Introduction

The coronavirus disease (COVID-19) pandemic has overwhelmed the health systems of countries across the globe like none other in modern memory. Those unable to contain the virus in the early stages have witnessed massive overburdening of their hospitals, including those with the most robust and advanced health systems. Some countries like South Korea which did a good job at early containment have witnessed second waves of COVID-19 of varying intensities. These, along with those that are deep into pandemic mitigation, have realized the importance of projection-based augmentation of healthcare capacity to handle ineluctable repeat outbreaks of COVID-19 in the vulnerable population. Containment measures form the primary and most desirable approach in epidemic response, since even the best healthcare systems flounder under rampaging infection. However, with a virus-like severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) which largely eludes successful containment through existing mechanisms of most countries, the importance of robust curative healthcare facilities at immediate public disposal has been increasingly realized.

India has fared relatively better than many advanced nations of the West in terms of COVID-19 morbidity and mortality, a trend common to many South Asian nations – with the caveats that infections are still rising and strict lockdown norms have had to be relaxed. However, while a series of lockdowns have helped slow down the growth of the infection, health systems have nevertheless been locally overwhelmed in worst-affected states. This is while access to non-COVID health services has been severely constrained due to the reorienting of the already frail public healthcare services in tackling COVID-19. As it stares at a protracted presence of COVID-19, India’s perennial neglect of public healthcare stands increasingly prone to criticism.

Upheaval, Path Dependence, and Transformation

At the same time, however, several parallels have been drawn between the pandemic and World War 2, identifying this crisis as a “window of opportunity” that could help overcome years
of inertia and push long-pending public healthcare reform in the country. Periods of crises have been known to facilitate drastic health system reforms, including universal health coverage (UHC), which otherwise are resisted during times of normalcy. This occurs due to the breaking of old interest groups resisting reform; social upheavals engendering social solidarity and mobilizing public support for comprehensive welfare; and changes in political configuration and priorities. Factors facilitating the above include the democratic nature of polity; social, ethnic, and income homogeneity; the presence of an organized left-wing; and political will. This was witnessed when the post-war United Kingdom (UK) nationalized its hospitals and organized its general practitioners into gatekeepers under its National Health Service (NHS) in 1948, overcoming years of resistance to switch from a partial, fragmented health insurance system into a universal, tax-financed one. In South Korea, nearly every incremental step of expansion and integration of social health insurance followed political or economic upheaval, including Park Chung-hee’s ascent to power, the democratic movement of 1987, and the foreign exchange crisis of 1997. In Turkey, the 1999 Izmit earthquake contributed to exposing the failures of a decade of unstable, coalition governments, and increased public expectations for health services, which laid the foundation of the Turkish Health Transformation Program (HTP). An examination of retrospective and emerging factors and conditions can help to estimate what shape a healthcare reform in the Indian context, in response to the current COVID-19 crisis, can take.

The necessity of crises or shocks to push change, often though not always, arises due to entrenched status quos which otherwise tend to progressively perpetuate and consolidate. Health systems are no different. This phenomenon, whereby institutional or system processes following a certain path find it progressively harder to jump to a different trajectory, is called path dependence. According to Mahoney (2000: 507), “path dependence characterizes specifically those historical sequences in which contingent events set into motion institutional patterns or event chains that have deterministic properties.” Each development along such a path tends to raise the chances of further developments along the same path, reinforces the path, and makes jumping into a new one difficult. A change of trajectory, or path transformation, entails either rare, radical shocks that open an opportunity for a new alternative, or a series of gradual, incremental, cumulative changes culminating into an altogether different path.

The potential of the COVID-19 pandemic to stir healthcare reform in India needs to be assessed keeping in view these concepts. It will be helpful to first look at the examples of two nations, the UK and South Korea, which in addition to serving as examples of path transformation and dependence, respectively, also feature two different models of healthcare financing, namely, tax-financing and social health insurance (SHI).

UK: A Case of Path Transformation

The NHS, a universal, tax-financed healthcare model, arose from the crucible of World War 2 and the ensuing post-war consensus on welfarism and the state’s duty to protect the health of its citizens. Before it, UK had a system of partial health insurance covering employees (excluding dependents) for mainly primary care services, while certain benevolent societies and charitable initiatives ran in parallel, comprising thus a fragmented healthcare ecosystem. It is possible to derive from the NHS example several key lessons about successful path transformation.

