

# वेदश्लोक

Issue 1, 2019

Evangelical Perspectives on Mission and Ethics



**ACCESSING  
HEALTHCARE  
IN INDIA**

**"Behold, I will bring to it health and healing, and I will heal them and reveal to them abundance of prosperity and security."**

*Jeremiah 33:6 English Standard Version (ESV)*

**Drishtikone** means perspective or viewpoint in Hindi. The magazine seeks to provide a space in which Christians can share their perspectives and points of view on wholistic mission in India.

Our Vision is that **Drishtikone** will motivate change in readers. The experiences of development practitioners, theologians, grassroot workers and others demonstrating God's love in a practical way, will influence and encourage Christians to join the struggle for peace and justice in this country.

**Drishtikone** seeks to present a Biblical perspective on social issues and provide readers with information and models of engagement in wholistic concerns. It is a forum for evangelical reflection and dialogue on development issues in India.

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*Letters to the Editor...*



*Dear Editor,*

*Greetings in the name of our Lord Jesus Christ! Thank for sending your magazine Drishtikone regularly. It has been an inspiration reading the magazine and we like the articles in the Drug Abuse - Issue 3, 2018. It has really brought an insight to the issue on drug addiction and abuse in India. We pray that the magazine will continue to influence many in the country.*

*Yours in His Vineyard,  
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## *Editorial...*

The WHO defines health, not merely as the absence of disease or infirmity, but as the state of complete physical, mental and social well-being. Access to healthcare is recognised as a basic human right, but due to poverty and inaccessible locations, quality healthcare is denied to many. Obtaining universal health coverage is a critical goal of health systems in all countries (WHO, 2013).

Health insecurity has increased in India since liberalisation, seen in the wake of escalating healthcare costs. The state of our public health services has compelled many to rely on private healthcare. Therefore, over the years, the private healthcare sector has gained a dominant presence - in medical education and training, medical technology and diagnostics, the manufacture and sale of pharmaceuticals, and the provision of medical services. Some offer good medical care but due to high costs, it is only accessed by a few. In order to deal with this issue, the Government has introduced various measures, including health insurance schemes, that target families below the poverty line. It has been argued that these schemes further enable liberalisation of the health sector, as they push patients towards private health providers without significantly reducing the financial pressure on the poor.

Meeting the health needs of the large base of poor households in India is a herculean task and it requires a comprehensive and sustained approach. What is required is a commitment from the government, the public and civil society to create health policies that make health services easily available and affordable to the poor. The Church in India also must realise the contribution it can play towards providing accessible and affordable healthcare services for all. This issue of Drishtikone, therefore, seeks to sensitise the readers towards these pressing need.

# Understanding Access to Healthcare

**Dr. Santhosh Mathew**

Access to health and healthcare is a complex subject for a nation like India, where 17.5% of the world lives, and where diversity is the defining culture. The diversity in terms of language, people groups, social stratification, geography and economy exists with such complexity that to consider India as a single nation in terms of healthcare access and to try to resolve these complex problems with outmoded simplistic thinking is pure folly.

The purpose of this article is to give a perspective into a selected few of those diversities and complexities that we need to consider if goals stated in the National Health Policy 2017 are to be achieved. The Policy states that its goal is “the attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive healthcare orientation in all developmental policies and universal access to good quality healthcare services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery”.<sup>1</sup>

But before looking at the complexities, one needs to consider the question of responsibility and rights. In our nation, who is responsible for the healthcare of its citizens? The framers of the Constitution incorporated the right to health in the Directive Principles of State policy (DPSP) which ‘enjoins the state to provide comprehensive, creative, preventive, promotional and rehabilitative health services and proper nutrition to all the people of India,’ as a constitutional obligation, but not as a right of the individual. (Adapted from the Constitution of India)

Despite years of deliberations, unlike the “Right to Education Act”, we as a nation have not been able come up with a Right to Health Act. So, instead of taking the responsibility of providing healthcare, the state has seen itself as a facilitator of health access through progressively achieving Universal Health Coverage. The state expects this to be done through:

A. Assuring availability of free, comprehensive primary

healthcare services, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable, non-communicable and occupational diseases in the population.

B. Ensuring improved access and affordability, of quality secondary and tertiary care services through a combination of public hospitals and well measured strategic purchasing of services in healthcare deficit areas, from private care providers, especially the not-for-profit providers.

C. Achieving a significant reduction in out of pocket expenditure due to healthcare costs and achieving reduction in the proportion of households experiencing catastrophic health expenditures and consequent impoverishment.<sup>2</sup>

Though the stated policy is a definitive step in the right direction, there is no Act which makes it mandatory for the state to be responsible. As a result, the right of the individual to access healthcare remains nebulous.

It is with this background one needs to consider the complexities of our nation, if universal health coverage is our dream and goal.

*The atmosphere in the intensive care unit was charged as doctors and nurses desperately tried to save the life of this young pregnant lady with severe cardiac failure. As she continued to slip in and out of life, something disturbing was observed among the relatives who brought her. They were more concerned with the survival of the preterm baby than about the mother's risk of dying, which they had been warned about in case she ever got pregnant. At one point, the hospital team had to make a tough choice – they had to decide and focus all efforts on saving only one of the two lives involved. When the family was approached with this question, their seemingly cold-hearted choice was clear. The unborn preterm baby boy (presumably identified through prenatal sex determination elsewhere), was way more valuable and worthy than the mother who risked life itself to bring him into the world.*

<sup>1</sup> National Health Policy 2017; Page 1

<sup>2</sup> National Health Policy; Page 3, 2017

This is not a one-off story, gender inequality in health access is well evidenced by the sex ratio, in particular, the under-five and infant mortality ratio differences in our nation. Over the past many years much has been done to address the same.

The High-Level Expert Group Report on Universal Health Coverage for India has done well to identify the four key barriers to health access for women, these being political and legal, economic, social and health system barriers.<sup>3</sup>

Public health programmes like Ayushman Bharat and others may address these barriers, but the social issue of gender inequality needs approaches that go beyond the traditional methods of health and healthcare access programmes.



Photo: www.pixabay.com

Yojana) card by presenting the BPL card. But most of those who got the RSBY card were informed that it is a cash card and if you go to a hospital, you will get money." This was narrated to the author.

Lancet editorial looks at the issue highlighted in the above story. One of the most disturbing of all India's predicaments, a disabling myth, is the caste system, which disfigures and disables a nation. Ingrained inequality has led to tacit acceptance of the caste system, which has created, among other challenges, a preventable epidemic of mortality among women and

children. Indeed, many of India's health indicators fare poorly in comparison with its neighbouring countries and economic peers. To improve the nation's health, we need to address the caste system. We must work towards

creating equality, opportunity, and investment in health and education.<sup>4</sup>

In a study on administrative remoteness in India, it was found that remoteness has a negative effect on the provision of public goods and economic outcomes in rural India.

Villages located at greater distances from their district

capital have a lower probability of receiving a paved road or a secondary school compared to neighbouring villages that are located substantially closer to their district capital. Villages that are more administratively remote also have significantly lower average income, a smaller share of households with a solid roof, lower literacy rates and a lower percentage of the workforce engaged in non-farm activities.<sup>5</sup> In addition to low income and illiteracy, these

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4 In a speech in June 2018, our esteemed head of the state said his aim was to bring about a “complete transformation” of the health sector through research, innovation, and technology. While these intentions are positive and hopeful, the transformation of key socio-cultural factors affecting health and its access must go hand in hand with transformation of the healthcare systems.

Talking to a village leader from the lower social strata in 2014, he shared this story. “In our village there are 300 BPL (Below Poverty Line) families. 100 BPL cards have come and are in the hands of the Pradhan who is from the higher social strata. He has kept 40 for himself and his relatives. Rest 60 has been given to us. Out of this 60, 50% have been able to get the RSBY (Rashtriya Swasthya Bima

<sup>3</sup> uhc-india.org/reports/hleg report, chapter 9

<sup>4</sup> The health of India: a future that must be devoid of caste www.thelancet.com; Vol. 384 November 29, 2014.

<sup>5</sup> The Cost of Distance: Geography and Governance in Rural India, Sam Asher, Karan Nagpal, Paul Novosad, February 21, 2017.

locations have other challenges that contribute to poor healthcare access. District hospitals that are expected to provide essential secondary care services in many of North India's larger states are between 50 to 100 kms away from the border locations of these states. Many of the rural Primary and Community health centres are sub-optimally manned since healthcare professionals tend to concentrate in larger towns. Even among those posted in these centres, absenteeism is high. The challenge of the urban poor in slums and resettlement

colonies, despite being so close but "far" from accessible healthcare systems is yet another complexity that needs to be addressed. Conflict

areas such as parts of the country prone to insurgency, international borders and pockets with international refugees etc. pose unique challenges to health access and information about these challenges remains mostly in the dark due to the volatility in these regions.

