From

The Alma Ata Declaration
to

Universal Health Coverage

Decoding the Changing Discourse on Health for all
Primers on Health Policy - 1

From Alma Ata to Universal Health Coverage
Decoding the Changing Discourse on Health for All

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Section I

The Alma Ata Declaration: and the political, institutional and intellectual context that made it possible
The Alma Ata Declaration: Reflections on its 40th anniversary

Almost to the day, 40 years ago, in an international conference held in Alma-Ata, from 6th to 12th September of 1978, 131 countries of the world adopted what is called the Declaration of Alma Ata. (full text in annexure- 1)

This was a remarkable declaration in many ways, for it set out a few principles that has influenced all thinking on health policy ever since. This was not the first time these principles were articulated. Nevertheless, the articulation of these principles in the Alma Ata Declaration is the most well known in the history of public health and it is a reference point for all health policies from then onwards.

The first and the most important of these principles was declaring health “a fundamental human right”. The International Covenant on Social, Economic and Cultural Rights (ICSECR), - a binding international treaty signed by 164 nations - which came into force on 1976 had already adopted this principle. The Alma Ata conference, and its inspiring declaration of “Health for All by 2000 AD,” served to give this principle widespread publicity and acceptance amongst nations and peoples all over the world.

A second major principle that the Alma Ata Declaration articulated is that “inequality in the health status of peoples between nations and within nations as unacceptable.”

A third key principle that the declaration articulated is that the social and economic path chosen by a nation had direct implications for health outcomes and its converse - that better health outcomes would contribute to better social and economic development.

A fourth key principle of the declaration was to become the basis for concepts of community health; which is that people have a right
and a duty to participate, individually and collectively in planning and implementation of health-care. Inherent in this principle is the acknowledgement that people are not mere consumers of healthcare – but should be viewed as co-producers. This principle, which, was stated quite emphatically in the preamble of the Bhore committee (see annexure 2), is altogether missing in the discourse on universal health coverage today.

The declaration’s fifth key principle is regarding the responsibility of the government to ensure the achievement of both health rights and health equity as a part of ensuring social justice.

The sixth key principle of the declaration is Primary Health Care as the key strategy to achieve health for all. Over time, the meaning of this term “primary health care” has gotten so mixed up, that its meaning is worth reiterating.

There are a few important differences between how both health and healthcare are perceived in the Health for All agenda, and in the UHC discourse.

One significant difference between the two is that the Alma Ata declaration is also about all the determinants of health, whereas the UHC discourse is largely about access to curative health-care services.

**6 principles:**

- Is a fundamental right
- Inequality is unacceptable
- Requires community as co-producer - not as passive consumers
- Primary Health Care is the key strategy
- Is essential for Development and Development for health
- Is Government’s responsibility
The articulation of rights and duties is also quite missing in the UHC discourse. The UHC discourse is consistent with the perception that health is a commodity that can be primarily purchased by governments from the market. In the Alma Ata declaration, the emphasis is on how the services are organized, and not on how it is financed.

<table>
<thead>
<tr>
<th>What Primary Health Care is NOT:</th>
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<tbody>
<tr>
<td>✗ It does NOT imply first contact care - which implies care for simple common illnesses and symptomatic care and referral for rest. But it includes this first contact care.</td>
</tr>
<tr>
<td>✗ It is NOT limited to Reproductive Health and National Health programs, though it includes this also.</td>
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<tr>
<td>✗ It is NOT to be confused with primary level care, in terms of Primary Care, Secondary Care and Tertiary Care. The opposite of primary health care is hospital-centric healthcare.</td>
</tr>
<tr>
<td>✗ It is NOT about healthcare for the poor or for developing nations, since they cannot afford costly healthcare. It is the best approaches to care for everyone, and developed nations with the best health outcomes have very good primary health care.</td>
</tr>
<tr>
<td>✗ It is NOT about low-tech care provided only by community health workers and other para-medicals. It needs teams of well trained personnel and includes specialist consultation as required.</td>
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For more on this, please read:


<table>
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<th>So, what is Primary Health Care?:</th>
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<tr>
<td>✗ Is comprehensive care that includes preventive, promotive, curative and rehabilitative aspects of health care for over 95%</td>
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From Alma Ata Declaration
of all illnesses, and it is not confined to some priority diseases alone.

- Is carried out in close proximity and direct relationship with the community. It shifts entry point to healthcare from hospitals and specialists to close-to-client generalist primary-care centers.

- Strengthens the role of the primary health-care team as coordinators of the inputs derived from other levels of care. It creates a network, usually synonymous with the entire district health system, where primary-care teams coordinate with specialist teams to ensure continuity of care.

- Gives primary-health care providers the responsibility for the health of a defined population: both in terms of access to care and in terms of health outcomes; also in terms of responsibility to aid the sick and to prevent disease in the healthy; to help those who choose to consult the services and reach out to those who choose not to do so.

- It is well integrated with public services that ensure nutrition, safe drinking water and sanitation, better living and working conditions, access to education - including health education - and safer, cleaner environments.
1. **The Context of the Declaration:** What made it possible to have such a historic declaration?

1.1. **The Political Context of the Sixties and Seventies:**

- **Socialism**

  In the 1970s, one third of the nations in the world were committed to socialism. Socialist ideology promoted health as a fundamental right, and it required governments to provide healthcare to all.

- **Social democracy**

  In a large part of the developed world, social democratic governments ruled. Social democracy believed that health and healthcare were part of the public services that governments had to ensure for its people. Over 90% of healthcare expenditure would be through public expenditure, additionally most of the providers would be public providers. Post World War II, there was rapid economic growth in most of these nations, and these governments had the money to put these public healthcare policies into practice.

  During that period, even non-socialist states invested in public healthcare. Part of their readiness was to ensure that their workers were not too attracted by socialism. With that danger decreasing, the readiness to invest in population health also decreases.

- **Decolonization**

  These were also the years of decolonization. The promise of free health care and better health was part of the mobilization for independence. Most nations becoming independent had promised free health care to its citizens.

1.2. **The Institutional Context of the Seventies:**

- **More representative UN bodies**
The World Health Organization was the leading global health institution and it led the global agenda setting for health. It was a representative organization, and most of its funds were from a cess that was made up of contributions from member nations. Countries contributed to the cess in proportion to their GDP. Other multilateral and bilateral agencies had relatively limited role.

Since most of the nations were socialist, social democratic or newly de-colonized nations, they had an influence on the thinking at WHO, even though western nations dominated these agencies. China became a member of the United Nations and WHO in 1973 and the prestige of socialist nations as leaders in public health was high.

Under the leadership of UNESCO, an International Covenant on Social, Economic and Cultural Rights was adopted in 1966 and it was implemented from 1976. This international treaty had declared health, food, education as fundamental rights. The USA was also a signatory to the treaty, though it never ratified the treaty.

In 1975, the WHO adopted essential medicines list, another major step forward towards health equity.

1.3. The Intellectual Context/ Discourse of the seventies:

Within capitalist nations and in mainstream economics, the understanding is that production and distribution of most goods and services are best left to markets. However, in this period, even within this framework, a consensus arose that health and healthcare should NOT be left to markets. Influential writings of economists of that period - John Keynes, Kenneth Arrow, JK Galbraith - contributed to this understanding.

In an influential paper published in 1963, the economist Kenneth Arrow argues that healthcare is unlike other goods and services and Markets will fail to work because:
   a. both provider and consumer are completely uncertain of the outcomes of the service purchased.
b. the consumer will never have the information required to make a proper choice of what he/she is purchasing. This was termed ‘information asymmetry’.

c. At the time of healthcare need, the purchaser is most vulnerable and cannot be negotiating prices or exercising choice.

d. The consumer has to delegate decision making to the provider, and the choice of the provider may often go against his or her own monetary interest.

