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Review Article

Global Lessons for Universal Health Care

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ABSTRACT

The World Bank and the WHO have come out with a disturbing finding that 50% of global population does not have the benefit of essential health service such as antenatal care, basic treatment for malaria, HIV and TB. Nobel laureate Angus Deaton has found that country's Gross Domestic Product (GDP) and life expectancy are correlated in a positive way. Primary health care is, therefore, extremely critical for all developing countries. In particular lack of adequate surgical facility makes surgery the neglected step child of global health. Universal health care has become not only imperative but inescapable for low income countries. The study brings out how Japan reached 80% universal health care when its GDP was low and how Thailand and Rwanda, a low income country have achieved significant reduction in Infant Mortality Rate (IMR) due to their universal health care programme. The paper laments that the promise of increasing allocation for national health from 1.5% to 2.0% in National Health Policy (NHP) (2002) has remained unimplemented and is concerned as to whether the promise to increase it to 2.5% by 2025 in National Health Protection Scheme, 2017 would be realized. The paper takes note of the initiative of the present government to provide medical insurance cover to 100 million families by bolstering its earlier programme of Rashtriya Swasthya Bima Yojana (RSBY) which covered only 36 million Below Poverty Line (BPL) families. The concept of establishing wellness centres in each district with comprehensive health care for the old and infirm is commendable. The health policy makes a significant departure from the British model of universal health care, which put a premium on improving health care infrastructure, diagnostics and basic medical care throughout U.K. and instead opt for the costly American model of outsourcing its responsibility to the private medical insurers. The health and family welfare is a state subject under the Constitution and receive a short shrift in terms of allocation and policy priority. The paper strongly argues that a healthy society with assured medical care and infrastructure and a universal health care system can be a true precursor to durable growth and happiness.

Keywords: GDP, IMR, NHP, RSBY, BPL

INTRODUCTION

The World Bank and the WHO, in a report in December, 2017 have found that at least half of the world's population of 7.6 billion does not have get essential health services, like antenatal care, treatment for malaria, HIV and TB. The Lancet, a premier medical journal, has estimated that 5 billion (70%) of population around the world cannot get basic survey such as a caesarean section, or a repair of the fractured bone.

It is estimated that around 80 crore people spend more than 10% of their household budget on health care. Nearly 10 crore are pushed to extreme poverty (less than $1.90 a day to live on), due to out of pocket health expenses. When Britain's National Health Service, the world's first

universal health care system free at the point of use was set up in 1948, the households received leaflets telling them that the service will relieve them of many worries in time of illness. Since then money more countries have followed suit with comprehensive health issuance schemes as per the figure given below.

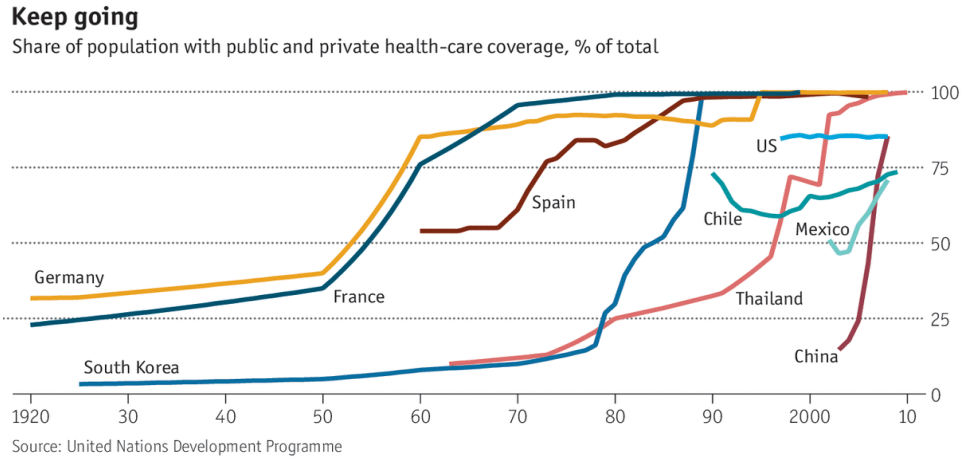

Figure 1: Share of Population with Public and Private health Care Coverage
Source: An Affordable Necessity by The Economist [1]

Importance of Universal Health Care

Universal healthcare is both desirable and possible even for low income countries. Japan reached 80% when its GDP per person was $5500 per year. Thailand has a universal health insurance program. Rwanda with a low per capita GDP has a health scheme covers more than 90% of its population and its IMR helped in a decade to 31.1 per thousand which is less than that of India (37.9).

Prof. Timothy Evans believes that spending on health speeds up growth. A study in 2011 reveals that 12 European countries between 1820 and 2010 showed a close link between expansion of health care and fall in mortality rate and growth in per capita GDP. Economists by Dean Jamison and Lawrence Summers, brings out that 11% of the income gains in developing countries between 1970s and 2000 is attributable to lower adult mortality rate.

