Chapter 3
History & Development of Healthcare Sector

3.0 Introduction

Health care is the prevention, treatment, and management of illness and the preservation of health through the services offered by the medical, nursing, and allied health professions. Health care embraces all the goods and services designed to promote health, including "preventive, curative and palliative interventions, whether directed to individuals or to populations\(^1\)". The organized provision of such services may constitute a health care system. This can include specific governmental organizations such as, in the UK, the National Health Service or cooperation across the National Health Service and Social Services as in Shared Care. Before the term "health care" became popular, English-speakers referred to medicine or to the health sector and spoke of the treatment and prevention of illness and disease.

In most developed countries and many developing countries health care is provided to everyone regardless of their ability to pay. The National Health Service, established in 1948 by Clement Atlee's Labour government in the United Kingdom, was the world's first universal health care system provided by government and paid for from general taxation. Alternatively, compulsory government funded health insurance with nominal fees can be provided, as in Italy. Other examples are Medicare in Australia, established in the 1970s by the Labor government, and by the same name Medicare was established in Canada between 1966 and 1984. Universal health care contrasts to the systems like health care in the United States or South Africa, though South Africa is one of the many countries attempting health
care reform.\textsuperscript{(2)} The United States is the only wealthy, industrialized nation that does not provide universal health care.\textsuperscript{(3), (4)}

Health care can encompass a wide number of milieus - from the informal milieu such as house calls, emergency medicine at an accident spot to milieu like nursing homes to 'typical' medical settings like doctor's practices, clinics and hospitals.

The health care industry is an industry which includes peoples' exercise of skill or judgment or the providing of a service related to the preservation or improvement of the health of individuals or the treatment or care of individuals who are injured, sick, disabled, or infirm. The delivery of modern health care depends on an expanding group of trained professionals coming together as an interdisciplinary team. \textsuperscript{(5), (6)}

Consuming over 10 percent of gross domestic product of most developed nations, health care can form an enormous part of a country's economy. In 2003, health care costs paid to hospitals, physicians, nursing homes, diagnostic laboratories, pharmacies, medical device manufacturers and other components of the health care system, consumed 16.3 percent\textsuperscript{(7)} of the GDP of the United States, the largest of any country in the world. For the United States, the health share of gross domestic product (GDP) is expected to hold steady in 2006 before resuming its historical upward trend, reaching 19.5 percent of GDP by 2016.\textsuperscript{(8)} In 2001, for the Organization for Economic Cooperation and Development (OECD) countries the average was 8.4 percent\textsuperscript{(9)} with the United States (13.9\%), Switzerland (10.9\%), and Germany (10.7\%) being the top three.

Systems: A single payer universal Healthcare system will save money through reduced bureaucratic administration costs. \textsuperscript{(10)} Social health
insurance is where the whole population or most of the population is a member of a sickness insurance company. Most health services are provided by private enterprises which act as contractors, billing the government for patient care. (11) In almost every country with a government health care system a parallel private system is allowed to operate. This is sometimes referred to as two-tier health care. The scale, extent, and funding of these private systems is very variable.

A traditional view is that improvements in health result from advancements in medical science. The medical model of health focuses on the eradication of illness through diagnosis and effective treatment. In contrast, the social model of health places emphasis on changes that can be made in society and in people's own lifestyles to make the population healthier. It defines illness from the point of view of the individual’s functioning within their society rather than by monitoring for changes in biological or physiological signs. (12)

Health and health care services is clearly distinguished from one another. Heath is just not the absence of disease. Pink of Health confers on a person or groups liberty from illness - and the ability to realize one's potential. Health is therefore best understood as the essential basis for defining a person's sense of well being. The health of population is a distinct key issue in public policy discourse in every society often determining the operation of huge society. They include its cultural understanding of ill health and well-being, extent of socio-economic disparities, reach of health services and quality and costs of care and bio-medical knowledge about health and illness.

Health care covers not merely medical care but also all aspects pre preventive care too. Nor can it be limited to care rendered by or financed out of public expenditure- within the government sector alone but must include incentives and disincentives for self care and
care paid for by private citizens to get over ill health. In India, private out-of-pocket expenditure leads the cost financing health care, the effects are bound to be regressive. Health care basic core is widely known to be a public good.

Four measures put forth - Firstly universal gain access to, and access to an passable level, and access without excessive burden. Secondly rational distribution of financial costs for access and rational distribution of load in allocating care and capacity and a constant search and research for improvement to a more just and fair system. Thirdly training providers for competence empathy and accountability, pursuit of quality care ad cost effective use of the results of relevant research. Fourthly exclusive treatment to vulnerable groups such as children, women, disabled and the aging populace.

3.1 Major Achievements in Health

A process understanding of long life and child health may be useful for understanding progress in the long run. Long life, is always a key nationwide aim, is not merely the decline of deaths as a result of better medical and rehabilitative care at old age. Quality of life requires as much external bio-medical interventions as culture based acceptance of unavoidable decline. Among infants through immunization and nutrition interventions and reduction of mortality among young and middle aged adults, including adolescents getting informed about reproduction and safe motherhood.

Reduction in child mortality involves as much attention to protecting children from infection as in ensuring nutrition and calls for a holistic view of mother and child health services. The cluster of services
consisting of antenatal services, delivery care and post mortem attention and low birth weight, childhood diarrhoea management are associated priorities. Programme of immunization and childhood nutrition is seen in better performing states indicate sustained attention to routine and complex investments into growing children as a group to make them grow into persons capable of living long and well. Often interest fades in pursuing the unglamorous routine of supervised immunization and is substituted by pulse campaigns etc. Which in the long run turn out counter-productive. Indeed persistence with improved routines and care for quality in immunization would also be a path way to reduce the world’s highest rate of maternal death rates.

