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HEALTH AND DEVELOPMENT OF HEALTH CARE IN INDIA

ZIBA ASL GHORBANI (PATANGIA)
RESEARCH SCHOLAR
GOKHALE INSTITUTE OF POLITICS AND ECONOMICS
(DEEMED TO BE UNIVERSITY)
PUNE

ABSTRACT

The vast majority of India suffers from a poor standard of healthcare infrastructure which has not kept up with the growing economy and high levels of malnutrition and communicable diseases especially in rural areas. Nearly one million Indians die every year due to inadequate healthcare facilities. The broad objective of this article is to observe the characteristic features of the health care and health progress in India. At the same time, India's health care system in urban areas also includes entities that meet or exceed international quality standards. The majority of the Indian population is unable to access high quality healthcare provided by private players as a result of high costs. Many are now looking towards insurance companies for providing alternative financing options so that they too may seek better quality healthcare. Despite having centers of excellence in healthcare delivery, these facilities are limited and are inadequate in meeting the current healthcare demands. India is at a critical juncture where policy choices made or options not considered could well have a profound impact on the health and wellbeing of future generations. At the present stage of development of India, the health indicators have lagged behind the impressive economic progress evident over the past two decades. A new public health policy needs to be drafted which will reconfigure the health system to make it more efficient and equitable. There is needed to consider a model of Primary Health Care where many of the health services would be provided by the locally selected and adequately trained health care providers. It is suggested that TFR (Total Fertility Rate) should be reduced to less than 1.5, especially between poor people and states of Assam, Uttar Pradesh, Bihar, Jharkhand, Rajasthan, Madhya Pradesh and Chhattisgarh. *And also primary health care of mother and child and access to safe drinking water for all should be more emphasised in health policy for developing of country, reducing poverty and huge costs of health and disease burden in India.*

KEYWORDS
Development, Health Care, Health Indicators and Progress.

INTRODUCTION
Improving health around the world today is an important social objective, which has obvious direct payoffs in terms of longer and better lives for millions. There is also a growing consensus that improving health can have equally large indirect payoffs through accelerating economic growth. Foe example, Gallup and Sachs (2001) argue that wiping out malaria in sub-Saharan Africa could increase that continent's per capita growth rate by as much as 2.6% a year and a report by the World Health Organization (2001) states:

"…extending the coverage of crucial health services…to the world's poor could save millions of lives each year, reduce poverty, spur economic development and promote global security''.

The Declaration of Alma Ata, 1978, 'Health…is a fundamental human right and the attainment of the highest possible level of health is a most important worldwide social goal…No individual should fail to secure adequate medical care because of inability to pay for it'.

The National Health Policy statement of 2002 and the National Macro-Economic Commission on Health are two key documents that describe the policy perspective on the health sector. The programmatic response to the policy that underscored the urgent need to revitalize and scale up access to basic health services in rural areas was the National Rural Health Mission (NRHM) which was launched in 2005. The Framework of Implementation of the NRHM enunciated the vision for strengthening the health system in the rural areas, which account for about 72 per cent of India's population.

PROGRESS OF HEALTH
a) KEY INDICATORS
Life Expectancy at Birth-Life expectancy in India has more than doubled in the last sixty years. It increased from around 30 years at the time of independence to over 63.5 years in 2002-06. The overall life expectancy increased by 14.1 years in the rural areas and 9.9 years in the urban areas during the period 1970- 75 to 2002-06. The wide variance in performance across states is of special concern. While in Kerala, a person at the time of birth is expected to live for 74 years, the expectancy of life at birth in states like Assam, Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh is in the range of 58-62 years, a level Kerala achieved during the period 1970-75. Globally India's life expectancy is lower than the global average of 67.5 years and the average of most countries that won their independence from colonial rule at about the same time–China, Vietnam, Sri Lanka, and so on. (Table 1)

