

6.1. HEALTHCARE AT A GLANCE

Healthcare
According to WHO, Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
India's Health care system <ul style="list-style-type: none">• Structure:<ul style="list-style-type: none">○ Primary: Primary Health Centres (PHCs), and Sub-Health Centres (SHCs)○ Secondary: Community Health Centres (CHCs), Sub-District Hospitals○ Tertiary: District Hospitals and Medical College Hospitals• Best practices: Mohalla Clinics Model (Delhi), Kerala and Tamil Nadu Insurance Model, ASHA• Global best practices for PHCs: Family clinics in Brazil and polyclinics and offices in Cuba.
India's Health status <ul style="list-style-type: none">• Government Health Expenditure: ~1.35% of GDP (41.41% of Total Health Expenditure) (2019-20)• Out-of-pocket expenses (OOPE): 47.1% of the total health expenditure (2019-20)• Health insurance coverage: 41% of households with any usual member covered under a health insurance. (NFHS-5)• Total Fertility Rate (TFR): 2.0 (NFHS-5)• Under-five mortality rate (U5MR): 41.9 (NFHS-5)• Infant mortality rate (IMR): 35.2 (NFHS-5)• Neonatal mortality rate (NMR): 24.9 (NFHS-5)• Maternal Mortality Rate (MMR): 97 per 1 Lakh Live births 2018-20 (Economic Survey 2022-23)• Institutional birth: 88.6% (NFHS-5)• Low doctor to patient ratio: 1:834 (including both allopathic doctors AYUSH doctors) (1:1000 prescribed by the WHO)• Geographical inequality: Around 2/3rd population in rural areas, yet 73% of the public hospital beds in urban areas.

- **Lack of Infrastructure (both quality and quantity)**
- As per WHO, the standard for the Doctor to people ratio should be 1:1000 but in India as per MHW that ratio is 1:834, and when only allopathic doctors are taken then the ratio is 1:1194
- As per WHO, the standard for the Nurse to people ratio should be 1:300 but in India as per MHW, that ratio is 1:670.
- As per the WHO, 53% of medical professionals do not have the requisite qualification which results in the issue of Quacks.
- Privatization of inpatient (60%)/outpatient (70%) care. It results in the issue of regularization.
- To deal with the issue of regulation the **Clinical Establishment Act, of 2010** was passed by Parliament. However, it faced issues due to health being a state subject, the states did not show dedication to its implementation.
- Thus it resulted in a high burden of out-of-pocket expenditure. It now accounts for 48.8% of total expenditure. Thus it is one of the most significant causes of Poverty.
- **Rural-Urban divide:** As per the report from the NITI Aayog on Secondary Health Care, 80% of the doctors, 75% of the dispensaries, and 60% of the hospitals are in urban areas. However, the majority of the Indian population lives in rural areas.
- Administrative corruption, misappropriation of funds.
- The lack of requisite infrastructure in existing hospitals makes it difficult to effectively implement government policies.
- **Weak PHC:** Where a wider base should be in Primary Health care (PHC) at the bottom, then Secondary Health Care, and then tertiary Health Care at the top.
- Lack of focus on emerging health issues such as Geriatric Care, Mental Health Care, NCDs, Road Safety, Addiction, Outdoor Pollution
- Four aspects of Health Care are Promotive, Preventive, Curative, and Rehabilitative. However, there is a lack of emphasis on promotive, and preventive care.

- **Absence of Medical Ethics:** g. prescribing branded medicine rather than generic. It is based on Provider induced demand.
- Lack of research and development and because of it, we are not able to generate or manufacture a generic version.
- High dependence on imports of API.
- Trust in the AYUSH/Traditional Medicinal system is less.
- Lack of integrated Health Management Information System (HMIS). This results in delays in treatment and high health costs.
- The problem of self-treatment.
- Lack of insurance coverage. According to The Insurance Regulatory and Development Authority of India (IRDAI), only 17 percent of the population has been covered under some kind of insurance.
- Lack of focus on correcting the attitude of people towards good health.
- Post-COVID, there has been a negative perception of the medical career. For example stigmatization of medical professionals by society.
- Lack of digitalization of Health care. For example Telemedicine and e-pharmacy.
- Dysfunctional state of the integrated disease surveillance program.
- Lack of an adequate number of medical colleges.
- Lack of robust and comprehensive selection process.

Universal Health Coverage

- ① What is UHC :-
-) Equity in health services
 -) Quality
 -) protection of people against financial risk.
- ② Prospects :-
-) It is a catalyst for socio-eco dev⁺
 -) ensures social justice, equity, inclusive growth, end to extreme poverty.
 -) Helps in aiding SDG goals such as
goal 1 (poverty), goal 4 (edu), goal 10 (inequality),
goal 5 (gender equality), goal 8 (work & eco growth)
goal 9 (infrastructure) etc.
- ③ Barriers :-
-) low govt. expenditure
 -) narrow interpretation of concept of 'good health'
 -) Lack of adequate infrastructure

-) Lack of Health workforce both w.r.t quality & quantity.
-) Lack of Integrated platform for data.
-) privatization of Health care
-) GoP expenditure.
-) lack of use of generic medicines
-) lack of Health insurance.
-) Regional variations (R-v divide etc).

④ Way forward

-) Community participation (all stakeholders)
-) training, skilling, retaining of health workers
-) Prioritizing health promotion & disease prevention
-) Strengthening legislative, regulatory framework.
-) Robust Health Information system.
-) More budgetary allocation
-) Multi-sectoral approach.

Challenges in achieving Universal Health Coverage

- **Low Health care spending:** As per, the Economic Survey 2022-23, central and state governments' budgeted **expenditure on healthcare increased marginally** from 1.6% in FY21 to 2.1 % of GDP in FY23 and is **among the lowest in the world.**
- **Lack of financial protection:** As per NITI Aayog, at least 30% of the population is devoid of any financial protection for health due to **existing gaps in coverage and overlap between schemes.**
- **High out-of-pocket expenditure (OOPE):** India's OOPE as a per cent of current health spending is 47.1% in 2019-20, significantly **above the global average of 18%.**
- **Inequitable Access:** Rural communities in India suffer from significant access to healthcare such as a **lack of qualified medical professionals, physical limitations** like distance, lack of established healthcare infrastructure and inability to pay for necessary medical treatment.
 - As per the Lancet publication (2023), the provision of **core health services lacks uniformity across state-run district hospitals.** Only 16 per cent of the district hospitals in Tamil Nadu offered all key services. In states like Assam, Punjab, Madhya Pradesh, Mizoram and UP, it was found to be just 1 per cent.
- **Lack of medical manpower:** India faces a shortage of healthcare professionals, including doctors, nurses, and paramedical staff, which impacts the delivery of healthcare services.

