Research Paper *IJMSRR*
*Impact Factor :**3.029*** *E- ISSN - 2349-6746*
ISSN -2349-6738

GROWTH PROSPECTS OF INDIAN HEALTH CARE SYSTEM AND MANAGEMENT: A MACRO VIEW

Dr. B. Yasodha Jagadeeswari
Assistant Professor, PG & Research Department of Economics, Holy Cross College (Autonomous), Tiruchirappalli, India.

Abstract
The paper seeks to show that health and socio-economic developments are so closely intertwined that is impossible to achieve one without the other. This paper sees those building health systems that are responsive to community needs, particularly for the poor, requires politically difficult and administratively demanding choices. Health is a priority goal in its own right, as well as a central input into economic development and poverty reduction. This paper finds that, while the economic development in India has been gaining momentum over the last decade, the health system is at a crossroads today. Even though Government initiatives in public health have recorded some noteworthy successes over time, the Indian health system is ranked 118 among 191 WHO member countries on overall health performance. This working paper describes the status of the health system, discusses critical areas of management concerns, suggests a few health sector reform measures, and concludes by identifying the roles and responsibilities of various stakeholders for building health systems that are responsive to the community needs, particularly for the poor.

Key words: Health care, Health Insurance, Awareness, Rural, Government Sponsored Health Insurance Schemes, Health Care Management.

INTRODUCTION

The health of the people in the Country is an essential component of development, vital to the economic growth and internal stability of the Nation.The healthier the population, the more will be the Index Value. Loss of health is most often irreversible and the potential loss of output for the individual cannot be compensated. Considerable achievements have been made over the last six decades to improve health standards such as Life Expectancy, Child Mortality, Infant Mortality and Maternal Mortality. The strong link between poverty and ill health needs to be recognized. Ill health and morbidity create immense stress even among those who are financially secured. High health care costs can lead to impoverisation or exacerbation of poverty. The importance of public provisioning of quality health care at affordable costs and provision of reliable health services cannot be underestimated. Health makes education possible and vice versa. Education of women delays age at marriage improves knowledge of contraceptives and enhances their status in society.

India's healthcare system is in need of reform (Reddy, Patel et al 2011). Child and maternal mortality is high (Paul, Sachdev et al 2011), and deaths from chronic diseases are increasing (Patel, Chatterji et al 2011). There is enormous inequity in the distribution of ill health across geographical, caste, wealth, gender and educational strata (Balarajan, Selvaraj et al 2011). A large proportion of the population are afforded little financial protection against healthcare costs, such that the poor are either unable to access quality healthcare or when they do so they are impoverished (Balarajan, Selvaraj et al 2011). The demand for hi-tech, hospital-based medical care stands in stark contrast to widely perceived defi ciencies in the provision of basic healthcare (Hammer, Aiyar et al 2007). To address these problems the Indian government in recent years has taken bold steps to promote universal healthcare.

BACKGROUND OF THE STUDY

The distinction between healthcare and healthcare cost is an important area of concern (Cutler, 2009). Debates on increasing the out-off pocket expenditure of health cornered on the thinking of 'sharing of risk or how risk can be spread'. A steadily increasing the health expenditure has widened the scope of emerging different health schemes to share its burden. Various strategies of having quality health care with affordable health insurance (Gengler, 2010) may be a difficult composition. There is a need for expanding and regulating health insurance sector (Harrington, 2010).

Per-capita expenditure on healthcare has been reduced drastically over a period of time. It is also visible that there is a wide income disparity in money spends for various health insurance schemes (Burtless, 2010). Health insurance schemes facilitate direct negotiations between providers over the price and quality of healthcare. Market share of health insurance has a symmetrical progression in recent years (Terhune, 2009). However these progressions are mainly to cater the needs of 'affordable' ones than the opposite. The public attention of many of such schemes is not very attractive as a high premium and low coverage. According to Connelly (2010) such public insurance schemes cannot be a success without proper government interventions.

