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HEALTH CARE SYSTEM IN INDIA : A STUDY

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INTRODUCTION

The health care system in India is as old as Indian civilization. In fact before the advent of the western system of medicine each nation had its own indigenous medicine system, which offered medical care to their citizens. These systems expanded independent of one another. Each system developed its own underlying principle of treatment. The existence of Ayurveda in India most likely dates back to the period of the Indus Valley Civilization. Jivaka, Charka, Susrata, Vaghbhata, Dhanvantri were some of the medical specialists of ancient time in India. It was also India that offers the world the first hospital service around 320 B.C., when the great ruler Ashoka built the first hospital. It was specially planned to treat diseases (Parsad, 1992).

The own indigenous system of medicine was developed in this country. The most vital of these are the Ayurveda and Unani method. The previous was developed in the early historical era by early Hindu physicians like Charaka and it was by and large pursued by the Hindus. The Unani method, on the other hand, was developed by the Mohammedan rulers of India and was usually pursued by the Muslims. The Allopathic method, which is comparatively novel to this country, was brought in by the Europeans. (Banerjee, 1976).

HEALTH CARE DURING BRITISH ERA

It took some time for the western system of medicine to make its influence on the people of India as a whole, even after the arrival of the Britishers in India. Because of the deliberate policy of the Britishers to keep the nation economically and socially backward, the health care system they introduced remained incomplete. As a consequence not only the Indian indigenous system of medicine was ignored, people in need of health care had to depend upon the limited capability of the practitioners of these systems. Fortunately this state of neglect did not continue for long time inspite of Britishers political policy of exploitation (Parsad, 1992).

During the British rule health services were built up mainly for looking after the Britishers and remained limited to urban areas. A huge number of poor and rural people did not obtain satisfactory relief from the system. During the pre- independence time the health status of Indian people was miserable which is shown in Table-1.1

Table 1.1: Health Indicators

A.	IMR*- 16.2 (1937)	B. HRD* (1941-42)
	Life expectancy (1920-30)	1 doctor / 6,300 people
	At birth: 26.0-M	1 nurse / 43,000 people
	: 26.5-F	1 lady health visitors / 40,000
	Fertility rate: (1930-40) – 45	1 pharmacist / 40,000
	Sex ratio: (1941) - M: F	1 dentist / 300,000
	1000: 945	

Source: Health Care a basic input in Development, Yojana (Mukherjee, August, 1998).
* Infant Mortality Rate (IMR)
*Human Resource Development (HRD)

Malnutrition was general phenomenon and 50 percent of children died before the age of 5 years. PHC was not there and only 14 medical colleges were there. Potable water was accessible to not more than 4.5 percent of the total population, less than 2 percent of people had accessed to sewerage disposal facilities (Mukherjee, 1998).

Although a highly structured system of public health was established under the British rule. A public health committee was appointed in 1864 for surveying the public health requirements of Bengal, Madras and Bombay presidencies. Plague Commission was also appointed in 1886 during British era (Banerjee, 1976).

HEALTH CARE IN THE POST INDEPENDENCE ERA

After independence, India faced a challenge of huge human migration of people from Pakistan. India inherited a devastated economy. It took long time to recuperate from this situation (Mukherjee, 1998). After independence in 1947, democracy was established with a written constitution. The Central Government had chosen the path of mixed economy in which both publicand private sectors could do extremely well. Planning was the essential method through which health administration was being done.

Since the method of planning was commenced in India there have been numerous five-year plans that leaded the health care programmes of the different state governments from time to time. The guidelines for National health planning given by different committees as described by Khan (2005) is specified below:

Bhore Committee, 1946: The Government of India in 1943 appointed a committee under the chairmanship of Sir Joseph Bhore to survey the then existing health conditions and health organizations. The committee recommended that no one shall fail to secure sufficient medical care as of his incapacity to pay for it. Keeping in view the complexity of medical practice, the health care services provider should provide when fully developed with all the consultant, laboratory and institutional amenities for proper diagnosis and treatment. There was urgent need to provide

medical assistance and preventive healthcare to huge rural inhabitants of the country and health services should be located as close to the people as possible.

Mudaliar Committee, 1962: The government of India in 1959 appointed another committee popularly known as Mudaliar committee to survey the progress finished in the area of health since submission of Bhore's committee report and to formulate recommendations for expansion and future development of health services in the country. The committee recommended the strengthening of the district hospital with specialist service to serve as centre base of regional services. Each primary health centre should not serve more than 40000 populations and improve the quality of healthcare provided by the primary health centers. They further suggested creation of an all India Health Services on the pattern of Indian administrative service.