Initiatives taken to achieve Universal Health Coverage

- **Ayushman Bharat Yojana:** It aims to undertake interventions to holistically address health at primary, secondary and tertiary level.
- **Ayushman Bharat Digital Mission:** It will improve equitable access to quality healthcare by encouraging use of technologies such as telemedicine and enabling national portability of health services.
- **National Health Policy 2017:** It aims at achieving universal health coverage and delivering quality health care services to all at affordable cost.
- **Intensified Mission Indra Dhanush:** It focusses on reaching **zero-dose children aged between 0 and 5 years** and pregnant women who might have missed any vaccine doses in the national immunisation schedule.

Way forward

- **Recommendations from report**
 - Adopting a **primary healthcare approach** can improve health systems and accelerate progress toward UHC.
 - **Expansion of essential services**, especially for Non-Communicable Diseases.
 - Removing financial barriers e.g., issues of **indirect costs** and **co-payments** in health care.
 - Strong commitments to **International Health Regulations** in acute public health risk.
- **Increase public spending:** Government spending should be increased to around 5.2% i.e., the average health spending of the Lower- and Middle-Income Countries (LMIC).
- **Address Structural Issues:** Structural weaknesses within the healthcare delivery system i.e., lack of medical supplies and healthcare workers; irrational treatments etc. can be addressed by **engaging the private sector, and civil society and expanding medical seats** etc.
- **Centre-State Coordination:** Central government should adopt a **collaborative mechanism allowing for flexible policy-making, and differential financing from the Centre to the state.**
 - This will also allow states to better meet the diverse requirements and develop health plans that are consistent with the needs and requirements of populations.

④ AYUSHMAN BHARAT PM-JAY

- ⇒ About the scheme :- (fully funded by CG, Cost of implementation will be shared by govt + states). ①
-) Centrally Sponsored Scheme
 -) Objective is to health insurance cover of Rs 5 lakh per family per year for secondary & tertiary care hospitalization to 10 cr poor + vulnerable families
 -) It has subsumed RSBY SC - Health Insurance Scheme. ② Launched in 2018 Recommended by NHP - 2017
 -) Implementing Agency: National Health Authority
 -) No cap on family size
 -) Identification of beneficiaries through SECC
 -) provide cashless, paperless access to services
 -) Both at public & pvt empanelled hospitals
 -) Covers upto 3 days (pre) + 15 days (post) hospitalization expenses (states are free to chose modalities of imp).
 -) free to chose basis of implementation (trust / society / mixed)

Prospects of PM-JAY

- .) It will help achieving UHC + SDG
- .) Strengthen public Health Care through Infusion of Insurance Revenue
- .) Enable creation of New Health Infrastructure in remote areas.
- .) Ensure improved access + affordability of quality secondary + tertiary care
- .) Reduce DoP expenditure
- .) Improvement in Quality of life
- .) Ensure transformation of HR \Rightarrow HC Capital
- .) Overall economic growth of Nation.

Key issues highlighted in the report

- **Inadequate registration:** Only 73% (7.87 crore) of the targeted households of 10.74 crore were registered.
 - The ministry has now increased the beneficiaries to **12 crore families**.
- **Irregularities in identification:**
 - Of the total registered beneficiaries, **less than 30%** (2.08 crore) were identified from the **SECC-2011 database**.
 - ✓ SECC database **does not account for economic development** and employment opportunities since then.
 - Also, there were **errors in the beneficiary database**, like invalid names and dates of birth, duplicate PMJAY IDs, etc.
- **Empanelled Health Care Providers (EHCPs):**
 - Many EHCPs **did not meet the minimum criteria and quality** of support system and infrastructure.
 - **Many beneficiaries were charged** for their treatment.
- **Financial irregularities:**
 - Many states did **not maintain a separate escrow account** for PMJAY.
 - National Health Authority (NHA) and State Health Agencies (SHAs) **did not fully comply** with the direction of **tracking the expenditure** flow through the **Public Financial Management System (PFMS)**.

- Other issues include the **release of grants** by NHA **before the implementation** of the scheme or **without ensuring the release of upfront shares** by the respective States.
- **Claim management:**
 - Inadequate validation checks like admission before pre-authorisation, **delay** in payment, **inadmissible payments** and **payment without penalty** to erring EHCPs, etc.
 - **More than half of the payment** went to **only six States** (Andhra Pradesh, Arunachal Pradesh, Rajasthan, Karnataka, Maharashtra and Tamil Nadu).
- **Monitoring and Grievance Redressal:**
 - Many states did **not adopt the Whistle Blower Policy** to receive complaints relating to allegations of corruption, fraud, etc.
 - Absence of **Anti-Fraud Cells, Claim Review Committees**, etc. in several States/UT.
 - **Less than 10%** of grievances **were redressed** within a turnaround time of 15 days.

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- **Registration:**
 - Devise **appropriate mechanisms to ensure coverage** of intended beneficiaries and **to avoid delay** in the registration.
 - Set up a **designated IEC** cell to maximise the reach of the scheme.
- **Weed out ineligible beneficiaries:**
 - Put a suitable mechanism for the **identification and validation of beneficiaries' data** to increase the accuracy and reliability of the data.
- **Hospital Empanelment and Management:**
 - Ensure **mandatory physical verification** for the empanelment of hospitals to **prevent** the empanelment of a **de-empanelled hospital**.
 - **Invest in public hospitals** and devise mechanisms to **curb instances of out-of-pocket payments** by the beneficiaries.
- **Financial Management:**
 - Ensure **SHAs** have **designated escrow accounts** for PMJAY to receive their upfront share without delay.
 - Have a **mechanism to map and identify PMJAY beneficiaries** to avoid overlap of PMJAY and state-specific schemes.
 - Also, implement **PFMS on priority** to track the flow of expenditure.

- **Claims Management:**
 - **Timely** payment of the claims **after** ensuring **necessary scrutiny** by SHA.
 - Ensure the **claim amount is utilised for improving the infrastructure**, functioning of the hospital, quality of services, etc.
- **Monitoring and Grievance Redressal:**
 - Initiate **Anti-fraud activities** on an urgent basis and **penalise defaulters** in a timely manner.
 - Ensure that **District Implementing Units** are formed in every District.
 - **Ensured effective redressal of grievances and implementation of corrective measures** for improving the working of the Scheme.

| Secondary Health Care in India

↳ Premise:) Niti Ayog released a performance assessment report
"Best Practices in the Performance of District Hospitals"

-) 1st ever assessment
-) shift towards data-driven governance for communities
+ people availing health services.
-) Jointly released :- Niti Ayog (+) MHFW (+) HRD India
By

↳ | Secondary Health Care

- 8-) 2nd tier of Health Care
-) patients from primary care are referred to specialist in higher hospitals
-) provided by district / regional hospitals

④ Global Health Security Index:

(measures pandemic preparedness of country)

India's rank (57)

US (1)

Brazil (22)

low govt spending on health care

b/w 1.2% - 1.6%
of GDP

Weak govt & accountability
eg: health tragedies such as Gorakhpur, Chhattisgarh sterilization camps

challenges in Secondary Health Care

Unmanageable patient load

lack of pandemic handling capacity

⇒ Accessibility

80% (Doctors)
75% (dispensaries)
60% (hospitals)
are in urban.

