ResearchGate

See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/340085233

Health Care System in India : An Overview

Chapter · March 2020

CITATION
1

READS
146,002

2 authors, including:

Seilan Anbu
Scott Christian College Nagercoil India
49 PUBLICATIONS **210** CITATIONS

SEE PROFILE

All content following this page was uploaded by Seilan Anbu on 21 March 2020.

The user has requested enhancement of the downloaded file.

Health Care System in India : An Overview

A. Sheeba [*]

Dr. A. Seilan [**]

This article published in the edited book titled	:	International issues on Health Economics and Management
Edited By	:	Dr. Arulraj
Published by	:	TISSL International Publications, New Delhi, India
Year of Publication	:	2010
Pages in which this article appears	:	215-218
ISBN No.	:	978-93-80449-15-9

Health care is the prevention, treatment, and management of illness and the preservation of mental and physical well being through the services offered by the medical, nursing, and allied health professions. According to the World Health Organisation, health care embraces all the goods and services designed to promote health, including “preventive, curative and palliative interventions, whether directed to individuals or to populations”. The organised provision of such services may constitute a health care system.

Health is defined as a state of complete physical, mental and social well being and just not the non existence of disease or ailment. Health is a primary human right and has been accorded due importance by the Constitution through Article 21.Though Article 21 stresses upon state governments to safeguard the health and nutritional well being of the people, the central government also plays an active role in the sector. Recognizing the critical role played by the Health Industry, the industry has been conferred with the infrastructure status under section 10(23G) of the Income Act.

The Indian Health sector consists of

- Medical care providers like physicians, specialist clinics, nursing homes, hospitals.
- Diagnostic service centers and pathology laboratories.
- Medical equipment manufacturers.
- Contract research organizations (CRO's), pharmaceutical manufacturers

[*] **Assistant Professor of Medical Surgical Nursing, Kozhys College of Nursing, Bangalore. India**

[**] **Assistant Professor of Economics, Scott Christian College (Autonomous), Nagercoil - 629003. India**

- Third party support service providers (catering, laundry).

Health Care Sector in India : A Historical Prespective

Before Independence

Conventionally health care in India has been based on voluntary work. Since ancient times traditional practitioners of health care have contributed to the medicinal needs of society. Acute knowledge in the medicinal properties of plants and herbs were passed on from one generation to another to be used for treatment. The colonial rule and the dominance of the British changed the scenario. Hospitals managed by Christian missionaries took centre stage. Even the intellectual elite in India with their pro west bias favored Western practices.

After Independence

Prior to independence the healthcare in India was in shambles with large number of deaths and spread of infectious diseases. After independence the Government of India laid stress on Primary Health Care and India has put in sustained efforts to better the health care system across the country. The government initiative was not enough to meet the demands from a growing population be it in primary, secondary or tertiary health care. Alternate sources of finance were critical for the sustainability of the health sector.

Entry of Private Sector

Till about 20 years back, the private sectors venture in the health care sector consisted of only solo practitioners, small hospitals and nursing homes. The quality of service provided was excellent especially in the hospitals run by charitable trusts and religious foundations. In 1980's realizing that the government on its own would not be able to provide health care, the government allowed the entry of private sector to reduce the gap between supply and demand for healthcare. The private hospitals are managed by corporate, non-profit or charitable organizations. The establishment of private sector has resulted in the emergence of opportunities in terms of medical equipment, information technology in health services, BPO, Telemedicine and medical tourism.

Large companies and affluent individuals have started five star hospitals which dominate the space for high end market. The private sector has made tremendous progress, but on the flip side it is also responsible for increasing inequality in healthcare sector. The private should be more socially relevant and efforts must be made to make private sector accessible to the weaker section of society.

Health care system in India

Traditional Healthcare Systems in India

In India, in addition to existence of modern medicine, indigenous or traditional medical practitioners continue to practice throughout the country. Popular indigenous healthcare traditions include Ayurveda, Siddha, Unani, Homeopathy, Naturopathy, and Yoga.

The **Ayurveda** (meaning science of life) system deals with causes, symptoms, diagnoses, and treatment based on all aspects of well-being (mental, physical, and spiritual). These professionals, traditionally, have been inheriting the skills from their ancestors. However, with the advent of education, a variety of institutions offer training in indigenous medical practice.

The **Siddha** system defines disease as the condition in which the normal equilibrium of the five elements in human beings is lost resulting in different forms of discomfort. The diagnostic methods in Siddha medical system are based more on the clinical acumen of the physician after observation of the patient, pulse and diagnosis and clinical history.

Yoga is a science as well an art of healthy living physically, mentally, morally and spiritually. Yoga is believed to be founded by saints and sages of India several thousand years ago. Yoga has its origin in the Vedas, and its philosophy is an art and science of living in tune with the universe. Yogis gave rational interpretation of their experiences about Yoga and brought a practically sound and scientifically prepared method within every one's reach.

