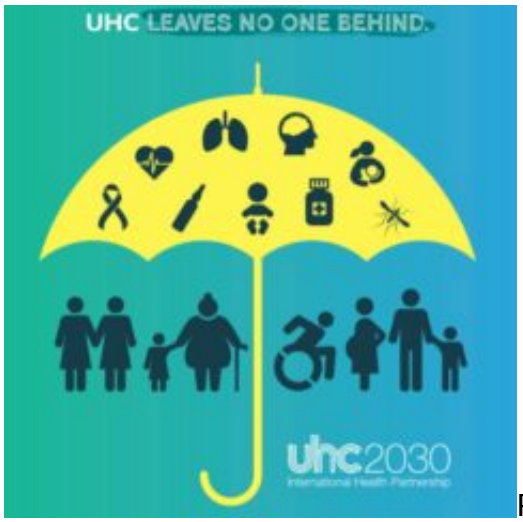
http://somatosphere.net/?p=18120

Health Technology Assessments: the metrical evangelization of UHC in India

2020-06-29 06:00:01

By Robert D. Smith



Promotional materials from the global campaign to achieve Universal Health Coverage by the year 2030. Copyright UHC2030 – reproduced here under 'fair use' for academic purposes.

"Health for All?" ***critically explores global moves towards Universal Health Coverage and its language of rights to health, equity, social justice and the public good. Highlighting emerging ethnographic and historical research by both young and established scholars, the series explores the translations and frictions surrounding aspirations for "health for all" as they move across the globe. The series is edited by Ruth Prince.***

Introduction

In this piece, I explore the impacts of the rise of the Health Technology Assessment (HTA) as a new global health metric for universal health coverage in India. I consider how health systems planners rely upon HTA metrics to generate populist political discourses of Universal Health Coverage that simultaneously allow for translations of the concept of the 'universal' into politically convenient structures of health systems. The HTA is significant because governments emphasize this metric as a tool for allocating funding to health systems. Compared to previous measures

including cost-effectiveness, quality-adjusted life-years (QALYs), disability-adjusted life-years (DALYs), and others, the HTA is seen as a tool that more thoroughly captures the social, political, and commercial determinants of health. Following HTA, I explore how 'universal' concepts are engaged and produced within health systems (Prince 2017). By identifying what type of information is produced by HTAs, I demonstrate what "counts" as health and for whom when this metric is used to fulfil imaginaries of health care universalism (Adams 2016: 36).

I first briefly detail the history of the HTA before providing an example of how the HTA has been used in decision-making for Ayushman Bharat (AB), India's recent 'universal' health insurance scheme. I argue that the HTA's branding as *the* metric for UHC health systems planning — recently officially endorsed by the World Health Organization (WHO) —allows governments to call upon ambiguous meanings of "universal" to support political aims while still often leaving behind the most vulnerable populations (WHA 2014).

A Brief Genealogy of the HTA

The HTA was first adopted as a tool for publicly funded health systems in the United Kingdom and Australia, where HTAs increasingly became tied to notions of political accountability (Chinitz 2004). This element of accountability helped the UK and Australia become models for publicly funded UHC systems. When the era of UHC dawned, the global health community thus embraced HTA methodology as a form of capacity-building for UHC in low-and-middle-income countries (LMICs).

However, the implementation of HTA in LMICs greatly differs from what has been seen in the UK and Australia. For example, for a health technology to pass assessment in the UK, it must be below a cost threshold, have better safety and efficacy than currently available in the health system, and be voted upon by health professionals, local government, and civilians (Bojakowski and Spoors 2014). However, in LMICs, determinants of medical costs to patients are more often related to insufficient supply chains than to market price, raising the question of how cost thresholds can be set which take into account the dynamics of a health system (CGD 2019). Further, patient populations in LMICs are often transient, which makes it difficult to achieve the accountability that HTAs supposedly provide (Sirohi et al. 2018). When I asked one HTA researcher how HTAs are translated to LMICs, they replied the following:

*It's a priority setting process in health that brings into account evidence that is important to those decision makers — **and hopefully that population** — that is somewhat of a transparent and accountable process … a rejection of the dictator problem … we don't want someone making*

decisions in the dark.