In this context we may refer to the large ratio-based rural health infrastructure consisting of over 5 lakh trained doctors working under plural systems of medicine and a vast frontline force of over 7 lakh ANMs, MPWS and Anganwadi workers besides community volunteers. The creation of such public work force should be seen as a major achievement in a country short of resources and struggling with great disparities in health status.

To promote Indian systems of medicine and homeopathy there are over 22000 dispensaries 2800 hospitals, besides 6 lakh anganwadis serve nutrition requirement of nearly 20 million children and 4 million mothers. The total effort has cost the bulk of the health development outlay, which stood at over Rs 62.500/- crores or 3-64 % of total plan spending during the last fifty years.

On any count these are extraordinary infrastructural capacities created with resources committed against odds to strengthen grass roots. There have been facility gaps, supply gaps and staffing gaps, which can be filled up only by allocating about 20% more funds and
determined ill to ensure good administration and synergy from greater congruence of services, but given the size of the hard work there always will be some failure of commitment and in routine functioning. No one ever in this field can achieve 100% satisfaction. These get aggravated by periodic campaign mode and other outreach programmes, which have only increased segmentation of vision of health problems. The initial key mistake arose from the needless bifurcation of health and family welfare and nutrition functions at all levels instead of promoting more holism. As a result of all this the structure has been precluded from reaching its optimal potential. There has not been enough convergence in "escorting" children through immunization coverage and nutrition education of mothers and ensuring better food to children, including cooked midday meals and health checks at schools. There has also been no constructive engagement between allopathic and indigenous systems to build synergies, which could have improved people’s perceptions of benefits from the infrastructure in ways that made sense to them.

One major task in the coming decades is therefore to utilize fully that created potential by attending to well known organizational motivational and financial gaps. The gaps have arisen partly from the source and scale of funds and partly due to lack of persistence, both of which can be set right. Primary Health Centre (PHC) is funded by States several of whom are unable to match Central assistance offered and hence these centers remain inadequate and operate on minimum efficiency. On the other hand over two thirds costs of three fourths of sub-centers are fully met by the Center due to their key role in family welfare services. But in equal part these gaps are due to many other non-monetary factors such as undue centralization and uniformity, fluctuating commitment to key routines at ground level, insufficient experimentation with alternatives such as getting public duties
discharged through private professionals and ensuring greater local accountability to users.

3.3 Health Status issues

The difference between rural and urban indicators of health status and the wide interstate disparity in health status are well known. Clearly the urban rural differentials are substantial and range from childhood and go on increasing the gap as one grows up to 5 years. Sheer survival apart there is also the known under provision in rural areas in practically all social sector services. For the children growing up in rural areas the disparities naturally tend to get even worse when compounded by the widely practiced discrimination against women, starting with killing of female foetus.

In spite of overall achievement it is a mixed record of social development specially failing in involving people in imaginative ways. Even the averaged out good performance ides wide variations by social class or gender or region or State. The classes in many States have had to suffer the most due to lack of access or denial of access or social exclusion or all of them.

Not only are the gaps between the better performing and other States wide but in same cases have been increasing during the nineties. Large differences also exist between districts within the same better performing State urban areas appear to have better health outcomes than rural areas although the figures may not fully reflect the situation in urban and semi-urban slums with large in migration with conditions comparable to rural pockets. It is estimated that urban slum population will grow at double the rate of urban population growth in the next few decades. India may have by 202 a total urban population of close to 600 million living in urban areas with an estimated 145 million living in slums in 2001. What should be a fair
measure for assessing success in enhancing health status of population I any forecast on health care?

3.4 Health Infrastructure in the Public Sector

Issues in regard to public and private health infrastructure are different and both of them need attention but in different ways. Rural public infrastructure must remain in mainstay for wider access to health care for all without imposing undue burden on them. Side by side the existing set of public hospitals at district and sub-district levels must be supported by good management and with adequate funding and user fees and out contracting services, all as part of a functioning referral network. This demands better routines more accountable staff and attention to promote quality. Many reputed public hospitals have suffered from lack of autonomy inadequate budgets for non-wage O&M leading to faltering and poorly motivated care. All these are being tackled in several states are part health sector reform, and will reduce the waste involved in simpler cases needlessly reaching tertiary hospitals direct These, attempts must persist without any wavering or policy changes or periodic denigration of their past working. More autonomy to large hospitals and district public health authorities will enable them to plan and implement decentralized and flexible and locally controlled services and remove the dichotomy between hospital and primary care services. Further most preventive services can be delivered by down staging to a public health nurse much of what a doctor alone does now. Such long term commitment for demystification of medicine and down staging of professional help has been lost among the politicians bureaucracy and technocracy after the decline of the PHC movement. One consequence is the huge regional disparities between states which are getting stagnated in the transition at different stages and sometimes,
polarized in the transition. Some feasible steps in revitalizing existing infrastructure are examined below drawn from successful experiences and therefore feasible elsewhere,

