Social Accessibility of Healthcare in India: A Policy based Study of Pre and Post-Independence Era

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Abstract

The accessibility of affordable and equal healthcare has always been a critical and significant issue in view of the low paying capacity of a large proportion of the population in India. As the role of the private sector healthcare providers is becoming more widespread (particularly in the past two-three decades), healthcare services are getting out of reach of the poor and marginalized sections of the population. There is an added emphasis on insurance-based healthcare system in the recent years. This system further deprives a large section of the poor from accessing healthcare facilities due to their inability to pay insurance premiums on time.After economic reform in India, a high degree of income differentiation has led to a rise in lifestyle diseases for the rich and under-nutrition and other communicable diseases for the poor. There are wide inequities in accessibility of healthcare services among the various sub-groups of society on the basis of class, caste, religion, region, gender, etc. The Scheduled castes and Scheduled tribes (SCs and STs) sub-groups have less access to private health services and are consequently more dependent on the public health sector, while public health sector become totally insufficient to treat majority of the people. According to studies More than 35 percent of the Indian population suffers from serious diseases or illnesses which have an adverse impact on the quality of life. India constitutes nearly 16.5 percent of the world's population but has a share of 20 percent of the world's diseases (.[62] The policy analysis is an established research and academic discipline in the industrialized and developed countries. But in developing countries like India, its application is still limited, particularly in the healthcare sector. On the behalf of public health policies many studies are arguing that health of the common people has never been a priority in Indian society as in many other places in the world. This can be highlighted through the fact that it is largely invisible in the domestic debates till now.

Statement of the Problems and Conceptual Framework

Health of the people in general is affected by many factors. At the community level, the role of the state is of paramount importance in achieving health standards particularly in federal and socialist structures. Even in other set-ups, the state exerts its power through policies, programmes and legislations on planning, prioritizing, implementation and evaluation of health activities. Every activity should start with a policy which is a principle or rule to guide decisions and achieve rational outcomes. A policy is a statement of intent, and is implemented as a procedure or protocol.[4] In India, health policies are generally adopted by the state or central government whereas procedures or protocols are developed and adopted by the senior executive officers. This system is in existence for a long time. But over a period of time, it has been observed that the health status of the people has not advanced at the same pace as other sectors of development. However, health has been recognized as one of the most vital areas for all types of development. But, the health of the people had never been in priority of the policy makers and implementers as well as for the exicutive authority, in pre and post-independence India. It is interesting to know why the poor health status of India still continues in spite of the fact that various health policies have been launched from time to time.

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It is a widely recognized fact that the good health is an important contributor to productivity and economic growth of the people and a nation. In a developing country like India, public health assumes greater significance as it is also directly linked to the survival of the people. Good health is a natural corollary for productivity and a systemic defense against illnesses. It is essential to every human being not only for his well-being but also for his survival. Public health services reduce the exposure to disease and death and should, therefore, be considered as an essential component of a country's infrastructure. Therefore, the state should safeguard the 'health right' of its citizens as the fundamental prerequisites of survival. The societal need for a healthy population necessitates a study of public health.

Although traditionally India has housed rich healing practices of medicine in the pre-colonial period, it would be useful and essential to focus on modern public health system (prevalent in the colonial as well as post-colonial period). The colonial state in the initial phase, introduced the western medical system for its own interests in India and the impact of this medical system was restricted to a small section of the population. The benefit of this health system was for the European civil and military servants and their families and but later on, this medical care was also made available to a few Indians who were residing in urban areas. In the present study it is argued that western medicine played an important role in increasing the power of colonialism and to regulate colonial societies. Therefore, even though modern medical services had been beneficial, the mass of Indian population did not benefit. Preventive campaigns such as vaccination and plague control which were never available to the general population demonstrated the failure of British health policy in coming to terms with the local society. Health measures probably had little influence on mortality and morbidity, but they did establish a framework of personnel, ideas and institutions that permitted more substantial post-independence provisions, whose impact is clearly noticeable.

