Health for All

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India's new National Health Policy 2017 signifies a paradigm shift in government policy towards comprehensive primary health care and is significant for two reasons: firstly, it defines health in terms of wellness rather than as absence of disease and secondly, it brings focus back on primary care and accords a key role to the public sector

Social security as a theme has always gained importance during periods of economic instability and crises. Though the landmark Beveridge Committee Report in 1942 defined social security in the broadest possible terms as 'Freedom from Want', this definition could not be followed through and the more operational and narrow interpretation of social security as contingency related measures was adopted at the International Labour Organisation convention in the 1950s. In 1989, Dreze and Sen proposed a broadening of the definition in the context of developing countries following which Prabhu[1] reiterated that what is relevant for India is the concept of *socio economic security* ensuring enhancement of social capabilities and economic security. Health security is an integral part of such a wider notion of social security.

Health for All:

Health security is linked inextricably with the notion of universal health care and received prime importance following the Alma-Ata Declaration in 1978 to achieve *Health for All* by 2000. Inspired by this goal and informed by the ICSSR-ICMR report 1981[2], the Government of India announced in 1983 the National Health Policy, which was subsequently replaced by the National Health Policy of 2002. The National Rural Health Mission (NRHM) was initiated in 2005 to revitalise the primary health care system in the country. Despite these policy initiatives, universal health coverage remains an unfinished agenda with basic indicators of health in India continuing to be below those of low income countries such as Bangladesh[3] and crucial health Millennium Development Goals (MDGs) being missed.[4]

India's health system mirrors the iniquitous nature of development that has taken place in the country. High income and wealth inequality[5] has resulted in a skewed pattern of health care oriented towards secondary tertiary level curative services, leading to the neglect of the more basic preventive and primary care services needed for the poor to survive. The World Health Organisation estimated that in 2008, 5.2 million Indians died of non- communicable diseases which accounted for 53 per cent of all deaths in the country[6]. Income and wealth disparities are also reflected in the sharply differing health outcomes across rural and urban areas, states and social groups[7]. In 2015, health inequality resulted in a loss of 24 per

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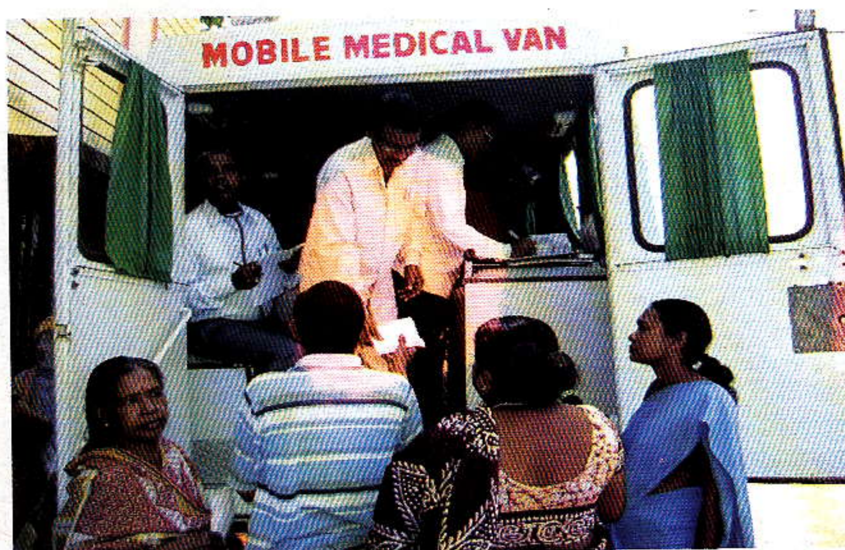
cent of India's health index value as per the Inequality adjusted Human Development Index computed by the UNDP[8].

Further, low political commitment to ensuring basic primary and preventive health care has meant that unlike education, *Health for All* has never been an important electoral issue, though the potential for electoral gains are evident as in the case of Andhra Pradesh [9, 10]. The general political apathy towards the health sector is also reflected in low budgetary allocations, with public spending accounting for not more than 1.5 per cent of GDP over the last decade despite impressive economic growth. This has meant that 75 per cent of health care costs are financed by out of pocket expenses and catastrophic health expenses regularly push a large number below the poverty line.