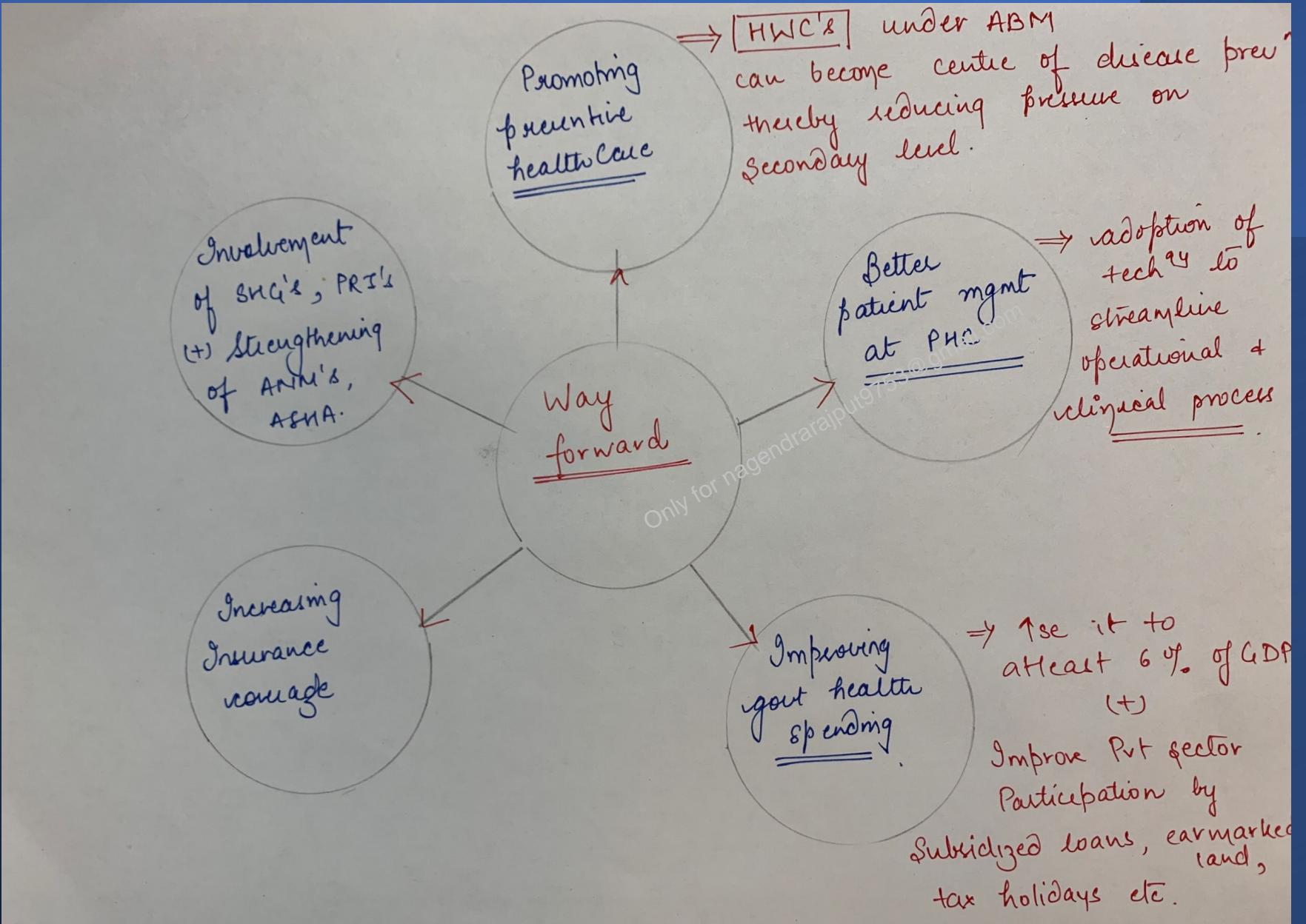
⇒ Major challenge for Rural Areas

Non-availability of skilled workforce
(esp in public hospitals)

⇒ patients will go for expensive pvt. healthcare

Weak PHC

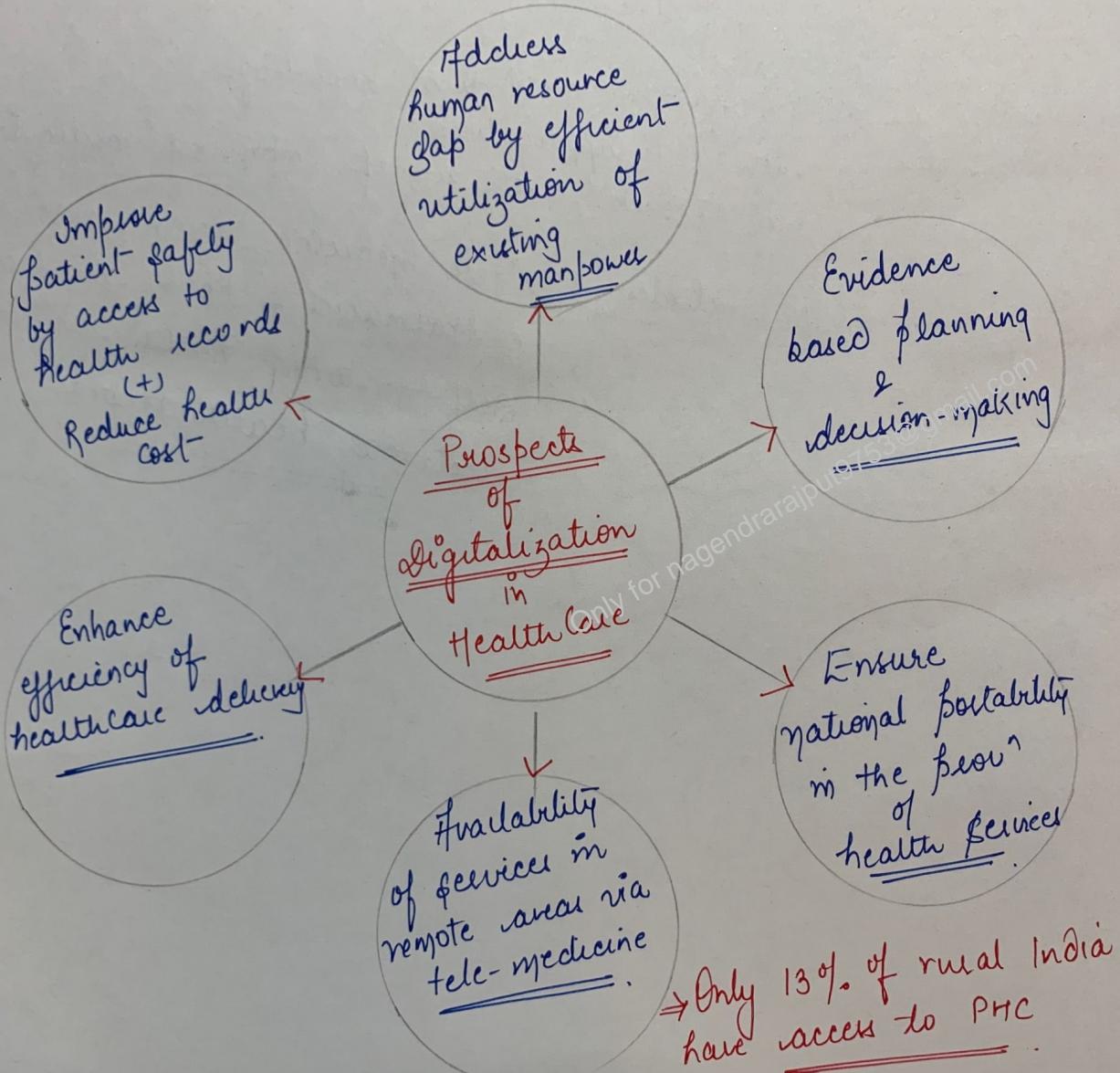
It impacts filtering of patients
Impact prevention & early detection