Chadah Committee, 1963: The Government of India in 1963 appointed a committee under the chairmanship of Dr. M.S. Chadah, the then Director General of Health Services to study the provision necessary for the maintenance phase of the NMEP. The main recommendations of the committee were the vigilance operations of National Malaria Eradication Programme should be the accountability of general health services, one worker should visit a population of 10,000, the basic health worker to look after additional duties of collection of vital statistics and family planning and 3-4 workers should be supervised by a family planning health assistant.

Mukerji Committee, 1965: This committee was appointed to appraise the strategy of familyplanning programme. The committee recommended that there should be separate staff for family planning programme and family planning assistant should look after family work solely. The basic health workers should not be utilized for family planning programme. The malaria eradication activities should be separated from the family planning, so that the later can focus on family planning programme.

Mukerji Committee, 1966: The committee worked out the details of the basic health services which should be provided at the block level and some consequential strengthening required at higher administration levels.

Jungalwalla Committee, 1967: The central government at its meeting in Srinagar in 1964 appointed a committee known as the committee on integration of health services under the chairmanship of Dr. N. Jungalwala the then Director National Institute of Health Administration and Education, New Delhi. The committee recommended the integration of organizations and personnel in the field of health from highest to the lowest level in the service through unified cadre, common seniority, recognition of extra qualifications, equal pay for equal work, specialized pay for specialized work, and no private practice but superior working conditions.

Kartar Singh Committee, 1973: The government constituted a committee in 1972 under the Chairmanship of Kartar Singh, Additional Secretary, Ministry of Health and family planning. The committee recommended that the present auxiliary nurse midwives to be replaced by the newly designated female health workers and the present day basic health workers, vaccinators, health education assistants, malaria surveillance workers, and family planning health assistants to be replaced by male health workers. Each primary health centre should be divided into 16 sub-centers

each having a population of about 3,000 to 3,500 depending upon geography and means of communication.

Shrivastava Committee, 1975: The government of India in1974 appointed a committee under the Chairmanship of Dr. J.B. Shrivastava, the then Director General of Health Services. The committee recommended the formation of groups of semiprofessional and paraprofessional health workers within the community itself e.g., postmasters, school teachers, and gram sewaks to provide simple, promotive, preventive health services needed by the community. The establishment of two cadres of health workers, namely – multipurpose health workers and health assistants between the community level workers and doctors at the primary health centers were also recommended. The establishment of medical and health education commission for planning and implementing the reforms was considered necessary.

Rural Health Scheme, 1977: The programme of training of community health workers was initiated during 1977-78. Steps were also initiated for involvement of medical colleges in the total health care of selected PHCs with the objective of reorienting medical education to the needs of rural people. Reorienting training of multipurpose workers engaged in the control of communicable disease programmes into unipurpose workers were also recommended.

Working group, 1981: A working group of health was formed by the planning commission in 1980 with the Secretary, Ministry of health and family welfare, as its Chairman, to identify in programmes terms the goal for health for all by year 2000 and to outline with that perspective, the specific programmes for the 6th Five year plan.

National Health Policy, 1983: It was formulated in 1983. The initiatives under this policy were a phased, time bound programme for setting up a network of comprehensive primary healthcare services, intermediation through health volunteers having appropriate knowledge and an integrated network of evenly spread specialty and super specialty services.

National Health Policy, 2002: The changed circumstances relating to the health sector of the country since 1983 have generated a situation in which it was necessary to review the field, and to formulate a new policy framework as the National Health Policy, 2002. It endeavors to maximize the broad-based availability of health services to the citizens of the country on the basis of realistic considerations of capacity.

The main aim of this policy is to accomplish an acceptable standard of good health amongst the general population of the country. It is anticipated that this initiative will strengthen the capacity of the public health administration at the state level to provide efficient service delivery. The contribution of the private sector in providing health services would be much enhanced, mainly for the population group which can afford to pay for services. Priority will be given to preventive and first line curative initiatives at the primary health level through increased sectoral share of allocation. Increased access to tried and tested systems of traditional medicine will be ensured.

The states of India are mostly free in matters concerning to the delivery of healthcare to the community. Each state has developed its individual system of healthcare delivery, independent of the central government. The central responsibility consists of policy making, planning, guiding,

assisting, evaluating and co-coordinating. The health ministries of different states in India work in manner to ensure health services cover every part of the states (Khan, 2005).