Naturopathy has several references in the Vedas and other ancient texts, which indicate that these methods were widely practised in ancient India. Naturopathy believes that all the diseases arise due to accumulation of morbid matter in the body and if scope is given for its removal, it provides cure or relief. It also believes that the human body possesses inherent self-constructingand self-healing powers. Naturopathy differs slightly with other systems of medicine, as it does not believe in the specific cause of disease and its specific treatment but takes into account the totality of factors responsible for diseases such as one's un-natural habits in living, thinking, working, sleeping, or relaxation, and the environmental factors that disturbs the normal functioning of the body.

Unani system of medicine believes that the body is made up of four basic elements viz., earth, air, water and fire, which have different temperaments i.e. cold, hot, wet and dry. After mixing and interaction of four elements a new compound having new temperament comes into existence i.e. hot-wet, hot-dry, cold-wet and cold-dry. The body has simple and compound organs, which got their nourishment through four humours, viz. blood, phlegm, yellow bile, black bile. Unani system of medicine believes in promotion of health, prevention of diseases and cure.

In addition to such healthcare systems, there are also faith / spiritual healers, who are largely present in rural parts of India. Some spiritual leaders use one or more of the traditional therapies, viz, Ayurveda, Yoga or Naturopathy as one of the healing modes to cure their clients.

Modern (Allopathic) Healthcare Systems in India

The modern (allopathic) health care system in India consists of a public sector, a private sector, and an informal network of care providers. The size, scale, and spread of the country hampered complete adherence to the number of well-intended guidelines and regulations. Although there are norms and guidelines, compliance is minimal. In reality, 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. Thus, wide disparities occur in access, cost, levels, and quality of health services provided across the country.

India's health system can be categorized into three distinct phases:

a) In the initial phase of 1947-1983, health policy was assumed to be based on two broad principles: (i) that none should be denied healthcare for want of ability to pay, and (ii) that it was the responsibility of the state to provide healthcare to the people.This phase saw moderate achievements.

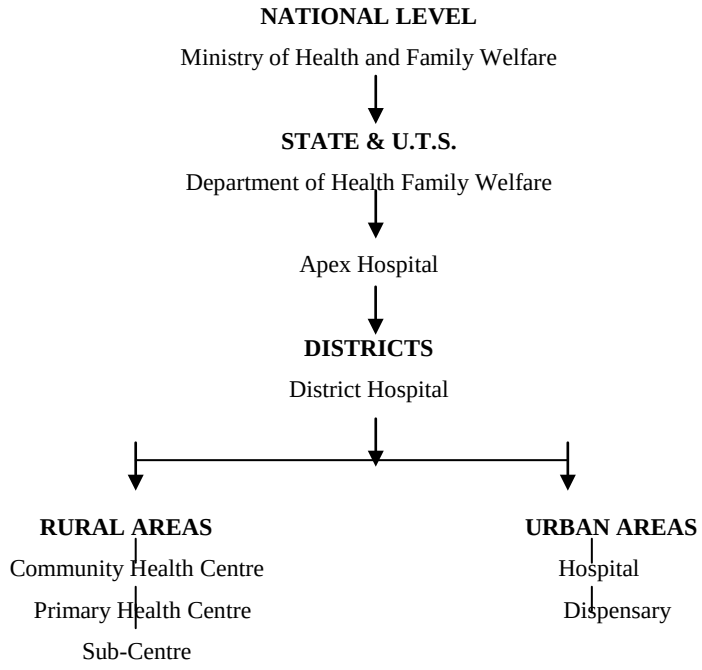
b) In the second phase of 1983-2000, a National Health Policy was announced for the first time in 1983, which articulated the need to encourage private initiative in healthcare service delivery and encouraged the private sector to invest in healthcare infrastructure through subsidies. The policy also enhanced the access to publicly funded primary healthcare, facilitating expansion of health facilities in rural areas through National Health Programmes (NHPs).

c) The third phase, post-2000, is witnessing a further shift and broadening of focus; the current phase addresses key issues such as public-private partnership, liberalization of insurance sector, and the government as a financier.

Role of Public Sector in Health Care

The public healthcare system consists of facilities run by the central and state government. These public facilities provide free or subsidized rates to lower income families in rural and urban areas.The Constitution of India divides health-related responsibilities between the central and the state governments. While the national government maintains responsibility for medical research and technical education, state governments shoulder the responsibility for infrastructure, employment, and service delivery. The concurrent list (in the 9th schedule to the Constitution of India) includes issues that concern more than one state, e.g., preventing extension of infectious or contagious diseases among states. While the states have significant autonomy in managing their health systems, the national government exercises significant fiscal control over the states' health systems.

Figure -1: The Health System Infrastructure in India



The Ministry of Health & Family Welfare is instrumental and responsible for implementation of various programmes on a national scale in the areas of Health & Family Welfare, prevention and control of major communicable diseases and promotion of traditional and indigenous systems of medicines. Apart from these, the Ministry also assists States in preventing and controlling the spread of seasonal disease outbreaks and epidemics through technical assistance.

Ministry of Health & Family Welfare incurs expenditure either directly under Central Schemes or by way of grants–in–aids to the autonomous/ statutory bodies etc. and NGOs. In addition to the 100% centrally sponsored family welfare programme, the Ministry is implementing several World Bank assisted programmes for control of AIDS, Malaria, Leprosy, Tuberculosis and Blindness in

designated areas. Besides, State Health Systems Development Projects with World Bank assistance are under implementation in various states. The projects are implemented by the respective State Governments and the Department of Health & Family Welfare only facilitates the States in availing of external assistance. All these schemes aim at fulfilling the national commitment to improve access to Primary Health Care facilities keeping in view the needs of rural areas where the incidence of disease is high.

