Research Paper
Impact Factor: 5.483
Peer Reviewed & Indexed Journal
www.ijmsrr.com

IJMSRR
E- ISSN - 2349-6746
ISSN -2349-6738

THE HEALTH CARE SYSTEM IN INDIA

Dr. I.S.Kishore Mathew Arnold
Academic Consultant,Department of Political Science and Public Administration
S.V.University, Tirupati.

Abstract
The Indian Constitution states that health is a state matter and that the state government, with the support of regional health organisations, is responsible for providing health services to all citizens. By using the services provided by the medical, nursing, and allied health professions, health care is defined as the avoidance, management, and treatment of disease as well as the maintenance of one's physical and emotional well-being. All products and services intended to advance health are included in health care, according to the World Health Organisation, and include "preventive, curative, and palliative interventions, whether directed to individuals or to populations." One such definition of a health care system is the systematic delivery of such services. An attempt is made to examine the Indian healthcare system in this research.

Key Words: Health Care, Public Sector, Private Sector, Health Policy.

Introduction

In India, the government establishes and upholds health standards, offers services for both prevention and treatment, and builds the necessary infrastructure for the provision of medical and health care. Any health institution in the nation may be established with authorization from Parliament under the Indian Medical Central Council Act (1970), which came into effect. The five main areas that make up India's health care system differ from one another in terms of the medical technology used and the funding sources for those sectors.. These are:

1) Public health care Sector: Public health care includes: (a) Primary Health Care such as - Primary Health Centers (PHC), Sub-centers, (b) Hospitals/Health Centers compressed by Community Health Centers (CHC), Rural Hospitals, District Hospitals/Health Centers, Specialist Hospitals, Teaching Hospitals, (c) Health Insurance Schemes like employee State Insurance, Central Government Health Scheme, and (d) Primary Health Care of defiance Services and Railways.

2) Private Sector: Corporate Hospitals, polyclinics, nursing homes, dispensaries, general practitioners and clinics are major contributors in private sector.

3) Indigenous System of Medicine: Ayurveda and Siddha, Unani, Tibbi, Homeopathy and unregistered practitioners are includes in indigenous system of medicine.

4) Voluntary Health agencies: Other than government health agencies in nearly every community there are non-governmental or voluntary agencies that supplement the work of the health department. Health services in India had their beginning with voluntary groups only (Missionaries from abroad who came and established services for women, children etc). Voluntary health agencies have their own administrative body or committee which raises fund through its membership or through private sources.

5) National Health programs: Separate Health Structures with strong central management dedicated to the planning, management and implementation of selected interventions.

Health Policy in India

In India, a systematic public health administration was introduced under the British rule. The British rulers appointed several committees and enacted a number of Acts in order to develop the health

system. After independence the era of scientific planning in India started with the establishment of Planning Commission in 1950. Since then, the Government of India has been giving priority to health matters and several steps have been taken through Five Year Plans. Health policy in India is formulated in each of the Five Year Plan.

First Five Year Plan (1951-56): The social, economic, and educational facets of a community are all closely related to its overall health. Prioritizing adequate housing and a reliable water supply, the First Five Year Plan also led to a rise in the nation's hospital and dispensary count.

Second Five Year Plan (1956-61): Plans were created for the training of more nurses, midwives, chemists, sanitary inspectors and other technicians in major hospitals and medical colleges under the Second Five Year Plan.

Third Five Year Plan (1961-66): The Third Five Year Plan's overarching goal was to increase access to family planning and health services in order to gradually improve people's health by guaranteeing a minimum level of physical well-being and fostering environments that encourage increased productivity and efficiency.

Fourth Five Year Plan (1969-74): The plan placed the utmost importance on family planning. It sought to promote both individual understanding of family planning techniques and group acceptance of modest families. Efforts were made to stop contagious illnesses like smallpox and malaria throughout this plan. Across the nation, leprosy control units were established by it.