While considering access to healthcare in economic terms, the issue of catastrophic healthcare expenditure and communities being pushed into poverty after a single healthcare event is well documented and studied. The cycle of high interest loans from local money lenders for such events, the inability to pay back and subsequent indebtedness to money lenders, the neo-slavery due to indebtedness to such money lenders and landlords are common events in rural North Indian states. Farmers' suicides after a catastrophic healthcare expense are well documented stories from our nation.

We will also highlight key factors which critically impact existing strategies in order to overcome these issues. The Global Diseases Burden Study results published in Lancet of November 2017 raise a few pertinent issues.

The state vs centre, the Empowered Action Group (EAG) states lack state level planning - The Government of India focuses more of the development work on the EAG states in north India and the states of the northeast region of India, which have poor health indicators than the rest of India. Diversity in the magnitude and causes of disease burden, as well as the risk factors, is generally anticipated between and within the broad state groupings, but no systematic and comprehensive analysis of the state-level variations for these is available to inform specific state-level planning.

Although the central government policies have significant influence on health initiatives across the country, health is a state subject in the Indian federal structure. Of total government spending on health at the state level, an average two-thirds is from the state budget and one-third from the central budget. A robust disaggregated understanding of the disease burden and risk factors trends in each state of India is essential for effective health-system and policy action to improve population health.

## **“A robust disaggregated understanding of the disease burden and risk factors trends in each state of India is essential for effective health-system and policy action to improve population health.”**

A new strategy that can be leveraged to improve access to health is the NITI Aayog's progressive action agenda for improving health in the country from 2017 to

2020, which includes data-driven and decentralised health planning focused on the specific needs of each state. Another critical but less discussed factor that complicates access is the ethics of healthcare. Corruption in healthcare contributes much to access issues for the poor. A recent study done in the hospital where I am associated highlights one such issue.

*“With the objective of understanding the prevalence of women who had undergone hysterectomy, 100 married women between ages of 18 to 50 were studied, of these, 58% were from rural areas and 85% were less than 40 years of age. Three out of every five women had undergone hysterectomy prior to their visit of which an alarming 72% had only minor symptoms not warranting the performance of such a procedure.*

Similar stories have emerged after the RSBY rollout (2012-14) from various states, where healthcare practitioners and institutions were misusing the insurance systems for economic gains, throwing to wind basic standards of ethical healthcare practice. Corporate hospitals and private nursing homes are coming up in every city and town, some with poor quality and regulatory standards. Undoing the web of corruption is a critical factor that can be leveraged to significantly brighten the future of ethical healthcare practice, which in turn will hugely impact access to healthcare. Finally, it is well known that access to health goes beyond availing hospital services. A critical review of the last few years would reveal that access to preventive and protective aspects of health such as right to food, education, employment, housing, clean water and

sanitation are less than optimum. Comprehensive and participatory approaches to address these important determinants will critically impact healthcare access.

There are many such issues that add on to the complexity of health and healthcare access in our nation and one could continue to dissect and discuss these. But the question we need to reflect is, where does all this leave us as a nation if we are to fulfill the dream of “Universal Healthcare and access” by 2025? Are we to despair or hold on to a hope for a healthy India of tomorrow?

**“To hold on to hope of a healthy nation of tomorrow, at the same time to work it out, much needs to be done at both the macro and micro levels. What is equally important is the need for more of women like V who will break barriers, compassionately reach out, journey alongside the many Ss who need accompaniment, at the same time, work alongside the challenged systems of healthcare.”**

I'd like to end with a real life story...

“She was cursed” said U about her daughter in law S. Her voice trembled as she recounted the horror and pain that S went through every time she lost a baby within days of it coming into this world. With all six of her babies dead, the family had given up all hope and S herself was convinced that this was her fate, the price she had to pay for her past sins. So, when she realised that she was pregnant the seventh time, she had no expectations. She did not visit any hospital. She did not meet any doctor. She was convinced that nothing would change this time either. Her family had spent all their money and they were not keen on caring for her anymore.

*But something did change one sunny afternoon in April when S was nearing her seventh month. A health worker called V had come to visit S's village. V noticed a lonely figure sitting in the shadows at the doorstep of the neighbouring house. Being considered “cursed”, S was shunned by her neighbours. After hearing her story, V realised that all the babies had died of neonatal jaundice which was easily treatable if identified early. Her words brought new hope to S and her husband. After a week or so, V was overjoyed to see S and her husband at the nearby*

*clinic. Once they experienced the care and support offered at this subsidised clinic, they came regularly. When the day arrived, and S started having her pains, she was not scared anymore. She knew how to contact the ambulance which*

*took her to the government hospital where she had a safe normal delivery free of cost. But all was not over yet. She carefully watched her baby every day and the moment she noticed his skin and eyes turning yellow, she admitted him to the hospital for treatment. After a week of phototherapy, baby K was healthy and was sent home.*

*Today, as S proudly holds her three-month-old, our minds resonate with*

*Emily Dickinson's words, “Hope is the thing with feather that perches in the soul and sings the tune without the words and never stops at all.”*

In order to hold on to hope of a healthy nation of tomorrow, at the same time to work it out, much needs to be done at both the macro and micro levels. What is equally important is the need for more of women like V (in the story above) who will break barriers, compassionately reach out, journey alongside the many Ss who need accompaniment, and, at the same time, work alongside the challenged systems of healthcare.

*(This article has been written by Dr. Santhosh Mathew, who works with the Emmanuel Hospital Association, with inputs from Dr. Sharon Stephen and Mrs. Sharmila Mohapatra. Dr. Santhosh Mathew can be reached at santoshmathewpersonal@gmail.com)*



# Bridging the Gap in Health Access - Our Responsibility

**Dr. Shantidhani Minz**

Dr. Santhosh Mathew has introduced us to the vastness of the issue of access to health and healthcare and the complexity that is unique to India. While most of us only think of healthcare when discussing access, health on the other hand opens up literally a Pandora's box. In my response, I would like to focus on our role in reducing the gap as God's people.

## *Fullness of Life*

John 10:10 gives Biblical equivalent of the definition of Health given by World Health Organization (WHO). The words used are "abundant life" or life in its "fullness". The other important point to remember in this verse is that this life Jesus promised is for "all". How do we as Christians translate this verse with respect to "health"? If we believe health contributes to the promised "fullness of life", then it is our responsibility that all of us strive towards making health a reality for "ALL" people created by God.

## *Who are in need of help? Who are at the fringes?*

Dr. Santhosh has brought out the problems of some of the groups as an example. I will explore two groups. We are all aware that in India most women have lesser access to everything that leads to a healthy and fulfilling life. The disadvantage starts early with baby girls getting less attention, food and healthcare than even their twin brothers. This baby girl has to survive all odds to reach adulthood, including the stage of getting healthcare when pregnant.

We are constantly faced with bias towards girls. Within our homes, communities, churches, school, college, workplace, even in the bus! Girls and women face harassment just because they are female! What does it speak of the health of our average male and female mind? Of the men who are

the perpetrators and women who refuse to take a stand and speak up when someone else is being harassed? We are followers of a master who gave women opportunity to learn,

speaking and leading, at a time when a Jewish male thanked God for not being born a female! We have a role model.

How do we make our society healthy? What do we do to make every girl and woman feel safe, respected and valued? We will bridge the gap that exists for women today, if we

accept God's creation, His image as He intended, equal in every aspect.

We can do this as individuals and as parents, teaching our children the intention in God's creation. The church can set the example for society by acting out the intention of God for men and women and not promoting the result of sin which differentiated them and created unequal relationship. The question is a big one, "Are we doing this?"

We have grown weary of the castes in our country. The popular belief until a year ago was that if we don't talk, it will go away. Hence, it was politically incorrect to ask someone their caste. But did we stop seeing Matrimonial advertisements specifying caste or subcaste even among Christians? Fortunately, the country has decided to add caste to the census. Acknowledging something is the first step towards addressing the problem. Dalits and Tribals have been on the fringes for as far back as Indian history goes. Disaggregated data analysis was done for the first time using NFHS III data which showed the level of disadvantage tribes faced in India. However, in some aspects of health, tribes fare better than the Dalits because some diseases are more common among them.

**“We can do this as individuals, as parents, teaching our children the intention in God's creation. The church can set the example for the society by acting the intention of God for men and women and not promoting the result of sin which differentiated between them and created unequal relationship.”**

Who will speak for them? Martin Luther King Jr. said, "In the end, we will remember not the words of our enemies, but the silence of our friends." One of the litanies for the Mind of Christ reads, "By thy words to the Pharisees: Give us the courage to rebuke the wrong in high places." When the oppressed raise their voices, it is easily misunderstood. The others must speak up. Are we doing enough as individual Christians, Churches, Christian organisations?