The Ministry of Health & Family Welfare comprises the following departments, each of which is headed by a Secretary to the Government of India:-

- Department of Health & Family Welfare
- Department of AYUSH
- Department of Health Research
- Department of AIDS Control

The health care infrastructure in rural areas has been developed as a three tier system :

Subcenters - In rural areas, health sub-centres form the institutional basis of primary health care. It typically performs basic medical services, immunizations, and referrals. Subcenters are usually temporary structures that employ 1–2 care workers in most locations. Concerns include inadequate and/or uneven geographic coverage and inadequate funding. Each sub-centre is supposed to provide essential services for up to 5,000 individuals. Jointly with other institutions, they also provide family planning and other public health programmes (e.g., hygiene and water purity programmes) that are supposed to be carried out by paramedical personnel such as auxiliary nurse midwives.

The sub-centres are complemented by community health workers under supervision of the sub-centre. These community members provide essential health care on a part-time basis. A three-month training course is supposed to enable them to perform first aid according to traditional and allopathic principles.

Primary health centers (PHCs) typically perform preventive and curative medical services. PHCs are usually small (about 5 beds) with 1–2 qualified doctors, and 14 paramedics and support staff. Each PHC is typically a referral unit for a subcenter cluster of about six. Concerns include inadequate and uneven geographic coverage and insufficient number of qualified doctors and staff. The primary health care centres (PHC) are in charge of six sub-centres each. Besides outpatient treatment, most PHCs offer inpatient treatment with four to six beds. According to the plan, each PHC serves 30,000 people and employs one physician supported by 14 staff members.

Community health centers

The secondary sector of the Indian health care system consists of rural hospitals and community health centres (CHC). Serving four PHCs, the CHC's specialised medical services are intended for 120,000 people. For several years now, there have been plans to upgrade 2,000 CHCs to the status of regional hospitals. Community health centres are supposed to have at least 30 beds, an operating theatre, a laboratory, xray facilities, as well as a team of four medical specialists and a support staff of 21.

Role of Private Sector in Healthcare

India is encouraging investment in healthcare sector; over the years, the private sector in India has gained a significant presence in all the sub-segments of medical education and training, medical technology and diagnostics, pharmaceutical manufacture and sale, hospital construction and ancillary services, as also the provisioning of medical care. Over 75% of the human resources and advanced medical technology, 68% of hospitals and 37% of total beds in the country are in the private sector.

The composition of private sector in India is diverse with large number of sole practitioners or small nursing homes having bed capacities of less than 20. There are also several corporate entities, including pharmaceutical firms, and non-resident Indians (NRIs), who have invested in the Indian healthcare sector and are providing world-class care at a fraction of the cost compared to many developed countries. In addition, there are also traditional healthcare providers, such as Ayurveda and Yoga, who have set up facilities. It is reported that there are 1369 hospitals with a bed capacity of over 53000 in India catering to the needs of traditional Indian healthcare; about 726,000 registered practitioners are working under the traditional healthcare system. Indian hotels are also entering the wellness services market offering Spas and Ayurvedic massages, tying up with professional organizations in a range of wellness fields.

Over the years the private health sector in India has grown remarkably. Given the overwhelming presence of the private sector in health, various state governments in India have been exploring the option of involving the private sector and creating partnerships with it in order to meet the growing health care needs of the population.

The private sector is not only India's most unregulated sector but also its most potent untapped sector. Although inequitable, expensive, over-indulgent in clinical procedures and without quality standards or public disclosure of practices, the private sector is perceived to be easily accessible, better managed and more efficient than its public counterpart. It is assumed that collaboration with the private sector in the form of Public/Private Partnership would improve equity, efficiency, accountability, quality and accessibility of the entire health system. Advocates argue that the public and private sectors can potentially gain from one another in the form of resources, technology, knowledge and skills,

management practices, cost efficiency and even a make-over of their respective images. Partnerships are expected to ameliorate the resource constraints of the public sector by reducing investments in expensive tertiary care services.

Partnership with the private sector has emerged as a new avenue of reforms, in part due to resource constraints in the public sector of governments across the world. There is growing realisation that, given their respective strengths and weaknesses, neither the public sector nor the private sector alone can operate in the best interest of the health system. There is also a growing belief that public and private sectors in health can potentially gain from one another. Involvement of the private sector is, in part, linked to the wider belief that public sector bureaucracies are inefficient and unresponsive and that market mechanisms will promote efficiency and ensure cost effective, good quality services.

The public sector must reorient its dual role of financing and provision of services because of its increasing inability on both fronts. Under partnerships, public and private sectors can play innovative roles in financing and providing health care services. While reviewing the health sector in India, the World Bank and the National Commission on Macroeconomics in Health strongly advocated harnessing the private sector's energy and countering its failures by making both public and private sectors more accountable.

