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HEALTHCARE SERVICES AND SYSTEM IN INDIA: AN OVERVIEW

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ABSTRACT

Healthcare has emerged as one of the largest service sectors in India the health sector has made significant progress in the years since the country's Healthcare in India features a universal health care system run by the constituent states and territories in order to gain competitive advantage, The Government of India has stated its commitment to improve the nation's health system through various policy, healthcare in India which consists of a public sector. This paper focuses health system and health opportunities, insurance and resources.

KEYWORDS: *Healthcare, Insurance, Public sector, Services.*

INTRODUCTION

Healthcare can be considered as one of India's largest sectors, especially in terms of its revenue and employment. The sector is also expanding rapidly. However, most part of the sector operates in a largely unregulated environment, with minimal controls on what services can be provided, by whom, in what manner, and at what cost. This is mainly because of the nature of the system of healthcare in India which consists of a public sector, a private sector, with a large section of informal network of care providers who are poorly regulated (Das & Rani, 2004.). Thus, wide disparities occur in access, cost, levels, and quality of health services provided across the country.

OVERVIEW OF THE HEALTH SYSTEM IN INDIA

Healthcare in India features a universal health care system run by the constituent states and territories of India. The Constitution charges every state with "raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002.

The health sector in India is characterized by: (i) a government sector that provides publicly financed and managed curative and preventive health services from primary to tertiary level, throughout the country and free of cost to the consumer (these account for about 18% of the overall health spending and 0.9% of the GDP), and (ii) a fee-levying private sector that plays a dominant role in the provision of individual curative care through ambulatory services and accounts for about 82% of the overall health expenditure and 4.2% of the GDP. Nationwide health care utilization rates show that private health services are directed mainly at providing primary health care and financed from private resources, which could place a disproportionate burden on the poor (Baru, 2005).

The Ministry of Health and Family Welfare (MHFW) oversees the national health system. The MHFW has three departments – the Department of Health and Literacy, the Department of Family Welfare, and the Department of Indian Systems of Medicine and Homoeopathy.

The delivery of primary health care in India is structured through i) Sub-centres that typically perform basic medical services, immunizations, and referrals, ii) Primary Health Centres (PHCs) which provide preventive and curative medical services, and iii) Community Health Centers (CHCs) that make available advanced medical services, including surgery (Mohawk, 2002).

The outcomes from meetings of the Central Council for Health and Family Welfare have provided a thrust to various sub sectors within the health sector (Banerji, 1985.). The private and voluntary sectors have emerged as an important arm of the health sector. From 1 April 1996 a change has been effected in the family welfare services with targets for contraceptive methods being replaced by a target-free approach.

A huge campaign to eradicate poliomyelitis through pulse polio immunization (PPI) was initiated in 1995. The traditional system of medicine is now playing a more significant role due to escalating costs of health care (Rohde & Viswanathan, 1994.). State health systems/projects have been formulated to improve efficiency in the allocation and use of health resources through policy and institutional development. Specific efforts have been made to consolidate and strengthen the PHC infrastructure, under the minimum needs programme, by providing enhanced assistance to regions with severe health problems, supporting voluntary organizations, improving IEC activities, etc. The convergence of services to provide a holistic approach to population control has also been promoted. In March 1995 a separate Department of Indian System of Medicine and Homeopathy (ISM & H) was created within the Ministry of Health and Family Welfare.

The Government of India has stated its commitment to improve the nation's health system through various policy documents such as the National Health Policy (1983 and 2002). Many policy objectives are consistent with the Millennium Development Goals (MDGs). However, many goals remain unfulfilled for a number of reasons, including planning-related issues and human resource scarcity in health service delivery (Gwatkin, Bhuiya & Victora, 2004).

HEALTH RESOURCES IN INDIA

The following are the key health resources available within the country to cater to the health needs of the people:

i) Human Resources

In the recent past, the number of medical colleges has increased significantly. The National Institute of Health and Family Welfare (NIHFW) is involved in providing in-service training for all categories of health and family welfare personnel (Rao et al, 2011). The main constraints faced with regard to human resources are the shortage of funds, particularly for government institutions imparting medical education, and the problem of deployment of medical personnel to rural areas due to inadequate facilities to meet personal and professional needs (CBHI, 2008).

ii) Financial Resources

As health is primarily a state subject, earmarked outlays are provided to state governments under the Minimum Needs Programme (MNP) with the explicit stipulation that these funds cannot be diverted elsewhere, and in case of diversion the central plan assistance to state governments will stand proportionately reduced. The family welfare/family-planning programme has been a 100% centrally sponsored scheme from its inception.