The war had sufficiently weakened the earlier opposition to a unified system, and this opportunity was utilized to introduce a scaffolding for the future NHS in the form of the Emergency Medical Services (EMS). The EMS took a centralized charge of all medical care considering the unusual demands due to wartime mass casualties, making it a legitimate alternative to the erstwhile fragmented system. It was also a feasible alternative, considering that the hospital system consisted predominantly of charitable and local government hospitals, and private interests were less strongly expressed. Feasibility enhanced legitimacy, and legitimacy reduced opposition.

In the post-war period, the then British Health Minister Aneurin Bevan led a series of negotiations with doctors, local governments, and other stakeholders, allowing them a range of concessions and garnering their support for a universal NHS. The wartime EMS, which catered for both the military and ordinary civilians, also greatly convinced the public of the benefits of a state-run universal healthcare system. As the British National Archives record, “The need to treat large numbers of civilian casualties from bombing raids gave people access to the healthcare they had never experienced before.” Widespread agreement across both professional and lay sections ensured that the NHS stood the test of time, something which a mere act of parliament could have hardly accomplished alone. Lastly, the landslide majority with the center-left labor party helped mobilize crucial political will for the NHS.

South Korea: An Instance of Path Dependence

South Korea, on the other hand, presents an example from the opposite end of the spectrum. Mandatory, multiple-payer health insurance was introduced in 1977 for employees in large firms and was extended to the entire population (universal health coverage) in 1989 when it managed to include the self-employed. Confronted with the economic crisis of the late 1990s, South Korea managed to successfully integrate its multiple insurers into a single National Health Insurance (NHI) in the year 2000. Insurance expansion and integration were largely driven by strong social movements, but while such movements targeted universalization of healthcare, the issue of weak public sector capacity was left largely unaddressed. With the expansion of insurance, the share of the public sector in healthcare fell rapidly, from having a 43.3% share of total beds in 1970 to
9.5% in 2007. A dominant and unregulated private sector has had multiple adverse consequences for Korean healthcare, such as deficient primary healthcare and excessive use of costly interventions.

South Korea thus exemplifies a path-dependent growth of the private sector where successive steps along the path kept reinforcing the trajectory. While it saw several social and political upheavals along this trajectory, it failed to introduce and leverage a new alternative path, that of expanding public sector capacity. With time, nationalizing private healthcare and securing support and legitimacy for a public-sector driven system became increasingly infeasible.

Lessons from these two countries will help understand the dynamics of the COVID-19 crisis and Indian healthcare.

**Wrong Trajectory for Indian Healthcare**

Given the overstretched and highly inadequate public sector hospital capacity in the wake of the COVID-19 pandemic, some proposals to nationalize private hospitals in India appeared initially. During the last few decades, the growth of healthcare services, particularly inpatient care, has been largely private-sector dominated. Such an arrangement is largely inept at mitigating amplified health emergencies of national concern, owing to limitations imposed due to geographical, logistical, financial, and administrative disparities and bottlenecks. At the same time, with the increasing realization that public healthcare needs fervent strengthening following this pandemic, the current crisis presents a critical juncture whereby introducing and leveraging pro-public healthcare measures can be of great significance for breaking away from the private sector dominated trajectory. A unified and coordinated mechanism to pool and distribute healthcare resources in the country (including manpower) financed by the government can meet both of the above purposes. Partial and disjointed measures, like some states taking over a few private hospital beds for COVID care and some expanding public health insurance, will prove ineffective in handling an amplified nationwide crisis. They would also be ephemeral, have little positive spill-over to the post-crisis phase, and may even end up further reinforcing the private sector dominated trajectory.