Health insurance schemes of government to a large extent overcome the disparity of coverage of the population. Such schemes generally targeted at low-income population. Willingness to pay for the micro health insurance schemes by the poor people has been gradually increasing (Mark, 2007). Social movement of such schemes must ensure community participation, autonomy and accountability (Atim, 1999). Mandatory coverage of health insurance for the poor by the state has got funding problems (Lincoln, 2009). The prevalence of the consumer-driven approach to health care will drastically increase in the years ahead (Munn, 2010).

OBJECTIVES OF THE STUDY

- Main objective of this study is to find out the improvement level of the Indian health care system.
- Secondary objective is to find out the success level of the Indian health care management.

METHODOLOGY

Research Design

- This paper is based on secondary data, primarily through literature, study of journals, articles and textual analysis. Overall this exploratory research tries to explore the existing condition of the health care management in India. Qualitative research approaches and procedures have been applied to explore pertinent information for this study.

UNIVERSAL HEALTH COVERAGE

Universal Health Coverage (UHC), as a concept, is about people having access to needed health care without suffering financial hardship, thus, encompassing improvements in access, quality and financial protection. This scheme focuses on effective health care delivery to the rural population with a fixed mission and a holistic approach. UHC aims to achieve better health and development outcomes, prevent people from being impoverished due to health-related causes and give people the opportunity to lead healthier, more productive lives. UHC has also featured prominently in discussions around the post-MDG agenda as a possible goal for the post- 2015 global development agenda. In recent years, a large number of countries around the world have stepped up their activities aimed at achieving Universal Health Coverage for their people. In India too, UHC is now clearly on the policy agenda and there is increasing willingness of central as well as state governments to increase their outlays for the health sector. However, within this overall commitment to increase public health spending, there are difficult decisions to be taken on allocating new resources between personal health care, catastrophic care and population-based public health interventions, when all of these are inadequately financed at present.

There has been a general concern for disparity across rural and urban areas particularly pertaining to human development. This is despite the persistent policies of investing more in rural health infrastructure and an orientation of health policies which remain rural focused in India. It is pertinent to explore the issue that why this outcome of adverse indicators of human development for rural areas has emerged as a prominent outcome of planned effort and to suggest remedy for this disparity. The objective of this paper is to analyse this disparity in terms of human development and health outcomes across major Indian states with a view to suggest suitable policy modifications to overcome the disparity between rural and urban areas in regard to these aspects. Unlike other studies our focus is to link the health and human development aspects using information from household level surveys. Instead of analyzing state level differentials alone the study contributes in understanding the causes of this disparity between rural and urban areas both in poorer and richer states of India and suggests policy imperatives to overcome this outcome.

INDIA'S HEALTH FINANCING CONTEXT

India has long been a low spender on health care, and allocated approximately 4.1 per cent of GDP or US$40 per capita in 2008-09 to the health sector. In terms of India's share in global health expenditure, the country with over 17 per cent of the world's population manages with less than 1 per cent of the world's total health expenditure. The share of health spending has also not kept pace with the country's dynamic economic growth (India's total health spending accounted for a much higher 4.8 per cent of GDP in 2001-02 and has reduced its share since then). Public spending on health as a per cent of GDP has varied little over the last two decades, hovering at about 1 per cent (Figure 1). In 2005, government (central, state and local) was the source of about one-fifth of spending while out-of-pocket payments represent about 70 per cent – one of the highest percentages in the world. Though, no official estimates are available for recent years, WHO estimates put the share of government expenditure at 30 per cent and that of out-of-pocket payments at about 60 per cent for 2011, a significant improvement over 2005 but still very high for the country's level of socio-economic development.

RURAL INDIA HEALTH SCENARIO

Majority of rural India people lives below poverty line and they are not capable of affording the expenses on medical needs. Health insurance is a tough task for these people. The condition of illness not only deprived them from earning but also pushes them into deep debt. The overall expenditure on health in India is 4.1% of GDP in which the government contribution is only 1%. With a low spending on health from government in thickly populated country like India force people to move towards the costly, unaffordable private sector. Today, India has most privatized health system in the world with 72% of health expenditure made in private sector that presently treats 78% of outpatients and 60% of inpatients. If we talk about insurance than it has been estimated that only 15% of total Indian population is covered under it. To cope with the high charging medical needs a high number of people coming below the poverty line as they cannot meet the expenses made for medical needs.