TABLE 1: HEALTH INDICATORS OF SELECT COUNTRIES

Country	GDP per capita PPP US $	IMR (PER 1,000 Live Births Births) 2009	Life Expectancy at Birth M/F (in Years) 2009	MMR (per 1,00,000 Live Births) 2005	TFR 2007
India*	2753	53	62.6/64.2	254	2.6
China	5383	19	71.6/75.1	45	1.7
Japan	33632	3	79.4/86.5	6	1.3
United States	45592	7	77.1/81.9	11	2.1
Indonesia	3712	25	69.0/73.2	420	2.2
Vietnam	2600	13	72.6/76.6	150	2.2
Bangladesh	1241	47	65.5/67.7	570	2.9
Pakistan	2496	73	66.5/67.2	320	3.5
Sri Lanka	4243	17	70.6/78.1	58	1.9

Source: *India—Registrar General of India, Government of India (GoI) (SRS 2008) and abridged life tables 2002-06 (2008); Others—'State of World Population' (2009) and 'State of World Children (2009)'. GDP per capita - HDR, 2009.

INFANT MORTALITY RATE (IMR) AND CHILD HEALTH - India's infant mortality rate too has declined steady but slowly, from 129 deaths per 1,000 live births in 1971 to 53 in 2008. Currently the urban IMR is 36 as compared to the rural IMR of 58.

As maternal and child health indicators, measured in terms of the number of maternal deaths or children that die within the first year of their life, childbirth, are accepted as proxies for assessing the functioning and status of the health system, high priority has been accorded to this aspect of health policy. The International Conference on Population and Development in 1995 was the milestone which resulted in India shifting the unitary focus on sterilization-centred

family planning approach to a broad-based reproductive and child health policy framework. Comprehensive policies containing the range of reproductive health services for women and an array of services for children were formulated.

The implementation of the Reproductive and Child Health Program was strengthened with its integration into the National Rural Health Mission, where improved program implementation and health systems development was seen as mutually reinforcing processes.

The strategy for child health care aims to reduce under-five child mortality through interventions at every level of service delivery and through improved child care practices and child nutrition.

More concerted efforts to tackle malnutrition and neo-natal mortality will facilitate a 5 point decline per year required for achievement of expected outcome. 6 States / Union Territories have achieved the goal of reducing IMR below 28 and 12 States are in the 30-40 range.

The implementation of the Reproductive and Child Health Program was strengthened with its integration into the National Rural Health Mission (NRHM), where improved program implementation and health systems development was seen as mutually reinforcing processes.

DECREASING MMR (MATERNAL MORTALITY RATE) - India had a MMR of 460 in 1984, declining to 254 deaths per 100,000 live births in 2004-2006. Kerala and Tamil Nadu reporting an MMR of 95 and 111 respectively, lower than Assam (480), Bihar/Jharkhand (312), Madhya Pradesh/Chhattisgarh (335), Orissa (303), Rajasthan (388) and Uttar Pradesh/Uttarakhand (440). These nine states account for 47% of India's population represent the core of poor performance on all four counts of life expectancy, IMR, MMR and TFR (Total Fertility Rate).

Key Strategies and Progress Achieved With the launch of the National Rural Health Mission (NRHM), the Reproductive and Child Health (RCH) program efforts got further boost with the two-legged policy of restructuring the rural health care system (the supply side) along with stimulating the demand side with the introduction of the innovative conditional cash transfer scheme for pregnant women to deliver in public health facilities.

In the five years since the launch of the NRHM in 2005, institutional deliveries have increased rapidly witnessing a remarkable jump in coverage from 7.39 to 90.37 lakh beneficiaries in 2008-09 accounting for an annual expenditure of Rs. 1,241 crores.

TOTAL FERTILIY RATE (TFR) - TFR is the average number of children that a woman would bear over her lifetime if she were to experience the current age-specific fertility rates. At a level of 2.1, which is called the replacement level, population stabilization could be said to have been achieved.

Total Fertility Rate had reduced from 5.2 in 1971 to 2.6 in 2008. Of concern are the states of Uttar Pradesh, Bihar, Jharkhand, Rajasthan, Madhya Pradesh and Chhattisgarh that account for over 40 per cent of India's population and have a TFR in the range of 3.0 to 3.9. India's record compares poorly with that of Japan, China and the United Sates which have TFRs of 1.3, 1.7 and 2.1, respectively. As per population projections, the population of India in the year 2025 will be 143.1 crore as compared to 145.3 crore of China.