The financial outlay has been increasing over the successive five-year plan periods. However, financial resources have continued to be a major constraint to developing the primary and secondary

levels of health care which are mainly provided by the government (Bhat, 1996.). Dependence solely on government resources has been another constraint.

iii) Physical Infrastructure

Since early 1990s, the emphasis has been towards consolidation and operationalization, rather than on major expansion of the infrastructure. For this purpose, the following targets have been set:
(a) One sub centre staffed by a trained female health worker and a male health worker for a population of 5000 in the plains and a population of 3000 in hilly and tribal areas. As of 1998, 137,006 sub centres had been established.
(b) One primary health centre (PHC) staffed by a medical officer and other paramedical staff for a population of 30,000 in the plains and a population of 20,000 in hilly, tribal and backward areas. A PHC centre supervises six sub centres. As of 1998, 23,179 PHCs had been established.
(c) One community health centre (CHC) or an upgraded PHC with 30 beds and basic specialities covering a population of 80,000 to 120,000. The CHC acts as a referral center for four PHCs. Up to 1998, 2913 CHCs had been established.

Urban family welfare centres (FWCs) have been set up to provide family welfare/family planning services. The status of the infrastructure to deliver primary health care appears to be satisfactory but actual programme implementation needs a lot of improvement. A substantial part of the physical infrastructure has still to be completed. A major factor has been that approved estimates/norms for construction have not kept abreast with the rising estimates of actual construction costs.

iv) Essential Drugs and Other Supplies

The government, in consultation with the states and relevant agencies, has developed a national essential drugs list comprising over 300 drugs classified for use at the different levels of health care. This list serves as a guide to procuring agencies in central and state governments. The drugs available in India as compared to those in other countries are considered cost effective and there is a price control on 78 essential drugs. However, budgetary constraint is the major obstacle in the way of essential drug availability in the public sector (Peters et al, 2002).

v) Health Research and Technology

India has a long history of biomedical research including health systems research. In several instances research results have directly influenced programme policies or led to modifications in programme strategies. Among the many research institutions, the Indian Council of Medical Research (ICMR), established in 1911, is the lead agency. In the 8th FYP (1992-1997), ICMR attempted to consolidate significant leads in priority or “thrust” areas that were identified by various scientific expert groups. These areas included emerging health problems like HIV/AIDS, other important communicable diseases like tuberculosis, leprosy, diarrhoeal diseases, malaria, filariasis, Japanese encephalitis, etc., non-communicable diseases like cancer, cardiovascular diseases, metabolic disorders, etc., contraception, MCH and nutrition (Mahal, Yazbeck, Peters & Ramana, 2001).

vi) Health Information System

In pursuance of the national health policy for the establishment of an efficient and effective management information system, a computer-compatible health management information system (HMIS version 2.0) has been designed in collaboration with participating states, the national information center (NIC) and WHO. The system is being implemented in phases. The first phase, involving 13 states/union territories (UTs) commenced in 1992-93 and is at present operational in two states with others in the process of implementation. In addition, each of the disease control

programmes has its independent MIS, e.g. the National Programme for Control of Blindness, the National Leprosy Eradication Programme, the AIDS programme, tuberculosis control programme, etc.

vii) Intersectoral Cooperation

There has been promotion of active interpectoral cooperation in order to meet current needs and emerging challenges of the health sector (Das, Shukla, Somanathan, & Datta, 2009). A number of working groups were constituted in 1996 to comprehensively review the existing health situation in its totality. The following areas are included: communicable diseases, health systems and biomedical research development, ISM & H, child development, environmental health, health education and IEC, women's development, and requirements for supportive and diagnostic services in primary, secondary and tertiary care.

Consultations have also been held with NGOs. Two other committees have been constituted, namely an expert committee to comprehensively review the public health system in the country and the National Mission on Environmental Health and Sanitation.

The active promotion of the *panchayati raj* (local administration) system from the village to the district is a measure directed towards ensuring interpectoral collaboration. Specific health areas that have effectively made use of interpectoral collaboration include malaria control, AIDS control programme, blindness control, nutrition, and water and sanitation to name a few (Lavy, Germain & World Bank, 1994).

viii) International Partnerships in Health

Various international organizations and UN agencies have continued to provide significant technical and material assistance which has had a positive impact. The various agencies include WHO, World Bank, UNICEF, UNFPA, USAID, Japanese Assistance, ODA (UK), SIDA, NORAD, DANIDA and German assistance. A National Institute of Biologicals has been set up as an autonomous organization, with funding from the Government of India, the Japanese and USAID.

