Chapter 1
INTRODUCTION

1.1. SERVICE SECTOR AROUND THE WORLD

Service sector is the lifeline for the social economic growth of a country. It is today the largest and fastest growing sector globally contributing more to the global output and employing more people than any other sector. For most countries around the world, services are the largest part of their economy. The real reason for the growth of the service sector is due to the increase in urbanization, privatization and more demand for intermediate and final consumer services. Availability of quality services is vital for the well being of the economy. In advanced economies the growth in the primary and secondary sectors are directly dependent on the growth of services like banking, insurance, trade, commerce, entertainment, social and personal, etc. The U.S. and other developed economies are now dominated by the services sector, accounting for more than two-thirds of their Gross Domestic Product (GDP).

A growing economy changes the proportions and interrelations among its basic sectors—agriculture, industry, and services and between other sectors—rural and urban, public and private, domestic- and export-oriented. One way to look at the structure of an economy is to compare the shares of its three main sectors—agriculture, industry, and services—in the country’s total output and employment. Initially, agriculture is a developing economy’s most important sector. But as income per capita rises, agriculture loses its primacy, giving way first to a rise in the industrial sector, then to a rise in the service sector. These two consecutive shifts are called industrialization and post industrialization. All growing economies are likely to go through these stages, which can be explained by structural changes in consumer demand and in the relative labor productivity of the three main economic sectors (Tatyana P. Soubbotina, 2004).

Most high-income countries today are post industrializing—becoming less reliant on industry—while most low income countries are industrializing—becoming more reliant on industry. But even in countries that are still industrializing, the service sector is growing relative to the rest of the economy. By the mid-1990s services accounted for almost two-thirds of world GDP up from about half in the 1980s. Between 1990 and 2000, growth of world services output was 2.9 per cent double that of agriculture which was only 1.4 per cent. As a result, the contribution of the service sector to world gross domestic product was 64 per cent in the year 2000, compared to 57 per cent in 1990. (World Bank, “World Development Indicators” 2001).

Between 1990 and 2000, the growth of exports of commercial services for developing countries (9 per cent) exceeded that for developed countries (5.5 per cent). The 49 least
developed countries also experienced particularly strong export growth of commercial services (6.3 per cent) (WTO statistics, 2001). Liberalization of services in developing countries could provide as much as $6 trillion in additional income in the developing world by 2015, four times the gains that would come from trade in goods liberalization (World Bank's report, 2001). As incomes continue to rise, people’s needs become less “material” and they begin to demand more services—in health, education, entertainment, and many other areas. Meanwhile, labor productivity in services does not grow as fast as it does in agriculture and industry because most service jobs cannot be filled by machines. This makes services more expensive relative to agricultural and industrial goods, further increasing the share of services in GDP. The lower mechanization of services also explains why employment in the service sector continues to grow while employment in agriculture and industry declines because of technological progress that increases labor productivity and eliminates jobs. Eventually the service sector replaces the industrial sector as the leading sector of the economy.

1.2. SERVICE SECTOR GROWTH AND DEVELOPMENT SUSTAINABILITY
The service sector produces “intangible” goods, such as health, education and some quite new services such as modern communications, information, and business services. Producing services tends to require relatively less natural capital and more human capital than producing agricultural or industrial goods. As a result demand has grown for more educated workers, prompting countries to invest more in education—an overall benefit to their people. Another benefit of the growing service sector is that by using fewer natural resources than agriculture or industry, it puts less pressure on the local, regional, and global environment.

Service sector plays a complimentary role and accelerates the process of development through quality improvement and enhancement with efficiency of productivity and developmental activities. Healthcare services enable a country to improve the quality of human capital thereby increases the productive efficiency of human resources.

1.3. WHAT IS HEALTHCARE?

Healthcare is defined as the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions. (American Heritage® Medical Dictionary, 2007). Healthcare is the maintaining and restoration of health by the treatment and prevention of disease especially by trained and licensed professionals (as in medicine, dentistry, clinical
psychology, and public health) (Merriam-Webster Dictionary, 2010). Healthcare is the efforts made to maintain or restore health especially by trained and licensed professionals. Healthcare is the prevention and treatment of illness or injury, especially on a comprehensive, ongoing basis (Webster's New World College Dictionary, 2010). WHO also defined health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. (Source: WHO 1986)

1.4. TYPES OF HEALTHCARE SYSTEMS AROUND THE WORLD – THE FOUR BASIC MODELS

There are about 200 countries on our planet, and each country devises its own set of arrangements for meeting the three basic goals of a healthcare system: keeping people healthy, treating the sick, and protecting families against financial ruin from medical bills. But we don't have to study 200 different systems to get a picture of how other countries manage healthcare. For all the local variations, healthcare systems tend to follow general patterns. There are four basic systems which are explained by Reid T.R. (2009) and are enumerated as follows:

1.4.1. The Beveridge Model

Named after William Beveridge, the daring social reformer who designed Britain's National Health Service. In this system, healthcare is provided and financed by the government through tax payments, just like the police force or the public library. Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government. These systems tend to have low costs per capita, because the government, as the sole payer, controls what doctors can do and what they can charge. Countries using the Beveridge plan or variations on it include its birthplace Great Britain, Spain, most of Scandinavia and New Zealand. Hong Kong still has its own Beveridge-style healthcare, because the populace simply refused to give it up when the Chinese took over that former British colony in 1997. Cuba represents the extreme application of the Beveridge approach; it is probably the world's purest example of total government control (ibid.)

1.4.2. The Bismarck Model

It is named after the Prussian Chancellor Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the 19th century. Despite its European heritage, this system of providing healthcare would look fairly familiar to Americans. It uses an insurance
system -- the insurers are called "sickness funds" -- usually financed jointly by employers and employees through payroll deduction. Unlike the U.S. insurance industry, though, Bismarck-type health insurance plans have to cover everybody, and they don't make a profit. Doctors and hospitals tend to be private in Bismarck countries; Japan has more private hospitals than the U.S. Although this is a multi-payer model -- Germany has about 240 different funds -- tight regulation gives government much of the cost-control clout that the single-payer Beveridge Model provides. The Bismarck model is found in Germany, of course, and France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America. (ibid.)

1.4.3. The National Health Insurance Model

This system has elements of both Beveridge and Bismarck. It uses private-sector providers, but payment comes from a government-run insurance programme that every citizen pays into. Since there is no need for marketing, no financial motive to deny claims and no profit, these universal insurance programmes tend to be cheaper and much simpler administratively than American-style for-profit insurance. The single payer tends to have considerable market power to negotiate for lower prices; Canada's system, for example, has negotiated such low prices from pharmaceutical companies that Americans have spurned their own drug stores to buy pills north of the border. National Health Insurance plans also control costs by limiting the medical services they pay for, or by making patients wait to be treated. The classic NHI system is found in Canada, but some newly industrialized countries -- Taiwan and South Korea, for example -- have also adopted the NHI model. (ibid.)

1.4.4. The Out-of-Pocket Model

Only the developed, industrialized countries -- perhaps 40 of the world's 200 countries -- have established healthcare systems. Most of the nations on the planet are too poor and too disorganized to provide any kind of mass medical care. The basic rule in such countries is that the rich get medical care; the poor stay sick or die. In rural regions of Africa, India, China and South America, hundreds of millions of people go their whole lives without ever seeing a doctor. They may have access, though, to a village healer using home-brewed remedies that may or may not be effective against disease. In the poor world, patients can sometimes scratch together enough money to pay a doctor's bill; otherwise, they pay in potatoes or goat's milk or child care or whatever else they may have to give. If they have nothing, they don't get medical care. (ibid.)
1.5. **HEALTHCARE AND ECONOMIC DEVELOPMENT-DIRECT AND INDIRECT**

Healthcare and education are the two main vital components of service sector. The relationship between health and economic development is fundamental, and health is essential for promoting economic growth. Health and economic development are linked bi-directionally with improved health promoting economic growth and economic growth promoting better health. Improved health, like increasing human capital (education), leads to increased labor productivity which provides income. This increased income in turn leads to better opportunities to save which can then be used to finance investment in both physical and human capital. In the other direction increased income leads to increased access to basic human requirements, such as food, shelter, and sanitation. Freedom from malnutrition allows the opportunity to learn and further invest in human capital, promoting awareness of basic sanitation and of diseases related to poor sanitation. These factors promote health and also lead to demographic changes, reducing birth rates. While these relationships are well understood, awareness of the magnitude of the economic cost associated with avoidable infectious diseases is often overlooked (Bryce S. Sutton, 2009).

**Enhancing Human Development: Critical Role of Improving Health Status**

Improvement in the health status directly contributes to human happiness and therefore, has an intrinsic value. Health is a basic component of human development, and hence, determines society’s well being. Through human development, sound health enhances labour productivity and contributes to material progress. It is a means to empower the deprived sections of society and thus, an important element in the strategy for poverty alleviation. Access to preventive and protective healthcare enhances entitlements of the poor by enabling steady employment, improving productivity and facilitating demographic transition. As argued by Sen, “...poverty must be seen as the deprivation of basic capabilities rather than merely as lowness of incomes” (Sen, Amartya. 1999). Capabilities provide freedom from hunger and poverty. Poor health condition can be a major source of capability deprivation and hence a cause for unemployment and poverty. Thus, enhancing health status by providing basic healthcare facilities has overwhelming importance in enhancing capabilities and hence, freedom.

Samuel Preston drew a remarkable relationship between income (national income per head) and health (life expectancy), (Preston, 1975). Figure 1.1 presents the relationship between national income and life expectancy (Deaton, 2003). The curve shifts upwards over time (Preston, 1975). For the same income countries can now expect a much better life expectancy. Something is happening over time to shift the relationship between health and
wealth. Both Preston and Wilkinson come to similar estimates; only 10 -15 per cent of the recent increase in life expectancy comes from moving along the curve; 85-90 per cent comes from the curve shifting upwards, lifting all others. Preston (1975), Cutler (2006) and Wilkinson (2006) all come to the conclusion that this shift must be caused by improvements in public health, health knowledge, health technology, and the rising quality of health determining factors worldwide. This evidence suggests that population health may be less influenced by income and more by the diffusion rates of health knowledge, and the successful social implementation of that knowledge. Pritchett and Summers (1996) present evidence that there is also a relationship between national income and infant mortality. At the broadest global level then, health seems to be intimately related to wealth.