Mentally challenged, mentally ill and persons with disabilities face many challenges in accessing even basic healthcare. Mentally ill persons sometimes are not even counted by the community because these are people "without the right mind". Families make decisions on their behalf. Persons with disability, if dependent on others physically or financially, are also powerless. In impoverished families, such individuals face more marginalisation since survival of the "able" is challenging enough.

Matthew 25:40 - "The King will reply, "Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me."

The least in the society need us, in whatever capacity we can help bridge the access gap. We can give time, help with transportation, care giving, financial support and provide support in other ways. Community psychiatry programmes are very difficult to implement because a large number of community care givers are needed to support the affected person and the family. Church groups can be this circle of caregivers in the community.

**Who is my neighbour?**

So the question for all of us is, "Who is my neighbour?" The good Samaritan story is known to anyone who has heard the Bible. But the moral of the story is generally missed because



Photo: EFICOR

the behaviour of the Pharisee and the Levite is highlighted. Jesus asks (Luke 10: 36), "Which one of these three do you think was neighbour to the man who fell into the hands of the robbers?" We often get lost in trying to understand who my neighbour is and who should I love as myself! But Jesus is challenging us in a different direction. He is asking us to be the neighbour, "Go and do likewise". He is challenging us to be the neighbour to every person we meet who has a need, who has no voice, no power.

**Power and Empowerment**

We always talk of empowerment. But what leads to empowerment? Sir Francis Bacon (1597) is accepted as the first person who said, "Knowledge is Power". Ignorance and illiteracy are identified with powerlessness, so the reverse must be true. We know that literacy on its own does not lead to empowerment, but true knowledge does

lead to empowerment. Knowledge informs, educates, provides choices and opportunities. What can we as individuals, groups of likeminded persons, communities, and churches do to change the power divide that is being perpetuated due to lack of adequate and appropriate knowledge?

Jesus taught, preached the good news and healed (Matthew 4:23). While we preach the good news about the

"fullness of Life", we can teach people to attain better health, not only how to be healthy or how to get healthcare, but also to know how to exercise the rights each of us have as citizens of India and God's wonderful creation.

**“We can give time, help with transportation, care giving, financial support and other ways. Community psychiatry programmes are very difficult to implement because a large number of community care givers are needed to support the affected person and the family. Church groups can be this circle of caregivers in the community.”**

*(Dr. Shantidani Minz is a community health worker, currently heading RUHSA department of Christian Medical College, Vellore. She can be reached at minzshanti@gmail.com)*

# Ayushman Bharat Yojana: Is it a Way Towards Universal Healthcare?

**Dr. Shailendra Awale**

The Pradhan Mantri Jan Arogya Yojana (PM-JAY) was launched to reduce the financial burden on the poor and vulnerable groups and to ensure their access to quality health services. PM-JAY seeks to accelerate India's progress towards achievement of Universal Health Coverage (UHC) and Sustainable Development Goal - 3 (SDG3). As per the Prime Minister's directions, this scheme will be completely paperless, cashless and portable. The golden card being given as part of PMJAY will provide a health insurance of 5 lakh to poor and needy families. The scheme is not a rights-based entitlement, but beneficiaries can register themselves under this scheme to get a Golden Card for a cashless facility. For this card, they need to spare Rs. 30 to avail medical benefit up to Rs. 5 lakh at some of the best private hospitals that would be listed under this scheme. Incidentally, the government-run public hospitals are also part of the scheme receiving reimbursement from the insurance company. The scheme will cover the beneficiary families identified on the basis of Socio-Economic Caste Survey (SECC) 2011 conducted in 444 districts of 30 states/Union Territories. However, few state governments like Odisha have opted for their own scheme called Biju Swasthya Kalyan Yojana (BKSJ) and claim a better scheme than the PM-JAY.

Notably, Uttar Pradesh government is also launching UP PM-JAY Health Insurance Scheme today but as complimentary to PM-JAY. This scheme will benefit around 1.18 crore poor families in the state. The family whose name appears in SECC-2011 data will get Rs. 5 lakh Insurance cover under the Pradhan Mantri Jan Arogya Yojana (PMJAY). The state government will also provide Golden Cards to the beneficiaries. Under this National Health Protection Scheme (NHPS), people will get secondary and tertiary hospitalisation at government and private empanelled hospitals. So fulfilling a promise of providing access to healthcare is a lofty goal and the government's intention and efforts need to be appreciated.

As noted by Dr. Santhosh, access to health and healthcare is a very complex subject in a country like India with diverse socio-political reality marked by social exclusion

based on caste, class and gender. And the devil lies in the detail. The scheme is criticised for a minimum allocation of the resources, Rs. 2000 crores. There is also a need for tremendous IT support for smooth and cashless hospitalisation. The scheme is a modified version of the RSBY and benefits from the infrastructure developed during the years of National Rural Health Mission.

## Our present public health infrastructure

Presently, there are 779 district hospitals, 1108 sub-district hospitals, 25650 PHC, 5624 CHC, 156231 sub-centers. The 'human resource for health' requirement for existing SCs is estimated to be around 12.6 lakh by 2022. Out of them, 1.5 lakh are identified to develop as a Health and Wellness Centres. At present, over half of them do not have an even composition of male/female health workers. The staff shortage (including specialists, doctors, radiographers, and technicians) is even more acute at primary and community health centres, which are supposed to cater to such needs.

A preliminary analysis shows identifying poor families; eligibility verification and issues over cashless delivery are significant roadblocks for smooth implementation of the scheme.

In 2018, we are also celebrating 40 years of Alma Ata declaration of primary healthcare. It must be noted that a significant push for PHC was from various Christian agencies and initiatives, promoting a true Christian mandate bringing healing and wholeness by recognising health as an issue of social justice. Necessary comprehensive efforts were compromised by selective healthcare, restricting the services to GOBI 5 (Growth Monitoring, Oral Rehydration, Breast Feeding and Immunisation). An emphasis on the medical services was preferred over a mission of social and economic justice and a goal of Health for All by 2000 remains elusive till today.

*(Dr. Shailendra Awale, is a medical doctor, a policy analyst and enthusiast about medical missions. He can be reached at shailendra.awale@gmail.com)*

# The Journey of Health Insurance in India

**Ms. Anuvinda Varkey**

## Introduction

After independence, the Government of India (GOI) adopted the system of providing free healthcare to its citizens with a network of public healthcare facilities from the block level through to the district, state and national level. This public healthcare system has proved to be grossly inadequate for India's population of 1.6 billion people. In 2017, the government unveiled the National Health Policy, 2017 (NHP) wherein it announced that healthcare, especially primary healthcare, would be the responsibility of the government. With regard to secondary and tertiary healthcare in the NHP, the government has stated that it would provide this healthcare by purchasing it from public, private, not for profit and for profit health providers. It is pertinent to note that the study, "Tracking Universal Health Coverage: 2017"

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Global Monitoring report of the World Bank (WB) and World Health Organisation (WHO), states that over 5 crore Indians are impoverished due to out of pocket expenditure (OPP). The GOI has committed to the Universal Health Coverage (UHC). It has attempted over the years to come out with policy, regulatory and financing measures to attempt to achieve this commitment of UHC.

## History of Health Insurance in India

In this article, an attempt is being made to present the journey of health insurance in India through various health insurance schemes, which are initiatives of the government, and policy issues, which have contributed to the growth of health insurance in India.

### Employees State Insurance Scheme

In 1948, the GOI promulgated the Employees State Insurance Act, 1948 (ESI Act). This act provided industrial workers an insurance scheme which covered contingencies for employees who incur loss of wages resulting from sickness, maternity, temporary or physical disablement or death, due to employment injury. The Employees State Insurance Corporation (ESIC) was set up under ESI Act to manage the scheme. The ESI Act began by being a scheme for industrial workers and then went on to cover establishments that had 10 or more workers. This scheme is applicable to all employees

who earn less than INR 21000 per month. It is a contributory scheme where the employee pays 1.75% of their salary with the employers contributing 4.75% of the employee's salary towards the scheme. Benefits for employees under ESI Act are unemployment cash benefit due to partial or complete disablement, maternity benefits and compensation to a designated beneficiary in the event of death.

### Central Government Health Insurance Scheme (CGHS)

CGHS was established in 1954. This scheme applies to central government employees, some autonomous government and semi-government employees, Members of Parliament, governors of states, accredited journalists and some other notified members of the public. The benefits under this scheme include medical care, home visits or home care, free medicines and diagnostic services. The government provides these services mainly through public hospitals, but also through empanelled private hospitals, who are reimbursed according to negotiated prices. The criticism of this scheme is that reimbursement takes time and a number of private hospitals get only 80% of their fees reimbursed. At this point of time, many private healthcare facilities have stopped providing healthcare under this scheme.

