

Health Care Services in India

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Abstract- The present paper tries to describe various of health care system in India. Health is that the level of functional and metabolic efficiency of a living organism. For any Country Health care System has been considered an important contributor to the health of society, the birth of the World Health Organization (WHO) has influenced the development of health care systems to the greatest extent. The relationship among various components of national health systems, which to an excellent extent determines the health service system, is discussed. The importance and implications of the 1977 World Health Assembly resolution "Health-For-All" and therefore the 1978 Declaration of the International Conference on Primary Health Care in Alma Ata for national health systems development placed special emphasis on primary health care and stressed family health services. The Health care Services especially public health care system consists of primary, secondary and tertiary care institutions

Index terms- Health, Health Care System, W.H.O, Primary Health Care Services, Secondary Health Care Services and Tertiary Health Care Services

I.INTRODUCTION

In every country, there are a number of interconnected systems or sectors, such as education, industry, agriculture, and transport. Their development has been shaped by the country-specific historical, cultural, geographic, and political context. One of these sectors is the health care system. Historically, medical care has been an important contributor to the health of society, helping to cope with disease or injury and in more recent times to prevent disease and promote health. With the rise of free trade and the exchange of goods and services, medical care has become one of many commodities and services sold in the marketplace. However, the development of parliamentary forms of government and growing social demands of the people has resulted in the concept of health care services as a public responsibility. Instead of health care services

that can be bought and sold, the idea of providing health care to people based on their needs and in the interest of community This has resulted in the development of national health care systems. The different economic, political, and social settings of various countries means health care systems are naturally very diverse and vary in their structure and performance, and in overall complexity.

Health has occupied a paramount important factor in the comprehensive development of any country, mainly for two reasons. First, health status has become a key indicator to measure the socio-economic welfare of the people (Sen-1985). Second, improving health status of people leads to better school performance of children (Bartel and Taubman, 1979), Health is the level of functional and metabolic efficiency of a living organism. In humans it's the power of people or communities to adapt and self-manage when facing physical, mental, psychological and social changes with environment. The World Health Organization (WHO) defined health in its broader sense in its 1948 constitution as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Access to health care reflects consumers' ability to pay, or a market approach where private financing offers people the chance to get more or better services, or access to health care as a citizen's right not influenced by income and wealth, which represents universal or near universal access to health care for all citizens.

Health care reforms to both the structure of health care financing and the delivery of health services were initiated in a large number of developed and developing countries. The highest attainable standards of physical and mental health are key to social wellbeing of the country. While continuing to battle communicable, maternal, neonatal and nutritional disorders in each State, India has also been facing one of the most epic epidemiological

transitions with a rapid increase in the extent of injuries and non-communicable diseases and the proportion of disease burden attributable to them.

The core public health mandate of the Department of Health & Family Welfare (DoHFW) is to supply equitable, affordable and quality healthcare services to the people of India. At the centre of its philosophy may be a strong primary healthcare system with a serious specialise in preventive and promotive healthcare. Health being a State Subject - each State and Union Territory endeavors to supply the simplest healthcare services to citizens. At the Central level, Ministry of Health & Family Welfare (MoHFW), therefore aims to strengthen the overall health system and leaves no stone unturned in its support to each.

India has moved at an excellent pace publicly health. Infant Mortality Rate (IMR) has registered 3 points decline to 34 in 2016 from 37 in 2015 at the National level and through an equivalent period, Neo-natal death rate (NNMR) has declined by 1 point from 25 to 24. In 2016, Under-5 death rate (U5MR) for the country decreased by 9%, a 4 points decline over 2015 (39 in 2016 against 43 in 2015). Number of Under-5 deaths for the first time in the country has come down to below 10 Lakhs with nearly 1, 20,000 fewer deaths in 2016 as compared to 2015. Sex Ratio at Birth for the country has gone down by 2 points to 898 in 2014- 2016 from 900 in 2013-2015 and the “Beti Bachao-Beti Padhao” Scheme needs



The Public Health care system consists of primary, secondary and tertiary care institutions.

Primary Health Care

The term “primary health care” was widely accepted after the Alma Ata Conference in 1978. Primary health care (PHC) represents quite 70% of all organized health care. It is here that most primary prevention (e.g. immunization) and secondary prevention (e.g. health screening) takes place. It is here also that patient education (health maintenance, nutrition, prevention of diseases, sanitation, etc.) is most efficient. It is also at this level that most patients make their first contact with the health system and simple medical conditions are diagnosed and treated. PHC has been termed the “gate or entrance door” to regional and hierarchical health care systems. To meet the broad objectives of PHC, it is necessary to develop a team approach. Teamwork must be an active process with common objectives shared by the team.

PHC is dispensed in various ways by individual health practitioners, by systems of ambulatory care, including “health centers,” and by independent outpatient departments, polyclinics, and group practices.

