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# Financing burden of non-communicable and lifestyle diseases in Northeast India

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Health is often considered by many scholars as the nation's capital stock by virtue of its reciprocal relationship with development. Most of the developed countries viewed health as a means to enhance economic development and devoted substantial public spending on health. Rightly so as health and demography have strong bearing on labor productivity and capital formation. Aristotle's on the ethical count of human flourishing too considered maintaining and improving health as society's obligation. However, India's expenditure on health accounts for just 1.3 % of the GDP as compared to 13.7 and 5.8 % in Maldives and Nepal respectively. Critics of health system in India attributes the persistent inequities, insufficient access and poor quality of healthcare to inadequate public health expenditure. Nevertheless, efforts are on enhance the public expenditure on healthcare, Niti Aayog is exploring resources for enhancing to 3% of the GDP. Besides a number of government sponsored schemes, including the Rashtriya Swasthya Bima Yojana (RSBY) under the National Health Mission. It is pertinent to assess whether such notable initiatives in healthcare have brought down considerable variation across states including the northeast both in health expenditure and health outcomes. The development of northeast India has gained momentum in recent years with a designated Ministry of Development of North Eastern Region (DoNER) and the present note on scenario of burden of diseases is confined to NER excluding Sikkim. Data used are from the recent reports of Longitudinal Ageing Study in India, Wave-I (LASI-I, 2017-18) released by the Ministry of Health & Family Welfare (MoHFW), Government of India.It is a nationally representative survey of 72,250 households spread over 30 states and 6 union territories excluding Sikkim.

Knowledge of burden of diseases of a region and inter and intra-regional variation are crucial inputs for evidence based public health intervention programmes. It is needles to highlight that programmes drawn from population based prevalence of diseases are more tangible than that of institution based prevalence from the consideration of selectivity issue associated with it. With rising number of elderly population and increasing trend of rural to urban migration strengthening geriatric care component in public health also plays pivotal role in curtailing burden of diseases. Lifestyle and diseases of old age incurred substantial out of pocket healthcare expenditure and also responsible for impoverishment of sizeable proportions of households. LASI-I reveals that burden of non-communicable diseases among persons aged 45 years and above in some of the states in northeast (NE) India are well above the national average. Except in Nagaland all other seven states in the NE have higher burden of cardiovascular diseases (CVD) at the national level of 20.7% with residential variation of 33.6% and 17.4% in urban and rural respectively. Among the states in NE the burden of CVD is 30.8% with considerable residential variation, 42.7% in urban and 28.3% in rural while the corresponding figures for the state of Tripura having second highest burden of CVD are 30.4, 40.7 and 25.7% respectively. These figures for Nagaland with the lowest burden of CVD in NE are 15.8, 22.8 and 13.1% respectively. Further Assam has the burden of hypertension (high blood pressure) higher than the national average and also the highest level of hypertension among the states in NE. At all India level the burden of hypertension is 19.3 percent while that in urban and rural are 32.3 and 16% respectively as compared to the corresponding figures of 29.4, 40.8 and 27% respectively. Tripura again followed Assam as the state with second highest burden of hypertension among the states in NE with state average of 28.6% and residential differential of 37.8% in urban and 24.4% in rural. The burden of hypertension among persons aged 45 years and above in Nagaland is again the lowest among the states in NE with 15.2% as state average and 21.8% in urban and 12.7% in rural.The other lifestyle burden of disease that the NE is engulfing is the diabetes which is highest in Manipur and Tripura with 9 and 8.9% prevalence rate respectively, followed by 8.2% in Mizoram, 7.2% in Assam and Nagaland, then 6% in Arunachal Pradesh and the least is 3.6% in Meghalaya as against the national average of 7.1%. When it comes to the burden of chronic heart diseases (CHD) in three states of NE have a higher prevalence rate of 3.1% in Tripura and 2.7% in Assam and Manipur than the national average of 1.6%. The burden of high cholesterol level among the states in NE is highest in Manipur with 4.5% and only in Assam and Arunachal Pradesh the burden of CHD is lower than the national average of 0.61%. All India burden of asthma is 3.5% and among the states in NE it is 5.4% in Tripura followed by 2.6% in Mizoram and 2.2% each in Assam and Manipur.

The foregoing oration provides empirical evidence that most states in NE have high of burden of non-communicable more than the nation. This undoubtedly put individuals and households in NE on financial hardship to meet the out of pocket (OOP) expenditure in healthcare. Household expenditure on healthcare as percent of their monthly per capita expenditure (MPCE) at all India level is 16.6% and corresponding figures for Arunachal Pradesh, Manipur and Tripura the highest and second highest in NE are 17.0, 14.4 and 14.2% respectively followed by 12.9 in Assam, 10.7% in Meghalaya, 9.9% in Mizoram and 7.9% in Nagaland. The source for financing for larger proportion of households are selling assets, taking loans and borrowing from relatives and friends. Meeting OOP healthcare by these means is 34.1% in Assam the highest of NE states and is 25.8% in Manipur the second highest and are above the national average of 21.1%. OOP healthcare expenditure is catastrophic in these two states in NE and are also very high in Meghalaya, Nagaland, Arunachal Pradesh and Mizoram with as many as 20.0, 18.1, 17.6 and 16.2% respectively of the households depending on disposing assets, loans and borrowing. The high OOP healthcare expenditure incurred by households in states of NE is despite the implementation of government flagship health insurance scheme Rashtriya Swasthya Bima Yojana (RSBY) for households below the poverty line (BPL). The scheme entitled families holding yellow ration cards to receive Rs.30,000/- per family per year for inpatient healthcare. Except for Nagaland and Manipur, the proportion of households having any health insurance is above the national average of 3.2% in comparison to 66.0% in Mizoram, 64.5% in Assam, 55.2% in Meghalaya and 38.7% in Tripura. RSBY is the main source of household health insurance in the four states of Mizoram, Assam, Meghalaya and Tripura with 65.2, 58.7, 54.0 and 38.4 % of households being covered by the scheme while the other states of NE are yet to expand its coverage. Among the states in NE it is only in Assam households covered CGHS and employee sponsored health are pronounced collectively covering 5.6% of households.

Two related empirical evidences important in public healthcare intervention in the northeast are emerging from the recent report of Longitudinal Ageing Study in India Wave-I (LASI-I, 2017-18) released by the Ministry of Health & Family Welfare (MoHFW), Government of India (GoI). First, the burden of non-communicable and lifestyle diseases in the NE are high and above the national average and secondly, out of pocket expenditure for healthcare is catastrophic in some of the states forcing a large number of households to either sell assets or take loan and borrow. The third fact is that government sponsored RSBY is adequate to cope with high OOP healthcare expenditure even in states of Assam and Mizoram where the coverage of RSBY is quite appreciable. The message is loud and clear that there is an urgent need to curtail the burden of non-communicable and lifestyle diseases in the NE from further escalation in the first place, enhance public expenditure on healthcare and promote health insurance by introducing tax incentives. There is also an urgent need to strengthen the mass media and social media outreach to promote healthy lifestyle through behavioral change and communication through public-private partnership intervention. Even when all initiatives are in place the financing of the burden of non-communicable and lifestyle diseases shall is always an uphill task.

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