Health Infrastructure

Health Infrastructure is an important indicator to understand the healthcare delivery provisions and mechanisms in a country. It also signifies the investments and priority accorded to creating the infrastructure in public and private sectors.The health infrastructure in India is spread over the different systems of medicine such as allopathic, ayurveda, siddha, Tibetan medicine, unani and homoeopathy, and can be categorized as follows:

a) Pysical infrastructure

b) Human resources

Physical Infrastructure

The physical infrastructure consists of health facilities in the public sector and those provided by the private sector. Public health services consist of a network of sub-centres, primary health centres (PHC), community health centres (CHC) and district hospitals.

The infrastructure in the private sector provides at least 80 per cent of health services in the country and can be classified as follows:

- Private dispensaries
- Private hospitals
- Charity hospitals, including medical centres managed by NGOs

• Corporate hospitals

Despite an extensive public health care infrastructure, the private sector now dominates the market.

Medical education infrastructures in the country have shown rapid growth during the last 19 years. The country has 300 medical colleges, 290 Colleges for BDS courses and 140 colleges conduct MDS courses with total admission of 34,595, 23520 and 2,644 respectively during 2009-10. There are 1,820 Institution for General Nurse Midwives with admission capacity of 65109 and 561 colleges for Pharmacy (dioploma) with an intake capacity of 33635 as on 31st March,2009.

There are 11,613 hospitals having 5,40,328 beds in the country. 6,281 hospitals are in rural area with 143069 beds, and 3,115 hospital are in Urban area with 3,69,351 beds. Rural and Urban bifercation is not available in the States of Bihar and Jharkhand. Medical care facilities under AYUSH by management status i.e. dispensaries & hospitals are 22,312 & 3,378 respectively as on 1.4.2009. There are 1,46,036 Sub Centers, 23,458 Primary Health Centers and 4,276 Community Health Centers in India as on March 2008. India has 961 Government licensed blood banks and 1386 Private blood banks till 2009. Total number of blood banks in the country till November 2009 were 2347.

Human Resources

Table -1

Density of Health Workers in India

Categories	Year	Number	Density per 1000
Physicians	2005	645285	0.60
Nurses	2004	865135	0.80
Midwives	2004	506924	0.47
Dentists	2004	61424	0.06
Pharmacists	2003	592577	0.56
Public and Environmental Health Workers	1991	325263	0.38
Community Health Workers	2004	50393	0.05
Lab Technicians	1991	15886	0.02
Other Health Workers	2005	818301	0.76

Source : Working Together for Health, World Health Report, 2006; World Health Organisation, 2006

Expenditure on Health

Health expenditure covers the provision of preventive and curative health services, public health affairs and services, health applied research, and medical supply and delivery systems, but it does not include provision of water and sanitation

