Thoughts and comments on the High Level Expert Group's report on Universal Health Coverage for India

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In October 2010, the Planning Commission of India constituted a High Level Expert Group (HLEG) on Universal Health Coverage. The HLEG was assigned the task of reviewing the experience of India's health sector and to submit its recommendations by July 2011. In October 2011, the HLEG submitted its report to the Planning Commission. A critical examination of its content reveals a number of shortcomings: a restricted conceptualisation of universal coverage, a narrow conceptualisation of public health, a persistent neglect of midwifery, a reductionist conceptualisation of social determinants and a flawed financial roadmap.

On the Conceptualisation of Universal Coverage

In making a long awaited case for universal health coverage (UHC), the High Level Expert Group (HLEG) adopts the concept as put forward by the World Health Assembly's Secretariat in 2005: "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost".[1] It then immediately moves on to the health-financing paths to UHC as highlighted by the 2010 World Health Report.[2] By doing so the HLEG somewhat neglects the less strictly financial aspects of UHC put forward in the 2008 Final Report of the Commission on Social Determinants of Health and in the 2008 World Health Report.[3]

In refining the definition of UHC, the Commission on Social Determinants of Health drew due attention to both the epidemiological notion of needs and the political notion of power[4]. It embraced Nitayarumphong's definition of UHC as "a situation where the whole population of a country has access to good quality services according to needs and preferences, regardless of income level, status, or residency",[5] adding the requirement "that people are empowered to use these services".[6]

The 2008 World Health Report defined universal coverage as "universal access to the full range of personal and non-personal health services they need, with social health protection" and outlined three dimensions of coverage: breadth, depth and height.[7]

The 2010 World Health Report restated the three dimensions as "the proportion of the population to be covered" (breadth of coverage), "the range of services to be made available" (depth of coverage) and "the proportion of the total costs to be met" (height of coverage).[8] The HLEG's report makes one implicit reference to these three dimensions: "(…) our nation needs to determine and maintain an appropriate balance between extending coverage to more people, offering more services, and covering more of the costs of care". Systematic use of the three dimensions however would have enriched both the analysis and the recommendations of the HLEG's report.[9]

On the Conceptualisation of Public Health

As in many countries in the global south, public health in India has a legacy of colonial politics, born out of concern with the health of trade and the army. While the former led to port health trusts and quarantines, the latter gradually widened its scope from the military to the surrounding civilians, and eventually to the general public. In any case the focus remained the threat of disease for the economy, not the promise of health for the people. It was the 1859 Royal Commission – inquiring into the sanitary state of the British Army in India – that prompted the sanitary commissions which led to the modern public health administration.[10]

Ever since, Indian public health workforce has successfully secured autonomy from curative medicine, leading to what Indian Medical Service (IMS) director general Megaw in 1933 termed "an undesirable cleavage between medical relief and public health" and a "diarchy".[11] In 1938 the then IMS director general Bradfield made a plea for co-ordination, arguing that "the activities of those responsible for medical relief and prevention of disease are so closely inter-related that it is impossible to draw any sharp line of distinction between them".[12] Megaw and Bradfield were well acquainted with India's healthcare needs. Bradfield had been instrumental in expanding the Subsidied Rural Medical Relief Scheme in Madras Presidency, the first Indian incentive scheme for rural healthcare delivery.[13] Megaw had a clear-cut rationale to provide medical relief alongside public health: "before any preventive action could have a hope of success the good will of the people must be enlisted by the cure of disease".[14]

The 1946 Health Survey and Development Committee (Bhore Committee) report echoed these remarks by stating that "curative and preventive aspects cannot be separated without lowering the efficiency of the service" and by questioning "as to whether the two departments should continue to work separately".[15] While the Bhore Committee has certainly shaped independent India's health system, it can be argued that its central point of integrating curative and preventive care has never been put in practice. Today, after more than six decades, the lines of command at state, district and taluka level are still awkwardly separated.