In fact some of the resolutions/ provisions of colonial rule changed during the formulation of famine policies and food distribution reducing the mortality. Also it led to an increase in the number of men and later women who were trained in medicine according to international standards of the time. Thus, hospitals and dispensaries began attracting an increasing number of patients and issues of disease prevention and public health provision were addressed.

In Independent India, particularly in the past two-three decades a high degree of income differentiation has led to a rise in lifestyle diseases for the rich and under-nutrition and other communicable diseases for the poor. There are wide inequities in accessibility of healthcare services among the various sub-groups of society on the basis of class, caste, religion, region, gender, etc. The Scheduled castes and Scheduled tribes (SCs and STs) sub-groups have less access to private health services and are consequently more dependent on the public health sector, while public health sector become totally insufficient to treat majority of the people.

Studies have revealed that after six decades of Independence, more than 35 percent of the Indian population suffers from serious diseases or illnesses which have an adverse impact on the quality of life. India constitutes nearly 16.5 percent of the world's population but has a share of 20 percent of the world's diseases.[62] About 26 percent of the total Indian population lives below the poverty line (BPL) and according to the Tendulkar Committee and the Planning Commission report [40] 37 percent of the population lives below the poverty line. Out of this more than 75 percent lives in rural areas.[40] About eighty percent of the total medical facilities are available in urban areas, where only 25 percent of the total population lives. However, 40 percent of the urban population lives in slums where health situations are worse than rural areas. Two-thirds of Indian children and more than half of women are suffering from anaemia and malnutrition. Nearly 80.5 percent of the Indian population lives on less than Rs. 20 per day, out of which more than 30 percent of the population lives on Rs. 10 per day. Whereas, India is rapidly emerging as a nation of medical tourism, 80 percent of the Indian population is not able to get even the essential drugs (WHO, 2010). Availability of infrastructure is poor as 54 percent PHCs do not have a labour room and a laboratory; 80 percent PHCs do not have communication and transport facilities. 58 percent of the PHCs have facilities for conducting deliveries which are availed by 30 percent of pregnant women (70 percent of total deliveries are still conducted at home by the traditional *Dai*); 6 percent of PHCs conduct Medical Termination of Pregnancy (MTP) and only 22 percent provide antenatal care (Facility

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Survey, Department of Family Welfare, Government of India 2003). Even, the percentage of total health infrastructure in rural areas has been declined over the years such as in 1951, 39 percent of total hospital were in rural areas which becomes 30 percent in 2003-04, similarly hospital and dispensary's beds 23 percent in 1951 becomes 21 percent, dispensaries become 50 percent from 79 percent during the same time.[15]

The issue of affordable healthcare becomes significant in view of the low paying capacity of a large proportion of the population. As the role of the private sector healthcare providers is becoming more widespread, healthcare services are getting out of reach of the poor and marginalized sections of the population. There is an added emphasis on insurance-based healthcare system in the recent years. This system further deprives a large section of the poor from accessing healthcare facilities due to their inability to pay insurance premiums on time.

A system based on consumption and over-professionalization is overburdened with a huge cost which is obviously unsuited to a developing country like India. It is therefore a tragedy for the nation that continues to persist with this model even when it is understood that it is not sustainable. Hence it is essential for the nation to take a conscious and deliberate decision to abandon this model and strive to create instead a viable and economic alternative suited to its own conditions, needs and aspirations. The new model will have to place a greater emphasis on human effort and resources (for which India has a huge potential) rather than on monetary and material inputs (for which we have severe constraints).

The history of Indian healthcare system has to take into account issues related to colonial policy on modern medicine as well as on indigenous health system in post-colonial India. Several studies have dealt with the issues of epidemics, leprosy, malaria, mental health, health infrastructure and health policies. In recent years, a number of studies have looked into various issues related to supply and accessibility of healthcare. They provide an insight into the negligence of public health resulting in adverse consequence for the individual, family and society. Some studies have given emphasis on the role of state to provide public healthcare. Several commissions and committees were set up to suggest ways and means of making the public healthcare system effective and a reliable source of accessing good healthcare services by the rural population and poor people in towns. Indian states have failed to achieve the goal of preventive and curative healthcare for all. Consequently, India fails to improve significantly on indicators like IMR, MMR, life expectancy, malnutrition and various communicable diseases.