These economists see it as essential that new social institutions develop, which ensure that those who need healthcare can obtain it. In some nations, the governments provide healthcare, and in others it was a combination of regulation and insurance mechanisms.

In the socialist nations, which were at the peak of their influence, health and healthcare was a right. Provision of healthcare was a
government responsibility. The production of health services was not computed in terms of money it earned, but health outcomes that they resulted. They believed that what care is provided should depend only on the need, and not on what profit it earned.

Learning from socialist nations, and from examples like the National Health Services of UK, other developing nations built public health systems where the employees were provided with a reasonable standard of living - through salaries, housing, education for children, pension etc - and in return, the employees provided healthcare service without charging patients anything. Doctors and nurses joined government health systems since they were interested in public services. The rest could go work in the private sector. However, both due to financial constraints and due to political will the size of the public sector was limited.

There was also considerable evidence from the action of non-government agencies world-wide and from socialist nations like China, that even where there were not enough doctors, community health workers and other para-medicals could ensure effective care at costs that were quite affordable, even in developing nations.

What do we mean by Discourse?

Discourse refers to the way conversation is organized around a particular theme. For carrying out these conversations, there are implicit frameworks of analysis based on some theories and ideologies. There are implicit sets of rules which highlights certain features and concerns and underplays, or is silent, about others. It highlights and quotes certain authors and sources, and ignores others. The same words could take on different meanings within different discourses. If one is not conscious of these, a particular discourse would appear as the only way of discussing the issue. Whereas, in reality the particular discourse would only be one of the many ways in which the theme could be discussed.

In this book, we consider Universal Health Coverage, Structural Adjustment and the Alma Ata Declaration as constituting three separate discourses. All of which are concerned with the same theme of making quality health and healthcare accessible and affordable to all.
Market do not work for health: Therefore...

Governments should intervene to make markets work for health

Markets should not be allowed into health care - the treatment I choose to give or not- should make no difference to what I earn

By Mainstream Health Economists

By Political Economists

‘Health care requires an entirely different body of economic theory, only the outlines of which are beginning to become clear, to which health economists have as yet contributed little. Progress and productivity in this field depend on new social relationships between public, patients and health professionals, based on levels of trust unattainable within commercial transactions’

- By Julian Tudor Hart

The influence of Alma Ata declaration on national health policies was mixed. Many developing nations did make considerable progress in the 1980s, but only a few persisted into the nineties. By 1985, the discourse had begun changing, and by 1995 it was so muted that it was almost inaudible. However, the Alma Ata declaration remained a beacon, both for practitioners of public health and within the emerging discipline of public health and health systems studies. Its influence over health activists in civil society never waned and as a result its influence on policy remains significant, even in these days of Universal Health Coverage. It will remain a rallying call.

Primary Health Care in India: distortions and slow progress!!

In its policy pronouncements, India has always been a votary of the primary health care approach. Much before Alma Ata
Declaration, India’s visionary Bhore Committee Report (1946) was adopted at almost the same time as the Beveridge Committee Report in the United Kingdom (1942). The latter led to the creation of the National Health Services - a primary health care centered, universal health care approach, which is a model for the world, whereas the Bhore Committee Report largely remained on paper.

One important reason for not implementing the Bhore Committee Report was because India was a much poorer nation. But, the bigger reason was that the family planning program and the National Malaria Control program hijacked the whole agenda of health systems development that the Bhore Committee had proposed. While public hospitals and medical colleges did develop in this period, the expansion of primary health centers and district hospitals was very limited. Whatever health facilities were created in the sub-district levels was engaged obsessively with just these two activities of family planning and malaria control. The rest remained on paper.

This obsession with family planning was part of a political agenda. “Population explosion” provided a great explanation for India’s poverty, drawing attention away from the damages wrought by colonization and the exploitative social order, and the inequity generating economic policies of that period. The discourse around population control had so convinced the policy makers, medical professionals and public health leadership, that it led to major distortions and weakening of primary health care systems, while failing to meet the fertility control objectives.
The logic of the market place.

Hurry up with my lunch, I have a woman whose labour pain has started. I have to rush back...

Why – is the case very complicated, do you have to operate?

Of course I have to operate – but if I am not back soon – she will have a normal delivery.
This degradation of the population control agenda reached its peak during the ‘Emergency,’ when the highly repressive and anti-people, compulsory sterilization was introduced. This program had to be abandoned when the emergency period came to an end in 1977, and democracy was restored. The coercive family planning program was to a large measure responsible for the fall of the Emergency.

In the dominant discourse of those years, unchecked birth rates and large family size was due to the poor and illiterate being too ignorant and too irresponsible to adopt contraception. This was bad for the family and for the nation. Only high levels of persuasion and coercion could get families to adopt more and better contraception.

The poor will not listen— they just go on breeding. We have to punish them if they have more than two children.

What nonsense! Once we knew our children have better chance of survival, once we were able to plan how many children to have and when, once bearing a son was not a social compulsion, once we could save for our old age.. we never chose to have large families.

And anyway sir - why talk of penalties- do you not know that most states have achieved population stabilization and others are following...
This understanding is discredited now. Internationally, the Global Conference on Population held in Cairo in 1995 and the National Population Policy of 2000 have officially announced so. We now know that once families understand that the baby born to them has a greater chance of survival, and women are educated and empowered to plan how many children they want and when they will have them, then the family size decreases. It is increasing women’s education, and more gender equality and better access to contraception that is critical. Development is the best contraceptive!! Now, most states have achieved population stabilization and the few large states are also fast approaching it.

But a discourse does not go away at once, and perhaps it never completely dies. Even after the change in policy, for many years the two-child norm was being enforced in most states. This meant imposing penalties on families, usually women for having more than two children. Even as recently as June 2018, 135 MPs have signed a petition for bringing back the two-child norm.

Hurrah... the emergency is over, we have signed an international treaty that guarantees health as a right, we have signed the Alma Ata declaration, and now we have a national health policy 1983!

So you think... I am not done yet !!!
Thus, in 1978, when Alma Ata declaration was being signed, there was already a strong move towards a democratic and more comprehensive rural health-care due to the political upheaval in India. India signed the International Covenant on Social, Economic and Cultural Rights in 1979.

In 1983, the government of India adopted its first National Health Policy. In the same year, under the Minimum Needs program it began expanding primary health care infrastructure in many states. However, this phase did not last long.

Why was the agenda of Alma Ata declaration, which India had so readily signed, and even that of the National Health Policy of 1983, not taken forward? To answer that, we need to look at the changes that took place in the next decade.
Section- II:

Health Sector Reform

Global Health Policy under Structural Adjustment:


In the nineties, thinking about health systems began to change. The World Bank’s Report in 1993, titled Investing in Health is a clear expression of the prescription that developing nations had to follow. To understand not only the prescription, but also the compulsion on governments to follow it, one needs to understanding the politics of that time.

In the eighties, the Indian government had taken a number of large loans from the International Monetary Funds, and was finding it difficult to pay it back. The World Bank and IMF were willing to re-structure these loans and give fresh loans, and allow external aid to flow only if the government made major changes to its economic and social policies. This was called structural adjustment. Most of these policies pertained to financial flows, trade and industry. They called for a free flow of foreign investment into this country, and less controls on what they would invest in and what they could take out as profits. It also called for the free flow of goods manufactured outside to enter the country, even though it was often at the cost of local producers. These policies are referred to as “globalization”.

Here loans for growth-development.

