IJHDIS: *Vol. 9, No. 2 (July-December 2016) pp. 189-202* ISSN : 0974-3529

INCLUSIVE PUBLIC HEALTH CARE IN INDIA

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Abstract: *It is well recognized that improvement in the health status of population is both an important means of increasing productivity and economic growth as well as an end in itself. The importance of improvements in health is also acknowledged in the Millennium Development Goals of the UNDP, which calls for a dramatic reduction in poverty and improvements in health, especially of the poor. In India, with its vast majority of poor population, ensuring the good health of the people is a challenging task. The concept of inclusive growth and development has gained momentum in the changing economic environment and policy regime. The term is widely used for inclusion of weaker, vulnerable and marginalized population in growth and balanced spatial development. We lack health infrastructure while delivery of public health care services are poor. The disease burden is also increasing due to change in life style, emergence of chronic diseases and poor coverage of health insurance. The role of private sector in health care services is gradually increasing while the role of public sector in heath case sector is diminishing. Against this view point, present paper purports to review the inclusive public health care in India.*

The concept of inclusive growth and development has gained momentum in the changing economic environment and policy regime. The term is widely used for inclusion of weaker ,vulnerable and marginalized population in growth and balanced spatial development. It is really a surprise for those who are keenly observing the trends of Indian economy as to how all of sudden the policy-makers have started thinking of inclusion of the downtrodden people into the growth process. Two things are clear from this change in the thought process. One, the increased growth rate of

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Gross Domestic Product, has miserably failed to yield the results desired of market-led and private sector-led growth. Two, unless something else is done, the higher growth rate of GDP alone cannot solve problems of the common people. The Government has now realized that high national income growth alone will not address the ever growing challenges of un-employment, poverty reduction and balanced spatial development and improving human development as well as quality of life. Inclusive urban planning and governance has got momentum in the context of economic liberalization and new policy regime. Government of India has also launched inclusive policies and programmes for mainstreaming the urban poor, marginalized and weaker sections in planning and development besides initiating citizen and pro-poor centric reforms in urban local governments.

The argument for inclusive development includes (i) there is consensus that investment in infrastructure is an essential ingredients for growth, (ii) if infrastructure is to contribute to inclusive growth, policy will have to focus on certain types of infrastructure, (iii) the focus of investment on infrastructure targeted towards inclusive development will have to be complimented by policies which improve utilization of the infrastructure by disadvantaged growth (Rauniyar, 2010). Inclusive growth is necessary for sustainable development and equitable distribution of wealth and prosperity. The concept of inclusiveness involves four attributes:

Opportunity: Is the economy generating more and varied ways for people to earn a living and increase their incomes over time?

Capability: Is the economy providing the means for people to create or enhance their capabilities in order to exploit available opportunities?

Access: Is the economy providing the means to bring opportunities and capabilities together?

Security: Is the economy providing the means for people to protect themselves against a temporary or permanent loss of livelihood?

Consistent with this, 'inclusive growth' is a process, in which, economic growth, measured by a sustained expansion in GDP, contributes to an enlargement of the scale and scope of all four dimensions. India's recent growth performance has been spectacular; the country remains one of the fastest growing economies in the world. But these achievements have created new challenges. It is essential for India's rapidly growing economy to improve the delivery of core public services such as healthcare, education, power and water supply to all its citizens. This means empowering its people to demand better services through reforms that create more effective systems of public sector accountability. Options include decentralizing to local governments, producing regular and reliable information for citizens, undertaking internal reforms of public sector agencies, or creating public-private partnerships. But ultimately, implementation is everything. Maintaining rapid growth will require more, and more effective, investments in infrastructure to create more jobs for low and semi-skilled workers. Growth should more equally be shared by all, as many parts of the country remain poor. Promoting inclusive growth includes revamping labor regulations, improving agricultural technology and infrastructure, helping lagging states and regions catch up, and empowering the poor through proactive policies that help them to take part in the market on fair and equitable terms. The experiences of last half a century of planned development in the country how that the benefits of economic grant have not percolated to the grassroots level. It is therefore, the decision makers have now felt that economic growth in the country has to be inclusive in order to make it sustainable. If policies that bring about economic growth do not benefit the people in a wide and inclusive manner, they will not be sustainable. Equally, inclusive growth is essential to grow the market size, which alone will sustain growth momentum and also will help build supply side with competitive cost. Above all, inclusive growth is the only just and equitable way that any society can grow.

