CHAPTER 4

NEO-LIBERAL STATE AND HUMAN SECURITY

GLOBAL EMPIRICAL TREND IN HEALTH SECURITY WITH SPECIAL REFERENCE TO INDIA
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Global Empirical Trend in Health Security with Special Reference to India

4.1 Introduction

The basic objective of this chapter is to explore the convergence and non-convergence between the neo-liberal state and human security with special reference to the empirical trend in health security in India by placing it within a global comparative perspective.

The unfolding of the current neo-liberal state shows that rather than a convergence, there is growing non-convergence between neo-liberal state and human security. This is true in almost all vital spheres and issues related to human security. The present study, which takes in detail the relationship between neo-liberal state and health security, explores these non-convergences with adequate examples and statistics. The basic non-convergences are:

(a) Eroding people’s as well as nation’s right and capacity to decide the course of health policies relevant for a particular society;
(b) Eroding people’s right to prioritize their health care devices in conformity with the prevalence of diseases;
(c) Using fruits of science and technology by the dominant forces in the health industry more as a means of profit rather than for prevention of diseases;
(d) Marginalizing the state’s capacity in the developing world to generate and consolidate a sustaining health care infrastructure;
(e) Consolidation of a line of distinction between the developed -West and developing -East in terms of implementation of the neo-liberal policies, particularly in the social security spheres. Whereas, almost all the states in the developing world have been forced to implement the neo-liberal policies at the behest of international financial institutions, particularly the World Bank, however, most of the developed West has not followed these policies and continues to indulge in ‘domestic and state protectionism’. This is equally
applicable in case of health care sector. The countries, which have refused to abide by the neo-liberal agendas, have also achieved high human development and high human security status.

4.2 Neo-liberal State and Third Generation of Health Reforms

The Neo-liberal paradigm received a great deal of enthusiasm for health reform during the early 1990s across the world. Both in the Developed West as well as in the Developing East a good number of countries introduced new financing and delivery schemes and many countries are still debating on it. Some countries in Western Europe— the Netherlands, Sweden, and United Kingdom and Northern Ireland, for example, have already entered into a new phase of health care delivery system.1 Amidst all these, the World Bank has been pursuing an aggressive campaign for reforms in health care forcing most of the third world countries to open up the residual components of health care for private investment. The World Bank has also been putting pressure to set new priorities in health care sector as laid down by the Bank and other international financial institutions. Many states such as Chile, China, Columbia, South Africa and Zimbabwe implemented or were soon to implement major health reforms. The least developed countries, where the private health care providers are already in a predominant position, are exploring the ways and means to make them more efficient and cost effective. The economies in transition also redesigned their health care system with more avenues for private health care providers in the context of the growing deterioration of health conditions and rapidly declining government revenues during early to mid-1990s.2 The basic objectives have been to ensure efficient and effective health system and to reduce the cost of the government exchequers through the greater participation of the private health care providers.

This emerging trend in health care symbolizes the consolidation of the Third Generation of Health Care Reforms around the World This reform has taken place,

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2 Ibid pp 119-221
as stressed by various international agencies including the UNO, at a peculiar context when most countries in the world are simultaneously facing rising costs of health services, growing demands for such services and increasing limited resources for the financing of these services. These stresses have forced the countries around the world to redesign their existing health systems. In this current generation of reforms, policy makers throughout the world are increasingly recognizing the importance of incorporating private health providers into overall national health systems, mostly in the developing countries.³

This current generation of health reforms has both continuity and differences with the earlier generations of health reforms.

The first generation of health reforms was launched in the 1940s and 1950s in developed countries. Gradually those extended to middle income developing countries. The main goal of these reforms was to establish national health systems with the promise of universal access (along with social insurance systems). However, these were abandoned in 1960s with the recognition of the following problems:

1. Rising medical costs with the increase in volume and intensity of hospital beds care;
2. Failure to guarantee the access by the poor to the national health system, despite the explicit goal of universal access.⁴

The second generations of health reforms attempted at ameliorating these failures and limitations. The basic objectives of this generation of reforms were to make the health care system more cost effective, fairer and accessible. During the era of these reforms primary health care received priority. It also received great success in terms of improving health at relatively smaller cost, particularly in the developing countries. For example, life expectancy at birth increased by more than 10 years in a matter of two decades in many developing countries. Child mortality rate declined and immunization rates increased significantly. Countries with great success in these areas included- but were not limited to- Botswana, China, Costa Rica, Cuba, Guatemala,

³ Ibid p 220
⁴ Ibid p 223
Indonesia, Mauritius, the Niger, Sri Lanka, The United Republic of Tanzania, Zimbabwe, and some states in India. Public health measures and prevention over cure received priority during this generation of reforms. Along with, the issue of health security was linked up with other social security measures like education, food, safe water, and sanitation. And all these had tremendous positive outcomes for most of the developing countries. Both the first and second generation of health reforms, particularly the second generation, were influenced by the 'pragmatic political imagination' as outlined in the first chapter. The state acted as a 'public domain' during the second generation of health reforms and it laid down its health care policies, in accordance with national requirements.

However, this generation of health reforms also witnessed many setbacks and limitations, particularly, owing to the following reasons: lack of optimum utilization of the public health care provision and at many instances bypassing of the system by the health care seekers; inadequacy in funding leading to insufficient health training and shortage of equipments; no proper motivation on the part of the health care workers; misallocation as well as non-equitable allocation of health resources etc. Most importantly, both the first generation as well as the second generation of health reforms was predominantly supply oriented and it grossly neglected the demand side of the health care system.\(^5\)

It is in the context of these failures and limitations that the third generation of health reforms became an urgent necessity, as pointed out by various international agencies including the UN. The current generation of health reforms, which is complex than the earlier ones, has the following important feature that differentiates it from the earlier generations of health reforms.\(^6\)

(1) While, supply side consideration remained predominant in the earlier generation of reforms, the third generation of health reforms have emphasizes on demand for health reforms as the primary issues to address the issues related to health care i.e. "to identify the causes of mismatches between

\(^5\) Ibid pp 224-25  
\(^6\) Ibid pp 225-240
demand, demand—what people really desire— and perceived needs—what people believed to need.” In the current generation of health reforms, it is the health workers and health care seekers who receive priority rather than the policy makers.

(2) The second feature is corollary to the first. The current generation of health reforms addresses the organizational and governance issues seriously. It has been pointed out that in the previous reforms, local health authorities and international experts treated local government officials, health professional and workers, as well as patients as ‘passive’ agents, “who obeyed a set of regulations and guidelines mandated by the health authorities” The new generation of health reforms assigns an active role both to the health professionals/ workers as well as to the patients;

(3) With this paradigmatic shift in organization and governance in health system, the role of the private health care providers towards the achievement of the new goal of ‘demand oriented health system’ has been increasingly realized and recognized. Greater involvement of the private sector has been justified from a logistic standpoint. The new approach to health care— what WHO has called as “new universalism”— does not call for the establishment of a large number of full-fledged hospitals in poor countries, rather it can be supported by smaller medical facilities run by private sectors.

(4) Another significant feature of this new generation of health reforms is the identification of new roles for the Government in managing private health service delivery. It has been increasingly realized that despite the advantage and complementary roles of the private sector in public health, the private sector not necessarily lead this health sector in a direction likely to maximize its contribution to the health of the population. So, the Government has to play a leading role in this regard. “The possible roles of the Government as regulator will need to be more sophisticated, requiring multifaceted intervention and coordination among the Government, Public and the Private providers and consumers, so as to maximize the contribution of a health system to the population” In this regard, the Government has to perform a few important functions: understanding the role of the private sectors in its own
country and institutionalizing policy instruments; expanding the effectiveness of health service regulations to assure the overall quality of health care; contracting out and improving access of the poor to health care, including the exemption of fees.