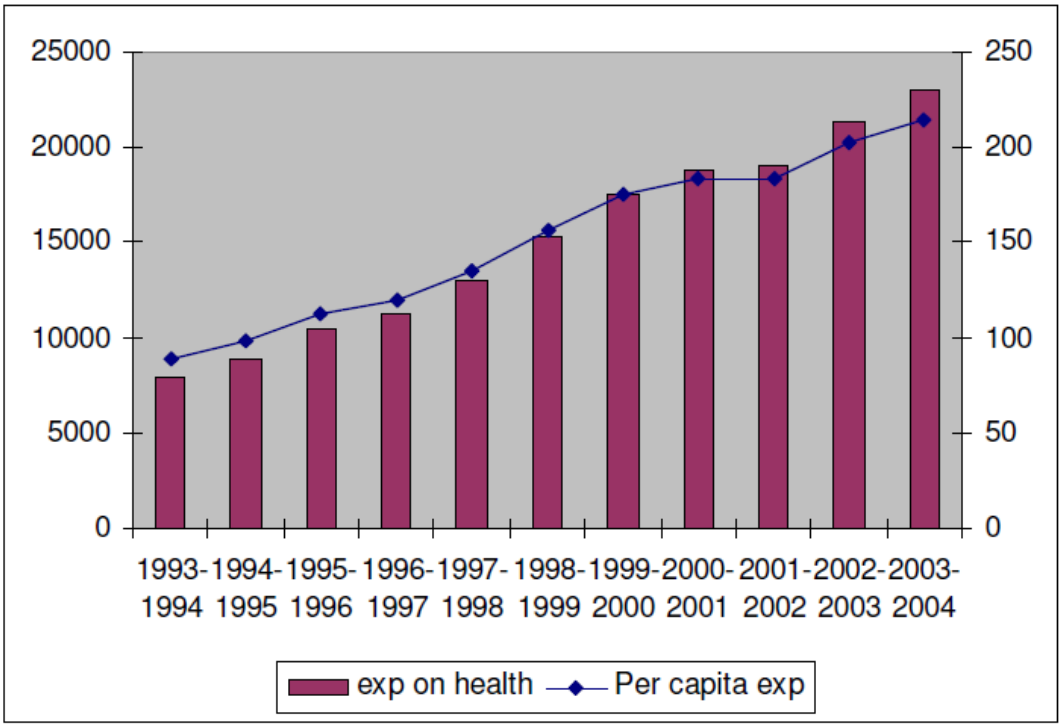
Table - 2

Health Expenditure

Sl. No	Description	Data
1	Total Expenditure on Health as % of GDP (2003)	4.8%
2	Government Expenditure on Health as % of Total Expenditure on Health (2003)	24.8%
3	Private Expenditure on Health as % of Total Expenditure on Health (2003)	75.2%
4	Government Expenditure on Health as % of Total Expenditure (2003)	3.9%
5	External Resources for Health as % of Total Expenditure on Health (2003)	1.6%
6	Social Security Expenditure on Health as % of General Government Expenditure on Health (2003)	4.2%
7	Out of Pocket Expenditure as % of Private Expenditure on Health (2003)	97.0%
8	Private Prepaid Plans as % of Private Expenditure on Health (2003)	0.9%
9	Per capita Total Expenditure on Health at Average Exchange Rates (US $) – 2003	27.0
10	Per capita Government Expenditure on Health on Average Exchange Rates (US $) - 2003	7.0

Source: Working Together for Health, World Health Report, 2006; World Health Organisation, 2006.

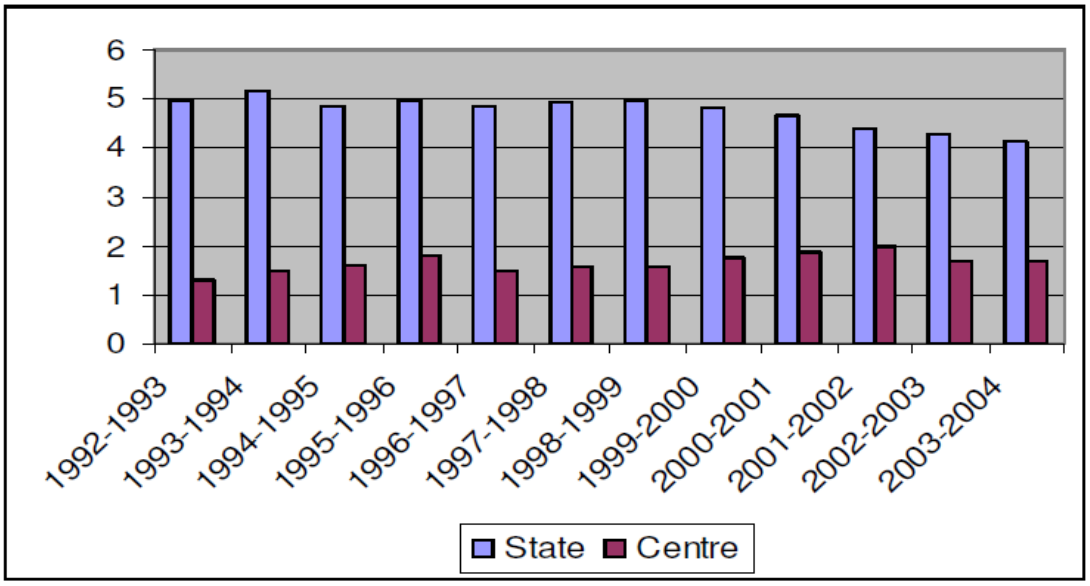
Figure – 2, Government Expenditure and Per Capita Expenditure on Health



The government expenditure on health has increased from 7938.36 crore in 1993-94 to 23028.3 crore in 2003-04. This shows the importance given to the health sector by the government. The per capita expenditure has increased from 89 in 1993-94 to 214 in 2003-04. However, there is a sharp reduction in capital investment in public hospitals from 25% of the budget in 1991 to less than 60% in 2001. Gross under funding of National Health Programmes (NHP) which require a minimum of Rs 11,210 crore against which the Centre and States spent an estimated Rs 5563 crores (2001-2002) resulting in the suboptimal functioning of the delivery system and huge out of pocket expenditures on services 'guaranteed' under the NHP. India is one of the five countries in the world where public spending is lesser than 0.9% of GDP and one of the fifteen where households account for more than 80% of total health spending. The Common Minimum Programme proposes to raise the public health spending to 2%-3% of GDP.

Statewide data analysis shows that public health expenditure of all states except Assam went down in the period 1990-96 but increased during the period 1996-2002 for all states except Uttar Pradesh and Assam. When compare to per capita health expenditure as per cent of per capita gross state domestic product (GSDP), in almost all states, public health expenditure as per cent of GSDP has not increased much during the past decade.

Figure – 3, Central and State Government Health Expenditure (As a percentage of total expenditure)



The state government expenditure as a percentage of total expenditure has decreased from 4.96 in 199-93 to 4.12 in 2003-04 whereas central government expenditure on health as a percentage of total expenditure has increased from 1.31 in 1992-93 to 1.69 in 2003-04.

Growth and Prospects of Health Sector in India

Healthcare has emerged as one of the most progressive and largest service sectors in India. The health care sector in India has been growing at an enormous pace. During 2002, India's health care industry contributed 5 percent to the GDP and employed approximately 4 million people. By 2012 this industry is projected to contribute 8.5 percent of the GDP. At present the sector is estimated to be around US$ 40 billion and will grow to US$ 78.6 billion by 2012. The Indian healthcare market is estimated to be US$ 30 billion and includes pharmaceuticals, healthcare, medical and diagnostic equipment and surgical equipment and supplies. The Indian healthcare sector is expected to become a US$ 280 billion industry by 2020 with spending on health estimated to grow 14 per cent annually.