Singh and others (2011) have highlighted the policy perspective, challenges and suitable strategies for inclusive development in India. They are of the view that achieving inclusive development and

economic growth is not so easy and major challenges in the path of inclusive development such as naxalism, development deprivation, development induced displacement, regional disparities, social exclusion, etc. need to be addressed while mainstreaming of women, marginalized and weaker sections in the development process is imperative. The inclusive development has been a subject of debate among policy makers, planners, administrators, social thinkers and activists mainly due to the failure of trickle down argument which has envisaged that the fruits of development would automatically reached to the lowest rung of ladder i.e. weaker and vulnerable sections of society. The inclusive policy includes general pro-poor policy for the welfare of the poor as a whole including the discriminated and deprived groups, equal opportunity policy for disadvantaged and deprived groups in the forms of measures like legal provisions against discrimination as well as pro-active measures in the form of reservation to give equal share in income earning capital assets, in public and private sector employment, in education and housing and participation in governance through fare share in legislature, executive and administration with necessary provisions in Constitution and the laws. The mass poverty has been the major problem in the developing countries and poverty remains endemic across South-Asian countries. Poverty can be seen as a set of social relationships in which people are excluded from participation in the normal pattern of social life. It is not only the lack of material resources but lack of personal security, inaccessibility to information as well as inability to influence political decisions are also included within the concept of poverty. World Bank (2005) has also highlighted that poverty reduction has become the primary mission of developing countries and international development community. In order to promote equity the policy should built equitable justice systems, ensure greater equity in access of land, make investment in the infrastructure of backward areas, activate measures such as expanding the access of poor to financial markets through the expansion of micro credit, maintain more flexible labour market while protecting core labour standards and stands for open market which provide help to the poor by investing in skill development and infrastructure in backward areas. The measures for empowering people at the grass roots level through

improving local level democracy by delegating real power to local government , holding regular free and fare elections at the local level and correcting the under representation of under classes in these local governments are imperative. Dev (2008) is of the view that inclusive growth is a broad concept covering economic, social and cultural aspects of development. A growth which is broad-based across sectors and inclusive of the large part of the country's poor, disadvantaged, deprived and excluded sections of the citizens. Inclusive growth strategy suggests that people of all sections and regions get an opportunity to participate in the growth process, which implies engender the policy design that includes the people who get excluded in normal course as also to make a variety of provisions and services accessible to all sections including those who got excluded so far. World Bank (2006) has maintained that inclusive growth may be achieved by focusing on expanding the regional scope of economic growth, expanding access and thriving markets and expanding equity in the opportunities for the next generation of Indian citizens.

It is increasingly being recognized that good health is an important contributor to productivity and economic growth. India has a vast network of health infrastructure ranging from sub-centres to super specialty hospitals. Most of the hospitals are being developed and managed by public sector, however, the increasing role of private sector in development of health infrastructure and delivery of health services is gaining importance (Mishra *et al.*, 2003). Though, India has large gains in health status since Independence however, the burden of diseases is gradually increasing. One of the biggest blots in the current health scenario is the failure to control the communicable diseases despite the availability cost effective and relatively simple technologies (Talib and Rehman, 2013) .These pre-transition communicable and infectious diseases constitute a major cause of premature death in India. They kill over 2.5 million children below the age of 5 and an equal number of young adult every year. Indian accounts for 1/3rd of global TB and the largest number of persons suffering from active TB in the world. According to available estimates, about 2.2 million people are added each year to the existing load of about 15 million active TB cases. The threat

presented by the rapidly growing HIV/AIDS infection has not received the priority attention that it deserves. It is estimated that the number of HIV infected persons in India are about 5 million and this number is gradually increasing (Planning Commission, 2011).