The International agencies like the UN and others have projected the current health care reforms as an outcome of the growing demands for a demand side oriented health care system owing to the failure of the supply side oriented system. But these interpretations provided by the international agencies- both financial and non-financial- have missed out many important points, particularly the political economy dimension of the current generation of health care reforms. The chapter on *Debate on Neo-liberal State* has pointed out that many of the important developments related to policies of the governments in 1990s around the world are inevitably associated with the change in global capitalism. The change in overall economic and political ideologies in 1990s had its impact on the new generation of health reforms around the world. Although, the UN, UNDP, WHO and particularly the World Bank assigns a benign character to the third generation of health reforms, however, the gross negligence of the political economy dimensions associated with it, brings limitation to their projections. Some organizations like the World Bank have done it very intentionally (The World Development Report 1993 titled *Investing in Health* is important in this regard) and other organizations like UN or UNDP had done it with good motives but uncritically. The net outcome has been the total distortion of the projected objectives and growing inaccessibility of the larger majority to even most essential and primary health care services. No doubt, the private health care providers assumed very significant position in most of the countries, particularly in the developing world, as revealed by the available statistics. But all these have not always helped to eliminate the hindrances towards universal health. The new set of priorities has been framed in accordance with the interests of the most developed countries and of global capital. Consolidation of technology beyond proportion has also not been good for the health of the population. The *active participation* of the health care seekers in the health system has also not been realized. The developments in Indian health system reflect all these limitations and contradictions.
Being influenced by the first generation of health care reforms, India articulated the collective responsibility in regards to the achievement of universal health in the constitution itself, particularly in the Directive Principles of State Policy. Socialism was one of the important legacies of India's struggle against colonialism. Driven by this legacy, the government of India expressed its intention to discharge this responsibility in the five year plans itself as well as in other policies and programmes meant to alleviate poverty or to ensure community development. A huge health care infrastructure was built up in India and a set of specific schemes was also launched to help the people realize the right to health. India was one of the signatories to the Alma-Ata Declaration of 1978. It adopted certain policies of positive intervention in the health sector, particularly through the National Drug Policy 1978 and the National Health Policy 1983.

The declared objectives, however, have not been implemented through adequate investments. India is one among those countries in the world investing the least in health security. The current public investment in health is less than even 1 percent of its GDP, comparable only with the poor human development countries of the world. This is despite the fact India is placed within medium human development countries of the world by UNDP. The implementation of the neo-liberal economic policies under the auspices of the World Bank and other international agencies has brought new challenges to this sector. The investment in health has been cut down gradually. In 1990 India invested 1.3 percent of its GDP in health. It was reduced to 0.9 percent in 2002. Besides, the new thrust area within health (family planning or non-communicable diseases etc.) at the cost of more dangerous and common diseases like T.B., malaria etc, have made the health care scenario more vulnerable. On the other, with the implementation of new drug/pharmaceutical policies (1985, 1994 & 2002) as well as with the enactment of new Patent Bill (amendment) 2005, the government control of prices over the drugs once declared as essential has been withdrawn. The result has been constant price hike of drugs and the alarming increase in out of pocket expenditure on health care.
The proliferation of private health care institutions under a virtual non-existence of any accreditation system to supervise the functioning, charges etc., as well as the growing nexus between the private health care establishments and that of public health personnel and also the consolidation of technology in health care have only compounded the difficulties associated with the right to health and health care. The government even subsidized the corporate health sector in India, particularly by allocating prime urban locations in exchange for the promised reasonable proportionate free or subsidized health care to the poor. However, there is increasing evidence of non-fulfillment of such promises by the major corporate/private hospitals.

There have been tremendous pressures both from within and outside the country to bring reform to this health care system. The pressure from within arises basically from democratic compulsions as continued negligence on these fronts is bound to erode the legitimacy of the ruling class. But, the outside pressure appears to be more powerful. Most important pressure has been the UNDP, whose Annual Human Development Reports, published since 1990 placed India in a very lower rank. UNDP has also forced upon India and other states in the World to come up with the national as well as provincial Human Development Reports. UNDP has also laid down the basic guidelines to prepare the Human Development Report as well as to articulate the HDI-Human Development Index. India also came up with its first ever National Human Development Report in 2001. Many States within India has also come up with their State Human Development Reports. UNDP has collaborated in preparing these Human Development Reports. All these have forced upon the Indian State to rethink its policies on social security including health security. One of the important outcomes of this retrospection has been the adoption of National Health Policy 2002. Acknowledging the severe flaws in the government policies as well as inadequate allocation in the health sector, NHP-2002 promised to increase the public expenditure on health and also outlined a definite time frame to eradicate the communicable and non-communicable diseases. However, the subsequent Budgets- either of the Union Government or the State Governments, do not reflect the promises of the NHP-2002. With all these, the status of health security in India is still very poor and only comparable with the low human development countries.
So, the study on right to health care in India needs to be studied taking into 
consideration these entire complex issues involved in.

4.3 Current Status of Health Security in India
On many fronts related to health security, India’s achievement over the decades has 
been worth mentioning- increased life expectancy, reduced maternal mortality, 
decline in fertility, some success in eradicating basic communicable diseases. Most 
importantly, during the post independence period, India unlike many other third world 
nations has succeeded in setting up a complex medical and health infrastructure 
involving teaching, training and research, drugs and medical instrument production, 
and Medicare including at the tertiary level.7

However, once put in a comparative setting, India’s achievement appears to be very 
dismal. India, along with other WHO member-nations, became signatory to the Alma- 
Alta declaration of 1978 promising ‘health for all’ by the year 2000. This Declaration 
recognized health as a collective endeavour and so called upon the world community 
to take special care of this sector. The Declaration very categorically stated: 
“Governments have a special responsibility for the health of their people which can be 
fulfilled only by the provision of adequate health and social measures. A main social 
target of Governments, International organizations and the whole world community 
should be the attainment by all people’s of the world by the year 2000 of a level of 
health that will permit them to lead a socially and economically productive life.” It 
aroused an expectation in India and other signatory countries that with adequate 
investment on health infrastructure and an appropriate mix of public health strategies, 
the countries would be well placed to meet the laudable goal. However, the country 
stands far behind of those expected goals. Some of this is reflected in the macro health 
statistics.

In India life expectancy still stands at 63.3, which is many years lower than not only 
of the high human development countries like Norway (78.7), Iceland (79.6) or

Sweden (79.9), but also of neighbouring country within South Asia i.e. Sri Lanka (72.3) and even of Small Latin American countries like Guatemala (65.3) or Nicaragua (69.1). The infant mortality rate (per 1000 live births) in India reduced from 80 in 1990 to 67 in 2001. But it is still very high in comparison to the countries mentioned above. (In the year 2001 in Norway IMR rate was 4, in Iceland 3, Sweden 3, Sri Lanka 17, Guatemala 43 and Nicaragua 36). The maternal mortality rate in India was as high as 440 (per 100,000 live births) in 1995, which was as low as 60 in Sri Lanka. The figures were relatively high both in Guatemala and Nicaragua i.e. 150 and 250 respectively, but still very much low in comparison to India. Under five mortality rate is also very high in India. It was 123 in 1990 and 93 in 2001 per 1000 live births. The corresponding figures for Sri Lanka are 23 and 19. India shares 17 percent of world’s population, but accounts for 23 percent of child deaths, 20 percent of maternal deaths, 30 percent of TB cases 68 percent of Leprosy cases and 14 percent of persons infected with HIV.8

All these have got its linkage with other important factors, particularly health care infrastructure as well as disease preventive structures like access to improved sources of drinking water, access to proper sanitation, level of nutrition, immunization against measles, births attended by skilled health personnel etc. For example, in India between 1995 and 2001 skilled health personnel attended only 43% of births. For Sri Lanka the figure is 97%. In terms of people’s access to improved water sources India’s position is relatively good- 79% in the rural areas and 95% in the urban areas. However, an enquiry into the infrastructure- or the pipes through which the water flows, tells us a different story. These crucial factors are overlooked at many times. In terms of people’s access to essential affordable drugs, India falls in the very poor category with 0-49% access. Sri Lanka’s position in this regard is far better with 95-100% access. Even, Pakistan’s position in this regard is better than India with 50-79% population having access to essential affordable drugs.9

9 These figures have been summarized from UNDP Human Development Report 2003
The variation in the statuses of health security is closely associated with the pattern of investment in health care. The available statistics suggests that those counties in the world, which have invested more public fund in health care, have also achieved high health security status. This co-relationship between investment and achievement in health will be taken up in due course.