The states of Andhra Pradesh, Delhi, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu and West Bengal have already reached the goal of population stabilisation, i.e. TFR of 2.1 or below. But states like Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh need much greater support to achieve it.

TFR varies significantly with female literacy, mean age of women at marriage, percentage of females working in non-primary sectors, infant and child mortality, type of housing, and level of urbanization.

THE SOCIAL DETERMINANTS OF HEALTH

Nutrition, access to safe drinking water and sanitation and education are the three most important proximate determinants of health status that have an impact on both infectious disease and vital health statistics.

All these three are closely related to poverty and marginalization. Unhealthy lifestyle, tobacco, alcohol and other substance abuse underlie much of the non-communicable disease epidemics we face. In addition marginalization and discrimination on account of gender and caste are social determinants themselves.

It is therefore not surprising that the poor performing states are those with the highest levels of poverty and the highest levels of malnutrition among children and adult women. Female literacy rates, School enrolment rates and rates of households with safe drinking water and sanitation are all distinctly lower.

MALNUTRITION AND ANEMIA*: of* great concern is the persistent level of malnutrition with over 40% of children and 36% of adults women classified as undernourished. The reasons for such high levels of malnutrition and anemia are complex. They include poverty, gender inequity, specific dietary patterns and recurrent illness all these acting in conjunction.

Patriarchy and gender discrimination contribute to malnutrition levels by early age of marriage and birth of the first child, reduced access to nutrition during critical periods like pregnancy, lactation, adolescence and the first five years of life and less access to education and health care. Keeping girls in schools till they complete adolescence could be one of the most effective health measures.

Half of children in India are underweight, one of the highest rates in the world and nearly same as Sub-Saharan Africa. India contributes to about 5.6 million child deaths every year, more than half the world's total.

The health department does promote correct infant and young child feeding practices including exclusive breastfeeding for the first six months and micronutrients supplementation, especially iron and folic acid tablets for children and pregnant women, Vitamin A supplementation and promotion of the use of iodised salt. The health department also organizes institutional care services in over 600 facilities for sick and severely malnourished children. The issues of availability of safe drinking water and sanitation along with other areas of preventive and promotive actions in health are also important.

WATER AND SANITATION- Water supply and sanitation in India is a matter of concern. As of 2003, it was estimated that only 30% of India's wastewater was being treated, with the remainder flowing into rivers or groundwater. The lack of toilet facilities in many areas also presents a major health risk; open defection is widespread even in urban areas of India, and it was estimated in 2002 by the World Health Organization that around 700,000 Indians die each year from diarrhea. No city in India has full-day water supply. Most cities supply water only a few hours a day. In towns and rural areas the situation is even worse.

According to the World Health Organization 900,000 Indians die each year from drinking contaminated water and breathing in polluted air. As India grapples with these basic issues, new challenges are emerging for example there is a rise in chronic adult diseases such as cardiovascular illnesses and diabetes as a consequence of changing lifestyles.

INDIA 'S DISEASE BURDEN

THE CAUSES OF DEATHS - Communicable diseases, maternal, prenatal and nutritional disorders constitute 38 per cent of deaths. Non-communicable diseases account for 42 per cent of all deaths. Injuries and ill-defined causes constitute 10 per cent of deaths each. However, majority of ill-defined causes are at older ages (70 or higher years) and likely to be from non-communicable diseases.

Rural areas report more deaths (41 per cent) due to communicable, maternal, prenatal and nutritional conditions. The proportion of deaths due to non-communicable diseases is less in rural areas (40 per cent). Injuries constitute about the same proportion (about 10 per cent) in both rural and urban areas**.**

DISEASE - India suffers from high levels of diseases including Malaria and Tuberculosis where one third of the world's tuberculosis cases are in India. In addition, India along with Nigeria, Pakistan and Afghanistan is one of the four countries worldwide where polio has not as yet been eradicated completely.