Figure 1.1: The Preston Curve in 2000 (Deaton, 2003). Life Expectancy compared with GDP per capita (Purchasing Power Parity, PPP, $).

Figure 1: The Preston curve: life expectancy versus GDP per capita
Note: Circles are proportional to population and some of the largest (or most interesting) countries are labeled. The solid line is a plot of a population weighted non-parametric regression. Luxembourg, with per capita GDP of $55,000 and LE of 77.04 years, is excluded.

The idea that health may in fact cause wealth seems eminently plausible, as a healthier workforce will surely be more productive. Mortality and morbidity results in less full-years of productive life, whilst placing economic burdens on the formal health sector and on informal care-givers. For example, coronary heart disease alone cost the UK £2.91 bn in lost productivity (Liu, J. et al., 2002). Furthermore, the economic benefit of treatment and prevention often outweighs the cost. The WHO's Commission on Macroeconomics and Health has called for a large scaling up of health services in developing countries on both health and economic grounds (WHO, 2001). For its selection of countries, it estimates the
costs to be $66Bn, saving 8 million lives and increasing economic output by $186bn/year. Nordhaus (1999) argues that the economic benefits of health improvements over the twentieth century are equal to all the non-health economic gains put together. Clearly then, the relationship between economic growth and health is a two-way process.

Bad health is very costly for the economy for the following reasons: irrecoverable losses in production due to absence of sick labor, and relatives called upon to help the sick; less well trained labor force; loss of human and financial resources used to treat the sick; higher labor force turnover and lower productivity in general; less competitive economy; lower profitability of enterprises; lower tax revenues; lower survival rates, in the long run, of less competitive enterprises; lower attraction for foreign investments; lower rate of growth and higher unemployment.

Bad health increases poverty and social imbalance in the following ways: disease of one member of the family means an increase in malnutrition for the whole family as a result of additional spending on treatment; malnutrition increases the risk of unemployment; an already poor housing situation risks further deterioration; opportunities for education and training are missed; the already low productivity of the family decreases further; access to healthcare, drinking water and social services becomes more precarious as a result of lower revenues and education; poorer families tend to have more children as a form of insurance whereby the children bring daily wages by working to run the home expenses; elevated risk of unwanted pregnancies; sale of assets for survival and further economic deterioration; increase in the powerlessness of the family.

1.6. GLOBAL HEALTHCARE SITUATION

Healthcare around the world is highly localized with pockets of advancement and most of the pockets in poor state of health. It has been reported by WHO (2006) that the total number of healthy life years lost to morbidity and premature mortality in the world is estimated at 1.49 billion years in 2002. An estimated 41 per cent of this total is due to infectious diseases and perinatal conditions, while non-communicable diseases and injuries explain 47 per cent and 12 per cent of the total respectively. Among infectious diseases, perinatal conditions and pneumonia (acute lower respiratory infections) account for an estimated 6.5 per cent and 6.1 per cent respectively of the total number of healthy life years lost to diseases. In principle, the share of infectious diseases in the total burden of diseases may decrease in the coming years, on the condition that the ongoing efforts to control these diseases are actively pursued. The share of non-communicable diseases (in particular, neuropsychiatric and mental disorders, cardiovascular diseases and cancers) is
likely to increase as a result of the demographic and epidemiological transitions. These averages hide wide disparities between high-income countries on the one hand and low and middle income countries on the other. For example, the risk of falling sick to infectious diseases is nine times higher in low and middle-income countries than in high-income countries, while the risk of being injured is twice as high. Contrary to popular belief, the risk of falling sick to non-communicable diseases is just as high in low and middle-income countries as in high-income countries. Just as serious, these averages also hide wide disparities in practically all countries between high and low income quintiles of the population, the poorer quintile running on the average a much higher risk of falling sick or injured than the high income quintile (WHO 2006).

Some of the main causes for these problems are proximate causes—malnutrition is the most important proximate determinant of the health situation in the world, explaining almost 16 per cent of the total number of lost years. Other main causes include infected water, unsafe sex, alcohol, indoor air pollution and tobacco. Beyond the proximate causes mentioned above, more fundamental and underlying factors are contributing in an important way to the poor health situation of particular countries. Among these factors are a low level of education, poorly functioning health services, environmental risks, bad governance (including the poor functioning of government institutions, internal and external conflicts, corruption and violations of human rights) and poverty. In many ways, these factors are at the root of the proximate causes mentioned above and can be considered as the ultimate causes of poor health.

1.7. HEALTHCARE SITUATION IN THE DEVELOPING COUNTRIES

Improving health services is a crucial part of achieving the Millennium Development Goals in low- and middle-income countries (David H. Peters. et.al. 2009). Healthcare in the developing world has almost all the same problems such as the world over. Only difference is there are a few economic transitional problems. Developing countries face the twin epidemic of continuing/emerging infectious diseases as well as chronic degenerative diseases. The former is related to poor implementation of the public health programmes, and the latter to demographic transition with increase in life expectancy. Economic deprivation in a large segment of population results in poor access to healthcare. Poor educational status leads to non-utilization of scanty health services and increase in avoidable risk factors.

The developed countries have in place many systems by which healthcare is provided to their needy citizens. It may be state owned healthcare delivery as in the case of National
Health Service (NHS) in UK or managed care services offered by health insurance firms as in the US. These systems, though they may have distinct disadvantages, serve to cater to the health needs of their people to a reasonable extent. It may be noted that even developed countries are shying away from supporting healthcare delivery by public sector. In many developing nations healthcare is provided jointly by the government and the private sector. Public health institutions are the only hope for the underprivileged people. Most of the developing nations are plagued by problems of under nutrition and a host of infections. Epidemics of diarrheal diseases provide a rough guide to the poor sanitation of the community. Safe drinking water is a dream for millions even now.

Healthcare financing continues to be a key challenge in the developing world. Despite efforts to improve the provision of health services, many low- and middle-income countries are still far from achieving universal health coverage. An estimated 1.3 billion people do not have access to effective and affordable healthcare, including drugs, surgeries, and other medical facilities. As documented by the World Health Organization, developing countries bear 93 per cent of the world’s disease burden, yet merely account for 18 per cent of world income and 11 per cent of global health spending. And existing infrastructure is too less for the size of the countries and has to be improved at the earliest possible time (Drechsler, Johannes Jütting, 2005).

In the developing countries the existing infrastructure has to be improved in education, safe water, and sanitation needs priority along with vaccination. As shown in Figure 1.2, the chronic diseases are overtaking communicable disease in the developing world.

**Figure 1.2. Global Burden of Disease 1990 – 2020 by disease group in developing and newly industrialized countries.**

![Global Burden of Disease 1990-2020](image)

**Source:** WHO, Evidence, Information and Policy Cluster, Global Burden of Disease database, 2000
Most of the healthcare problems of developing countries is due to poverty. Anand and Ravallion's (1993) findings remind us of the need to ensure growth is converted into reduced poverty. This is not guaranteed. Butler (2004) argues that South Africa's apartheid growth was capital-intensive and characterized by human investment in “Whites”. Black rural poverty and black unemployment had reached 33.4 per cent in 1998. This perspective suggests that, for growth to be healthy, a shift is required towards labor-intensive, job creating growth in sectors such as agriculture. In a similar vein, UNICEF argues that developing countries will need to identify their poorest areas, and try to stimulate poverty-reducing growth there (Taylor et al., 1998). This should have the greatest impact on poverty, which as we have seen is linked to both average and pro-poor population health aims.

1.8. INDIAN SERVICE SECTOR

In alignment with the global trends, Indian service sector has witnessed a major boom and is one of the major contributors to both employment and national income in recent times. The activities under the purview of the service sector are quite diverse. Trading, transportation and communication, financial, real estate and business services, community, social and personal services come within the gambit of the service industry. One of the key service industries in India would be health and education. They are vital for the country's economic stability. A robust healthcare system helps to create a strong and diligent human capital, who in turn can contribute productively to the nation’s growth.

The service industry forms a backbone of social and economic development of a region. It has emerged as the largest and fastest-growing sectors in the world economy, making higher contributions to the global output and employment. Its growth rate has been higher than that of agriculture and manufacturing sectors. It is a large and most dynamic part of the Indian economy both in terms of employment potential and contribution to national income.

In 2000/01 India’s services sector accounted for around 49 per cent of GDP and employed around 19 per cent of the total workforce (in 1999/00), which suggest that the sector’s labour productivity may be considerably higher than the national average. Other infrastructure services, such as electricity, gas and water, accounted for 2.5 per cent of GDP. As a significant and growing contributor to the economy, an efficient services sector is crucial for economic growth. In India, growth rate of commercial services in the 1990s was 14.5 per cent, more than double that of world trade of 6.4 per cent (WTO News, 2002). Services negotiations offer real opportunities for all WTO members and more so for developing countries.
The services sector has been at the forefront of the rapid growth of the Indian economy, contributing nearly 63 per cent of the GDP in 2007-08. The sector has come to play an increasingly dominant role in the economy accounting for 59.6 per cent of the overall average growth in GDP in the last eight years between 2000-01 and 2007-08 (IBEF, 2010).

As per the Central Statistical Organization, the services sector has continued to grow in the second quarter of 2009-10. Trade, hotels, transport and communication grew 8.5 per cent in July-September 2009 from a year earlier. Financing, insurance, real estate and business services grew at 7.7 per cent in July-September, 2009 from a year earlier. Community, social and personal services grew at 12.7 per cent in July-September, 2009 from a year earlier (Healthcare, CII, 2009, Delhi). Healthcare comes in the category of community, social and personal services.