### 4.4 Pattern of Burden of Disease in India

The study on right to health care needs to look at the burden of diseases as well as whether the investment in health—both of public and private—has been in accordance with the burden or not.

India is confronted with the burden both of the Communicable and Non-communicable diseases.

However, in India, communicable disease constitutes the highest burden. It is higher not only in comparison to the average of high-income countries, but higher even than the average of the low-and middle-income economies. The following Diagrams illustrate the point.

**Diagram 4.1 Pattern of Disease Burden in India**

- Communicable Disease: 50%
- Non-Communicable: 33%
- Injuries: 17%

**Diagram 4.2 Pattern of Disease Burden in High Income Economies**

- Non-Communicable: 81%
- Communicable: 7%
- Injuries: 7%
The diagrams reveal that in India communicable disease constitutes 50% of its total diseases. Whereas the respective percentage for China is 18%; for the high income economies is only 7%; even for the low and middle income economies in average is 44% and for the world in average is 41%. Not merely the share of communicable disease is higher in India, the rate of mortality due to the communicable diseases is also equally higher in comparisons to other countries and regions in the world.
4.5 The Projected Pattern of Disease Burden in 2020

Various projections show that the communicable diseases will substantially be reduced in future. But, in comparison to most other countries, India will still own high percentage of communicable diseases even by the year 2020 despite a major shift in the demographical profile. The proportion of communicable to non-communicable diseases is expected to almost reverse in India during 1998 to 2020 with former dropping from 50% to around 24% and the share of non-communicable disease will go up from the current 33% to 57%. But, this will still be higher in comparison to world average (20%). China will almost eliminate communicable diseases. Its share will be just 4.3%. This will even be lower than the projected 5% for the industrialized countries.

4.6 Intensity of Communicable Diseases in India

As far as communicable diseases are concerned the situation in India is very ironic. India has failed to control the communicable diseases despite the availability of cost effective and relatively simple technologies. The pre-transition communicable and infectious diseases constitute a major cause of pre-mature death in India. According to latest information they kill over 2.5 million children below the age of five and an equal number of young and adults every year. The proportion of total deaths caused by communicable diseases continues to be unacceptably very high at 42 percent.

Despite the global eradication of small pox and despite expectations that current efforts will ensure the elimination of leprosy and polio within the next five years, environmental and social factors impose severe constraints on the control of two communicable diseases that pose a special threat – malaria and TB. The total T.B. patients in India is estimated at fifteen millions. Moreover India has been identified as a hot spot for the Multi-Drug Resistant (MDR) T.B., which is both difficult and expensive to treat. With all these, India accounts for one-third of Global T.B., and the largest number of patients suffering from active T.B. in the World.¹⁰

Malaria is another severe threat to Indian health scenario. Initial efforts after independence aimed at malaria eradication brought down the caseload from an estimated 75 million to 100,000 cases in 1960s, with negligible death. However, the growing negligence in the following period due to varieties of reasons including a sense of complacency contributed towards the resurfacing of malaria in 1976 to a high of 6.47 million cases. Through positive intervention, the cases were brought down to 2.18 million cases in 1984. But after one decade several local outbreaks of malaria were once again witnessed, resulting in high mortality. This recurrence of malaria was basically due to a multiple set of reasons: poor disease management, increasing malaria risk factors, and an overall failure of the health system caused by the gradual depletion of trained personnel.11

It is not only the other sexually transmitted diseases, but also two other poor man’s diseases i.e. visceral leishmaniasis popularly known as Kala-azar, and filaria popularly known as elephantiasis have been neglected very severely in the wake of granting very high priority on combating AIDS/HIV positive. It has been estimated that about 200,000 people in India are affected with Kala-azar every year and as high as 20% of them die every year and there are 21 million people are suffering from elephantiasis.12 It must be pointed out that Kala-azar is both preventable and curable disease.

Polio is also another challenge before India. Of the seven nations that are the last remaining refuges of poliovirus in the World, India topped the list with the highest cases. The country accounts for 85 percent of all polio cases in the world reported to the WHO in the year 2003. Uttar Pradesh accounted for 75 percent of these cases and has been dubbed as epicenter of the epidemics. The virus has also spread in North India and to Polio free states such as Maharastra, West Bengal and Gujarat.13

11 Ibid p58.
12 The Times of India, 5th June 2004
The problems have also been intensified by the globalization that has brought a phenomenon called 'risk transition' – to use the WHO phrase. As globalization continues to affect societies anywhere, the risk transition seems to be gaining speed. Today more people than ever before are exposed to products and patterns of living imported and adopted from other countries that pose serious long-term risks to their health. The fact is that so-called 'western risks' no longer exist as such. There are only global risks, and risks faced by developing countries.14

AIDS has not yet assumed a dangerous trend in India as the adult (15-49) prevalence rate is estimated at 0.79%, which is reasonably lower in comparison to many of the African countries like South Africa (20.10%), Botswana (38.80%) or Zimbabwe (33.73%). However, India has entered into a vulnerable position, because the infections of AIDS are not confined to high-risks group or only to urban areas and it is spreading rapidly. India may become an AIDS hub. In the year 2000, the number of Indians infected with HIV was estimated at 3.86 million. The rate of mortality due to AIDS is increasing: in 1999, nearly 300,000 Indians are estimated to have died from the disease. According to UNDP estimates (2001), 1,500,000 women (age 15-49) and 170,00 children (age 0-41) are living with HIV/AIDS.15 Estimates for the year 2002 released by the National AIDS Control Organization indicated that there might be 4.58 million people living with HIV in the country, an increase of more than 6,00,000 cases since 2001.16 Despite massive awareness campaign by the government and various Non-Governmental Organizations throughout the length and breadth of the country for last several years, still many vulnerable groups are not aware of potential danger of the disease and the preventive measures to be taken by them. A recent BBC report from Rajasthan pointed out that 60% of truck drivers who regularly visit prostitutes do not use condoms and similarly the sex-workers too do not demand the use of condoms from their customers.17

15 Ibid p 5
16 India Book of the Year (2004) The Hindu p 227
17 The BBC World News 8 July 2004
4.7 Health Care Infrastructure in India

India compares unfavourably even with low-income countries in terms of availability of health care infrastructure and its utilization.

There is no accurate data on availability of health personnel and health infrastructure in India. Recent studies suggest that urban areas have only 4.4 hospitals, 6.16 dispensaries and 308 beds per one hundred thousand of urban population. For the rural areas, the situation is much worse, with 0.77 hospitals, 1.37 dispensaries, 3.2 public health centers and just 44 beds per one hundred thousand rural populations. For the country as a whole, number of beds per one hundred thousand populations, which has increased from 32 in 1951 to 83 in 1982, was only 93 in 1998.

Similarly, the number of doctors per one hundred thousand populations increased from 17 in 1951 to 47 in 1991, but stood at 52 in 1998. So, the progress of the country in the health sector since independence has been grossly inadequate.\(^{18}\)

There may be slight variations in the figures. However, all available statistics reveal the poor health care infrastructure in India. Let us put India’s position in a comparative setting.

Table 4.6 International Comparison of Health Manpower and Hospital Beds 1990-98

<table>
<thead>
<tr>
<th></th>
<th>Physicians per'000 population</th>
<th>Nurses per'000 population</th>
<th>Midwives per'000 population</th>
<th>Hospital Beds per'000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian Public Sector</td>
<td>0.2</td>
<td>-------------------------</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td>India total</td>
<td>1.0</td>
<td>0.9</td>
<td>0.2</td>
<td>0.7</td>
</tr>
<tr>
<td>World Total</td>
<td>1.5</td>
<td>3.3</td>
<td>0.4</td>
<td>3.3</td>
</tr>
<tr>
<td>Low Income countries</td>
<td>1.0</td>
<td>1.6</td>
<td>0.3</td>
<td>1.5</td>
</tr>
<tr>
<td>Middle Income Countries</td>
<td>1.8</td>
<td>1.9</td>
<td>0.6</td>
<td>4.3</td>
</tr>
<tr>
<td>High Income Countries</td>
<td>1.8</td>
<td>7.5</td>
<td>0.5</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Source: India Health Report 2003 P 19

\(^{18}\) Social Watch India (2003) p 28
The above figures put India in lower position not only in comparison with the world average, but also in comparison with the average of low-income countries in terms of Physicians, Nurses Midwives as well as hospital beds per 1000 population.