**3.4.1 Feasible Steps for better performance:**

The adoption of a ratio based approach for creating facilities and other impulse has led to shortfalls estimated upto twenty percent. It functions well wherever there is diligent attention to supervised administrative routines such as orderly drugs procurement adequate O&M budgets and supplies and credible procedures for redressal of complaints. Current PHC CHC budgets may have to be increased by 10% per year for five years to draw level. The proposal in the Draft NHP 2001 is timely that State health expenditures be raised to 7% by 2015 and to 8% of State budgets thereafter. Indeed the target could be stepped up progressively to 10% by 2025. it also suggests that Central funding should constitute 25% of total public expenditure in health against the present 15%. The peripheral level at the sub center has not been (and may not now ever be) integrated with the rest of the health system having become dedicated solely to reproduction goals. The immediate task would be to look deepening the range of work done at all levels of existing centers and in particular strengthen the referral links and fuller and flexible utilization of PHC/CHCs. Tamil Nadu is an instance where a review showed that out of 1400 PHCs 94% functioned in their own buildings and had electricity, 98% of ANMs and 95% of pharmacists were in position. On an average every PHC treated about 100 patients 224 out of the 250 open 24 hour PHCs had ambulances. What this illustrates is that every State must look for imaginative uses to which existing structures can be put to fuller use such as making 24 hours services open or trauma facilities in PHCs on highway locations etc.
The persistent under funding of recurring costs had led to the collapse of primary care in many states, some spectacular failures occurring in malaria and kalazar control. This has to do with adequacy of devolution of resources and with lack of administrative will probity and competence in ensuring that determined priorities in public health tasks and routines are carried out timely and in full. Only genuine devolution or simpler tasks and resources to panchayats, where there will be a third women members- can be the answer as seen in Kerala or M.P. where panchayats are made into fully competent local governments with assigned resources and control over institutions in health care. Many innovative cost containment initiatives are also possible through focused management - as for instance in the streamlining of drug purchase stocking distribution arrangements in Tamil Nadu leading to 30% more value with same budgets.

The PHC approach as implemented seems to have strayed away from its key thrust in preventive and public health action. No system exists for purposeful community focused public information or seasonal alerts or advisories or community health information to be circulated among doctors in both private practice and in public sector. PHCs were meant to be local epidemiological information centers which could develop simple community.

Tertiary hospitals had been given concessional land, customs exemption and liberal tax breaks against a commitment to reserve beds for poor patients for free treatments. No procedures exist to monitor this and the disclosure systems are far from transparent, redressal of patient grievances is poor and allegations of cuts and commissions to promote needless procedure are common.
The bulk of non corporate private entities such as nursing homes are run by doctors and doctors- entrepreneurs and remain unregulated either in terms of facility of competence standards or quality and accountability of practice and sometimes operate without systematic medical records and audits. Medical education has become more expensive and with rapid technological advances in medicine, specialization has more attractive rewards. Indeed the reward expectations of private practice formerly spread out over career long earnings are squeezed into a few years, which becomes possible only by working in hi tech hospital sometimes run as businesses. The responsibilities or private sector in clinical and preventive public health services were not specified though under the NHP 1983 nor during the last decade of reforms followed up either by government of profession by any strategy to engage allocate, monitor and regulate such private provision nor assess the costs and benefits or subsidization of private hospitals. There has been talk of public private partnerships, but this has yet to take concrete shape by imposing public duties on private professionals, wherever there is agreement on explicitly public health outcomes. In fact it has required the Supreme Court to lay down the professional obligations of private doctors in accidents and injuries who used to be refused treatment in case of potential becoming part of a criminal offence.

The respective roles of the public and private sectors in health care have been a key issue in debate over a long time. With the overall swing to the Right after the 1980s, it is broadly accepted that private provision of care should take care of the needs of all but the poor. In doing so, risk pooling arrangements should be made to lighten the financial burden on theirs who pay for health care. As regards the poor with priced services, taking into account the size of the burden, the clinical and public health services cannot be shouldered for all by
government alone. To a large extent this health sector reform in India at the state level confirms this trend. The distribution of the burden, between the two sectors would depend on the shape and size of the social pyramid in each society. There is no objection to introduce user fees, contractual arrangements, risk pooling, etc. for mobilization of resources for health care. But, the line should be drawn not so much between public and private roles, but between institutions and health care run as businesses or run in a wider public interest as a social enterprise with economic dimensions. In a market economy, health care is subject to three links, none of which should become out of balance with the other - the link between state and citizens' entitlement for health, the link between the consumer and provider of health services and the link between the physician and patient.

3.5 Phases of Development of Healthcare Industry

Public Expenditure Status

Fair financing of the costs of health care is an issue in equity and it has two aspects how much is spent by Government on publicly funded health care and on what aspects? And secondly how huge does the burden of treatment fall on the poor seeking health care? Health spending in India at 6% of GDP is among the highest levels estimated for developing countries. In per capita terms it is higher than in China, Indonesia and most African countries but lower than in Thailand. Even on PPP $ terms India has been a relatively high spender information sheets based on reporting from a network associating private doctors also as has been done successfully at CMC Vellore in their rural health projects or by the Khoj projects of the Voluntary Health Association of India. It is only through such community based approach that revitalization of indigenous medicines can be done and people trained in self care and accept responsibility for their own health.
PHC approach was also intended to test the extent to which non-doctor based healthcare was feasible through effective down staging of the delivery of simpler aspects of care as is done in several countries through nurse practitioners and physician assistants, ANMs; physician assistants etc can each get trained and recognized to work in allotted areas under referral/supervision of doctors. This may indeed be more acceptable to the medical profession than the draft NHP proposal to restart licentiates in medicine as in the thirties and give those shorter periods of training to serve rural areas. Such a licentiate system cannot now be recalled against the profession’s opposition nor would people accept two level services.

Clearly this may be a better approach than leaving it to the market and welcome as path breaking of innovative efforts as a precursor to launching a public program. But as a long run delivery mechanism it is neither practical nor sustainable as such arrangements tend to bypass government under our constitutional scheme of parliamentary responsibility and would also cut into the potential of panchayatraj institutions. Each major disease control program has now got a separate society at state and district levels often as part of access to foreign aid. What is lost is the principle of parliamentary accountability over the flow of funds that arise out of voted budgets and international agreements to which Government is a party and answerable to parliament. Like campaign modes and vertical interventions, the registered society approach would weaken the long-term commitment and integrity of public health care systems.