In other words, the HTA is seen to provide a shift from illiberal, 'dictatorial' decision-making without evidence, to health systems planning which considers evidence 'hopefully' relevant to the health needs of the population. This evidence is thus understood to represent who and what is seen as legitimate within conceptions of 'universal' health coverage.

The HTA Goes to India

The HTA in India is most commonly used at the level of the central government to make decisions about funding for high-cost medical technologies in national health insurance schemes. For nearly 20 years India relied upon a Medical Technology Assessment Board which employed similar methods and evolved to form today's Health Technology Assessment in India (HTAin) board (DHR 2019). To understand the use of HTA in India it is important to first discuss the broader politicization of UHC in India.

Universal Health Coverage Populism

In the 2018 central government elections, India's new health insurance scheme, Ayushman Bharat (AB), was for the first time branded as UHC; grandiose claims of 'being on the path to UHC' were seen as a central element to the Modi government's election (Narayanan 2018). However, the structure and spending of AB often supports the privatization of care (Leo 2019). Rather than choosing to invest in existing public health infrastructure, AB provides the 'poorest 500 million Indians' with up to 5,00,000 INR in coverage which can be spent in public or private facilities (Chalkidou 2019). In an interview with the former CEO of the National Health Authority — the Ministry of Health and Family Welfare's (MOHFW) implementing branch which was created for the purpose of AB — he suggests that monitoring public hospitals across India would be too challenging and tracking patient spending within AB enables a better understanding of the demand side of the health system (Arora 2019). The emphasis on the private sector in Modi's method of reaching a form of UHC is echoed in other central government recommendations including private-public-partnerships in medical training (Niti Ayog 2019). Unsurprisingly, the 2020 MOHFW budget report confirmed that over 50% of AB insurance funds were spent in private medical facilities (MOHFW 2020). It is within this context of privatizing state logics that the HTAin board operates, almost exclusively for the purpose of approving health technologies for coverage within AB.

The HTA for Universal (Private) Health Coverage

When I first attempted to understand what the HTA does in India, a health economist told me that a "*real* HTA in India is almost entirely an academic exercise" and explained that in practice most HTAs are reduced to cost-effectiveness analyses. An often-cited reason for this is the decentralization of India's health care system; health is primarily seen as a state responsibility and relies on small central government funding and insurance schemes. Aggregating state level data in a comparable way for HTAs at the central government level "requires the rapid development of a robust data infrastructure … would have to [follow health outcomes] over longer time periods … [and relies on] limited human resource capabilities in health economics" (Rao et al. 2018: 6). The lack of comparable and comprehensive evidence for HTAs begs a closer analysis of the activities of HTAin to understand who is seen as a legitimate beneficiary of 'universal' coverage.

When I spoke with members of the HTA-in-India (HTAin) board, some emphasized how, despite strong advocacy, discussions of equity were almost never considered. Examples of HTAs by HTAin demonstrate their emphasis on high cost treatments; for example, some of the most recent HTAs include cardiac stints and cataract surgery equipment (Chalkidou 2019). However, the technologies reviewed by HTAin do not reflect the burden of disease shared amongst the poor. Instead, the HTA supports a notion of the 'universal' which can only become universal by relying upon a privatized health system that ensures the 'efficient allocation' of resources.

Accessing Universal Health Coverage

To understand what the HTA actually does for the health system it is useful to turn to the encounters patients have when attempting to access health insurance which has been shaped by HTA methodology. Elsewhere in this series, Marine Al Dahdah noted how "the mechanisms of inclusion of individuals" within AB can block "access to health facilities … based on technical criteria" (Al Dahdah 2020; also see: Bärnreuther 2020, this series). Specifically, the implementation of AB was followed by anecdotal accounts of the shortcoming of the scheme. Many patients were unable to receive health insurance cards due to broken machines in government offices (Medical Buyer 2019). In January 2020, a patient died while waiting to un-enroll from one health insurance scheme in an effort to be eligible to enroll in AB (Nagarajan 2020).