Health insurance can play a crucial role in preventing people from burden of debts. Insurance can provide them support at the time of emergency and needs. Indian government has introduced many health insurance schemes for rural people during past years with affordable prices so that they can be covered by insurance without much burden on them. Insuring people can also leads to a better health access. Along with the government policies, several non-government organizations (NGO) also introduce many schemes for the people living below the poverty line.

RECENT HEALTH CARE PROGRAMS IN INDIA

The bottom- u p design for of health coverage, starting with coverage of the rural and the poorest segments of the population first, and the rapid scale up of population coverage in a short period of time, are unique facets of India's recent strides towards universal health coverage. Two prominent national programs in this respect have been the National Rural Health Mission (NRHM) of the Ministry of Health and Family Welfare (now rechristened as National Health Mission and being further expanded in urban areas) and the Rashtriya Swasthya BimaYojana (RSBY) of the Ministry of Labour and Employment. In addition, several state programs such as the Rajiv Aarogyasri scheme launched by the state government of Andhra Pradesh and similar programs such as the Vajpayee Arogyashri Scheme (Karnataka), Chief Minister's Comprehensive Health Insurance Scheme (Tamil Nadu), Comprehensive Health Insurance Scheme (Kerala), Rajeev Jeevandayee (Maharashtra), Mukhyamantri Amritam (Gujarat), Megha Health Insurance scheme (Meghalaya) , Mukhya Mantri Swasthya BimaYojana (Chhatisgarh), and RSBY Plus (Himachal Pradesh) are examples of state-government led efforts to expand access to tertiary, surgical care for their poor and vulnerable population groups.

All these programs were designed and implemented by di fferent institutions almost in parallel, over a similar time period in the last 7-8 years and used different financing and delivery approaches. However, there are several commonalities- they all aim at extending health coverage and improved financial protection to the poor and other vulnerable groups in the country, are fully subsidized by the government and to the extent of their benefits packages, they are 'cashless' for their beneficiaries, not requiring any contributions, upfront payments to providers or bearing a share of the costs of treatment.

Introduced in 2005, NRHM is the flagship initiative of the Ministry of Health and Family Welfare (MOHFW), Government of India, aimed at expanding health coverage in the country. In a context where the country's constitution lays out health as being a subject for state governments, NRHM supplements and strengthens the state-owned public health systems by providing additional resources with a focus on rural areas, primary care and public health programs. NRHM also leverages this financial support to facilitate the creation of institutional mechanisms that enable some degree of financial autonomy and a faster flow of funds.NRHM has led to several service delivery innovations and to significant, though still inadequate, increases in central government investments in health, especially for public health interventions and primary care. In addition to significantly increased financing, the flexibility around hiring contractual staff, supply chain reforms, introduction of a cadre of grassroots workers paid entirely based on performance, innovative financial flow mechanisms and an overall increased emphasis on public health expenditure, distinguish NRHM from the situation prior to its existence. The NRHM beneficiaries, in theory, can include anyone walking into a public health facility, regardless of income, geography, or other factors. The country's rural population of 833 million (Census 2011) in general, and of these, the 490 million residing in 'high focus' states for NRHM in particular, are the target beneficiaries for the program.To illustrate the scale of the intervention, one of the largest components in NRHM is the Janani Suraksha Yojana, which offers a conditional cash transfer to poor women for availing free institutional maternity services created under NRHM, and is currently utilized by over 10 million women each year. Over 22 million financing, the flexibility around hiring contractual staff, supply chain reforms, introduction of a cadre of grassroots workers paid entirely based on performance, innovative financial flow mechanisms and an overall increased emphasis on public health expenditure, distinguish NRHM from the situation prior to its existence. The