Have to pay back these loans- so you have to put up with austerity measures.
This policy suited the rich in western nations. Owners of financial capital had accumulated large wealth, which needed more avenues for investment. Therefore, opening up new markets was essential to them. The rich and a part of the middle class in developing nations were also happy with this change. They could now access many attractive goods from abroad, and there were new business opportunities. But

![Diagram of economic activity distribution, 1989](image)

**Distribution of economic activity, 1989**
- **Percentage of world total**
  - GNP: 82.7
  - World trade: 81.2
  - Commercial lending: 94.6
  - Domestic savings: 80.6
  - Domestic investment: 80.5

**Quintiles of population ranked by income**
- Richest fifth
- Each horizontal band represents an equal fifth of the world’s people

- Poorest fifth
- GNP: 1.4
- World trade: 1.0
- Commercial lending: 0.2
- Domestic savings: 1.0
- Domestic investment: 1.3

**Year 1989**

Year 1989 jobs for the majority did not increase, and certainly inequality increased very sharply.

With respect to public services, the recommendations were to cut back all employment in the government and limit government expenditure in public services, while allowing private sector to grow and profit from delivery of these services. The immediate effect on healthcare and other public services was a pressure to privatize them.

The other big change was the collapse of “socialism as was being practiced”. There were many internal and external
reasons for this. The lack of internal democracy was one major reason. Whatever the reasons, with this collapse, one major pressure on western societies to redress inequality and for governments to provide basic services for the poorest sections had also collapsed.

Privatization of public services were pushed under the regime of Ronald Reagan in the USA and Margaret Thatcher in the UK, and there were such pressures even in social democracies. So, when the World Bank and the IMF pushed its LPG (liberalization, privatization, globalization) policies on the developing world, the international institutions lacked the balancing voices of the socialist camp. It was now a unipolar world and the character of international institutions had changed. Most third world countries had to give in to the pressure.

3. The Institutional Context:

The World Health Organization ceased to be the guiding force in health policy. Till the 80s, most of the funds of the WHO came from the proportional contribution of its member nations into a cess fund. Angry with WHO’s leadership for essential medicines list and the Alma Ata declaration, the US froze its payment to WHO. Other rich nations too followed.
For its survival, the WHO became dependent on negotiated bilateral agreements with the rich nations. In the last decade, WHO was drawing a considerable part of its funds from private philanthropies of multinational firms like the Bill and Melinda Gates Foundation. Increasingly the role of WHO was limited to technical opinion on global public health issues and it was marginalized in its role of agenda setting at the global level and guidance for health systems strengthening at the national level.

In the nineties, the World Bank became the main agenda-setting global institution, though its capacity in health policy was limited. The World Bank has representatives from nations, but voting rights are proportional to GDP. Which means, the richer nations are in control. Its main function, like that of any bank, was to take deposits from rich nations and give loans to governments and private companies in poor nations, and earn interest from this. This is a safer way for rich nations to lend to poor nations. Also, it could be used to twist the arms of those who have taken loans to change their policies in favor of the private sector.

Well when I took a loan from another bank for my daughters wedding, But they did not get to decide who should be the groom. The bank should be happy with the interest- why do you lay down conditions to change our policies….
Other than the World Bank, the donor agencies of the US, UK and European Union also provided external aid for development. They had an agreement to coordinate their aid activities, which only meant that they all had to follow the prescriptions of the World Bank and the USAID.

In the last decade, there was a new development: the rise of Global Health Institutions. Most important of these were the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund against TB, AIDS and Malaria (GFATM) and the Global Alliance for Improved Nutrition (GAIN). These became grant-making institutions to developing nations, to private bodies and to international health institutions. Its board had not only the more wealthy nations in command, but also provided direct representation for multinationals.

Given these institutional transformations, the shift in health policy is not surprising. But, it is important to understand how this works.

- One approach is direct - conditions apply when aid or loans are given.
- The other is by winning over elite sections in civil society, academia and in governance through their financing, their prestige and a good amount of personalized favors.
- But, the most powerful of all is the way these institutions - by their command and influence over the generation and shaping of knowledge - can generate public discourse on health and health policy that paves the way and manufactures consent for even the most anti-people of health policies.
4. The Intellectual Context: Health Sector Reform Discourse

The mainstream of political and economic thought of this period was neo-liberal. This held that all that matters was higher and higher economic growth rates. It believes that with such growth rates, there would be reduction in poverty through a trickle-down effect, and this in turn would lead to reduction in malnutrition and ill health. Therefore, governments were/are not pressed to act on health.

In line with this thinking, the structural changes in the health sector was a decrease in public health expenditure and a decrease in government role as provider of health care. In the name of decentralization there was a reduction of centre and state accountability. There was also a call for privatization of public services and a re-organization of remaining public services along market principles and the privatization of public services or reorganization of existing services along market principles. Governments had to choose to deliver only a very selective package of services that are considered to be “essential” and leave the rest to the markets.

The World Bank put it thus:

“The three rationales for government intervention in the health sector are provision of public goods, reduction of poverty, and market failure corresponds roughly to three different kinds of services. First, the services classified as public goods, and some of those characterized by large externalities, constitute what is known as “public health.” Second, the inclusion of health care as
part of a strategy for combating poverty justifies public financing of “essential” clinical or individual services. These are highly cost-effective services that would greatly improve the health of the poor…. If government was to intervene it should do so in a limited way through technical strategies that were to be prioritized on a technical measurement called DALYs and shown to be cost effective on an index of dollar spent per DALY saved. Beyond these cost effective interventions which together form a very selective set of services, it is best left to the market - the role of the state would be to develop the markets for health products and health care services (World Bank, 1993, pg. 57-58).

One of the most important elements of the discourse in health policy was how the essential list of services was to be made. This list of essential clinical services was to be made on the basis of a technical measurement, which not only excluded the possibility of community participation in setting priorities, but there were almost no technical agencies within India who could do these measurements.

By virtue of the prestige that was imparted to this discourse by international institutions, it could persuade political and
administrative leaderships about this being the only “scientific” or “technically correct” path to follow. This scientific black-box creation was new, it was not a feature of the Alma Ata discourse, or of earlier discussions on health policy.

The second important component of this discourse was that necessarily public services were inefficient and of poor quality, and therefore would fail. This was because the workers and managers would get their salaries irrespective of whether they worked or not. They had no motivation to do more. According to this, private healthcare, driven by the profit motive, would always be more efficient, and of better quality. So, where public hospitals could not be closed down, they were to be made to behave more like private hospitals. User fees were introduced in public hospitals, with exemptions for the poor. Hospital boards were to be organized into autonomous bodies and required to raise funds and earn money. Introducing user fees was meant to ensure that public

<table>
<thead>
<tr>
<th>People do not value what they get free.</th>
<th>That is not what I mean. If the drugs are free- then people think they are not good.</th>
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<tbody>
<tr>
<td>Really- when your mother cooks for you- do you not value it.</td>
<td>But do you know most generic essential drugs are pretty cheap as compared to the costly overpriced and often useless drugs that get prescribed for money.</td>
</tr>
<tr>
<td>But can a healthcare transaction be like a parent looking after their child?</td>
<td>Can we organize services where caring is a relationship?</td>
</tr>
<tr>
<td>Its about caring – is it not. Caring is a relationship...</td>
<td>Oh yes- there are many successful examples that we can learn from- and we have to re-think health economics as a discipline.</td>
</tr>
</tbody>
</table>
providers would be more accountable, and people would value services more.

In the earlier discourse of the sixties price and payments were to be kept out of the health care relationship, whereas in the structural adjustment discourse it has become central to it. The value of healthcare depends not on how it is provided, but on how it is priced and paid for.