Fifth Five Year Plan (1974-79): The Fifth Five Year Plan's main goals were to improve health personnel's education and training standards and make self-service more accessible in rural areas.

Sixth Five Year Plan (1980-85): During this Plan, priority was given to health infrastructure, incomplete buildings and some new buildings were constructed for family planning centers. Primary Health Centers (PHCs) were upgraded as 30-beded hospitals. Medical college admission had also been increased.

Seventh Five Year Plan (1985-90): In the Seventh Plan, priority was assigned to medical educational facilities, training of paramedical, to meet the requirements of community health services.

Eighth Five Year Plan (1992-97): This Plan gave importance to human development and committed to attain "Health for all by 2000". It initiated major efforts to expand health and educational facilities.

Ninth Five Year Plan (1997-2002): The approach during this Plan was to enhance the quality of primary health and promotion of human resource for health. To enable Panchayat Raj Institutions (PRIs) to Plan, monitor and improve the work environment in industrial and agricultural sectors.[2]

Tenth Five Year Plan (2002-2007): This plan's objective was to develop and put into effect a wide range of comprehensive standards for the provision of services, including minimal standards for staff qualifications and prerequisites for performing specialty interventions. a set of accepted practises for quality control; encouragement of the prudent use of medications and diagnostics; development, implementation, and oversight of open standards for the cost and quality of care in various healthcare settings.

Investigating alternate health care finance models, such as health insurance, to ensure that everyone has access to basic, need-based, and reasonably priced healthcare; enhancing the quality and content of pre-medical and health professional education. in order for all medical professionals to get the knowledge, mindset, and abilities required to properly address patients' health issues and enhance their overall state of health. Developing an accurate Health Management Information System (HMIS) using currently accessible Information Technology (IT) tools is one of the plan's other objectives. This communication link will transmit information on births, deaths, and diseases as well as requests for medication, diagnostics, equipment, and the status of ongoing programmers via service channels.

Additionally, it will support decentralised district-based planning, execution, and oversight; it will also strengthen and maintain civil registration and the sample registration system while establishing an efficient system. Enhancing the effectiveness of the current healthcare system in the public, private, and nonprofit sectors; creating the necessary connections between them; and mainstreaming practitioners of the Indigenous System of Medicine (ISM) so that, in addition to providing their own care, they can contribute to expanding the reach of the Family Welfare Programme and the National Disease Control Programmes; raising the participation of nonprofit and private organisations. Self-help groups and social marketing organisations can enhance health care accessibility, enhance intersectoral coordination, and transfer finances and duties to Panchayati Raj organisations.[3]

Eleventh Five Year Plan (2007-2012): This plan's goals are to evaluate methods for calculating maternal and pediatric mortality and morbidity as well as to examine how well the family welfare system is operating. Manpower in both rural and urban regions, as well as proposing strategies for infrastructure restructuring, rationalisation, the creation of an efficient health system, a thorough assessment of the state of health at the moment, and the creation of pertinent policy actions. regulations and standards-setting for gauging the public and private sectors' performance in the health sector, guidelines released to assist the states, and the formation of partnerships with non-governmental entities. Creating a framework for efficient interventions through, decentralisation and capacity building, including the transfer of funding and programmes to the states, where the central government would still have a role to play. The main focuses of the Central Government's interventions will be disease surveillance, monitoring, and evaluation; effective performance monitoring; support for capacity development at all levels; sharing of best national and international practises; and increased financial resources to drive reforms and accountability.[4.]

Twelth Five Year Plan (2012-2017): Priorities in 12th Plan Document Financing: Funding as an instrument of incentive and reform National Health Mission with universal coverage and greater flexibility to States Public Health Cadre for decentralized planning, program management, Behaviour Change Communication, community participation, quality control, HIS, regulation, convergence of social determinants of health. Access to Essential Medicines in All Public Facilities: Operationalize CPA Human Resource strengthening Building effective Health Information Systems Health Systems Strengthening Health Division.