3.6 Shape of the Private Sector in the Medicine

The key features of the private sector in medical practice and healthcare are well known. Two questions are relevant. What role should be assigned to it? How far and how closely should it be regulated? Over
the last several decades, independent private medical practice has become widespread but has remained stubbornly urban with polyclinics, nursing homes and hospitals proliferating often through doctor entrepreneurs. At our level tertiary hospitals in major cities are in many cases run by business houses and use corporate business strategies and hi-tech specialization to create demand and attract those with effective demand or the critically vulnerable at increasing costs. Standards in some of them are truly world class and some who work there are outstanding leaders in their areas. But given the commodification of medical care as part of a business plan it has not been possible to regulate the quality, accountability and fairness in care through criteria for accreditation, transparency in fees, medical audit, accountable record keeping, credible grievance procedures etc. Such accreditation, standard setting and licensure systems are best done under self regulation, but self regulation systems in India medical practice have been deficient in many respects creating problem in credibility. Acute care has become the key priority and continues to attract manpower and investment into related specialty education and facilities for technological improvement. Common treatments, inexpensive diagnostic procedures and family medicine are replaced and priced out of the reach of most citizens in urban areas.

Public health spending accounts for 25% of aggregate expenditure the balance being out of pocket expenditure incurred by patients to private practitioners of various hues. Public spending on health in India has itself declined after liberalization from 1.3% of GDP in 1990 to 0.9% in 1999. Central budget allocations for health have stagnated at 1.3% to total Central budget. In the States it has declined from 7.0% to 5.5% of State health budget. Consider the contrast with the Bhore
Committee recommendation of 15% committed to health from the revenue expenditure budget, Indeed WHO had recommended 55 of GDP for health. The current annual per capita public health expenditure is no more than Rs. 160 and a recent World Bank review showed that over all primary health services account for 58% of public expenditure mostly but on salaries, and the secondary/tertiary sector for about 38%, perhaps the greater part going to tertiary sector, including government funded medical education. Out of the total primary care spending, as much as 85% was spent on or curative services and only 15% for preventive service. World Bank report 1995 states about 47% of total Central and State budget is spent on curative care and health facilities. This may seem excessive at first sight but in face the figure is over 60% in comparable countries, with the bulk of the expenditure devoted publicly funded care or on mandated or voluntary risk pooling methods, in India close to 75% of all household expenditure on health is spend from private funds and the consequent regressive effects on the poor is not surprising.

3.7 Private expenditure trends

Many surveys confirm that when services are provided by private sector it is largely for ambulatory care and less for inpatient carte. There are variations in levels of cost, pricing, transactional conveniences and quality of services. There is evidence to suggest that disparities in income as such do not make a difference in meeting health care costs, except for catastrophic or life threatening situations. Finally it has been established that between 2/3rds to 3/4ths of all medical expenditure is spend on privately provided care every household on the average spends up to 10% of annual household consumption in meeting health care needs. This regressive burden shows up vividly in the cycle of incomplete cure followed by
recurrence of illness and drug resistance that the poor face in diseases like TB or Kalazar or Malaria especially for daily wage earners who cannot afford to be out of work.

Privatization has to be distinguished from private medical practice which has always been substantial within our mixed economy. What is critical however is the rapid commercialization of private medical practice in particular uneven quality of care. There are complex reasons for this trend. First is the high scarcity cost of good medical education, and second the reward differential between public and corporate tertiary hospitals leading to the reluctance of the young professional to be lured away from the market to public service in rural areas and finally there is the compulsion of returns on investment whenever expensive equipment is installed as part of practice. Increasingly, this has shifted the balance from individual practice to institutionalizes practice, in hospitals, polyclinics, Etc. this conjunction explodes into unbearable cost escalation when backed by a third party payer system/- This in turn induces increases in insurance premiums making such cover beyond the capacity to pay. There is a distinct possibility of such cycles of cost escalation periodically occurring in the future, promoted further by global transfer of knowledge and software, tele-medicine etc. especially after the advent of predictive medicine and gene manipulation.

Doctors practicing in the private sector are sometimes accused of prescribing excessive, expensive and risky medicines and with using rampant and less than justified use of technology for diagnosis and treatment. Some method of accreditation of hospitals and facilities and better licensure systems of doctors is likely within a decade. This will enables some moderation in levels of charges in using new technology. High cost of care is sometimes sought to be justified as necessary due
to defensive medicine practiced in order to meet risks under the
Consumer Protection Act. There is little evidence from decisions of
Consumer Courts to justify such fears. While the line between
mistaken diagnosis and negligent behaviour will always remain thin,
case law has already begun to settle around the doctor's ability to
apply reasonable skills and not the highest degree of skill. What has
lien established is the right of the patient to question the treatment
and procedures if there is failure to treat according to standard
medical practice or if less than adequate care was taken? As health
insurance gets established it may impost more stringent criteria and
restrictions on physician performance which may tempt them into
defensive medicine. There may also be attempt to collusive capture
and (indirect ownership) of insurance companies by corporate
hospitals as in other countries. Advances in medical technology are
rapid and dominant and easily travel worldwide and often seen as
good investment and brand equity in the private sector. Private
independent practices - and to smaller extent hospitals, dispensaries,
nursing homes tele- are seen as markets for medical services with
each segment seeking to maximize gains and build mutually
supporting links with other segments. More than one study on the
quality of care indicates that sometimes more services are performed
to maximize revenue, and services/ medicines are prescribed which
feel not always necessary. Allegations are also widely made of
collusive deals between doctors and hospitals with commissions and
cuts exchanged to promote needless referral, drugs or procedures
<World Bank A 1995> Appropriate regulation is likely in the next
decade for minimum standards and accountability and that should
consist of a balanced mix of self regulation external regulation by
standard setting and accreditation agencies including private
voluntary health insurance.
3.8 How far can health insurance help?

