ISSN 2347-5579

Unique Journal of Medical and Dental Sciences

Available online: www.ujconline.net

Review Article

PICTURE OF HEALTH CARE SYSTEM IN INDIA AND NEED OF TODAY- A REVIEW

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Received: 10-12-2015; Revised: 08-01-2015; Accepted: 06-02-2015

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ABSTRACT

India's health care system consists of a mix of public and private sector providers of health services. Networks of health care facilities at the primary, secondary and tertiary level, run mainly by State Governments, provide free or very low cost medical services. The system suffers from the weaknesses of availability of health care services from the public and private sectors, quality of healthcare services varies considerably in both the public and private sector and affordability of health care is a serious problem for the vast majority of the population, especially in tertiary care. The problems outlined are likely to worsen in future. To combat these problems inclusive growth is the policy adopted by the Indian government during 11 plan and continued in the 12 plan.

Keywords: Health Care System, Tertiary Health Care, Universal Health Care, Primary Health Care.

INTRODUCTION

Health has been declared as fundamental human right whether above or below poverty line. Health is an indicator of well-being that has direct implications not only for the quality of life but also it has great indirect implications for the production of economic growth and services.

In independent India, keeping in view the constitutional obligations, the Government of India planned several approaches for the health care delivery. The basis for organization of health services in India through the primary health care was laid by the recommendations provided by the 'Health Survey and Development Committee' (Bhore Committee) in 1946[1].

The High Level Expert Group has defined UHC as follows: 'Ensuring equitable access for all Indian citizens in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) as well as services addressing wider determinants of health delivered to individuals and populations, with the Government being the guarantor and enabler, although not necessarily the only provider of health and related services.

In the last two decades, there has been a growing concern over the performance of the health care delivery system in India. As per the Government of India's (GOI) National Rural Health Mission (NHRM) Document (2005), only10% of Indians have some form of health insurance and around 40% of Indians have to borrow money or sell their assets to meet their health care expenses[2]. This review suggests the reforms to be introduced in the health care system in order to improve the picture Indian health care system.

HEALTH CARE SYSTEM IN INDIA

Health service delivery in India is characterized by a three-tier system. At the lowest level are the sub centers, with each covering a population of about 5,000 in the plains and about 3,000 in hilly and difficult terrain. Only paramedical staff is available in these subcenters. The first points of contact with a doctor are the primary health centers with each covering about 30,000 people in the plains and about 20,000 in hilly and difficult terrain[2].

Community health centres provide secondary care and are organized at the block levels. The sub divisional hospitals and district level hospitals constitute the higher tiers. In principle, the sub centers, primary health centers, and community health centers are required to handle the preventative aspects of health care, institutionalize deliveries, treat minor diseases, and act as referral centers. The subdivision and district level hospitals would then treat major ailments as referral hospitals. However, in practice this has not been the case, as the sub-division and district-level hospitals deal with all aspects of health care.

HEALTH PROFILE OF INDIA

There has been an increase in number of public health facilities over the 2007 11 period—Sub Centres by 2 per cent, PHC by 6 per cent, CHC by16 per cent and District Hospitals by 45 per cent. Yet shortfalls remain, 20 per cent for Sub-Centres, 24 per cent for PHCs and 37 per cent for CHCs, particularly in Bihar, Jharkhand, Madhya Pradesh and Uttar Pradesh. Though most CHCs and 34 per cent Primary Health Centres (PHCs) have been upgraded and operationalized as 24 × 7 facilities and First Referral Units (FRU) have doubled, yet the commitment of Eleventh Plan to make all public facilities meet IPHS norms,

and to provide Emergency Obstetric Care at all CHCs have not been achieved. Access to safe abortion services is not available in all CHCs, a gap which is contributing to maternal mortality. Though Mobile Medical Units (MMUs) have been deployed in 449 districts of the country, their outreach medical services are not adequate for the need.