### Medical Insurance Policy

In 1986, the first medical insurance policy was launched. The policy covered only hospitalisation and began with a minimum policy cover of INR15000/- and a maximum of INR 5 lakhs. This policy was available to the general public and covered only inpatient treatment for the policy holder. High premium costs and domiciliary treatment therefore saw this policy being used only by the urban middle class.

### Community Based Insurance Schemes

Various NGOs, as part of their programmes, initiated integrated life, health and livelihood insurance policies to protect their beneficiaries. The Self Employed Women's Association was one of the organisations to have this kind of an insurance policy. Here members would contribute a yearly premium for basic cover of health-included insurance system. The RAHA - a community based

<sup>1</sup> <https://timesofindia.indiatimes.com/india/healthcare-costs-land-5cr-indians-in-poverty/article-show/62076906.cms> accessed on 13th October 2018.

organisation in Chhattisgarh has a scheme where they provide preventive and promotive medical cover for its beneficiaries for a contribution of Rs. 70 per year. Other NGOs, like Aga Khan Health Services, ACCORD, etc., have developed their own health insurance schemes. It has been observed that the coverage of these schemes is mainly for the workers of the NGOs or their beneficiaries. It is usually for purpose of primary and secondary care that these organisations have tied up with local hospitals.<sup>2</sup>

### Insurance Regulatory Development Authority (IRDA)

IRDA is the regulatory body for insurance in India created by the Insurance Regulatory and Development Authority of India (IRDAI) Act, 1999. According to the Mission Statement of IRDA<sup>3</sup>, its mission is: to protect policy holders and the general public; to set standards for transparent, fair, competent and sound insurance practices; to ensure that fraud does not occur; to provide an effective grievance redressal system; and to build an effective enforcement mechanism for the sector. One of the regulators is to issue licences to run an insurance business. With health insurance being opened up to private players and the huge potential of growth in the healthcare sector, the health insurance sector is set up to grow in a big way. It is interesting to note that healthcare insurance companies stocks went up by 1.4 % after the finance minister, in his budget speech this year, allocated INR 1200 crores for specialised healthcare and wellness centres.<sup>4</sup>

### Demand Side Health Insurance Schemes

In the year 2003, the Finance Ministry of the GOI introduced the demand side health insurance scheme called the Universal Health Insurance Scheme and thereafter a number of state governments began their own health insurance schemes. These schemes were launched mainly to provide health insurance cover for the vulnerable sections of society. In 2007, the government of Andhra Pradesh (AP) launched the Rajiv Arogyashree for tertiary care cover. The rationale for this was that government hospitals provided free secondary care cover. The government of AP set up the Arogyashree trust. Claims were made electronically and the use of IT solutions was born in health insurance. The AP model was taken up by Tamil Nadu, Karnataka, Gujarat and Maharashtra. Most of these models were

approached through the Public Private Partnership (PPP) mechanism.

The Rashtriya Swasthya Bima Yojana (RSBY) was an initiative of the Ministry of Labour, GOI which is a national level scheme. It was felt that insurance scheme needed to cover secondary care for simple illnesses like fever, diarrhoea, minor surgeries etc, which the AP model did not cater to. This scheme was launched for the Below Poverty Line (BPL) population of this country in April 2008. The aim was to provide health insurance to the identified poor and unorganised labour force of this country. The GOI expanded the base of this scheme. It is pertinent to note that different states implemented this scheme in different ways. Some states followed the Trust method like the AP model while others used the insurance model as a Third Party Assurer (TPA). Here, the responsibility of identifying the beneficiaries was given to the TPA as well as inspection and whetting of the bills raised to the insurance company. Sometimes, this led people who were not rightful beneficiaries of the scheme benefiting from the scheme and a huge cut in the bills that hospitals raised, leading to substantial losses by hospitals.

The Finance Minister of India allocated INR 1200 Crores for the Prime Ministers' National Health Protection Scheme. This scheme would cover 10.74 Crore families i.e. 50 Crore beneficiaries. This scheme was launched by our Prime Minister on the 23rd of September 2018. The scheme now known as the Pradhan Mantri Jan Arogya Yojana (PM JAY) provides a cover of INR 5 lakhs per year per family. The size of the family is not a barrier. There is no exclusion for pre-existing conditions. People whose names appear on the National Social Economic Caste Census (NSECC) would be eligible to access this scheme. Treatment would be free for 1,350 medical packages. This scheme has been heralded as the largest health protection scheme in the world.

PM JAY has the possibility of being a game changer in the health sector in the country. A lot will depend on the implementation of the scheme. So far, 32 states and union territories have signed up to the scheme. If this works out, the poorest of the poor will have access to free healthcare. The cost of healthcare may stabilise as rates for the listed procedure have been fixed and a number of private healthcare facilities have signed up to the scheme. The government is monitoring it closely. At present, there are internet connectivity issues and health providers are worried as to how payments will be recovered as in some states some hospitals have faced huge losses for non-payment of bills. As the scheme has just been launched, there are some practical initial implementation challenges. However, the government is confident of seeing this scheme through.

<sup>2</sup> Dilip Mavalankar, Mahesh Bhatt, Health Insurance in India: Opportunities, Challenges and Concerns, IIM Ahmedabad, 2000.

<sup>3</sup> [https://www.irdai.gov.in/ADMINCMS/cms/NormalData\\_Layout.aspx?page=PageN-01332&mid=1.9](https://www.irdai.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageN-01332&mid=1.9) accessed on October 16th 2018.

<sup>4</sup> <https://www.moneycontrol.com/news/business/stocks/budget-2018-healthcare-stocks-up-1.4-as-govt-allocates-rs-1200-cr-for-specialised-health-wellness-centres-2496883.html> accessed on October 16th 2018.

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# FACTS

**1** billion people worldwide currently lack access to affordable health care

**79%** urban | **Most ailments treated in private hospitals**  
**72%** rural

**Pollution** Top reasons  
**Dietary habits** for sickness

**More women tend to fall sick**

 13.5%

**WOMEN URBAN MEN**

 9.9%

**WOMEN RURAL MEN**

 10.1%

 8%

**DOCTOR - POPULATION RATIO**

**1:2000 (in 2014)**

**1:1000 (WHO requirement)**

**59.5 YEARS**

**healthy life expectancy for India**

**India has the highest Maternal Mortality Rates (MMR) in South East Asia (WHO report)**

**350** total medical colleges

**only 34%**

**Indian population relied on clean fuels (as of 2012)**

## DIFFERENTIALS IN HEALTH STATUS AMONG RURAL/URBAN INDIA

Sector	BPL	IMR	Under 5 MMR	MMR
India	26.2	70	94.9	408
Rural	27.09	75	103.7	-
Urban	23.62	44	63.1	-

## HEALTH STATUS DIFFERENTIALS AMONG SOCIO-ECONOMIC GROUPS (NFHS III)

Indicator	Infant Mortality	<5 Mortality	% of children underweight under 3 years (<2SD)
India	57	74.3	44.9
Social Inequity			
S/C	50.7	65.4	47.9
S/T	43.8	53.8	54.5
OBC	42.2	54.5	43.2
Others	36.1	42.1	33.7

**In 2017, the Infant Mortality Rate in India was 32 deaths per 1000 live births compared to the global average of 12. The Under 5 Mortality rate of India is 30 per 1000 live births which is worse than Bangladesh and Nepal which are 32 and 34 respectively, and they have a lower per capita income than India.**

**Tuberculosis remains a major global health problem with an estimated 10.4 million new TB cases and 1.4 million TB deaths, with an additional 0.4 million deaths resulting from TB among HIV-positive people in 2015.**

## Children under 5 years of age, globally in 2016

**155 million stunted (too short for their age)  
52 million wasted (too light for their height)  
41 million overweight**

# Reflections on Christian Hospital-based Healthcare

**Dr. Naveen Thomas**

If Jesus were to physically walk through the streets of our country today, would He be involved in healthcare? As His ambassadors to the world, do we have a 'carte blanche' to be committed to the third mandate as mentioned in Matthew 4:23?

*"Jesus went throughout Galilee, teaching in their synagogues, proclaiming the good news of the kingdom, and healing every disease and sickness among the people."*



Historically, much has been done through mission hospitals. In small ways and big, they continue to be lighthouses and beacons of testimony, despite all their inherent weaknesses and shortcomings. Do you know why? The Lord continues to use

small, imperfect and weak offerings... the 5 loaves and 2 fish, broken as they are, are still valuable in His sight. At the same time, it is imperative that we acknowledge

The answer is very evident. "Teach, preach and heal" is the commission we have received; that is the job description and the supreme directive. We dare not neglect one third of the mandate! Who knows how far the little ripple created will travel in ever widening circles.