1.9. HEALTHCARE SECTOR IN INDIA

Healthcare is part of the services sectors in India. Health has always been a high priority area in any country. It has been recognized as an important component in the process of economic and social development. It does not simply mean absence of diseases; rather it is a state of complete physical, mental and social well-being. Sanitation and hygiene, nutrition as well as safe drinking water are the basic determinants of good health. The indicators like infant mortality and maternal mortality rates, life expectancy and nutrition levels, birth rate and death rate, along with the incidence of communicable and non-communicable diseases reflect the health status in an economy. The existence of proper and well-defined healthcare facilities are vital not only for having a healthy productive workforce and promoting general welfare, but also for attaining the goal of population stabilization as well as enhancing the overall quality of life of people.

Over the years, India has built up a vast health infrastructure and manpower, with a wide variety of hospitals and dispensaries being set up at different levels and run both by public and private sectors. They are being managed by qualified doctors and trained nurses. Expansion in access to healthcare services combined with technological advancements in this field has resulted in substantial improvement in health indices of the population and a steep decline in mortality rates. The health sector in India has been fragmented between the Centre and the States. Items like public health, hospitals, sanitation, etc. comes under the State list of the Constitution, while the items having wider ramification at the national level like population control and family welfare, medical education, prevention of food adulteration, quality control in manufacture of drugs etc. have been included in the
Concurrent list. At the Central level, the Ministry of Health and Family Welfare is a nodal authority for the growth and development of healthcare sector in the country.

The Indian healthcare system consists of medical care providers like physicians, specialist clinics, nursing homes, hospitals and diagnostic service centers and pathology laboratories. It also consists of medical equipment manufacturers, Contract Research Organizations (CRO’s), pharmaceutical manufacturers and third party support service providers (catering, laundry, housekeeping, security, etc).

1.10. HEALTHCARE SECTOR AND ECONOMIC DEVELOPMENT

The most important objective of the government of any nation would be to achieve faster economic development and to see that the benefits of economic development percolate to the mass of people.

Two of the most crucial social inputs which may be considered as ‘drivers’ of economic development are health and education. As far as health is concerned it has bidirectional causality with economic development i.e. economic development leads to better health status of people and also improved health leads to economic development.

The state of health of Indian citizens is important since it reflects the quality of life of its people and impacts economic development. Healthcare helps to enhance welfare of the people. With provision of good healthcare by the nation it results in healthy citizens who can contribute by giving more or increased man-days of work resulting in increased productivity and earning thereby contributing more to the GDP of the nation.

Investment in health contributes directly to a nation’s economic growth. The most direct effect of improved health is in terms of improved productivity and reduced absenteeism. Improved health also increases the likelihood that children will enroll in and remain in school and learn better and thus contributing indirectly to economic development via improved educational status of people in the long run.

Improvement in survival rates and life expectancy, as a result of improved health, has other benefits as well. As life expectancy increases, individuals save more in order to ensure their income and quality of life after retirement. This increases the overall investment in a nation’s physical capital. In addition, when people live longer, investment in human capital, such as in education, brings about an increase in per capita GDP growth. Therefore health can provide a complimentary role with development process.

Sen., Amartya. (1999) in his writings on welfare economics, specifically said “social choice, distribution, and poverty, constitute the analytical foundation and building blocks of economy. Development as Freedom draws together a lifetime of scholarship spanning the
disciplines of ethics, economics, sociology, politics, demography, and moral philosophy into a grand synthesis: social choice underpinned by substantive freedoms of individuals promotes the development of economies and societies in their broadest sense. At the same time, he states “development should be seen as the expansion of real freedoms that people enjoy, requiring, among other things, the removal of major sources of "unfreedom," including poverty, tyranny, poor economic opportunities, neglect of public facilities, and intolerance”

Sen’s first major theme is that analysis of development should go beyond material progress to encompass concerns of social development and social justice, which he argues can be done by focusing on "functioning’s" and "capabilities" of individuals. Functioning does can be viewed as a person's states of being and doing, which include a broad range of individual actions and conditions that a person has reason to value: being healthy and avoiding premature mortality, among others. Capabilities can be viewed as all states of being and doing available to a person. This notion of capabilities broadens the information base used to assess economic welfare, while the "capability set" can be seen as a mathematical representation of freedom for formal analysis. The extensive literature spawned by the capability perspective is testimony to the practical and analytical reach of this concept in development and welfare analysis.

1.11. DIFFERENT HEALTHCARE SYSTEMS IN INDIA

The Indian System of medicine is of great antiquity. It is the culmination of Indian thought of medicine which represents a way of healthy living valued with a long and unique cultural history, as also amalgamating the best of influences that came in from contact with other civilizations be it Greece (resulting in Unani Medicine- so-called Galenic medicine of herbal medical practice.) or Germany (Homeopathy) or our scriptures/sages which gave us the science of Ayurveda (meaning science of life), Siddha as also Yoga and Naturopathy. Like the multifaceted culture in our country, traditional medicines have evolved over centuries blessed with a plethora of traditional medicines and practices.

As per a report generated by government of India (Ayush, 2008), it enumerates all the different types of Indian recognized systems of medicine known as alternative medicine.

Ayurveda is perhaps as old as our civilization. This "Science of Life" (Ayu +Veda) takes an integrated view of the physical, mental, spiritual and social aspects of human beings, each impinging on the others. Ayurvedic was referred to in the Vedas (Rig-Veda and Atharvveda) and around 1000 B.C. the knowledge of Ayurveda was comprehensively documented in Charak Samhita and Sushrutha Samhita.
The Siddha System is one of the oldest systems of medicine in India and is practiced in the Tamil speaking parts of India and abroad. The Siddha system of Medicine emphasizes that medical treatment is oriented not merely to disease but has to take into account the patient, the environment, age, sex, race, habits, mental frame, habitat, diet, appetite, physical condition, physiological constitution, etc.

The Unani System of Medicine, which originated in Greece and passed through many countries before establishing itself in India during the medieval period, is based on well established knowledge and practices relating to the promotion of positive health and prevention of diseases. The Unani System has grown out of the fusion of the traditional knowledge of ancient civilizations like Egypt, Arabia, Iran, China, Syria and India.

Yoga is primarily a way of life, first propounded by Patanjali in systematic form. It consists of eight components namely, restraint, observance of austerity, physical postures, breathing exercise, restraining of sense organs, contemplation, meditation and Samadhi. These steps in the practice of Yoga have the potential to improve social and personal behavior and to improve physical health by encouraging better circulation of oxygenated blood in the body, restraining the sense organs and thereby inducing tranquility and serenity of mind.

Naturopathic medical system is rooted in the healing wisdom of many culture and times. The principles and practices of Naturopathy are integrated in the life style if Indians which continue to grow and evolve, incorporating elements that advance knowledge of mechanism of Natural healing and therapeutics.

The physicians from the time of Hippocrates (around 400 B.C.) have observed that certain substances could produce symptoms of a disease in healthy people similar to those of people suffering from the disease. Dr. Christian Friedrich Samuel Hahnemann, a German physician, scientifically examined this phenomenon and codified the fundamental principles of Homoeopathy.

Homoeopathy was brought into India around 1810 A.D. by European missionaries and received official recognition by a resolution passed by the Constituent Assembly in 1948 and then by the Parliament (Ayush, 2008b).

The Amchi system also known as Tibetan system of medicine (Bodh-Kyi Sowa– Rig-pa), traces its origin to Ayurvedic system of India. Tibetan medicine is a science, art and philosophy that provide a holistic approach to healthcare on the basis of principles which are systematically enumerated and logically framed, based on an understanding of the body and its relationship to the environment.
1.12. HISTORICAL PERSPECTIVE OF INDIAN HEALTHCARE

1.12.1. Before Independence
Conventionally healthcare in India has been based on voluntary work. Since ancient times traditional practitioners of healthcare have contributed to the medicinal needs of society. Acute knowledge in the medicinal properties of plants and herbs were passed on from one generation to another to be used for treatment. The colonial rule and the dominance of the Britishers changed the scenario. Hospitals managed by Christian missionaries took centre stage. Even the intellectual elite in India with their pro-west bias favored Western practices.

1.12.2. After Independence
Prior to independence the healthcare in India was in shambles with large number of deaths and spread of infectious diseases. After independence the Government of India laid stress on Primary Healthcare and India has put in sustained efforts to better the healthcare system across the country. The government initiative was not enough to meet the demands from a growing population be it in primary, secondary or tertiary healthcare. Alternate sources of finance were critical for the sustainability of the health sector.
Since Independence, India has taken massive strides towards improving the health of its population. India has made remarkable strides in increasing the life expectancy of its citizens. During the beginning of the 1930s, the average life expectancy of an Indian adult was only 32 years. As of 2007, the average life expectancy stands at 64 years (India Chronicle: 2007). More Indians are able to live to old age than previously.
The primary answer, of course, lies in India’s increasing prosperity. At Independence, India’s economy was dominated by subsistence agriculture. Now, the country is becoming a global player in such high value industries as Pharmacy and IT, and is posting consistently robust economic growth rates.

1.12.3. Entry of Private Sector
Till about 20 years back, the private sector’s venture in the healthcare sector consisted of only solo practitioners, small hospitals and nursing homes. The quality of service provided was excellent especially in the hospitals run by charitable trusts and religious foundations. In 1980's realizing that the government on its own would not be able to provide for healthcare, the government allowed the entry of private sector to reduce the gap between supply and demand for healthcare. The private hospitals are managed by corporate, non-profit or charitable organizations. The establishment of private sector has resulted in the emergence of opportunities in terms of medical equipment, information technology in health services, Business Process Outsourcing, Telemedicine and Medical Tourism.
Large companies and affluent individuals have started five star hospitals which dominate the space for high end market. The private sector has made tremendous progress, but on the flip side it is also responsible for increasing inequality in healthcare sector. The private sector should be more socially relevant and efforts must be made to make private sector accessible to the weaker section of society. Medical tourism is a relatively new concept, which is becoming popular globally. India has several advantages in favor of medical tourism like infrastructure, technology, cost-effective medical care and hospitalization, qualified and skilled doctors. Traditional Indian rejuvenation methods like yoga, ayurvedic massage find favor with people in western countries and corporate hospitals and wellness centers are cashing on this.