4.8 Rural Health Care Infrastructure in India

India is a predominantly rural society. Majority of its population live in the rural areas. However, the rural sector has been grossly neglected by the Indian state on almost all developmental fronts. In terms of health care infrastructure as well as health care delivery the rural India is yet to receive adequate attention both from the public as well as private health care providers. Besides, health system of a country encompasses a wide range of issues. And the essential health service delivery covers only a portion of a broad spectrum. Other critical health system issues include, inter alia, production, distribution and pricing of pharmaceuticals, equipments and other inputs, health insurance and the financing of health system.19 The rural India is the worst victim on all these fronts.

However, with substantial financial support during 1980s (Sixth and Seven Five Year Plans) the rural health care infrastructure received a boost. A three-tired system, it has sub centres for every 5000 population and Primary Health Centre (PHCs) for every 100,000 population. The sub centre is the most peripheral contact point between the primary health care system and the community. There were 137,271 sub centers as on 31st March 1999. The PHC is the first contact point between the village community and the medical officer and there were 22,975 PHCs operational as on 31st March 1999. The PHCs provides primary outpatient care with minimal arrangements for inpatients, while the Community Health Centre has facilities for secondary care, with specialists and inpatient beds. There were 2935 functioning CHS’s in India as on 31st of March 1999.20

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19 World Economic and Social Survey (2002) Ibid p 221
20 Health Information of India, 1999 (2002) Ministry of Health and Family Welfare, Govt. of India
But, the existing health personnel, both at the primary as well as secondary levels are grossly inadequate in rural India. The sanctioned posts of any category of health personnel for rural India is invariably lower than the required numbers. In position health personnel are also invariably lower than the sanctioned one's. So, vacancies and shortfall are very high.

Table 4.7 Availability of health personnel in rural health institutions in India.

<table>
<thead>
<tr>
<th>Category</th>
<th>Required</th>
<th>Sanctioned</th>
<th>In position</th>
<th>Vacant</th>
<th>Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialists (As a whole)</td>
<td>11740</td>
<td>6579</td>
<td>3741</td>
<td>2838</td>
<td>7406</td>
</tr>
<tr>
<td>Pediatricians</td>
<td>2935</td>
<td>1028</td>
<td>453</td>
<td>575</td>
<td>1970</td>
</tr>
<tr>
<td>Physicians</td>
<td>2935</td>
<td>1265</td>
<td>585</td>
<td>680</td>
<td>1841</td>
</tr>
<tr>
<td>Obs &amp; Gyneo</td>
<td>2935</td>
<td>1435</td>
<td>771</td>
<td>664</td>
<td>1652</td>
</tr>
<tr>
<td>Surgeon</td>
<td>2935</td>
<td>1524</td>
<td>809</td>
<td>715</td>
<td>1614</td>
</tr>
<tr>
<td>Doctors at PHCs</td>
<td>22975</td>
<td>29702*</td>
<td>25506</td>
<td>4199</td>
<td>2306*</td>
</tr>
<tr>
<td>Block Extension Educator</td>
<td>..........</td>
<td>6534</td>
<td>5508</td>
<td>892</td>
<td>..........</td>
</tr>
<tr>
<td>Health Workers (M)</td>
<td>137271</td>
<td>87504</td>
<td>73327</td>
<td>14177</td>
<td>64590</td>
</tr>
<tr>
<td>Health Workers (F)</td>
<td>160246</td>
<td>144012</td>
<td>134086</td>
<td>9947</td>
<td>27875</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>259110</td>
<td>22871</td>
<td>21077</td>
<td>2409</td>
<td>6990</td>
</tr>
<tr>
<td>Laboratory Technicians</td>
<td>25910</td>
<td>15865</td>
<td>12709</td>
<td>3177</td>
<td>13239</td>
</tr>
<tr>
<td>Nurse Midwife</td>
<td>43520</td>
<td>22672</td>
<td>17673</td>
<td>5064</td>
<td>20571</td>
</tr>
</tbody>
</table>


These figures, however, do not reflect the reality in rural health care. Because it does not take into account the large-scale absenteeism of doctors in rural areas. Besides, in almost all states in India, government doctors practice privately, with or without the permission of the Government.

On the other, due to the failure on the part of the government to bring into force any comprehensive rules and regulation to supervise the functioning of the government health care system, the net result has been under-utilization as well as, in many cases,
near collapse of the rural health care infrastructure, particularly the PHCs and CHCs. in most of the states in India.

4.9 Private Health Care in India

Private health care system has been significantly dominant in India since 1950s itself. However, the policy makers and implementers grossly neglected this fact while formulating policy, plan, and strategies towards achieving 'health for all' goal. Evidence from studies in 1963 reveals that only 10 percent of the population treated most illness episodes in rural India used government facilities.21 The consolidation of the private health care system, both in terms of Hospitals and Hospital Beds, has been explicit over the decades. Let us refer to the following figures.

Table 4.8- Growth and Share of Private Sector Hospitals and Beds

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospitals</th>
<th></th>
<th>Hospitals Beds</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public</td>
<td>Private</td>
<td>Total</td>
<td>Public</td>
</tr>
<tr>
<td>1974</td>
<td>2832</td>
<td>644</td>
<td>3176</td>
<td>211,355</td>
</tr>
<tr>
<td></td>
<td>(81.4%)</td>
<td>(18.6%)</td>
<td>(100%)</td>
<td>(78.5%)</td>
</tr>
<tr>
<td>1979</td>
<td>3735</td>
<td>2031</td>
<td>5766</td>
<td>331,233</td>
</tr>
<tr>
<td></td>
<td>(64.7%)</td>
<td>(35.3%)</td>
<td>(100%)</td>
<td>(74.2%)</td>
</tr>
<tr>
<td>1984</td>
<td>3925</td>
<td>3256</td>
<td>7181</td>
<td>362,966</td>
</tr>
<tr>
<td></td>
<td>(54.6%)</td>
<td>(45.4%)</td>
<td>(100%)</td>
<td>(72.5%)</td>
</tr>
<tr>
<td>1988</td>
<td>4334</td>
<td>5497</td>
<td>9831</td>
<td>410,772</td>
</tr>
<tr>
<td></td>
<td>(44.1%)</td>
<td>(55.9%)</td>
<td>(100%)</td>
<td>(70.1%)</td>
</tr>
<tr>
<td>1996</td>
<td>4808</td>
<td>10,289</td>
<td>15,097</td>
<td>395,604</td>
</tr>
<tr>
<td></td>
<td>(31.9%)</td>
<td>(68.1%)</td>
<td>(100%)</td>
<td>(63.4%)</td>
</tr>
</tbody>
</table>

Source: India Health Report 2003 p 103

Besides, an estimated 56 percent of dispensaries and 75 percent of allopathic doctors were in the private sector.

21 India Health Report 2003 p 102
4.10 Pattern of Public/Private investment in Health Care and its implication for Health Security: Putting India in a Comparative Setting

Despite the paradigmatic shift in the health care sector, the empirical evidences have shown that all the OECD countries have kept their health care system either under the exclusive control of the state or adopted a mixed pattern of investment. These countries have also kept the private health providers under the strict vigilance of the state.

However, most of the developing countries including the erstwhile USSR and East European Socialist Bloc, known as economies in transition, are characterized by the predominance of private health care system. The empirical evidences suggest that the countries either with predominance of public health care system or a mixed pattern under strict vigilance of the state have performed better than the system with the predominance of the private health care providers.

Let us have a comparative analysis to prove the point.

The countries selected for comparative analysis is Norway, USA, Mexico, Sri Lanka, China and Pakistan. While selecting these few countries a very loose criterion has been adopted. Norway is the top rank holder in the UNDP HDI both in the year 2003 & 2004 and is also characterized by a predominantly public health care delivery system; the USA is the only Super Power in the world now and still continuing with a mixed health care delivery system but with strong tendencies towards predominance of private health care system; Mexico occupies the last rank within the high human development countries (as per 2003 UNDP Human Development Report) and the private investment already surpassed public investment in health care; Sri Lanka is fore runner both in social security as well as in health security in South Asia and maintaining almost equal share of investment in health care between the public and private; China has gradually opened up the health sector for private investment; Pakistan is from the Indian sub-continent and has the predominance of the private health care delivery system. A critical analysis shows that the countries with the predominance of the public health care system or of a mixed character are enjoying
high status both in terms of human security as well as in terms of health security. The following table is explanatory in this regard.