India had an estimated 2.27 million HIV-positive persons in 2008, with an estimated adult HIV prevalence of 0.29 per cent. This is nearly 7 per cent of the global burden of 33 million HIV cases.

As HIV prevalence among high-risk groups (HRG) is very high compared to that among the general population, India continues to be in the category of concentrated epidemic. The sexual mode continues to be the major mode of transmission, though transmission through injecting drug use and men having sex with men are on the rise in many new pockets.

EPIDEMIOLOGIC TRANSITION OF INDIA - Many countries have in the course of their development gone through what is known as an 'epidemiologic transition', where the initial high burden of disease and mortality due to infectious diseases and maternal and child mortality, declines and gives way to non-communicable diseases, injuries and geriatric problems as the main burden of disease.

India's epidemiologic transition, however, is marked by three challenges in disease control, all of which need to be managed concurrently. First, India has to complete its unfinished agenda of reducing maternal and infant mortality as well as communicable diseases such as Tuberculosis, vector-borne diseases of malaria, kala-azar and filaria, water-borne diseases such as cholera, diarrhoea, leptospirosis and the vaccine-preventable measles and tetanus. Second, India has to contend with the rising epidemic of non-communicable diseases including cancers, diabetes, cardiovascular diseases, chronic obstructive pulmonary diseases and injuries. And finally developing systems to cope with there is the category of the new and re-emerging infectious diseases like HIV and avian influenza.

ORGANISATION OF HEALTH CARE SERVICES

THE PUBLIC HEALTH SECTOR- The provision of health care by the public sector is a responsibility shared by the state government, Central Government and local governments. General health services are the primary responsibility of the states with the Central Government focusing on medical education, drugs, population stabilisation and disease control. The National Health Programs of the Central Government related to reproductive and child health and to the control of major communicable diseases like malaria and tuberculosis have always contributed significantly to state health programs. More recently, under the NRHM, the Central Government has emerged as an important financier of state health systems development.

THE PRIVATE HEALTH SECTOR- At the time of independence only about 8 per cent of all qualified modern medical care was provided by the private sector. But over the years the share of the private sector in the provision of health care has at about 80 per cent of all outpatient care and about 60 per cent of all in-patient care.

Over 75 per cent of the human resources and advanced medical technology, 68 per cent of an estimated 15,097 hospitals and 37 per cent of 623,819 total beds in the country are in the private sector. Of these, most are located in urban areas. Of concern is the abysmally poor quality of services being provided at the rural periphery by the large number of unqualified persons. The rural women are more likely to die during childbirth due to lack of access to caesarean operations.

NATIONAL RURAL HEALTH MISSION- The policy response of the government to strengthen the health sector and attain its health objectives was the launching of the National Rural Health Mission in 2005. In its design and implementation, the NRHM has been greatly influenced by the principles of primary health care as outlined in the Alma Ata Declaration of 1978.

The NRHM seeks to be pro-poor in its focus and stresses on community participation and most critically aims to bring the people back into the public health system. The aim and thrust of the mission is ensuring a fully functional, community-owned, decentralized health care delivery system with inter-sectoral convergence and institutional integration across levels. The NRHM is thus conceived as a scheme that includes reproductive and child health programs and disease control programs as part of a sector wide health systems strengthening approach.

FINANCING OF HEALTH CARE

Health Financing is an important component of health systems' architecture and deals with sources of funding the health system. From a public policy point of view, it is desirable that health financing is so arranged that it reduces the overall out-of-pocket (OOP) expenditure on healthcare and protects against financial catastrophe related to healthcare.

The per capita public health spending is low in India, being among the five lowest in the world. The public health expenditure in the country over the years has been comparatively low and as a percentage of GDP it has declined from 1.3 per cent in 1990 to 0.9 per cent in 1999, increased marginally to 1.1 per cent by 2009. The Central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 per cent, but has almost doubled to 2 per cent by 2008-09. Taking cognizance of the important role of public health expenditure, the Eleventh Five-Year Plan (2007-12) document suggests the necessity of building a responsive public health system with the need for increasing the public spending on health from 0.9 % of GDP to 2-3% of GDP and stepping up investment on primary care, communicable diseases and HIV/AIDS prevention.