**Impact of the structural adjustment reforms >**

The impact of these reforms and the ideology that went with it were disastrous to public health systems in India:

a) In many states there were no new beds added to public hospitals and no new hospitals and health centers came up. For two decades private hospitals grew to cater to the needs of the middle classes and the rich in the cities; in the rural areas, it was largely unqualified providers who proliferated.

b) Medical and nursing education got privatized. Few government medical colleges or nursing schools were established. Concurrently, the private sector in medical and nursing education grew exponentially and from less than 5% of all such institutions in 1990 it became over 50% by 2005. But, this growth was highly uneven and was largely in the four southern and two western states. Further, these private colleges had such high fees that the resulting candidates were unsuited for public services.

c) All recruitment in public health systems decreased, more so in the most challenged northern states. Between 1993 and 2005, there were no recruitments, even to replace doctors and nurses who were retiring, or leaving practice. This not only meant a decrease in all services, but also that the vertical programs like TB control or care in pregnancy could not be delivered effectively. In some states like Uttar Pradesh and Bihar, the diminished staff numbers could not carry out much work beyond the pulse polio campaign. Even routine immunization rates were as low as 15%.

d) User fees drove the middle classes who were using public services into the private sector. This meant that the public pressure to ensure availability and quality of services in public sector decreased. The exemptions for the poor were very limited and the poorest lost access to any sort of service.
e) As public primary health care was oriented to serving less than 15% of health care needs even in the ‘better performing’ states, people seeking care were dissatisfied with the care they got. It was inappropriate care when given, but more often they were referred away.

f) Private primary care providers increased exponentially to meet the remaining needs. Anywhere from 30 to 50% of all such private care providers are unqualified because qualified doctors were either unavailable or unwilling to work in such rural and remote areas.

Whatever illness I come with, it is the same white or yellow or black pill that I get.

We provide only basic care- anything else go to district hospital or private doctor.

The impact of these reforms was least in Kerala and Tamilnadu, who in this period had no major externally aided health systems program. They were maximal in states where external aid, with conditions attached, was the major driver of health policy.

Does that mean that all of this is some form of foreign conspiracy? Not really. Foreign aid to India was less than 2% of what Indian governments themselves spent. It was even less than the money from Indian budgets that remained unspent at the end of each year. These policy changes were largely driven by Indian industry, and the influence they have over policy. Indian private sector was happy with the

Interesting Fact:
Most developing nations which have progress furthest towards universal health care- Cuba, Brazil, Thailand, Sri Lanka- did not, for varied reasons, implement structural adjustment policies, did not have World Bank aid- and maintained a strong commitment to Health for All.
reorganization of healthcare as another profit making industry. In the name of technical assistance, these external aid institutions could influence the policy process by promoting a discourse that would legitimize and facilitate such an anti-people policy change.

4. Resistance and Revival: A small but significant counter-trend.

In the first decade of the 21st century, there was some slowdown and re-thinking of these processes. One important reason could have been the emergence of peoples’ health movements, which was able to give voice to the degradations wrought by structural adjustment policies. It could deconstruct the health sector reform discourse and revive the Alma Ata declaration.

The First International Assembly of the Peoples Health Movement took place in Dhaka in December 2000, with representatives of political and social movements and non-governmental health organizations from over 90 nations. Preceding this, over 1500 health activists from all the states of India held the first National Health Assembly of India’s newly established Peoples Health Movement.

Their slogan was simple, “Governments of the world may have forgotten the Health for All by 2000 AD commitment, but we the people have not”.

The peoples’ movements were clear-on who was accountable for the betrayal of the Alma Ata declaration - governments of the powerful western nations and the international institutions they had set up, and national governments too.

Most importantly, they could trash the discourse of health sector reforms and structural adjustment and its pretensions, as was exemplified in a debate between the World Bank representative and
representatives of peoples movements in the International Peoples Health Assembly. This was also visible in the many publications of the various network organizations.

Another important development was a number of economists and planners emphasizing the needs for investing in health and education as a necessary condition for economic growth. Amartya Sen was one such figure, this development economist underscored the importance of this contribution. More controversially, and in a rather mixed manner, the Sachs Commission on Macroeconomics and Health also made that point. Health is important for economic development and public health systems would be required to deliver much of it. What marks these figures is that they are staying within the overall framework, that it is economic growth that matters most, but showing that population health and education is needed to achieve this growth.

There was also political resistance and some revival of democratic forces. In many nations, more conservative governments lost out to more center-left coalitions. Or, national governments required to offset growing disaffection by more popular and visible programs in the health sector. Nations like Brazil, Thailand, South Africa and others went through political processes that helped strengthen a right to health approach. Yet another reason was a sharp increase in growth rates in many developing nations, making it more possible for them to spend on health.

With and without the WHO, a number of international and national conferences were held on the theme of primary health care. An interest rose in studying health systems and primary health care. There was recognition that without strengthening public health systems, even the vertical programs and limited

“Development has to be primarily concerned with enhancing the lives we lead and the freedoms that we enjoy. And among the most important freedoms that we can have is the freedom from avoidable ill-health and from escapable mortality.” Amartya Sen, speech to WHO General Assembly, 1999
health packages would fail. There was also an understanding that the rise in private sector, consequent to structural adjustment had contributed little to health outcomes. This had however increased healthcare costs and exploitative practices of private health care.

In India, there was a change of government in 2004, a center-left coalition came to power on a mandate of making pro-poor policies. In this context, the National Rural Health Mission (NRHM) was launched. Though still limited to a large degree by the externally funded central vertical programs around reproductive and child health, TB, HIV etc, the NRHM did lead to a revival of the agenda of strengthening health systems and increasing community participation. Since the economic policies and ideology of the government was still largely neo-liberal, there was a tug of war within the policy makers as to whether the focus should be on strengthening public health providers or whether there should be a push for insurance and public private partnerships. The resulting document that defined NRHM was an uneasy compromise and this uneasy compromise is also reflected in other policy documents of this period - the 11th and 12th five year plan. In practice during the first five to six years since 2004, the emphasis was largely on strengthening public health delivery. But after 2009, the emphasis on insurance and PPPs began to increase. This was partly due to the weakened influence of the left and of peoples movements. It was also due to changes in the private healthcare sector and changing strategies of global health institutions. Above all it was due to the rise of a new discourse-Universal Health Coverage.

It took over 18 months to finalize the NRHM framework for implementation. The first draft of the NRHM, was more or less an adjunct to the externally funded RCH programme. Subsequent to a dialogue between members of the peoples health movements and the prime ministers office. This was revised. Nine task forces were set up - with involvement of academics and civil society and pointedly excluding the externally funded agencies. The recommendations from these task forces were woven into the NRHM framework - before it finally got cabinet approval.
Section III:

Universal Health Coverage:
The rise of a discourse:

The rise of the Universal Health Coverage discourse is astonishing. In 2005, there was a resolution in the World Health Assembly on universal coverage with a very limited scope. In 2008, in the World Health Report, “Primary Health Care- Now More than Ever: Universal Coverage” was a chapter following other chapters that detailed elaboration of primary health care. In 2010, The World Health Report, dealt exclusively with UHC. By 2012, Global support for universal health coverage had gathered momentum, and a number of international declarations – the Bangkok Statement on Universal Health Coverage (January 2012), the Mexico City Political Declaration (April 2012), and the Tunis Declaration (July 2012) all endorsed UHC. It culminated in a resolution adopted by United Nations on 12 December 2012 urging governments to move towards providing all people with access to affordable, quality healthcare services, through Universal Health Coverage.

In her 2012 reconfirmation speech as the WHO Director-General, Dr Margaret Chan asserted “universal coverage is the single most powerful concept that public health has to offer. It is our ticket to greater efficiency and better quality. It is our savior from the crushing weight of chronic non-communicable diseases that now engulf the globe.” .... Wow!!