What constitutes a fair distribution of the costs of care among different social groups will always be a normative decision emerging out of political debate. It includes risk pooling initiatives for sharing costs among the healthy and the sick leading to insurance schemes as a substitute for or as supplementary to State provision for minimum uniform services. It also covers risk sharing initiatives across wealth and income involving public policy decisions on progressive taxation, merit subsidy and cross subsidization by dual pricing. Both will continue to be necessary in our conditions with more emphasis on risk sharing as growth picks up. Risk pooling within private voluntary and mandated insurance schemes has become inevitable in all countries because of the double burden of sickness and to ensure that financial costs of treatment do not become an excessive burden relative to incomes. It is difficult but necessary to embed these notions of fair financing into legislation, regulations and schemes and programs equity is aimed at in health care.

With the recent opening up of the general Insurance sector to foreign companies, there is the prospect of two trends. New insurance product will be put out so expand business more be deepening than widening risk covered. The second trend would be to concentrate on urban middle and upper classes and settled card holders with capacity to pay and with a perceived interest in good health of the family. Both trends make sound business sense in a vast growth market and would increase extensive hospital use and protection against huge hospitalization expenses, and promoted by urban private hospitals since their clientele will increase.
Insurance is a welcome necessary step and must doubtless expand to help in facilitating equitable health care to shift to sections for which government is responsible. Indeed for those not able to access insurance it is government that will have to continue to provide the minimum services, and intervene against market failures including denial through adverse selection or moral hazard. Indeed in the long run the degree of inequity in health care after insurance systems are set up will depend ironically on the strength and delivery of the public system as a counterpoise in holding costs and relevance in technology.

The insurable population in India has been assessed at 250 million and at an average of Rs 1000/- per person the premium amount per year would be Rs 25,000/- crores and is expected to treble in ten years. While the insurance product will dutifully reflect the demands of this colossal market and related technological developments in medicine, it should be required to extend beyond hospitalization and cover domiciliary treatment too in a big way; for instance, extending cover to ambulatory maternal and selected chronic conditions like Asthma more prevalent among the poor. The insurance regulatory authority has announced priority in licensing to companies set up with health insurance as key business and has emphasized the need for developing new products on fair terms to those at risk among the poor and in rural areas. Much will turn on what progress takes place through sound regulation covering aspects indicated below. In order to be socially relevant and viable the scheme must aim at a proper mix of health hazards and cover many broad social classes and income groups. This is possible in poor locations or communities only if a group view is taken and on chat basis a population-based nsk is assessed and community rated premiums determined covering families for all common illnesses and based on epidemiological determined risk. In order that exclusions co-payments deductibles etc.
remain minimum and relevant to our social situation, some well
gjudged government merit subsidy can be incorporated into anti
poverty family welfare or primary education or welfare pension
schemes meant for old age. Innovative community based new
products can be developed by using the scattered experience of such
products for instance in SEWA, so that a minimum core cover can be
developed as a model for innovative insurance by panchayats with
reinsurance backup by companies and government bearing part of
promotional costs. The bulk of the formal sector maybe covered by an
expanded mandatory insurance with affordable cover and convenient
modes of premium payment. Outside the formal manufacturing sector
innovate schemes can be designed around specific occupation groups
in the informal sector which are steadily becoming a base for old age
pension entitlements, as in Kerala and Tamil Nadu - and brought
under common risk rating. Finally, as in the West health insurance
should develop influence and capacity as bulk purchaser or medical
and hospital services to impact on quality and cost and provide
greater understanding about Indian health and illness behaviours,
patterns of utilization of care and intra family priorities for accessing
medical care. Health insurance should be welcomed as a force for a
fairer healthcare system. But its success should be judged on how well
new products are developed with a cover beyond hospitalization, how
fairly and inclusively the cover is offered and how far community
rated premiums are established. The IRDA has an immense
responsibility and with its leadership one can optimistically expect
about 30% coverage by 2015 relieving the burden on the public
systems.
3.9 Health System:
Health perceptions play an important part in ensuring sound health outcomes. To a large extent they are culturally determined but also subject to change with economic growth and social development. People intuitively develop capacity to make choices to being treated under the western of indigenous systems of medicines, keep a balance between good habits traditionally developed for healthy living and modern lifestyles, decide on where to go for chronic and acute care and how to apportion intra-family utilization of healthcare resources. Some movement is occurring among eminent allopathic doctors trying, for instance, to rework Ayurveda theory in a modern idiom starting from respectful reverse analysis for actual successful contemporary practice of Ayurveda and provide a theoretical frame linking it to contemporary needs. There is evidence from public health campaigns in Tamil Nadu where every seventh person spontaneously expressed a preference for Sidda Medicine. Homeopathy for chronic ailment is widely accepted. The herbal base for Ayurveda medicine widely practiced in the Himalayan belt has drawn world attention a huge export market remains to be tapped according to the knowledgeable trade sources but the danger of bio-privacy remains and legal enablement's should be put in place soon that would fully expand on our rights under the WTO agreements. There is hope for the survival and growth of the sector only if it becomes an example of convergence between people's and planner's perceptions and ensures its relevance, accountability and affordability to contemporary illnesses and conditions.

