced with worsening health outcomes and costs of care after a decade of such reforms, there was a partial reversal of policy toward improving health sector performance that relied on nonmarket solutions built around notions of solidarity, trust, and rights. In India, this took the form of the National Rural Health Mission. Examples of health systems research that supported this direction of change are discussed. In the last decade, a second wave of health sector reforms sought to make markets work by repositioning government as purchaser of health care from private providers through insurance and contracts. There is little evidence that this worked. The need to rely on public services to cope with the COVID-19 pandemic, further questioned this direction of reform. We emphasize the need to expand and develop a framework of health systems and policy studies that are more appropriate to the achievement of universal health care, health equity, and health rights in the Indian context.

Key words: Health systems research, health systems strengthening, National Rural Health Mission

Introduction

Thank you for the honor of inviting me to deliver the 65th KN Rao Memorial Lecture. He was a pioneer in the study and practice of health policy and health systems strengthening, and I am happy to be presenting on this very theme in my oration. This paper relates to one of the most rapidly developing areas within the discipline of public health, namely health policy and systems research (HPSR), and outlines the need for developing a research agenda in India that is appropriate to our needs and context.

"Health policy and systems research (HPSR) is an emerging field that seeks to … draw a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape - and be shaped by-health systems and the broader determinants of health."[1]

HPSR is characterized not so much by its methods but by its questions. Its rise parallels the rise of the discourse around health sector reforms and it engages with approaches to improving health systems performance and increasing public accountability of public health systems, not only at the level of providers and facilities but even more so at the level of policies and institutions.

Social context is important, as "Health systems are ultimately *social systems* that reflect the way in which societies organize themselves."[2] Since ideas, values and power relationships all shape these social systems, the questions we ask, the framework of analysis in use, and societal objectives that are served could differ with ideological contexts, and the researcher and student of HPSR needs to be conscious of this.

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Within this emerging discipline of HPSR, there is one central question, which is almost the foundational question of the area of study and practice, namely the choice between different approaches to health sector reform. It is essentially a question of the most appropriate form of organization and financing of health-care services that would yield better health outcomes. It is well accepted that health outcomes are more dependent on social determinants of health and policies outside the health sector than on access to health services (WHO, 2021), but health services do contribute to health outcomes and access to health services is itself a social determinant of health.

The preceding decade has been characterized by the rise of universal health coverage (UHC) as the dominant concept driving health sector reform.[3] Although at the definitional level, it is neutral to the pathway or approach to achieving it, in practice, most measures tended to push for making markets work for health care – either through insurance or through different forms of contracting and strategic purchasing.[4-6] The pandemic has called this into question, by emphasizing the importance of the role of government and the failure of markets.[7] This was reflected in the call by world leaders to declare vaccines global public goods. It is also reflected in the joint move by over 100 countries led by India and South Africa to exempt all access to COVID-related technologies from trade-related patent restrictions.[8] However, there has also been a push back from the developed countries, who have claimed that government action that makes the use of and strengthens market mechanisms will deliver better.[9] As nations and global institutions recover from the pandemic and the call goes out to build back better, this old debate gains fresh life. This paper draws extensively from HPSR that this author had been part of, and also on his experience in the implementation of health policies and systems innovations over the last two decades to explore the emerging priorities in health systems and policy studies.

Foundational Principles for Organizing Health Services: Health Rights and Health Markets

After the Second World War, a global consensus emerged that called for health and health care to be perceived as a basic fundamental right and considered it as an obligation of the state to deliver this. This is captured in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the Declaration of Health for All, adopted at Alma Ata in 1978.[10] It was also captured in the reports of a number of national commission reports set up to guide each nation's postwar future. Among the most well-known of these is the Beveridge Commission Report in the UK which set up UK's post-war public services and as part of that the National Health Services[11] and in India, at about the same time, the Bhore committee report.[12] All of these make what are essentially two ethical propositions. First is that the enjoyment of the highest attainable level of health care is a human right. And second, (as so well put by the Bhore committee report in the very first line of its preamble), "no person shall be denied an adequate quality of health care merely because of his or her inability to pay for it." Clearly, therefore this called for state (government) action, but the architecture of health systems that could deliver it is now a matter of contestation.