Health Insurance in India:

Countries such as Brazil, Bolivia, Indonesia and Thailand, all characterised earlier by situations of high inequality and uneven access to health care systems, have revamped policies since the 1980s towards universal health care. The 30 baht scheme in Thailand, decentralisation reforms and social health insurance in Indonesia, and the unified health system in Brazil provide examples of how countries have addressed basic health requirements of the entire population. These examples indicate that strengthening of the primary health care system is a prerequisite for achieving universal health coverage.[11,12]

Health insurance in India began with Employment State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS) that cater to government employees and their dependants. These schemes focus on high-end secondary and tertiary care and together provide protection to less than 10 per cent of the India's population working in public sector undertakings.[13, 14]

A conditional cash transfer scheme *Janani Suraksha Yojana* (JSY) was introduced in 2005 to encourage institutional deliveries among poor women in rural areas. The scheme led to substantial improvement in institutional delivery, particularly in poorer states, though it has not necessarily translated into a reduction in the maternal mortality rate.[15, 16]

The *Rashtriya Swasthiya Bima Yojana* (RSBY) was launched in 2008, to provide financial protection against catastrophic health expenditure for vulnerable groups and to ensure better access to quality health care for people below the poverty line. Though initially the scheme was to cover only BPL families, it was extended to vulnerable groups in the informal sector such as rickshaw pullers and rag pickers. The scheme provides a coverage of Rs. 30000 in case of hospital based inpatient care, on an annual registration fee of Rs. 30 by the beneficiary for the family. The coverage limit has recently been enhanced to one lakh rupees. RSBY coverage as on end March 2016 was 41.3 million families out of an eligible 72.8 million families.[17]. Total hospitalization cases however were only 11.8 million pointing to low utilisation of the scheme. Further, evidence from the field indicates that one of the main desired outcomes of the RSBY, to reduce the financial burden of health expenditure among the poor, may not have been realized and Out-of-Pocket (OOP) expenditures have not diminished[18] owing to payments for drugs and diagnostics and other inpatient services not covered by RSBY, additional transport expenses and the like. The RSBY performance is better in states such as Kerala, that have built a good health care infrastructure.

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Atleast eight state governments are operating health insurance schemes, prominent among them being *Vajpayee Arogyashri Scheme* (VAS) for BPL families and *Yeshasvini*

Cooperative Farmers Healthcare Scheme in Karnataka, Rajiv Gandhi Arogyasri Scheme (RAS) in Andhra Pradesh (including Telangana), CM Health Insurance Scheme in Tamil Nadu, *Rajiv Gandhi Jeevandayee Arogya Yojana* in *Maharashtra, Mukhyamantri Amrutam Yojana* in Gujarat, and *Sanjeevani Kosh* in Chhattisgarh. Of these, RAS of Andhra Pradesh with 85 per cent coverage is closest to universal health care. However, due to its orientation towards secondary and tertiary care, nearly half of the payments were for cardiac, cancer and kidney failure whereas for the poorest 40 per cent of the population, the burning issues continue to be premature mortality and disability due to lower respiratory infections, diarrheal diseases, tuberculosis and ischemic heart disease, all of which need attention and can actually be treated at the primary level[19]. Overall, as of 2015, some form of health security is being provided to more than 280 million or about one fourth of the population, through insurance programmes run by the government, viz., CGHS, ESIS, state specific insurance schemes, and RSBY. However, none of the central or the state level insurance schemes cover primary care in the insurance package, with the exception of Meghalaya that provides partial coverage. All of these schemes focus on secondary and/or tertiary care.

Way Forward:

India's new National Health Policy 2017 signifies a paradigm shift in government policy towards comprehensive primary health care and is significant for two reasons: firstly, it defines health in terms of wellness rather than as absence of disease and secondly, it brings focus back on primary care and accords a key role to the public sector. Surprisingly, though it has pushed back the modest goal of spending 2.5 per cent of GDP for health to the year 2025 even as the expectations from the health sector are increasing. Public-Private Partnerships are being relied upon as a way out of the financial crunch. However, evidence in this regard is not encouraging and indicates that unless carefully designed, often it leads to enriching the private sector at the expense of liberal public subsidies. International experience clearly shows that health insurance can only function when the basic health infrastructure is in place and this is a function that the government alone can perform. There is no getting away from the fact that if Health for All is to be a reality, then government must find the necessary funds to enhance expenditure on the health sector while simultaneously reforming the sector to ensure greater efficiency.

Rao (2017)[20] provides an idea of the extent of funding that is required for the purpose. As per her estimates, strengthening the delivery system would require 1 to 1.5 per cent of GDP as capital investment to ensure adequate health infrastructure, with another 1 per cent of GDP being required to provide free universal access to comprehensive primary care, secondary care and a select set of tertiary conditions for 60 per cent of the population. Additionally, atleast 2 per cent of GDP would be required towards capital investment to build required supporting infrastructure related to public sanitation, waste disposal, nutrition and housing.

Achieving universal health coverage is listed as goal 3.8 in the Sustainable Development Goals agenda for 2030. India's performance holds the key to achieving this global aspiration. The Government of India's implementation of the National Health Policy 2017 in letter and spirit is crucial for ensuring India's long cherished goal of health security for all by 2030.