Union Ministry Of Health And Family Welfare

The Union Ministry of Health and Family Welfare is the apex executive organisation dealing with issues of health and family welfare in India. It lays the national health policy in accordance with the policy decisions of the Cabinet. "Health" is the state subject in India, so the Union Ministry of Health and Family Welfare acts as a co-coordinator between the state health departments, Planning Commission, Central Council of Health etc., besides implementing various national programmes and

items under Union list and Concurrent list. In the process, it is aided by the Directorate General of Health Services. Health administration at the apex level of the Government of India consists of Secretary for Health, Secretary for Family Welfare supported by additional and joint secretaries who are recruited from the Indian Civil Service. The rest of the organisation is mostly program/project based. Ad-hoc project structures such as TB project and Malaria project etc., Since State Governments implement the projects and deliver the regular health services they have fairly well demarcated systems. Separate directorates or head offices usually exist at state capital for primary, secondary and tertiary health care, which includes medical colleges and medical education. Many states have separate structure for family welfare operations, since population control through family planning is given great importance. At district level, health administration consists of a number of officers and doctors who on average handle 10 to 15 hospitals, 30 to 60 primary health centers and 300 to 400 sub centers.

This entire complex arrangement results in a number of vertical channels of information, multiplicity of agencies and dual reporting systems etc.[5]

The Health Insurance Schemes

Improvement in health status is vital for the enhancement of human capabilities. Illness is an important source of deterioration to human health. Of all the risks facing poor households' health risks pose the greatest threat to their lives and livelihoods. A health shock adds health expenditures to the burden of the poor. Even a minor health shock can cause a major impact on poor persons' ability to work and curtail their earning capacity. Moreover, given the strong link between health and income at low income levels a health shock usually affects the poor the most.[6] Non-availability of necessary finances is a major obstacle in the health care attainments of people in many developing countries including India. With the continuing resource constraints of the government and competing sectoral demands the allocation needed in the health sector may not increase to adequate level in the near future. Nonetheless, the present trend of cut in government subsidies as a part of the 'new economic reforms' is likely to put more pressure on this sector.

Taxonomy of Health Insurance in India

The health insurance situation in India can be understood under the following headings:

Public/Social Health Insurance Schemes

The most prominent among the protective schemes are the Employees' State Insurance Scheme (ESIS) for workers in the organised private industrial sector and the Central Government Health Scheme (CGHS) for its employees. The beneficiaries of the above schemes are the salaried class who belongs to formal sectors. Some "Employer- managed health facilities" and the "reimbursements of health facilities" are also available in India which is limited to only a few. The Union budget proposed introduction of a universal health insurance (UHI) plan for people below the poverty line in tie-up with Insurance companies.

Micro-Health Insurance (MHl) Schemes

MHI schemes are based on not-for-profit principle and targeted to the underprivileged sections of the society. In India, currently there are more than 20 MHI units and many organisations are coming ahead with various proposals to introduce health insurance for getting inspiration from the successful stories of the existing MHI units.

Private Health Insurance (PHI) Schemes

The Private Health Insurance (PHI) schemes, often called Private Voluntary Health Insurance schemes (PVHI), are the schemes offered by insurance companies in the open market in which enrolment into the scheme is not determined by legislation. In India, the public and private sector companies provide the PHI (voluntary). The General Insurance Corporation (GIC), which comprises of four insurance companies namely NIC, NIAC, OIC and UIC, is the largest public sector organisation of providing the PHI in India. The various policies introduced by the GICs are Mediclaim Policy (group and individual), Jan Arogya Bima, Personal Accident Policy, Nagarik Suraksha Policy and Overseas Mediclaim Policies (employment and study corporate frequent travel/business and holiday).

Among these policies, the Mediclaim policy is relatively popular. After the establishment of Insurance Regulatory and Development Authority (IRDA), many private corporate also have entered the Health Insurance market. The Bajaj Allianz, Royal Sundaram, Cholamandalam, Tata and Reliance are the prominent private insurance companies. An important peculiarity of these corporations is the tie-up with some health care provider having super specialty facilities.