In some countries individual health practitioners still flourish. This form of practice is gradually changing as various types of group practices develop, although the specific role of individual health practitioners remains undiminished. However, the trend is perhaps to what is called in some countries health centers, and in others a kind of “polyclinic.” The health center and the polyclinic provide both medical treatment and preventive services. These include promotion of health, prevention, early diagnosis, and all those aspects of medical care that can be carried out on an ambulatory basis. This is the sole thanks to reconcile the permanent availability of medical aid, quality, and therefore the use of recent equipment. No patients should be referred to the higher level of a health services pyramid without their needs first being identified at the PHC level.

Accessible health centers should be capable of responding adequately to local health problems and priorities, and of cooperating with other sectors-educational, environmental, industrial, and housing and institutions in the public, private, and nongovernment sectors. This includes providing a competent medical service and carrying out a range of preventive activities such as immunizations, antenatal care, and family planning. The

multidisciplinary health center team with complementary skills enables a holistic approach that promotes individual and family health care and health development.

PHC can also be delivered by hospital outpatient clinics and emergency services, and by public health services (maternal and child health, family planning, communicable disease control and treatment, and other special clinics and services). Hospitals can play a direct role in PHC, especially in dense urban settings. This implies that hospitals actually provide polyclinics, rehabilitation, and other services needed for ambulatory care. Such a hospital-based health care system that would cover all needs in one place is one approach.

Self-care or self-delivered health care is equally important in developing and industrialized countries although, in the latter, often in more “sophisticated” forms, such as self-diagnosis and self-medication. It is important to integrate it with organized, usually state-supported, PHC. Self-care and community care can be expected to assume an increasingly important role. In order to improve its quality and extent within the population, it must be carefully evaluated and appropriate health education and information must be given both to individuals and to communities.

Unfortunately, in most countries there is a separation between the health and social services. The integration of the social welfare and health services of a community under one roof would permit all problems, whether concerning children, elderly people, or people of working age, to be discussed in one place and resolved. This type of community service would provide individuals in society with better contact possibilities than is possible under the present system where health care and welfare services are often separated.

The primary health care infrastructure provides the primary level of contact between the population and health care providers. Realizing its importance in the delivery of health services, the centre, states and several government related agencies simultaneously started creating primary health care infrastructure and manpower. This has resulted in substantial amount of duplication of the infrastructure and manpower.

The government funded primary health care institutions include: The rural, primary health care infrastructure created by the states.

1. Sub-centers
2. Primary Health centers
3. Community Health centers

Sub-Centre

The Sub-centre (SC) is that the most peripheral health institution available to the agricultural population. Even though the sub-centre or population norms at the national level have been met, there are wide inter-state variations. States with poor health indices do not have the required number of sub-centers especially in remote areas. In order to ensure that lack of funds does not hamper the filling up vacancies in the posts of auxiliary nurse midwife (ANM) the Department of Family Welfare has taken up funding of sub-centre ANMs (1.37lakh) from 1st April 2002. The States should in return take over the funding of the staff of the rural family welfare and post partum centre, which have for the last two decades functioned as a part of the respective institutions in the state. There are an outsized number of vacancies within the posts of male multi-purpose workers (MMPW) whose salaries are borne by the government, even where they're present, their contribution to the continued national disease control programmes, disease surveillance and water quality monitoring is negligible. There are a large number of male multi-purpose workers with insufficient workload in various centrally sponsored disease control programmes. With appropriate skill up gradation these uni-purpose male workers and contractual staff should be able to perform the task of MMPW in improving the coverage and quality of all health programmes.

Sub centre level

- 1 subcentre-5000 population in general but in hilly, tribal and backward areas 1subcenter -3000 population.
- Two functionaries at this level -Health worker male and health worker female (multipurpose worker).
- 6-8 month in service training and orientation by PHCs medical officer.
- Form a link between health guide and PHC and responsible for all health services and programs in that area, work under the supervision of health assistant

Primary Health Centres (PHCs)

PHC is a referral unit for six sub-centers. All PHCs provide outpatient services; a majority has four to 6 in-patient beds. According to the norms they need one medic, 14 Para-medical and other supporting staff. At the national level there are quite an adequate number of PHCs and doctors posted at PHCs but the distribution across states is uneven, there are not any functional PHCs in many remote areas in dire need of health care.

Primary health centre level

- 1 PHC for every 30,000 population rural population in plains,
- 1 PHC for every 20,000 population in hilly, tribal and backward areas has been proposed for effective coverage.