As a result of industrialization, changing age structure there is gross disparity in health status and availability of health care services all over the country. India is facing a growing burden of non-communicable diseases due to urbanization and changing lifestyles. Diseases claimed to be under control like malaria, poliomyelitis, dengue fever and kala-azar are reappearing with renewed retribution. From the table below it is clear that Indian population is bearing the burden of communicable and non-communicable[2]. Addition to these is the load of re- emerging diseases with resistance towards existing drug regimens.

THE BURDEN OF COMMUNICABLE AND NON COMMUNICABLE DISEASES IN INDIA

Disease/health condition	Estimates in 2005 (lakh)	Projected estimates	Cases reported in 2010 (lakh)
COMMUNICABLE DISEASES			
Pulmonary tuberculosis			11.74
HIV/AIDS			
Acute respiratory infection			247.2
Diarrheal disease(episodes/year)			101.73
Malaria and other vector borne diseases			13.73
Enteric fever			10.35
Pneumonia			7.32
Leprosy			-
Otitis media			-
NON COMMUNICABLE DISEASE			
cancer			9.8
diabetes			376.70
Mental health			-
blindness			-
Cardiovascular disease			469.70
COPD and Asthma			

INDIA'S PUBLIC HEALTH INFRASTRUCTURE

It is grossly underfunded, under staffed, and poorly equipped. Urban population in India accounts for less than a third of its total population. Allopathic physicians are highly concentrated in urban areas compared to rural areas (13.3 and 3.3 per 10,000 population, respectively). Nurses and midwives are also similarly concentrated in urban areas (15.9 and 4.1 per 10,000 populations)[3].

The density of allopathic physicians is 4.28 per 10,000 populations. There are approximately 0.81 nurses per allopathic physician in India, suggesting that there are more doctors than nurses. From a health systems point of view, the ratio of nurses to doctors is very low. According to the 1993 World Development Report, as a rule of thumb, the ratio of nurses to doctors should exceed 2:1 as a minimum with 4:1 or higher considered more satisfactory for cost-effective and quality care. Nurses can deliver many of the basic clinical care and public health services, particularly at the community level, at a lower cost than trained physicians[4].

EMERGING INDIAN HEALTH CARE MARKET

Ripeness of the Indian healthcare sector provides it the ability for the expansion and significant growth. One of the main factors is rising of medical tourism in India. Medical tourism in India is growing at a compounded annual growth rate of over 27 per cent during 2009-2012. Medical tourism market is valued to be worth USD 310 million and is expected to generate USD 2.4 billion by 2012 and is growing at 30 per cent a year[2,3]. There is a need to upgrade the service standards and provide the facilities to bring the service levels on par with global standards[5].

With the growing demand of health care services there is the emergence of reputed private players, so there is need of huge investment in the healthcare sector. Healthcare sector being a social sector where right to use and equity are important.

NEED OF FOCUSING ON TERTIARY HEALT CARE IN INDIA

There are two challenges that need a significant amount of effort and those are in the related domains of primary care and the integration of primary care with higher levels of care. In India, the government in its planning had focused on primary health care, conducting immunization, maternal and child health and family planning at the expense of hospital based care. The provision of government funded hospital based care in the taluk, district and medical college level has developed in a skeletal manner.

Primary and secondary care is supported by tertiary care, and hence is necessary for effective care at the level of PHC and CHC. Expenses involved in tertiary care makes health systems costly. Tertiary care is the setting within which medical education and medical research take place. In Indian health system primary and secondary care in the public health system in is weak and publicly funded tertiary care is even scarcer. For all these reasons it is important to consider the issues of tertiary care in relation[6].

The common public health conditions in India that require large hospital care, both outpatient and emergency conditions. Emergency conditions (eg. head trauma, strokes, heart attacks, organophosphate poisoning, neonatal emergencies) and chronic conditions (eg. cancer treatment, palliative care, stroke

rehabilitation) require provisioning of tertiary care at the district level. These services particularly for emergency conditions should be available to the public as close as possible to their residence.

So the definition of tertiary care should focus on:[2,7, 8]

1. Public health conditions requiring tertiary care
2. Tests and treatments that are cost-effective and can be provided to everyone at different levels of the health system (PHC, CHC and medical college).