Further, many large corporate hospital chains do not accept AB. Hospitals complain that AB takes too long to issue reimbursements to be considered financially pragmatic. Hospitals also complain that the reimbursement caps which have been set by AB are below the at-cost price charged by the hospital. Because of this, patients must often utilize poor quality public

facilities, or resort to ‘middle of the road’ private facilities. Private hospitals which accept AB have been characterized as having “quality challenges, including a general lack of awareness about cleanliness, infection control, and patient safety, and insufficient infrastructure, support services, and skilled human resources” (Chatterjee 2019: 4).

For hospitals which do accept AB, patients face a number of challenges in utilizing insurance for the purpose of treatment. For example, one physician anecdotally recounted to me a cancer patient who cobbled together funds for treatment expenses from AB, a state health insurance scheme, and private and public philanthropic funds, but still faced significant out-of-pocket-expenditures (OOPE). For this patient, the 5,00,000 INR cap of AB per family household was far below the total cost of their cancer treatment. Further, because the patient had to draw upon multiple funding sources, the physician had to adapt the treatment plan based upon what was covered by AB and other insurance and subsidy schemes. This had the effect of lengthening the treatment plan, and subsequently further increasing total OOPE.

What these examples demonstrate is how AB represents a notion of ‘universal’ health coverage which often remains very distant from the needs of patients when accessing health care. These cases echo what has elsewhere been called ‘austerity welfare’: the provision of public health services alongside the “commercial valorization” of patients’ needs and their produced health data (Kar 2017; Al Dahdah 2020). In this case, the HTA works to enable broader populist brandings of aspirations for UHC while paradoxically necessitating privatized health services as the primary vehicle of delivery for ‘universal’ health coverage.

Robert D. Smith is an MA candidate in Anthropology and Sociology at the Graduate Institute of Geneva. He is interested in primary health care in the treatment of non-communicable diseases in Delhi, India, and more broadly practices of public health policy prioritization.

Works Cited

Adams, Vincanne. 2015. *Metrics*. Duke University Press. https://www.dukeupress.edu/metrics/.

Al Dahdah, Marine. 2020. “The Public-Private Welfare State: constructing a data-driven health coverage in India.” *Somatosphere.*

Arora, Dinesh. 2019. “Can Countries Afford 2019 UN High Level Meeting Declaration On UHC”. *Center For Global Development*. https://www.cgdev.org/event/can-countries-afford-2019-un-high-level-meeting-declaration-uhc-0.

Bojakowski, Steve, and John Spoors. 2014. “The Funding of Orphan Medicines in the UK.” *British Journal of Healthcare Management* 20 (8): 384–91. https://doi.org/10.12968/bjhc.2014.20.8.384.

CGD Center for Global Development. 2019. “Tackling The Triple Transition In Global Health Procurement.” Promoting Access To Essential Health Products Through Aid Eligibility.

Chalkidou, Kalipso, Nishant Jain, Francoise Cluzeau and Amanda Glassman. 2019. “Modicare Post-Election: Recommendations To Enhance The Impact Of Public Health Insurance On UHC Goals In India”. CGD Note. London, United Kingdom: Center for Global Development.

Chatterjee, Patralekha. 2019. “Modi’s Health Reforms: Between Hope and Hype.” *The Lancet* 394 (10208): 1495–98. https://doi.org/10.1016/S0140-6736(19)32601-7.

Chinitz, David. 2004. “Health Technology Assessment in Four Countries: Response from Political Science.” *International Journal of Technology Assessment in Health Care* 20 (1): 55–60. https://doi.org/10.1017/S0266462304000789.