Are there issues we should be cognizant with, in this regard?

- While individual efforts count, the efforts of mission hospitals are also still relevant. The mission hospital model is not the only model to fulfil the third mandate... nevertheless, it is an important one.

**“We can be involved in the healing ministry in any capacity. It may be a simple home visit to an ailing neighbour; a hospital visit; a small help to someone who is unwell; or delivering a food packet to a family in need. It may also mean a personal phone call, an email, a prayer for the sick, visiting the aged or raising some money for the treatment of a terminally ill patient. All these are acts of wiping away one tear at a time.”**

medical, nursing and allied personnel working in private settings, clinics and government hospitals, who also have a role to play wherever they are placed. Could we be known as a community of hard working, efficient, honest people of integrity? We are grateful for so many positive

examples and models; but we need many more.

- The demands and the felt needs of the community around us have changed drastically. "The only thing that is constant is change" - Heraclitus. If the mission hospitals do not change and adapt, they will remain as



the 'Fiats and Ambassadors' of the yesteryears. It just took one brand - namely, the new entrant 'Maruti 800' to totally undermine (legitimately so), the established brands. A willingness to change is essential. We must figure out how it applies to each situation.

- Sustainability: To be a viable operation, there must be an embrace of the "both-and" philosophy. Sticking to the poor alone is not economically viable. (there are vibrant exceptions to this rule; but these remain exceptions). Are we called to be good business men and business women? (Read Luke 16:1-15). What better business is there, than to be a viable operation which positively impacts lives and communities! 'Economies of scale' must moderate the prices; at the same time, if we are not relevant to the disadvantaged, there is no reason to exist! This is a juggling act, but it is an essential juggle.

- The person of Christ: Wholistic care will mean presenting the person of Christ. (Not the religion, but the person... It is He who is able to transform individuals and communities and make them better citizens of our beloved country). Seeing the person as a whole is a choice that we must make. When we try to compartmentalise, there will be incoherence and lack of concordance in all our actions. A wholistic approach considers the person who has the illness, not just the disease process or the diagnosis. This approach also empowers the patient to participate in the management of his or her own healthcare. In the

**“Wholistic care will mean presenting the person of Christ. (Not the religion, but the person... It is He who is able to transform individuals and communities and make them better citizens of our beloved country). Seeing the person as a whole is a choice that we must make.”**



Photo: Stephen Marandi

long run, the community recognises the value of what is being offered. The teachings of Christ must be the guiding principles of all our healthcare initiatives.

We are also called to be realists who are fully aware of the existing social and economic realities. A patient encounter deeply affected me: A chirpy school girl was brought to my outpatient clinic by her mother and grandmother. After the consultation, I asked them where the father of the child was. "He was a farmer and he committed suicide last year," the grandmother said, in a 'matter of fact' manner. "This child's little brother was severely pre-mature. He was admitted to your hospital in the NICU for more than 2 months... was on a ventilator for a while. The subsidised 'general' bill itself was Rs. 3 lakhs. You gave us a further concession of 50%. But that amount of Rs. 1.5 lakh was borrowed at a very high interest rate. This episode was followed by 2 consecutive seasons of crop failure and famine.

The farm loans were impossible to negotiate through." None of them cried; they just sighed and added, "We have now got some money through the Chief Minister's Fund." It was as if there were no more tears left in them. Where had we gone wrong? We thought we had done a great job of reducing the bills so significantly. Well-meaning, high-tech care had contributed to his taking the extreme step 2 years down the line. I do not have answers

here... only questions! We must do what we do with great humility knowing our limitations and failings in the context of a broken world.

It is important that we recognise the importance of little deeds. One late evening, I was going through one of the inpatient wards of the hospital. Everything was quiet, a nun

from the Mother Teresa's group (Sisters of Charity) was silently seated next to a patient they had brought to the clinic – a deformed, bent, “invalid” figure lying on the bed. The nun sat there holding the patients' hands and I noticed tears in her eyes. I dare say those were tears of love; and even through those tears, she was joyful in her heart. The reason for this is that there really is no better fulfilment and satisfaction than to know that one is useful, positively touching others' lives. That unnamed, unsung nun was fulfilling the third mandate in a profoundly inspiring way.



Photo: Tom Price

Coming down the hospital stairs, I remember meeting one of our chaplains. He had befriended a very poor man. Asked where he was going, the chaplain said he was taking this man to the canteen for breakfast. He came to know that the gentleman, an attendant of one of the general ward patients, was skipping meals to save money.

Others among us had missed the reality of hunger right in front of us, and were moving on, occupied and pre-occupied. The abject need was visible to the discerning instrument of healing and wholeness, in the form of that chaplain. He was available and was present at the point of need. Paul in Ephesians 2:10 said, “*We are God's handiwork... created in Christ Jesus to do good works which God prepared in advance for us to do*”. Can you imagine that? *The intent behind our formation is to do good works assigned by Him, 'prepared in advance'. I am reminded of what John Wesley said: “Do all the good you can, by all the means you can, in all the ways you can, in all the places you can, at all the times you can, to all the people you can and as long as you can.”*

In the hospital where I work, there is an impressive young man who comes once every week to volunteer as part of the ‘Helping Hands Volunteers’ group. It is very touching to see that this man, who regularly donates his time to help others,

does not have hands on both sides. His right upper limb was amputated above the elbow and on his left, he just has a forearm stump (amputated below the elbow). He had an unfortunate accident when he was a high school student and was electrocuted while playing on the terrace of a building, when he touched a low hanging live wire, left carelessly dangling. I remember being involved in amputating the charred, blackened limbs as the operating surgeon. That was

years ago. The experience could easily have turned him into one bitter, angry, difficult person, justifiably so. But he refused to be defeated. Gainfully employed, gifted, with a positive attitude, he now lends a helping hand even when he himself doesn't have any! There were many who were involved in his becoming an instrument of healing

for others. That young man is a true model of someone fulfilling the third mandate. It is a choice that one makes. We are given to give; blessed to bless and healed to pass on that healing. We are called to “be” and not just to “do”. Our ‘doing’ must spring from our ‘being’.

**“We are stewards of what we have received. May we be found wise and faithful at our place of work and vocation. May we be enabled to do little things with great love. That will be our offering to God.”**

We are stewards of what we have received. May we be found wise and faithful at our place of work and vocation. May we be enabled to do little things with great love. That will be our offering to God. Who knows how far the little ripples we initiate will travel in ever widening circles affecting healing. May we receive the ultimate compliment: “She has done what she could/ He has done what he could” (Mark 14:8). What a certificate and commendation to receive from the Great Physician!

*(Dr. Naveen Thomas is a Paediatric Surgeon and has been working with Bangalore Baptist Hospital since 1988. Presently, he is the Director of the hospital. Dr. Thomas is married to Dr. Asha and is blessed with 2 children. He can be reached at drnaveenthomas@gmail.com)*

# The Challenges Faced by the Elderly in Accessing Healthcare in India

**Dr. K. Jacob Roy & Dr. C.T. Sudhir Kumar**

India has a fast growing population of elderly. In 2001, the elderly constituted 7.7% of the Indian population, which increased to 8.14% in 2011. It is estimated that the elderly population will be around 133 million in 2021 and over 300 million in 2051. Challenges associated with organising and delivering adequate and appropriate healthcare for the elderly are manifold. However, the barriers that senior citizens face to accessing healthcare are huge. It is difficult to generalise the findings across varying socioeconomic strata and regional backgrounds. The data comes mostly from surveys and observations.

