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Healthcare Services in India: On Overview

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ABSTRACT *Healthcare in India features a universal health care system run by the constituent states and territories of India. The Constitution charges every state with "rising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002.*

1. INTRODUCTION:

Healthcare can be considered as one of India's largest sectors, especially in terms of its revenue and employment. The sector is also expanding rapidly. However, most part of the sector operates in a largely unregulated environment, with minimal controls on what services can be provided, by whom, in what manner, and at what cost. This is mainly because of the nature of the system of healthcare in India which consists of a public sector, a private sector, with a large section of informal network of care providers who are poorly regulated (Das & Rani, 2004.). Thus, wide disparities occur in access, cost, levels, and quality of health services provided across the country.

2. OVERVIEW OF THE HEALTH SYSTEM IN INDIA

The health sector in India is characterized by: (i) a government sector that provides publicly financed and managed curative and preventive health services from primary to tertiary level, throughout the country and free of cost to the consumer (these account for about 18% of the overall health spending and 0.9% of the GDP), and (ii) a fee-levying private sector that plays a dominant role in the provision of individual curative care through ambulatory services and accounts for about 82% of the overall health expenditure and 4.2% of the GDP. Nationwide health care utilization rates show that private health services are directed mainly at providing primary health care and financed from private resources, which could place a disproportionate burden on the poor (Baru, 2005).

The Ministry of Health and Family Welfare (MHFW) oversees the national health system. The MHFW has three departments – the Department of Health and Literacy, the Department of Family Welfare, and the Department of Indian Systems of Medicine and Homoeopathy.

The delivery of primary health care in India is structured through i) Sub-centers that typically perform basic medical services, immunizations, and referrals, ii) Primary Health Centers (PHCs) which provide preventive and curative medical services, and iii) Community Health Centers (CHCs) that make available advanced medical services, including surgery (MoHFW, 2002).

The outcomes from meetings of the Central Council for Health and Family Welfare have provided a thrust to various sub sectors within the health sector (Banerji, 1985.). The private and voluntary sectors have emerged as an important arm of the health sector. From 1 April 1996 a change has been effected in the family welfare services with targets for contraceptive methods being replaced by a target-free approach.

A huge campaign to eradicate poliomyelitis through pulse polio immunization (PPI) was initiated in 1995. The traditional system of medicine is now playing a more significant role due to escalating costs of health care (Rohde & Viswanathan, 1994.). State health systems/projects have been formulated to improve efficiency in the allocation and use of health resources through policy and institutional development. Specific efforts have been made to consolidate and strengthen the PHC infrastructure, under the minimum needs programme, by providing enhanced assistance to regions with severe health problems, supporting voluntary organizations, improving IEC activities, etc. The convergence of services to provide a holistic approach to population control has also been promoted. In March 1995 a separate Department of Indian System of Medicine and Homeopathy (ISM & H) was created within the Ministry of Health and Family Welfare.

The Government of India has stated its commitment to improve the nation's health system through various policy documents such as the National Health Policy (1983 and 2002). Many policy objectives are consistent with the Millennium Development Goals (MDGs). However, many goals remain unfulfilled for a number of reasons, including planning-related issues and human resource scarcity in health service delivery (Gwatkin, Bhuiya & Victora, 2004).

3. HEALTH RESOURCES IN INDIA

The following are the key health resources available within the country to cater to the health needs of the people:

i) Human Resources

In the recent past, the number of medical colleges has increased significantly. The National Institute of Health and Family Welfare (NIHFW) is involved in providing in-service training for all categories of health and family welfare personnel (Rao et al, 2011). The main constraints faced with regard to human resources are the shortage of funds, particularly for government institutions imparting medical education, and the problem of deployment of medical personnel to rural areas due to inadequate facilities to meet personal and professional needs (CBHI, 2008).

ii) Financial Resources

As health is primarily a state subject, earmarked outlays are provided to state governments under the Minimum Needs Programme (MNP) with the explicit stipulation that these funds cannot be diverted elsewhere, and in case of diversion the central plan assistance to state governments will stand proportionately reduced. The family welfare/family-planning programme has been a 100% centrally sponsored scheme from its inception.