④ | Digitalization of Health Infrastructure

↳ What is digitalization
of healthcare?

-) Integration of Medical knowledge with IT application (or IT Tech⁴ with aim of improving medical care).
-) It includes
 -) Tele-medicine, e-insurance, e-pharmacies, Robot assisted surgeries, self-monitoring health care devices, electronic health records

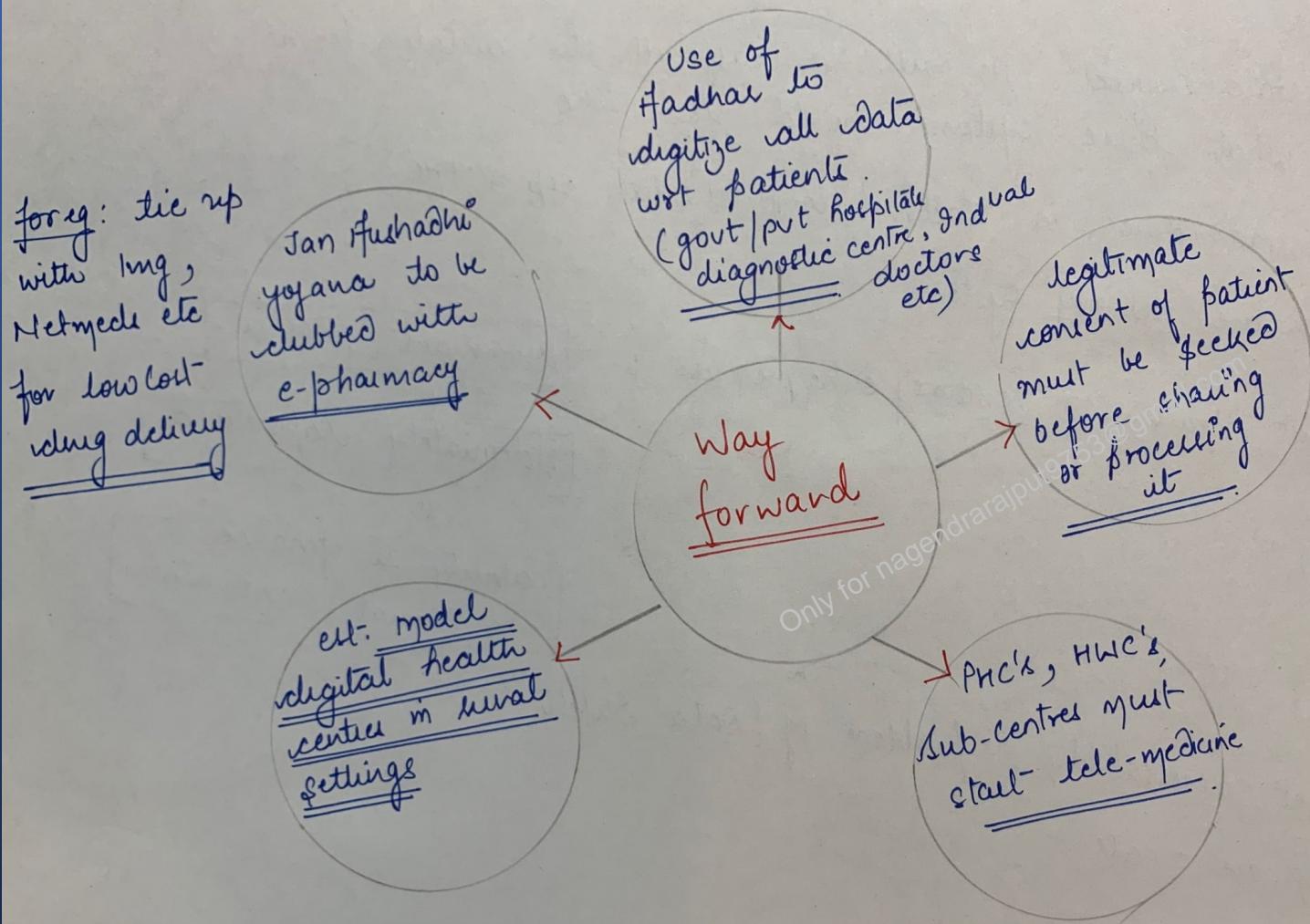


④ Challenges :-

- Health is a **state subject**. It will be difficult to dictate from central level, what these system should look like
- **Under developed Infrastructure** ie Lack of computerization esp in PHC.
- **Fragmented HealthCare delivery system**
- Lack of **dominant Health IT vendors** | enterprise :-
 - Dominant player**
 - Inadequately capitalized**
 - ability to finance continual innovation**

- Lack of **Internet accessibility**, problem of **Data Safety**
- **Information stds** are weak.

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Initiative taken to promote digital healthcare

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- ◎ **Ayushman Bharat Yojana (AYB)** to deliver a comprehensive healthcare services
- ◎ **National Digital Health Mission (NDHM)** for developing the backbone for a unified digital health infrastructure.
- ◎ **National Digital Health Blueprint (NDHB)** to transition into integrated digital services in a comprehensive and holistic manner.
- ◎ **States are supported under National Health Mission (NHM)** for services like Telemedicine, Tele-Radiology, Tele-Oncology, Tele-Ophthalmology and Hospital Information System (HIS).
- ◎ **Telemedicine Practice Guidelines, 2020** for regularization and diversification of tele-consultation services across the country.
- ◎ Digital applications like **eRaktkosh, eSanjeevani, CoWIN etc.**

About ABDM

- **Aim:** To develop the backbone necessary to support the integrated digital health infrastructure of the country.
- **Implementing Agency:** NHA under the Ministry of Health and Family Welfare.
- The digital infrastructure under the scheme is being developed by adopting **India Enterprise Architecture Framework (IndEA)** released by the Ministry of Electronics and Information Technology.
 - IndEA is holistic a framework for **streamlining, standardizing, and optimizing the e-Governance efforts across the country for interoperability and integration.**



**national
health
authority**

National Health Authority
(NHA)



Genesis: Set up in 2019 as a successor of the **National Health Agency**.