NRHM beneficiaries, in theory, can include anyone walking into a public health facility, regardless of income, geography, or other factors. The country's rural population of 833 million (Census 2011) in general, and of these, the 490 million residing in 'high focus' states for NRHM in particular, are the target beneficiaries for the program.To illustrate the scale of the intervention, one of the largest components in NRHM is the Janani Suraksha Yojana, which offers a conditional cash transfer to poor women for availing free institutional maternity services created under NRHM, and is currently utilized by over 10 million women each year. Over 22 million per cent of the population, had access to some form of health insurance in 2010. Table 1 depicts the number of beneficiaries covered by different insurance schemes in the country, in three time zones, 2003-04, 2009-10 and projections for 2015.

In the light of current trends, and assuming continued political and financial support from the government, insurance coverage is expected (perhaps conservatively) to reach more than 630 million persons, 50 per cent of the population by 2015.

HEALTHCARE MANAGEMENT SYSTEM (HMS)

Healthcare Management System (HMS) need to promote improved customer services, greater collaborations within Health System, more innovations in HMS designs, judicious use of IT, reengineering of the conventional processes, greater emphasis on total quality management, improved flexibility to respond quickly to changing needs of the patients etc. This means innovation of alternative HMS configurations and their performance evaluation so that senior management can make best decisions. For meeting these challenges, simulation models can offer animation of alternative HMS configurations that are derived from the knowledge of other domains of work. The best practices from alternative domains can be thus adapted for the HMS domain. Since the HMS domain has its own characteristics and constraints, it is important to incorporate these into the simulation models. Most health administrators and health system leaders need to visualize the derived models to get convinced that they will be useful to the health systems. For instance it is important to show how one configuration offers more flexibility and better quality of service than the other configuration. The experts need to visualize a dynamic system that is complex and offers the desired flexibility. In this context animated simulation models can play an important role. It is the widely accepted solution through which number of scenarios and solutions can be developed. The number of solutions can be used to analyze "what if" scenarios. The opportunities and insights afforded by simulation software in meeting such challenges have not been adequately utilized for discussions with the healthcare system owners and administrators in India. Outside India, simulation has traditionally been used in large hospital settings and wellfunded institutions with substantial resources and highly skilled personnel (Karys 1998, Krakauer et al. 1998).

GROWING HEALTHCARE COST IN INDIA

Though India has experienced a rapid increase of private players in healthcare, facilities at public hospitals are grossly lacking. Public hospitals have failed to provide free and low-cost quality care to people. As a result, there is an increased financial burden which is found to be one of the important reasons of indebtedness in rural areas. Moreover, public health financing is also inadequate in meeting the rising cost of healthcare. This is due to the focus of public finance on disease control rather than on the well-being of the person. At the same time, due to high-value diagnostics and drugs, the cost of healthcare has gone up drastically.

Government expenditure on healthcare in India is far below that of other developing countries. According to the World Health Organization Report published in 2002, India ranked thirteenth from the bottom in terms of public spending on health. In light of the fiscal crisis facing the government at both central and state levels, in the form of shrinking public health budgets, escalating health care costs coupled with demand for health-care services, and lack of easy access of people from the low-income group to quality health care, **health insurance is emerging as an alternative mechanism for financing of health care.**

HEALTH INSURANCE IN INDIA

Health insurance in the form of healthcare financing (Mediclaim) was introduced in India in 1986-1987 by **four subsidiaries** of General Insurance Company (GIC) to support the ailing healthcare industry. They are,

- The New India Assurance Company,
- Oriental Fire and Insurance Co.,
- National Insurance Co., and
- The United India Insurance Co

In recent years, there has been a liberalization of the Indian healthcare sector to allow for a much-needed private insurance market to emerge. Due to liberalization and a growing middle class with increased spending power, there has been an

increase in the number of insurance policies issued in the country. In 2001 with entry of various private Insurance companies now the customers have choice of buying this insurance from various Insurance companies.The Insurance Regulatory and Development Authority (IRDA) eliminated tariffs on general insurance as of January 1, 2007, and this move is expected to drive additional growth of private insurance products.