Private health care will form a large chunk of this spending, rising from US$14.8 billion to US$33.6 billion in 2012. Private spending accounts for almost 80 per cent of total healthcare expenditure. The public sector however is likely to contribute only around 15-20 per cent of the required US$ 86 billion investment. The corporate India is therefore, leveraging on this business potential and various health care brands have started aggressive expansion in the country. Some of the companies that plan to increase their footprints include Anil Ambani’s Reliance Health, the Hindujas, Sahara Group, Emami, Apollo Tyres and the Panacea Group.

The rural healthcare sector is also on an upsurge. The Rural Health Survey Report 2009, released by the Ministry of Health, stated that during the last five years rural health sector has been

added with around 15,000 health sub-centres and 28,000 nurses and midwives. The report further stated that the number of primary health centres have increased by 84 per cent, taking the number to 20,107.

The size of the Indian medical technology industry may touch US$ 14 billion by 2020 from US$ 2.7 billion in 2008 on account of strong economic growth, higher public spending and private investments in healthcare, increased penetration of health insurance and emergence of new models of healthcare delivery.

Recent Health Improvements

The improvement in the quality of health care over the years is reflected in respect of some basic demographic indicators. The Crude Birth Rate (CBR) has declined from 40.8 in 1951 to 29.5 in 1991 and further to 22.8 in 2008. Similarly there was a sharp decline in Crude Death Rate (CDR) which has decreased from 25.1 in 1951 to 9.8 in 1991 and further to 7.4 in 2008. Also, the Total Fertility Rate (average number of children likely to be born to a woman between 15-44 years of age) has decreased from 6.0 in 1951 to 2.6 in the year 2008 as per the estimates from the Sample Registration System (SRS) of Registrar General India (RGI), Ministry of Home Affairs. The Maternal Mortality Rate has also declined from 437 per one lakh live births in 1992 – 93 to 254 in 2004-06 SRS, according to the Report brought out by RGI. Infant Mortality Rate, which was 110 in 1981, has declined to 53 per 1000 live births in 2008. Child Mortality Rate has also decreased from 57.3 in 1972 to 15.2 in 2008.

Institutional births, a main focus of the National Rural Health Mission, have increased from 41% in 2004 to 47% in 2008. Nevertheless, meeting the Millennium Development Goal (MDG) for infant mortality of 27 per 1000 live births by 2015 represents a formidable challenge.

Prevalence rates of HIV, TB and malaria are in sustained decline. The national AIDS program is well on track in achieving its coverage targets. The government's TB program exhibits adequate implementation of DOTS activities across the country, with good outcomes in case detection and cure rates at the national level.

Health Care Situation : Areas of Concern

- Only 43.5% children are fully immunised.
- 79.1% of children from 6 months to 5 years of age are anaemic.
- 56.1% ever married women aged 15-49 are anemic.
- Infant Mortality Rate is 58/1000 live births for the country with a low of 12 for Kerala and a high of 79 for Madhya Pradesh.
- Maternal Mortality Rate is 301 for the country with a low of 110 for Kerala and a high of 517 for UP and Uttaranchal in the 2001-03 period.

- Two thirds of the population lack access to essential drugs.
- 80% health care expenditure born by patients and their families as out-of -pocket payment (fee for service and drugs)
- Health inequalities across states, between urban and rural areas, and across the economic and gender divides have become worse
- Health, far from being accepted as a basic right of the people, is now being shaped into a saleable commodity
- poor are being excluded from health services
- Increased indebtedness among poor (Expenditure on health care is second major cause of Indebtedness among rural poor)
- Difference across the economic class spectrum and by gender in the untreated illness has significantly increased cutbacks by poor on food and other consumptions resulting increased illnesses and increasing malnutrition

Medical Tourism

India has several advantages in favor of medical tourism like infrastructure, technology, cost effective medical care and hospitalization qualified and skilled doctors. Traditional Indian rejuvenation methods like yoga, ayurvedic massage find favor with people in western countries and corporate hospitals and wellness centers are cashing on this. More and more people have started traveling to India for Medical Treatment and Medical Tourism is finally coming of age. The Indian medical tourism industry is presently at a nascent stage, but has an enormous potential for future growth and development on the back of low cost range of treatments provided by the country. The growth in India's medical tourism market will be a boon for several associated industries, including hospital industry, medical equipments industry and pharmaceutical industry.

India boasts of several good private owned hospitals with facilities second to none. They have some of the best doctors, with most top end being educated in USA and UK. When it comes to becoming a doctor, India also has some of the stringest criteria. Language is another plus factor - English, which is widely spoken throughout the country and in all good hospitals. Furthermore, the costs are much lower than most countries and most importantly, there are no waiting lists. With all the media hype about medical tourism, most hospitals have geared themselves up for medical tourists from abroad. India has a high success rate and a growing credibility. Indian specialists have performed over 500,000 major surgeries and over a million other surgical procedures including cardio-thoracic, neurological and cancer surgeries, with success rates at par with international standards. The success

rate of cardiac bypass in India is 98.7 per cent against 97.5 per cent in the U.S. India's success in 110 bone marrow transplants is 80 per cent. The success rate in 6,000 renal transplants is 95 per cent.