Before we examine the UHC discourse itself and contrast it with the Alma Ata discourse, let us examine the changing global and national political and institutional contexts of this period.

The Political Context:

The main development of this period is the huge global recession of the year 2008. Many called it the worst depression since the 1920s. Conventional areas of investment, even in public services, were reaching their limits. Healthcare was however seen as an industry that could yield high returns on investment. Healthcare industry now included hospitals, pharmaceuticals, medical devices, health insurance and healthcare IT.
Healthcare in the USA:

By the 1980s, the real problem for the emerging healthcare industry in the US was that there were a number of small players in a highly competitive market who could set the prices lower than was compatible with the ambitions of healthcare industry. So, a state policy was built that pushed out small providers, as well as public hospitals, and encouraged the growth of large chains of Health Management Organizations (HMOs). These are large organizations that have a network of hospitals that provide primary, secondary and tertiary care. These HMOs also sell insurance plans which individuals have to choose from. Now, the prices for these insurance plans could really go up unchecked by competition and choice. Those who could not pay these higher rates had to have no insurance cover whatsoever. So, by 2005, close to 25% of population had no insurance and another 25% had some insurance but not enough to pay for their healthcare needs. And those with no insurance had to pay even higher rates for availing any healthcare; or, decide to go without it. The USA spends 19% of its GDP on healthcare – the costliest in the world. Yet, this is what they get.

The US healthcare system - and the ideological framework that defines the US healthcare system – where health is a commodity like any other, and therefore its allocation is best done through competition and choice, and the state supposedly plays a role limited to regulation of both providers and insurance companies, but it actually promotes the development of monopoly HMO networks, is what global health institutions are promoting.

By the year 2000, after two decades of structural reforms and rising inequities, there was now enough elite in the developing world who could afford high cost healthcare. Curbs on foreign ‘Private Equity’ driven healthcare

Equity driven? Is that not what we wanted? Far from it. Here equity means finance capital. Rich persons whose only work is to invest large amounts of money, hoping to make even larger amounts of money.
direct investment in hospitals in India were removed in the year 2000. With the onset of the economic crisis of 2008, there was a huge inflow of foreign capital into the Indian healthcare industry. Many private corporate hospitals and hospital chains came up. Soon there was a problem. Though the number of persons who were ill was increasing, there were not enough patients who could pay for their healthcare, and the profits of these hospitals could dwindle. Medical tourism was one answer to the problem, but the scope of this was very limited,

“Now I do not have to go abroad for treatment. Every treatment is available here.

and its adverse impact on Indian healthcare was high. Clearly public expenditure on healthcare that could be routed through private healthcare industry became desirable.

The economic policies of the last two decades had seen a huge rise in inequality. Impoverishment due to healthcare costs was also rising sharply. This could lead to popular dissatisfaction and a call for return to free care through public providers. Right-wing economists and mainstream media condemned popular schemes like NRHM and the Employment Guarantee Scheme, and the food security schemes as populist. They would derisively characterize these as giving freebies and subsidies. Funds for these schemes would be curtailed, and gaps in implementation would be highlighted, to declare the programs a failure. Only if public expenditure in social sector was routed through private sector at terms where the corporate sector too could benefit from it, was it acceptable to the neo-liberal economists. So government had to announce pro-poor schemes but design it such

Interesting Fact: The private equity and venture capital funding in healthcare has risen by over 13 times, from $ 94 million in 2011 to $ 1,275 million in 2016 !! Foreign capital flows in at about 600 million USD every year. Typically such funds aim for over 30% return on investment- whereas for most capital investment it is 5% to 15%.
that it allowed private sector to profit from this expenditure.

The Institutional Context:

External aid had always been limited in India. It had largely been positioned as technical assistance, which often meant an undue influence over influencing policy. But now, even this more or less ceased. One reason is because the developed nations were themselves in an economic crisis, and had little surplus as aid. Another reason was that nations like India were competitors in the world market and have increasingly large GDPs. A third was, while taking aid for development, nations like India were buying costly military equipment from their competing nations and building their nuclear weapons. All of this made it difficult to justify aid to their own citizens. However, the intellectual influence of the healthcare industry over policy had to be maintained. How was that to be achieved? This took many forms.

Firstly, Global Health Institutions, which had private corporates as part of its management structure, were giving aid directly to governments. Now they were also directly funding non-government agencies and private healthcare industry. Of the funds that International Finance Corporation (– the arm of the World Bank that funds private sector -) distributed, India was the largest recipient. USAID would give bank guarantees for private players to set up hospitals or primary care networks. The Bill and Melinda Gates Foundation (BMGF) also emerged as the largest funder. A large part of BMGF efforts were going into funding research and advocacy and pilots that would influence policy in favor of private sector participation in public healthcare, especially in primary healthcare.

A second major development was by creating and shaping Indian knowledge centers to follow the health policies and ideologies of the USA. One such institution was the Public Health Foundation of India. The US embassy directly organized the first consultation leading up to the creation of this institution. The American Association of Public Health was a leading partner in this effort, and was represented in its board. Its Board was constituted under the leadership of leading corporate sector and with the blessings of the government. Then, a large number of young scholars and researchers were recruited in India and sent to the Universities of the USA and UK, with support of the Rockefeller Institute, for training in health economics and health policy, and they had signed bonds to come back and serve as faculty and researchers with PHFI.
But this is not the problem of one institution alone. Public health and health systems studies in other institutions like TISS and IIHMRs have also been shaped by similar partnerships. The academic disciplines introduced were not politically neutral, though they could be presented and internalized as such. Large numbers of civil servants also go abroad for training at the International schools of public policy and internalized the emerging discourse. A large number of research projects where the research questions, conceptual framework and main authorship is from the international metropolis while Indian centers are effectively reduced to field stations, contribute to the propagation of the dominant discourse. Changes in higher education in this period made publication in international journals almost mandatory for ranking and recognition and financing.

At one level, all this was quite acceptable, and even welcome. Internal institutional capacity in public health and health policy was weak and stuck in the idiom of the past. The departments of preventive and social medicine had failed to engage with the social sciences, with economics and with public policy, and restricted themselves to a very limited mandate.

It is creditable that the PHFI and many of the new academic institutions of public health produced an impressive body of research on health systems and public health in a relatively short time. Much of it has been a valuable contribution to public health in India and not limited to any discourse. Also, to the credit of those working in such institutions, it must be recorded that Indian government funding for health systems and policy research is so abysmally poor (almost non-existent) that young talented researchers have little other opportunity for employment. Indian research agencies who have a clearer perception and would like to work outside the neo-classical and neo-liberal economic paradigms have no funding. The Indian university system also has such entry barriers and fund constraints that organizations like PHFI may have been important to break this stagnation.

However PHFI, was also a route of introducing the theories and practice of “new public management” and the emerging discourse of universal health coverage. Thus, even before their educational programs were in place, the PHFI became the heart and soul of a High Level Expert group on Universal Health Coverage, set up by the Planning Commission. This expert group and its recommendations, and a considerable part of the research emanating from the PHFI was
to introduce the discourse on UHC in India in a most effective manner by winning support of wide sections of administration and civil society for this understanding. Such high level expert groups were set up in many developing nations of Asia and Africa and most came up with similar recommendations. Unlike the structural adjustment discourse, the UHC discourse could thus be discovered afresh and adapted within each nation.

A number of the US universities and schools of public health are also increasingly engaged directly in public health research in India by setting up offices, organizations and networks. In this, they are supported by donors – often, corporate philanthropies back home – and the trend is to bypass Indian academic institutions and directly become advisors to government planning and capacity building efforts.

