People Power

Towards a National Health Service

In many ways the 2004 Lok Sabha election verdict is an expression of discontent by the poor and dispossessed. But the verdicts are not against economic reform; they are for a more inclusive growth process that meets the aspirations and basic needs of the underprivileged.

Ideologues see growth and equity as incompatible. But history has taught us the invaluable lesson that growth and equity are durable only when they reinforce each other. Education, healthcare, infrastructure, natural resources development and institutions of rule of law and good governance – all these promote both growth and equity. Happily, there are some sectors in which with minimal investments we can promote maximum public good. The problems of resources, growth and equity can thus be addressed simultaneously – an economist's dream!

Healthcare is one such sector. Although our knowledge and skill in this field can match the best in the world, our health indicators are very poor. India accounts for nearly half the global preventable disease burden. Public health expenditure in India is appallingly low at 0.9% of GDP; it has fallen from 1990 when it was 1.3%. The private healthcare expenditure – mostly out-of-pocket – accounts for 83% of total health expenditure, public health accounts for the balance 17%. This low share of public health expenditure is matched only by Cambodia, Burma, Afghanistan, and the former Soviet Republic of Georgia – all of them suffering decades of civil war conditions, with virtually no organized government.

Even the low public expenditure is skewed, with 60% going towards curative care and only 26% for preventive care. Consequently, preventable sickness has become the single biggest cause of impoverishment and indebtedness. For a single episode of hospitalization – whether in a public or private hospital – on an average about 60% of annual income is spent. As the rich and middle classes spend far less, the poor probably spend a year's income or more for inpatient treatment. The economic consequences of this are devastating – 40% of those hospitalized are forced to sell their assets, or borrow at usurious rates of 60-100% per annum; and about 25% of them fall below poverty on account of ill-health. The picture varies across India, with 17% falling below poverty because of hospital costs in Kerala, whereas the figure is 35% for Bihar. The picture is indeed grim.

But there is hope. We have a large pool of skilled health manpower, and we can easily increase the training capacity to meet the growing needs. Our health research capability, though underutilized, is impressive. The hospital infrastructure is growing in private sector. We have a mature, low-cost pharmaceutical industry unmatched in the world. Even the new patent regime will not affect most of the routine drugs which are needed. As Amartya Sen points out tirelessly, our democratic system and public discourse afford us a great opportunity to generate demand for better delivery systems and shape policies. People are forced to pay heavily for healthcare, and this capacity and will to pay could be harnessed in a sensible

healthcare model. On the population front, the southern states could serve as a model for the rest of the country. We have demonstrated ability to launch massive campaigns to eradicate smallpox and guinea worm disease, and almost eradicate polio and leprosy. The administrative machinery, creaking though it is, can still deliver if we innovate and involve the people. And there is a wide network of 500,000 rural medical practitioners – who are the first point of contact for most patients.

We can, and must, leverage these strengths to transform our health sector at low cost. The US spends $4600 per capita on health care. Spending only a third of that, Britain ranks much higher in healthcare. This is largely because of the National Health Service introduced by the Labour government in 1948. Aneurin Bevan, the then Health Minister, dreamed of a system which provides access to quality care to all citizens, and laboured hard to make it a reality against heavy odds, including a shattered economy, poor infrastructure, and resistance from medical profession. Nearly six decades later, India is much better placed to create a healthcare system which can ensure access and quality to all poor Indians at low cost.

The National Common Minimum Programme (NCMP) of the UPA government attaches great importance to healthcare, and promises to enhance allocation of public expenditure from the current 0.9% of GDP to 2–3%. The NCMP also envisages a national health insurance for the poor. Such risk-pooling is clearly necessary. But traditional insurance has two major weaknesses. First, it emphasizes curative medicine whereas most sickness in India is an offshoot of failure of primary health. Second, insurance puts public money in private pockets, whereas our public health system is weak and under-funded. Addressing these concerns, the National Advisory Council (NAC) approved a comprehensive restructuring of our health sector at a modest additional cost of about 0.3% GDP per annum. Balanced emphasis on primary care, decent hospital infrastructure and effective risk-pooling in public sector can radically transform our health sector and reduce the burden of poverty crushing millions of families and enhance productivity and growth.

Training a million, locally accountable, female community health workers to address the preventive needs of the people and strengthen the primary healthcare network will significantly reduce the disease burden. Ensuring a community hospital (30-50 beds) for every 100,000, as a backup to primary care, is critical to enhance the credibility of public health. This involves building of 7000 new Community Health Centres over the next five years. Finally, Rs 100 per capita will be raised annually for risk-pooling and hospital care – equally from the union, state, and the non-poor citizens as local health tax. This fund will be held by a locally controlled District Health Board and will be utilized to reimburse public hospitals for the care delivered on standard costs and services basis. Patients will have a choice to visit any public hospital within the district, and hospitals must compete to provide service and earn money by reimbursement from District Health Fund. Once people pay local health cess, demand for better services will grow. Where the supply cannot match demand, local private providers can be involved on standard cost basis. The DHB will control all local hospitals and primary healthcare network, integrate vertical programmes, and monitor sanitation and water supply.

The NAC proposals are aimed at building the necessary public infrastructure, creating new incentives and choice, and ensuring local accountability. These together will build the foundations of a National Health Service. The total additional cost of all these interventions will be only Rs 7000 crore per annum excluding short-term capital investments – the lowest imaginable investment for a radical overhaul of healthcare delivery.

There cannot be a better investment in our future, and greater value for every rupee spent. Short-term populism and lazy policies must give way to genuine efforts to combat poverty and eliminate avoidable suffering.

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