Market failure in health care

One reason for the acceptance of health rights was that close to one-third of the world was under socialist governments who were committed to the public provision of health services. But curiously, at the same time, even free-market economies of the industrialized West came to accept that health care was an area of market failure and to declare the role and obligations of government to assure, if not directly provide, health care.[13]

The rise of Keynesian economics was a central reason for this understanding. The arguments were well set out in 1963, in one of the most influential papers on health care ever written, a paper that has been called the foundational paper of modern health economics, namely Kenneth Arrows " Uncertainty and the Welfare Economics of Medical Care."[14] This paper argued that all of health and health care is an area of market imperfections and failure, and even insurance as known till then fails to address it, and it therefore calls for new social institutions to ensure better health-care delivery. If public health is interpreted to mean societal level preventive and promotive measures which are non-excludable and non-rivalrous (such as vector control, or prevention of food adulteration, or pollution control) then, from the time of Adam Simth and the rise of classical economics, these are well accepted as areas of market failure requiring government intervention. But where this paper broke fresh ground was that it argued for market failure even in all of personal health care (viz. clinical care), a service that cannot be characterized as nonexcludable or nonrivalrous.

Arrow's paper posits four major reasons for market failure – much of it built around uncertainty that prevents informed rational consumer choice. First, demand is uncertain – one does not know when one is going to fall sick and need care. Second, outcomes are uncertain, and cure is not guaranteed. Even providers cannot be sure of outcomes. Third, there is what is called a high degree of information asymmetry – the patient does not know what is the correct treatment required but has to trust the provider to make the correct choice. But unlike most other commodities on the market, the self-interest of the buyer and the seller is not aligned by the market, and therefore does not lead to optimal choices in terms of health outcomes. Finally, professional power plays out differently, and entry into profession, professional status, terms of professional practice, all lead to high levels of professional control. Under such conditions for trust to exist, the clinical or public health decision, must be ring fenced from any monetary or other personal incentives.[14]

One derivative of this is that the worst possible organization of care is for a fee for service to be paid at the point of care – where sickness compounds the already existing powerlessness of the

patient. To avoid this, some form of third party is required to negotiate and make the purchase and payment on behalf of the service user. This is so central to understanding health systems that the health systems of all countries are best categorized and characterized on the basis of how this objective is addressed. One of the best examples of such organization of services in the developed world was the National Health Services of the UK which created "an extra-ordinary and unprecedented economy more or less independent of the surrounding market-place, in which healthcare, previously a highly valued commodity, was suddenly made available to everyone at zero price."[15]

In low- and middle-income nations, newly independent governments were promising health rights as their objective and expanding government-provided health care to meet the aspirations that the process of decolonization had created in the people. The private sector grew in parallel with little regulation, but public health institutions reflected this intention and addressed the problems of inequity in access to health care. Public services were free to the user and were to be provided by salaried staff employed by the government. The architecture was that the basic necessities of life like housing, schooling for children, essential supplies, and job security were all provided to the government provider, who in return for being freed of material worries could focus on public service. Private sector employment could yield higher incomes, but public service and the spirit of contributing to nation building informed public sector employment.

The need for reform

But because of high levels of underdevelopment, poverty, and internal strife, all of which were the legacy of decades of colonial rule, few nations could make the financial commitment required or remain true to their initial commitments to universalizing health care. Beyond investment, there were also a number of barriers that public health services faced with respect to good performance which related to a wide range of problems, of which poor accountability and corruption was one. There were issues such as the challenge of retaining skilled workers in public services, choice of technologies, problems with responsiveness and quality of care, to name a few.[16]

The National Rural Health Mission and Health Systems Research

By the 1990s, the deficiencies of public health services were well recognized, but most efforts at addressing these were in the changed ideological climate informed by market-based solutions. There were relatively few studies;much less theorization of how these gaps could be addressed through non-market-based solutions.