Community Health Centers (CHCs)

Community Health Centre (CHC) is that the first referral unit (FRU) for four PHCs offering specialist care. According to the norms each CHC should have at least 30 beds, one operation theatre, X-ray machine, labour room and laboratory facilities and is to be staffed at least by four specialists i.e. a surgeon, a physician, a gynecologist and a pediatrician supported by 21 para-medical and other staff. The reported gap in the number of CHCs is more apparent than real. Currently there are over 2000 functioning sub-divisional, taluk and other specialty hospitals below the district hospital. From the Seventh Plan onwards, it has been emphasized that these should be reorganized and brought into the mainstream, given status of CHC and the responsibility of being the referral centre for well defined PHCs and SCs. Many CHCs or FRUs have sub-district post partum centers located within their premises or in the vicinity, but they are not functioning as a part of CHC.

Community health center level

- One out of 4 PHC's in community developmental block upgraded and recognized as Community Health Center (CHC).
- Should have 30 beds with the specialist in surgery, medicine, gynecology and pediatrics with x-ray and laboratory facilities.
- Covers population of 80,000 to 1, 20,000.

Secondary Health Care

The secondary health care infrastructure at the district hospitals and urban hospitals is currently also taking care of the primary health care needs of the population in the city or town in which they are located. This inevitably leads to overcrowding and underutilization of the specialized services. Strengthening secondary health care services was an identified priority within the Ninth Plan. In addition to the funds they get from the state plan, seven states have taken World Bank loans to initiate projects to build up FRUs/district hospitals.

The states have initiated construction works and procurement of equipments. They have reported increased availability of ambulances and medicines, improvement in quality of services following training to health care providers, reduction in vacancies and mismatches in health personnel/infrastructure and improvement in hospital waste management, disease surveillance and response systems. All these states have attempted to levy user charges for diagnostics and therapeutics services from people above the poverty line. Some states are unable to make sure that the collected charges are retained to be used within the same institution and this problem need be speedily resolved.

Tertiary Health Care

Over the last two decades a majority of the tertiary care institutions in the governmental sector have been facing a resource crunch and have not been able to obtain funds for equipment maintenance, replacement of obsolete equipments, supply of consumables and upgrading the infrastructure to satisfy the rapidly growing demand for increasingly complex diagnostic and therapeutic modalities. There is a need to optimize facilities available in tertiary care institutions, enhance the quality of services and strengthen linkages with secondary care institutions. Overcrowding in tertiary care hospitals and underutilization of expert care due to the lack of a two way referral system with primary and secondary care levels requires correction. To meet some of the recurring costs and to improve the quality of services in tertiary health care institutions the Ninth Plan suggested levying user charges and establishing pay clinics.

Some states have provided land, water and electricity at a lower cost to private entrepreneurs setting up

tertiary care or super specialty institutions on the condition that they provide outpatient and inpatient care free of cost for people below the poverty line. In an effort to augment the availability of tertiary care, several states (eg: Rajasthan and Himachal Pradesh) are trying out innovative schemes to give greater autonomy to government institutions, allowing them to generate resources and utilize them locally. Most states have not yet fully documented the extent and impact of their efforts in this direction. Available data suggest that Kerala, Punjab and Haryana have cost recovery ratios of around 10 per cent and quite 80 per cent of the fees for public facility care were paid by the richest 40 per cent of the population both within the urban and rural areas. This may be because this section uses the services more or the quality of care provided to those who pay may be better than to those who are exempt from paying. Health services delivery can be defined as those activities aiming at improving health, relieving symptoms, or supplying comfort through services including advice, preventive measures, early diagnosis, treatment, or care given to an individual or a community.

This term refers to a wide array of services that affect health, including physical and mental illnesses. It includes services aimed at preventing disease and promoting health and providing acute, long-term, rehabilitative, and palliative care. The definition applies to many types of health care practitioners (eg: physicians, nurses, and various other health care professionals) and to all settings of care from hospitals and nursing homes to physicians' offices, community sites, and even private homes. The extent of relationships between and among primary, secondary, and tertiary care, and regionalization will also vary in different systems. Health care may be provided by patients themselves, by members of their families, by primary care teams, by specialists, and finally by hospitals. Health care is thus concerned not only with curing disease, but also with providing care and compassion.

CONCLUSION

Health is an Essential input for the development of human resources and the quality of life and in turn the socio-economic development of the nation. Improved health may be a a part of total socio-economic development and is considered an index of social development. the government both Central and

state, along with Non-governmental agencies have been trying hard to provide the affordable and quality health services through its network of public health facilities in the state. The core public health mandate of the Department of Health & Family Welfare (DoHFW) is to supply equitable, affordable and quality healthcare services to the people of India. At the centre of its philosophy may be a strong primary healthcare system with a serious specialise in preventive and promotive healthcare. Health being a State Subject - each State and Union Territory endeavors to supply the simplest healthcare services to citizens. At the Central level, Ministry of Health & Family Welfare (MoHFW), therefore aims to strengthen the overall health system and leaves no stone unturned in its support to each State and UT to achieve this goal.

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