HOSPITALS IN INDIA

A hospital is a residential establishment, which offers short-term and long term medical care consisting of diagnostic, observational, therapeutic, and rehabilitative services for persons suffering or supposed to be suffering from a disease or injury. It may or may not also offer servicesfor ambulatory patients on an outpatient basis (WHO). Today, a hospital is a place for treatment of human ills and restoration of health and well-beings of those temporarily deprived of these (Khan, 2005).

Hospitals may vary in size, funding, type of patients, and conditions of treatment. But fundamental job of hospitals is the treating of and caring for patients (Kurtz & Chalfant, 1984). Hospitals are key health care delivery institutions of our country, as in most of the developing countries of the world. The hospitals offer primary, secondary and tertiary health care services (Sahni, 1985). Primary healthcare services are provided by primary health centers at local level, secondary health services are provided at district hospitals and tertiary health services are more specialized, requires specific facilities and highly specialized health workers which is provided by the regional or central level institutions like medical colleges hospitals, All India Institutions and specialized hospitals (Khan, 2005).

Early Indian rulers considered the provision of hospital care to the sick as their spiritual and temporal responsibility. The forerunners of the present hospitals in India can be traced to the times of Buddha, followed by King Ashoka. India had well-organized healthcare delivery system even inthe ancient times. The most notable of the early hospitals were those built by King Ashoka (173- 232 BC).

The modern system of Medicine in India was introduced in the 17th Century with the arrival of European Christian missionaries in South India. In the 17th Century, the East India Company established its first hospital in 1664 at Chennai for its soldiers and in 1668 for civilian. Medical training was initiated with the first medical college opening in Calcutta in 1835, followed by Mumbai in 1845 and in Chennai in 1850 (Khan & Khan, 2005).

Today's hospital is a complex organization and contains within itself many diverse function, services and personnel. The essence of modern hospital- Its pride and success is that it is the workshop where sophisticated and increase complex assemblage of specialists working as a team can apply their skills and techniques in increasingly successful interventions (Khan, 2005). The types of hospitals are:

- The term general hospital involves a multipurpose facility. The general hospitals offer services to patients with all types of diseases and health conditions. The general feeling is that voluntary and government hospitals put the needs of patients first, whereas private

facilities are more interested in profits. But many people also believe that private hospitals run more efficiently than not-for-profit facilities (Kurtz & Chalfant, 1984).

- Specialty hospitals focus their services on specific kinds of health conditions or on certain categories of patients. For instance, some specialty hospitals treat only mental illness, cancer, tuberculosis, cardiac problems, and broken bones. Some deal solely with the children problems, some with adults only, other with disease of women (Kurtz & Chalfant, 1984).

HEALTH SPENDING IN INDIA

During the eighties government financing increased considerably and demonstrate the prospect for taking the public health sector to new height. But at the turn of the nineties the World Bank guided economic reforms (1991 onwards) set in a trend where the private sector has taken control of the health sector in India at the cost of the public health sector. Until 1991 public health budgets moved in a steady upward trajectory slowly expanding access to public healthcare. But budgets after 1991 have set in a liner downward trend and this has severely impacted the government healthcare system, has affected adversely the huge majority of the poor who are the main users of the public healthcare facility and have forced them to migrate to the private health care services provider. The government funds allocated to healthcare sector have always been low in relation to the population of the country, and in 2004 were as low as 0.85 percent of the GDP (Duggal, 2007).

Table 1.2: Growth of Private Health Expenditures in India in comparison to Public Health Expenditure 1951-2006

		1951	1961	1971	1981	1986	1991	1995	1998	2000	2003	2004	2006BE
Health Expenditure (Rs.Billion)	Public Private	0..22 -	1.08 3.65	3..35 10.99	12.86 52.84	29.66 90.54	53.50 146.98	85.65 278.59	126.35 459.00	172.16 835.17	201.21 1282.8	216.19 1450.0	301.21 1850.0
Health Expenditure (percent of GDP)	Public Private	0.25 -	0.71 2.25	0.84 2.60	1.05 4.06	1.19 3.61	1.04 2.88	0.93 3.04	0.91 3.30	0.88 4.76	0.89 5.69	0.85 5.75	0.91 5.61

Source: The Indian Economy Review (Duggal, 2007)., BE = Budget Estimate.

Table 1.2 shows that health expenditure incurred by private sector in comparison to public sector is increasing from 1961 onward, it is 6.7 times high in 2004. It also shows that health expenditure (percent of GDP) is also increasing from 1961; it is more then double in 1991 and 5 times high in 2004.