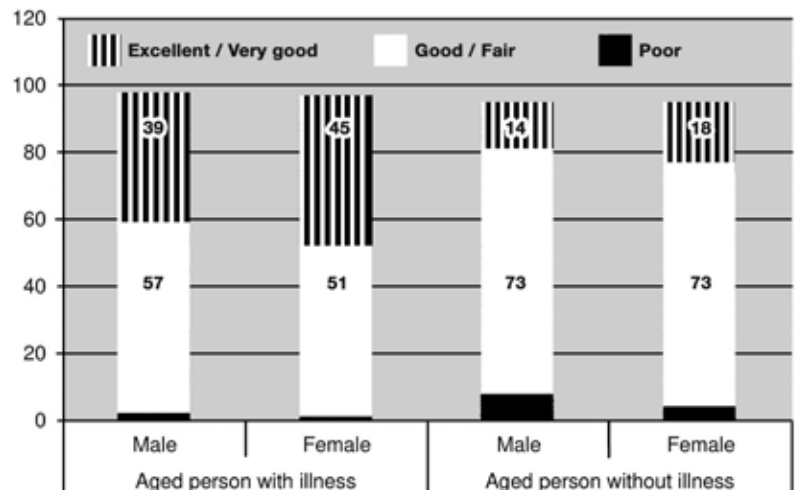
The majority of Indian elderly live in rural areas. Many are from low socioeconomic backgrounds and are dependent on their families financially. The elderly have a high prevalence of non-communicable and communicable diseases. They are at a high risk of cardiovascular diseases, stroke, cancer, other lifestyle diseases and dementia. The prevalence of diabetes, respiratory problems, kidney diseases, bone and joint diseases is high. They also suffer from sensory impairments, such as visual and hearing problems. Nutritional problems, like anaemia, take a significant toll on them. They may have poor mobility and suffer from incontinence. Many of them have mental health problems, like depression. Tobacco and alcohol consumption also contribute to disease burden among the elderly.

Age is the biggest risk factor for cognitive impairment and dementia. It is estimated that there are around 42 lakh people with dementia in India. However, only around 10 percent of them ever receive a diagnosis. Poor access to services arises out of several factors. Lack of awareness among the public is an important reason. Symptoms of dementia are often considered part of normal ageing. Even though it is recognised as a neuropsychiatric condition requiring professional help, there are many barriers to treatment. Besides, there is no definite cure for dementia including Alzheimer’s disease. Often overlooked are the medical and psychosocial interventions that address various problems associated with dementia and which help the

person with dementia and their families. Due to cognitive impairment, dementia patients are often not able to directly access treatment and heavily rely on their families for support. Alzheimer’s and Related Disorders Society of India (ARDSI) have brought out guidelines to establish multidisciplinary memory clinics aimed at increasing access and improving care. Dementia, including Alzheimer’s disease and vascular dementia, are often mistakenly seen as part of normal ageing, resulting in lack of appropriate care, misunderstanding and even abuse.

Loss of income, dependency on family, urbanisation and nuclearisation of families have a major impact on healthcare of the elderly. Elderly people who live alone, who are poor, dependent on their families, and from rural areas, have poor access to healthcare. In addition to social determinants like caste, gender inequality is often reported as a major barrier to healthcare access. Women in general across rural and urban regions, widows and women with less education could access healthcare less compared to others. Even when living away from their immediate family members, those with stronger social contacts in the local community enjoy better access to care.

Per cent distribution of rural aged persons by own perception about current state of health



Many senior citizens suffer from multiple health problems. Social issues like poverty and loneliness cause, contribute or compound these health issues. It is unfortunate that as the medical needs of the elderly

**“Even though India has a strong culture of respect towards its elders, ageing, unfortunately, is a matter of stigma, visible and evident across various spheres of life. This has a major impact on the elderly's access to healthcare.”**

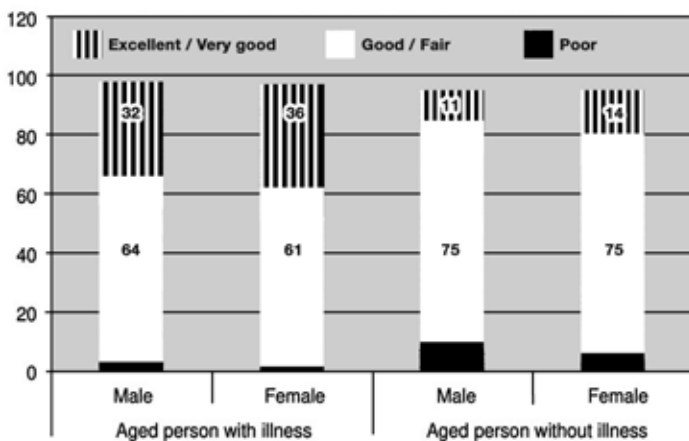
accessing healthcare. Mental disorders, memory problems and dementia further stigmatise the sufferer. Poor mobility has a major impact on access to care. Many elderly are physically restricted to their homes. Not even our major cities are

increase, the accessibility decreases. This is a multifactorial issue. Access is most often not just a matter of availability but affordability. Those who are financially independent have better access. India does not have a robust social security system which most high income countries enjoy. The elderly have to continue to work to earn. Less than half the population is supported by pension or insurance schemes. The elderly, even when employed, are often paid less. A significant amount is spent by the elderly and their families as an out of pocket expenditure for healthcare, for consultations, and medications. The costs of cancer treatment, heart surgeries and joint replacements are huge. This expenditure is ongoing as the conditions they suffer from are often chronic, progressive and multiple. This can drive them further to poverty and limit their access to healthcare.

elder-friendly when it comes to mobility. Home care is non-existent in large parts of the country and even when available it can be expensive, inconsistent and unreliable. Even when programmes and interventions specifically designed for senior citizens are available, the information often does not reach them due to inefficient communication systems. Information about health promotion schemes and preventive clinics are often not widely publicised. There are several measures which can be implemented to improve the elderly's access to healthcare in India at the government level and this is an area where non-governmental voluntary organisations can play a meaningful role. Improvement in government social security schemes would be the most important step. Strengthening the public healthcare sector and making them elder-friendly would cut costs on out of pocket expenditure. Community health workers who are familiar with the local population can be effectively utilised to improve the healthcare of the elderly with some additional training and increasing human resources. Improving physical accessibility by making the areas which the elderly commonly access elder-friendly will help their cause a long way. Ensuring trouble free access to schemes and funds earmarked by government should be seen as a priority by government officials.

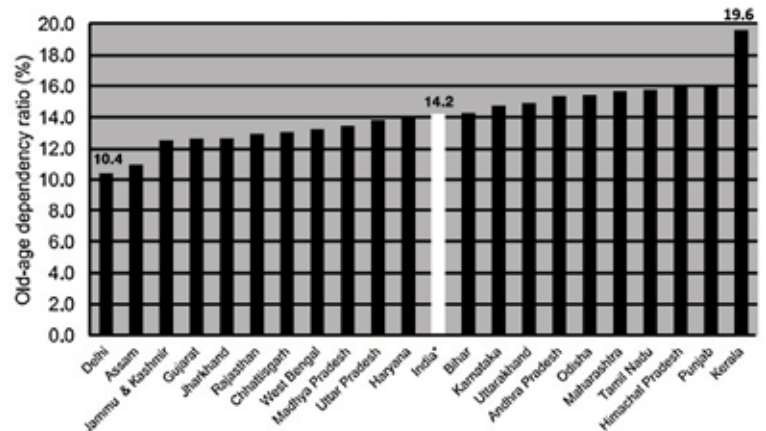
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Per cent distribution of urban aged persons by own perception about current state of health



Even though India has a strong culture of respect towards its elders, ageing, unfortunately, is a matter of stigma, visible and evident across various spheres of life. This has a major impact on the elderly's access to healthcare. As a result, the elderly are often reluctant to report the full extent of their problems and access care, even when available. Many problems are mistakenly seen as a normal part of ageing. Behaviours perceived as stigmatising from care providers, relatives and the public reduces further the likelihood of

Old age dependency ratio in major states of India



Sensitising health and social care professionals and creating awareness among them about the needs of the senior

citizens would improve the quality of care and services. Manpower is the major asset we have as a country with a population of more than a billion. We have to consider

innovative ways to use this wealth of ours to improve the lives of the elderly. We have to consider how the youth can re-establish meaningful connection with their elders in a practical and philosophical sense. Family

continues to be the main source of support for the aged. Serious consideration need to be given regarding measures to empower the family to address the needs of their aged relatives. Awareness creation and skills development, probably through informal means and by local health workers, needs to be looked into. Outreach services would help the elderly to a significant extent.



Photo: www.pixabay

There have been several strategies by governments to facilitate the care of the elderly and break barriers to accessing healthcare. The national Policy for Older Persons in 1999, by the Ministry of Social Justice and Empowerment, validated the specific needs of the elderly on a background of various international strategies. According to Section 20 of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 the state government shall ensure that government hospitals or hospitals funded fully or partially by the government shall provide beds for all senior citizens as far as possible; arrange separate queues for senior citizens; provide expanded facilities for treatment of chronic, terminal and degenerative diseases; earmark facilities for geriatric patients in every district hospital duly

headed by a medical officer with experience in geriatric care.

**“It is clear there is no dearth of well-meaning policies and strategies but the real test lies in the realisation of those visions which can be achieved only through concerted efforts of various stakeholders.”**

The Ministry of Health and Family Welfare launched the National Program of Healthcare for the Elderly in India during the year 2010-11, to address the various health related problems of elderly people. The specific objectives include providing an easy access to promotional, preventive, curative and

rehabilitative services through community based primary health-care approach, identifying health problems in the elderly and providing appropriate health interventions etc. It also aims to build capacity of the medical and paramedical professionals as well as for family caregivers. Some of the strategies include community based primary healthcare approach including domiciliary visits by trained healthcare workers, information education and communication using mass media, folk media and other communication channels and reorienting medical education to support geriatric issues.