In fact, while the public health system falls short of the healthcare needs of the population,[16] the public health community has preserved and strenghtened its isolated identity. An Indian Public Health Association (IPHA) was founded in 1956. A Public Health Foundation of India (PHFI) was created in 2006 and organises public health training in four Indian Institutes of Public Health, disconnected from medical education. Community medicine made its entry in medical education as early as 1955[17] and the resulting cohorts of new public health and family doctors have joined the Indian Association of Preventive and Social Medicine (IAPSM) since 1974. Beyond some joined conferences, there has been no confluence between IPHA and IAPSM.[18]

Today, the HLEG's conceptualisation of public health leaves no room to deplore the historical divorce between medical services and public health programmes. On the contrary, it justifies the cleavage by subscribing to a strictly economic distinction between public and merit goods on the one hand and private goods on the other hand, putting public health in the first and curative services in the second basket. As Khaleghian and Das Gupta recognize, the distinction is not merely academic: "the market would have few incentives to provide public goods, and would be expected to underprovide merit goods".[19] In practice, this logic leaves the toil of public health to the state and the profit of healthcare to the market. Public health is then reduced to the so-called essential public health functions[20] and integration with the healthcare system becomes a distant dream.

We see good reasons to consider curative services as more than just a private good. First and foremost, on ethical and legal grounds: health and healthcare are human rights. The Indian Constitution doesn't explicitly mention health or healthcare as fundamental rights, but it does recognize the right to life,[21] and the Indian Supreme Court has repeatedly placed the right to health and healthcare under this constitutional ambit.[22] Furthermore,

India ratified the International Covenant on Economic, Social and Cultural Rights that includes among a country's duties "the creation of conditions which would assure to all medical service and medical attention in the event of sickness".[23]

A good second reason is one of efficiency: as Megaw noted in 1938, curative services build the necessary trust to make preventive services effective; and as the Bhore committee recorded in 1946 "preventive and curative health work have to be dovetailed into each other if the maximum results are to be obtained".[24]

These ethical and rational motives are as valid today as they were yesterday. At international level, they informed the principles of the Tavistock group and the renewed attention for health systems,[25] ideally giving due attention to both the responsive and the protective function of a health system.[26]

In India, the aim of achieving equitable and sustainable improvements across health services and health outcomes led the state of Gujarat to include a chapter on healthcare provision in its 2009 draft public health act and the state of Assam to assume full responsibility for service access in its 2010 enacted public health act.[27]

By contrast, the HLEG – as Das Gupta and colleagues did before[28] – depicts the amalgamation of medical and public health services as eroding career incentives for the latter, and recommends setting up "separate Health Systems Management (HSM) and Public Health cadres". Such recommendation builds on an interpretation of the Tamil Nadu experience, but is understandable only within a simplistic comprehension of Tamil Nadu's recent achievements. It can be argued that Tamil Nadu's public health successes have a much broader causality than just separate cadres, including a long-lasting commitment to primary care and a series of enabling conditions.[29]

A stronger rationale is to be found in the recommendation put forward by Gupta and colleagues to reconstruct and integrate the cadre structure for public health workers,[30] overcoming once and for all the medical-public health divide.

On the Persistent Neglect of Midwifery

"I hope that you will forgive me for adressing you directly on the subject of female nursing in India", wrote Florence Nightingale in 1867 to Viceroy John Lawrence.[31] Two years earlier she had sent him her 'Suggestions on a system of nursing for hospitals in India'.[32] Thirteen years earlier government had sanctioned the first training school for

midwives in the Lying-in Hospital in Madras; formal training started in 1871[33]. For over a century, professional midwives would become the backbone of Indian maternal healthcare.