Ministry: **Ministry of Health and Family Welfare**

Governing Board: Chaired by the Union Minister for Health and Family Welfare

Functions: Apex body responsible for-

- Implementing **Ayushman Bharat Pradhan Mantri Jan Arogya Yojana**"
- Designing strategy, building technological infrastructure and implementation of "Ayushman Bharat Digital Mission"

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Components of the mission

Ayushman Bharat Health Account (ABHA) Number	<ul style="list-style-type: none">• A randomly generated 14-digit number generated through self-registration.• Purpose: Identifying individuals, authenticating them, and threading their health records (only with the informed consent of the patient) across multiple systems and stakeholders.
ABHA app	<ul style="list-style-type: none">• A Personal Health Records {PHR} application available on Android and iOS platforms.• Allows the self-uploading/scanning of existing physical health records such as diagnostic reports, prescriptions, etc.
Health Facility Registry	<ul style="list-style-type: none">• A comprehensive repository of all the health facilities of the country across different systems of medicine.• Includes both public and private health facilities including hospitals, clinics, diagnostic laboratories and imaging centers, pharmacies, etc.
Healthcare Professionals Registry	<ul style="list-style-type: none">• A comprehensive repository of all healthcare professionals involved in the delivery of healthcare services across both modern and traditional systems of medicine.

Challenges in the implementation of ABDM

- **Digital divide and illiteracy** make it difficult for certain sections of the population to adopt ABDM.
- **High cost of digitization of medical data.**
- **Poor interoperability between states**, with data migration and inter-state transfer facing multiple errors and shortcomings.

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- **Capacity building and digital skilling of medical professionals** needed to prepare them to use digital tools.
- **Concerns about personal data security and privacy**: For instance, the recent ransomware attack on the All-India Institute of Medical Sciences (AIIMS), Delhi has brought questions of safety and privacy.
- **Limited awareness among citizens** about the app and its use.
- **Health is a state subject**: There are state schemes and initiatives that have the same vision and mission as ABDM leading to a multiplicity of efforts. For instance, the eHealth initiative by Kerala.

Way forward

- **Protecting details of patients through methods like anonymization** and ensuring that the health records of the patients remain entirely confidential and secure.
- **Encourage Research and Development** in digital health technologies, especially in areas such as artificial intelligence, machine learning, and predictive analytics.
- **Streamlining processes and standardizing medical data** to ensure the smooth transfer of data between states.
- **Increase Public Awareness** to ensure that citizens understand how to access and utilize the digital healthcare services available.
- **Introducing the concepts of ABDM and digital health in the curriculum** for medical professionals.
- **Incentivizing private providers** to participate in the process of digitization of medical health records. E.g., the Digital Health Incentive scheme aims to incentivize stakeholders such as hospitals, labs etc. to adopt a digital health ecosystem.

6.6. MENTAL HEALTHCARE AT A GLANCE

Mental Healthcare



- Mental health is a state of well-being, where an individual realises their capabilities, can cope with the normal stressors of life, work productively, and is able to contribute to their community .
- Mental illnesses or mental health disorders refer to a wide range of mental health conditions like depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviors .



Current status of mental illness in India

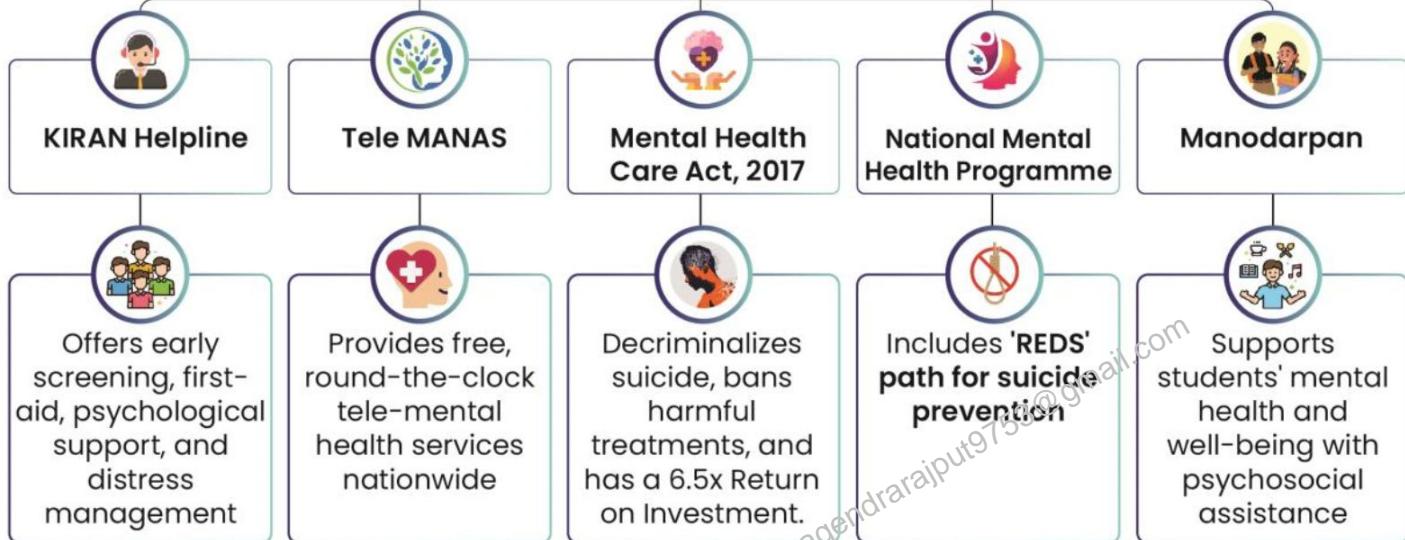
10.6% of adults in India suffer from mental disorders

Treatment gap for mental disorders ranged between 70 to 92% for different disorders.
(National Mental Health Survey 2015-16).

Individuals aged 25-44 years are the most affected by mental illnesses

One in every eight people (or 970 million people globally) were living with a mental disorder. (WHO)

Key initiatives to deal with the issue of Mental illness



Challenges in tackling mental illness	Way ahead
<ul style="list-style-type: none">Challenges faced by patients: Social stigma, higher cost, and long duration of treatment.Inadequate doctors: Only 0.75 psychologists per lakh population.Regional disparity: Inadequate resources in rural and remote areas.Rehabilitation issues: Inadequate community-based rehabilitation facilities.	<ul style="list-style-type: none">Careful mapping and research: Essential for producing quality data and understanding the scope of the problem.Awareness programme: Aims to counter social stigma and enhance understanding of mental illness.Budget allocation: Increase and effectively utilize financial resources for mental health.Affordability: Regulate insurance norms and counseling costs to make mental health services more accessible.Intersectoral coordination: Improve collaboration between mental health and social welfare departments.Community care: Shift from institutional care to community-based approaches.