Geographical and Socio-Economic Inequalities in Health Accessibility

The availability of health services is also judged by the range of services provided in the healthcare units in relation to the needs of the population. The primary healthcare infrastructure is poorly equipped in this regard. There is no provision for attending to health problems arising out of a degraded environment resulting from development activities such as industrialization, urbanization, intensive agriculture and industrial expansion. These problems are caused by pollution of air, water resources and degradation of land and biodiversity, which have also affected livelihood of people and their productivity. The healthcare units have no infrastructure, as health personnel and regulatory norms regarding industrial hazards are extremely lax. The enforcement of the existing norms to deal with the serious ailments is caused by these factors.

The access to health services is the key to realize health policy goals. The availability of health facilities and their functional condition do contribute to the access of people to avail the services. The lack of health facilities happen due to lesser number of health units than the prescribed norms, which enlarges the jurisdiction of the existing units and the population to be served or uneven spatial distribution the health units, which puts it at a disadvantage, across the country-viz. till today it has not reached the level prescribed by *the Bhore Committee* in 1946. The hilly, remote, tribal, rural and slums areas/ regions suffer from constraints in accessing health facilities. The functioning of the health units or services are also important factors which inhibit accessibility of health care. In cases where the available facilities are not functioning due to the inadequacies mentioned earlier; the hilly, tribal, remote, rural and slums areas are facing non-functioning (viz. inability) of health infrastructure/ units due to the unwillingness of the service providers to work there. The access to healthcare is constrained by

several other factors, one of which relates to the location of the unit. The accessibility of health units is determined by its road connectivity and transport facilities, nearness to the economic centers or social life as well as the average distance covered by the population in its jurisdiction (Ibid).

The poor condition of the public healthcare system is also evident from a recent estimate which claims that more than 16 percent of the rural population is living at more than 10 kilometers away from any medical facilities in India. The high levels of maternal mortality are especially distressing because the majority of deaths can be prevented if women have adequate health services.[67]

Pravin Visaria and Anil Gumber [9] in their study on hospitals for child birth argue that the reason for not going to hospital for births is the 'non-availability' of a hospital. This is shown as the single reason; the quality of services and the cost factor being the others. In rural areas prenatal and postnatal care is provided mainly by public sector functionaries, whereas private hospital or doctors are approached for this purpose in urban areas. The inaccessibility of prenatal services in rural areas proves hazardous not only to the mothers but also leads to millions of deaths of new born babies. The situation becomes grim when it comes to post-natal care.

Several studies have revealed that between the access and utilization of medical facilities there exist marked disparities between socio-economic groups and geographical location which make some section of the population highly vulnerable. Though one of the main recommendations of the *Bhore committee* was the creation of 'Basic Doctors' in India, but, the Indian policy-planners (viz. the Government) did not carry it forward properly. The basic weakness of the Indian health system is the absence of an accessible basic doctor. Even today 70 percent of the primary healthcare is provided by unqualified practitioners (N.J. Kurien, January 16, 2010). India's infant mortality rate is 56 per 1000 live birth as compared to 12 in Sri Lanka; similarly, life expectancy at birth is 64 years in India as against 75 years in Sri Lanka.

According to the National Family Health Survey-3 (NFHS-3), there are large regional variations in medical facilities in India. Most of the healthcare facilities are situated in the southern parts of the country. Besides, these were marked by regional variations. For example, there is a shortage of 70.2 percent doctors in rural areas, which comprises 75 percent child specialists, 70.9 percent surgeons and 60 percent female specialists (The Statistics Division, Ministry of Health and Family Welfare, GOI, 2007).