1.13. FIVE YEAR PLANS RELATED TO HEALTHCARE

In India, Government health services follow a traditional model of health funding and provision. The Government is both the financier and the provider of the public healthcare facilities. The State governments determine health allocations according to their policies and budgets. The states spend more than 80 per cent of the total expenditure on curative cure. The Central Government spends more than 70 per cent of the total expenditure on preventive and promotive healthcare (Prime Minister’s Advisory Council on Trade and Industry, 2000). The traditional model however has its limitations as it does not provide sufficient incentives for efficiency and innovation. The performance of states in healthcare innovation has varied, with some states showing more initiatives than others in devising new delivery and funding models. Just as China, India uses a five-year planning process to determine national goals and priorities. This process reinforces state dependence on the central government and institutionalizes a top-down decision making process that sets priorities (World Bank, 1997); implements centrally sponsored, vertical disease-control programmes; and creates plans for healthcare personnel and facilities (Peters, D. H., K. S. Rao, R. Fryatt. 2003). As per Table 1.1 public spending on health in India gradually accelerated from 0.22 per cent in 1950-51 to 1.05 per cent during the mid-1980s, and stagnated at around 0.9 per cent of the GDP during the later years (i.e. spending by only Central and State health departments). Of this, recurring expenditures such as salaries and wages, drugs, consumables, etc. account for more than 90 per cent and is on the rise in recent years. In terms of per capita expenditure, it increased significantly from less than Rs. 1 in 1950-51 to about Rs 215 in 2003-04. However, in real terms, for 2003-2004 this is around Rs 120. Estimates, irrespective of the definition, reveal that the per capita spending by the Government is far below the international aspiration of US$12 recommended for an essential health package by the World Development Report 1993 and, again by the Commission on Macroeconomics and Health (World Health Organization, 2001) for low-
income countries. As a result of stagnant budgetary allocations, the quality of care suffered substantially and adversely impacted on the utilization of government services by households. Besides, health services that were earlier being provided free were in some cases charged, forcing patients to seek private healthcare.

Table 1.1. Trends in Public Health Expenditure in India by the government (GDP is at market price, with base year 1993-94)

<table>
<thead>
<tr>
<th>Five Year Plans</th>
<th>Year</th>
<th>Health expenditure as per cent of the GDP</th>
<th>Per capita public expenditure on health in Rs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Five Year Plan</td>
<td>1950-51</td>
<td>0.22</td>
<td>0.61</td>
</tr>
<tr>
<td>Second Five Year Plan</td>
<td>1960-61</td>
<td>0.63</td>
<td>2.48</td>
</tr>
<tr>
<td>Third Five Year Plan</td>
<td>1965-66</td>
<td>0.61</td>
<td>3.47</td>
</tr>
<tr>
<td>Fourth Five Year Plan</td>
<td>1970-71</td>
<td>0.74</td>
<td>6.22</td>
</tr>
<tr>
<td>Fifth Five Year Plan</td>
<td>1980-81</td>
<td>0.91</td>
<td>19.37</td>
</tr>
<tr>
<td>Sixth Five Year Plan</td>
<td>1985-86</td>
<td>1.05</td>
<td>38.63</td>
</tr>
<tr>
<td>Seventh Five Year Plan</td>
<td>1990-91</td>
<td>0.96</td>
<td>64.83</td>
</tr>
<tr>
<td>Eighth Five Year Plan</td>
<td>2000-01</td>
<td>0.9</td>
<td>184.56</td>
</tr>
<tr>
<td>Ninth Five Year Plan</td>
<td>2001-02</td>
<td>0.83</td>
<td>183.56</td>
</tr>
<tr>
<td>Tenth Five Year Plan</td>
<td>2002-03</td>
<td>0.86</td>
<td>202.22</td>
</tr>
<tr>
<td>Eleventh Five Year Plan</td>
<td>2007-2012</td>
<td>1.41</td>
<td>Not available</td>
</tr>
</tbody>
</table>

Sources: Report on Currency and Finance, RBI, various issues; Statistical Abstract of India, Government of India, various issues; Handbook of Statistics of India, RBI, India.

Recognizing the significant potential and challenges in the health sector, the government has prioritized it in the Eleventh Five Year Plan (11TH Five Year Plan, 2007-2012). The private sector plays a significant role by contributing 4.3 per cent of GDP and 80 per cent share of healthcare provision. However, deficiencies persist with respect to access, affordability, efficiency, quality and effectiveness, despite the high level of overall private and public expenditure on health. Public health expenditure is up from 0.9 per cent of GDP in 2001-02 to 1.41 per cent in 2008-09. The eleventh plan allocation is Rs 1,40,135 crore (Rs 1401.35 billion) for health, an increase of 227 per cent over the tenth plan.

The health expenditure in India is dominated by private spending. To a large extent this is a reflection of the inadequate public spending that has been a constant feature of Indian development in the past half century.

The latest data from the National Sample Survey Organization (NSSO) 61st Round shows that 22.2 per cent of Indians were living below the poverty line during 2004–05. According
to the NSSO data 55th Round, households’ spend about 5 per cent–6 per cent of their total consumption expenditure on health, which is 11 per cent of all non-food consumption expenditure (Singh. S, Mukherjee A, 2004). The high cost of services in the private sector makes it unaffordable for the poor and the underprivileged section of the society.

The healthcare industry in the country, which comprises hospital and allied sectors, is projected to grow 23 per cent per annum to touch US$ 77 billion by 2012 from the current estimated size of US$ 35 billion (ASSOCHAM and YES Bank 2009). There is now growing recognition amongst economists that growth comes not through centrally-imposed government plans and protection of industry, but through governments allowing private enterprise to get on with the serious business of creating wealth. The state’s proper role is as a guardian of the institutions that allow businesses to invest in their future, safe in the knowledge that their property is secure.

India’s total healthcare spending (Government spends 1.2 per cent and private 4.9 per cent totaling 6.1 per cent of the GDP) is way below most developed countries. The public spending on health is among the lowest in the world (Business Standard, April 25, 2010). India 6.1 per cent of its GDP to health, is ahead of Pakistan (4.0 per cent) and Sri Lanka (3.7 per cent) but behind Brazil (7.6 per cent), and the United States (15.6 per cent). The striking fact about Indian health expenditures is that they are heavily in the private sector. According to The Business World, Ernst and Young Survey (June 2007), only 0.9 per cent of the country’s GDP is spent on public-sector health programmes, whereas 4.2 per cent is private. India ranks 171st out of 175 countries in percentage of GDP spent in the public sector on health and 17th in private-sector spending. The public spending could double if the government reaches its target spending level of 2 per cent of GDP, up from the current 0.9 per cent, according to the report. Coupled with the expected increase in the pharmaceutical sector, the total healthcare market in the country could increase to Rs 232,000-Rs 320,000 Crore (6.2-8.5 per cent of GDP) in the next five years (WHO Statistics, 2009).

As per the policy of Indian government during 2009-10 people Below Poverty Line (BPL) families are covered under Rashtriya Swasthya Bima Yojana (RSBY). Allocation under RSBY has increased by 40 per cent over previous allocation to US$ 74 million in Budget Estimates. 2009-10. The government has announced several measures which will have a positive impact on the sector such as: 150 per cent reduction in R&D outsourcing expenditure would encourage higher research spend and improve competitiveness of outsourcing players, Allocation under National Rural Health Mission (NRHM) is proposed to be increased by US$ 431 million over and above US$ 2.53 billion provided in the Interim Budget (India Budget 2009).
1.14. PRESENT SCENARIO OF HEALTHCARE IN INDIA

The vast majority of the country suffers from a poor standard of healthcare infrastructure which has not kept up with the growing economy. Despite having centers of excellence in healthcare delivery, these facilities are limited and are inadequate in meeting the current healthcare demands. Nearly one million Indians die every year due to inadequate healthcare facilities and 700 million people have no access to specialist care and 80 per cent of specialists live in urban areas. Quality health-care remains inaccessible throughout the country, despite the presence of a highly skilled and qualified medical workforce. The hospital services market represents one of the most important segments of the Indian healthcare industry. Various factors such as increasing prevalence of diseases, improving affordability and rising penetration of health insurance continue to fuel growth in the Indian healthcare industry.

Chronic disease care has also emerged as a major challenge for healthcare leaders struggling to develop systems to deliver high-quality, cost-effective care (J.L. Wolff and C. Boul.t. 2005). Although chronic disease is a problem across the age span, the challenge of caring for people with chronic illnesses will intensify as our society ages and the prevalence of chronic disease increases (G.F. Anderson. 2000).

As per Technopak (2009) report Indian healthcare market is estimated to touch US$ 77 billion by 2013 and US$ 309 billion by 2023. Ernst and Young (2008) report states that healthcare industry has accounted for 5.1 per cent of the country’s GDP in 2006. The healthcare sector is estimated at about US$ 38 billion and expected to grow at a compound annual growth rate (CAGR) of 15 per cent for the next 15 years to reach 309 billion in the year 2023. (IBEF and E&Y 2009). Nearly 90 per cent of this growth will come from the private sector. Further, private hospitals in the country are expected to rake in $35.9 billion (Rs 147,154.1 Crore) in 2012 compared to $15.5 billion (Rs 63,534.5 Crore) in 2006. Correspondingly, along with a shift in emphasis from socialized to privatized healthcare, the share of the private sector in India’s healthcare industry is set for a quantum increase in the coming decade.