Nonetheless, midwives (and nurses) have been traditionaly regarded as inferior professionals, especially by doctors. The HLEG subtly recognizes and explains by stating that "within the health sector, the hierarchy between Doctors and Nurses is such that women have less power and leverage than men".[34] Mavalankar and colleagues had been more explicit and comprehensive in pointing at the female, rural and lower-caste identity of most midwives versus the male, urban and higher-caste identity of most doctors.[35] In an evidence-based intent to reverse the tide, Sharma and Mavalankar in 2009 presented their road map for India towards midwifery-based maternal care.[36] In 2011, the United Nations Population Fund added evidence from all over the globe to make a case for professional midwifery.[37] Yet today the HLEG does not recommend the (re)professionalition of midwifery in India. One should ask why. After all India – despite all progress made[38] – still accounts for one out of five maternal deaths in the world (one out of six of the world's population living in India) following nearly 11,000 birth complications per day, of which nearly 8,000 in rural India.[39] It is precisely in such conditions that midwifery can make a difference, as it did in Sri Lanka and Malaysia.[40]

Upon independence, all three countries – India, Sri Lanka and Malaysia – were conscious of maternal health needs and recognised the potential of professional midwifery for improvement.[41] In India, the Bhore Committee had urged "making available, as quickly as possible, an increasing number of (…) trained workers for midwifery service".[42] In fact, India had a comparative advantage over Sri Lanka and Malaysia: India indeed had a Central Board of Nursing and Midwifery since 1902, a Madras Nursing and Midwifery Act in 1926 – the first South-East Asian legislation on midwifery – and a separate register for midwives since 1930.[43] Everything seemed to be in place for the upscaling and consolidation of midwifery-based maternal care, but it didn't happen. The once separate midwives' profession was merged with the nurses' in ANM (auxiliary nurse midwives), and converted later in female MPW (multipurpose workers). The midwifery training component was reduced from 18 to eight to six months. Addition of non-maternal health tasks further diluted the skills for conducting births. Ironically, the well-intended integration effort of the Kartar Singh Committee[44] was a kiss of death for

India's midwives' profession. In 1980, the maternal mortality ratio (MMR) in India was still 677 per 100,000 live births.[45]

By contrast, Sri Lanka and Malaysia strenghtened maternal care making properly trained midwives widely available in rural areas, ensuring them a steady supply of appropriate drugs and equipment, linking them to back-up services, and improving communication and transportation. In 1980, Sri Lanka and Malaysia had reduced MMR to 92 and 137 per 100,000 live births, respectively.[46] There is today no doubt that the deployment of and support for midwives were key in this MMR reduction.[47] This confirmed what Van Lerberghe and De Brouwere evidenced when reviewing the evolution of maternal mortality in high-income countries: "countries that managed to get doctors to co-operate with a midwifery-based policy fared (…) well. Where doctors won the battle for professional dominance – and for their share of the market – women died".[48]

It took modern India a long time to consider maternal mortality as more than just one more unfavourable condition.[49] Since safe motherhood finally reached the policy agenda, considerable progress has been made.[50] Yet the progress is uneven,[51] and insuffient to reach the maternal health Millennium Development Goal on time. A substantial cause of the latter is the lack of investment, despite all evidence, in the optimal human resources for care of childbearing: midwives.

It is hard to believe that the HLEG was unaware of the WHO's 2005 well-founded recommendation for birth attendance to be delivered by skilled, experienced and adequately supported midwives.[52] Or of the Cochrane review's 2009 evidence-based determination that policy-makers should consider midwife-led maternal care models.[53] All the same, in its chapter on human resources for health, the HLEG sees sufficient prospect for progress in merely scaling up the nurse/ANM to doctor ratio. One would have expected a more attentive and woman-friendly answer to the question Mavalankar and colleagues asked three years ago: "Achieving Millennium Development Goal 5: is India serious"?[54]

On the Conceptualisation of Social Determinants

The HLEG recognizes that UHC will be difficult to attain and sustain without action on the social determinants of health (SDH) and makes a plea for integrating action in the Twelfth Plan. This is worth praise, and in line with the laudable tradition of the first

country in the world that has been trying to address social inequities ever since its first independent constitution.[55]

Less up to expectations is how the HLEG interprets social determinants in a seemingly reductionist, evasive and superficial way, in the dedicated chapter and throughout the report.