And the same appears to have already commenced. In April, the government decided to make COVID-19 testing and treatment free under the Ayushman Bharat-Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY), which covers close to 50 crore poor citizens (about 40% population). States like Tamil Nadu followed suit under their state health insurance schemes. In May, the worst-hit state of Maharashtra announced universalization of eligibility under its state health insurance scheme, the Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY), to include every resident of the state. There have also been suggestions to universalize entitlement under AB-PMJAY. The high-level group on health to the 15th Finance Commission has looked at expanding AB-PMJAY to the remaining 60% population as a medium-term measure. Public health insurance schemes have a reasonably long history in India. Beginning with the Rajiv Arogyasri Health Insurance Scheme of undivided Andhra Pradesh in 2007, a plethora of state-specific schemes appeared in the following years. The union government initiated the Rashtriya Swasthya Bima Yojana (RSBY) in 2008, whose scope was broadened first in 2016, and then in 2018 while rechristening it as AB-PMJAY. In 2019, the National Institution for Transforming India (NITI) Aayog released a long-term health financing reform agenda entitled “Health system for a new India: Potential pathways to reform” which advocated the insurance route to UHC, mainly building on the AB-PMJAY. Driven largely through private hospitals and insurance companies, public health insurance schemes invariably expand the private sector’s role in healthcare. Given that the insurance route is largely a manifestation of the dominant private sector trajectory, it appears that the pandemic may only reinforce the later rather than transform it. Moves to expand insurance during the pandemic could, therefore, entail exacerbated privatization in the pandemic aftermath. Indeed, certain states like Delhi, Telangana, and Rajasthan have capped COVID-19 treatment charges at private hospitals – with Maharashtra going a step forward and capping both COVID and non-COVID care charges for 80% beds in the private sector. However, such measures are ad-hoc and appear unlikely to translate into a nationwide mandate for price regulation in private healthcare once the pandemic recedes.

**Bleak Prospects of Change**

Some lessons from the country case studies cited earlier would help further underscore why no major leap towards a publicly financed and provided healthcare model (hereinafter “the model”) should be anticipated. According to Johnson (2001: 254), “the weight of past and preexisting paths strongly constrain and limit the impact of the most radical ruptures.” The private sector’s strong path-dependent legacy and institutional stability in India would not only deter garnering of enough support for the model but also renders a dramatic decision to nationalize private hospitals practically impossible. The absence of a precursor to the model during the pandemic, akin to the wartime EMS for the post-war NHS, would prevent mobilization of strong public demand for the model. These factors would undermine both feasibility and legitimacy, which are indispensable for pushing lasting reform. Also, a protracted COVID-19 pandemic, expected to last for many months, may dampen the acute nature of the crisis and erode the urgency for major reform. Lastly, the present right-wing political dispensation with its pro-private sector leanings is unlikely to bring enough political will to back the model. The Prime Minister’s call in July for greater US investments in India’s fast-growing healthcare sector can be a testament to this.

**Impact on Primary Healthcare**

The impact of the pandemic and the afore-discussed trajectory of Indian healthcare on primary care can be twofold.
Firstly, since public health insurance schemes like AB-PMJAY cover secondary and tertiary care hospitalization, they can deprive primary care of enough attention and resources. The stagnation of the union National Health Mission budget in recent years suggests that public health insurance can entail the displacement of crucial funds meant for primary healthcare to secondary and tertiary healthcare. Besides, there has been relatively less emphasis on Health and Wellness (H&W) centers compared to the AB-PMJAY, both of which were supposed to be equal components of the Ayushman Bharat mission. One author has suggested that the purpose behind the H&W centers component could be more about facilitating the insurance component of the mission viz. AB-PMJAY and public-private partnerships, rather than strengthening primary healthcare itself.[13] Considering that current talks of extending UHC following COVID19 remain centered on AB-PMJAY, it is likely that primary healthcare, which is the main pillar of UHC, remains neglected or even gets compromised. The latter seems likely given the fiscal constraints arising due to the COVID19-driven economic slowdown.

Secondly, the pandemic itself could offer an incentive to prioritize hospital care for state patronage over primary healthcare. Since serious and critical cases of COVID-19 enjoy disproportionate visibility and public attention, public demand, and political will may rally behind strengthening hospitals and underplay the importance of strengthening primary healthcare, which is indispensable for effectively tackling future pandemics. This becomes more concerning given the fact that industry interests are similarly aligned.

Shedding Our Persistent Neglect of Healthcare

Cultivating a lasting legacy from the learnings of the current pandemic, particularly in terms of mitigation capacity, demands that public healthcare be comprehensively strengthened. The current trend of pursuing UHC through the insurance route is largely a compromise, born out of the imperative to make use of the expansive private sector to extend healthcare to the poor. Global experience is indicative that such an insurance model does not address the problems of inequity and access. Further, the economic slowdown and revenue shortfalls entailed by the pandemic may discourage capital spending in public healthcare and reinforce the private sector dominated the insurance route. The set of announcements made in May under the 20 lakh crore fiscal stimulus package displayed our persisting lethargy towards making substantial commitments to public health. Health was discussed in the 5th tranche (final day), and the first half of the health briefing was spent discussing what was done until then in the pandemic. The measures under “Increased investments in Public Health” were the same generic and ritualistic commitments we have been hearing for decades, like higher investments in public health and grassroots institutions, without explicit and substantive financial appropriations. The reforms conceived under pandemic preparedness are promising, such as creating infectious diseases blocks in district hospitals, but will hardly suffice for a moderate outbreak. For example, today, there is a pressing need for a public tertiary care hospital in every district of the country. Responding to massive health emergencies warrants the capability to mobilize and coordinate the whole pool of a nation’s health resources towards emergency response as a single unit. Fragmented reform initiatives, therefore, will not do – there is a need for a comprehensive “Post-COVID Health Reconstruction Plan.”