HEALTHCARE MARKET IN INDIA

Healthcare has emerged as one of the largest service sectors in India. Some estimates suggest that by 2012, healthcare spending could contribute 8 per cent of GDP and employ around 9 million (million) people.

India is undergoing a major transition in its healthcare delivery system. The change started with the liberalisation policies ushered in the early 1990s, which began to attract private investments into the healthcare sector. Private sector dominates healthcare delivery in India (Gupta & Dasgupta, 2000.). At present, India's healthcare burden has gone beyond the Government's budgetary applications and reduced public spending is leading to poor availability of services in the government hospitals. Private players (which include hospitals, nursing homes and charitable trusts) account for almost 78 per cent of the healthcare delivery market (Peters & Muraleedharan, 2008). Over the last few years an estimated 95 per cent of new hospital beds have come up in the private sector. The market for hospital services in India is estimated at over US$ 4 billion (MoHFW, 2009).

The increased spending power of the 250-300 million strong middle class is driving growth opportunities for corporate healthcare providers. Factors like privatisation of medical insurance, apart from giving rise to a new healthcare delivery system, are making the market more attractive for international and national corporate players (Chanda, 2011). These trends have led large corporate players such as the Apollo Group, Wockhardt, Fortis and Max Healthcare to rapidly expand their operations in India. In order to gain competitive advantage, these Indian corporate players are increasingly entering into collaborations with established global leaders.

A number of ambitious hospital projects are in the planning stage. Opportunities for multinationals to build hospitals in India are coming either through joint ventures (Parkway) or

individually (Columbia Asia). There are reportedly at least 20 international players, not necessarily having healthcare expertise, from Bangladesh, Philippines and Burma to the US and the UK vying to have a pie of the Indian healthcare market.

The following are the major factors that need a mention while discussing the robust growth of the healthcare services market in India:

i) Growing incomes and literacy: Much of India's healthcare expenditure comes from private patients' pockets, primarily the higher-income households. Tertiary-care treatments tend to be expensive. A survey by NCAER, an independent economics research agency, suggests that per-capita expenditures on healthcare rise with higher education levels. Households that have higher education levels tend to spend more per illness than households with lower education levels. Rising literacy in India is improving health awareness, especially about lifestyle-related diseases – which tend to be more costly to treat than infections (MoHFW, 2009.).

ii) Shift to lifestyle-related diseases: While rising incomes and growing literacy are likely to drive higher per-capita expenditures on healthcare, the shift in disease profiles from infectious to lifestyle-related diseases are expected to raise expenditures per treatment. Lifestyle-related diseases are typically more expensive to treat than infectious ones. India's disease profile is expected to follow the same pattern as in developed economies. Based on demographic trends and disease profiles, lifestyle diseases - cardiovascular, asthma and cancer have become the most important segments, and in-patient spending is expected to represent nearly 50 per cent of total healthcare expenditure (MoHFW, 2009).

iii) Increased life expectancy and an ageing population: In the domestic market, health spending is sustained by two demographic trends: increased life expectancy and an ageing population. Although the rate of ageing in India is slower than the developed world, the large population makes any increase significant in terms of absolute numbers, and therefore also in terms of market potential (Yip & Mahal, 2008).

iv) Rising share of the private healthcare sector: As seen earlier, the majority of healthcare services in India are provided by the private sector (Selvaraj & Karan, 2009). The contribution of the private healthcare sector is on the rise, with investments from the corporate sector steadily growing since the mid- 1990s. In the last few years, a number of new players have entered the healthcare delivery sector, and set up specialty and super-specialty centres. In the government sector, the states provide the bulk of healthcare. Presently, the public spending is at a level of 1.3 per cent of the GDP (MoHFW, 2009). Public spending on healthcare will continue to rise, but the prospect of large and sustained increases is low.

v) Significant investment opportunities for private sector: Limited government investment provides significant opportunities for private healthcare service providers as large investments are required to scale up the country's healthcare infrastructure. India's healthcare infrastructure needs substantial investment. The government is likely to meet only 15-20 per cent investment in hospital beds, assuming it increases expenditures by 6-7 per cent from the current base. Assuming 10-15 per cent commitment from international donors, there would be a shortfall of 70 per cent, which could be funded by private companies (Yip & Mahal, 2008). India's unmet demand for healthcare facilities, rapidly changing demographics, increasing private spending on healthcare, and a readily available intellectual pool are fuelling the growth of the healthcare industry and making it highly attractive for international investors.