While the HLEG recognizes – in line with the 2010 Annual Report of the Ministry of Health and Family Welfare[56] – "poverty and marginalisation as key social determinants of health in India", its report by and large blanks out structural determinants and power structures in favour of intermediate determinants and lifestyle characteristics.[57] One example is how the report frames and envisions empowerment: the framing is that of personal agency much more than that of structural determinants,[58] whereas the operationalisation can take the forms of "behaviour change to avoid risk, training of community health workers, community monitoring of health services, and demand generation for attention to local concerns".[59]

While the HLEG recognizes "huge differentials among and between classes and castes, gender gaps and wide regional variations in both disease burden and response by the health system and others concerned with development" in India, and cites hard evidence for caste-related and other health inequities,[60] the report's recommendations avoid any reference to what should and could be done to reduce the pervasive impact of caste on health.

Indeed a somewhat reductionist conceptualisation of social determinants and the evasion of caste reality seem to have led the HLEG to the formulation of four disappointingly superficial policy recommendations. While – in Devaki Nambiar's words[61] – "the High-Level Expert Group has noted that universal health coverage will only be possible if there is accompanying action on the social determinants of health", it remains unclear what form such action would take.[62]

The first recommendation – to support initiatives on social determinants of health – sounds rather hollow and is not further elaborated.

The second recommendation contains a plea for much needed convergent action on social determinants, but assigns this task to Social Determinants Committees – at district, state and national level – of which the composition and mandate are all but clear. Even the namegiving is confusing, as it is suggested that a Social Determinants *Committee*'s

functions can be performed by the recommended Health *Councils*, which are rebaptized existing Health *Committees*.

The third recommendation de facto undermines the possible mandate of the proposed Social Determinants Committees[63] by including social determinants in the mandate of the yet to be established National Health Promotion and Protection Trust (NHPPT) and its state chapters (HPPTs), a body of which the main objective is "to play a catalytic role in facilitating the promotion of better health culture".

Finally, the fourth recommendation echoes the WHO's Commission on Social Determinants on Health's importunity of developing a national health equity surveillance system,[64] suggests a facilitating role for the HPPTs in this task but fails to assign an overall responsibility, and disregards the Commission's linked recommendation of also surveying the government's finance policy.[65]

While all four recommendations in one way or another touch on evaluation of health inequities, none of them clarifies the locus of political leadership and accountability. Such omission of a requisite of good governance is hardly conducive to a coherent policy response.[66]

Frankly, one would have expected a more comprehensive and at the same time more straightforward approach to the indeed crucially important social determinants of health.

On Financing Choices and Prospects

Despite the ambitious announcement that the HLEG understands UHC as "beyond 'insurance' by providing an 'assurance' of health care for multiple needs", the report's key chapter on health financing and financial protection is surprisingly meagre in rationale, objectives and elaboration.

The case made against health insurance – throughout the preface, the vision and the financing chapter – is flimsy. Obviously, all governments have a health insurance function, that is to provide access to healthcare with financial risk protection.[67] A government can fulfill this health insurance function mainly through taxes (as in the UK), mainly through insurance contributions (as in Germany), or through a mix of both.[68] In this sense a British citizen is equally well insured as his German counterpart, and the distinction insurance-assurance becomes a word game.

The HLEG's statement that, globally, "UHC has generally been achieved on the basis of tax-based public financing, combined with some components of social health insurance" is a partial truth, needlessly fueling the anachronistic debate between Bismarckian and Beveridge partisans.[69] By contrast, the HLEG's addition that, in India, "a substantial increase in tax-based public financing would be required to finance UHC" is more than true, but hardly taken into account in the financial recommendations.