Another change in the institutional climate in this phase was the increasing role played by the commercial consultancy firms in research for government policy. Firms like McKinsey, Ernst and Young, Deloitte, Accenture, IPE Global, Price Waterhouse Cooper have turnovers of over a few hundred crores annually, and most of their business is for private corporate clients. Their research has been characterised as “client driven”, which often means that such agencies essentially capture what the client wants to say and giving it a brush of respectability and a lot of articulation. Seldom is any primary research or even secondary data analysis undertaken. The conflict of interests between the government as client and their main business clients is obvious, but ignored. This ready acceptance of foreign private consultancy firms for supporting policy making and implementation, while increasing restraints on academic and research institutions with foreign funding, and the decreased reliance on Indian technical support institutions, would make sense, if the government is searching for agencies who would generate the arguments and write-ups required to support different forms of privatization. The commercial consultancies would go further in “managing” knowledge to support such objectives then institutions like PHFI would ever go.

If government is now limiting foreign funding to PHFI – how come they are happy to outsource major policy work to US based consultancies – and research work to foreign commercial research institutions.
The Intellectual context- the UHC as a discourse:

At one level, the UHC discourse has similarities and overlaps with the Alma Ata declaration. There is the same reiteration of the theme of universal access to health care, better effectiveness and quality and affordable health-care, but expressed in different words. Unlike Alma Ata declaration, which had health as its central theme, in UHC there is a more exclusive prioritization of healthcare and within that of financial risk protection. The emphasis on primary health care is missing, but there is an emphasis on “continuity of care”. In most discussions of UHC, there is acknowledgement of the importance of health promotion across sectors, and even of the importance of primary healthcare.

Universal Health Coverage has been defined, as “Those in need of healthcare are able to access healthcare which is effective, without financial hardship.” Policy documents have also reiterated that there is no one road map to achieving UHC, and nations are free to choose their own road map.

UHC has been visualized as a cube. Progress towards UHC is to include progress in all three dimensions of the cube.

All of the above is welcome, and part of what UHC promises. However, when there are discussions and written texts on UHC, there are implicit rules that frame the conversation differently and there are different boundaries for the discussion. And, if not critically understood, many of these are a problem.

This is the way the key problematics of healthcare are framed with the UHC discourse:

“People have to go to private providers, even though there are public providers who are available, since the quality of healthcare in the public facility is so poor.
In the private sector, however, the costs of health care are far too high. Efforts at improving public health systems have been tried and have failed. The alternative is therefore to allow people to go to private providers, with the government paying on behalf of the patient.

The role of the government is thus no longer providing services. It becomes one of purchasing services from private providers—on behalf of the patient."

Then the discourse goes further. It states that: “governments must not favor public providers. They must be equally ready to fund public or private provider depending on where the patients choose to go. Since government providers are unlikely to do so, this purchasing should be done by a separate agency—and not by the department of health itself.”

This purchase of services could take two forms:

“a) Public Private Partnerships: Government could have a contract with a private provider and specify a sum of payment to be paid in return for a certain quantity of patient care or related services that is provided.

b) Insurance: Payments are made to empanelled hospitals by the government—either by a government agency, or through hired insurance companies—as a fee for services that have been provided to the patient.”

Such a discourse legitimizes shifting of government financing to private providers. Of course there are also words spoken about
strengthening public services, but the fact is that most payments from insurance go to private providers. When this is pointed out, it is only seen as supporting the understanding that anyway most people prefer private sector care.

An announcement of a government funded insurance program wins support of the population, since it leads them to think that they can get care in big private hospitals free of costs. It makes the private hospitals happy because now a lot of their under-utilized beds will get used, they will do more business, and they can make large profits. It also makes the government happy because now, as compared to providing services, their work would be reduced - just sign one contract and it is done. They will not have to undertake the complexities of managing a large workforce, full of inner fights and problems. Also, the bureaucrats are less likely to be blamed when they were not responsible for providing services. Even the regular salaried employees are not unhappy since their jobs are protected and only new recruitments and expansion is being limited. Many government doctors and staff are anyway having private practices, and they would now do better in private practice, plus they would have a government salary.

But such a “public discourse” must be challenged.

Problems of government funded insurance programs:

- Beneficiaries, often, do not know that they are beneficiaries. Even if they do, they cannot enforce their rights. Poor people are often denied free care in empaneled private hospitals. Often, care is provided by private hospitals only for those diseases which the hospital finds profitable to provide. Or, care is available where public sector is providing free services.

- Private hospitals often charge patients in addition to getting paid by government. They justify this, though it is illegal, by saying that government is under-paying. For private providers, this is the main demand, higher fee per service. But, higher fees does not reduce double-charging.

- Public services get weakened. The existing employees may not protest, but the number of jobs available in public services for their children is going down. Additionally, for every type of health worker, except for doctors, this means less wages and more insecurity.
Most elements of this discourse were also present and driving the earlier health sector reforms of the nineties. But, the UHC discourse has more emphasis on introducing state intervention to shape markets. One new development in the UHC discourse was inclusion of criticisms of insurance on two grounds. One criticism was that because insurance plans on a fee for service basis, it leads to excessive, unnecessary consumption of healthcare services. The second was that most insurance plans did not cover primary (outpatient) care which accounted for a major part of the expenses.

The solution that is offered is even more dangerous. The solution is to outsource health care in entire geographical regions – like a block or a district - to a corporate-owned agency or organized network of providers. The rates for outsourcing such a block would be fixed based on the size of the population, and paid to a corporate agency. It would be left to this agency to empanel both public and private provider, and this network of providers would provide primary, secondary and tertiary care. These providers would be paid by the corporate agency that owns / leads the network.

According to this reasoning, the corporate agency would recognize that if it delivered preventive and primary health care better than the government, it would have to spend less on tertiary care. Since it is paid on a population basis (also called capitation basis) and not on fee for service basis, the agency would have the right incentive to reduce unnecessary care and increase ambulatory care. Within this discourse, health is just a commodity and the only challenge is to work out the appropriate way to price and pay for services. So packaging and outsourcing primary care is the next logical step in...
privatization of healthcare.

There is only one small discussion allowed: should this network of providers be owned/controlled by a private corporate firm or should be controlled by government-led trust or society? Some would argue that it is desirable for government to control the network, but that government would be unable to manage this. Therefore, it is proposed that it should be awarded to a corporate agency. Others would argue that government might be willing and able to do so, but it is desirable to give it to a private agency since there would be more innovation and more profits.

That is a devious debate.

De-constructing the Discourse:

One could easily get carried away with this discourse. Academic publications, media stories, training camps and orientation program at global and national levels push this line of thinking. This discourse acquires the prestige of being “modern”, “progressive” and “innovative”. Most, especially the young who are entering public health, are not aware of alternative ways of analysis.

But such a discourse is misleading. An alternate analysis would be as follows:

The overwhelming choice of private provider over public provider does not mean that an active preference for the former. Reasons for not going to a public provider can be attributed to

A) lack of availability of the appropriate services. This is not the local doctors’ fault, this is part of the selective care policy introduced under structural adjustment.

B) The lack of capacity of number of beds and staff in secondary hospitals and the inadequate staff in primary centers is not the local management’s fault. This too is a direct consequence of the policies introduced under structural adjustment.

C) The introduction of user fees - raising the costs of care in public hospitals - was also forced upon the public health systems by structural adjustment.

D) UHC discourse fails to mention that the weaknesses in public services are because of past public policy. The same stakeholders who are now using it as an argument for outsourcing public services enforced these
“erroneous” past policies. They treat the failure of public services as natural or pre-ordained.