Table 4.9- Achievement in Crucial Factors related to Health Security

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Norway</th>
<th>USA</th>
<th>Mexico</th>
<th>Sri Lanka</th>
<th>China</th>
<th>India</th>
<th>Pakistan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>78.7</td>
<td>76.9</td>
<td>73.1</td>
<td>72.3</td>
<td>70.6</td>
<td>63.3</td>
<td>60.4</td>
</tr>
<tr>
<td>Population with access to improved sanitation(%)</td>
<td>.......</td>
<td>100%</td>
<td>74%</td>
<td>94%</td>
<td>40%</td>
<td>28%</td>
<td>62%</td>
</tr>
<tr>
<td>Population with access to affordable essential drugs (%)</td>
<td>95-100%</td>
<td>95-100%</td>
<td>80-94%</td>
<td>95-100%</td>
<td>80-94%</td>
<td>0-49%</td>
<td>50-79%</td>
</tr>
<tr>
<td>Births attended by skilled health personnel(%)</td>
<td>.......</td>
<td>99%</td>
<td>86%</td>
<td>97%</td>
<td>89%</td>
<td>43%</td>
<td>20%</td>
</tr>
<tr>
<td>Under nourished people(%)</td>
<td>.......</td>
<td>.....</td>
<td>5%</td>
<td>23%</td>
<td>9%</td>
<td>24%</td>
<td>19%</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live birth)</td>
<td>4</td>
<td>7</td>
<td>24</td>
<td>17</td>
<td>31</td>
<td>67</td>
<td>84</td>
</tr>
<tr>
<td>Maternal Mortality Rate (Per 100,000 live births)</td>
<td>6</td>
<td>8</td>
<td>55</td>
<td>90</td>
<td>55</td>
<td>540</td>
<td>.......</td>
</tr>
</tbody>
</table>

Source: UNDP Human Development Report 2003
We find variations in the health security statuses among the countries taken for comparative analysis. As stated, these variations have close linkage with the pattern of public/private investment in health sector. The following table is illustrative in this regard.

Table 4.10- Pattern of Public and Private Expenditure on Health Care

<table>
<thead>
<tr>
<th>Name of the State and HDI rank</th>
<th>Public expenditure as % of GDP</th>
<th>Public/Private expenditure on health as % of GDP (2000)</th>
<th>Govt. expenditure on health as % of total general Govt. expenditure</th>
<th>Govt./ Private expenditure on health as % of total expenditure on health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norway</td>
<td>1</td>
<td>6.4</td>
<td>6.6</td>
<td>1.1</td>
</tr>
<tr>
<td>USA</td>
<td>7</td>
<td>4.7</td>
<td>5.8</td>
<td>7.3</td>
</tr>
<tr>
<td>Mexico</td>
<td>55</td>
<td>1.8</td>
<td>2.5</td>
<td>2.8</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>99</td>
<td>1.5</td>
<td>1.8</td>
<td>1.9</td>
</tr>
<tr>
<td>China</td>
<td>104</td>
<td>2.2</td>
<td>1.9</td>
<td>3.4</td>
</tr>
<tr>
<td>India</td>
<td>127</td>
<td>0.9</td>
<td>0.9</td>
<td>4.0</td>
</tr>
<tr>
<td>Pakistan</td>
<td>144</td>
<td>1.1</td>
<td>0.9</td>
<td>3.2</td>
</tr>
</tbody>
</table>


Norway not only invested the highest of its GDP in health care among the countries taken for comparison, but also maintained the higher share than the private investment/expenditure. In case of the USA, although there has been an increase in public investment in health as % GDP between 1990 and 2000 from 4.7% to 5.8%, however, the share of private investment as % of GDP (7.3%) in 2000 is higher than the share of public expenditure (5.8%). In case of the share of total expenditure on
health, one finds the dominance of the private in the USA. One also finds that the private expenditure is gradually increasing, whereas the public expenditure is gradually declining. In 1995, the share of the private expenditure on health as % of total expenditure was 54.7%, which grew to 55.7% in 2000. On the other, the public share declined from 45.3% to 44.3% during the period. In case of China also one finds gradual decline in public share of expenditure on health care and gradual increase of private share. In 1995 the government-private share of total expenditure on health was 46.7% and 53.3%. However in 2000, the government share reduced to 36.6% and the private share increased to 63.4%. Sri Lanka, however, maintained an equal share between the Government and the private both in 1995 and in 2000. Indeed, the Government share increased slightly from 48.9% in 1995 to 49% in 2000. In case of India also one finds the slight increase of Government share from 1995 to 2000 and corresponding decrease of private share. However in India, the private share has been predominant both in 1995 (83.8%) and in 2000 (82.2%).

A comparative analysis of the linkage between public-private share of investment in health care and that of the achievement in health security in the respective countries reveal a positive relationship between the role of the state and that of higher health security status.

In the recent past, the public health establishment in the West was caught short by the return of malaria, cholera, tuberculosis, dengue, and other communicable diseases, which people in the 1970s thought to have disappeared forever. People have also been threatened by the appearance of apparently new infectious diseases: most threatening of which is AIDS, but also Legionnaire's disease, Ebola virus, Toxic shock syndrome, multiple drug resistance tuberculosis, and many others.22

The situation in the US has been the worse. Richard Levins, an expert on the US health care system, suggests that this was due to change in the operation of the health care system. It is ironic for the US as percentage of GDP United States spends more

than any other countries on health care i.e. around 13 percent. But, still not performing well. Levins made capitalism responsible for this. Because, under the logic of capitalism, the medical decisions are no longer taken on medical grounds but on the grounds of profit at different domains related to health security.

4.11 The Issue of Accreditation of Health Care Providers
While welcoming the new demand oriented reform in health system around the world, the UN has categorically stated that the government has to play a leading role in this new generation of health reform too: “The possible roles of the Government as regulator will need to be more sophisticated, requiring multifaceted intervention and coordination among the Government, Public and the Private providers and consumers, so as to maximize the contribution of a health system to the population” In this regard, the Government has to perform a few important functions: understanding the role of the private sectors in its own country and institutionalizing policy instruments; expanding the effectiveness of health service regulations to assure the overall quality of health care; contracting out and improving access of the poor to health care, including the exemption of fees.\(^{23}\) To carry out these functions, the Government has to develop a comprehensive regulatory/accreditation system. And this is more important for India as the health care delivery in India is multifaceted, consisting of diverse practitioners and institutions, mixed ownership patterns and differing systems of medicines.\(^{24}\) The utilization data (NSSO 1998) reveals that the private sector predominates in terms of provision of care, with 82 percent of out patient service being sought in the private sector. In other spheres, excluding immunization, the dominance of the private sector is very high. Whereas in case of immunization, private sectors contribution is only 9%, in antenatal care private sector’s share is 40%. In institutional delivery private sector controls 50 percent and in case of hospitalization its share is 55%.\(^{25}\)

\(^{23}\) World Economic and Social Survey (2002) pp 237-239
\(^{24}\) Nandraj and Khot (2003) Accreditation System for Health facilities: Challenges and Opportunities, Economic and Political Weekly, December 13, p 5251
Cost of private health care is under-researched in India. Recent studies, however, suggest that 7-9 percent of annual household consumption is spent on health care needs, about 85 percent of which goes to the private sectors. The costs of private sector health care are influenced by provider payment mechanism. In India most of payment are of an out-of-pocket, fee-for-service basis. Over prescribing, and subjecting patients to unnecessary investigation etc are characteristics of fee-for-service payment basis. This unnecessary medical intervention assumed dangerous in some particular profitable sectors like in the caesarean section.