CURRENT STATE OF AFFAIRS OF HEALTHCARE SERVICES

In the last five years hospitals have been equipped with world class infrastructure, latest sophisticated technology and world class surgeons to undertake high end procedures, Indian need

not go abroad for treatment. Multimodality comprehensive treatment of cancer, heart, bone- marrow transplant, organ transplant and treatment of almost all kind of other diseases are available with the advance diagnostic facility. Increase in the strength of trained nursing staff, keeping pace with the changing need of the patients, more infrastructure and finance, continuous up-gradation of technology, and national or more particularly international accreditation is required for further improvement in the quality of healthcare services. Hospitals assess their services from patients' perspective collect feed back information from patients and their relatives for further enhancement in quality. Many specialty hospitals are known for their quality of treatment and for high end procedures like cardiac, cancer, organ transplant, orthopedic and neurosurgery. Patients inflow is increasing more and more, however, if the existing capacity is increased they can treat more number of patients. Since patients' inflow is increasing extra space, infrastructure, accommodation, and more equipment are needed and hence more finance is required.

Private and charitable hospitals advertise their services and spend on promotion of services, while government hospitals are not spending on advertisement because they are not provided any fund for advertisement by government. Accreditation is symbol of quality, international patients prefer accredited hospital, in India some hospitals are accredited from Joint Commission International; many hospitals are seeking accreditations form National accreditation Board for Hospital (NABH), hospitals already accredited from NABH are applying for JCI. Accreditation is necessary for to create brand image of the hospital at national and international healthcare market. Hospitals are investing best input in the technology and manpower and are trying to creating star facility.

TRENDS IN HEALTHCARE SERVICE INDUSTRY IN INDIA

With the entry of big business houses in healthcare sector, large corporate hospitals are being setting up giving a new light to the existing competition. Number of hospitals applying for national accreditation with NABH is increasing; those already accredited with NABH are applying for international accreditation from Joint commission International. With the emerging of national & international accredited hospital competition in health sector is going up. More particularly competition is increasing among hospitals of private sector. Fortis healthcare recently bought 90 percent stake in Escorts hospital for Rs.585 crore and is acquiring another 250 bed hospital in the Bangalore city. Wockhardt hospital under its expansion and diversification plan is setting up a 200 bed hospital in Devanhalli, Bangalore. Manipal healthcare group is considering a 350 bed hospital in Bangalore. St John's hospital is setting up a large super-specialty corporate hospital in the same campus where it runs a 1000 bed missionary hospital. Fortis is acquiring another newly built Imperial hospital in Bangalore city. Besides adding more facilities at their domestic units Apollo, Max, Wockhardt and Fortis healthcare groups are planning for overseas expansion also. Apollo hospital group has planned to set up and manage hospital projects in Fiji and Mauritius. Max healthcare another leading hospital of India is trying an entry in to the US, UK, and far-east markets besides the expansion of its operations in countries like Bangladesh and Afghanistan.

Wockhardt is eyeing markets of Europe, more particularly UK, the company is already building its brand presence through tie –ups with leading healthcare insurance providers in the US, UK, and Singapore. Competition on costs could also make healthcare affordable for more people in India. India has cost advantage. It is only one-fifth of the costs in the West. The price of certain high-end procedures is already coming down. A heart bypass surgery for instance could cost Rs.3.5-4 lakh five years ago, and cost today not more than Rs. 2 lakh. For the first time travel industry partners tour operators, hotel and airlines and premium corporate hospitals are busy forging tie-ups to attain more market share in India and from overseas as well (Rao, 2005).

MEDICAL TOURISM IN INDIA

Future of medical tourism is bright and is considered as a mile stone for growing Indian economy. World class facilities and infrastructure will make India a most sought after destination for medical tourism in the world. Specialty hospital serves the patient with latest innovative technology at less cost in comparison to other countries. Hospital by marketing efforts are successful in presenting their services in international healthcare market and are successful to attract more patient and market share. India has a potential to attract foreigners because India enjoys a unique position as it offers a unique basket of services i.e. holistic medicinal services with yoga, meditation, ayurveda, allopathy besides other system of medicines. Clinical outcomes in India are at par with the world's best center, besides having internationally qualified and experienced specialists (Baxi, 2004).