Caste, class and gender disparities in health have also persisted over the years. It has been observed that people in the same country live in two different worlds in terms of health, the burden of illness, malnutrition status and the burden of treatment. Poor people and scheduled castes and scheduled tribes are more dependent on public facilities than other groups of society. Nearly half (47 percent) of the children are born underweight in India as compared to the world average of 38 percent. It has been observed that underweight children are mostly born in the households of scheduled tribes (ST), scheduled castes (SC), illiterate mothers, women married at a young age and low socio-economic household families. Around 75 percent children (6-35 months aged) who are suffering from anemia belong to SC/ ST communities (MHFW, GOI, 2007).

Although the socioeconomic factors contribute significantly to the accessibility of healthcare facilities, there is not only disparity of healthcare services but also the governments' major programs like immunization and vaccination is affected by these factors. Rohini Pandey and Abdos Yazbeck analyze inequalities in immunization in different regional and economic groups. They find the southern states have better immunization levels and lower inequality in immunization as compared to many northern states. Wealth and regional inequalities are co-related with overall levels of immunization in a non-linear fashion.[36]

The immunization differential conformed to a priori expectations and the level was the lowest among the STs, intermediate among the SCs and highest among the non-scheduled communities. An interesting feature of the data is the indication that children of SC/ ST and the bottom and middle MPCE groups relied almost exclusively on the government agencies for immunization. In the urban areas the non-scheduled groups and the top MPCE groups evidently relied on the non-government agencies for the immunization. A difference in vaccination according to MPCE and educational level of the adult female of the household is visible in the survey. The level of immunization seems to be lower among a household having two children aged 0-4 years in comparison to a single child household. The level of immunization is higher among self-

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employed households engaged in non-agricultural occupations and those that have regular income or employment. In rural Gujarat, the SCs and STs reported a higher proportion of medically attended birth than others, while in urban Gujarat there was no difference between the SCs and others, but the STs reported a lower proportion of attendance by medical personnel (NFHS-3, MHFW, GOI, 2007).

Papia Raj and Aditya Raj revealed the major variation among castes**,** place of residence, education of household, status of women and standard of living (socio-economic differentials) in pattern of access to health care and utilization. The caste variation in the Reproductive Health Index (RHI) is the highest in West Bengal, followed by Orissa and Bihar. Caste variation in the RHI is discernible in all the three states with the upper caste women showing better reproductive health status than the lower caste women.[47]

David H. Peters, Abdo S. Yazbeck, Rashmi R. Sharma, G.N.V. Ramana, Lant H. Pritchett & Adam Wagstaff have analyzed the large disparities across India, based on region, caste, community and gender. The burden of diseases, medical cost, etc. fall mostly on the poor, women, schedule castes and schedule tribes such that 20 per cent of the population of India has more than double mortality and malnutrition rates. Further analysis shows that the shape and reform of the healthcare system are dependent on political decision and implementation of policies at the national, state, district and local levels. In India, there are no priority issues and choice of options according to the conditions at the different places and levels.[38]

The social exclusion of the Scheduled Castes (SCs) caused by caste discrimination and the Scheduled Tribes (STs) by ethnicity and Muslims by communal bias affects their access to health services. This is evident from the disparity in respect of health indicators belonging to the population of these groups when compared to the so called general population. The SCs and STs have the most adverse profile in respect of IMR, under 5 years age group mortality rate as well as the percentage of malnourished. The STs Population has even worse condition than SCs in this respect. The Muslim and other minorities have also low health status than other or the general population. This shows that the social biases operate at the level of service providers in public health facilities even when there is no discrimination in entitlements and the service is available free of cost. Even then there has been no intervention by the government in terms of programme content, resource allocation, approach to delivery, training and orientation of service providers focused on this problem.[54]

Regarding economic inequalities, the Planning Commission deputy chairman Montek Singh Ahluwalia admitted that income distribution has never reached the desired level and inequalities increased in both the rural as well as in the urban areas. Correcting the inequities in public health is a matter of social justice and an ethical imperative. He is confident that health inequities can be bridged in a generation, if all the stakeholders take it up seriously (J. Amalorpa Vanathan, October 12, 2010). Michal Marmot argues that a toxic combination of poor social policies and unfair economic arrangement are responsible for most of the avoidable health equities seen in today's world, especially in developing world like India (Ibid).