It is envisaged that the value of healthcare market will almost double – from Rs. 100,000 Crores in 2005 to over Rs. 300,000 Crores by 2012. Largest component of healthcare spending is from the private sector and by 2012 it is expected to rise from the current level of Rs. 69,000 Crore to Rs. 156,000 Crore. In addition public spending could double from current Rs. 17,000 Crores if the government reaches its target spending level of 2 per cent of GDP, up from 0.9 per cent today (ASSOCHAM-YES Bank, 2009).
It is estimated that Indian healthcare market is estimated to touch US$ 77 billion by 2013 (IBEF and E&Y, 2009). It is expected to generate employment opportunities for nine million people by 2012. Private healthcare is to form a large share of the healthcare spend, and would increase to US$ 33.6 billion in 2010 from US$ 14.8 billion in 2002.

The health sector has registered a growth of 9.3 per cent annually between 2000-2009, comparable to the sectoral growth rate of other emerging economies such as China, Brazil and Mexico (ASSOCHAM YES Bank 2009). The growth in the sector would be driven by healthcare facilities, both private and public sector, medical diagnostic and pathology labs and the medical insurance sector.

“The Indian healthcare sector has immense opportunities for growth by providing affordable quality healthcare facilities. As the healthcare sector will develop, it will create new growth avenues for players with innovative products and business models. (RNCOS, 2010).”

The Table 1.2 below gives a clear picture of the public healthcare infrastructure as of 2008. These facilities are part of a tiered healthcare system that funnels more difficult cases into urban hospitals while attempting to provide routine medical care to the vast majority in the countryside. Primary health centers and sub centers rely on trained paramedics to meet most of their needs.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Centres</td>
<td>22669</td>
<td>72.06</td>
</tr>
<tr>
<td>Community Health Centres</td>
<td>3190</td>
<td>10.14</td>
</tr>
<tr>
<td>District Hospitals</td>
<td>4,400</td>
<td>13.99</td>
</tr>
<tr>
<td>State Owned Hospitals</td>
<td>1,200</td>
<td>3.81</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>31459</td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: India Chronicle: 2007, Fostering quality healthcare for all, Ernst and Young, 2008

In India we have 688,000 Doctors and 14,62,000 Nurses. There are 229 recognized medical colleges of which 106 were established through the private route and 25,000 medical graduates pass out each year. 136 medical schools admit more than 6,000 PG trainees in their programmes. In the year 2008 the density of doctors and nurses is 1.6, hospital beds for 10,000 population is 7, Physicians per 10,000 population is 6 and Nurses per 10,000 population is 13. Disability adjusted life years per one lakh population is a universally
accepted indicator of burden of disease which is 27,536.79. It is a measurement of the gap between current health status and an ideal situation where everyone lives into old age free of disease and disability. It has been reported that the number of doctors per lakh population is 60 in India whereas it is 313 in Norway, 247 in Australia, 106 in China and 76 in Pakistan (Human Development Report 2002, 2007).

Indian healthcare infrastructure is not advanced compared to developing countries like China and Korea. Our current bed to thousand population is at 0.9 (World Bank, 2005) compares poorly even with our neighboring countries. For example China, Korea and Thailand have about 4.3 beds per thousand populations (CII & Mckinsey Company, 2002). India has 0.9 beds per thousand patients as against a world average of 2.6 (Ernst & Young, 2008). Bed to thousand-population ratio of 1.85 is likely to be reached by 2012. In order to be comparable with the healthcare parameters of other developing countries, India’s healthcare sector faces many challenges. For example, to reach a ratio of 2 beds per 1000 population by 2025, an additional 177 million beds will be required which will need a total investment of US$86 billion. There is an acute shortage of doctors, nurses, technicians and healthcare administrators and an additional 0.7 million doctors are needed to reach a doctor population ratio of 1:1000 by 2025. "Changing demographics and disease profiles and rising treatment cost will cause the spending on healthcare delivery to over Rs 200,000 Crore by 2012” (CII & Mckinsey Company, 2002).

The growth in per capita income, increasing urbanization, insurance liberalization, and availability of modern biomedical technology, education and overall awareness indicate that demand for healthcare is bound to increase in the country.

It is this growing wealth that has allowed India to buy its improvements in health. Much of the improving life expectancy and infant mortality rates are due to better sanitation, cleaner water and greater access to life-saving medical technologies. Advances in medical science and improvements in sanitation have reduced the spread of infectious diseases, and better medical facilities; preventive measures using vaccines against diseases such as polio, measles and awareness have contributed to the rise in life expectancy.

The health industry has emerged as one of the most challenging sectors as well as one of the largest service sector industries in India with estimated revenue of US $35 billion; it constitutes 5.2 per cent of India’s GDP and employs 4 million people. The Indian health industry is expected to grow at 15 per cent per annum to US$78.6, reaching 6.1 per cent of GDP and employing 9 million people by 2012 (IBEF and E&Y, 2007).
Notwithstanding the current global economic crisis, India's pharmaceutical industry and its healthcare market are expected to grow rapidly in the next few years. Driven by strong local demand, Indian healthcare market is expected to continue growing close to previously projected rates of 10 to 12 per cent. The high growth of the Indian healthcare sector is primarily driven because of domestic reasons. With average household consumption expected to increase by more than seven per cent per annum, the annual healthcare expenditure is projected to grow at 10 per cent and also the number of insured is likely to jump from 100 million to 220 million. Further hospital beds are expected to double from 1.5 per thousand to 2.9 per thousand and the diagnostic laboratories to grow by 20 to 25 per cent. There will be an addition of 300,000 to 400,000 doctors and another 250,000 to 300,000 nurses (The Economic Times, 2009).

Table 1.3 gives a clear picture of how the healthcare pie will evolve itself by the year 2012 and which of the sub sectors of healthcare will contribute towards this. Indian healthcare market currently is estimated at US$ 34.2 billion. Healthcare delivery and pharmaceuticals account for nearly 75 per cent of the total healthcare market. Private healthcare is estimated to be the largest component of the healthcare sector by 2012, expected to double to US$ 38 billion by 2012.

Table 1.3. How The Healthcare Pie Will Evolve By 2012

<table>
<thead>
<tr>
<th>Year 2006</th>
<th>Year 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 per cent = $34.2 bn</td>
<td>100 per cent = $78.6 bn</td>
</tr>
<tr>
<td><strong>Amount</strong></td>
<td><strong>Amount</strong></td>
</tr>
<tr>
<td>14 per cent</td>
<td>4.79</td>
</tr>
<tr>
<td>5 per cent</td>
<td>1.71</td>
</tr>
<tr>
<td>35 per cent</td>
<td>11.97</td>
</tr>
<tr>
<td>18 per cent</td>
<td>6.16</td>
</tr>
<tr>
<td>2 per cent</td>
<td>0.68</td>
</tr>
<tr>
<td>11 per cent</td>
<td>3.76</td>
</tr>
<tr>
<td>1 per cent</td>
<td>0.34</td>
</tr>
<tr>
<td>3 per cent</td>
<td>1.03</td>
</tr>
<tr>
<td>1 per cent</td>
<td>0.34</td>
</tr>
<tr>
<td>3 per cent</td>
<td>1.03</td>
</tr>
<tr>
<td>1 per cent</td>
<td>0.34</td>
</tr>
<tr>
<td>6 per cent</td>
<td>2.05</td>
</tr>
</tbody>
</table>

*Source: The Business World, Ernst and Young Survey; June 2007*
The most important drivers in the healthcare industry of India are, shift to lifestyle related diseases, quality driven approach-accreditations, health cities-the evolving concept of healthcare in India, Hospotels- an emerging novel concept, impelling technology, health insurance-current and future scenario, reverse in brain drain, healthcare players are now targeting smaller cities, mergers and acquisitions, funding by private equity, new entrants KEY foreign players, medical value travel, public private partnerships and hospital planning and consulting (IBEF AND E&Y 2007).

The most important drivers are a growing middle class and patient preferences in India and increase in paying capacity. There is a favorable increase in percentage of working class population from 32 per cent in 2006 to 36 per cent in year 2016. There is also a growing general awareness, literacy rates and patient preferences in healthcare decisions (Ernst and Young. 2008).

**Figure 1.3: Growth drivers for Indian Healthcare**

![Figure 1.3: Growth drivers for Indian Healthcare](image)

**Source: CRISIL Research 2009**

As per (IBEF and E&Y 2010) the increase in the incidence of lifestyle-related diseases among Indians has triggered a demand for specialized treatment. For example, cardiac and related disorders. A higher proportion of the Indian population is living in urban areas, where the propensity to seek treatment for ailments is higher. This is primarily due to easy access to healthcare facilities and higher disposable income to undergo expensive treatments. Lifestyle-related diseases are likely to assume a greater share of the healthcare market. In-patient revenues of hospitals have increased since expenditure on lifestyle-related diseases has risen substantially.
1.15. HEALTHCARE FINANCING IN INDIA

Financing is the most critical of all determinants of a health system. The nature of financing defines the structure, the behavior of different stakeholders and quality of outcomes. It is closely and indivisibly linked to the provisioning of services and helps define the outer boundaries of the system’s capability to achieve its stated goals.

Health financing is by a number of sources: (i) the tax-based public sector that comprises local, State and Central Governments, in addition to numerous autonomous public sector bodies; (ii) the private sector including the not-for-profit sector, organizing and financing, directly or through insurance, the healthcare of their employees and target populations; (iii) households’ through out-of-pocket expenditures, including user fees paid in public facilities; (iv) other insurance-social and community-based; and (v) external financing (through grants and loans).

While taxation is considered the most equitable system of financing, as tax is a means of mobilizing resources from the richer sections to finance the health needs of the poor, out-of-pocket expenditures by households’ is considered the most inequitable. Under a system dominated by out-of-pocket expenditures, the poor, who have the greater probability of falling ill due to poor nutrition, unhealthy living conditions, etc. pay disproportionately more on health than the rich and access to healthcare is dependent on ability to pay.

Assessing how pro-poor a system of financing is again depends on how the different types of financing interact with each other. For example, a country may have a social health insurance policy but may not cover public hospitals as they are in theory expected to provide free care. In such a situation there may be greater incentives for patients to go to private hospitals as expenses are covered by insurance resulting in no incentives for the public hospitals to function well. In that case, the poor who have no immediate access to insurance or private hospitals may stand to lose with poor quality public care.