In the last five years, the number of patients visiting India for medical treatment rose from 10,000 to about 120,000. With an annual growth rate of 30 percent, India is already inching closer to Singapore, an established medical care hub that attracts 150,000 medical tourists a year. India's share in the global medical tourism industry will reach around 3 per cent by the end of 2013. Medical tourism is expected to generate revenue around US$ 3 billion by 2013, growing at a CAGR of around 26 per cent during 2011–2013. The number of medical tourists is anticipated to grow at a CAGR of over 19 per cent during the forecast period to reach 1.3 million by 2013. Going by the current pace with which this segment has been growing, the revenues from this segment could touch US$ 2.2 billion by 2012. The Government has also been proactive in encouraging prospects in this sector with a number of initiatives: A new category of visa "Medical Visa" ('M'-Visa) has been introduced which can be given for a specific purpose to foreign tourists coming into India.

Domestic medical tourism in the country has also seen growth in the recent years. As per the report 'Domestic Tourism in India, 2008-09' released by the National Sample Survey Office (NSSO), trips for 'health and medical' purposes formed 7 per cent of overnight trips in the rural population and about 3.5 per cent in the urban population. 'Health and medical' purposes accounted for 17 per cent of same-day trips in rural India and 8 per cent in urban India. Expenditure on medical trips accounted for 30 per cent of all overnight trip expenditure for rural India and 15 per cent for urban.

Health Insurance

The growing affluence of the Indian middle-class accompanied with lifestyle-related diseases and inflationary healthcare costs are driving the demand for health insurance in India today. Launch of new hospital chains with a stress on holistic well-being is further accentuating this demand, especially in urban areas. Meanwhile the government, in collaboration with non governmental organisations and insurers, is launching various schemes to provide low cost health insurance facility to all citizens. All factors combined contributed to the nearly 40% compound annual growth rate (CAGR) in premiums of health insurance since the sector's liberalisation a decade ago.

The Indian health insurance market has emerged as a new and lucrative growth avenue for both the existing players as well as the new entrants. The health insurance market represents one the fastest growing and second largest non-life insurance segment in the country. The Indian health insurance market has posted record growth in the last two fiscals (2008-09 and 2009-10). Moreover, as per the report, the health insurance premium is expected to grow at a CAGR of over 25 per cent for the period spanning from 2009-10 to 2013-14. However, certain intrinsic factors inhibit this segment from

reaching its fullest potential. On the one hand, low awareness and lack of understanding of product features, in addition to perceived apprehension in claims procedures and settlement, intimidates consumers from buying a health cover.

Key Challenges

Despite these gains, a high proportion of the population continues to suffer and die from easily preventable diseases, lack of access to affordable and quality care, and malnutrition. Women and children from low-income households are the most vulnerable. Problem areas include:

Maternal and child health: Only about half of pregnant women receive adequate antenatal coverage - at least three visits during one pregnancy. This percentage remains low and stagnant. While the percentage of children between 12-23 months of age that are fully immunized rose from 46% in 2004 to 54% in 2008, these levels remain unacceptably low. Infant and maternal mortality rates are decreasing, but slowly. At the current rate of progress, India will not be able to achieve the Millennium Development Goals for health.

Childhood nutrition: Despite the largest child-nutrition program in the world, rates of childhood malnutrition have remained unchanged for nearly two decades: 48% of children under the age of five are stunted (low height for age), 43% are underweight (low weight for age), and 20% are wasted (low weight for height).

New diseases on the rise: At the same time, new health challenges are emerging. The rise in chronic adult diseases and injuries is stretching the system's capacity to respond. Non-communicable diseases and injuries already account for about 60% of India's disease burden, led by cardiovascular disease, mental health, injuries, cancer, and diabetes.

Unfinished agenda of communicable diseases: Although the prevalence of HIV has recently been lowered to an estimated 0.41% of the adult population, or approximately 2.5 million individuals, this still poses a very significant burden and requires continued efforts to avoid a devastating, more generalized epidemic. Tuberculosis, malaria, polio, and dengue fever still remain serious threats in a number of states.

Financial burden: At over 70% of all health spending, out-of-pocket expenditures are by far the main financing mechanism for health care in India. This poses considerable financial burden on households. Based on the National Sample Survey (60th round), in 2004, 63 million individuals or 12 million households fell into poverty due to health expenditures (6.2% of all households). The majority of these households (79%) became impoverished due to spending on outpatient care, including drugs, and the remainder (21%) fell into poverty due to hospital care.

In order to meet manpower shortages and reach world standards, India would require investments of up to $20 billion over the next five years. 40 per cent of the primary health centres in India are understaffed. Currently, India has approximately 860 beds per million population. It is estimated that 450,000 additional hospital beds will be required by 2014. The government is expected to contribute only 15-20 per cent of the total, providing an enormous opportunity for private players to fill the gap.