Rural versus Urban Inequalities

The disparity in the rural and urban healthcare facilities results in the mushrooming of private healthcare sector in the rural and sub-urban areas with the opening of nursing homes and maternity centers. It is not only the government policy failure that leads to the rise of private sector but growing per capita income, and doctors' vested interests also contributed to this new trend. We could see the impact being double when it comes to the mushrooming of private healthcare system in sub-urban area-first the accessibility to good healthcare (not at par with metropolitan) and second the rise in the cost of treatment as there are no effective public policies to regulate the development of new small medical centers.

The concerns of rising medial and treatment cost is raised by T. N. Krishnan in his paper on 'Access to Health and Burden of Treatment in India: An Inter-State Comparison', where he maintains that the cost and burden of treatment are closely tied to access to healthcare. The cost of treatment is the highest in those states where public health infrastructure is least developed on account of private hospitalization and out-patient treatment. The high out-patient treatment cost for the rural population in backward states clearly indicates the failure to deliver primary healthcare. Sparse health facilities are likely to increase the cost of treatment in government hospitals. The high cost of hospitalization may also act as a deterrent against treatment leading to mortality in severe cases,

apart from acting as a catalyst for infection in the community in case of communicable diseases (T.N. Krishnan, 1999).

According to the Planning Commission of India, 20 percent of the population lives in urban areas with 70 percent of the total hospital beds and 80 percent of doctors in the country. However, though all varieties of health services are available in our cities, they are not accessible to a large section of the population. There is a wide gap in the utilization of even primary health services between various sections of society. C. Sathyamala has pointed out that the existing system of health care is functioning ineffectually due to the growing disparities between the rich and the poor as well as the rural and the urban. Hence, the problem of providing medical based health care/ services cannot be solved without first solving the problems of lack of health care (C. Sathyamala, 2006).

Rama V. Baru also argues that there exist severe disparities in the utilization of health services among rural and urban areas in terms of the availability of public health services, pattern of health services and structure of private enterprises. A survey of non-government medical hospitals, dispensaries, nursing homes and maternal and child welfare clinics in private and voluntary sector shows that out of 122849 private institutions, nearly 34879 (28 percent) were in rural areas and 87970 (72 percent) were situated in urban areas (Rama Baru, in Ibid).

Women's & Child Health Issues

Women's health is also poor in India; they do not have access to adequate health care, nutrition, and medical care. The number of women who visited hospitals is less than the male patients when it comes to both public and private health care facilities among all sections of the society in the rural and urban areas. Even the proportion of expenditure on women's healthcare is far less than the expenditure on men's healthcare both in out-patient care as well as inpatient care.[67] Policies concerning women's health have been focused only as family planning and reproductive health issues instead of other health issues. i.e. other health related aspects have been neglected by the government, policy makers, public health experts as well as social activists (Imrana Qadeer 2002 and Alpna Sagar, 2001). Monika Das Gupta and Sonal Desai argue that one of the main reasons for the poor health of Indian women is the discriminatory treatment towards girls and women as compared to boys and men (Monika Das Gupta, Cited in Victoria A. Velkoff et al., 1998). Moreover, the Indian medical system has not achieved its target because 60 percent of the women are suffering from reproductive diseases, in which about 85 percent are suffering from pre-natal syndrome, 40 percent are suffering from leucorrhea, only 35-37 percent of the Indian married women (aged 13-49 years) are using modern contraceptive. Female sterilization is the main form of contraception. According to NFHS-1 (1992-3), more than 75 percent women gave birth to their child at home out of which more than 66 percent (2/3 of all) births were not attended by trained medical persons. The NFHS-3 shows that 56.18 percent of Indian women suffer from anaemia. Due to anaemia the chances of death during delivery is high (MHFW, NFHS-3, GOI, 2007).