The Life Insurance Corporation (LIC) of India introduced a special insurance programme called 'Ashadeep' which covers medical expenses for four dreaded diseases namely: Cancer (malignant), Paralytic stroke resulting in permanent disability, Renal failure of both kidneys or Coronary artery diseases where by-pass surgery has been done, another policy by the LIC, called Jeevan Asha Plan, covers many surgical procedures. But these policies are a kind of savings schemes and the premium is almost equal or more than the insurance amount in short, do not follow the principle of insurance (risk pooling) in strict sense of the term.

Health Insurance Schemes and their Target Population

As mentioned earlier, that there are around 20 MHI schemes operating in some specific regions of India including both rural semi- urban and urban locations. Similarly, around 11 General Insurance Companies comprising of both the public and private sectors offer different Health Insurance (HI) schemes through their branches which is operational allover India. The figure below shows the target population of both PHI and the selected MHI schemes. The most of the MHI schemes aim at low-income population especially farmers and woman members of Self-Help Groups (SHGs). But both public are offering that the PHI schemes and private sectors do not put any restriction on their target population. In other words, his or her policies are open to everybody who has the ability to pay the premium.

The role and relevance of social health insurance based intervention has come to occupy central stage in recent years in several countries that are undertaking measures to reform health systems. Health insurance as a tool to finance health care has very recently gained popularity in India. While health insurance has a long history, the upsurge in breadth of coverage can be explained by a serious effort by the Government to introduce health insurance for the poor during recent years.

This marks a major milestone in the financing of health care in the country. There is, however, considerable variation across states in coverage. Whether insurance is offered through employment, purchased voluntarily or sponsored by the government for select populations, all potentially contribute towards the health systems goal of providing financial risk protection and reducing the

financial barriers to quality health care. By pooling funds, insurance offers the opportunity to spread costs across different stakeholders.

Provision of Health Care

All the insurance schemes currently operating in India offer beneficiaries the option of seeking hospital care with either private or public sector providers. This is significant because it enables patients to take advantage of both sectors for affordable care. In particular, this is beneficial to patients in areas where the public sector is overburdened or weak and there is a credible private sector presence. Insurance schemes have little value if a strong provider network does not exist. In rural areas there are few qualified private providers and the condition of public health facilities is generally not up to the mark. Health insurance schemes may not necessarily change this situation, though they are likely to have a different effect in areas (e.g. urban) where qualified human resources are easily available.

Conclusion

The contemporary state of Indian health paints a different picture. Even if private healthcare and health tourism are being promoted, a sizable portion of the Indian population continues to be at risk for treatable illnesses that legislators are failing to give enough consideration to. Unquestionably, the National Rural Health Mission in India is an initiative that prioritises public health care. Much work still has to be done, even though the government has been trying to raise healthcare spending through programmes like the National Rural Health Mission. The development of efficient and long-lasting health systems that can satisfy the demands of an increasing number of non-communicable diseases as well as the general public for higher-quality, more comprehensive healthcare will take precedence.

References

1. Park, K. (2002), "Textbook of Preventive and Social Medicine", Jabalpur Publishers, Banaras, p.662.
2. Goel S.L and Kumar, R. (2004), "Hospital Core Services – Hospital Administration in 21st Century", Deep & Deep Publications, New Delhi, pp.48- 49.
3. Planning Commission of India, Document of 10th Five Year Plan, 2002- 2007.
4. Government of India, Health and Family Welfare Report, 2007.
5. Pramod K Singh (2007), "GIS for Governance of Health Services and Infra structure in Rural India", GIS development.net, accessed on 7th September 2007.
6. Dror, O.M, Radermacher, R. and Koren, R. (2007), "Willingness to pay for health Insurance among rural and poor persons: Field evidence from Seven Micro Health Insurance Units in India", Health Policy, Vol. 82, Issue 1, p.14.