In India, as in most countries, there is a clear urban-rural, rich-poor divide. Affluent sections, urban populations and those working in the organized sector covered under some form of social security such as the ESIS or CGHS, have unlimited access to medical services. The rural population and those working in the unorganized sector have only the tax-based public facilities to depend on for free or subsidized care, and private facilities depending on their ability to pay. The impact on equity then gets determined on whether the tax-based
public facilities are able to provide a similar quality of care as provided under the Social Health Insurance Scheme. Because, if funding is low and the quality of care falls below expectation, is inaccessible, entails informal payments, etc., then the benefit of free care at the public facility gets neutralized with the second option of paying out-of-pocket to a relatively hassle-free private provider available close by, making the system of financing inequitable as well as inefficient.

The majority of the Indian population is unable to access high quality healthcare provided by private players as a result of high costs. Many are now looking towards insurance companies for providing alternative financing options so that they too may seek better quality healthcare. The opportunity remains huge for insurance providers entering into the Indian healthcare market since 75 per cent of expenditure on healthcare in India is still being met by ‘out-of-pocket’ consumers. The Insurance Regulatory and Development Authority (IRDA) is the governing body responsible for promoting insurance business and introducing insurance regulations in India. The share of public sector companies in health insurance premiums was 76per cent and that of private sector companies was 24per cent for the period 2005-06. Health insurance premiums collected over 2008 registered a growth of 35per cent over the previous year (See Figure 11). In 2001 the IRDA introduced provisions for Third Party Administrators (TPAs) to support the administration and management of health insurance products offered by insurance companies. TPAs are facilitators in the coordination process between the health insurance provider and the hospital. Currently there are 27 TPAs registered under the IRDA.

Health insurance has a way of increasing accessibility to quality healthcare delivery especially for private healthcare providers for whom high cost remains a barrier. In order to encourage foreign health insurers to enter the Indian market the government has recently proposed to raise the Foreign Direct Investment (FDI) limit in insurance from 26per cent to 49per cent. Increasing health insurance penetration and ensuring affordable premium rates are necessary to drive the health insurance market in India.

Today, healthcare costs are rising, which is a concern to many people. Because of ongoing advances in medical care and in technology, medical treatment is becoming more expensive. These advances help people to live longer. Today there are more senior citizens than ever before – our population is aging. The elderly population is more frail and prone to illness thus requiring more medical care than a younger population that is healthier. This enumerates the need and importance of Health Insurance in India. Healthcare costs are also rising due to personal health choices made by individuals. Poor eating habits, smoking, drug
and alcohol abuse, a lack of exercise, obesity are some of these poor health choices. Health insurance is a major source of financing healthcare expenditure around the world and it is comparatively new in India but recently it has seen rapid growth.

Although the health insurance sector is projected to grow to US$3.8 billion in collected premiums by 2012 from the annual collected premium of US$711 million in 2006, there is a dismal health insurance penetration rate; at present only 10 per cent of the total population is insured. For the desired changes and a healthy growth of the healthcare sector, a well-defined partnership between the government and the private sector is essential (IBEF and E&Y 2009).

Figure 1.4. Market Size of Medical Insurance in India

Voluntary health insurance market, estimated at US$ 86.3 million currently, is growing fast. Total medical insurance premium income is estimated to grow to US$ 3.8 billion by 2012 (IBEF AND E&Y, 2009). Over 80 per cent of private health insurance is concentrated with four leading players like ICICI Lombard, Bajaj Allianz, Royal Sundaram and Iffco Tokio.

Health expenditure in India (2004-05) is 4.2 per cent of the GDP and about Rs. 2.2 lakh crores. Over three-fourths (78 per cent) of all health spending is private (71 per cent of total is by households’) (National Health Accounts for India 2004-05).
Figure 1.5. Sources of finance in the Indian health sector during 2001-02

More than 40 per cent of the people hospitalized had to borrow money / sell assets to cover expenses. A quarter of those hospitalized fall below the poverty line because of high costs (Peters D, Yazbeck A, Sharma R, Ramana G, Pritchett L, Wagstaff A. (2002). Medical care is one of the 3 main causes of impoverishment in the country. Recent NSSO data (60th round) indicates a large share of consumption expenditure is on health (13 per cent in rural, 10 per cent in urban).

Medical Insurance penetration in India is very low. The government should facilitate this migration through introduction of multiple healthcare financing schemes targeted at different socio-economic segments of the population. This should be done through a mix of private and public sources. In addition, there could be other measures such as reallocation of funding and increased revenues for the government.

Steps to ensure that these measures do not unduly increase healthcare costs across the society, have to be taken, primarily through increased insurance coverage. The organized sector should be mandatorily covered though social insurance. The existing schemes (such as CGHS and ESIS) should be consolidated at the state level. Many developing countries are moving forward to provide health coverage to most of the population with increased government initiatives and universal health insurance.

Health insurance coverage among urban, middle- and upper-class Indians, however, is significantly higher and stands at approximately 50 per cent. China is an example moving in this direction where the Chinese government is hoping that if the country's social safety net is stronger, its people will feel secure enough to spend more, which is badly needed to help
offset the global demand slump. Beijing wants to expand basic health coverage to most of the population by 2011 and it is willing to spend the billions needed to do so. Leaders are betting that the ambitious programme will help stave off social unrest, as the country slows to its weakest pace of growth in seven years. China’s State Council approved a plan Wednesday to spend 850 billion Yuan ($124.3 billion) in the next three years to reform the country’s troubled healthcare system. Measures include expanding health insurance coverage to 90 per cent of the populace and overhauling woefully inadequate public hospitals (Tina Wang, 2009).

1.16. THE CASE OF HOME CARE SERVICES (HCS) IN INDIA
The main objectives of healthcare providers are to improve quality, accessibility, availability, acceptability, and efficiency of healthcare services. Lifestyle-related chronic diseases such as high blood pressure, heart disease, cancer and diabetes are common, not only among the 300 million or more emerging Indian upper middle and the upper classes, but also among the rural masses. This will cause a huge burden on the existing overloaded healthcare infrastructure. There is a large population of disabled people and a bigger ageing population leading to greater dependence. Considering the fact that Indians give prime importance to family, many patients prefer spending time at home either as post-operative care or in case of chronic illnesses. There are many problems faced by consumers in the hospital, especially in urban parts such as high healthcare cost, lack of hospital beds for admission, long waiting time and travelling time, lack of emotional support, surroundings of pain and agony, lack of recognition as an individual, indifference of staff towards patients, loss of earnings of relatives due to caring of patient in hospital, risk of contracting infection in a hospital, lack of a human touch with empathy for the patients in a hospital, on the verge of dying, lack of doctors spending more time with patients to explain the progress and disease condition and many more. Some of these problems faced by households’ are prompting health providers to think of innovative methods of delivering care such as the emotional surplus.

As per the McKinsey projections, by the year 2030, there will be 590 million people living in urban India which is nearly twice the United States population today contributing to a staggering 270 million net increase of human population of working age leading to 70 per cent of employment generation in these urban areas. There will be 91 million urban households’ in middle class, up from 22 million today. Therefore, there is a need to strengthen the healthcare system in the urban parts of the country and to cater to their needs by enhancing the quality of life of people who are willing to opt for HCS. The HCS in urban setup can provide the necessary service support and bring in customer comfort with better cost-effective care.
1.17. HOME HEALTHCARE – A NEW ALTERNATIVE

Healthcare awareness and demand for quality healthcare has been increasing in the country due to the incidence of chronic disease and health related problems of ageing population. There's also a need for providing affordable and effective care with easy accessibility. Indian healthcare infrastructure is not advanced but needs to develop innovative methods to counter these challenges. Home Care services can be an effective alternative to provide efficient and effective care to the needy population.

The term Home care has been defined as the provision of health services by formal and informal caregivers in the home (WHO. 2000).

According to National Association for Home Care and Hospice, "Home care" encompasses a wide range of health and social services. These services are delivered at home to recovering, disabled, chronically or terminally ill persons in need of medical, nursing, social, or therapeutic treatment and/or assistance with the essential activities of daily living (http://www.nahc.org/2009). Several other definitions and descriptions of Home Care Services exist (Mosby’s Medical Dictionary, 2009; McGraw-Hill Concise Dictionary of Modern Medicine, 2002). In order to devise the working definition, the researcher has built on these earlier definitions. The researcher believes that this definition captures the essence of the field and provides a base on which the research frame works.

“It is a multidisciplinary field of allopathic health service provided as fee for service in the patients’ place of residence for the purpose of promoting, preventing, maintaining, or restoring health or minimizing the effects of illness and disability. Service may include such elements as medical, dental, and nursing care; speech therapy, physical therapy and respiratory therapy; homemaking services of a home health aide; and provision of transportation. The nature and extent of care needed and the ability of the patients’ family and friends to assume responsibility for that care are assessed and prescribed by the physician at home, clinic or emergency. Nursing may be provided by a registered nurse, or licensed B.Sc. Nurse, practical nurse, or home health aide. Hospitals have home care services as a department that includes regular visits by a nurse, family physician, therapist, etc to the patients’ home for delivering treatment. As much as possible the diagnostic equipments are carried in a vehicle to the patients’ home otherwise patient is taken to the diagnostic center by the Home Care Services department. Home Care can sometimes decrease or avoid the need for hospitalization.”

The following are the professionals required to deliver HCS: Doctor, Nurse, Physiotherapist, Respiratory therapist, Occupational therapist, Pharmacist, Ambulance driver, Social worker, Volunteer, Home Care aides, Dietitian, Insurance broker, Accountant, Lawyer and a Banker.