The government of India initiated a National Programme for Prevention and Control of Cancers, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) during 2010. The focus of NPCDCS is on the promotion of healthy lifestyles, early diagnosis and management of diabetes, hypertension, cardiovascular diseases and common cancers, treatment and follow up through setting up of NCD clinics etc. The main strategies include health promotion through behaviour change with the involvement of the community, civil society, community based organizations, media etc, and outreach camps for opportunistic screening at all levels in the healthcare delivery system for early detection etc. It is clear there is no dearth of well-meaning policies and strategies but the real test lies in the realisation of those visions which can be achieved only through concerted efforts of various stakeholders.

*(Dr. K. Jacob Roy is the Honorary Vice Chairman, Alzheimer's Disease International and Founder-Chairman, Alzheimer's and Related Disorders Society of India (ARDSI). He can be reached at - kjacobroy@gmail.com.*

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# Books on our Desk

## Equity and Access

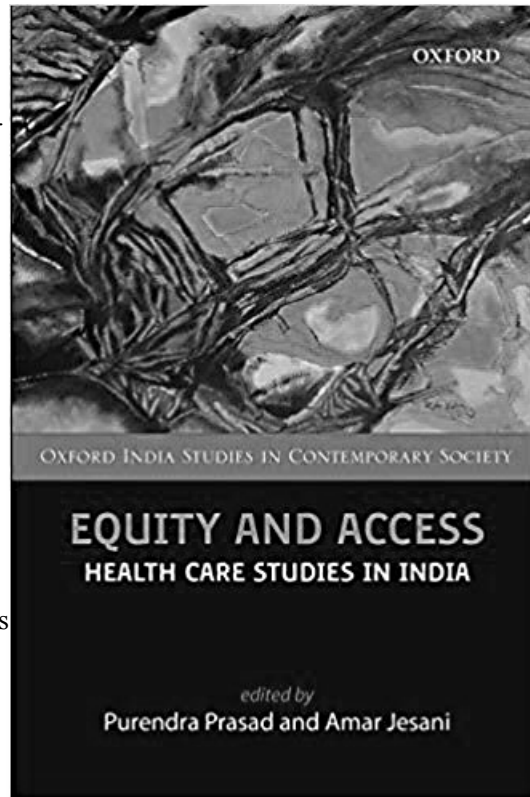
By Purendra Prasad and Amar Jesani (ed.)  
Oxford University Press, 2018. Pages 418.

**Mrs. Joan Lalromawi**

The book attempts to unravel the complex narrative of why inequities in the health sector are growing and access to basic healthcare is worsening. There are many factors behind health inequalities such as caste, class, gender and spatial locations. For many vulnerable groups like the poor, there is no reliable social protection, instead they have to face the rising costs of healthcare on their own. This presents a contrast to an equity framework which systematically focuses attention on the socially disadvantaged, the marginalised, and the disenfranchised groups within countries, including but not limited to the poor.

The book, consisting of 4 main chapters and 17 sub-topics in the chapter, is a compilation of healthcare studies in India. It seeks to draw attention to the way globalisation has influenced India's development trajectory as healthcare issues have assumed significant socio-economic and political significance in contemporary India. The contributors of the volume have highlighted the crucial role played by the state in allowing private capital to enter the healthcare industry. It also points out how corporatisation of healthcare is evident in the profit maximisation principle of the market making the cost of healthcare beyond the reach of the common man. Individual patients are reduced to consumers who receive/purchase healthcare depending on what they can afford. In this context, an important issue which confronts us are the implications of rising clinical trials and pharmaceuticals in terms of cost, exclusion and ethicality.

Thus, this volume thus consciously adopts a political economy approach positing that inequity and inequality change historically within and across social structures. The contributors analysed the politics of social relations,



technological choices, organisational politics, perceptions of different social groups as well as dynamics of gender, disability and their implications for inequity in health and healthcare. As mentioned by one of the contributors Ritu Priya, since individuals are central actors in their own health, health systems studies and health systems needs to take the designing of knowledge and behaviours as important components of the healthcare system. Beginning at this end of the system and moving up the pyramid of healthcare is the bottom-up approach to understanding systems and planning that is likely to produce contextually suited health care. This is why there is a need for further research and action through wholistic health systems studies and action research.

The authors' interdisciplinary approach within a broader political economy framework, bringing in critical discourses along with epidemiological and ethnographic analyses, presents a comprehensive analysis of the issues as experienced in India. This theoretical framework is useful in understanding power relations within social groups and complex organisational systems. They have documented inequalities in the distribution of health by social class, gender, and ethnicity very well. Inequalities in health have been measured using many different outcomes including infant deaths, mortality rates, morbidity, disability, and life expectancy. The book is important due to its timeless engagement with the global issue of health inequities.

(Mrs. Joan Lalromawi works with EFICOR.  
She can be reached at joan@eficor.org)

## Do We Care?

By K. Sujatha Rao

Oxford University Press, 2017. Pages 446

### Mr. H. Kamlalzom



This book by K. Sujatha Rao documents the history of health policy initiatives in India and examines the efforts to strengthen the public healthcare system that have been made in the last decade. Having served as the former Union Secretary of the Ministry of Health and Family Welfare, as well as the Director General of the National AIDS Control Organisation (NACO), she presents an insider's view, but with careful analysis draws a critique.

The title of the book itself suggests a distinct view which highlights the voice of the deprived and discriminated groups living on the margins, who are often ignored by the Indian health system.

The book is broadly divided into two parts - Part one highlights the history, health financing and governance systems. Part two depicts the implementing policy and discusses the factors that have contributed to the successes and failures in the implementation of government health initiatives, such as the National Rural Health Mission. Rao argues that the healthcare system in India cannot be understood in isolation and is a reflection of the paradoxes of the country's development since independence. While on the one hand, in India we have hospitals providing 'world class' treatment, with medical tourism being seen as an emerging sector, on the other hand, diseases like Japanese encephalitis, tuberculosis and malaria continue to kill hundreds of people, especially children. Malnutrition in India is amongst the highest in the world. Health spending is largely financed from out-of-pocket expenses which is catastrophic and further pushes people into poverty.

The book provides not just an analysis of the causes for failure but also highlights what needs to be done in order to take corrective action. It is a good reference book for those who want to understand India's health challenges as well as for researchers working in health. It is therefore, relevant for people working on health systems and also for those broadly interested in public health policy in India.

*(Mr. H. Kamlalzom currently works with the Railway Ministry in Kolkatta.*

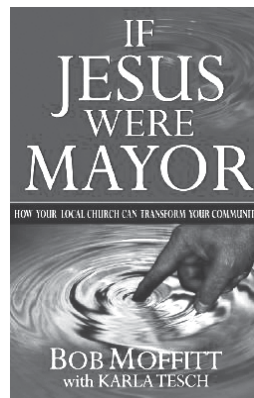
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## If Jesus Were Mayor

by Bob Moffitt, with Karla Tesch (Editor)

Published by Harvest Pub, India, 2004, Pages 272.

### Ms. Sharlyn Suanlianching



This book is essentially about how a Christian entity should strive on in life, be it the Church, community, society, family or individual. It underscores the Church's bigger role in cultural transformation and in fulfilling His agenda, compared to other institutions whose existence is for similar goals in developing the society or community.

The author challenges readers to grasp an enlarged biblical

understanding of the church's pivotal importance to the welfare and development of its community. The author Bob Moffitt encourages readers to catch a vision of Jesus' agenda for their community and perceive the church's role in cultural transformation through the lenses of the Scripture, history and current examples. He mentions the various ways in which we could develop and transform society, help the weak and the destitute through the lens of the Scripture. The book not only provides good theories of change and development, but also shares very practical examples on how every group that wishes to be a part of this godly transformation can chip in to bring change. Moffitt also demonstrates how local churches can be equipped and mobilised. Jesus' agenda for community health and transformation is expressed and modeled through His church. The author mentions that the church is far more important for the transformation of a society than the president of the nation. The principal and most strategic institution God appointed to carry out His big agenda is the Church. We serve the head of the Church.

The verses in Ephesians (1:11, 18-20) was explained by Bob in ways which educate the readers of our glorious part in the big 'mystery'. It explains the real meaning of wholistic mission, what seed project is all about and many others. The main highlight of the book is that it draws insight into the significance of servanthood, Biblical servanthood, with Jesus Christ as the role model. This book is recommended for anyone who has the passion to help make the world a better place.