KEY OPPORTUNITIES FOR PRIVATE INVESTORS

The investors interested in exploring the healthcare services market in India have following as the major opportunities:

Medical Tourism

Medical tourism has gained momentum in India over the past few years, a trend underpinned by India's low-cost advantage and the emergence of new high-quality healthcare service providers. India is seeing a surge of patients from developed countries as well as from countries in Africa and South and West Asia that lack adequate healthcare infrastructure. The emergence of low-cost, high value specialist medical care territories in India have been responsible in making it an attractive destination for medical tourism (Economic and Social Commission for Asia and the Pacific, 2007).

These "medical hotspots" are beginning to witness an influx of health tourists from non-traditional geographies. Among others, foreign health travellers to India comprise a large number of Non Resident Indians (NRIs). This is mainly because the healthcare systems in Europe and the United States are under severe pressure; particularly the National Health Service (NHS) in the UK, which has a long list of patients waiting for over a year for surgery. In the US the healthcare crisis has a different dimension. Around 50 million citizens are uninsured, with even the insured having to pay dearly for treatment. Further, the shortage of paramedical professionals such as nurses has aggravated the situation. Patients from the US are now regularly beating a path to India, as many of their insurance companies have entered into tie-ups with private Indian hospital chains (Yip & Mahal, 2008).

India offers highly cost-competitive medical treatment and technological advances in areas such as cardiology, cosmetic and orthopedic surgery, dentistry, eyecare and preventive health checks. India offers world class cardiac bypass surgery, hip replacements, organ transplants, cosmetic, dental surgery and vision correction. Costs of comparable treatment in India are on average one eighth to one fifth of those in the West. For instance, a cardiac procedure costs anywhere between US$ 40,000 - 60,000 in the United States, US$ 30,000 in Singapore, US$ 12,000 -15,000 in Thailand and only US$ 3,000 -6,000 in India (Gopalan, 2008). Likewise, the associated costs of surgery are also low. Not only are skilled Indian surgeons available for less, they are also less susceptible to costly litigation. The cost of malpractice insurance in New York is around US$ 100,000 but only US$ 4000 in India. This brings down the overall cost of treatment (Gopalan, 2008).

Cost is not the only factor weighing in India's favour. The overall success rate of cardiac bypasses is 98.7 per cent in India, as opposed to only 97.5 per cent in the United States. India's healthcare industry is thus both competitive on cost and quality. It is widely believed that there is not a single surgery/procedure, which is done abroad but cannot be done in India.

Apart from being in step with changing healthcare delivery technology, leading Indian medical care facilities are increasingly complying with stringent quality standards and queuing up for international accreditations. Further, hospital chains are offering special packages, which include airport pickups, visa assistance and boarding and lodging. Thus, India is fast emerging as a leading destination for medical tourism.

Medical Devices

The medical devices market in India is highly promising. The market size for medical devices in India is expected to touch US$ 1.7 billion by 2010, against US$ 1.2 billion presently. The demand for hi-tech products constitutes close to 80 per cent of the overall market in India (Thaindian News, 2008). Since domestic production comprises primarily of low-tech devices; there is a higher involvement of foreign companies in sourcing hi-tech devices, which alone account for US$ 770 million of market value. Presently, nearly 90 per cent of the demand is being met by imports from countries like USA, Japan and Germany.

Pathology Services

Presently, the lab testing market is largely serviced by small unorganized players and hospitals. Believing that diagnostics is a high-margin and asset intensive business, many focused players are in

the process of developing national networks - such as Dr. Lal's Path labs, Metropolis, SRL Ranbaxy, Thyrocare, and Nicholas Piramal.

Most renowned path labs are expanding regionally and foraying into the international markets as well. Some national players have been successful in attracting the interest of foreign investors. Among all the diagnostics molecular diagnostics is the fastest growing segment of the in-vitro diagnostics (IVD) market with a projected growth of 25 per cent per annum. Viral diagnostics, immune system disease diagnostics, bacterial, parasitic and fungal identification, cancer diagnosis and monitoring are the segments where molecular technologies enjoy significant cost-benefit advantage. Similarly, pharmacogenomics testing too is believed to usher in an era of personalised medicine where diagnostic tests that will help in selecting the best of the several therapies will be a prerequisite for prescribing a therapy. With the Government expected to bring in a relaxation on customs duty and service tax, molecular diagnostics and pharmacogenomics testing too are touted as the future drivers of the diagnostic industry (Thaindian News, 2008).