The HLEG recommends increasing public health expenditure on health from the current level of around 1.2% of GDP to at least 3% by 2022. To put it mildly, such recommendation disrespects the billion of Indians to whom the Government of India committed to reach this 3% by 2012.[70] Even so, the HLEG remains very hollow on how this public expenditure will be reached and look like. It recommends using general taxation as a principal source, but is silent on how to do so in a country where the tax ratio remains low,[71] and where fiscal deficits negatively affect public health spending.[72] It assumes and projects that public financing will sizeably reduce out-of-pocket expenditure, but gives no clue how to ensure that collection, pooling and spending will be progressive or at least proportional.[73]

Largely overlooked is the dismal absorption capacity of Indian health services. Even with the actual low public spending on health, funds are often underused or inefficiently used at state and peripheral level.[74] A clear example is to be found in the National Rural Health Mission (NRHM): over the period 2005-2008 the states of Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan left between 34 and 42% of central NRHM funds unspent.[75] Under such conditions, increased public spending is on its own insufficient, and has to be supplemented with a serious enhancement of the health system's absorption capacity.[76] On how this will happen, the HLEG provides no clarity.

Beyond financial absorption capacity are the unresolved issues of political alignment and effective spending. A clear example for both is to be found in the Rashtriya Swasthya Bima Yojana (RSBY). While the Ministry of Labour has exhausted its 3.6 billion budget for the scheme and has announced expansion of the scheme beyond the BPL population, the Ministry of Finance is hesitant on sanctioning fresh funds.[77] At the same time, uptake of the scheme by the target population does not necessarily lead to improved utilisation of services.[78]

Plenty of other key issues remain unresolved. The HLEG makes a case for central financing of a basic package of services with cost-effective treatment targeted toward

specific risk factors, thereby failing to notice that countries that achieved UHC have not restricted the package of services to cost-effective services of a very basic nature.[79]

The HLEG makes a case for complementing provision of services with contracting in and strategic purchasing. It also makes a case for "innovative IT solutions" to monitor the quality of healthcare delivery.[80] Until today however, the most positive Indian experiences – besides a lot of unsuccessful ones – with contracting in and strategic purchasing did not involve any advanced technology. Outstanding examples are the state of Karnataka contracting in Karuna Trust for the management of primary health care centres since 1996,[81] and SEWA's piloting of strategic purchasing (called preferred provider system) in Gujarat in 2004.[82]

The HLEG makes a case for integrating the government-funded insurance schemes into the envisaged UHC system. As far as the central government's RSBY is concerned, this would possibly enhance breadth, depth and height of coverage. However, by suggesting state government (and community-based) schemes to top up government coverage, it opens a wide door for a bifurcate health system: poor for the poor majority, rich for the happy few.

All in all, the HLEG's financing roadmap is unfinished homework. As for the whole report, one would have expected better, for Bharat's sake.

NOTES

[1] See World Health Assembly 2005a. This conceptualisation is today worldwide accepted. It should however be noted that the HLEG's interpretation of the concept has been criticised earlier (based on the HLEG's February 2011 progress report) as possibly limited in terms of the realisation of the right to health. See Phadke 2011.

[2] WHO 2010.

[3] Commision on Social Determinants of Health 2008 and WHO 2008.

[4] We will comment on (em)power(ment) as treated in the Report later, in 'On the Conceptualisation of Social Determinants'.

[5] See Nitayarumphong 1998. Note that this definition refers to "the whole population (…) regardless of (…) residency", not national citizens only.

[6] Commission on Social Determinants of Health 2008, p 100.

[7] WHO 2008, p 25-26.

[8] WHO 2010, p 12.