SOURCES OF FUNDS- As per the National Health Account (2004-05), the total health expenditure in India, from all the sources, was Rs. 1,33,776 crores, constituting 4.25 % of the GDP. Of the total health expenditure, the share of private sector was the highest at 78.05 %, public sector at 19.67 % and external flows contributed 2.28%. The provisional estimates from 2005–06 to 2008– 09 show that health expenditure as a share of GDP came down to 4.13 per cent in 2008–09. Though health expenditure has increased in absolute terms, the proportionately higher growth of GDP has resulted in a moderate increase in the share of health expenditure to GDP over the years. But the share of public health expenditure in the GDP has increased consistently from 2005–06 to 2008– 09. It increased from 0.96% in 2005-06 to 1.10 % in 2008–09.

PUBLIC FINANCING OF HEALTH - Public spending on health accounts for around 1 per cent of the GDP. This ratio is among the lowest in the world, although in recent years the share of public spending in total health spending has been steadily increasing. An important issue in public spending on health relates to the distribution between the Central and state sectors. With the launch of National Rural Health Program (NRHM), the level of public spending on health has risen nearly 2.6 times between 2004-05 and 2009-10 (the estimates for 2009-10 are budget estimates). The share of the Central Government in the total health expenditure increased from 32.1 per cent in 2004-05 to 38.4 per cent in 2007-08. However, there has been a change in the composition between the treasury and society routes in so far as the Central grants to states are concerned. The share of Central grants through State health societies increased from 5.1 per cent in 2004-05 to 16.1 per cent in 2007-08. On the other hand, the share of Central grants to states through treasury route declined from 14.9 per cent in 2004-05 to 8.5 per cent in 2007-08.

Looking at the significance of public health expenditure in achieving better health outcomes and reducing catastrophic health expenditure, the Central and state governments in India have been increasing their expenditure on health, especially since 2005-06, due to the focus on health with the launch of NRHM. . The Union Health Budget increased from Rs.5,255 crores in 2000-01 to Rs.8,086 crores in 2004-05 and to Rs.21,680 crores in 2009-10 while that of States for 2009-10 was Rs. 43,848 crores.

TABLE 2-GROWTH OF PUBLIC HEALTH EXPENDITURE AND GDP, INDIA, 1998-2006

Year	Growth of GDP (in %) Expenditure on health (%)	Growth of total public on health as % of GDP	Total Public expenditure
1996-97	15.9	12.9	0.88
1997-98	11.8	15.5	0.91
1998-99	15.8	18.7	0.94
1999-2000	12.1	14.7	0.96
2000-01	7.7	8.1	0.96
2001-02	8.7	4.5	0.93
2002-03	7.5	3.4	0.89
2003-04	12.8	7.5	0.85
2004-05	11.8	18.8	0.90
2005-06	12.9	17.2	0.94

Source: Database on Public Finance, CMIE.

HOUSEHOLD SPENDING ON HEALTH - Out-of-pocket (OOP) expenditure on healthcare forms a major barrier to health seeking in India. According to the National Sample Survey Organisation, the year 2004 showed 28 per cent of ailments in rural areas go untreated due to financial reasons—up from 15 per cent in 1995–96. Similarly, in urban areas, 20 per cent of ailments were untreated due to financial reasons—up from 10 per cent in 1995-96. Those who access 'free' government health services are expected to purchase medicines from private pharmacies; pay user fees for laboratory tests and of course the ubiquitous informal fees. Those who use the private services of course have to pay considerable amounts. Significantly, those who are insured also do not get full protection. While their OOP payments are reduced, they still have to pay for ambulatory care and for excluded conditions. It is clear that Indians (especially the vulnerable sections) do not have any form of financial protection and are forced to make OOP payments when they fall sick. This is regressive and has both economic as well as social consequences**.**