Present Scenario of Health Insurance Market in India

The development of health insurance in India is a reflection of broader policy changes that are being felt in the Indian economy. As a part of its financial sector reform agenda, the Indian Government liberalized the Indian insurance industry by the enactment of the **Insurance Regulatory and Development Authority (IRDA)** Act by the Indian Parliament in 1999. This led to the opening up of the sector for participation of private insurance companies. Prior to liberalization, the insurance sector consisted of the government-owned Life Insurance Corporation of India that had a monopoly on life insurance business and the General Insurance Corporation (GIC)of India and its four non-life subsidiaries namely, National Insurance Co., New India Assurance Co., Oriental Insurance Co. and United India Insurance Co. The results of liberalization have been significant. Since 1999, IRDA has licensed 24 new private insurance companies, of which 21 have foreign equity participation. Major global players like Aegon, Fortis, Future Generali, Principal and Dai-Ichi have tied-up with Indian partners to set up life insurance operations. Health insurance remains vastly underdeveloped in India. The regulations only permit general insurance companies to offer stand-alone health insurance products, while life insurers are allowed to offer riders such as critical illness cover attached to basic life policies – although subject to certain restrictions. Health cover premiums, however, account for less than 1 per cent for life insurers and 10 per cent for general insurers of total premiums. Following figure shows the market share of private and public sector non-life insurance companies in terms of new business premiums from the health segment.

Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) in Tamilnadu

In order to achieve the objective of Universal Health care to the people of Tamil Nadu, the Government is implementing the Chief Minister's Comprehensive Health Insurance Scheme. Under the new scheme, the eligibility criteria will be persons with income ceiling limit below `72,000/-per annum. While the sum assured is `1.00 lakh per year per family along with a provision to pay upto `1.5 lakh per year per family for certain specified procedures, the new scheme will cover 1016 life saving procedures. This new scheme not only includes life saving procedures, but also essential medical procedures, diagnostics and follow up procedures to ensure comprehensive care to the people. Government hospitals will also be encouraged to participate fully under the scheme. The scheme has been launched in January 2012 with an outlay cost of `3500.00 crore for the Plan period. Certain treatments involving transplants cost much higher than the ceiling of `1.50 lakh stipulated under the CMCHIS and to bear the additional expenditure, a corpus fund has been created.

SUCCESS OF THE TAMIL NADU HEALTH CARE MANAGEMENT

Health is a state subject and it is the leadership at the state level that makes all the difference. Every state in India has its own story – of successes and failures in the public health sector. However, Tamil Nadu leads the way in transformation of its public health system and is far ahead of others in the totality of its innovations in the health sector. Therefore the Tamil Nadu model has gained respectability and recognition in government circles and can be discussed as a possible role model for a National Health Policy – and scheme for universal coverage of health care.

Tamil Nadu is the only State in the Country which has an exclusive public health management cadre at the district level. Tamil Nadu is again centre stage in the way it has used NRHM funds to ensure that the Primary Health Centres (PHCs) work round the clock and are fit for quality institutional deliveries. The turnaround seen was in the resultant decline of maternal and infant mortality ratios in the state.

Tamil Nadu took the lead in providing universal health coverage by setting up an effective drugs procurement and distribution mechanism since 1994. Its IT enabled supply chain management system ensures delivery to needy patients, transparency to prevent misuse and stringent quality control to eliminate spurious drugs. Kerala and Rajasthan are successfully emulating this model. The central government has also announced that it will provide 52% of the population with 350 free essential drugs by April 2017 at a cost of Rs. 300 billion. The cost will be shared by the centre and state governments in a 75:25 ratio.

The Tamil Nadu Medical Services Corporation (TNMSC) a state owned company, was set up with the mission to ensure availability of essential affordable drugs to all. The TNMSC built its procurement and distribution system on a well designed

IT architecture ensuring that the supply chain from manufacturer to ware house to pharmacy and finally to the patient is tracked. The IT system ensures quality compliance, transparency in procurement and distribution. Today states in India are learning from each other to adopt innovations that have worked. Over 6 states have set up corporations like the TNMSC to provide quality generic drugs and experiments at reasonable costs.