#

CAUSES

- ① Urbanization, Modernization
- ② discrimination
- ③ Relative Deprivation
- ④ Isolation
- ⑤ Imbalance in Means + Goals
- ⑥ Negative Impact of Social Media (FOMO)
- ⑦ objectification + Commodification
- ⑧ Hormonal factors

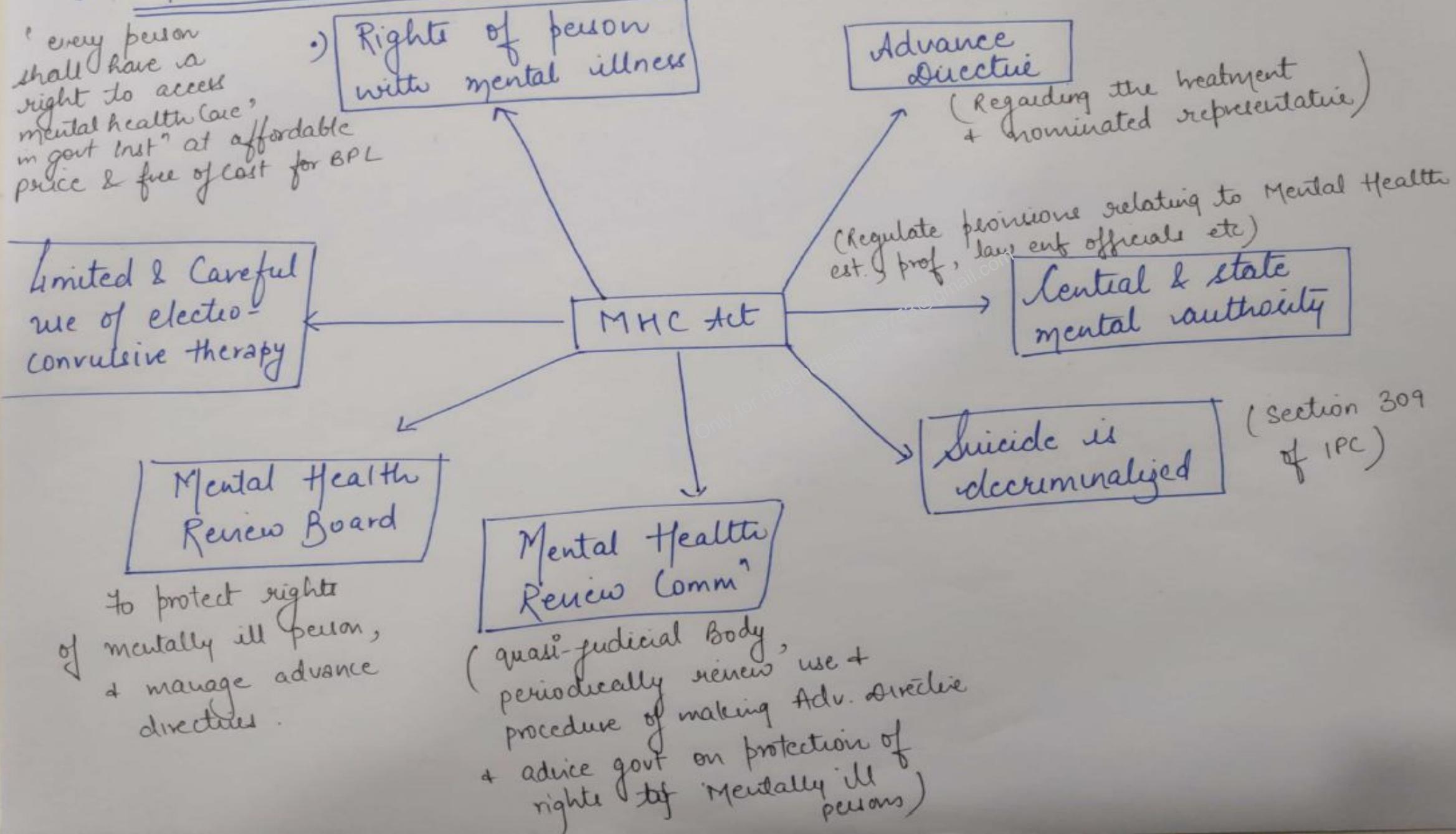
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Way forward

-) Awareness abt Mental Health
-) De-stigmatization
-) Robust Infrastructure
-) Promoting Yoga, Meditations
-) strengthening role of community
-) Tele-Medicine
-) Integrated Approach :-
 - DETECT
 - TREAT
 - MANAGE

↳ Mental Healthcare Act '2017



Sexual + Reproductive Health :- Acc. to a study by WHO, Inequalities w.r.t access to Sexual + Rep. Health Care.

↳ SRHR :-) Access to SRH services, care + inf' as well as autonomy in dec-making about their SRH's (including spacing + timing of children)