Endnotes

1 Prabhu, K. Seeta. 2001. *Socio-Economic Security in the Context of Pervasive Poverty: A Case Study of India*, Geneva: International Labour Organisation

2 ICSSR/ICMR. Health for All: An Alternative Strategy. Pune: Indian Institution of Education; 1981.

3 India's graduated to a middle income status but with a huge burden of poverty and disease dramatically exposes the mismatch between economic performance and improvement in social indicators

4 MoSPIs MDG Report, World Bank data sets and NFHS 3, indicate that under five mortality rate halved between 1992-93 and 2014-15, reduced from 109 to 50 live births per 1000, however this pace was not fast enough to meet the MDG target of 27. Similarly, MMR declined from 437 in 1990 to 174 in 2015 per 1,00,000 live births, missing the target of 109. In 1990, more than half of the children in India were underweight, and given the current speed of decline

it is expected to reduce to 33 percent by 2015, thereby falling short of the target of 26 percent..

5 Income inequality when measured in terms of incomes (rather than consumption expenditure) is 0.51, a level equal to or higher than in Latin American countries. Wealth inequality is much higher with the gini value of 0.70

6 World Health Organisation Non-communicable Diseases Country Profile 2014, available at http://www.who.int/nmh/countries/ind_en.pdf

7 Infant mortality among the scheduled castes and scheduled tribes in 14 and 8 per cent higher than among the higher income groups (NFHS 3). While a child born in Kerala can expect to live up to an age of 74.9 years, a child born at the same time in rural Bihar can only expect to live upto an age of 67.8 years (SRS Abridged life tables 2010-14). Gender disparity is pervasive and overwhelms even the wealthy as is evident in the high child sex ratio of 880 and 906 is richer states of Haryana and Punjab respectively (Census 2011).

8 http://hdr.undp.org/en/composite/IHDI

9 For example, in Andhra Pradesh reports indicate that the Arogya Sri scheme could have led to a 5 per cent swing in the vote for the ruling party in 2009.

10 Rao, S. 2017. *Do we Care: India's Health System*, New Delhi: Oxford University Press

11 World Health Organisation. 2003. *Social Health Insurance*, Report of a Regional Expert Group Meeting, New Delhi: WHO

12 Planning Commission of India. 2011. *High Level Expert Group Report on Universal Health Coverage for India*, New Delhi

13 Kumar, et al. 2011. 'Financing Healthcare for All: Challenges and Opportunities', *The Lancet* , 377 (9766): 668- 679

14 Selvaraj, S., and Karan, A. K. 2012. 'Why Publicly-Financed Health Insurance Schemes are Ineffective in Providing Financial Risk Protection.' *Economic & Political Weekly* , 47 (11): 60- 68.

15 Lim SS, Dandona L, Hoisington JA, James SL, Hogan MC et.al. (2010) India's Janani Suraksha Yojana: 'A Conditional Cash Transfer Programme to Increase Births in Health Facilities: An Impact Evaluation', *The Lancet*, 375(9730): 2,009– 2,023.

16 Randive, B., Diwan, V., & De Costa, A. 2013. 'India's Conditional Cash Transfer Orogramme (the JSY) to promote Institutional Birth: is there an Association between Institutional Birth Proportion and Maternal Mortality', *PloS one*, 8(6):e67452

17 http://www.rsby.gov.in/Overview.aspx

18 Karan, A., Yip, W. and Mahal, A. 2017. 'Extending Health Insurance to the Poor in India: An Impact Evaluation of Rashtriya Swasthya Bima Yojana on Out of Pocket Spending for Healthcare', *Social Science and Medicine*, 181: 83-92.

19 Rao, Sujatha. 2017. *Do we Care: India's Health System*, New Delhi: Oxford University Press

20 Rao, Sujatha, 2017, *ibid*

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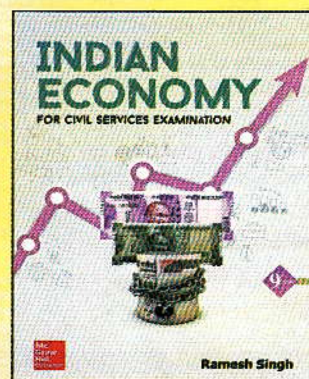

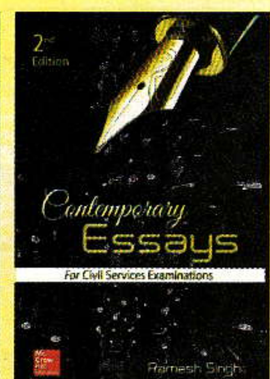

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