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India's "tryst" with universal health coverage: Reflections on ethnography in Indian health policymaking

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ABSTRACT

In 2011, India stood at the crossroads of potentially major health reform. A High Level Expert Group (HLEG) on universal health coverage (UHC), convened by the Indian Planning Commission, proposed major changes in the structure and functioning of the country's health system. This paper presents reflections on the role of ethnography in policy-based social change for health in India, drawing from year-long participation in the aforementioned policy development process. It theorizes that international discourses have been (re)appropriated in the Indian case by recourse to both experience and evidence, resulting in a plurality of concepts that could be prioritized for Indian health reform. This articulation involved HLEG members exerting para-ethnographic labour and paying close attention to context, suggesting that ethnographic sensibilities can reside within the interactive and knowledge production practices among experts oriented toward policy change.

Introduction

A crisp November morning in 2011, the Chairman of India's High Level Expert Group (HLEG) on universal health coverage (UHC) concluded his hour-long presentation with the following exhortation: "As Toni Morrison said, 'If we don't create the future, the present extends itself.' I believe it is time that we set about creating our own future and address our new tryst with destiny in 2012." For a brief second, the room was silent.

Seated around him were his Expert Group colleagues, members of the Indian Planning Commission, representatives of India's bilateral donor agencies, international health policy scholars, and the Expert Group's technical secretariat. Some of us were hanging on Morrison's words, while others recreated in our heads the iconic moment of Indian Independence, when the first Indian Prime Minister and architect of Indian modernity, Jawaharlal Nehru, spoke of India's nascent nationhood as a "tryst with destiny." With this carefully chosen quote and semantic tribute, the Chairman had likened this meeting on India's health reform to the cusp of Indian independence 64 years prior.

The Expert Group was proposing a (re)construction of India's health system so as to honour a universal entitlement to health, with guaranteed, cashless access to an essential health package of primary, secondary and some tertiary care, from a choice of public or contracted-in private providers (High Level Expert Group on Universal Health Coverage, 2011). As noted by the Chairman, the policy process for universal health coverage, preparing for its "tryst with destiny" under the Twelfth Five Year Plan, entailed constructing a future for a diverse, often fragmented, republic of states with complex histories, varied priorities, and myriad stakeholders. The report intended to provide "a framework…a useful beginning" (High Level Expert Group on Universal Health Coverage, 2011: 2).

Such a beginning signalled the possibility of resurrecting a Nehruvian, welfarist approach to health in India, helping to reverse the damage of two decades of neglect of the Indian public health sector. As in the early years of India's independence, this vision for the future had to be relevant, feasible, and resonant to state leaders across the Indian republic, since health is constitutionally designated as a state subject. While over a third of funding and the bulk of planning guidance in India comes from the central government (advised by entities like the Expert Group), the implementation of any health reform policy is ultimately in the hands of the political and bureaucratic leadership of each of India's 29 states and 7 union territories. All of them, including states with better-performing health indices like Tamil Nadu and Kerala, exhibit in varying degrees what health systems researcher Sania Nishtar has called the "mixed health systems syndrome" (2010: 74). This syndrome is characterized by insufficient public funding for health, a dominant and largely unregulated private sector, and lack of transparency in governance (Nishtar, 2010). Research corroborates this for the Indian case: 1) public funding for health in the past three decades

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has never passed 2% of India's Gross Domestic Product, among the lowest allocations in the world; 2) the private sector, accounting for 70–85% of health-seeking at the grassroots, lacks national regulations for health care provision (Kumar et al., 2011); and 3) corruption has been a persistent feature of the health sector (George, 2009; Huss et al., 2011), as indeed, the governance institutions of other sectors.

Proposing a plan to transform a mixed, ailing health system into a universal, sustaining one, that too in the course of roughly a year as per our mandate from the Planning Commission, required continuous researching, pitching, drafting, presenting, discussing, dismissing, revising, and (re)developing. These actions – conceived in gerund – are echoed in the HLEG's very definition of universal health coverage:

> Ensuring equitable access for all Indian citizens resident in any part of the country, regardless of income, social status, gender, caste, or religion, to affordable, accountable, and appropriate, assured quality health services (promotive, preventive, curative, and rehabilitative) as well as public health services addressing wider determinants of health delivered to individuals and populations with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services.
>
> High Level Expert Group on Universal Health Coverage (2011): 3

To a participant observer in this process, the gerundive connotation of continuous action is significant. The HLEG saw UHC as a process of responsibility (ensuring), recognition (addressing), and state identity formation (being guarantor and enabler). This nascent policy process offers important lessons with regard to the relationship between ethnography and social change, the subject of this special issue.