There were 2510 CHCs, 23391 PHCs and 145894 sub-centres in India during 2009. There were 127690 government hospitals and out of them 3748 hospitals were found located in urban areas in 2009 in India. The higher numbers of CHCs were found located in Uttar Pradesh, Maharashtra, Rajasthan, West Bengal, Madhya Pradesh, Karnataka and Gujarat while numbers of CHCs were reported higher in the state of Uttar Pradesh followed by Karnataka, Maharashtra, Rajasthan, Bihar and Andhra Pradesh. Numbers of total government hospitals were reported higher in Maharashtra followed by Bihar, Orissa, Karnataka and Uttar Pradesh. India's health indicators are almost at the same level as the average of low income economies. The distribution of burden of diseases between communicable and non-communicable diseases and injuries in India, China, high income, low and middle income countries highlights our failure to control communicable diseases. These account for more than half of the burden. Non-communicable diseases account for about $1/3^{rd}$ of the total burden of diseases. Among the communicable diseases in India, the major diseases include infectious and parasitic diseases (50 per cent), respiratory infections (19 per cent), pre-natal conditions (17 per cent), nutritional deficiencies (8 per cent) and maternal conditions (6 per cent). Non-communicable diseases include mainly neuropsychiatric disorders, cardiovascular disease, respiratory disease, digestive disease, congenital anomalies, malignant neoplasm, sense organ disorders, etc. Average per hospitalization expenditure is reported higher in urban areas as compare to rural areas. The expenditure is reported higher in case of private hospitals as compare to government hospitals since public sector hospitals are being supported by subsidies. India has lowest per capita drug expenditure except Bangladesh (Planning Commission, 2012). However, per capita drug expenditure was reported much higher in the countries like Japan, Germany, America and Canada. India's achievements in the field

of health have been remarkable however; there is a lot of scope for improvements. The burden of diseases among the Indian population remains high. Infant, children and maternal mortality and morbidity affect millions of children and women. Infectious diseases such as malaria and T.B. are remerging as epidemics and there is growing specter of HIV/AIDS. Many of these illness and deaths can be prevented and treated cost effectively with primary health care services provide by public health system (SAGPA, 2013).

The hospital segment holds a major share of the healthcare industry and is out pacing the overall industry growth. The share of private sector in healthcare has been reported to be 70.8 per cent in India as compared to 53 per cent in Brazil, 46.4 per cent in China and 39 per cent in Russia. The size of the private hospital industry in India is estimated to be around $25 billion as per Assocham and growing at a CAGR of 20 percent. The demand for hospital services has been consistently soaring in the country, with every class of the society demanding better quality and standards of healthcare. Realizing the continuous growing demand, many investors worldwide have expressed their keenness towards investing in the Indian hospital service market. The country is making strides in the right direction as evident from the 100 percent allowance of FDI in the hospital segment under the automatic route, since January 2000. The country needs to cover the cumulative deficit of around 3 million hospital beds to match up with the global average of 3 beds per 1000 population. The Indian healthcare industry has witnessed a massive spurt in healthcare spend and is expected to reach $100 billion1 by 2015 from the current $65 billion in 2012, growing at a CAGR of 20 percent a year India currently faces a chronic shortage of healthcare infrastructure, especially in rural areas and Tier II and Tier III cities, and it is expected that India will have potential requirement of 1.75 million new beds by the end of 2025 The industry is adopting innovative business models to work in the sector but still needs high upfront investments, has long gestation periods and faces ever-rising real estate costs. The market size of healthcare services in India has been reported to be about $45 billion (IBEF, 2012). The healthcare market segmentation demonstrates that hospitals accounted for 71 per cent shares while pharmaceutical

companies have share of 13 per cent and 9 per cent share goes to medical equipments and diagnosis accounts 3 per cent. Medical insurance has a smaller share of 4 per cent. The segmentation of healthcare industry is shown in Chart 1.

Chart 1
Healthcare Market Segments

	Hospitals	**Government Hospitals** – Includes Healthcare centers, district hospitals and general Hospitals
		Private Hospitals – Includes nursing homes, mid tier, and top-tier private hospitals
Healthcare	**Pharmaceuticals**	Includes the manufacturing, extraction and packaging of chemical materials to be used as medicines for human & animals.
Market	**Diagnostics**	Comprises of businesses and laboratories that offer analytic or diagnostic services including body fluid / blood analysis.
	Medical Equipments	Includes establishments primarily engaged in manufacturing medical equipment and supplies, such as surgical, dental, laboratory instruments, etc
	Medical Insurance	Covers an individual's hospitalization expenses and medical care bills incurred due to sickness

At present, chains of diagnostic centers, chains of single specialty hospitals (such as eye or dental clinics), chains of pharmacies, day-care surgery centers are all witnessing significant growth opportunities Several unique initiatives have been undertaken by the state governments such as those in Tamil Nadu, Andhra Pradesh and Chhattisgarh, have proved successful in providing access to good quality healthcare for the economically challenged section of society through public-private-partnership schemes (KPMG,2011).