That is the nature of a discourse, the hidden rules that limit the conversation. The discussion on UHC ignores examples of successful performance of public health services and reform measures that have worked. It also proceeds as if there are no effective ways or innovations by which public service delivery can be strengthened.

The discussion only allows different forms of private sector engagement to be considered as alternatives. It pretends as if it is the first time such alternatives (based on purchase from private sector) have been tried, and it ignores the many examples when these have been tried and have failed to work. When confronted by failures in purchasing, it remains optimistic that the problem would go away by tweaking the contracts. But when it comes to failures of public delivery, it considers it immutable.

There is also considerable evidence that while insurance programs shift healthcare services to private providers, they do little for
population level health outcomes. Even in financial protection against hospitalization, they are failing.

When the UHC discourse addressed financial protection, it usually fails to consider free or subsidized provision of services by public providers as a form of delivering financial protection. This is despite the evidence that free public services could be more effective and efficient in doing so, as compared to the concept of insurance.

The discourse insists that it should not matter whether the provider is a public provider or a private provider, since people’s choice would make the decision. But in the real world, there are many forms of exclusion other than financial in both private and public sector. Whereas in the public sector, there is a notion of entitlement, that potentially can be leveraged, there is no equivalent notion in the private sector. Denial of care for some treatments and cherry-picking cases where it suits the provider, and collusions among providers are the rule rather than the exception.

If we use political economy as our framework of understanding, then we see a fundamental difference between the production of health services as a commodity - that is when it is produced for the market, with the prime purpose of earning a profit - and when it is produced as a public service – fulfillment of an obligation of the government to its citizens. Therefore, the case is made for always preferring to produce healthcare as a public service, and purchase from private, commercial providers, only to close gaps.

But when we use mainstream (neo-classical) economics, then the problem is seen as one of market failure. Ideally, for all goods and
services, markets are best for driving production and distribution, but markets fail to act for healthcare services. This market failure should be addressed in different ways.

At the time of the Alma Ata Declaration, the dominant economic paradigm – Keynesian economics - believed that market failure should be addressed by government action. Since curative health services cannot be left to competition and choice, government must provide these services (as was done in the UK, Spain and the Scandinavian countries). If they were to be purchased from private providers (as is done in Japan, Germany or France), then the terms of contracting must exclude profits and thereby ring fence the transaction from market forces.

At the time of structural adjustment, the dominant economic paradigm was neo-liberal, and it wanted all services including health services to be left to the markets and allowed as an area of investment for profits. Only health services, which were public goods, were to be provided by the state, and therefore it did not include curative health care services. Curative health services were to be left to competition and choice. The problem of information asymmetry and uncertainty could be taken care of by people choosing between insurance companies and plans, instead of between providers and letting the insurance company negotiate with the provider. In other words, private insurance was the solution.

At the time of universal health coverage, knowing that private insurance is not working (only about 1% of people have bought private insurance) and that competition and choice in the private sector is NOT keeping prices low, nor ensuring quality of care, there is a need to respond to peoples health care needs. But simultaneously, it is also true that there is too much competition from small providers to allow for the high profits that global investors seek. Therefore, state policy has to promote corporate ownership and what is called industry

State and markets

In the 60s and 70s- states have to intervene to counter market failures. In the 80s and 90s- state must not intervene in markets for health. In the 2000s - state must intervene to prevent competition and promote monopoly. Competition only between a few corporates.
consolidation - meaning the slow exclusion and absorption of all other small providers - public and private and the emergence of monopolies. The idiom of competition and choice is maintained, but now it is the state that gets to choose from the few corporate-controlled network of providers, and the consumer’s choice is only between providers who are contracted in by the corporate.

However, transition to such a corporate control, is not easy. So, one of the first steps towards such ‘consolidation (viz monopoly building)’ is to design government run insurance schemes, so that over time they will increasingly favor the larger hospitals. One tactic of favoring larger hospitals is by limiting empanelment of hospitals, based on inappropriate quality standards that go against small affordable care providers. The rules of Clinical Establishments Act can be designed such that there is no restriction on pricing or unethical practices like kick-backs, commissions or conflict of interests. But, the affordable and not for profit hospitals would find it difficult to survive. Another way is to set rates for reimbursement at levels favorable for corporate participation, but much higher than what is indicated by costing studies and not for profit providers. A third is to define the technology packages such that it favors corporate providers and cannot be matched by small providers done through measures of regulation.

The argument is that insurance programs can be improved by including primary health care and outpatient care in the package are deceptive. That could allow even greater profits and monopoly to the private providers. A government that is unable to prevent denial and inappropriate care for hospitalization, can never do so for out-patient care.

In short, markets cannot be made to work for healthcare. Only a system built on the notion of public service, where commercial incentives of any sort are completely kept out of the process of organization and financing of health services, can provide the health care we need.
But, how are we to make public services work better? That is one central question that will need to be taken up in an accompanying book.

And of course, do not fail to note - also missing from the UHC discourse is any reference to community, whether as community participation, or community health workers or community monitoring. This is not surprising since there is no community in this vision, only so many individuals who are consuming healthcare, much like one would consume candies or soft drinks.

Health Care in times of Universal Health Coverage: The Policy-Practice-Theory Interface:

We know the Alma Ata Declaration did not play out in the way that those who drafted the resolution intended it to. The dominant nations led by the USA undermined the role of the institutions that had created it, and the political contexts also changed thereafter. National governments too, more often than not prioritized the needs of the elite over that of larger public.

But that is true in the other direction as well. The discourse that legitimized structural adjustment and universal health coverage also had to compromise. There is resistance and protest against some of
the reforms that these drive, and governments have to take these into account. Even in nations where the government or the political party in power is mainly acting on behalf of the rich and the level of protest is low, it is important for governments to have some degree of acceptance of the poor. There is also a need to take along the policy community - that amorphous group of individuals and organizations from academics, civil society and bureaucracy who guide government policy.

Thus, many elements of the spirit of the Alma Ata declaration and many propositions and formulations survive into the official policy documents. Institutions also carry along past memories and ways of thinking. The intentions of the dominant influence, but never completely determine the final practice of governments and people. Government policies and management can be theorized as a terrain where different sections of society with different levels of influence over the levers of power meet and contend. This is better than characterizing it as a puppet of any one section.

Which means that the actual policies documented and the ways in which they are implemented are more like the result of a negotiation
of different views and different motivations, without losing sight of whose interests are dominant.

The National Health Policy 2017 is an interesting example of this. On one hand, in paragraph 2.3.1, it states that primary health care will be universal, comprehensive and completely reserved for provision by public provider. Yet, a few pages later in paragraph 13.6 it states that there is scope for commercial providers to participate in primary health care. One can project paragraph 13.6 as the real intention and paragraph 3.2 as subterfuge, or one could project paragraph 2.3.1 as the real intention and paragraph 13.6 as a concession to pressures from private healthcare industry. Or, one can even see the text as representing an uneasy balance between different views.

The battle for supremacy of discourses continues into implementation. Each stakeholder mobilizes evidence, prestige or even unfair gratification of decision makers to bolster the viewpoints that represents their interest. Money power is not equal, and the main power more democratic forces can bring to bear may be evidence.

Is the zebra- a black animal with whit stripes, or a white animal with black stripes.

Is the National Health Policy- a plan for privatization with some salutary comments for strengthening public services. Or is it a plan for strengthening public services with some concessions to private industry.

A zebra is an animal with black and white stripes.

Even here, it is easier for the health care industry to ensure selective generation - reading and amplification of evidence, favorable to it. But in a democracy, an informed people have power also.