A number of ethnographies of international development address ethnography and social change in developing countries (Escobar, 1994; Ferguson, 1990; Green, 2007; Mosse, 2005; Pigg, 1992; Unnithan & Heitmeyer, 2012). Mosse's (2005) ethnography of agricultural development in India concluded that mobilizing metaphors (like 'participation' and 'governance') are generated in policy discourse to conceal ideological differences within aid agencies, enable compromise and importantly, multiply criteria of success applied to projects. Escobar (1994) and Pigg (1992), drawing from Latin American and South Asian fieldwork, also refer to developmental categories that fuse the global and the local, in turn shaping the possibilities of every day experience. Recounting "policy stories" related to criminal justice in the UK, Stevens talks about how the global category of social exclusion has shifted attention away from inequality itself such that "silence on inequality prevailed" (Stevens, 2011: 248). An ethnographic study of NGO activity in western India reflects on partnerships between civil society organizations and the state, signalling a shift from opposition to collaboration – and a "fulcrum" for the state to reassert its legitimacy as a response to a global rights-based discourse (Unnithan & Heitmeyer, 2012). Such recursivities in relation to global discourses occur in the domain of health policy-making as well, and are the object of study in this paper.

But going a step further, examining these recursivities more closely, we see that whether through mobilizing metaphors, policy stories, or collaboration, not just ethnographers, but a variety of other stakeholders interpret, analyse and intervene upon social change. I submit that to understand ethnography and social change, we need not limit ourselves with ethnography *of* social change, but turn our minds to the possibility of ethnography *in* social change, where ethnographic subjects themselves co-construct our understandings and action *for* social change.

Methods

My analysis emerges from a year-long membership (late 2010 to late 2011) of the technical secretariat supporting the Indian Planning Commission-appointed High Level Expert Group on universal health coverage (referred to here as Expert Group, though commonly referred to in India as "HLEG").

The Expert Group was convened by a Notification dated 5th October, 2010 of the Health and Family Welfare Division, Planning Commission of India with the approval of the Indian Prime Minister, "recognizing the importance of defining a comprehensive strategy for health for the Twelfth Plan"(High Level Expert Group on Universal Health Coverage, 2011: 315). The group comprised sixteen eminent academics, policymakers, and practitioners in the field of public health and was to be supported by a technical secretariat housed at my parent institution. The Planning Commission tasked the Experts with six terms of reference: 1) developing a blueprint for human resources, 2) evolving physical and financial norms for health service delivery, 3) designing management reforms to improve system efficiency, effectiveness and accountability, 4) proposing guidelines for the constructive participation of communities, locally elected bodies, civil society, and the private sector, 5) conceiving a plan for the production, import, pricing, distribution and regulation of essential drugs, vaccines and consumables, and 6) considering a financing system to offer universal access to health services with high subsidy for the poor (High Level Expert Group on Universal Health Coverage, 2011: 316).

Between October 2010 and November 2011, various meetings spilling across three to five day periods took place. They included ten meetings of the Expert Group (with visitors, some without, and a quorum of at least 4-5 members present), three additional meetings pertaining to specific terms of reference, as well as five consultative meetings with external and international experts and stakeholders (including a two-day international conclave). The Chairman of the Expert Group along with one or two members gave progress reviews to the Planning Commission on multiple occasions as well. The technical secretariat also had a writing retreat about halfway through the consultative process to prepare an interim report that was also submitted to the Planning Commission. A description of the process of consultations informing the HLEG's recommendations is appended to its report (High Level Expert Group on Universal Health Coverage, 2011: 303–316).

As a member of the technical secretariat working in support of many of the Expert Group's meetings, I synthesized research evidence in the form of summary statistics and case studies, based on individual and group requests fielded to us via our Study Director. I would be present at Expert Group meetings and took responsibility, along with one or two other colleagues for taking notes and transcriptions of conversations *in vivo*, which I would later, in collaboration with one or two other colleagues, condense into summary minutes for email circulation to HLEG and technical secretariat members.

Members of the HLEG were powerful, influential, and busy: there were competing demands for their time. Therefore, technical secretariat members tried to prioritise timely responses to their requests for information and updates on the discussions of meetings. Bureaucrats with on-going responsibilities in their home state, grassroots practitioners based in more remote parts of the country, and those who frequently travelled abroad were unable to attend regular meetings in Delhi. These members would sometimes be teleconferenced in and other times submit points and comments in writing that would be discussed by the larger quorum of members present. In this instance, policymaking becomes a cultural practice where "communities aligned around shared cultural repertories