The loopholes and the profit motive in the private health establishments invite urgent regulatory mechanisms and this can be provided only by a transparent and accountable public mechanism. For that, the state has to take important initiatives. But, in most of the states in India, there is an absence of legislation regulating private health care facilities, laboratories and various types of health centers. The standards of medical practice in terms of qualification of staff employed, equipments needed, administration or treatment offered has not been prescribed. The private health care providers and their associations have resisted attempts at enacting legislation for clinical establishments.26

So, the private health care providers are operating in an unchecked atmosphere inviting multiple points of vulnerabilities for the health care seekers, particularly for the poor categories in the society. "The lack of any kind of quality assurance mechanisms (such as accreditation) not only make it difficult for people to make informed choices in selecting health providers but also limit their capacity to demand optimum services." 27

It is in this context that the notion of accreditation is gaining popularity around the world. Accreditation is a system based on awarding of "professional and national recognition to facilitate that provide high quality of care. It is implicit that the


27 Ibid p 5251
particular health facility has voluntarily sought to be measured against high professional standards and is in substantial compliance with them."28 In accreditation system, as has been pointed out by Nandraj and Khot, standards are clearly defined and graded, compliance is assessed by intermittent external review by health professional and accreditation is awarded for a limited period. The performance is determined by comparing actual practice with agreed standards.

Many countries around the world have already been practicing accreditation system and number of other countries is developing it.

United States of America is one among those having the mechanism of accreditation of health care providers for quality assurance. The US started this practice as early as 1900s itself. Over a period of time, it transformed into the Joint Commission on Accreditation of Hospitals, subsequently renamed Joint Commission on Accreditation of Health care Organizations (JCAHO) in 1987. This organization accredited around 5000 hospitals in the US. With initiatives from medical profession and hospital association, the Canadian Council on Hospital Accreditation came into being. This was renamed Canadian Council on Health Facilities Accreditation (CCHFA) in 1988. This autonomous independent body received official recognition in 1958. CCHFA accredits 74 percent of acute care hospitals, 32 percent of long-term facilities, 79 percent of mental health centers and 65 percent of rehabilitation centers. Countries like UK, Australia, and New Zealand are some of the other well-established players in this process. Besides, the other countries that have an accreditation system and those in the process of setting up one are Spain, France, Netherlands, and Israel amongst others.29 In India, the mechanism of accreditation is yet to consolidate its ground. Some states, of course, have started enacting laws to regulate the function of private health care providers. For example, Assam enacted Assam Health establishment Act in 1993 and issued Assam Health Establishment Rules in 1995. Karnataka drafted the Karnataka Private Health Care establishment Bill in 2000. The central government is also examining the possibility of legislation for clinical establishments in order to

28 Ibid 5251
29 Ibid p 5252
protect the patients against poor quality of services provided by the private clinical establishments.

At the private and voluntary levels also some attempts are going on for evolving accreditation mechanism in India. Indian Hospitals Association (IHA) in Mumbai and Delhi attempted to promote a voluntary accreditation system in 1993. In the recent past, there are efforts underway for the formation of an accreditation body namely Accreditation Council for health care standards in Mumbai.30

Despite all these attempts, India has to go miles ahead to develop an effective and comprehensive accreditation system. The accreditation mechanisms developed by the states, as is the case with Assam today, are performing very poor.

4.12 Availability and Accessibility of Drugs and People's Right to Health Care
The vulnerability of people's right to health care has been intensified with people's growing inaccessibility to essential drugs. This has been caused by the change in drug policies in India in the recent past. Government of India adopted the Drug Policy 1978 and National Health Policy 1983, in the backdrop of the WHO Alma-Declaration of 1978, with a pledge to ensure universal health by the year 2000. But, from mid 1980s onwards, along with the adoption of structural changes in its welfare policies, India has also embarked upon a new drug policy regime. Through the 1978 drug policy total 347 drugs were brought under controlled price. The 1986 drug policy, however, reduced the number to 166. But the modification of the 1986 Drugs policy in 1994 reduced the number to 73. Today the number stands at 33. As a result, there has been substantial hike in almost all drugs in India. Wishvas Rane31 compared the Drug prices of total 778 product packs (that constitutes around 55 percent of all products in 1990) between 1980 and 1995 and found that in case of some drugs the price hike was above 2000 percent. Out of the 778 product packs 118 showed a price rise less than 50 percent, 145 showed 50 to 100 percent and 50 product packs showed decline in prices. The remaining product packs showed a price hike above 100

30 Ibid p 5253
percent. For example, the drugs meant for cancer showed a maximum hike of 336 percent. Anti-allergic drugs showed a price hike of 259 percent. Drugs acting on the respiratory system have registered a rise of 258.45 percent. Drugs acting on the alimentary system showed a price rise of 243 percent. During this time anti-obesity drugs showed a hike of 193 percent, vitamins 186 percent and tonics 185 percent. In contrast to the recent Survey reports, where it has been argued that prices of medicines have either declined or remained unchanged (Survey conducted by A C Nielsen- ORG), Rane argues that a close look at prices of drugs over the years showed a consistent overall rise in drugs which need to be used over a long period, such as those used for tuberculosis and diabetes etc. Besides, as a result of delicensing and import liberalisation, drugs are both imported more freely and sold more aggressively. Anant Phadke very rightly pointed out that this is especially true in the context of a consumerist culture (‘there is a pill for every ill’), and the track record of the drug industry world wide of pushing unnecessary, ineffective, obsolete and even hazardous drugs and their combinations.

The Government of India already brought into force the Patents (Third Amendment) Act 2005 to comply with India’s commitments under the TRIPS (Trade Related Intellectual Property Rights). The amendment will have enormous negative implications both for the Indian pharmaceutical Industry as well as for the consumers. The Bill proposes to curtail the scope of awarding “compulsory licenses” which allows the patent controller to grant permission to any interested authority to make product without taking the consent of the patent holder. It is apprehended that the New Act will allow the MNCs to patent the products they originally developed. Local firms won’t be allowed to produce the generic versions available across the world. In addition, the Bill intends to do away with what is called the “pre-grant opposition”, which eventually will allow all patent applicants to evade public scrutiny.

32 Ibid p 2331  
33 Wishvas Rane (2003) ibid p 4640
As mentioned, India is already marked by very low accessibility to essential and affordable drugs. The changes in national drug policy already reduced people's access to affordable drugs. Now, with the adoption of the Patents (Third amendment) Act, the drugs will become less and less accessible for the larger majority in the society. The treatment of fatal diseases like cancer or Diabetes will be beyond the reach of the common people. All these are happening at a moment when people's access to life and livelihood has already been put into danger by cutting subsidies in essential commodities as well as abandoning the pro-people welfare policies.

The Danger, however, is not limited only to the price hike. The pharmaceutical world in the recent past has been involved in an aggressive campaign for their products. They want to expand their market. Market will expand provided more drugs are used. To achieve this goal, the manufacturers are already indulging in giving commission to the medical practitioners/doctor for excessive prescription. This will have manifold negative impact on the patients. First, they will have to carry the burden of huge expenditure involved in. But, second and most importantly, they will also be the victims of excessive use of drugs, making the patients totally dependent on drugs. Their natural resistance will collapse. The ultimate aim of all these is to create an ill society.

4.13 Insurance Regime and people's Right to Health Care
One of the very important points of justification of the hike in health care expenditure arising out of privatization of this sector is that it will be taken care of by the insurance sector. This new perception is accompanied by the opening up of the insurance sector for more and more private investment including foreign direct investment (FDI) around the world including in India.

Health care insurance has vital significance today. This is due to the fact that at a point of privatization of health care and the resultant hike in health care, the growing out of pocket expenditure on health care can be managed and balanced to a greater extent by pre-disease insurance schemes. Besides, insurance provides protection against risks or uncertain events and is based on the principle that what is highly
unpredictable to an individual is predictable to a group of individuals. Health insurance protects against the cost of illness, mobilizes funds for health services, increases efficiency of mobilization of funds and provision of health services, and achieves certain equity objectives.\(^{34}\) This is more important in a country like India where more than 40 percent of hospitalization patients borrow money or sell assets to meet medical costs. In the process, an average of 24 percent of hospitalized patients become impoverished.\(^{35}\)

Insurance coverage, however, has been very low in India, although the process started as early as 1948, just after independence. With the enactment of the Insurance Regulatory and Development Authority (IRDA) Bill in the year 2000, India had definitely moved towards the privatization of the Insurance sector. Up till then the various types of formal insurance was under the exclusive control of the public sector.\(^{36}\)

India has various forms of health insurance today, which can be broadly categorized (based on ownership of schemes) as follows: state based systems, market based systems, member or organized (NGO or cooperative) based system, and private household based system.