The most common conditions and treatments delivered by HCS are treatment of infections,
particularly genitourinary tract, respiratory tract, skin, joint and soft tissue infections; anticoagulant therapy; post-surgical acute care; congestive cardiac failure treatment; treatment of chronic obstructive pulmonary disease; oncology and palliative care; and rehabilitation services (Shepperd S. 2009). The majority of programmes operate as hospital outreach programmes, although HCS programmes may also be operated by community health services, or hospital based teams working in conjunction with community based services (Shepperd S. 2009b). By definition HCS units depend upon referrals for their patients. Many programmes spend time and effort in generating these referrals. For example, programmes may employ staff to identify patients, provide information sessions and written material for staff and use personal contacts to increase and maintain throughput. In most admission avoidance HCS programmes, patient referral is from Department of Emergency Medicine staff. Patients are also commonly referred from medical practitioners in the community. Early discharge HCS referrals are predominantly from inpatient wards (Shepperd S. 2009c).

**Elements of Home Care Services**

There is no agreed list of minimum or core services in home healthcare, but the elements listed below are the most common. As need arises we may wish to add others that are more relevant in a given place or situation or may choose not to provide all of the listed elements. It is essential to ensure that the decisions about what to include are made carefully and are well publicized, and that the information is easily accessible to those in the healthcare sector, to those who require care, to informal caregivers, and to members of the broader community. Hospitals and HCS agencies may wish to consider alternative ways of meeting needs, taking into account the economy, personal and community preferences, client or caregiver mobility, and the availability of transport.

In addition to the list in the following elements of health and social systems in general are also relevant to home-based long-term care:

— Ensuring continuity of care between the home, community facilities, hospitals, and institutions;

— Collection and recording of client data that can be used in information systems for planning, management, and policy-making;

— Supervision and technical support;

— Monitoring, evaluation, and feedback.
Elements of home-based long-term care

1. Assessment, monitoring, and reassessment.
2. Health promotion, health protection, disease prevention, postponement of disability.
3. Facilitation of self-care, self-help, mutual aid, and advocacy.
4. Healthcare, including medical and nursing care, personal care, e.g. grooming, bathing, meals, household assistance, e.g. cleaning, laundry, shopping.
5. Physical adaptation of the home to meet the needs of disabled individuals.
6. Referral and linkage to community resources.
7. Community-based rehabilitation.
8. Provision of supplies (basic and specialized), assistive devices and equipment (e.g. hearing aids, walking frames), and drugs.
10. Specialized support (e.g. for incontinence, dementia and other mental problems, substance abuse).
11. Respite care (at home or in a group setting).
12. Palliative care, e.g. management of pain and other symptoms.
13. Provision of information to patient, family, and social networks.
14. Counseling and emotional support.
15. Facilitation of social interaction and development of informal networks.
16. Development of voluntary work and provision of volunteer opportunities to clients.
17. Productive activities and recreation.
18. Opportunities for physical activities.
19. Education and training of clients and of informal and formal caregivers.
20. Support for caregivers before, during, and after periods of care giving.

1.18. NEED FOR THE STUDY

Home Care Services are becoming popular in advanced western countries and its prevalence has brought advancement to peoples’ comforts and care. In the Indian context it is not picking up. The present study is focusing on answers to questions like what are the perceptions of people about Home Care Services and whether people are willing to accept Home Care Services in Indian Urban centers. There are no studies conducted in the Indian context to throw light on the home care services, customer perception and acceptance of home care services which needs a closer look. The present research study aims to study on the customer perception and acceptability of home care services in Indian urban parts. The proposed research study also aims to
address the constraints in development of home care services and ways and means to make Home care Services more affordable.
The study also envisages studying the benefits of patients in choosing Home Care Services against the difficulties in the regular hospital care and the financial benefit to the healthcare providers or entrepreneurs by starting Home care Services.

1.19. **STATEMENT OF THE PROBLEM**
This research is an empirical study on Home Care Services and Development Perspective – A Study on Customer Perception and Acceptability in the Urban Parts of India. The key areas are the Perception of the households’ and experts’ towards Home care Services and the Acceptability issues of Home care services by the households’ and experts’.
Metropolitan cities (Metros) are specifically chosen for the reason assuming there will be higher acceptability in metros rather than in other parts of the country due to lifestyle patterns, higher earning capacity and increased affordability of home care services. The study was carried out in Mumbai, Delhi, Kolkata and Chennai. These samples represent a cross section of General Households’ and Experts’ who are doctors with more than five years experience after Post Graduation across the country.

1.20. **RESEARCH QUESTIONS**
After studying various literatures related to home care services, the researcher has derived at the following individual research questions.

1. What are the perceptions and expectations of people as regarding to home care services?
2. How to make home care services acceptable and accessible among Indian urban population?
3. What are the constraints and apprehensions in the development of home care services in India?
4. How can home care services be provided within the affordable price range?
5. Can home care services be used by different age groups of the population?
6. Can home care services create an entrepreneurial avenue for the service providers?
1.21. OBJECTIVES OF THE STUDY

The objectives of the research study are as follows:

1. To find out the perception of people in terms of merits and constraints of HCS.

2. To explore acceptability and affordability of the people pertaining to home care services.

3. To identify the problems/apprehensions and limitations for development of home care services in the Indian urban centres.

4. To explore the entrepreneurial avenue for home care services in the urban parts of India.

5. To provide recommendations to make the home care services acceptable and affordable among people.

1.22. HYPOTHESIS OF THE STUDY

The following are the hypothesis formulated:

1. Home care Service is acceptable to the households’ only if the expenses under home care services are lesser than the hospital care services in the urban parts of India.

2. Acceptance of Home Care Service is dependent on the strong economic base (income level) of the family.

3. Acceptance of Home Care Services is the function of education level of the households’ in urban parts of India.

1.23. RELEVANCE OF THE STUDY

The study will throw light on the beneficial impact of home care services for long term care, palliative care, respite care and old age people. It also sees usefulness in patients with terminal disease and also how it can be useful for policy makers, government and healthcare providers. From the point of view of aged people who are separated from children, home care services provide necessary support and helping hand. Patients suffering from terminal or chronic diseases are in need of regular nursing support. The study will also showcase the new avenues for entrepreneurial opportunity as a business proposition. Governments have the objective to enhance the quality of life of people and in that process can also plan and support the home care services as part of their developmental schemes.
1. India’s life expectancy was 49.1 years in 1970. This has increased to 64 years by 2009. India has the highest infant mortality rate in the world, a nationwide survey reveals. India has slipped from 128 to 134 rank in 2009 according to a United Nations Human Development report (2009). The NRHM aims to bring the infant mortality down to 30 per 1,000 births by 2012 and the Integrated Child Development Scheme (ICDS) programme focuses on providing nutrition supplement to children under the age of five. There are two important consequences of the improvements in health. One, as populations become healthier, they also age. This is known as demographic transition. The second consequence of improved health is that the pattern of disease changes as development proceeds. This is known as epidemiological transition. This transition is caused because the relative importance of some other diseases rises when some diseases and causes of ill health are eliminated or controlled. The other reason is that as individuals live longer, diseases that only affect older individuals increase in absolute terms. Therefore Home Care Services will be handy.

Some variables, such as geography and demography, indirectly link health with economic growth. Geography, particularly tropical location, is highly correlated with disease burden, which in turn affects economic performance. Demography, on the other hand, is determined in part by health status, and has a direct effect on economic growth through the age structure of the population, in particular the ratio of the working age to the total population.

In India the ratio of the working age to the total population is reducing. This will bring more non working people who are disabled, sick and life style disease made them more dependent. There will be greater burden of people who will be dependents in the coming years and therefore this study highlights the home care services which are a tool to handle these issues. The number of people aged 60 years and older is growing rapidly, and the middle aged population (people 35-59 years old), who are growing most rapidly, will soon begin moving into old age. This will lead to continuous growth of the population aged 60 and above. The percentage of population aged 60 years or over in selected countries between 2000 and 2050 is going to increase significantly and there is a larger concern for India since its aging population is increasing from 8 per cent in the year 2000 to 21 per cent by the year 2050 (Rowan H. Harwood 2002). The researcher therefore would like to use home care services to deal with this problem.
People in middle and older age groups typically have longer illness episodes, and as they age, begin to have several long-term or chronic conditions, with corresponding costs. Typically, people aged 65 and above use 3.5 times the healthcare, the cost per episode is higher, and their use of pharmaceuticals is 2.5 times higher than the average. They are the main users of healthcare, and therefore their growth will increase both healthcare demand and costs. Home care services will be very helpful for this aging population.

2. Changing Disease Profile: Infectious diseases will take a back seat and lifestyle diseases will form the major chunk of illnesses in India. In 2007 alone, lifestyle diseases accounted for 27 per cent of the total disease afflictions in the year; second only to acute diseases (36 per cent). Chronic conditions which include lifestyle diseases are health problems that require ongoing management over a period of years or decades. India is fast becoming a den of chronic diseases. (IBEF AND E&Y, 2009; Mathers, C. D, D. Loncar. 2006),

Low and middle-income countries are the biggest contributors to the increase in burden of disease from non communicable conditions. In China or India alone, there are more deaths attributed to cardiovascular disease than in all other industrialized countries combined. In 1998, 77 per cent of all mortality related to non communicable conditions was in low- and middle-income regions, as was 85 per cent of the global burden of disease (WHO, 2005a).

India stands to lose on average International $ 200 billion in national income due to deaths from chronic diseases from 2005 to 2015. The government needs to incorporate innovative methods such as home care services to care for these groups of people who suffer chronic disease conditions.