Angus Deaton, [2] a Nobel Laureate, was the first to show a relationship between per capita GDP and its life expectancy as the following graph will show.

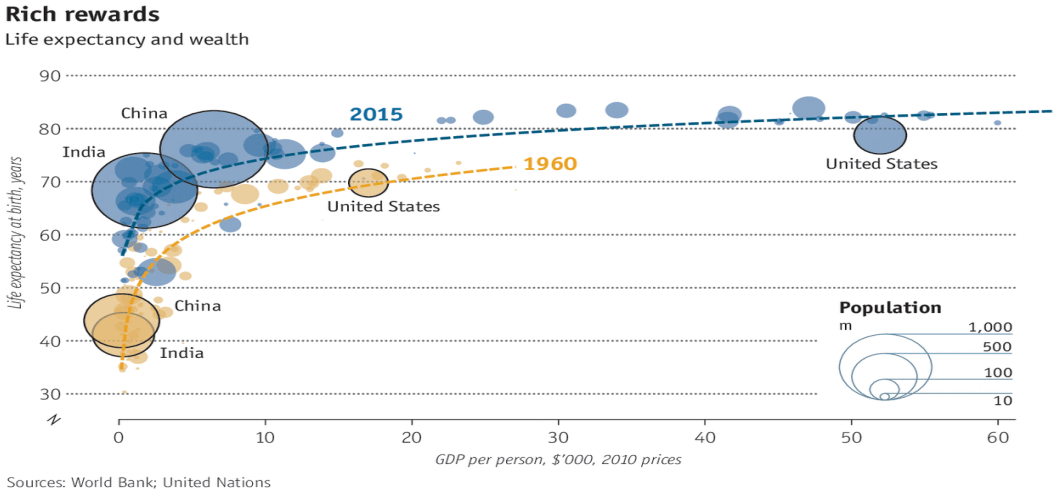

Figure 2: Life Expectancy and Wealth
Source: An Affordable Necessity by The Economist

On average, as the country's GDP per person rises, their people live longer. For Deaton increase is not only the only factor; the application of knowledge also matters. "There are ways of ensuring good health at low incomes", he says "America is a case in point".

Importance of Primary Health Care

It is universally realized that proper primary health care is an essential precondition for a decent health care system. In most of the developing countries like India, people get their health care mostly for informal private providers such as drug shops or unqualified practitioners. In India, informal providers account for 75% of all visits. Often their markets exist side by side with public sector providers. The findings show widespread woefulness. In one Chinese study, the average consultation time is 90 seconds. In India, the average length is double that. Only 30% of consultation in India and 20% in China resulted in correct diagnosis. The consequences of such ineptness are severe. In India, about half a million children die of diarrhoea. The other area of serious concern is lack of elementary surgical facility in all developing economies.

The Unkindest Cut

Nine in ten people living in developing countries do not have access to 'safe and affordable' surgical care. Surgery is an essential part of any universal health care scheme. The WHO estimates that 5% of the women require a caesarean section. A survey of East African countries reveal that less than 1% of women had access to such treatment. Globally one billion women would not get the urgent care in the event of complications with a pregnancy. Some 57% operations in developing countries are for emergencies, as compared with 25% in rich ones. Dr. Paul E. Farmer, [3] the Co-founder of 'Partners In Health', calls surgery the "neglected step child of global health".

Need for Political will and Higher Allocation

If universal healthcare is to become ubiquitous, the politicians would have to act more badly. Thailand went for universal coverage scheme in 2000 which has become a model for other countries. It has demonstrated the power of health insurance to bring "range of averages to the aid of millions", as Winston Churchill put it. Thailand spends 5.6% of its public expenditure to expand their coverage. There are two district approaches. The first is to start by covering a small group of workers in department and work outward for there. The second approach is to cover mega people but start with a limited range of benefits.

Mexico introduced "Seguro Popular" [4] that covered 50 million people in the informal sector. This has reduced drastically the number of Mexicans facing catastrophic health cost and reduced infant mortality to 11.3%. Rwanda is another example where mortality rate for TB has fallen from 50 to 14, per one lakh people between 2000-2014. 98% of this has health insurance. The experience of different developing countries, who have adapted universal health care system vis-à-vis developed countries like UK & Japan, is tabulated below.

Table 1: Health Outcomes: The Global Trend

Country	Per Capital Income ($)	IMR	Physician per 10000	Public Health Expenditure
Rwanda	1617	31.1	0.6	2.9
Thailand	14159	10.5	3.9	5.6
Mexico	16383	11.3	21.0	3.3
India	5663	37.9	7.0	1.4
China	13343	9.2	19.4	3.1
UK	37931	20	28.1	7.6
Japan	37268	2.0	23.0	8.6

Source: Human Development Report 2016 [5]

Quite clearly they spend more on health care as compared to India and their record in terms of infant mortality is far less disturbing than in case of India.