3.10 World Health Organization
The World Health Organization (WHO) is a specialized United Nations agency that acts as a coordinator and researcher for public health
around the world. WHO has been established on 7 April 1948, and headquartered in Geneva, Switzerland. The WHO's constitution states that its mission "is the attainment by all peoples of the highest possible level of health." Its major task is to combat disease, especially key infectious diseases, and to promote the general health of the peoples of the world. Examples of its work include years of fighting smallpox. In 1979 the WHO declared that the disease had been eradicated - the first disease in history to be completely eliminated by deliberate human design. The WHO is nearing success in developing vaccines against malaria and schistosomiasis aims to eradicate polio within the next few years. The organization has already endorsed the world’s first official HIV/AIDS Toolkit for Zimbabwe from October 3, 2006, making it an international standard. (13)

The WHO is financed by contributions from member states and from donors. In recent years the WHO's work has involved more collaboration, currently around 80 such partnerships, with NGOs and the pharmaceutical industry, as well as with foundations such as the Bill and Melinda Gates Foundation and the Rockefeller Foundation. Voluntary contributions to the WHO from national and local governments, foundations and NGOs, other UN organizations, and the private sector (including pharmaceutical companies), now exceed that of assessed contributions from its 193 member nations. (14)

3.11 Healthcare Sector at Global Level

3.11.1 Countries and their Healthcare Systems Operation.

Australia: Medicare was introduced by the Whitlam Labor Government on 1 July 1975 through the Health Insurance Act 1973. The Australian Senate rejected the changes multiple times and they were passed only after a joint sitting after the 1974 double dissolution
election. Yet Medicare has been supported by subsequent
governments and became a key feature of Australia’s public policy
landscape. The exact structure of Medicare, in terms of the size of the
rebate to doctors and hospitals and the way it has administered, has
varied over the years. The original Medicare program proposed a
1.35% levy (with low income exemptions) but these bills were
rejected by the Senate, and so Medicare was originally funded from
general taxation. In October 1976, the Fraser Government introduced
a 2.5% levy. The program is now nominally funded by an income tax
surcharge known as the Medicare levy, which is currently set at 1.5%
with exemptions for low income earners. In practice the levy raises
only a fraction of the money required to pay for the scheme. If the levy
was to fully pay for the services provided under the medicare banner
then it would need to be set at about 8%. There is an additional levy of
1.0%, known as the Medicare Levy Surcharge, for those on high annual
incomes ($50,000) who do not have private patient hospital coverage.
This policy was instituted by the former Coalition Federal Government
in an attempt to encourage people to take up private health insurance.

Europe: All of Europe has publicly sponsored and regulated health
care. Countries include Austria, Belgium, Czech Republic, Denmark,
Finland, France, Germany, Greece, Hungary, Ireland, Italy, Bosnia &
Herzegovina, Slovakia, Slovenia, the Netherlands, Norway, Poland,
Portugal(15) Romania, Russia, Spain, Sweden and the United
Kingdom(16).

Ireland: The Irish health care system is a universal, public health care
system governed by the Health Act 2004, which established a new
body to be responsible for providing health and personal social
services to everyone living in Ireland - the Health Service Executive.
The new national health service came into being officially on 1 January
2005; however the new structures are currently in the process of being established as the reform programme continues.

Italy: The Italian health care system is a universal, public health care system governed by the Legge 23 dicembre 1978, n. 833, which established the national health system, coming into effect on 1 January 1980.

Slovenia: The Health Insurance Institute of Slovenia (the Institute) was founded on March 1, 1992, according to the Law on health care and health insurance, after declaring independence from Yugoslavia. The Institute conducts its business as a public institute, bound by statute to provide compulsory health insurance. In the field of compulsory health insurance, the Institute's principal task is to provide effective collection (mobilisation) and distribution (allocation) of public funds, in order to ensure the insured persons quality rights arising from the said funds. The rights arising from compulsory health insurance, furnished by the funds collected by means of compulsory insurance contributions, comprise the rights to health care services and rights to several financial benefits (sick leave pay, reimbursement of travel costs and funeral costs, and insurance money paid in case of death). The Institute comprises 10 regional units and 45 branch offices distributed around the territory of Slovenia. The functional unit the Information Centre and the Directorate complete the Institute structure. At the end of 2005, the Institute staff numbered regular 929 employees. The Institute is governed by an Assembly, whose members are the (elected) representatives of employers (including the representatives of the Government of the Republic of Slovenia) and employees. The executive body of the Assembly is the Institute Board of Directors. The Slovene health insurance card system was introduced, at the national
scale, in the year 1999. The system provided the insured persons with a smart card and set up data links between the health care service providers and health insurance providers (the Health Insurance Institute and the two voluntary health insurance providers).

Switzerland: Healthcare in Switzerland is regulated by the Federal Health Insurance Act. Health insurance is compulsory for all persons resident in Switzerland (within three months of taking up residence or being born in the country). International civil servants, members of permanent missions and their family members are exempted from compulsory health insurance. They can, however, apply to join the Swiss health insurance system, within six months of taking up residence in the country. Health insurance covers the costs of medical treatment and hospitalisation of the insured. However, the insured person pays part of the cost of treatment. This is done (a) by means of an annual excess (or deductible, called the franchise), which ranges from CHF 300 to a maximum of CHF 2,500 as chosen by the insured person (premiums are adjusted accordingly) and (b) by a charge of 10% of the costs over and above the excess.

United Kingdom: Each of the countries of the United Kingdom has a public health service that provides healthcare to all UK permanent residents that is free at the point of need and paid for from general taxation. However, since Health is a devolved matter, considerable differences are developing between the systems in the different countries. (17) Though commonly referred to as the NHS across the UK, in fact the National Health Service just covers England with separate 'National Health Services' in the other parts of the UK.

England: The NHS provides the majority of healthcare in England, including primary care, in-patient care, long-term healthcare,
ophthalmology and dentistry. The National Health Service Act 1946 came into effect on 5 July 1948. Private health care has continued parallel to the NHS, paid for largely by private insurance, but it is used by less than 8% of the population, and generally as a top-up to NHS services.