The financial outlay has been increasing over the successive five-year plan periods. However, financial resources have continued to be a major constraint to developing the primary and secondary levels of health care which are mainly pro-

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vided by the government (Bhat, 1996.). Dependence solely on government resources has been another constraint.

iii) Physical Infrastructure
Since early 1990s, the emphasis has been towards consolidation and operationalization, rather than on major expansion of the infrastructure. For this purpose, the following targets have been set:

(a) One subcentre staffed by a trained female health worker and a male health worker for a population of 5000 in the plains and a population of 3000 in hilly and tribal areas. As of 1998, 137,006 subcentres had been established.

(b) One primary health center (PHC) staffed by a medical officer and other paramedical staff for a population of 30,000 in the plains and a population of 20,000 in hilly, tribal and backward areas. A PHC center supervises six subcentres. As of 1998, 23,179 PHCs had been established.

(c) One community health center (CHC) or an upgraded PHC with 30 beds and basic specialities covering a population of 80,000 to 120,000. The CHC acts as a referral center for four PHCs. Up to 1998, 2913 CHCs had been established.

Urban family welfare centres (FWCs) have been set up to provide family welfare/family planning services. The status of the infrastructure to deliver primary health care appears to be satisfactory but actual programme implementation needs a lot of improvement. A substantial part of the physical infrastructure has still to be completed. A major factor has been that approved estimates/norms for construction have not kept abreast with the rising estimates of actual construction costs.

iv). Essential Drugs and Other Supplies
The government, in consultation with the states and relevant agencies, has developed a national essential drugs list comprising over 300 drugs classified for use at the different levels of health care. This list serves as a guide to procuring agencies in central and state governments. The drugs available in India as compared to those in other countries are considered cost effective and there is a price control on 78 essential drugs. However, budgetary constraint is the major obstacle in he way of essential drug availability in the public sector (Peters et al, 2002).

v) Health Research and Technology
India has a long history of biomedical research including health systems research. In several instances research results have directly influenced programme policies or led to modifications in programme strategies. Among the many research institutions, the Indian Council of Medical Research (ICMR), established in 1911, is the lead agency. In the 8th FYP (1992-1997), ICMR attempted to consolidate significant leads in priority or "thrust" areas that were identified by various scientific expert groups. These areas included emerging health problems like HIV/AIDS, other important communicable diseases like tuberculosis, leprosy, diarrhoeal diseases, malaria, filariasis, Japanese encephalitis, etc., non-communicable diseases like cancer, cardiovascular diseases, metabolic disorders, etc., contraception, MCH and nutrition (Mahal, Yazbeck, Peters & Ramana, 2001).

vi) Health Information System
In pursuance of the national health policy for the establishment of an efficient and effective management information system, a computer-compatible health management information system (HMIS version 2.0) has been designed in collaboration with participating states, the national information center (NIC) and WHO. The system is being implemented in phases. The first phase, involving 13 states/union territories (UTs) commenced in 1992-93 and is at present operational in two states with others in the process of implementation. In addition, each of the disease control programmes has its independent MIS, e.g. the National Programme for Control of Blindness, the National Leprosy Eradication Programme, the AIDS programme, tuberculosis control programme, etc.

vii) Intersectoral Cooperation
There has been promotion of active inter sectorial cooperation in order to meet current needs and emerging challenges of the health sector (Das, Shukla, Somanathan, & Datta, 2009). A number of working groups were constituted in 1996 to comprehensively review the existing health situation in its totality. The following areas are included: communicable diseases, health systems and biomedical research development, ISM & H, child development, environmental health, health education and IEC, women's development, and requirements for supportive and diagnostic services in primary, secondary and tertiary care.