[9] The non-systematic use of the three dimensions of coverage (breadth, depth and height) is in fact surprising, if one compares it to their systematic use in a recent study (Reddy et al 2011b) published by the Public Health Foundation of India. Consider for instance the proportion of the population to be covered (breadth of coverage): the HLEG takes the call of the World Health Assembly literally, "The Fifty-eighth World Health Assembly (…) urges Member States (…) to plan the transition to universal coverage of their *citizens*" (World Health Assembly 2005b. The *italics* in the quotation are ours). The HLEG in its report repeatedly subscribes to "the right to be free from discrimination". Yet the very working definition of universal health coverage as adopted in the report is both a substantiation and a source of discrimination in restricting equitable access to "Indian citizens" only. Whatever budgetary or other considerations might have been determinative in the "great deliberation" that led to the working definition, and whatever political sensitivities might be at stake, such proposed restriction is at odds with Indian reality and with what India could possibly aim at. From a strictly legal perspective, India could invoke Article 2, paragraph 3 of the *International Covenant on Economic, Social and Cultural Rights* (United Nations 1966): "Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights in the present Covenant to non-nationals". From a moral perspective however, the restriction proposed by the HLEG can be seen as unbecoming to the world's fourth-largest economy with an average per annum growth rate of over 7% for more than a decade. It is eye-opening to compare this per annum growth rate with the 1.56% progress made in human development (measured as Human Development Index, HDI, composite statistic of long and healthy life, access to knowledge and a decent standard of living) over the same period (United Nations Development Programme 2011, and Drèze and Sen 2011). Virtually excluded are external migrants, who make up 0.5% of the total population – or 5,700,000 people – in official statistics only, and whose contribution to India's economic growth is not negligible (United Nations, Department of Economic and Social Affairs, Population Division 2006. Residents without an official permission are de facto considered 'illegal' and most likely not counted in official statistics). Denied is the fact that migrants are people too, with identical human rights, including health (International Commission of Jurists 2011: "Each state has the obligation to realize economic, social and cultural rights, for all persons within its territory, to the maximum of its ability"). In addition, the restriction is at odds with earlier commitments of India, particularly with the 1950 Indo-Nepal Treaty of Peace and Friendship that grants Nepalis to be treated at par with native citizens in India. See article 8 of the *Treaty of Peace and Friendship* (http://untreaty.un.org/unts/1_60000/3/9/00004432.pdf). A revision of this treaty has been announced by both Nepalese and Indian authorities, but the treaty is still binding. See also Bhattrai 2007. In defining the breadth of coverage, one would have expected from India a more comprehensive and inclusive aim.

[10] See, among others, Harrison and Pati 2009, Harrison 1994, Ramasubban 1988, and Health Survey and Development Committee 1946a.

[11] John Megaw (1933), quoted in Bradfield 1938.

[12] Bradfield 1938.

[13] Muraleedharan 1992.

[14] No author 1938.

[15] Health Survey and Development Committee 1946a, vol I, p 28-29.

[16] Shukla et al 2010.

[17] Bangdiwala et al 2011.

[18] A similar divide can be observed in their respective journals, the IPHA's *Indian Journal of Public Health* and the IAPSM's *Indian Journal of Community Medicine*.

[19] Khalegian and Das Gupta 2005.

[20] See Khaleghian and Das Gupta 2005, Pan American Health Organization 2002, Institute of Medicine, Committee on Assuring the Health of the Public in the 21st Century, Board on Health Promotion and Disease Prevention 2002, and Institute of Medicine, Committee for the Study of the Future of Public Health, Division of Health Care Services 1988. In India, the PHFI adheres to this school of thought. According to Thakker and Reddy "Public health systems, unlike most personal medical services, produce 'public goods', and are of high priority and assure good health outcomes for a nation" (Thakker and Reddy 2009, p 4).

[21] See Article 21 of Part III, *Fundamental rights*, of *The Constitution of India* (Government of India 2007).

[22] Balakrishnan 2008.

[23] See Article 12 of United Nations 1966.

[24] Bradfield 1938, and Health Survey and Development Committee 1946b, vol II, p 18.

[25] See Tavistock Group 1999 and WHO 2006.

[26] Marchal et al 2009.