(1) India embarked on the insurance scheme in 1948 with the promulgation of the Employees State Insurance (ESI) Act in 1948. It introduced a mandatory Social Insurance Scheme (SIS) with managed care concepts for employees in


the formal sector. The employees State insurance Scheme (ESIS) introduced in 1952, is managed by the Employees State Insurance Companies (ESIC), a fully government owned enterprise. It is compulsory social security measure for workers having an income of less than Rs 6,500 a month and also covers the dependants. In the year 2000, about 33.4 million beneficiaries were covered by the scheme.

(2) The Second initiative was the Central Government Health Scheme (CGHS) in 1954 for employees of the central government, members of parliament, judges, freedom fighters etc. This is mainly financed by the central government and according to a 1996 estimate it covers 4.4 million beneficiaries.

(3) For persons, not covered by these schemes, Government run insurance companies have introduced market-based scheme, such as the mediclaim scheme of General Insurance Company (GIC) in 1986. This scheme is, however, confined to inpatient treatment.

(4) Many charitable and voluntary organizations have also designed social security schemes for specific groups of population- tribal, women etc., and some NGOs provide some kind of social security to the poor and those working in the unorganized sector, particularly in the rural areas. These schemes are also known as Community Based Heath Scheme (CBHI). These schemes have gained popularity in India in the recent past, because the real benefit of CBHI lies in keeping the transaction costs low, in designing the scheme suited to community needs, influencing health behaviour through health education and affecting the supply of health care. Some of the NGOs involved in CBHI are SEWA in Ahmedabad; ACCORD in Nilgiris, Tamilnadu; Karuna Trust in Mysore; Yeshasvini Trust in Bangalore etc.

Despite all these developments the insurance coverage in India is as low as around 11 percent. It has been estimated that the formal sector mandatory schemes have an aggregate coverage of about 40 million. In addition to this, the scattered

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employer-based schemes in the formal sector have provided varying degree of social security to around 30 million individuals; while community based insurance schemes have provided some cover to 30 million people. “In totality, some degree of social security cover has been available to about 110 million people, out of which less than 30 million are the poor from the unorganized sector.”

In the recent past the government has announced two new initiatives in the social sector- Universal Health Insurance Scheme (UHIS) and the Unorganised Sector Worker's Social Security Scheme (SIS)- which appear substantive by way of coverage.

Universal Health Insurance Scheme (UHIS) offers a package of insurance cover for a limited reimbursement of expenses for hospital services. The aggregate quantum of cover is Rs 30,000, subject to a sub-cap of Rs 15,000 for a single illness. The scheme also provides personal accident cover of Rs. 25,000 for the contingency of accidental death of the earning head of the family; and provides a disability cover, by a way of per diem compensation to an earning head of family, during his hospitalization on account of accident/illness, for a maximum of fifteen days. The coverage under the health insurance scheme, inter alia, excludes all pre-existing diseases, and also some common medical conditions even when contracted after enrolment under the scheme. The insurance cover becomes substantively effective after the expiry of 30 days from the enrolment of the subscriber. Initially the premium payable for this package of cover under the UHIS was fixed at Rs 365 per annum (Rs 1 per day) for an individual; Rs 548 per annum (Rs 1.50 per day) for a family upto five members (Including the first three children); and Rs 730 per annum (Rs 2 per day) for a family up to seven members (including the first three children and dependant parents). The state’s contribution of Rs. 100 per family comes by way of subsidy towards the premium for BPL beneficiaries. The policy covers expenditure incurred during the hospitalization in listed health service centers having prescribed infrastructure facilities/qualified.

professional manpower. The scheme is to be operated by a TPA and will be a
cashless transaction to the extent possible. The scheme is available to a group
consisting of a minimum of 100 individual/family subscribers.\(^{39}\)

The scheme, however, failed to evoke proper response from the people in more
than one year of its operation as till May 2004 UHIS could cover only 11, 408
beneficiaries. So, P. Chidambaram, the Union Finance Minister of the new UPA
Government, in his Budget presentation (Budget 2004-05) re-designed the scheme
by reducing the premium amount of all three categories of beneficiaries without,
however, reducing the benefits. This is now exclusively meant for the BPL
people. Now the annual premium for one individual is Rs. 165; Rs. 248 for a
family of five members and Rs. 330 for a family of seven members. Accordingly,
the Finance Minister also announced the increase in government subsidies for all
three categories of insurances. Earlier, the subsidy was confined to Rs. 100 for all
BPL families. Now the subsidy stands at Rs. 200 for the first category; Rs. 300 for
the second category and Rs. 300 for the third category of beneficiaries.

The earlier NDA government on the eve of election announced social security
Scheme (SSS) for unorganized sector. The plan was to cover 25 lakh workers in
50 districts over the next two years under the pilot projects. The total number of
workers within this sector is 367 million, constituting 93 percent of the total
number of workers employed. The ultimate aim was to enact an overarching law-
the Unorganized sectors Worker’s Act- to regulate the employment and conditions
of service of all the workers of the unorganized sector, and to provide for their
safety, social security, health and welfare. The proposed legislation envisages the
establishment of a central unorganized sector worker’s board along with similar
boards at the state levels. The package of benefits offered as a part of the SSS has
the following significant components:

(i) An old age pension of Rs. 500 per month on attaining the age of 60 years.
    Also provisions for pension to widows/orphans;
(ii) A personal accident insurance cover of Rs. 1,00,000;

\(^{39}\)Javid A Choudhury (2004) ibid pp 3165-6
Under the old age pension scheme, the subscribers of the unorganized sector were to be divided into two age groups: group I- age 18-35; group II: age 36-50 years. Enrolment under group II would be restricted to the first five years of the scheme, after which entry would only be under the group II eligibility norm. The eligibility to the benefits of the SSS will be limited to the workers with wages up to Rs. 6,500. To participate in the integrated scheme the workers of group I would have to contribute Rs 50 per month and workers from group II would contribute Rs. 100 per month. The scheme envisages that the employer's contribution will be equal to that of the employee. The self employed, and such worker's, whose employer's are not identifiable, could also register under this scheme, but on the payment of their contribution as also the employer's contribution.

Both these schemes appear to be revolutionary both from the perspectives of its coverage as well as target groups. If can be implemented in its true spirit, the current coverage of mere 11 percent will go many times up. But, both the schemes have many shortfalls. For example, the first scheme i.e. UHIS does not include the outdoor patient care as well as the pre-existing diseases. This will not help out the target groups, provided Government does not build up parallel comprehensive primary health care system. On the other, if not taken care of other vital issues like nutrition, safe drinking water and other preventive measures, the out patient treatment that costs huge out of pocket expenditure under the current state of health care, will not decrease. As far as the second scheme i.e. SSS is concerned, the most vital issue is the contribution from the employer. As is widely known, as has also been pointed out by the experts, only a few individuals of the unorganized sector have steady employment. It is therefore very difficult in most cases to legally determine the identity of the employer.

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40 Ibid p 3167
41 Ibid p 3167
4.14 Responding to the Poor Health Care Status: National Health Policy 2002

National Health Policy (NHP) 2002 appears to have taken into consideration the current constraints towards health security and accordingly attempts have been made to bring back the active role of the state. NHP- 2002 has very categorically identified many of the loopholes of the current public health care system such as inadequate funding for outdoor facilities, absentee phenomena of health personnel, negligence towards consumable items in the health care institutes, obsolescent and unusable equipment in many public hospitals, dilapidated state of buildings of health care institutes etc. In case of the indoor treatment facilities also, this policy has pointed out that the equipment is often obsolescent, the availability of the essential drug is minimal, the capacity of the facilities is grossly inadequate, which leads to overcrowding, and consequentially to a steep deterioration in the quality of the services.