It is being recognized that good health is an important contributor to productivity and economic growth. In India, health assumes greater significance; however, Indian health scenario presents sounding challenges. The low base of health indicators

combined with an overwhelming burden of available morbidity and mortality accounted for by pre transition diseases makes possible dramatic improvements in health status in a relatively short time span. This calls for enhanced public investment in health, accompanied by wide reaching reforms at every level. This can be achieved only with strong political will and commitment. Restructuring of the public health systems of the states is called for integrating preventive, promotive and curative services, decentralizing authority and providing health services to poor. Public private partnership is felt necessary in order to reduce the burden of health expenditure as well as to promote community based strategies, including comprehensive health education, counseling and providing RCH services. Tertiary' care refers to more specialized care and, therefore, involves knowledge, skills and resources that are typically available at regional or national levels, as opposed to being amenable to replication in every local context. The current availability of tertiary care services is only a very small fraction of what is actually needed in the country. Of the available tertiary care facilities, most are concentrated in large urban areas, with a large share represented by the private sector.

India has 9 hospital beds per 10,000 people (including in-patient and maternity beds) against a WHO recommended norm of 30. The ratio of Government hospital beds to population in rural areas is fifteen times lower than in urban areas. It is the private sector, however, which with 49% of the total number of hospital beds is managing to provide 60% of all in-patient care and 78 percent of all out-patient care in the country . This indicates low utilization of the public sector, and a rather efficient utilization of private beds and facilities. It also offers an opportunity to enhance services through more efficient capacity utilization. Notwithstanding efforts at prevention and primary care, tertiary care services comprising specialized in-patient and out-patient services would be required to address needs of referred, complicated, and uncommon cases. Efficient tertiary care services are also required to meet our national health outcome indicators (Gudwani *et al.* 2012).

Increasing awareness, rapid advances in technology, wider accessibility and better paying capacity are translating into rising

demand for healthcare services by some. With the launch of Government Health Insurance Schemes in some States, and the proposed rollout of Universal Health Care, financial barriers in accessing tertiary care by the more marginalized are also expected to reduce. Tertiary healthcare services, therefore, need to be expanded, with strategies to ensure their cost-effectiveness, professional efficiency and universal accessibility.As creation of new tertiary care facilities would be both time and capital intensive, the strategy should be to focus on existing facilities for improved quality of care, optimal utilization of existing capacities, in-situ expansion, addition of multi-speciality units and making AYUSH services available. Given India's mixed economy, as also the large-scale deployment of health human resource and existence of bed capacity in the private sector, the goals of tertiary care would necessarily have to involve combined efforts from the public and private sectors. It should, however, be ensured that the interests of the common person with low paying capacity are safeguarded.

Teaching hospitals represent the most specialized centres for medical care in a region. They also represent the pinnacle of the health-care pyramid, which is composed of tertiary non-teaching institutions, secondary and primary facilities and community-based care systems. The health-care system would work best if there were cross-linkages between institutions positioned at different levels of the healthcare pyramid, in any given region. Thus, cases would be detected and treated at the lowest feasible level, but with requisite support from the tertiary care facilities; correspondingly, joint efforts would be made towards developing skills of providers at the lowest levels of the pyramid and to underscore the value of prevention and early detections of prevalent health problems. For example, if a region is experiencing more than the average number of cases of cancer, medical colleges should commission epidemiological studies to find out its determinants and also conduct Continuing Medical Education programmes for primary providers so that most cases are detected and managed at these levels. Currently, teaching hospitals do not have any organic linkages with other components of the health care system leading to lost opportunities and suboptimal utilization of existing resources. Comprehensive Rural

Health Services Project at Ballabgarh run by AIIMS is an exception, and is a good example of a primary care-teaching facility linkage, which should be broadened. The potential offered by tele-medicine for remote diagnostics, monitoring and case management should be fully realized. Existing hospitals like District hospitals, Railway hospitals, Armed Forces hospitals, Employees State Insurance hospitals and AYUSH teaching colleges and hospitals should be developed into effective tertiary care centres with strengthened laboratory and diagnostic services and foolproof medical waste management systems. Making AYUSH therapies available and encouraging their use, particularly for non-communicable, degenerative and geriatric conditions, is likely to lower costs, while increasing the choice of therapies (Planning Commission,2012).