TERTIARY HEALTH CARE WITH EXISTING INDIAN HEALTH CARE SYSTEM

Integration of health services should be done. Primary health care that is essential health services can be provided at primary and secondary level. Referrals from primary and secondary care to tertiary care should be done when it is required and referred back to primary and secondary level after completing of their tertiary care treatment.

Against this chain the medical and dental colleges functions as a standalone entity under the Department of Medical Education, and not as part of a functioning health system. Publicly funded tertiary care varies in availability depending on the presence of a medical college in the region. While government medical colleges are supposed to provide tertiary care, they may not have the infrastructure, resources and staffing, and are often functioning at the secondary level.

In order to provide tertiary care, the following steps are necessary[2,9-12]

a. Medical colleges should be responsible for the health provision of given geographical area (one district or set of districts) for which it provides tertiary care services in lias on with the district health services.
b. Strengthening of district hospitals to provide effective secondary level care
c. Strengthening of medical colleges to provide tertiary care for the district

There should be one medical college for every district or 3-4 districts depending on population, geographic area and existing availability of hospital based services. The medical college should support the secondary and primary level services through referral linkage and training. Undergraduate and postgraduate students could be trained not just in the medical college, but also at the district hospital, taluk hospital and PHC level.

Strengthening Of District Hospitals to Provide Effective Secondary Care

For tertiary care to be provided at the district level, it requires strengthening of district hospitals to provide high end secondary care and strengthening of linkage between district hospital and the medical college.

There is a need of good referral linkage with the medical colleges so as to support the district hospital in a referral continuum. Telephonic and telemedicine, consultant visits and specialist clinics of Medical colleges can support district level care.

They could also provide the training of district hospital staff in specialist care. In order to enhance the referral linkage, ambulance services and electronic transfer of patient information should be done.

Strengthening of medical colleges to provide tertiary care

With the liberalization of the economy and with the increasing demand of quality health care there has been the proliferation of private interest and investment. This is one of reasons for catastrophic health expenditure and debt that is resulting from patients accessing hospital based care in the private sector. Specialities like general surgery should be upgraded in relation to urology, cancer and neurosurgeries so that they can serve at district hospitals. Development of Infrastructure and up gradation of technology for provision of tertiary care services in each medical college is necessary to facilitate the development of specialist services. This effort of up-gradation will help in reducing the cost of tertiary care and also will improve the accessibility of health care.

REFORMS REQUIRED IN SYSTEM OF EDUCATION

There is a need of defining the standards of care and services based on the requirements of the district. Undergraduate Medical Education is not providing the training services that are required for district level health care.

According to principal of Universal access to health care, medical colleges are having social responsibility in providing the health care to patients. Those who are motivated to work for long term to meet local needs should be given preference. Training should be provided to the medical and dental graduates, so that they can support local health services at the district or taluk hospital. The focus of research in medical and dental colleges should be, to identify and to answer priority health issues.

CONCLUSION

Tertiary care is a *systemic* problem related to the structure of medical knowledge, the market driven mode of private tertiary care as has occurred in India and there is a lack of development of public curative services. Despite the structural nature of the problem, it is possible to re-envisage and redistribute the problem for the Indian health system. There is a need to re-define what is tertiary care in relation to the common diseases, what would considered cost-effective and feasible treatments to provide all citizens of the country- *an appropriate tertiary care for India*. The problem of *cost* is not necessarily one of actual cost of technology or a drug but the mode of market medicine to maximize profit. It is possible to provide tertiary care at an affordable cost by working on economy of scale and common sense approach of treatments that can feasibly be provided across the health system. Today, the district hospitals the apex referral hospital of the health system and the function of the medical college isprimarily for training and isolated from the health system. Tertiary care can be provided in a non-market mode, through medical colleges and dental college servicing a district population and supporting a district health system. Upgrading the district hospital and improving linkages between the medical, dental colleges and district hospital can work to support a functioning health system within which tertiary care can be provided. The use of a functioning district health system for teaching and service can make it economically viable and fulfil thetwin goals of providing universal access to health care and training future doctors and health professionals in the practice of an appropriate medicine for India.

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Source of support: Nil, Conflict of interest: None Declared