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Health for all, in small doses?

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The Planning Commission and finance ministry must take a health system approach and not follow a path of fragmented programme-by-programme allocation

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Will the Budget 2013 deliver health for all as it promises? The overall allocation for health has increased from R29,272 crore (revised estimate for 2012-13) to a Budget estimate of R37,330 crore for 2013-14. This increase of 21% is welcome, though it falls below by the expectations raised by statements of high level government functionaries over the past two years that health would be the major priority of the 12th Five Year Plan (2012-17), with public financing rising to 2.5% of GDP. Even the plan document, adopted by the National Development Council in December 2012, commits to an increase in public financing for health to 1.87% from the present 1.04% of GDP. So, it is disappointing to see the allocation fall below expectations, in the second year of Plan period.

The National Rural Health Mission (NRHM) is now to be expanded with addition of the National Urban Health Mission (NUHM). The National Health Mission (NHM), which unifies the two, receives 64% of the total budget of the health ministry, rising from the 57% received by NRHM alone till last year. While NUHM is an overdue response to the long neglected needs of urban primary health care, the allocation is to meager to launch the urban health mission in real earnest. To be effective, the urban component will have to suck out resources from the NRHM, a course that must be avoided under any circumstances. If the central government is to convey a message to the states that it is earnest in launching a major programme for urban health which requires their active engagement, the financial commitment to that mission surely should be higher.

The reason for prioritising the NHM is compelling. It is only through this mission that the primary health services can be strengthened and the 12th Plan goals of reducing the infant mortality rate to 25 and maternal mortality rate to 100 by 2017 can be accomplished. Even non- communicable diseases like high blood pressure and diabetes are best detected, and provided chronic continuing care, through primary health services. The NHM will also help to overcome the present fragmentation of health services by linking primary to secondary and tertiary care in a cost-effective and sustainable manner.

The contention that the health ministry was unable to fully utilise previously allocated funds, including those demarcated for NRHM, ignores the fact that a weak health system is incapable of absorbing and effectively utilising funds. The weakness lies not only in the infrastructure but also in the size and skills of the health work force, available public health expertise, management processes, regulatory systems and governance. Many of these require investment of new resources. Only then will the health system rise to higher levels of performance. The Planning Commission and finance ministry must take a health system approach and not follow a path of fragmented programme by programme allocation.

Increased allocation for medical education and development of new AIIMS like institutions will help to strengthen health services over time. It would have been reassuring to see the commitment to primary health care clearly reflected in allocation for training and deployment of more nurses, allied health professionals and community health workers. Health research will now receive R1,008 crore (up by 32%). A large fraction of this should be devoted to problem solving health systems research that will enable national programmes to overcome implementation barriers, to enhance their outreach and effectiveness while reducing health inequities.

The expansion of RSBY to cover rickshaw pullers, sanitation workers, auto and taxi drivers is

laudable to the extent of benefiting some more vulnerable groups. However, the unanswered question is whether governmental policy is to continue RSBY as a programme independent of the UHC frame work proposed in the 12th Plan. Indeed, the Plan document calls for a critical review of the existing government funded health insurance schemes, to assess their impacts, sustainability and weakness. Such schemes focus on hospitalised secondary or tertiary care to the exclusion of primary health services and outpatient care. The resulting fragmentation of care imposes a high cost because neglect of primary care progressively raises the demand for expensive (and to a great extent avoidable) secondary and tertiary care. That in turn consumes a higher and higher share of the health budget, diverting resources further from primary care and over time, becoming financially non-sustainable. The National Advisory Council is presently studying mechanism by which RSBY and other government funded insurance schemes can be integrated into the unifying frame work of UHC.

The increased allocation for AYUSH signals policy intent to strengthen and effectively utilise traditional systems of health care. This is responsive to both the need to effectively utilise all available health professionals to meet the huge unmet demand for primary health services and the rising global interest in non-allopathic systems of health promotion and care. The challenge to the health ministry is to effectively integrated AYUSH into NHM, overcoming the current disconnect between departments that oversee different services.

Finally, a continuing quibble on tobacco taxes. While the 18% increase in the excise tax on cigarettes is a good move, why are beedis still out of the tax net? When will our policy makers recognise that sparing beedis does not in any way protect the interests of poor beedi workers who will be better served by alternate occupations that can be funded through the increased tax revenue? Reducing tobacco consumption, in all forms, will reduce the high cost of health care for cancer and cardiovascular disease and reduce much of the mid-life mortality that decreases national productivity and harms the economy.

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