SOCIAL HEALTH PROTECTION- Apart from increasing public expenditure on direct provision of healthcare, the Central and state governments have also initiated various innovative schemes to increase access and choice of healthcare provider (public or private) to the people, especially in the form of various subsidized health insurance schemes. In order to reduce OOP expenditure of poor sections of the society, especially the unorganized sector which constitutes 93 per cent of the total work force, the XI Plan envisages effective risk pooling arrangements at the state level. A lot of health insurance schemes have been launched in the recent past, with Rashtriya Swasthya Bima Yojana (RSBY) being the most important one announced in the Union Budget 2007-08.

Since 2005-06, the Central Government has been implementing a health insurance scheme for handloom weavers and ancillary workers, and in 2008-09 the outlay for this was Rs.340 crores. The scheme covers handloom weavers and three dependents and the benefit package includes hospitalisation expenses including for all pre-existing diseases, as well as substantial provision for outpatient services. The scheme had covered 1.8 million weavers by 2008-09.

Haryana, Punjab, Maharashtra, Pondicherry, Tamil Nadu and Karnataka, Assam, Himachal Pradesh, Kerala, Sikkim, Uttarakhand, Himachal Pradesh and Jammu and Kashmir have initiated various models of health insurance schemes in 2008-09 and 2009-10.

POLICY ISSUES FOR HEALTH FINANCING IN INDIA- India should reiterate its commitment to achieving a target of increasing public spending on health to 3 per cent of the GDP. To achieve this level of funding, the following critical issues need to be addressed.

More attention needs to be paid to Centre–State financial flows. Under the NRHM, the Central and state governments are expected to share additional health expenditures in the ratio of 85:15. Beyond 2012, the state governments are expected to absorb a higher burden, with the ratio changing to 75:25. As per the estimates made in the note prepared by the Ministry of Health & FW for the XIII Finance Commission, the additional funding needed for this increase in states share is Rs. 15,710 crores for the period 2012-15. This arrangement, however, needs to be carefully examined on a state-by-state basis, mainly with due consideration to the state's fiscal ability. This also calls for working out appropriate incentive systems to ensure that states are rewarded financially for better utilization of public funds and also for recording improved health outcomes. Governments should move away from uniform norms of financing based on population size, geographical area and unit of operation (such as Primary Health Center PHC or sub-centre) towards differential funding based on services delivered, disease burdens, remoteness and difficulty of access.

Public expenditure in the health sector falls short of the target of 2 per cent of the GDP, as suggested in the Eleventh Five-Year Plan document. In order to achieve that target, the public expenditure on health will have to increase to around Rs.1,60,000 crores by 2011-12 as against the budgeted amount of Rs. 66,000 crores in 2009-10 by the Centre and states put together. This will imply that the annual expenditure in the health sector will have to increase by 56 per cent per annum in the next two years. Raising the level of public expenditure by this magnitude in such a short span is a difficult proposition and would require fundamental changes in some key macro-economic indicators. The Tax/Revenue-GDP ratio could be an important factor in this regard, as currently (as per World Development Indicator 2008) the Central Government revenue-to-GDP ratio in India is 12.7 per cent as against the 27 per cent global average. This clearly shows that increasing the tax to GDP ratio may go a long way in raising the level of public health spending to the desired levels, along with increasing the absorptive capacity in the states.

DEVELOPMENT OF HEALTH CARE IN STATE OF KERALA

Kerala's development experience has been distinguished by the primacy of the social sectors. Traditionally, education and health accounted for the greatest shares of the state government's expenditure. Health sector spending continued to grow even after 1980 when generally the fiscal deficit in the state budget was growing and government was looking for ways to control expenditure. But growth in the number of beds and institutions in the public sector had slowed down by the mid-1980s. From 1986–1996, growth in the private sector surpassed that in the public sector by a wide margin.

