

FINANCING AND DELIVERING HEALTH TO RURAL POOR IN INDIA

SYNOPSIS

MERIN MARY THOMAS
HYDERABAD , INDIA

Brent Walker
Sydney, Australia

The Indian economy has been performing consistently high in the last four to five years by registering 8% and above GDP growth. This phenomenal achievement was possible due to rapid growth in industrial and service sectors. The agriculture sectors is still lagging behind with lesser investments and remains far behind the expected levels of performance. The age-old issues of poverty, unemployment, diseases and illiteracy still persists in the 600,000 villages in the country

India has a population of nearly 1.06 billion (as on July 2004) of which 70 % live in rural areas in nearly 6, 50,000 villages. The health status of common man in rural India is of grave concern. Contagious, infectious and water borne diseases like diarrhea, typhoid, hepatitis, malaria, tuberculosis, respiratory infections, pneumonia and reproductive tract diseases etc dominate causes of mortality , especially in rural areas. Life expectancy in India has reached 63 years which is comparable to the global average of 66 years. Yet infant mortality rate (34 / 1000) and maternal mortality rate (438/ 100 000) are higher in comparison to the developed countries of the world.

Healthcare has traditionally been state (India has 28 States or administrative units) government's responsibility as resources available, priorities and budgetary allocation differs from state to state. Prevalence of inequity in disbursement of budgetary allocation leads to unequal distribution of medical facilities. Lower income states show higher infant and maternal mortality rate. Of 25 million children born every year in India, nearly 2 million children die before attaining the age of one year and this is because of the poor medical facilities, unawareness of diseases, poor sanitation facilities, illiteracy and poor income levels. Even today many children are disabled for life due to polio. Tuberculosis which is curable claims nearly 5 lakh lives every year. Water borne diseases accounts for about 80% of India's health problem and every fourth person dying of such diseases are Indians. Every third person in the world suffering from leprosy is also an Indian. This abysmal health scenario exists more in rural India.

This brings about the question: what has been done regarding health and medical facilities by the government for the common Indian citizen and what more has to be done? After independence in 1945, the Bhole committee introduced the concept of primary health centers (PHC) which was implemented from 1952. Various issues like population control, healthcare,

sanitation, hygiene, drinking water, nutrition, care during pregnancy was addressed and awareness was spread among the masses. This was one of the major contributors to the rise of life expectancy from 33 years during 1945 to 63 years in 2007. Various healthcare programmes that have been introduced over the years, of which many failed to take off, few were implemented but failed and very few succeeded in achieving the goals even marginally.

Today there is a great need to look closely into various streams that would help improve the rural health scenario. Suggested solutions

- Greater budget allocation for health facilities in India and equal distribution of the same in all the states with special stress on states that have high death rate and infant mortality due to prevalence of contagious diseases and low access to medical facilities.
- Greater penetration of medical facilities in rural areas by setting up of curative centers that are customized to the needs of the rural poor with doctors who are sensitive to the plight of the rural poor, subsidizing the costs involved in treatments and essential drugs, larger number of beds and other infrastructural facilities in hospitals, administering free vaccination against diseases etc.
- Deeper penetration of micro insurance which is essentially health, life and property insurance for the rural poor which would help the rural poor meet medical expenses.

A report by World Bank on 7 October 2007 says “Government of India has launched a plan to offer health, life and disability insurance about 400 million working poor in order to target poverty in rural India. Under the new health insurance scheme, India's central government would contribute 75 % of an estimated annual premium of INR 750 (US\$ 19) per head with state governments shouldering the rest. The beneficiary would pay INR 30 a year for a smart card that would access health insurance. The Government of India is planning to spend US\$ 187 million in fiscal year 2008 as it implements the program over five years.” There is greater need for developing and implementing such financial aid schemes so as to make changes at the grass root level.

- Above all educating the rural masses regarding diseases, prevention and timely treatment is essential. This is a daunting task in a country with nearly 30 different languages and 2000 dialects, where illiteracy levels are high.

Greater stress on prevention and promotion of public health will have more significant impact on public health indices.

The presentation prepared by Brent Walker looks at the criteria needed for micro health insurance programs in India and suggests a model based on the actuarial concepts of open and closed health insurance systems. This model is designed to fit within the requirements of the Insurance Regulatory and Development Authority in India but should work in similar form in many countries with significant numbers of rural poor. The paper discusses the Yeshasvini scheme, which was conceived by the world famous heart surgeon Dr Deprivan Shetty and implemented with the co-operation of the Karnataka Government. The Yeshasvini scheme provides open health insurance cover for 2.3 million people in Karnataka for approximately US\$ 3.00 per person per annum.