Consultations have also been held with NGOs. Two other committees have been constituted, namely an expert committee to comprehensively review the public health system in the country and the National Mission on Environmental Health and Sanitation.

viii) International Partnerships in Health
Various international organizations and UN agencies have continued to provide significant technical and material assistance which has had a positive impact. The various agencies include WHO, World Bank, UNICEF, UNFPA, USAID, Japanese Assistance, ODA (UK), SIDA, NORAD, DANIDA and German assistance. A National Institute of biologically has been set up as an autonomous organization, with funding from the Government of India, the Japanese and USAID.

4. CONCLUSION.
While the health sector has made significant progress in the years since the country's independence, India still faces significant challenges. The major challenges in the delivery of health services in India is the inadequate physical infrastructure, ineffective management, limited availability, and lack of qualified health care professionals. Thus, the Indian healthcare sector can be viewed as a glass half empty or a glass half full. The challenges the sector faces are substantial, from the need to improve physical infrastructure to the necessity of providing health insurance and ensuring the availability of trained medical personnel. But the opportunities are equally compelling, from developing new infrastructure and providing medical equipment to delivering telemedicine solutions and conducting cost-effective clinical trials. For companies that view the Indian healthcare sector as a glass half full, the potential is enormous.

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REFERENCE

1. Banerji, D.1985. Health and family planning services in India: An epidemiological, socio-cultural and political analysis and a perspective. New Delhi: Lok Paksh. | 2. Baru, RV. 2005. "Private health sector in India – raising inequities". In: Gangolli LV, Duggal R, Shukla A, eds. Review of healthcare in India. Mumbai: Centre for Enquiry into Health and Allied Themes. | 3. Bhat, R. 1996. "Regulating the private health care sector: the case of the Indian Consumer Protection Act". Health Policy Plan; 11: 265–79. | 4. CBHI. 2008. Health Infrastructure, national health profile (NHP) of India–2008. New Delhi: Central Bureau Of Health Intelligence, Government of India. | 5. Chanda. 2011. Globalization and Health, 7:1 http://www.globalizationandhealth.com/content/7/1/1 (accessed on Oct 11, 2011). | 6. Das Gupta M, Rani M. 2004. India's public health system: how well does it function at the national level? Washington, DC: World Bank. | 7. Das Gupta M, Shukla R, Somanathan TV, Datta KK. 2009. How might India's public health systems be strengthened? Washington DC: World Bank. | 8. Economic and Social Commission for Asia and the Pacific. 2007. Medical Travel in Asia and the Pacific: Challenges and Opportunities. Bangkok. [http://www.unescap.org/ESID/hds/lastestadd/MedicalTourismReport09.pdf]. (Accessed on Oct 15, 2011). | 9. Gopalan. 2008. "India Emerging as International Medical Tourism Hub": Health Watch. [http://www.medindia.net/news/healthwatch/India-Emergingas-International-Medical Tourism-Hub-42144-1.htm]. (Accessed on Oct 15, 2011). | 10. Gupta I, Dasgupta P. 2000. "Demand for curative health care in rural India: choosing between private, public and no care". Inst Econ Growth; 14: 1–35. | 11. Gwatkin DR, Bhuiya A, Victora CG. 2004. "Making health systems more equitable". Lancet; 364: 1273–80. | 12. Lavy V, Germain JM, World Bank. 1994. Quality and cost in health care choice in developing countries. Washington, DC: World Bank. | 13. Mahal A, Yazbeck A, Peters D, Ramana G. 2001. The poor and health service use in India. Washington, DC: World Bank. | 14. MoHFW. 2009. National Health Accounts–India (2004–05)–with provisional estimates from 2005-06 to 2008-09). National Health Accounts Cell. New Delhi: Ministry of Health and Family Welfare, Government of India. | 15. MoHFW. 2002. National health policy. Delhi: Ministry of Health and Family Welfare, Government of India. | 16. Peters DH, Muraleedharan VR. 2008. "Regulating India's health services: To what end? What future?" Soc Sci Med; 66: 2133–44. | 17. Peters DH, Yazbeck AS, Sharma RR, Ramana GNV, Pritchett LH, Wagstaff A. 2002. A better health system for India's poor: findings, analysis, and options. Washington DC: World Bank. |