Some gender related barriers also affect the accessibility of healthcare to women. These include unsuitable timings of facilities, insensitivity of healthcare providers, absence of privacy in the clinics, indifference to their problems by the family, attitude of self denial by women themselves and failure of the existing programmes to cover health problems experienced by women (Ritu Priya, 2001).

According to new research associated with the 'Save Children' (Latest Sample Registration Data), over 55 percent children under two years of age do not receive basic healthcare or immunization against diseases such as diphtheria, whooping cough, tetanus and measles. Studies also show that the highest numbers of children die in India among the 25 countries, although these diseases and conditions are mostly preventable and curable (*The Hindu*, 23 July 2011, Delhi).

The poor condition of postnatal care in terms of parental guidance about the availability of nutritious food, along with the medical care causes malnutrition and other health issues in children. As per a report of Save Children (HUNGaMA, NGO), India has the highest number of underweight children among all the Commonwealth countries. About 64 percent of World's underweight children live in 54 Commonwealth countries, and India has both the highest number and the highest proportion of the underweight children. Although, these 54 countries have one-third (33 percent) of total world's children, but have two-third of underweight children or malnourished children under 5 year age group (Arti Dhar, October 15, 2010, The Hindu, Delhi). Thus, 43 percent of India's

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children are severely malnourished and 59 percent are suffering from moderate to severe stunting-viz. their height is much lower than the median height-for-age of the reference population. The survey found that the prevalence of malnutrition is significantly higher among children from low income families. It is also found that children from Muslim or SC/ ST householders generally have worse nutritional indicators i.e. 50 percent of the children born are underweight because of the lack of awareness among mothers about nutrition, 92 percent mothers had never heard the word malnutrition. No doubt the educational level of mothers also determines children's nutrition/ health (Ibid).

Madhur Tankha argues that a child is dying in India every 20 seconds due to preventable diseases like pneumonia, diarrhea, and natal care, etc. due to improper and untimely care. This number is 1.73 million children every year in the age group 0-5 years, in which nearly one million die within their first month. This is not only highest in the world; but points out that India has worse situation than Nepal, Bangladesh, Nigeria, the Democratic Republican of Congo, Pakistan, China, Ethiopia, Indonesia and Afghanistan (mortality Report, UNICEF 2012). India is highest in child mortality and lowest in public expenditure on health among the other countries of the world (Madhur Tankha, November 23, 2011, The Hindu, Delhi).

Health Insurance

The Indian healthcare sector has witnessed tremendous boom over the years with the improvement in public healthcare services, escalation in private medical care and rise in drugs industry. The government has taken essential measures from drafting to the implementation of these policies. It also works on the synchronization of health policies to suit the international environment with the promotion of internationally funded programmes to overcome their health problems. International community has given emphasis on health coordination, exchange programmes, medical education programmes and other specific issues that cater to the public healthcare needs. In-spite of these drastic measures, public healthcare in India is still tottering. This raises serious concerns and perhaps the government need to view the problem from a new angle. This situation also forces the government to search for a framework that suits their interests as well as meet the requirement of the masses. Besides this, socio-economic factors also played a critical role in the worsening of the healthcare system as discussed earlier. This has created a wide gap between the quality of services accessed by the rich and the poor. The widening of the gap between good quality and manageable quality of service forces the government to introduce a healthcare insurance scheme in the country in order to provide equitable services. The insurance based healthcare system is supposed to help people in drastic emergencies and out-of-pocket expenses that have proved extremely detrimental to the general masses. With the establishment of the healthcare insurance in the country, a non-discriminatory healthcare regime is established that caters to both the poor and rich people. It also gave solace to the government so that it could draft plans to cater to specific needs of the people who can afford elementary and to an extent within the insured limit the healthcare services on the basic of annual payment. The burden on the government to meet the public requirement with the establishment of low-budget hospital and medical centers could be removed provided it promotes an equilibrium healthcare insurance in the country.