The pricing is sensational, medical costs in India could be any where between one-fifth to one- tenth of the cost in the west. For instance a heart surgery in the U.S costs $30000 while it costs even less than $6000 here. Similarly a bone marrow transplant in U.S. costs $250000 while it is $26000 in India (Baxi, 2004). The standards and infrastructure of hospitals in India are now at par with global best practices. Some hospitals in India today have the infrastructure and equipment that matches the best centers in the world, be it transplantation, cancer treatment, radiotherapy, neurosurgery including sterotactic surgery. Many hospitals have affiliations with international bodies, the Asian heart institute in Mumbai is affiliated to the Cleveland Clinic, and Wockhardt to Harvard Medical. Fortis heart has consulted Massachusetts General Hospital for its protocols (Bisserbe & D'Silva, 2005). Recognizing the importance of accreditation in medical tourism many hospitals are applying for NABH for its accreditation, those already accredited with NABH are applying for Joint Commission International. Indian healthcare federation is working on evolving a common band of pricing of accredited hospitals for foreign patients, the other area of focus include improving the human resources for health delivery and ensuring that quality becomes the driving force for all hospitals and healthcare providers. In future healthcare business will flourish in India and future of medical tourism is bright.

REFERENCES

Agnihotri, R.C. (1995). Geomedical Environment and health care- A Study of Bundelkhand Region. Delhi: Rawat Publications.

Banerjee, U. (1976). Policy and legal Framework for Health Services, Health Administration in a metropolis. N.Delhi: Abhinav Publications.

Baxi, A. (2004, October 31). Its' advantage India in medical tourism, says CII, The Economic Times, p. 3.

Bisserbe, N. (2005, September 22). Health no longer just for wealthy, The Economic Times, p. 20.

Bisserbe, N. & D'Silva, J. (2005, October 31). Indian hospitals see growing biz from Europe, US. The Economic Times, p. 21.

Dubos, R. (1968). Man, Medicine and Environment, Harmondsworth, Pelican.

Duggal, R. (2007, February 15). Changing Health Budgets. The Indian Economy Review, N. Delhi: Publishers Roller act Press services, (4), 35-46.

Jampani, S. (2006, June). Innovation in the healthcare services industry in India- Case Study. Journal of Services Marketing, 4(2), 60-62.

Khan, F. M. (2005). Health Planning and Management, A Text Book of Health Awareness. N. Delhi: Modern Publishers, 1. 157-171, 215-220, 228.

Khan, F. M. & Khan, H. (2005). World health organization definition of hospital, Management of Super Specialty Hospitals. N. Delhi: Deep and Deep publishers.

Kurtz, A. R. & Chalfant, H. P. (1984). Hospitals and Healthcare Agencies, The Sociology of Medicine and Illness. Boston: Allyn and Bacon Publishers.

Karanjekar, R. (2007, August). Should Hospitals Increase their Spending on Marketing? Express health care, www.expresshealthcaremgmt.com Accessed on 23-6-09.

Mukherjee, A.K. (1998, August). Health care: A Basic Input in Development. Yojana, 42(8), 65.

Mishra, S. (2005, February). Scope of marketing in Healthcare sector. Indian Journal of marketing, 35(2), 5.

Mukherjee, W. & Mookerji, M. (2004, December 22). Hospitals busy tying up with hospitality Inc. The Economic Times, 6.

Nath, U. (2005, July 15). Specialty hospitals: Need market impact and its implications. Southern Economist, 44(6), 21-22.

Nagar, D. (2007, August). Should hospitals increase their spending on marketing? Express health care. www.expresshealthcaremgmt.com, Accessed on 23-6-09.

Park, K. (1994). Preventive and social medicine. Jabalpur: M/S Banarsidas Bhanot publishers.

Phillips, D. R. & Verhasselt, Y. (1994). Introduction: Health and Development, Health and Development. London: Routledge publishers.

Parsad, P. B. (1992, September). Marketing of Health Services in Maternity Care- A managerial approach, Doctoral Thesis, Venkateshwara University, Tirupati, 1-5, 12,13, 41, 42.

Phillips, R. D. & Verhasselt, Y. (1994). Introduction: Health and Development, Health and Development, London: Routledge publishers.

Prakash, G. & Singh A. (2007, June). Out sourcing of healthcare Services in Rajasthan: An Exploratory Study. IIBM Management Review, 19(2), 158,159,168.

Raman, N. & Prasad, B. M. (2005, June). Creating and sustaining superior performance of hospitals in Coimbatore. Indian Journal of Marketing, 35.

Rao, G. (2005, October 8). Healthcare sector in expansion mode. The Economic Times, 13.

Ramanujam, P.G. (2009). Marketing of healthcare services, www.infibeam.com, Accessed on 6-7-09.

Sahni, A. (1985). Financing of health services in India. Bangalore: Indian Society of Health Administrators.

Sharma, G. (2004). Service Industry management, Chandigarh: IIFT Research-consultancy and Publication division, , 27, 28.