The Government medical colleges should be strengthened for the dual purposes of creating a larger pool of doctors and other health workers that can be deployed at PHCs and CHCs and also for providing super specialty healthcare to the population in that region. By the year 2011, 26 medical colleges have been supported under Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) and 46 State Government owned medical colleges have been given assistance for the strengthening and up-gradation of facilities needed to start new PG Departments under the Centrally Sponsored Scheme of Up-gradation of State Government Medical/Dental Colleges. An additional 80 medical colleges should be strengthened during the 12th Plan to increase their capacity for teaching, patient care and research. As a result, nearly 90% of all Government medical institutions would have been upgraded. On similar lines, other medical colleges in the private or voluntary sector should also be encouraged to upgrade and strengthen their facilities.

In the Government sector, four new AIIMS like Institutions (ALIs) may be established during the 12th Plan period in addition to the eight already approved ones, which should be completed and made operational during the Plan period. The selection of regions for developing these facilities should be based on suitable geographical location, available physical infrastructure, ease of connectivity with State medical colleges and district hospitals, as well as local health indicators and disease burden. Existing teaching

institutions can be strengthened to develop as national centres in disciplines such as Cancer, Arthritis and musculo-skeletal diseases, Child Health, Diabetes, and Mental Health and Behavioural Sciences, Bio-medical and Bio-Engineering, Hospital and Health Care Administration, Nursing Education and Research, Information Technology and Tele- Medicine and Complementary Medicine. For optimizing the functioning of existing and proposed institutions, sound governance and management systems based on principles of autonomy and accountability should be evolved. Adequate flexibility should be accorded to the management, especially in financial and personnel matters, so that they are able to attract and retain the best talent. Suitable incentives linked to assigned duties should be devised (Planning Commission,2012) .

Given the gap in need and availability of tertiary care facilities and to ensure maximization of benefits from limited public funds, public facilities should be encouraged to part-finance their recurring costs by mobilizing contributions (including under Corporate Social Responsibility) and self-generation of revenues. Under the recently drafted Companies Bill, 2011, the Government has proposed that companies should earmark 2 percent of their average profits of the preceding three years for Corporate Social Responsibility (CSR) activities. Tamil Nadu has issued guidelines to authorize Medical Officers in charge of particular healthcare facilities to enter into MoUs with interested persons to receive contributions for capital or recurrent expenditure in the provision and maintenance of facilities. On available models for self-generation of revenues, the option for cross-subsidy in line with the Aravind eye care system should also be explored Tertiary care facilities would have an incentive] to generate revenues if they are provided an autonomous governance structure, which allows them flexibility in the utilization of self-generated resources within broad policy parameters laid down by the Government (DCA, 2012).

Public-Private Partnerships offers an opportunity to tap the material, human and managerial resources of the private sector for public good. In a PPP, “the Government provides the strength of its purchasing power, outlines goals for an optimal health system, and

empowers private enterprise to innovate, build, maintain and/or manage delivery of agreed-upon services over the term of the contract. An encouraging development is the inclusion of health, education and skill development (in addition to solid waste management, water and sanitation management, which existed earlier) in the infrastructure sector for Viability Gap Funding, without annuity provisions, up to the ceiling point of 20 percent of total project costs under the scheme , to support Public Private Partnerships. As a result, private sector would be able to propose and commission projects in the health sector, such as hospitals, medical colleges even outside metropolitan areas, which are not remunerative per se and claim up to 20% of the project cost as grant from the Government to cover the gap in financial viability of the project. Some potential models for PPP in healthcare, covering PHCs, diagnostic centres and hospitals have been identified and can be considered The PPP arrangements must, however, adequately address issues of compliance with regulatory requirements, observance of Standard Treatment Guidelines and delivery of affordable care. An additional model for consideration is the not for- profit Public Private Partnership (NPPP) being followed in the International Institute of Information Technology (IIIT), which have been set up as fully autonomous institutions, with partnership of the Ministry of Human Resource Development, Governments of respective States and industry members. PPP and Not-for-Profit PPP models can be considered to expand capacities for tertiary care in the 12th Plan.

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