The Way Forward

While UHC should be a priority, the proposal to achieve it by expanding health insurance, such as through AB-PMJAY, merits reconsideration. Suggestions have been made to universalize AB-PMJAY by allowing premium contributions from sections not currently covered under the scheme. There is evidence indicating that such contributory insurance in countries with a large informal sector (like India) may not be the best way forward for UHC.[10] Rather, public provisioning of healthcare financed mainly through tax revenues ensures equity and is simpler to implement. SHI has been associated with higher per capita expenditures without corresponding improvements in health outcomes vis-à-vis tax-financed systems.[14] Persistent, high out-of-pocket expenses; disparities in access; pervasive fraud and malpractices; and high, wasteful administrative expenditures are likely with the insurance route in India.

The entrenched trajectory of private healthcare entails that no quick and radical transformation should be expected. A “Post-COVID Health Reconstruction Plan” should envisage gradual but cumulative reforms to augment public healthcare. However, a bold beginning, in the form of a robust short-term action plan, needs to be made during the pandemic itself. Policymakers could then engage in garnering legitimacy and support towards scaling it up incrementally and steadily. Such measures would cement an alternative path that itself can be self-preserving. For example, despite the drive for privatization under the Thatcher regime (1979-90) in the UK, the NHS remained largely intact in its core principles. This is owing to path dependency. It is for similar reasons that the state of Kerala, despite having undergone considerable privatization over the last few decades, still has better public healthcare than most other Indian states.

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References
1. Stuckler D, Feigl AB, Basu S, McKee M. The political economy of universal health coverage. Background paper for the Global Symposium on Health Systems Research 16-19
Bhaduri: COVID and Indian healthcare reform

November, 2010, Montreux, Switzerland; 2010. [Cited 2020 May 18]. Available from: http://www.healthsystemsresearch.org/hsr2010/images/stories/political_economy.pdf

2. Mckee M, Balabanova D, Basu S, Ricciardi W, Stuckler D. Universal health coverage: A quest for all countries but under threat in some. Value Health 2013;16:539-45.

3. Lee SY, Kim CW, Seo NK, Lee SE. Analyzing the historical development and transition of the Korean health care system. Osong Public Health Res Perspect 2017;8:247-54.

4. Atun R, Aydin S, Chakraborty S, Sümer S, Aran M, Gürol I, et al. Universal health coverage in Turkey: Enhancement of equity. Lancet 2013;382:65-9.

5. Mahoney J. Path dependence in historical sociology. Theor Soc 2000;29:507-48.

6. Djelic ML, Quack S. Overcoming path dependency: Path generation in open systems. Theor Soc 2007;36:161-86.

7. Light DW. Universal health care: Lessons from the British experience. Am J Public Health 2003;93:25-30.

8. The National Archives [Internet]. Origins of the NHS. [Cited 2020 May 18]. Available from: https://www.nationalarchives.gov.uk/cabinetpapers/alevelstudies/origins-nhs.htm.

9. Lee JC. Health care reform in South Korea: Success or failure? Am J Public Health 2003;93:48-51.

10. Yang BM. The role of health insurance in the growth of the private health sector in Korea. Int J Health Plann Manage 1996;11:231-52.

11. Johnson J. Path contingency in postcommunist transformations. Comp Polit 2001;33:253-74.

12. Hooda S. Decoding Ayushman Bharat. Econ Political Wkly. 2020;55:107-15.

13. Tangcharoensathien V, Patcharanarumol W, Ir P, Alijunid SM, Mukti AG, Akkhavong K, et al. Health-financing reforms in Southeast Asia: Challenges in achieving universal coverage. Lancet 2011;377:863-73.

14. Wagstaff A. Social Health Insurance Vs. Tax-Financed Health Systems-Evidence From The OECD. Washington: The World Bank; 2009. [Cited 2020 May18]. Available from: http://documents.worldbank.org/curated/en/5451214680288688365/Social-health-insurance-vs-tax-financed-health-systems-evidence-from-the-OECD.