The NHP 2002 also acknowledges that the growth of public health services, as reflected in the attainment of improved public health indices, is closely linked to the quantum and quality of investment in the primary health sector. The Policy also envisages kick starting the revival of the primary health system by providing some essential drugs under central government funding through the decentralized health care system. The Policy also recognizes the significance of the Alternative System of Medicine- Ayurveda, Unani, Siddha and Homeopathy- which can play a substantial role, particularly in the under served, remote and tribal areas, because of inherent advantages, such as diversity, modest cost, low level of technical input and growing popularity of natural plant based products.

NHP-2002 also acknowledges the fact that private health services are very uneven in quality, sometimes even substandard. Private health services are perceived to be financially exploitative, and observance of professional ethics is noted only as exception.
Taking into consideration all these shortfalls the NHP -2002 proposes to increase the public expenditure in health as well also pledges to eradicate different diseases within stipulated time period. Accordingly NHP developed a time frame for eradicating various diseases and pledged to increase the public expenditure on health. Under *Goals to Be Achieved by 2002-15*, NHP proposes to eradicate polio and Yaws and Eliminate Leprosy by 2005; Eliminate Kala Azar by 2010; Achieve Zero level growth of HIV/AIDS by 2007 Reduce Mortality by 50% on account of TB, Malaria and other Vector and Water Borne Diseases by 2010 etc. it also promises to Establish an Integrated System of Surveillance, National Health Accounts and Health Statistics by 2005; Increase health expenditure by Government as % of GDP from the existing 0.9% to 2.0% by 2010; Increase share of central grants to Constitute at least 25% of total health spending by 2010 etc.

Despite the ambitious objectives of NHP-2002, it has lot of limitations and flaws. The Policy has failed to take into account the entire developments in health care related activities. The government, in contrary to its commitments are implementing new drug policy and enacting new Patent Act. These will put hindrance towards the attainment of the Objectives of NHP- 2002.

The policy limitations apart, even the policy objectives themselves have failed to find adequate attention in the post –2002 Budgets. Both the budget 2003-04 and 2004-05 fails to implement the promised increase in the budget.

With the Congress led UPA government assuming power at the center, which is also backed by the left parties, there was an illusion around that there will be a qualitative change of Indian Government's approach towards social security within the constraints of the ongoing liberalization policy. Accordingly, health sector was expected to receive adequate attention from this government. The Common Minimum Programme (CMP) of UPA very categorically announced this sector as one of its priorities: “The UPA will raise public spending on health to at least 2% of GDP *(which now stands at 0.9%)* over the next five years with special focus on primary health care.” Prime Minister Dr. Manmohan Singh in his first address to the nation on
June 24, 2004 also assured of a humane health care by his government: “We need new thinking on health policy. While the Government will continue to help in the growth of private and community-based health and medical care, there is a crying need for the reform of public health and public hospitals. We will make public hospitals more efficient and accessible, through public-private partnership aimed at offering affordable and humane health care. We need community based and public-health oriented solutions to tackling communicable diseases, epidemics, especially HIV/AIDS, and disability management and population stabilization.”


The high claims of NHP-2002 as well as the promises of the UPA government have not been reflected in the subsequent Budgets of the Union Government. Neither there is any qualitative change between the NDA government’s and that of the UPA government’s approach towards this sector.

Let us look at the Budget proposals of 2003-04 (the last full-budget of the NDA government) & 2004-05.

**Table 4.11 Budget Proposals of 2003-04 (The last full-budget of the NDA Government) & 2004-05 related to the Health Sector**

<table>
<thead>
<tr>
<th>Ministries/Department</th>
<th>Budget 2003-04 (Rs. In crore)</th>
<th>Budget 2004-05 (Rs in Crore)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Non-Plan</td>
</tr>
<tr>
<td>Grand total of all Ministries/Departments</td>
<td>120974.00</td>
<td>317821.07</td>
</tr>
<tr>
<td>Ministry of Health &amp; Family Welfare</td>
<td>6581.30</td>
<td>1038.79</td>
</tr>
<tr>
<td>Department of Health</td>
<td>1506.30</td>
<td>962.79</td>
</tr>
<tr>
<td>Department of ISM &amp; Homeopathy</td>
<td>145.00</td>
<td>51.47</td>
</tr>
<tr>
<td>Department of Family Welfare</td>
<td>4930.00</td>
<td>24.52</td>
</tr>
</tbody>
</table>


Analysis of the figures shows that despite the high claims of the National Health Policy of 2002 as well as the illusion of qualitative difference between the NDA and UPA governments, the Ministry of Health and Family Welfare received only 1.73
percent and 1.76 percent respectively out of the total expenditure outlays of the Union Budgets 2003-04 and 2004-05. The Ministry of Defence, on the other, received 17.53 percent out of the total expenditure outlay in the Budget 2003-04, which was raised to 18.65 percent in the Budget 2004-05, despite the fact that the UNDP Human Development Reports as well as the India's National Human Development Report 2001 stress on transforming security from an exclusive concern on territorial security to a much greater people's security.

The Ministry of Health and Family Welfare has three basic components: Department of Health; Department of Indian System of Medicine and Homeopathy and Department of Family Welfare. In accordance with the prescription of the World Bank, the Budget allocated the highest share to the Family Welfare Department. Out of the total outlay for the Ministry of Health and Family Welfare, the Department of Health received 2469.09 crores i.e. 32.40%. (2469.09 crores out of 7620.08 crores) in the Budget 2003-04, which got reduced to 31.85 percent (2687.62 crores out of 8438.12 crores) in the Budget 2004-05. The Indian System of Medicine and Homeopathy received 196.47 crores i.e. 2.57 percent in the Union Budget 2003-04 and this remained more or less same in the budget 2004-05 too i.e. 225.73 crores out of 8438.12 crores (2.67 percent), despite the fact that NHP-2002 promised to rejuvenate this sector because of its growing popularity. On the other, the Department of Family Welfare alone received 4954.52 crores i.e. 65.01 percent in the Budget 2003-04 which even increased more in the Budget 2004-05 i.e. 5524.77 crores out of 8438.12 crores (65.47 percent).

The total allocation earmarked for the Department of Health is being distributed among various sub-heads like Hospital and Dispensaries (Allopathy); Medical Education, Training and Research; Public Health, which also includes National AIDS Control Programme; Other Programmes like setting up of a National Illness Assistance Fund etc. and Aid Material and Equipments.

The component of public health in the Department of Health has gradually been neglected. And within public health the AIDS Control programme has been a priority
for the Government for the last couple of years. As a result, the other components of public health like anti-malaria, T. B. control; Filaria control programmes etc. have received less attention from the government in terms of budgetary allocation. In the 2003-04 Budget, Public Health received total 839.21 crores out of the total allocation for the Department of Health i.e. 33.98%. In the Budget 2004-05, public health received 907.40 crores out of the total allocation of 2687.62 crores for the department of health i.e 33.76 percent. Analysis shows that out of the total allocation earmarked for various programmes under public health, National AIDS Control Programme alone received 205.00 crores i.e. 24.42 percent in the budget 2003-04 and 232.00 crores out of 907.40 crores i.e 25.56 percent in the Budget 2004-05.

Most of the programmes related to communicable diseases are financed by the Central government on 100 percent basis. These include National T.B. control programme; National Leprosy control programme; National Scheme for prevention of Visual Impairment and blindness including Trachoma; National I.D.D. control programme and National AIDS Control Programme. On the other, National Malaria Control Programme and National Filaria Control Programme are sponsored on 50 percent basis by the central government. All these diseases constitute the highest burden of diseases in India. These diseases also occur due to the failure on other fronts like lack of nutrition; lack of safe drinking water; lack of access to proper primary health care at affordable range etc. Most of these diseases are also poor man’s disease. So, tackling these diseases need an integrated approach- right from tackling poverty to ensuring employment to spreading education. All these have failed to receive adequate and comprehensive attention from the government both in the pre-reform as well as post reform era. But it assumed more dangerous turn with the implementation of the neo-liberal economic policies. The growing focus on health insurance schemes, as a way out to meet the increasing health expenditure, is yet to provide coverage to the larger majority. As a cumulative effect of all these, access to proper health care by the larger majority has gradually been marginalized.