There is a strong demand for tertiary care hospitals, which emphasise on the treatment of lifestyle diseases, focusing on specialities such as neurology, cardiology, oncology and orthopaedics. Tertiary hospitals are projected to grow faster than the overall healthcare sector, in response to the growing incidence of lifestyle disease and the accelerating growth of medical tourism.

Shortage of trained medical personnel : India faces a huge shortage of trained medical personnel, including doctors, nurses and especially paramedics, who may be more willing than doctors to live in rural areas where access to care is limited. There is an immediate need for medical education and training, which could provide additional opportunities for private sector providers or public-private-partnerships (PPP).

Systemic Constraints

Despite the Central Government's focus on health issues, a major challenge is to carry the momentum to the states. Increased funding will need to translate into greater access to health care and more effective delivery of health services. The following systemic constraints will need to be overcome to achieve the MDGs for health:

Low Effectiveness of Public Health Spending due to: (i) general absence of accountability **a**rrangements and incentives for performance; (ii) ineffective targeting and inadequate emphasis on core public health functions; (iii) very weak information environment, including deficient monitoring and near absence of impact evaluations**;** (iv) insufficient engagement with non-government sector and absence of a "whole system**"** perspective; (v**)** inadequate human resources in both numbers and quality; (vi) insufficient capacity in the states,(vii) little attention to or assessment of quality of care**;** and (vi) variable political priority for health across states.

Unregulated Private Provision of Health Care: 80% of Indians seek private provision when faced with an illness. However, only half of these visits are to doctors trained and licensed in modern medicine. Many private facilities remain unlicensed or are rarely inspected**.** The private medical market is unregulated with little concern for effectiveness, quality, costs and consumer safety. Accreditation is still in its infancy. While the government recognizes the potential for public-private partnerships to improve basic health care, many ongoing initiatives appear ad hoc. Innovative partnerships with NGOs

and private providers need to be monitored and evaluated to improve the delivery of priority health services.

Lack of Adequate Health Insurance: Only about 20% of Indians have any form of health insurance, and much of it is inadequate. Nearly all private health service providers require families to spend out-of-pocket at the point of service. This leaves people, especially the poor, highly vulnerable. There is still a long way to go before a sizeable proportion of the Indian population has adequate financial protection against health related events.

Little Emphasis on Communication to Improve Health and Create Demand for Health Services: India's health system is unprepared to deal with non-communicable diseases**.** To address them, much more effort is required to expand health promotion and prevention. Addressing malnutrition involves refocusing efforts on behavior change around key issues such as feeding practices for infants and young children.

Conclusion

India's health scenario currently presents a contrasting picture. While health tourism and private healthcare are being promoted, a large section of Indian population still reels under the risk of curable diseases that do not receive adequate attention of policymakers. India's National Rural Health Mission is undeniably an intervention that has put public heath care upfront. Although the government has been making efforts to increase healthcare spending via initiatives like the National Rural Health Mission, much still remains to be done. The priority will be to develop effective and sustainable health systems that can meet the dual demands posed by the growth in non communicable diseases and peoples' needs for better quality and higher levels of health care.

Reference

Bhat Ramesh (1999). Characteristics of private medical practice in India: a provider perspective Health Policy and Planning 14 (1): pp. 26-37.

Bhat Ramesh (2006). Financial Health of Private sector hospitals in India. Working Paper No 2006-01-01, Indian Institute of Management, Ahmedabad.

Bhat, Ramesh and Nishant Jain (2006). Analysis of public and private healthcare expenditures. Economic and Political Weekly, Vol XLI (1)

Berman, P (2010). 'The Impoverishing effects of health Care payments in India: New methodology and findings'. *Economic and Political weekly* 27(16): 65-71.

Chaudhuri, A., and Roy, K. (2008). 'Changes in out-of-pocket payments for healthcare in Vietnam and its impact on equity in payments, 1992–2002'. *Health Policy* 88(1): 38–48.

Economic Research Foundation (2006). *Government health expenditure in India: a benchmark study*. New Delhi.

Garg, C., and Karan, A. (2009). 'Reducing out-of-pocket expenditures to reduce poverty: a disaggregated analysis at rural-urban and state level in India'. *Health Policy and Planning*, 24(2): 116–128.

International Institute for Population Sciences (IIPS) and ORC Macro (2007). *National family health survey (NFHS-3), 2005–06*, India: Volume I. Mumbai: IIPS.

National Commission on Macroeconomics and Health (2005). *Financing and delivery of health care services in India*. New Delhi: Government of India.

National Sample Survey Organisation (NSSO) (2006). *Morbidity, health care and the condition of the aged (NSSO 60th Round, January–June 2006).* New Delhi: NSSO, Ministry of Statistics and Programme Implementation, Government of India.

O'Donnell, O., van Doorslaer, E., et al. (2007). 'The incidence of public spending on health care: comparative evidence from Asia'. *The World Bank Economic Review*, 21(1): 93–123.

Ramesh Bhat and Nishant Jain, (2006). "Analysis of Public and Private Healthcare Expenditures," *Economic and Political Weekly*, vol. XLI, no.1, pp. 57-68.

View publication stats