One major exception to this was the experience of the National Rural Health Mission (NRHM) in the 11th 5-year plan period (2007–2012). The NRHM blueprint stated that while increasing investment was the key, there had to be a simultaneous set of design corrections and accountability measures. These called for five sets of reforms – decentralization, increasing community ownership and participation, innovations in human resource management, flexible financing, and professionalization of management.

This period also saw a rapid expansion in schools of public health and health systems research in India. Publications on health systems according to one systematic review rose from 92 in 2006 to 314 in 2012. Most of these were descriptive and covered topics like service delivery (40%). Other topics covered were information (16%), medical technology and vaccines (15%), human resources (11%), governance (5%), and financing (8%). One feature that this review notes is the skewed development of health systems research – with most articles relating to only 5 states, close to 30% of the studies would be by foreign authors.[17]

One important development in this period was the establishment of the National Health Systems Resource Center (NHSRC) as a government-financed autonomous institution that provided evidence and ideas for what was called architectural corrections of the existing public health systems. This itself was set up on the basis of the earlier experience with the State Health Resource Center in Raipur, which had been set up to lead health sector reforms in that newly created state of Chhattisgarh. One important governance decision of NHSRC was to keep this institution independent of external aid funding, so that it was under less pressure to subscribe to market-based solutions and could prioritize questions and frameworks which were responsive to the needs and vision of the NRHM. One major area where health systems studies were used to systematically improve public health functioning was in community engagement and in human resources for health. Examples of such studies that were published include a number of papers on community health workers[18,19] strategies for better retention of skilled workforce in rural and remote areas,[20,21] on choice of providers in primary health care[22] and overviews of the issue of human resources for health in India.[23] Much of the work associated with NHSRC was done within the framework of health rights and the conceptualization of all health care as public goods. Such a framework recognizes the difference between the relationship of the factory worker with the factory output and the different health-care providers with the community or even individual patients they serve. There are requirements for high levels of solidarity and trust that characterize the latter relationship, which are not features of commodity production. One paper that explored this dimension with such a perspective was "Location and vocation: why some government doctors stay on in rural Chhattisgarh, India,"[21] but this is a theme that needs to be explored much further if one has to understand how to address some of the challenging workforce management issues of public services.

The other major areas where health systems research contributed to the relative success of the NRHM, were in its ability to build learning systems that led to a constant stream of innovation, learning from best practices and failures to find

creative ways to overcome barriers instead of being limited in imagination to mere enforcement of the rules and guidelines. The rise of knowledge management strategies[24] of the development of public health informatics[25] and organizational innovation that could search for nonmarket solutions to strengthen health care as a public service are documented in some publications.[26,27] However, these are areas where the need for further studies is immense.

Many of the key efforts at reform under NRHM, like decentralization, weakened with time, or were incompletely implemented. One important reason was that <50% of the envisaged investment came through in the 11th plan period and subsequently investments plateaued. But despite these constraints, much of the reforms initiated in the first 7 years of the Mission played a major role in a revitalization of health care and led to increase access and equity in health care.[28] Moreover, it did demonstrate that one could think of health systems strengthening without taking recourse to market-based reforms.

Health Sector Reform-Introducing Market Mechanisms into Health Care

By the late eighties, the entire discourse on public health services changed. Partly due to the undermining of the socialist challenge, and partly in response to the problems in addressing the problems of public service delivery, but largely driven by the new economic and social philosophy of neoliberalism, public services were seen as inherently designed to fail. The proposed solution in the new paradigm, was to make the public sector behave more like the private sector by introducing market incentives, and in addition limit public services to a narrow package of essential services, thus allowing the private sector to grow and dominate both professional education and health-care delivery.[29,30] Only public health, defined as nonpersonal health care, was to be with government.