*(Ms. Sharlyn Suanlianching is currently pursuing Master of Arts in History.*

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# Walking and Working Alongside the Community

**Pastor Muninder Paswan**

The Jehanabad Community Church was initiated with the setting up of a non-formal school for poor children in Rajapur Bazar Daulat village in Jehanabad, (Bihar) in February, 1996. There were 300 children in this school and it was run with contributions received from the villagers themselves. The school got damaged when there was heavy flood. After few years, the local MLA was able to revive the school again. During 2002, the church started with just 12 people who met in the community hall of the school. It gradually expanded to the neighbouring villages. In 2004, their ministry got registered as 'Utkarsh Jan Vikas Seva Society' it had the vision of sharing the gospel to the poor, with an emphasis on giving and offerings in order to develop their own church and community.

**22** In 2011, the pastor came in contact with EFICOR and he was invited to attend a workshop on Integral Mission. He had earlier thought that Christian ministry was all about caring for the church members and only about the development of the church, but this workshop changed his perspective. It challenged him to do wholistic ministry. In 2013, he was introduced to the Parivartan model of working with the community as a church. This motivated him to not just work for the poor, but to work alongside the community for their development. With this motivation, they started working with the community and were able to see a lot of change in the lives of the people.

The church did a lot of work like opening a school in 2014 for poor children who were not able to pay fees. At the same time, a tuition centre was set up for 35 children and it was later taken up by the state government. As a result of a greater awareness of environmental issues and creation care, a tree plantation drive was done by the villagers. A monthly, cleanliness programme has been undertaken since 2016 and it is ongoing till today. Hence, sanitation has improved in the area. Social protection schemes such as ration cards were made for most of the poor households. Various development work happened due to the initiative of the church such as - a 2500 metres road was constructed with the participation of the community during 2016-18, every household to get electricity, setting up micro enterprises for 3 people, enrollment of students under Kanya Nidhi Yojana, medical

camps conducted from time to time and hand pumps recently installed in the village.

Due to all these good works, the community sees the church in a positive light and now cooperation and relationship between church and the community has increased. People are now able to make use of the hand pumps and access safe drinking water. The road has increased their mobility and access to markets and other facilities. They now have good electricity in the village. The children are enrolled in government or private schools and are now studying, since their parents became aware of the importance of education. They also started micro-businesses and are now able to save money to meet the needs of their families. In times of sickness, the community has now started going to government hospitals or trained doctors instead of going to unauthorized doctors or traditional healers. Even when the church faced persecution or opposition from outside, the community stood along side the church and protected the church. Many of the poor in the community became aware of their rights and today, people raise questions to the local government or panchayat. Earlier people were not able to go to government offices but now people can easily access the local authority. There is a decrease in domestic violence and women are able to raise their voices and participate in the family decision making matters, showing women empowerment.

However, the church has also faced challenges. There has been little male participation in the activities initiated or started by the church and community and there are no employment options for the women of this village. Despite all these challenges, the church has been able to walk and successfully work alongside the community for their own development.

*(Pastor Muninder Paswan is the Pastor of the Jehanabad Community Church in Jehanabad village, Bihar. He can be reached at [u.v.s.society@gmail.com](mailto:u.v.s.society@gmail.com))*



# Accessing Health, Delivering Health, Securing Health

**Dr. Bobby John**

India accounts for about 1/6<sup>th</sup> of humanity, with an annual birth cohort larger than the population of Australia. It also accounts for one of the largest cohorts of people now entering their 7<sup>th</sup> decade of life. What was defined as primary healthcare half a century ago needs to be reframed – restoring the fading eyesight of the elderly by removal of cataracts has become as primary a need as the rapid diagnosis of malaria or anemia in pregnancy.

Understanding differentiated primary care demand patterns is the beginning of community and individually sensitive approaches to delivering healthcare in India today. Christ's responses to people's health situations were as varied as the people themselves – the blind got differing interventions for the restoration of their sight. (Mark 10:46-52 vs John 9:1-12)

Health is not merely the absence of disease – this is the starting point of all discussions on health. There is unanimity on the statement's import, but very little action that enables the realization of physical, mental and social well-being by everyone, everywhere. Where services are “universally” provided, pockets of marginalised and unreached still persist.

Where services are priced, or provisioned via markets, the widow and the orphan, the stranger and the poor get left out. Ensuring all have access to interventions that will restore physical and mental well-being requires working on the social determinants of health. The Syrophenician woman and the Samaritan leper both were recipients of healing that transcended societal barriers. (Mark 7:25-30 & Luke 17:11-19)

When there are health services available, the barriers to accessing health are primarily determined by geography – the distance and terrain that people need to get through to be able to reach the place or person who delivers them the service they need.

It is also determined by social status – the distance from the centre of societal power and prestige structures in a

highly caste and class aware society makes access to health services a matter of great difficulty.

Even when geography and social standing are not barriers, lack of means to pay for health services in a market-oriented delivery landscape becomes a significant barrier to reaching for or continuing health services.

Contrast the above barriers to a situation where there is no service provisioning at all – either by neglect or by design because the effort is somehow not proportionate to the desired outcomes. The Christian mandate is to reach out – the one is as precious as the ninety-nine. To someone who does not have access to services because they are not available in the first place, the Christian encouragement to go and be of service comes from the salutation in Isaiah: How lovely on the mountains are the feet of them who bring good news! (Isaiah 52:7)

“What do you want me to do for you”, is a question that Jesus asked - of his disciples (Mark 10:35-36) and of the blind Bartimaeus (Mark 10:51). In the same manner, we ought to ask this question of ourselves as Christians: What is it that God and the community want from us?

The answers are already apparent – As Christians and Christ's ambassadors, we are called to serve (Mark 10:45), and in response to the cry “we want to see / be healed”, we are to respond by using that which has been entrusted to us, beyond silver and gold (Acts 3:6), and bring healing to those whose lives are blighted by disease, deformity and neglect.

These become our mandate to breaking down barriers to accessing health, and the mandate to deliver health where there is no one to provide it. When we live out these mandates, we begin to incarnate the prayer which Jesus taught us to pray: Our Father in Heaven, hallowed be thy name, Thy Kingdom come, on earth, as it is in heaven! In doing so, we begin the process of sustaining health, and an abundant life for all (John 10:10).

*(Dr. Bobby John is Managing Director of Aequitas Consulting and Editor of the Journal of Development Policy and Practice. He can be reached at [bj@bjohn.org](mailto:bj@bjohn.org))*



# IDEAS FOR ACTION FOR HEALTHY LIVING AND ACCESSING ADEQUATE HEALTHCARE

## AS AN INDIVIDUAL

- Take care of your health by maintaining a disciplined and active lifestyle. Eat fresh vegetables and fruits.
- You can volunteer in health camps organised by Government Health Departments or Hospitals – polio, hepatitis campaigns, etc.
- Visit the homes of elderly persons and inquire or help them get access to mobile screening services so that the elderly don't have to leave their homes.
- Promote online support groups to care for the needs of people fighting chronic illnesses like cancer.
- Organise a community event related to physical activity and/or nutrition, such as walk/run-a-thon, healthy food potluck, etc.
- Stagnant water and trash pollute the neighbourhood or surroundings. Mobilise the welfare committees to maintain cleanliness around homes so that diseases do not spread.
- Encourage people to drink clean water and use mosquito nets especially in malaria-prone areas.
- Cover cooked food and store food items in a clean and dry place.
- Ensure sanitation and a hygienic environment – wash hands frequently with soap and water.

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## AS A CHURCH

- Encourage, help and/or facilitate the poor community living near you to access medical treatment in Government recognised hospitals and clinics.
- Motivate the youth or Sunday school children to take care of the sick and the aged by visiting them in hospitals or at their homes.
- Your church could connect with organisations who give training for church members on spiritual and pastoral care for the sick, their families and healthcare workers ([www.hospivision.org.za](http://www.hospivision.org.za)) by providing practical guidance.
- Make plans to support the infected and affected people by encouraging a healthy lifestyle.
- HIV/AIDS has become a chronic disease. The biggest challenge is to reduce the number of new infections. If your congregation is situated in an area where HIV infections are common, your church could form a committee to look at combating the spread of HIV.
- Encourage expectant women to attend antenatal clinics to have necessary health screenings. Monitoring the growth and development of all infants and children is one of the most important interventions, together with immunisation against common infectious diseases. Also, the role of the father is often neglected in improving mother and child health and could be encouraged by your church.
- Encourage your congregation members to reach out to those with special needs for counseling and intervention.

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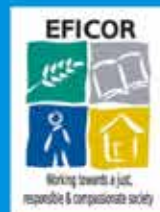
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