Scotland : NHS Scotland was founded by the National Health Service (Scotland) Act 1947 (since repealed by the National Health Service (Scotland) Act 1978) which came into effect on the same day as the NHS in England and Wales but has always been a separate organisation.

Wales : NHS Wales was originally formed as part of the same NHS structure created by the National Health Service Act 1946 but powers over the NHS in Wales came under the Secretary of State for Wales in 1969 (18).

Latin America : Most countries in Latin America have public health care provided. Mexico is planning to launch its own universal health care network (19) though at the moment the standards of health care in Mexico are seriously lacking with large divides between rich and poor. Puerto Rico is planning its own health reform for the poorest of the population. Health care in Venezuela is probably the most extensive and given the country’s fortunes in oil wealth, expenditure has recently increased greatly, starting with mass vaccinations under the Plan Bolivar 2000. Trinidad and Tobago has universal healthcare, but there are shortages of equipment, supplies, space and staff.

Cuba : The Cuban government operates a national health system and assumes fiscal and administrative responsibility for the health care of its citizens (20). Following the Revolution, the new Cuban government
asserted that universal healthcare was to become a priority of state planning. In 1960 revolutionary and physician Che Guevara outlined his aims for the future of Cuban healthcare in an essay entitled "On Revolutionary Medicine", stating: "The work that today is entrusted to the Ministry of Health and similar organizations is to provide public health services for the greatest possible number of persons, institute a program of preventive medicine, and orient the public to the performance of hygienic practices." (21) These aims were hampered almost immediately by an exodus of almost half of Cuba’s physicians to the United States, leaving the country with only 3,000 doctors and 16 professors in University of Havana’s medical college. (22) Beginning in 1960, the Ministry of Public Health began a program of nationalization and regionalization of medical services. (22) In 1976, Cuba’s healthcare program was enshrined in Article 50 of the revised Cuban constitution which states

"Everyone has the right to health protection and care. The state guarantees this right by providing free medical and hospital care by means of the installations of the rural medical service network, polyclinics, hospitals, preventative and specialized treatment centers; by providing free dental care; by promoting the health publicity campaigns, health education, regular medical examinations, general vaccinations and other measures to prevent the outbreak of disease. All the population cooperates in these activities and plans through the social and mass organizations." (23)

Like the rest of the Cuban economy, Cuban medical care has suffered from severe material shortages following the end of Soviet subsidies and the ongoing United States embargo against Cuba that began after the Cuban Missile Crisis. (24) Data for 2004 show that Cuba has one of the highest life expectancy rates in Latin America. Costa Rica, Chile,
Virgin Islands, Guadeloupe, and Martinique now have a higher life expectancy for combined sexes from birth. (25)

North America: Canada: The federal government of Lester B. Pearson, pressured by the New Democratic Party (NDP) who held the balance of power, introduced the Medical Care Act in 1966 that extended the HIDS Act cost-sharing to allow each province to establish a universal health care plan. It also set up the Medicare system. In 1984, the Canada Health Act was passed, which prohibited user fees and extra billing by doctors. In 1999, the prime minister and most premiers reaffirmed in the Social Union Framework Agreement that they are committed to health care that has "comprehensiveness, universality, portability, public administration and accessibility." (26) The Canadian system is for the most part publicly funded, yet most of the services are provided by private enterprises, private corporations. Most of all doctors do not receive an annual salary, but receive a fee per visit or service. About 30% of Canadians’ health care is paid for through the private sector. This mostly goes towards services not covered or only partially covered by Medicare such as prescription drugs, dentistry and optometry. Many Canadians have private health insurance, often through their employers, that cover these expenses. In Canada, some services are permitted and some are not. The Supreme Court of Quebec ruled, in Chaoulli v. Quebec, that private services must be allowed to compete with the public program, (27) thus opening the door to a dual system of private and public healthcare. Quebec has been the fastest to adopt this system and has the most private healthcare available of all the Canadian provinces.

United States: In the federal government of the United States, the United States Department of Health and Human Services is the
executive department responsible for health. It is managed by the Secretary of Health and Human Services, a member of the Cabinet.

State governments maintain state health departments, and local governments (counties and municipalities) often have their own health departments, usually branches of the state health department. Regulations of a state board may have executive and police strength to enforce state health laws. In some states, all members of state boards must be health care professionals. Members of state boards may be assigned by the governor or elected by the state committee. Members of local boards may be elected by the mayor council.

The United States does not have a federal board of health. Congress has authorized the assigned advisory committees and councils to the United States Health Service which is a section of the Department of Health and Human Services. The departments were created in 1953 as the Department of Welfare and Health.

In 1980 the United States Congress legislated that the Department of Welfare and Health become the Department of Health and Human Services. The agencies of the Public Health Service are the Health Administration, which regulates health care to people without health care, the Food and Drug Administration, which certifies the safety of food, effectiveness of drugs and medical products, the Centers for Disease Prevention, which prevents disease, premature death, and disability, the Agency of Health Care Research and the Agency Toxic Substances and Disease Registry, which regulates hazardous spills of toxic substances. Numerous publicly funded health care programs help to provide for the elderly, disabled, military service families and veterans, children, and the poor, (28) and federal law ensures public access to emergency services regardless of ability to pay; (29) however, a system of universal health care has not been implemented.
Massachusetts is attempting to implement a near-universal health care system by the Massachusetts 2006 Health Reform Statute, mandating that residents purchase health care coverage with little or no control over how much the health insurance policies cost. This is a significant business boom for the insurance industry. (30)

Asia: Israel, (31) Brunei, China, Hong Kong SAR, India, Kuwait, Qatar, UAE, Saudi Arabia, Japan, Malaysia, Sri Lanka, Taiwan, and Thailand have universal health care.

