Getting the basics right

_Times of India, DIPANKAR GUPTA Dec 5, 2011_

After so many wrongs, the Planning Commission may have just got it right. According to leaked accounts, its universal health coverage proposal may become reality as early as the next five-year Plan. Once this policy is in place, India can legitimately enter the club of welfare states through the front door. Now, at last, it has a scheme that is truly inclusive for it includes us all.

When implemented, this measure will reduce private health expenditure across categories, especially from the high middle class down to the poorest. Because the coverage is 'universal', hence inclusive, and not just for the deprived as NREGA and Rashtra Swasthya Bima Yojana are, it is bound to do well.

Universal health coverage will have a better run for it will be pressured by a broad band of the non-poor who can make a noise and also a difference. The very poor are nearly always mute spectators of a process outside their control. Except for the ultra-rich, health costs are a serious concern for everybody. Yet, from the beginning of time, most Indians have had little option but to groan and bear it.

If, as has been envisaged, state expenditure in health is raised to roughly 3% of our GDP by 2020, that would mean a stupendous three-fold increase. This would let the sick concentrate on getting well rather than scrambling for money to pay medical bills. Most of all, as this policy would also draw in the middle classes, it would get a fighting chance of staying alive.

Health statistics in India are grim beyond belief. About half the admissions in rural hospitals are paid for with borrowed money. According to development economist and national advisory council member A K Shiva Kumar, a little less than a third of the sick in rural India do not seek medical help at all because they cannot afford it. Go to a public hospital, one might say, but because those are meant for the poor, the services there are, predictably, poor as well.

As nobody, not even the economically deprived, want to chance with health, roughly 71% of the sick go to private health providers. The Indian Human Development Survey slices this statistic further to show that the trend remains the same for both long and short-term illnesses. This tells us why the private purchases of drugs and medical advice account for as much as 78% of the country's total health bill. It is often supposed that if hospital beds are free, that is all that the poor need. What is forgotten is that 72% of out of pocket private expenditure is on account of drugs.

In contrast, the average private expenditure on health in OECD countries is a mere 26.9%; the rest is picked up by the state. In Britain, this figure is even lower, just 12.7%, which is truly remarkable. In Norway it is 16.4%, in France 21.3%, and so on. This should not be seen as a rich versus poor contest. Even a developing economy like Mexico does better than us when it comes to state support of healthcare. The one country we should not imitate is the US.

Even after the Planning Commission's proposal is accepted, we will still have a long way to go before we are world class. Of course, the poor would be the first to access such services, but if specialists are paid well and facilities up to the mark, then that would attract the middle classes too.
It is really not a question of money, but of political will. First, there is enough money going around as all these scams have amply demonstrated. But on a more fundamental level, there have been countries that have thought of universal coverage for health and education even when poor.

Sweden's unemployment rate was around 25% in 1932 when it established the "folkhemmet" (home of the people) programme guaranteeing universal welfare. This gradually grew to become a model for the world. Today, when we talk health and education, we think of Sweden first.

Basque Spain introduced Osakidetza in 1982 when its economy was still recovering from the depredations of the Franco era. It did not take long for this region to prosper and now it has the best health service in Spain with a ratio of 4.5 doctors for every 1,000 patients.

The Canadian province of Saskatchewan introduced healthcare in 1947 even though it had fared badly during the war years. This was the poorest region of Canada, but that did not deter it from doing remarkable things on the medical front. Britain, likewise, implemented the National Health Scheme in 1946 when it was reeling under the burden of war expenses and needed food parcels from America to survive. It was so poor that it could not even hold on to India. Today, Britain leads the pack in terms of universal health coverage the world over.

We can get there too, but we need the political resolve. The Planning Commission has provided the compass, but politics must have the strength to undertake the journey.

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