The government should frame policies that encourage healthcare insurance companies to spread their wings in sub-urban areas that would not only help people but also encourage the medical players to set their infrastructure in the neglected areas. Besides, the players should also work on the plans that meet the requirement of low income people who need good healthcare system.

However, there are some basic problems with medical insurance such as it provides a partial response, out-of-pocket expenditure still remains about more than 80 percent and its coverage is for only in-patients care. While out-patients care, maternal care, all pre-existing diseases, HIV/ AIDS, drugs and basic diagnostic tests are out of its coverage.[51] The Kolkata group of High Levels Expert Committee Group (HLEG), headed by Amartya Sen has argued about health insurance that such schemes whether funded by central and state government at best provide limited health care and at worst divert a large ratio of health budget to expensive hospitalized tertiary and secondary care to the great neglect of primary care, which cater around 95 percent of the total population (Ibid).

The Indian government has proposed a Universal Health Insurance Scheme (UHIS) focusing exclusively on persons and families below the poverty line. The government proposed subsidized premium under this scheme, but facts are showing different reality; that scheme covered 1.16 million people in which 11,408 persons belongs to BPL (about 1 percent of the total covered persons), while at the same time (2004), the total BPL population was 26 percent (1999-2000), in which absolute poverty was 260.3 million Economic Survey, 2004).

The major problem confronted by the government is the lack of universal health care schemes in the country that provide suitable and manageable insurance to people at large. The concern of the government becomes more crucial considering the fact that there is still a large section of the Indian population living below the poverty line and do not have a sustainable source of income as it depends on unorganized system/ sector. Lack of universal insurance based healthcare creates a demand and supply gap. Charu Garg analyses the risks associated with health insurance in terms of the demand and supply limitations such as supplier induced demand, risk selection and exclusion. She holds that social health insurance is generally more equitable and comes with lower risk of adverse selection and supplier induced demands. However, she adds that it may not be feasible to cover more than 20 percent of the population under social insurance because of the difficulty in collecting premiums from the unorganized sector and the high administrative costs associated with it. She further examines the possibility of expanding private and social health insurance coverage by raising resources and collecting premiums from different sections of the population in terms of their occupation, income and location.[42]

On the basis of a qualitative study conducted with village based women's groups in Andhra Pradesh, Rama Buru also argues about health insurance or financing. As felt by her, a comprehensive national health insurance scheme could be one way to reduce inequities of access prevalent in the country. She also points out in her study that community health financing is a challenging alternative, but it needs to link demand that it creates with the issue of supplement services (Rama Baru, Cited in Ibid).

Some other studies also argue about the inadequacy of healthcare facilities and health infrastructure like health personnel (i.e. doctors, nurses and other technicians), wards, beds, and medicine, even drinking water, sanitation and hygienic environment. The expanding health insurance services without considering whether medical services are available or not is a sure way to making it dysfunctional from the beginning. Moreover, who will regulate these providers is a significant matter that has to be dealt with. The Government is trying to divert attention from the insufficient health care delivery system by using a health insurance 'Mantra' (Rajiv Ahuja, 2004).

K. Srinath Reddy argues that a large ratio of the existing lower fund allocation for health has been plunged into tertiary care instead of primary care and the state-led insurance schemes are focusing only on tertiary care. For example in Andhra Pradesh about 55 percent the total health budget goes to tertiary care, while this ratio in Delhi and Tamil Nadu crosses 50 percent. He argues that if we do not articulate at this point what is the rational need for a universal health care system, then many states will allow, suit and start developing these insurance programs which will be difficult to withdraw later. Further, on this issue the High Levels Expert Committee Group (HLEG) very clearly argues that the all health services including under Universal Health Coverage (UHC) must be tax funded and cashless at delivery level, and that the user fee has to be abolished.[51] The contributory social health insurance is not appropriate for the countries like India where a large segment of the work forces, close to 93 percent is working in the unorganized sector and a vast number are below or near the poverty line (Ibid).