Public sector spending reveals that in recent years, expansion has been limited to revenue expenditure rather than capital, and salaries at the cost of supplies. Many developments outside health, such as growing literacy, increasing household incomes and population ageing (leading to increased numbers of people with chronic afflictions), probably fuelled the demand for health care already created by the increased access to health facilities. Since the government institutions could not grow in number and quality at a rate that would have satisfied this demand, health sector development in Kerala after the mid–1980s has been dominated by the private sector.

Expansion in private facilities in health has been closely linked to developments in the government health sector. Public institutions play by far the dominant role in training personnel. They have also sensitized people to the need for timely health interventions and thus helped to create demand. At this point in time, the government must take the lead in quality maintenance and setting of standards. Current legislation, which has brought government health institutions under local government control, can perhaps facilitate this change by helping to improve standards in public institutions.

CONSEQUENCE AND SUGGESTIONS

The Indian healthcare industry is seen to be growing at a rapid pace and is expected to reach over US$70 billion by 2012 and US$280 billion industry by 2020. The Indian healthcare market was estimated at US$35 billion in 2007. In order to meet manpower shortages and reach world standards India would require investments of up to $20 billion over the next 5 years.

Forty percent of the primary health centers in India are understaffed. According to WHO statistics there are over 250 medical colleges in the modern system of medicine and over 400 in the Indian system of medicine and homeopathy (ISM&H). India produces over 250,000 doctors annually in the modern system of medicine and a similar number of ISM&H practitioners, nurses and Para professionals. Better policy regulations and the establishment of public private partnerships are possible solutions to the problem of manpower shortage.

India faces a huge need gap in terms of availability of number of hospital beds per 1000 population. With a world average of 3.96 hospital beds per 1000 population India stands just a little over 0.7 hospital beds per 1000 population. Moreover, India faces a shortage of doctors, nurses and paramedics that are needed to propel the growing healthcare industry.

The majority of the Indian population is unable to access high quality healthcare provided by private players as a result of high costs. Many are now looking towards insurance companies for providing alternative financing options so that they too may seek better quality healthcare. Only 10% of the Indian population today has health insurance coverage, this industry is expected to face tremendous growth over the next few years as a result of several private players that have entered into the market. Increasing health insurance penetration and ensuring affordable premium rates are necessary to drive the health insurance market in India.

Special focus on 235 poor performing districts which contribute the bulk of child and maternal mortality and high fertility rate in the nation. The intervention would be in the form of a special district plan and closely monitored by a joint State–Centre monitoring mechanism. It also involves the introduction of skilled human resources from outside in the form of well-supported trainers and skilled and quality supervisors who would ensure that the necessary skills development in the existing workforce is improved.

The Report to the People on Health examines the progress made in the health sector, identifies the constraints in providing universal access and provides options and future strategies. In terms of life expectancy, child survival and maternal mortality, India's performance has improved steadily. Life expectancy is

now 63.5 years, infant mortality rate is now 53 per 1000 live births, maternal mortality ratio is down to 254 per lakh live births and total fertility rate has declined to 2.6. However there are wide divergences in the achievements across states. There are also inequities based on rural urban divides, gender imbalances and caste patterns.

Disease Control Programs have also shown considerable improvements. Polio is near elimination and diseases like Tuberculosis, Neonatal Tetanus, Measles and even HIV have shown decreasing trends. However, Malaria continues to be a challenge.

The crisis in unavailability of skilled human resources for the health sector has been addressed through the rapid expansion of medical education in the country.

There is needed to consider a model of Primary Health Care where many of the health services would be provided by the locally selected and adequately trained health care providers with medical doctors contributing largely to more specialised care.

Some key policy issues that need to be addressed in the short term.

1. Role of Centre in State Health Systems Development
2. Increase Public Investment
3. Role of Purchasing Health Care Services from the Private Sector
4. Focus on Health Determinants
5. Human Resources for Health
6. Impact of Technology
7. Health Promotion
8. Health training to public
9. Decreasing extremely TFR, especially between poor people

The new initiatives in health policy must be uniform and influence by vigorous public debates. The consensus of national goals, emerging from such a process is, likely to gain greater acceptance and honored by professional bodies, civil society organizations, the private sectors and community representatives.

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