The challenge to UHC is still huge but as the Tamil Nadu model shows, e-health care structured around a robust IT infrastructure is the key. It ensures transparency and accountability along with efficient supply and inventory management. In a country where a huge chunk of the population falls below the poverty line due to high medical costs, effective delivery of free essential drugs can change the quality of lives of our people.

Tamil Nadu spends the most on drugs among all states.While Tamil Nadu spends them maximum, that of Rajasthan is the lowest followed by states which have poor health indicators, such as Bihar, Uttar Pradesh, Madhya Pradesh, Odisha, Chhatisgarh andM Jharkhand. Some estimates of the fund requirements have been worked out by the Commission on Macro Economics and Health (CMEH) based on national burden of diseases, treatment cost per episode based on standard treatment procedures with use of quality generic medicines available at the lowest cost. Other estimatesare based on market calculations. Both these calculations suggest that about Rs. 75 per capita or Rs. 9000 crore would be required to provide free medicines to all out patients. This is one seventh of the annual allocation for government interventions like the National Rural Employment Guarantee Scheme. This additional allocation will not still lead to an increase in public expenditures on health beyond 2% of GDP.

Tamil Nadu spends the most on drugs among all states. But its spending on buying medicines declined from 15.3% (2001) to 12.2% (2010) of its total healthcare budget. By procuring drugs at around 3-10% of their retail price, the real beneficiaries are the patients.

As far as quality control and transparency goes, TNMSC's efficient tendering process helped to discover the lowest possible price. It purchases only from manufacturers holding Good Manufacturing Practice Certificates and follows stringent procedures for testing products. Its procurement process is equally effective. Tendered drugs received at the central ware house undergo testing and on approval, TNMSC releases them to its 23 district ware houses. A centralized computerized management information system tracks inventory and places orders, ensuring drug availability without over stocking in every part or region of the state for needy patients.

In the final stage of distribution, all government run clinics and hospitals are issued a passbook – the central pillar of the system's architecture. When they require a drug, it is noted in the passbook and the system informs the nearest ware house to fulfill the demand. Since primary health is a subject transferred to panchayats by the constitution, the NRHM's framework for implementation provided a very active role for the Panchayats. There are umpteen examples of rural Panchayats performing a commendable leadership role in Tamil Nadu in building up a culture of good health governance by helping to manage all the health related schemes (primarily NRHM fund based) at the rural level. Some examples may be quoted here:

Entire Gram Panchayats have been fully sanitized with the support of Panchayat leaders to make the Tamil Nadu government's scheme on sanitation successful. Thousands of toilets were constructed with government funding in villages. Malnutrition has been reduced among children and the ban on plastics enforced in rural areas with complete success. By involving the staff of health departments in the planning process, the staff are made to commit themselves to delivering the services and implementing the prioritized activities. Having started a new culture of working with officials, Panchayat leaders are able to make the officials deliver services with regard to water supply, street lighting, primary health centers and public distribution systems by monitoring their performance. The Panchayat leadership in Tamil Nadu has really become effective agents of health service delivery and real change makers at grassroots.

In Tamil Nadu the success of the state healthcare system, which functions more effectively than most states has been attributed to greater political will and the administrative commitment to the \ subaltern population constituted of various castes and communities over a period of time built by grass roots movements of the under-privileged. Besides the contribution of Panchayat leaders to the health goals have been used for operationalizing a universal health care system in the state.
Tamil Nadu's health care system has become a role model for others because it has achieved universal health care within the same administrative structure and finances as that of other states. The key difference however is that Tamil Nadu (a)