This new theoretical and academic discourse initiated and legitimized promarket changes of health policy. Changes in economic policy, referred to as structural adjustment programs, were introduced as conditionality of receiving loans from World Bank and IMF and bilateral aid from the overseas development agencies of the Western nations. In the health sector, these policy changes were termed health sector reforms. The first wave of reforms took place in the nineties, and was focused on privatization of health-care services. In developing nations like India, it took the form of limiting the role of government's primary health-care services to a very selective range of health conditions and leaving the rest to markets. In hospital care, further public investment in infrastructure and human resources ceased. Public hospitals focused now on treating only those who could not afford private services or who had diseases that private sector shunned. To make government services more like private, user fees were introduced. To expand the number of private hospitals, foreign direct investment (FDI) was allowed into health care, now perceived as health-care industry.[13,31]

It is not only in policy circles that a discourse changes, but also it is the public discourse. Statements like "people will not value what is provided free" (to justify user fees) and "whether a government servant works or does not work, he will get his pay-so why will they work" against salaried employment, or "our colleagues in the private sector earn lakhs per week, why should we continue in public service" became widespread. It is a whole value system that changes and is reflected in the changed public discourse. These changes have been poorly studied and documented.

The immediate outcome of health sector reform of the nineties, was not an increase in range and quantity and quality of services provided but a sharp increase in costs of care leading to impoverishment and exclusions of many sections from any health care. With weakened public health systems, national health programs also failed to reach their public health objectives.[32] It was clear that government intervention was actively required. Since ideologically public provisioning was seen as undesirable, the market-based reforms encouraged different forms of government purchasing health care from private providers on behalf of public health objectives.

The Second Wave of Health Sector Reforms

Market-based health sector reforms in the first decade of the 21st century, largely took two forms – one was the introduction of state-wide government-funded health insurance (GFHI) programs that provided insurance cover for the poor, and the other was different forms of contracting private providers to provide public services.

All GFHIs in India, empanelled both public and private hospitals and promised cashless hospitalization services against the payment of a premium. The government largely or entirely paid this premium. By design, outpatient services were excluded. Initially, this program was initiated and managed by state governments, but more recently, they have been incorporated into the centralized Pradhan Mantri Jan Arogya Yojana.

There were great expectations of the program and this in turn attracted a large number of health systems studies. Many studies have however raised questions about the effectiveness of GFHIs in either increasing access to necessary health care or in financial protection against the costs of care. A detailed study on out-of-pocket expenditure on hospitalization using the National Sample Survey 71st round data, failed to show any benefits with GFHI coverage,[33] and now, a large number of similar studies and reports have validated our contention.[34,35]

Contracting of services, often referred to as public–private partnerships, or outsourcing of services, was the other big reform measure of this period. Contracting was expected to increase effectiveness, efficiency, and quality of care by making expected outcomes explicit and measurable, by basing payments linked to such measurable outputs, and by ability to link it to performance-based incentives. In the

absence of market forces, performance-based incentives built into contracts were to provide the stimulus. Such contracting did work, but it largely did so in nonclinical domains – infrastructure, security, sanitation, and diet services. It worked to some extent in ancillary services – ambulances, diagnostics, and imaging services – and has largely failed to work in clinical care – for reasons that hark back to Kenneth Arrow's paper.[16,36]

The poor performance of government purchasing care through insurance or contracting, did not lead to reversal of strategy. Rather given the power of the discourse in favor of market-based reforms, these failures were attributed to inadequate management skills and the need for improving contracting designs. In this set of reforms, the emphasis was on purchaser–provider separation, and what is termed strategic purchasing.Most states failed to establish any successful public–private partnerships (PPP), based on these principles. The Niti Aayog,interpreting this as reflecting the inability to design better contracts, set itself the task of creating and circulating model contracts that states could use to contract out their services.But such PPPs have still not happened.