[27] The Gujarat draft Public Health Act was immediately contested by the Indian Medical Association, see Government of Gujarat 2009. For the Assam Public Health Act, see Government of Assam 2010. Other states have been more restrictive in their conceptualisation of public health, e.g. Karnataka when drafting its public health act in 2010. See Government of Karnataka 2010.

[28] See Das Gupta et al 2010 and Das Gupta et al 2009.

[29] See Muraleedharan et al 2011 and Shiva Kumar et al 2011.

[30] Gupta et al 2011.

[31] See Vallée and McDonald 2006, p 968.

[32] See Nightingale 1865, in Vallée and Mc Donald 2006, p 950-955.

[33] Tamilnadu Nurses and Midwives Council 2011.

[34] It is useful to remember that gender disadvantage in India goes well beyond the health sector, as illustrated by its Gender Inequality Index (GII) of 0.617 (GII being 0 when women and men fare equally; GII being 1 when one gender fares as poorly as possible). See United Nations Development Programme 2011.

[35] Mavalankar et al 2011.

[36] Sharma and Mavalankar 2009.

[37] United Nations Population Fund 2011.

[38] See, among others, Lozano et al 2011 and Hogan et al 2010.

[39] United Nations Population Fund 2011.

[40] Pathmanathan et al 2003.

[41] See, among others, Shiffman and Ved 2007, and Pathmanathan et al 2003.

[42] The Bhore Committee calculated – on the basis of population and birth rate estimates, and one midwife to 100 births – that about 100,000 midwifes would be required. It estimated that of 11,000+ certified midwifes only 5,000 were actually practicing, leaving a gap of 95,000. See Health Survey and Development Committee 1946a, vol I, p 58 and p 156.

[43] See, among others, Tamilnadu Nurses and Midwives Council 2011, and Mavalankar et al 2011.

[44] See Government of India 1973, p 2: "Steps should be taken for the integration of medical, public health and planning services at the peripheral level". It can indeed be argued that there is a strong rationale for integration (even today, and not only at the peripheral level – see earlier comments in the section on the conceptualisation of public health). Integration should however be balanced with the need for skills and experience. As the plans for multipurpose workers were laid out and in the specific case of the midwives, the pendulum clearly swung too far.

[45] As estimated by the Institute for Health Metrics and Evaluation, see Hogan et al 2010, p 1614. Declared uncertainty intervals are 408-1,080 per 100,000 live births.

[46] As estimated by the Institute for Health Metrics and Evaluation, see Hogan et al 2010, p 1614. Declared uncertainty intervals are 81-105 per 100,000 live births (Sri Lanka) and 118-160 per 100,000 live births (Malaysia).

[47] See, among others, Pathmanathan et al 2003, and WHO 2005, p 65-67.

[48] See Van Lerberghe and De Brouwere 2001, p 17.

[49] For a detailed account of how the perception of maternal mortality changed gradually from a condition to a problem, see Shiffman and Ved 2007.

[50] See, among others, Lozano et al 2011 and Hogan et al 2010.

[51] For a detailed account of a comprehensive and successful Indian state approach, see WHO 2009.

[52] WHO 2005, p 65-67.

[53] Hatem et al 2009. Series of other well-informed publications point in the same direction. See, among others, Koblinsky et al 2006, Filippi et al 2006, and Green 2006.

[54] Mavalankar et al 2008.

[55] The most known of these efforts being reservation, dealt with extensively in *The Constitution of India*, Part XVI, *Special provisions relating to certain classes*, Articles 330-342, see Government of India 2007. It should however be noted that reservation has not been entirely successful in addressing "the anomalies and contradictions of our society, specifically focusing on caste, religion, and patriarchy". For a recent and comprehensive critique, see Heredia 2011.

[56] Government of India 2010, p 19.

[57] For a clear conceptualisation of structural versus intermediate determinants, and the need to also tackle the former, see Solar and Irwin 2010. "Arguably the single most significant lesson of the CSDH conceptual framework is that interventions and policies to reduce health inequities must not limit themselves to intermediary determinants, but must include policies crafted to tackle structural determinants" (p 64-65).