separates the medical officers into public health and those in the medical tracks (b) mandates those in the public health track to secure a public health qualification in addition to their medical degree; and (c) orients their work towards managing public health centres-while others in the medical track to provide hospital services. Tamil Nadu uses a mere 1% of its government medical doctors to be trained as public health managers. With adequate incentives, Tamil Nadu's per capita health expenditure is close to the national average. Kerala spends 2.8 times more than the national average on private expenditures bringing its total per capita expenditure to 2.5 times the national average (GOI 2009). Authority commensurate with responsibility has been granted to the medical officers-in-charge of rural and urban health facilities to professionalize management of public health facilities at all levels in Tamil Nadu. Here, as in other Indian states, government funding is based on inputs – such as the quantity of drugs supplied, the number of staff employed and salaries paid, the kind of medical equipment provided etc. But Tamil Nadu has succeeded where others have failed because the system has strict internal controls and accountability mechanisms to oversee the delivery of services with requisite standards.

Tamil Nadu therefore offers an organizational model for operationalizing a universal health care system within the existing administrative and fiscal resources available to other states of India.

It is widely recognized that good public health services is a key to improving health outcomes. Tamil Nadu performs better than all other states in key indicators of maternal and child health care. Tamil Nadu is better organized than most Indian states to manage public health threats and its health department seeks actively to protect public health in urban as well as rural areas.

CONCLUSION

Healthcare is a gigantic sector in India, estimated to be around 80,000 crores. But unfortunately the sector remained fragmented and non-competitive till very recently. It is projected that in the next few years approximately Rs 4000 will be pumped in to modernize the Indian health care services. The new facilities provided particularly in super specialty hospitals with the start-of–art equipment should be able to provide not only quality services to the patients but also meet the expectations of all the stake holders. Corporate sector has come up in many states of India, who are adopting different business models like "Hub and Spoke Model", and "Networking Model" to achieve their strategic objectives and goals. Regretfully, money is generally at the top of the agenda. To meet the rising demands, India will need 80,000 beds every year for the next 5 years. . It is uncertain whether the public sector could fill the gap. Private sector has the potential to meet such a huge demand. There is continuing evidence of the possibility of 'good health at low cost' (GHLC) in a variety of socio-political settings and in a number of low income contexts. (BalaBanova, McKee and Mills 2011).

REFERENCES

1. Sunitha, C., & Pugazhenthi, V. (2014). An analysis of awareness about the features of Chief Minister's Comprehensive Health Insurance Schemes of Government of Tamil Nadu. Intercontinental Journal of Marketing Research Review, 2 (4), 1-17.
2. Forgia, G. L., & Nagpal, S. (2012). Are you covered? Directions in development - General government-sponsored health insurance in India. Washington.
3. Arora, D. A. (2011). Towards alternative health financing: The experience of RSBY in Kerala. In J. D. Robert Palacios (Ed.), India's health insurance scheme for the poor: Evidence from the early experience of the Rashtriya Swasthya Bima Yojana (pp. 189-214). New Delhi, India: Centre for Policy Research.
4. Johnson, D., & Kumar, S. (2011). Do health camps make people healthier?: Evidence from an RCT of Health camps on usage of RSBY.
5. Reddy, R. K. (2011). Health needs of North Coastal Prakasam Region, Andhra Pradesh, India. Hyderabad: Access Health International and Nimmagadda Foundation.
6. Government of Tamil Nadu. (2011). Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS).
7. Aggarwal, A. (2010). Impact evaluation of India's 'Yeshasvini' community- based health insurance programme. Health Economics, 1 (19), 5-35. doi: 10.1002/hec.1605.
8. Kadam, S. et al. (2009). A rapid evaluation of the Rajiv Aarogyasri Community Health Insurance Scheme, Andhra Pradesh. Hyderabad, India: Indian Institute of Public Health.
9. Kuruvilla, S. , & Liu, M. (2007). Health security for the rural poor? A case study of a health insurance scheme for rural farmers and peasants in India. International Social Security Review, 60 (4), 3-21.
10. United India Insurance. (2012). New Health Insurance Scheme 2012.
11. http://www.tn.gov.in , http://www.aarogyasri.org, http:// www.yeshasvini.org ,http://www.tnnhis2012.com .