In parallel to shift of government efforts to purchasing care through government-funded insurance and contracting services, investment in strengthening public health services has stagnated. This was a matter of deep concern, and in one comment, the government had been cautioned that the "chronic and sustained under-financing of public health systems over the last four years has now reached such critical levels, that there is a serious threat to health security of the nation as well as to its economic growth—not only in the long run, but also in the immediate—not only for the poor, but for everyone".[28]

Lessons from COVID-19 Pandemic

It was in such a health systems context that the pandemic struck. The experience with the pandemic brought home the lesson that epidemic preparedness had to rest largely on the public sector.[7] Despite all the limitations of the public sector, almost all of the testing and treatment was done in the public health-care facility. However, public health systems were ill equipped to deal with it. The fact that primary health-care systems were weak and understaffed meant that a lot of essential public health activity-home visits for health communication, testing, contact tracing, and support to home quarantine and isolation never took place.[7] The lack of surge capacity in the public hospitals meant that the load overwhelmed them very quickly and many public hospitals had to stop all other health services to accommodate this demand. Moreover, since for 40% of the population and most of them from the poorer sections, the public hospital is the only space for not only tertiary care but also comprehensive primary health care, it did mean an exclusion from services of the poor. Programs such as tuberculosis and HIV have suffered major setbacks. But despite this, the majority of care was from the public provider.[37]

The role of the large, carefully cultivated private sector was very limited and belied the expectations that these would be the main source of health care. In the first 2 months, many private hospitals just closed practice out of fear.[38] In the next 2 or 3 months, they opened up but remained reluctant to see COVID cases, though by now, it was covered by government-funded insurance. Then, when some of them started COVID care, there were widespread reports of high charges, and lack of commitment to the cashless care under the health insurance – then, there was cherry picking of cases widely reported with treatment being offered to those with less risk and more paying capacity.[39,40] As a rule, the private sector beds could not be contracted in, though there are some few positive examples in this area. Then, when vaccination arrived, private hospitals had 25% of vaccination reserved for delivery through them, but even with active support from the government, the empaneled hospitals could deliver only 7%–10% of the vaccines.

World over, the pandemic response rested largely on the government for both financing and the provision of care. But even in access to medicines, the problems of corporate domination over innovation, manufacturing, and supply chains became apparent. As early as April 2020, the UN Secretary General and the WHO Director General had committed to making COVID-19 vaccines available as global public goods and ensuring vaccine equity. India and South Africa supported by most low- and middle-income countries (LMICs) have moved a resolution in the World Trade Organization to suspend all trade-related intellectual property rights and support the domestic manufacture of essential medicines. However, the industrialized world has defended these rights and proposed an alternative market-based mechanism called COVAX funded by the rich nations that would enable universal vaccine access. As it turns out, this mechanism has largely failed and we now have a situation where the richest nations have three to five times the vaccines they need and are nearing universal vaccination, whereas Africa has <3% coverage and much of Asia <10%.[41,42]

Which Way to go? Market-Based Reforms or Global Public Goods

In the aftermath of the pandemic, health systems would have to be reassessed and rebuilt. There is clearly a need to rethink health sector reform. The call to reaffirm the importance of UHC or a slogan like "UHC, now more than ever" does not reply to the core health policy question of our time: whether we should persist with market-based reforms, or whether we should search for an alternative paradigm.

There is little evidence that market-based reforms are working. Yet, such is the power of ideology and public discourse in combination with corporate interest, that despite the lessons of the pandemic, the thrust of health sector reforms continues to be developing health care as a high-return profitable private industry that contributes to economic growth rate, rather than

as a public service that contributes to better health outcomes as a human right. The current thrust to privatization has also a lot to do with the weakening of democratic institutions and the voicing of people's interest. One new solution proposed to address current reform failures is to move from insurance to government-funded corporate-owned "managed care" models, where health maintenance organizations (HMOs) are contracted by government to provide services for an entire block or district. These contracts could cover primary and secondary and tertiary care in a given region, and the HMO would be supported to contract in all providers in this area to provide the service. This is projected as a solution that addresses the problem of weak primary health care and what is called the fragmentation of providers into many different categories and types of payment and risk pooling.