[58] "…enable individuals, groups and communities to improved access to healthcare services and empower them to make better health choices".

[59] Compare this reductionist conceptualisation to the more comprehensive – and powerful – conceptualisation of e.g. Ibrahim and Alkire; see Ibrahim and Alkire 2007.

[60] Most notably Borooah 2010, Nayar 2007, and Mohindra et al 2006.

[61] Core team member of the HLEG on behalf of the Public Health Foundation of India, quoted in Chatterjee, p 708.

[62] Chatterjee 2011.

[63] Or at least adds up to confusion and complexity.

[64] See Commission on Social Determinants of Health 2008, p 206, Recommendation 16.2: (The Commission recommends that:) "National governments establish a national health equity surveillance system, with routine collection of data on social determinants of health and health inequity".

[65] See Commission on Social Determinants of Health 2008, p 204, Recommendation 10.3: (The Commission recommends that:) "The monitoring of social determinants and health equity indicators be institutionalized and health equity impact assessment of all government policies, including finance, be used".

[66] See Krech and Rasanathan 2011, p 13: "Coherent policy responses to reduce health inequities require establishing governance that clarifies the individual and joint responsibilities of different actors and sectors" as well as "establishing who drives the action and takes the initiative".

[67] See Kutzin 2001 and Kutzin 1998.

[68] It is often overlooked that pure tax-based ('Beveridge') or pure insurance ('Bismarckian') systems are the exception, more than the rule. It was Beveridge' 'Report to the Parliament on *Social Insurance* and Allied Services' that laid the foundation for the UK's National Health Service. Bismarck included *state subsidies* in the first German health insurance schemes soon after making them compulsory. Social health insurance systems today increasingly rely on revenue from general taxation. See Criel et al 2008.

[69] For a comprehensive overview of the characteristics and challenges of social health insurance and tax-based financing for universal coverage, see Carrin and James 2004, and Savedoff 2004. For a definitive argument of the pointlessness of contrasting social health insurance with tax-based financing, see Carrin et al 2008, p 859: "It is the combination of institutional arrangements and legislation relating to revenue collection, pooling and purchasing/provision that determine how equitable and efficient a system is, rather than the name that is used to describe it. In fact, we have been unable to find evidence that implementation of universal coverage either via tax-based funding or social health insurance is more important to the final outcome".

[70] Government of India 2005.

[71] Besides maintaining a low tax-GDP ratio (currently no more than 16% despite robust increase in tax collection, see ET Bureau 2011), India has as few as 3% of its population paying income taxes (see BS Reporter 2011). It remains to be seen if these conditions will improve with the possible replacement of the 1961 Indian Income Tax Act by the announced Direct Taxes Code.

[72] Durairaj and Evans 2010.

[73] For a clear exposition of these key functions and the importance of addressing them in policy formulation, see Carrin et al 2008 and McIntyre 2007.

[74] Phadke 2011, Reddy et al 2011a, and Shiva Kumar et al 2011.

[75] See Gill 2009, p 65.

[76] Shiva Kumar et al 2011. See also George 2011 and Husain 2011.

[77] Sen 2011.

[78] In Karnataka, 85% of eligible households were aware of RSBY and 68% enrolled. Six months after enrolment, only 0.4% of enrolled households had actually used their card to access hospital services.

Design problems are a main cause: RSBY incentivises the insurance company to enrol as many as possible, but certainly not to encourage utilisation. See Rajasekhar et al 2011.

[79] Rannan-Eliya 2008.

[80] It is remarkable to see how close many of the HLEG's recommendation come to a system of managed care, without mentioning the term. Remarkable also – certainly if compared with the judgment on health insurance – is the HLEG's silence on the enormous difficulties to make managed care a success story for the end users.

[81] Prashanth 2011.

[82] See, among others, Ranson et al 2006 and Soors et al 2010.

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