Budgetary Trends in Health in India

In the National Health Policy (2002), it was recommended that allocation to health should be increased from 1.5% to 2.0%, without indicating any timeframe, India's health allocation has remained at 1.5%. In the National Health Protection Scheme (2017), [6] it has suggested that the allocation should go upto 2.5% by 2025. The trend during the last 3 years is as under.

Table 2: Budget Trends: Health & Family Welfare [7]

Year	Allocation			
	Revenue	Capital	Total	% Change
2016-17	36447.4	12231	48678	11.5%
2017-18	48300	3250	51550	5.8%
2018-19	50007.9	2720	52727	2.3%

Source: India Budget 2018-19 [8]

What is disappointing about this year's budget is the poor allocation of only Rs.2000/- crore towards the promised health insurance against a requirement of at least Rs.20000/- crore.

But what is even more disappointing is the low increase in overall allocation (3%) during 2017-18 for health and family welfare, which will fell short of expected inflation (CPI) of around 5-6%. Also the sharp decrease in the capital allocation of Rs.12231/- crore to Rs.1720/- crore is indeed most disappointing. Given the pathetic medical infrastructure that we have in most of the dispensaries rural sector and small towns, and the lip service that the state pays to this sector, the central government must significantly increase both its revenue and capital allocation, and maintain it from the next 10 years to a level of at least 3% of the GDP. Social justice and health without allocation priority to the health sector is an impossibility. Countries like Ghana have adapted a novel method of expanding the tax base. Possible candidates are taxes on extractive industries and on goods harmful to health such as tobacco, alcohol and air pollution. That would not only raise money but have greater health benefits. Every subsidy should be curtailed.

New Health Policy (2017)

India has embraced a new health policy in 2017 which seeks to reach everyone in a comprehensive way towards wellness. Patient centric and quality driven universal health coverage at affordable cost is the objective where private sector will do strategic purchasing and capacity building. The defining feature of the policy is to bolster primary health care through health and wellness centres. This would be comprehensive to include geriatric health and rehabilitation care. The policy wants the government to increase the share of health expenditure from a measly 1.4% now to 2.5% by 2025. This is indeed a grandiose promise.

Presently the centre spends around Rs.52000/- crores and the states together spend around 1.5 lakh crore, accounting for 1.4% of their GDP. If this is to be increased to 2.5%, they will have to commit 4 lakh crore. Budget (2017-18) has came up with the health insurance scheme which is expected to cover 10 crore families with an insurance sum of 5 lakh. This is a significant expansion of the Rashtriya Swasthya Bima Yojana, (2008) [9] when the BPL families by subscribing Rs.30/- could have medical care coverage upto Rs.30000/- 36 million families were enrolled. The present scheme would cover 100 million families. While the scheme needs to be complimented, the budget that is earmarked is far too less (Rs.2000/- crore) than what is required (Rs.20000/- crore). But more importantly, the concept of health and wellness centre which was envisaged as part of the National Health Policy has been given a goby, by opting for the private insurance option. The British National Scheme has established a credible structure, where the government is the basic provider of comprehensive health care to all the citizens.

CONCLUDING THOUGHTS

From a sclerotic health care structure, which grossly neglected the rural hinterland and the poor, India took baby

steps in 2008 to have RSBY, which embraced 36 million poor families in it ambit. The National health Policy promises "wellness centres" at each district with a comprehensive package for the old and infirm as well. There is also a commitment that the central budget allocation for the health sector would be increased for 1.5% of GDP to 2.5% in 54 years' time. Budget 2017-18 has been a watershed moment for the poor, which promises 100 million poor families, a health insurance cover of Rs.5/- lakh. While this falls short of universal health care, it deserves "two cheers" (E.M. Forster) as a public resolve to ensure social inclusion, a healthy India. India has abdicated the, more difficult system of the British universal health care system, which has improved the health infrastructure, diagnostics and basic medical care throughout UK, straddling income differences. At the height of Britain's resolve to quit the E.U. (Brexit), the predominant refrain was the perception that the government is outsourcing its responsibility for the poor and the middle class to the wiles and guiles of market economics. India has fallen into the same trap of free market where the private sector players enjoy the patronage of the power that be and do not spare a thought about the affordability part of quality of education and health for a vast majority of its population. Both the centre and state governments cannot abdicate their responsibility to provide a healthy and affordable health care system to the citizens which is mandated by the Constitution. The politics of rhetorics must give way to the pragmatism, of having a healthy nation, where the citizens cutting across ages, have the benefit of comprehensive health care in the wellness centre. As Jeffrey Sachs rightly put it in the context of USA, "Our greatest illusion is that a healthy society can be built on mindless pursuit of wealth". This is equally true of India and a wakeup for our political dispensation.

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