So, health insurance per se is just a financing mechanism towards private sector and does not in any way ensure that health services are delivered efficiently and effectively.

In fact, given the complexities of the insurance market, unregulated private medical sector and voluntary insurance are a sure way of leading the health system to cost ineffective, inaccessible and highly inefficient health insurance market that is fundamentally complex in nature. In health sector we have neither invested to build capacity to manage their mechanism, nor have we developed adequate regulatory and administrative infrastructure to ensure that such systems work effectively and efficiently (Ramesh Bhatand Somen Saha, August 14, 2004, EPW). Even with the development of the private insurance market it will cover only less than half of the population of the

country. The others, more than half-which consists of the low income population (30-37 percent) of BPL and additional 20-23 percent living dangerously close to this line-is likely to remain outside the ambit of private health insurance unless there is an explicit social obligation in this respect which could come only from the insurance regulators. For the people with low income, who are the main needy people/ section of our society, neither the government is providing nor is the market arranging any appropriate medical care. The other conditions laid down include that hospitals should have a minimum of 15 beds with fully functioning operation theatres, fully qualified nursing staff and doctor round the clock. We do not think that these conditions are being met by the majority of the health facility systems, especially in rural India. As discussed earlier, more than 80 percent health services are in the rural areas and even urban slums are providing services without proper equipment by unqualified health practitioners. Hence, in the case of access to health insurance, there is a wide gap in Indian society, since there is nothing for a large section of the lower middle class. In fact, the gap between the rich and poor/ BPL is rather striking. Private insurance can be afforded by the upper crust/ rich people, while the government is providing health insurance for BPL section.

Summing Up

The accessibility of affordable and equal healthcare has always been a critical and significant issue in view of the low paying capacity of a large proportion of the population in India. As the role of the private sector healthcare providers is becoming more widespread (particularly in the past two-three decades), healthcare services are getting out of reach of the poor and marginalized sections of the population. There is an added emphasis on insurance-based healthcare system in the recent years. This system further deprives a large section of the poor from accessing healthcare facilities due to their inability to pay insurance premiums on time.After economic reform in India, a high degree of income differentiation has led to a rise in lifestyle diseases for the rich and under-nutrition and other communicable diseases for the poor. There are wide inequities in accessibility of healthcare services among the various sub-groups of society on the basis of class, caste, religion, region, gender, etc. The Scheduled castes and Scheduled tribes (SCs and STs) sub-groups have less access to private health services and are consequently more dependent on the public health sector, while public health sector become totally insufficient to treat majority of the people. According to studies More than 35 percent of the Indian population suffers from serious diseases or illnesses which have an adverse impact on the quality of life. India constitutes nearly 16.5 percent of the world's population but has a share of 20 percent of the world's diseases.[62] Even, the percentage of total health infrastructure in rural areas has been declined over the years such as in 1951, 39 percent of total hospital were in rural areas which becomes 30 percent in 2003-04, similarly hospital and dispensary's beds 23 percent in 1951 becomes 21 percent, dispensaries become 50 percent from 79 percent during the same time.[15]

The policy analysis is an established research and academic discipline in the industrialized and developed countries. But in developing countries like India, its application is still limited, particularly in the healthcare sector. On the behalf public health policies many studies are arguing that health of the common people has never been a priority in Indian society as in many other places in the world. This can be highlighted through the fact that it is largely invisible in the domestic debates till now. Every Indian dreams to avail the best medical facilities irrespective of constraints that emerge from society, economy and polity. National and international forces also play critical roles in the accessibility of quality medical healthcare. For instance, class, caste, regional, religious, socio-economic, external economic and ideological variations determine the parameters for health services. Healthcare is a subject that gives equal power to the centre and states to legislate and frame policies as per the requirements of the region. The government has also opened the sector for private institutions to provide their services and compete with the public funded programs and hospitals. In spite of these measures, a large section of the Indian population is deprived of good medical facilities and primarily depends on the public funded programs.

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