Similarly, paragraph 3.3 in the Health Policy states that strategic purchasing of services would largely be from public providers, and if there were critical gaps, this would be bridged by purchasing from not-for-profit providers, and only later consider commercial providers. But the question arises as to why it changed the language to purchasing? Why did it not state that public provision of secondary and tertiary services would be the main-stay? Was the use of purchasing a compromise with the discourse while prudence dictated
the government to stay with public providers? Or, was the use of strategic purchasing opening up the door for increasingly switching to purchase from private sector?

When it comes to implementation of the policy, there is process of selective amplification and attenuation. We can find how this plays out in the recent initiative of Ayushman Bharat.

Universal Health Coverage is declared as the framework to which Ayushman Bharat, is aligned.

Second. Formally it is introduced as composed of two pillars - the National Health Protection Scheme (NHPS) which is an insurance approach and the universal comprehensive primary health care packaged as delivered by health and wellness centers (HWCs). The NHPS gets all the attention and funds and the HWC is on the slow track. The NHPS program only woos commercial private sector participation, and it attenuates any mention of strengthening public hospitals.

In the health and wellness centers, instructions were sent to states to maximize private sector partnerships in this scheme. There are few takers… as yet. Most international aid agencies, especially the Bill and Melinda Gates Foundation and USAID, are busy sponsoring or supporting efforts to outsource blocks/districts to integrated networks of providers managed by a consortium of corporate agencies. None of these have taken off, but this is the direction they are pushing.

On the other hand, there are sources of resistance and alternative directions too.

Tweet from CEO of NHPS:

@ibhusan
Urging all eligible private hospitals to empanel with Ayushman Bharat. We are are offering you business of 50 crore people!
#AyushmanBharat 9:14 AM - 23 Jul 2018
Many state governments are cautious with the push on the insurance scheme. Many states have reserved a large part of the services for the public sector and have capped the rates to be paid to hospitals at a more reasonable level.

Some states have taken up the Health and Wellness centers seriously, as a real measure of moving towards universalization of healthcare.

There are also a large number of studies, mostly non-externally funded, which are bringing out the problems with PPPs, insurance and other forms of purchasing. These are making administrators and politicians cautious about rushing into such programs.

Peoples health movements are documenting the failures of the PPPs and pointing out the real reasons why public services remain weak.

Lessons for Peoples Health Movements:

This narrative of the changes in health policy at the global and national levels has several lessons for peoples health movements.

One obvious lesson is the close relationship between the dominant dynamics of political and economic policy at any given time to health policy. This political dynamics changes the nature, type and political direction of institutions that are playing an important role at the global level. [There are also institutional changes at the national level, but this we have not gone into].

Outwardly independent of these dynamics, and seemingly as an internal development of the science/technical understanding, and ostensibly autonomous of politics of the day, a technical discourse emerges about how health and healthcare is being delivered and how it ought to be reformed. The reforms that subsequently happen are promoted and win consent because of the way the technical discourse shapes the public discourse and how those in governance and academia come to accept these choices as inevitable (there is no alternative) and scientific (evidence based). Thus, a progressive party with a stated ideology of promoting health equity and health rights may come to power in a state, but may see its task as implementing these “technically correct
and scientific policy prescriptions without corruption and cronyism” as its main task, and after five years would be surprised to find that industry has benefitted more than people.

The policies and programs that emerge at any given time and place are influenced by the dominant discourse, but not dictated to by it. The discourse itself is not cast in stone, it remains flexible and constantly changing, and it is responsive among other things to new studies, new experiences, peoples perceptions and response as well.

Therefore, another lesson that peoples health movements can draw is that the responsibility for poor progress on health equity and health rights is not only that of the politician but also that of those in the policy community and academia. Often there is a failure to have a critical engagement with theory and policy, and a passive consumption and dissemination of such a discourse. Recollecting what was said about policy being a negotiation, it is also worth looking into not only what each member or group in the policy community bought into the negotiation, but how their inputs shaped the final outcome in terms of the public discourse and the formulation of policy.

And the third lesson is that there are important roles that health activists can play as participants in decision making platforms, as implementers within the public sector, as providers of healthcare outside the public health system and as activists engaged in promoting public understanding, advocacy and agitation. Some of the major progressive actions in health policy, including the Alma Ata Declaration and the Right to Food Act and the National Rural Health Mission, would not have come about but for the action of peoples health movements and of individuals associated with it. In a democracy both academicians and activists influence the discourse before, during and after policies are formed and implemented. If one is conscious and has a critical understanding of how policy gets made, one would often have opportunities to intervene.

From those working for health equity and working against the evolution of the healthcare as an avenue for profiteering,
there are dangerous portents in the UHC discourse, and in the Ayushman Bharat program as it is unfolding. But within these, there are also possibilities for shaping it in a pro-people direction and for making health rights a reality. Not recognizing the latter is to fail to acknowledge the contributions and effects of the peoples health movement itself, and to give ourselves over to pessimism and inaction. Even a progressive political change would fail to transform into an opportunity for strengthening health systems and achieving health equity if an alternative discourse, supported by evidence and experience, is not built up.

“While we welcome the recent upsurge of interest in the concept of universal health coverage, we oppose the idea that this be achieved through the promotion of a minimalistic insurance model that would operate within a marketized system of health care, or worse still, be used as a context or excuse to dismantle or undermine public hospitals and promote corporate interests in health care delivery. Universal health coverage must be achieved through organized and accountable systems of high quality public provision.”

Resolution in International Peoples Health Assembly, Cape Town, 2012

So do PHMs oppose Universal Health Coverage.

Not so. We wanted universal health care. See our statement on universal health coverage:
Annexure 1:

Declaration of Alma-Ata
International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I
The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II
The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III
Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV
The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V
Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI
Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:
1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.
VIII
All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country’s resources and to use available external resources rationally.

IX
All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X
An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world’s resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.
Annexure 2:

**Bhore Committee Report, 1946- the Foreword.**

“In this foreword an attempt is made to present, in a nutshell, the main principles underlying the Committee’s proposals for future health development in the country. These are:

1. No individual should fail to secure adequate medical care because of inability to pay for it.

2. In view of the complexity of modern medical practice, the health services should provide, when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment.

3. The health programme must, from the beginning, lay special emphasis on preventive work. The creation and maintenance of as healthy an environment as possible in the homes of the people as well as in all places where they congregate for work, amusement or recreation are essential. So long as environmental hygiene is neglected, so long as faulty modes of life of the individual and of the community remain uncorrected, so long as these and other factors weakening man’s power of resistance and increasing his susceptibility to disease are allowed to operate unchecked, so long will our towns and villages continue to be factories for the supply of cases to our hospitals and dispensaries.

4. The need is urgent for providing as much medical relief and preventive health care as possible to the vast rural population of the country. The debt which India owes to the tiller of the soil is immense and although he pays the heaviest toll when famine and pestilence sweep through the land, the medical attention he receives is of the most meager description. The time has therefore come to redress the neglect, which has hitherto been the lot of the rural areas.

5. The health services should be placed as close to the people as possible in order to ensure the maximum benefit to the communities to be served. The unit of health administration should therefore be made as small as is compatible with practical considerations.

6. It is essential to secure the active cooperation of the people in the development of the health programme. The idea must be inculcated that ultimately, the health of the individual is his own responsibility and, in attempting to do so, the most effective means would seem to be to stimulate his health consciousness by providing health education on the widest possible basis as well as opportunities for his active participation in the local health programme.

7. We therefore consider it essential to the success of the scheme that its development should be entrusted to Ministers of Health who enjoy the confidence of the people and are able to secure their cooperation.”
Note: This is the foreword of the Report of Health Survey and Development Committee” chaired by Dr. Joseph Bhore. This report was submitted in 1946- when Indian independence was now inevitable and a new nation would require a long time vision on health. Its foreword, which is a vision statement, remains as relevant today, as when it was first stated.