Increasing health consciousness among common people has created avenues for preventive healthcare. Hospitals have started witnessing a number of patients who visit for health check-ups as a preventive measure. Outsourcing of pathology and laboratory tests by foreign hospital chains is becoming is a huge opportunity because of the high cost differential in India.

Telemedicine

In India, only about 27 per cent of the population lives in urban areas, while a sizeable 73 per cent of the population is rural. While 72 per cent specialist doctors practice in urban areas, only 25 per cent reside in semi-urban areas and a mere 3 per cent in rural areas. The outcome of this lop-sided distribution is that 80 per cent of the medical facilities are concentrated in urban areas and a mere 20 per cent in rural areas, which continue to remain deprived of proper healthcare facilities (Thaindian News, 2008). The answer to patient treatment in inaccessible areas in India with fewer medical facilities, is telemedicine.

The exponential growth in the ICT (Information & Communication Technologies) sector and the plummeting telecom costs are making India highly competitive in telemedicine. The early successes of pioneers such as Apollo Hospitals, Narayana Hridulaya, AIMS Kochi, SGPGI Lucknow, and SRMC Chennai has resulted in increased acceptance and proliferation of telemedicine. At present, there are around 120 telemedicine centres spread in the country.

Though India is yet to pass legislation on telemedicine related issues, a beginning has been made. 'Guidelines & Standards for Practice of Telemedicine in India' has already been recommended by the Ministry of Information Technology, Government of India, to standardise digital communication in telemedicine. The Medical Council of India has also constituted committees to look into this and other legal aspects of telehealth. The role played by the Indian Space Research Organisation (ISRO) in not only providing VSATs but also telemedicine hardware and software has also contributed immensely to the growth.

Pharmaceutical Industry

Despite widespread poverty and inadequate public healthcare provision, India has much to offer the leading drug makers. An increase in lifestyle diseases resulting from the adoption of unhealthy western diets, combined with a growing middle class that has more disposable income to spend on treatment, will provide new opportunities for global pharmaceutical firms.

Healthcare BPO

Spiralling healthcare costs, unbearable squeeze on margins, process inefficiencies, acute talent shortage and an aging population are compelling healthcare establishments in the US and Europe to

look at Indian healthcare BPOs. Outsourcing healthcare business processes to Indian service providers can result in cost savings to the tune of 20-30 per cent.

India capable of offering a wide spectrum of outsourced healthcare services. The types of services being offered by Healthcare BPOs in India include:

- Data capture– include reporting of diagnostic tests and radiology reporting
- Documentation– data coding, medical transcription, billing and data migration
- Commercial– invoicing, disbursal, expense reporting, procurement, cash management, general ledger and receivables management
- Administration– claims processing, adjudication, mailroom services and records management
- Human resources– employee assistance, training and payroll
- Customer care– dispatch and activation services, technical support Companies are further involved in various functions such as converting existing data to HIPPA format (Health Insurance Portability and Accountability Act), USA, administrative functions, billing and coding tasks, processing forms, including scanning written documents, converting them into an electronic format, and sending them back. BPOs are further involved in claims forms processing for health insurance companies.

Health Insurance

India offers tremendous opportunity for private medical insurance players. Increasing awareness levels and large-scale group insurance policies have pushed growth in the health insurance segment in recent years. With escalating medical costs, companies are already looking at the option of increasing the premium by about 15 per cent to 20 per cent for health insurance.

CONCLUSION

While the health sector has made significant progress in the years since the country's independence, India still faces significant challenges. The major challenges in the delivery of health services in India is the inadequate physical infrastructure, ineffective management, limited availability, and lack of qualified health care professionals. Thus, the Indian healthcare sector can be viewed as a glass half empty or a glass half full. The challenges the sector faces are substantial, from the need to improve physical infrastructure to the necessity of providing health insurance and ensuring the availability of trained medical personnel. But the opportunities are equally compelling, from developing new infrastructure and providing medical equipment to delivering telemedicine solutions and conducting cost-effective clinical trials. For companies that view the Indian healthcare sector as a glass half full, the potential is enormous.

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