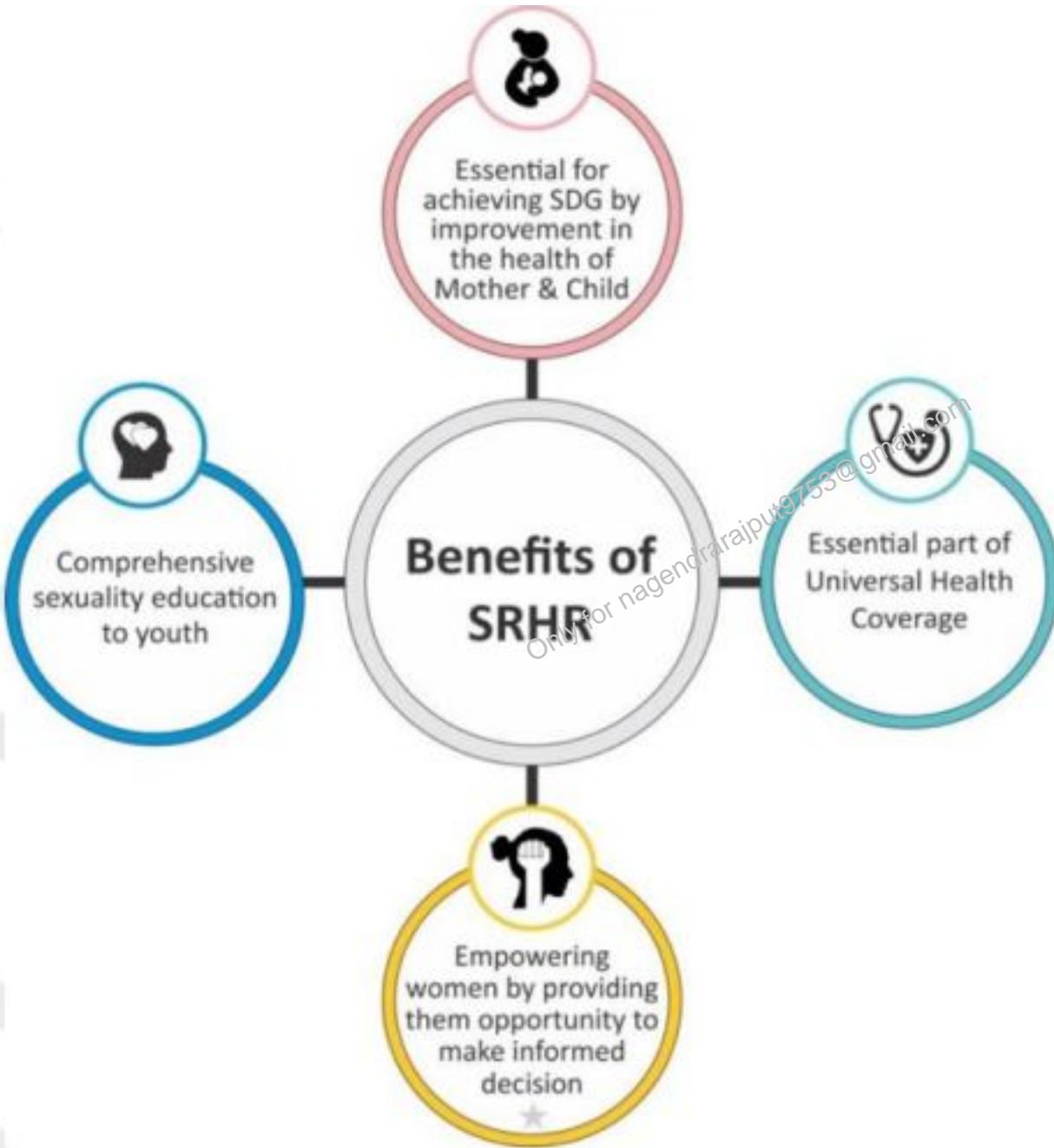
.) Human Rights

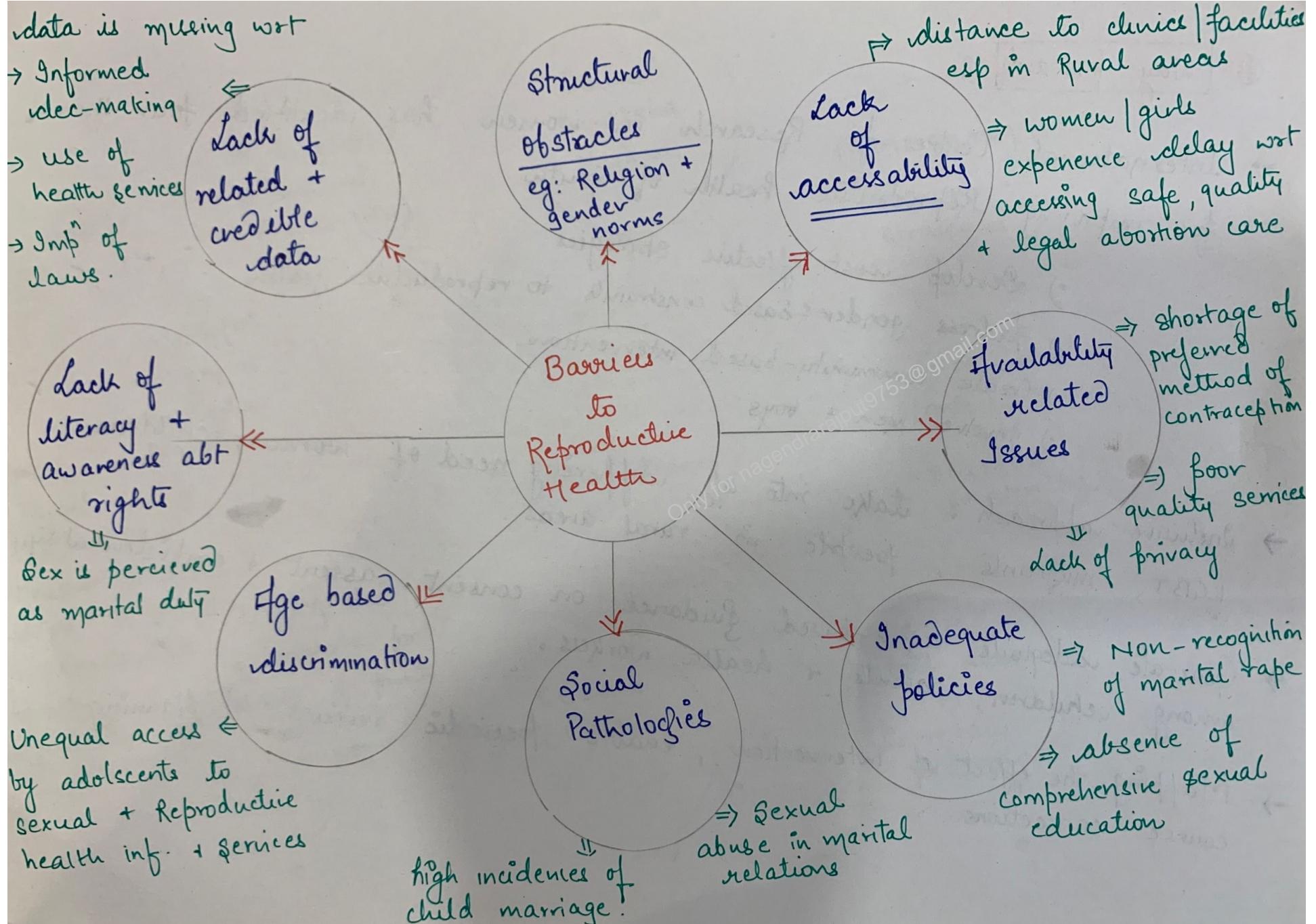
.) Universal, indivisible & undeniable

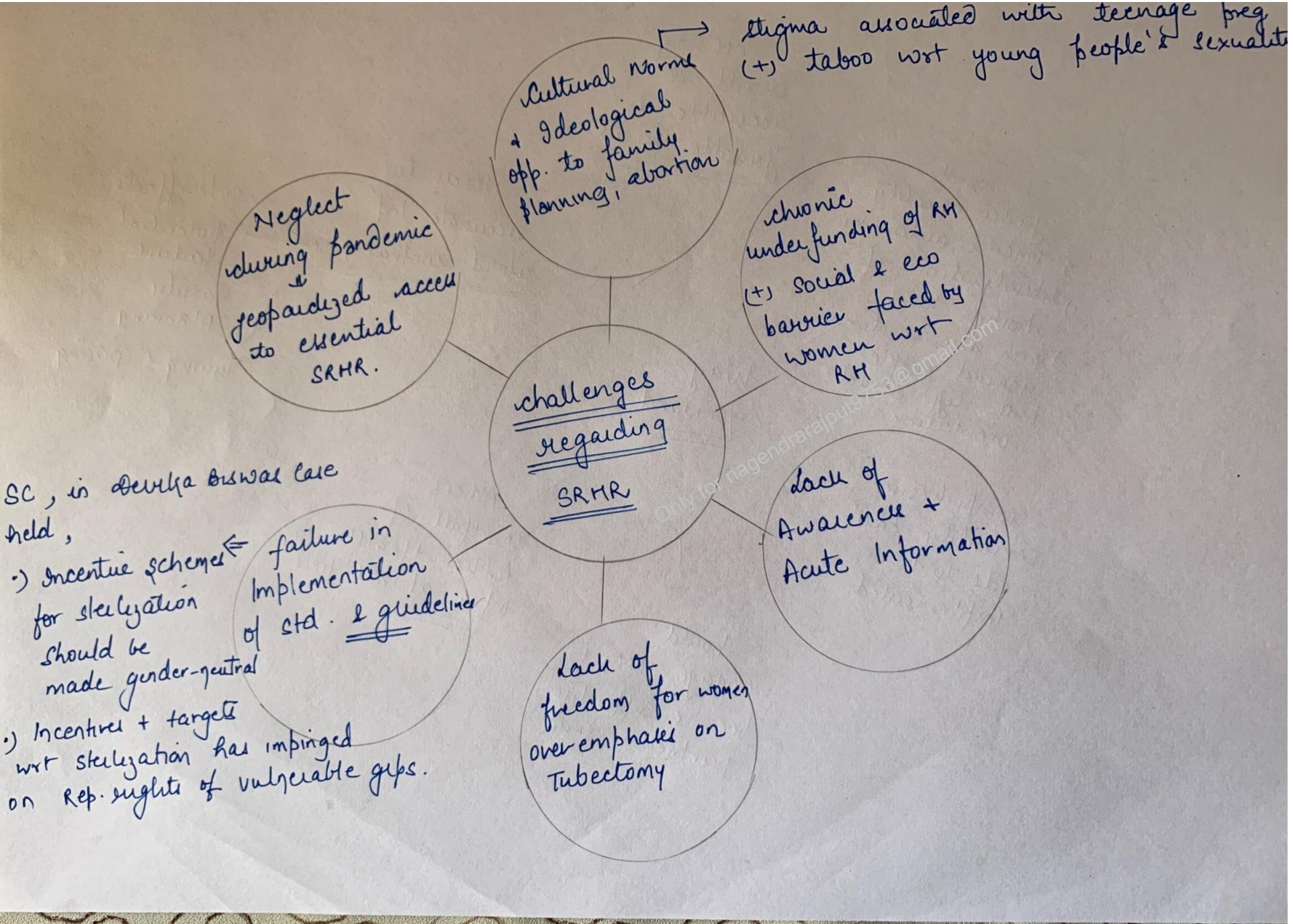
.) Sexual Rights : Include Right to sexual edu, freedom from sexual violence & coercion right to decide whether / not to have children

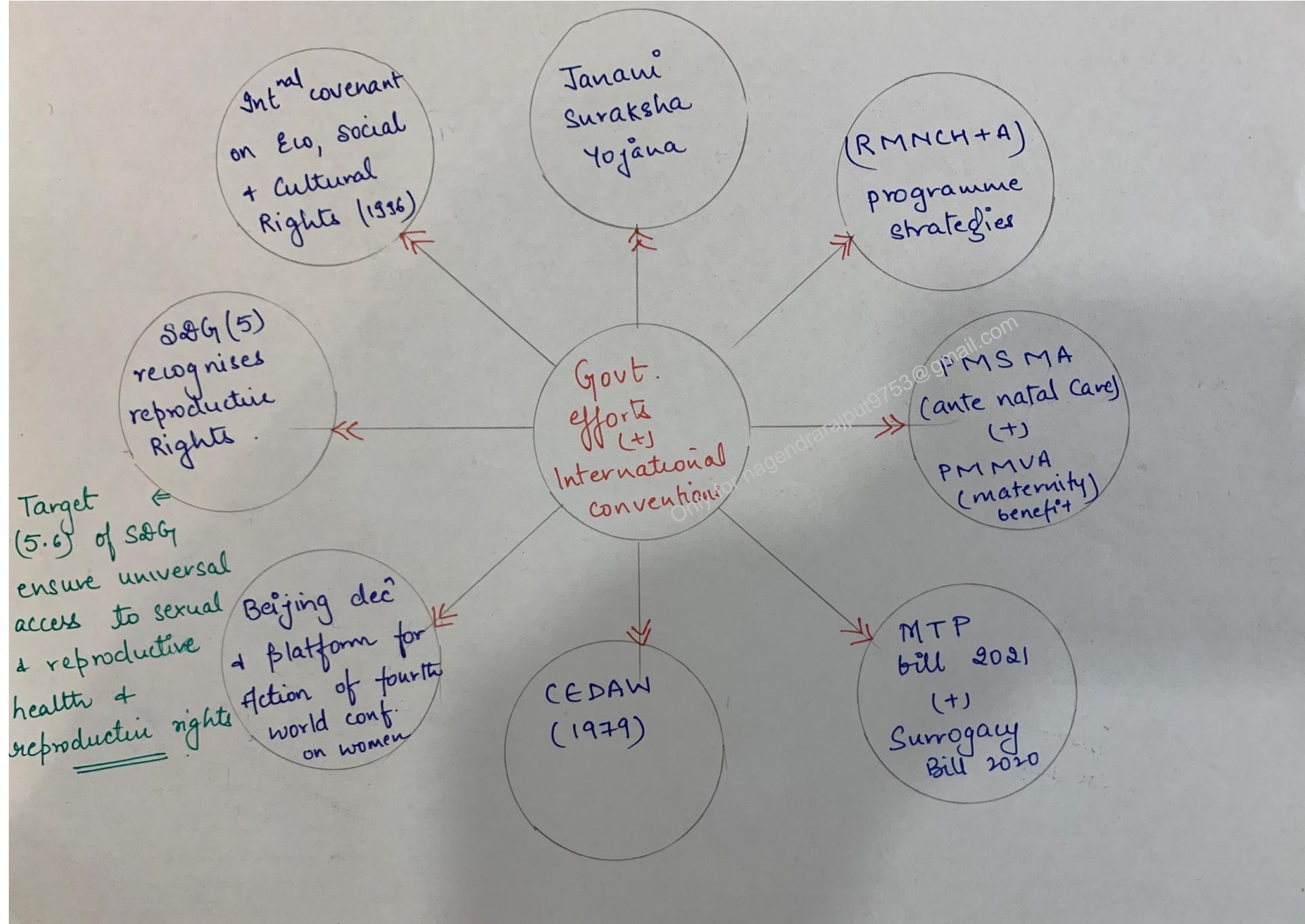
.) Reproductive Rights : Include access to contraception, access to menstrual & sanitary products, access to safe & legal abortion, ensuring safe pregnancies + childbirth.

-) SRHR deals with violations ie elimination of
 - eg: FGM, forced sterilization
 - OR, preventing STD.
-) To promote reproductive health
voluntary + safe sexual + Rep. choices









SRH Inf' should be accessible & affordable to all.

-) promote gender equality
-) women's autonomy
-) liberalization of abortion laws
-) prot. discrimination against people with diff sexual orientation

Way forward

Access to accurate Inf' about contraceptive

side effects
potential failure
family planning
Timing & Spacing

comprehensive sexuality Edu' needs to be implemented

Address Shortfall of Public Health Infra at all tiers

Should engage men to become supportive partner in SRHR