Since few Indian companies could take on this task at such scales, more FDI could be welcome. The Niti Aayog held a major meeting on March 31, 2021, even as the second wave of COVID-19 was rising, to announce a scheme to welcome FDI into the health-care industry in India, promising higher profits and more PPPs in district hospitals and medical colleges.[43] Another parallel development, again stewarded by the Niti Aayog, is the National Digital Health Mission and the National Data Management Policy.[44] These would develop health informatics on terms where health services could easily be integrated into international digital architecture. These policy developments should be interpreted together with two economic developments- the rise of the corporate sector in health care and the entry of high levels of venture capital into Indian health-care industry. In such a context these policy developments could signify a push to integrate Indian health sector into the global market for health services. However, there are new dangers with such a development. Many nations are persuaded or coerced into signing bilateral or plurilateral trade treaties, which have a clause, protecting FDI from what it calls "unfair competition." Government-run hospitals can get characterized as such. Going by the experience of other nations, we know that such treaties could make it mandatory for international arbitrators and not our courts to settle the dispute, and they are known to do so in a completely nontransparent manner. These may sound bizarre but are true and are consistent with historical accounts of how neoliberal thought designs international institutions. These global financial institutions would protect international markets in health care and private capital against the demands of democracy and human rights by being able to strike down national regulations and even legislations that come in the way of global profits.[45,46]

An Indian Agenda for Health Policy and Systems Studies

It is important for the public health community to first recognize the highly political nature of health sector reforms and alert policymakers and public to the dangers of an uncritical integration into global health markets or an equally uncritical absorption of the dominant international policy discourse that promotes market-based health sector reforms. It is not only to document the reality around market-based reforms that we need a new generation of Indian health systems and policy studies. There is also a need for considerable scholarship and studies and innovation and creative design that can lead to effective health systems strengthening built around the principle that the entire health system must be organized as a global public good.

Global public good must not be narrowly defined to include only those public health measures, which can be categorized as nonexcludable or nonrivalrous, or having high externalities. The definition must be expanded to include even the organization of all health services including the delivery of personal curative health services, on the grounds that these are also areas of market failure and that one cannot separate the curative care from the preventive and promotive aspects. Health-care services have to be organized around principles of equity, solidarity, and health rights and decision-making at the individual level or at the policy level requires to be protected from commercial interests. There is a small body of health policy and systems studies that builds on this understanding, but much more needs to be done.

The COVID pandemic has been like a stress test on all health systems and has amplified and punished weaknesses in the system wherever they are. Many countries that were rated high in the global health security index have not performed well in containing the pandemic. On the other hand, many countries including some LMICs with modest ranks on the index have done remarkably well. Systems studies that can explain these variations in preparedness and response are ongoing and more can be expected. Preliminary studies and commentaries indicate that once again, the crisis has emphasized market failures in even curative health care and the public goods character of all health services and even of health technologies. However, there is simply far too little academic work and theorization that can document this private sector failure even where it was under contract or explain public providers rising to the occasion despite worsening conditions of employment. Good health systems research on pandemic response and systems resilience can use the COVID-19 experiences to guide health systems strengthening in developing countries. It is likely that studies will indicate that "building back better" requires to be based on rethinking the direction of health sector reform away from market-based solutions to measures based on solidarity, trust, and human rights.

But for this to happen the capacity and motivation to undertake robust well designed, health systems and health policy studies must increase considerably. And further, these studies must engage critically with the ongoing reforms and the theories and politics that support these reforms. This presentation is also therefore a call to expand and develop a framework of health systems and policy studies that are more appropriate to the achievement of universal health care, health equity, and health rights in the Indian context.

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