Cardiac, oncology and diabetes collectively accounted for 13.8 per cent of the hospitalization cases in 2008. In terms of value, these three ailments accounted for 39 per cent of the in-patient revenues. These ailments are estimated to account for 17.4 per cent and 20.0 per cent of the hospitalization cases in the year 2013 and 2018, respectively (CRIS INFAC; Ernst and Young, 2008). The McKinsey report said there would be rise in prevalence of chronic diseases- congestive heart disease, diabetes, asthma and obesity would see double digit growth (McKinsey 2009). According to a CII-Mckinsey and Company study infectious diseases will take a back seat and lifestyle diseases will form the major chunk of illnesses in India (CII and Mckinsey Company, 2002).
3. **Home Based Neonatal Care (Gadchiroli Study).** Infant Mortality Rate in 2005 was 58 deaths for every 1000 births which is very high compared to other developing countries. Millennium developmental goals for 2015 are to have IMR as zero. (Tenth Five Year plan, 2000, RCH II, NPP 2000, and Millennium Development Goals.) 83 per cent of births are at home in rural areas. This study showed a very promising new avenue in Home based care especially for the poor and rural based tribal community which can be replicated all over the country by starting home care services. Home-based management of Low Birth Weight and the preterm neonates is feasible and effective. It remarkably improved survival by preventing co morbidities, by supportive care, and by treating infections (Bang AT, Reddy HM, Deshmukh MD, Baitule SB, Bang RA, 2005).

4. As per Prime Minister’s Advisory Council on Trade and Industry (April 2000), the quality of life in relation to health can be gauged by morbidity information. NCAER’s study reveals that the short duration morbidity prevalence rate (diarrhea, cough and cold, unspecified fevers) is 122 per 1000 population. The prevalence rate of major morbidity (epilepsy, heart disease, hypertension, tuberculosis, diabetes, mental disorders and leprosy) is found to be 46 per 1000 population. Home Care Services surely have an impact on the morbidity levels and works to bring the morbidity levels down.

Short term morbidity and major morbidity are disproportionately high among the vulnerable population groups including wage earners and those with low levels of income. About 20 per 1000 children in the 0-4 age group and 29 per 1000 population in the 5-12 age group suffer from physical disabilities such as bitot spot, visual impairment, hearing impairment, speech impairment and locomotor disability.

According to WHO, almost 80 per cent of the diseases in India are water borne or are caused by water bodies – cholera, diarrhea, typhoid, hepatitis A, malaria and filarial (WHO, 2006). It is primarily the poor who are most affected (Prime Minister’s Advisory Council on Trade and Industry, April 2000). If Home care services are started by the government for these poor, it will surely bring the morbidity levels lower. Home care if started will be relevant in this context.
5. India faces a formidable challenge in providing healthcare services to its people for several reasons. There is still an unfinished agenda in India for addressing childhood and maternal morbidity and mortality, and communicable diseases. These health problems are largely preventable. Home care services can be used effectively for providing preventive healthcare. In 2005, it was estimated that chronic diseases in India accounted for almost 53 per cent of all deaths and 44 per cent of disability-adjusted life years (DALYs). It is estimated that deaths from chronic diseases would register a sharp increase from 3.78 million in 1990 to 7.63 million in 2020 accounting for 66.7 per cent of all deaths.

India’s loss in terms of losing potentially productive years due to deaths from cardiovascular diseases in people aged between 35-64 years is one of the highest in the world. By 2030, the loss is expected to rise to 17.9 million years which is 940 per cent more than the loss estimated in the USA.

In India diabetic nephropathy is expected to develop in 6.6 million of the 30 million patients suffering from diabetes. Number of people with hypertension is expected to see a quantum leap from an estimated 118.2 million in 2000 to 213.5 million in 2025. Chronic diseases in India accounted for almost 53 per cent of all deaths and 44 per cent of disability adjusted life years (DALYs).

6. The burden of disease is the cost a society bears - measured in death and disability from illness and disease. The healthcare system must anticipate and respond to this changing burden of disease, ideally through preventive as well as curative measures. The demand for healthcare will be driven primarily by demographic changes and changes in epidemiological profile. India’s population is currently around one billion and is still experiencing high population growth rates, at 1.3 per cent per annum, which is high, compared to most emerging nations. Moreover, there is expected to be a significant change in the demographic profile. According to WHO, typically, in low income countries, the greatest burden of disease typically results from communicable disease (respiratory illness, measles), malnutrition and complications of pregnancy and childbirth. In higher income countries, the burden of disease is greatest from non-communicable conditions - heart disease, cancer, and accidents. Developing countries typically experience an epidemiological transition from a communicable disease profile to one characterized by non-communicable diseases on their path to economic development (WHO, 2006).
The worst possible scenario is a partial transition wherein a large part of society makes the transition and begins requiring costly hospital treatment for chronic illness. On the other hand, the very significant balance remains mired in an earlier (communicable) disease profile. India is currently in this stage. Therefore Home Care services will provide cheaper and a good alternative at the time of this healthcare scenario. Home care services can be used for both communicable and non communicable diseases.

7. Improvement in survival rates and life expectancy, as a result of improved health, has other benefits as well. As life expectancy increases, individuals save more in order to ensure their income and quality of life after retirement. This increases the overall investment in a nation’s physical capital. In addition, when people live longer, investment in human capital, such as in education, brings about an increase in per capita GDP growth. The interaction of exogenous demographic changes with human and physical capital development can lead to a virtuous cycle of growth, enabling a country to break free of a poverty trap. Home Care services will certainly improve the survival rates and life expectancy. A major result to emerge from recent research is that survival rates or life expectancy are powerful predictors of income levels or of subsequent economic growth (Prime Minister’s Advisory Council on Trade and Industry. (April 2000). The studies consistently find a strong effect of health on economic levels or growth rates. Interestingly, economic historians have concluded that perhaps 30 per cent of the estimated per capita growth rate in Britain between 1780 and 1979 was a result of improvement in health and nutritional status.

8. Hospitals are built assuming long in-patient stays often extending through the various stages of an illness episode - diagnosis, treatment, and rehabilitation - with long lapses of time between activities. This model has long been superseded in many countries by shorter, discrete periods of ambulatory and in-patient treatment. While extended lengths of stay may suit rural patients who travel long distances to urban specialty hospitals, long lengths of stay utilize facilities inefficiently, inflate costs and easily lead to hospital-induced infections and complications. A high percentage of time spent in hospitals may be unnecessary and even undesirable. This service delivery model leads to unnecessary over-capitalization of physical infrastructure. Home Care will save that expenditure and simultaneously give customer comfort.
9. There is a wide disparity between urban and rural areas in the distribution of physical infrastructure and human capital. The gap is more pronounced in States in which the population is geographically dispersed. 84 per cent of hospitals in India are situated in urban areas, which only account for approximately 35 per cent of the population. India lags behind in the availability of hospital beds compared with most other emerging economies. However, this may not be as serious an issue as the urban-rural distribution of hospital beds. As India begins to adopt more efficient hospital management practices, patients’ length of stay in hospital will decline rapidly, and many conditions will be treated on an ambulatory basis. However, accessibility of services is likely to remain a problem in rural areas for some time to come, unless urgent measures are taken to correct this imbalance. There is a wide disparity between urban and rural areas in the distribution of physical infrastructure and human capital.

10. In 1946, the Bhore Committee established the guiding principles for provision of healthcare to the citizens of India. They are:

- That no individual should fail to secure adequate medical care because of inability to pay for it.
- The health programme, must, from the very beginning, lay special emphasis on preventive work with consequential development of environmental hygiene.
- The health services should be placed as close to the people as possible in order to ensure the maximum benefit to the communities to be served.
- The doctor – the leader of the health team should be a social physician, who should combine remedial and preventive measures as to confer the maximum benefit on the community and the future doctors should be trained to equip them for all such duties”.

63 years have passed since the committee gave these recommendations but our nation is still lagging behind. Home care services will be an important tool in fulfilling these recommendations.

11. Developing countries will be unable to afford the costs of institutional or hospital care, they should therefore establish policies of community based care through Home Care (WHO, 2006).
12. Increasing paying capacity: India's healthcare sector has been growing rapidly and estimated to be worth US$ 40 billion by 2012, according to Pricewaterhouse Coopers in its report, Revenues from the healthcare sector account for 5.2 per cent of the GDP, making it the third largest growth segment in India. The sector's growth will be driven by the country's growing middle class, which can afford quality healthcare. Over 150 million Indians have annual incomes of more than US$ 1,000, and many who work in the business services sector earn as much as US$ 20,000 a year (as on 2008). Today, at least 50 million Indians can afford to buy Western medicines - a market only 20 per cent smaller than that of the UK (Pricewaterhouse Cooper's report 2007).

13. Long-term care (LTC) has been a major issue in the developed countries and appropriate policies are formulated to provide healthcare to the populations in these countries. Although, there is a rapid increase in the need for Long Term Care (LTC) in the developing countries, but not yet acknowledged widely at the national and international levels. The LTC needs in the developing countries are increasing at a rate that far exceeds than that experienced by the industrialized countries. These changes in the LTC needs are mainly due to rapid demographic and epidemiologic transitions resulting in increase in the ageing population and changing patterns of disease burden in many developing countries. Most of these countries are unprepared to meet the challenges of the rising disease burden of long-term illnesses in terms of high cost and supportive care at the family and healthcare institutions. There is neither a well-formulated policy for long-term care, nor preparedness of the public care and services. India is experiencing similar challenges due to changing population structure and pattern of disease burden. The elderly population, which is currently about 6 per cent of the total population, would rise to 13 per cent by 2020. The disease burden due to non communicable diseases and HIV, that would require long-term care, will be more than 60 per cent of the total disease burden in the country. Given the income levels and per capita expenditure on health, rising cost of healthcare, poor efficiency of public health system, and rapidly transforming social systems at the family level, India needs to search for policy options and guidelines for long-term care.
1.24. CHAPTER SCHEME

This thesis is divided into 7 chapters.

First chapter deals with Introduction. It covers aspects related to healthcare in general.

The Second chapter discusses the global and Indian Scenario. It deals about the problems faced by patients in hospitals, studies related to HCS, models of HCS, and types of ailments treated in HCS, cost effectiveness of HCS, HCS-specific case for old aged people, adoption of technology in HCS, HCS in Urban India, etc.

Third chapter deals with research methodology.

Fourth Chapter deals with the profiles of the city.

Fifth Chapter deals with analysis of field work done.

The Sixth chapter gives summary of findings.

In the Seventh chapter, recommendations and conclusions are arrived at.