DHR Government of India Department of Health Research. 2019. “Concept Note For Establishing Medical Technology Assessment Board (MTAB) And Institutionalizing HTA In India.”

Kar, Sohini. 2017. “Austerity Welfare: Social Security in the Era of Finance.” *Anthropology Today* 33 (5): 12–15. https://doi.org/10.1111/1467-8322.12378.

Leo, Leroy. 2019. “Niti Aayog Calls Healthcare System A ‘Sinking Ship,’ Urges Private Medical Buyer. 2019. “In Rajasthan, Registration Quagmire Leads To Zero Beneficiaries Of Ayushman Bharat.” *Medical Buyer* (blog). 2019. https://www.medicalbuyer.co.in/in-rajasthan-registration-quagmire-leads-to-zero-beneficiaries-of-ayushman-bharat/.

MOHFW. 2020. “Notes on Demands for Grants, 2020-2021.” MINISTRY OF HEALTH AND FAMILY WELFAR Department of Health and Family Welfare. https://www.indiabudget.gov.in/doc/eb/sbe42.pdfz.

Nagarajan, Reema. n.d. “Delhi: Caught in Cracks between Two Schemes, 17-Year-Old Dies | Delhi News – Times of India.” The Times of India. Accessed May 3, 2020. https://timesofindia.indiatimes.com/city/delhi/delhi-caught-in-cracks-between-two-schemes-17-year-old-dies/articleshow/73568850.cms.

Nayantara Narayanan, Nithya Subramanian & Rohan Venkataramakrishnan. 2018. “The Election Fix: How Will Voters Pick between Ayushman Bharat and a Right to Healthcare?” Text. Scroll.In. https://scroll.in. 2018. https://scroll.in/article/917623/the-election-fix-how-will-voters-pick-between-ayushman-bharat-and-a-right-to-healthcare.

Niti Ayog. 2019. “Public Private Partnership In MEDICAL EDUCATION.” New Delhi, India: Government of India NITI Aayog. https://niti.gov.in/sites/default/files/2019-12/ModelConcessionAgreement-forSetting-upMedical-Colleges-under-Public-private-Partnership-Draft-for-Comments.pdf.

Prince, Ruth. 2017. “Universal Health Coverage in the Global South: New Models of Healthcare and Their Implications for Citizenship, Solidarity, and the Public Good.” *Michael* 14 (2): 153–72.

Rao, Neethi V, Laura Downey, Nishant Jain, Rama Baru, and Francoise Cluzeau. 2018. “Priority-Setting, the Indian Way.” *Journal of Global Health* 8 (2): 020311. https://doi.org/10.7189/jogh.08.020311.

Sirohi, Bhawna, Kalipso Chalkidou, C S Pramesh, Benjamin O Anderson, Patrick Loeher, Omar El Dewachi, Omar Shamieh, et al. 2018. “Developing Institutions for Cancer Care in Low-Income and Middle-Income Countries: From Cancer Units to Comprehensive Cancer Centres.” *The Lancet Oncology* 19 (8): e395–406. https://doi.org/10.1016/S1470-2045(18)30342-5.

WHA World Health Assembly. 2014. “WHA67.23 Health Intervention And Technology Assessment In Support Of Universal Health Coverage.” Geneva, Switzerland.

AMA citation
Smith R. Health Technology Assessments: the metrical evangelization of UHC in India. *Somatosphere*. 2020. Available at: http://somatosphere.net/?p=18120. Accessed June 26, 2020.

APA citation
Smith, Robert D.. (2020). *Health Technology Assessments: the metrical evangelization of UHC in India*. Retrieved June 26, 2020, from Somatosphere Web site: http://somatosphere.net/?p=18120

Chicago citation
Smith, Robert D.. 2020. Health Technology Assessments: the metrical evangelization of UHC in India. Somatosphere. http://somatosphere.net/?p=18120 (accessed June 26, 2020).

Harvard citation