In Sri Lanka, drugs are provided by a government owned drug manufacturer called the State Pharmaceuticals Corporation of Sri Lanka. In the Philippines, the Department of Health organizes public health for the country, and was established at the initiative of the American governors, before independence. Saudi Arabia has a publicly funded health system, although its levels are lower than the regional average.

China: Since the founding of the People's Republic of China, the goal of healthcare programs has been to provide care to every member of the population and to make maximum use of limited health-care personnel, equipment, and financial resources.

The current health insurance system in China provides virtually free coverage for people employed in urban state enterprises and relatively inexpensive coverage for their families. The situation for workers in the rural areas or in urban employment outside the state sector is far more varied. There are some cooperative health care programs, but their voluntary nature produced a decline in membership from the late 1970s.
The severest limitation on the availability of health services, however, appears to be the serious lack of resources, rather than discrimination in access on the basis of the ability of individuals to pay. An extensive system of paramedical care has been fostered as the major medical resource available to most of the rural population, but the care has been of uneven quality. The paramedical system feeds patients into the more sophisticated commune-level and county-level hospitals when they are available.

China is undertaking a reform on its universal health care system. The New Rural Co-operative Medical Care System (NRCMCS) is a new 2005 initiative to overhaul the healthcare system, particularly intended to make it more affordable for the rural poor. Under the NRCMCS, the annual cost of medical cover is 50 yuan (US$7) per person. Of that, 20 yuan is paid in by the central government, 20 yuan by the provincial government and a contribution of 10 yuan is made by the patient. As of September 2007, around 80% of the whole rural population of China had signed up (about 685 million people). The system is tiered, depending on the location. If patients go to a small hospital or clinic in their local town, the scheme will cover from 70-80% of their bill. If they go to a county one, the percentage of the cost being covered falls to about 60%. And if they need specialist help in a large modern city hospital, they have to bear most of the cost themselves; the scheme would cover about 30% of the bill. (35)

Japan: In Japan, payment for personal medical services is offered through a universal insurance system that provides relative equality of access, with fees set by a government committee. People without insurance through employers can participate in a national health insurance program administered by local governments. Since 1973, all elderly persons have been covered by government-sponsored
insurance. Patients are free to select physicians or facilities of their choice. In the early 1990s, there were more than 1,000 mental hospitals, 8,700 general hospitals, and 1,000 comprehensive hospitals with a total capacity of 1.5 million beds. Hospitals provided both out-patient and in-patient care. In addition, 79,000 clinics offered primarily out-patient services, and there were 48,000 dental clinics. Most hospitals sell medicine directly to patients, but there are 36,000 pharmacies where patients could purchase synthetic or herbal medication.

National health expenditures rose from about 1 trillion Yen in 1965 to nearly 20 trillion Yen in 1989, or from slightly more than 5% to more than 6% of Japan’s national income. However, this rise was in accordance with Japan’s post-war economic boom (GDP had increased four times between 1965 and 1989.) Another problem is an uneven distribution of health personnel, with cities favored over rural areas.

Africa: Health care in Africa is usually non-existent or highly limited and under resourced. The outbreak and spread of HIV/AIDS in Africa has crippled many populations and sent life expectancies plummeting. However, some countries have been able to tackle the challenges, for instance health care in Uganda as well as education has reduced HIV/AIDS infections from 13% to 4.1% from 1990 to 2003. This contrasts to some governments’ approach, especially that of the South African Health Ministry who until recently denied the link between HIV/AIDS.

Nigeria: Health care provision in Nigeria is a concurrent responsibility of the three tiers of government in the country. However, because Nigeria operates a mixed economy, private providers of health care have a visible role to play in health care delivery. The federal government's role is mostly limited to coordinating the affairs of the
university teaching hospitals, while the state government manages the various general hospitals and the local government focus on dispensaries. The total expenditure on health care as % of GDP is 4.6, while the percentage of federal government expenditure on health care is about 1.5%.\(^{(39)}\) A long run indicator of the ability of the country to provide food sustenance and avoid malnutrition is the rate of growth of per capita food production; from 1970-1990, the rate for Nigeria was 0.25%.\(^{(40)}\) Though small, the positive rate of per capita may be due to Nigeria’s importation of food products.

Historically, health insurance in Nigeria can be applied to a few instances: free health care provided and financed for all citizens, health care provided by government through a special health insurance scheme for government employees and private firms entering contracts with private health care providers.\(^{(41)}\) However, there are few people who fall within the three instances. In May 1999, the government created the National Health Insurance Scheme, the scheme encompasses government employees, the organized private sector and the informal sector. Legislative wise, the scheme also covers children under five, permanently disabled persons and prison inmates. In 2004, the administration of Obasanjo further gave more legislative powers to the scheme with positive amendments to the original 1999 legislative act.\(^{(42)}\)
3.11.2 **India Healthcare Sector**: India has both private health care system and a public, universal health care system. The universal health care system runs by the local (state or territorial) governments. The "government hospitals", some of which are among the best hospitals in India, (36) provide treatment at taxpayer cost. Most drugs are offered free of charge in these hospitals.

Most government hospitals do not charge people below poverty line, proof of citizenship or residency is required for the same. Government hospitals in some parts of the country and some private non-profit (including teaching) hospitals charge a nominal fee to prevent abuse of the system. Most hospitals are operated on an annual budget allocated by the government, and do not rely on individual billing. However, they charge less than comparable private hospitals.

The private clinics and hospitals are owned and operated by private individuals, small corporations and large hospital chain corporations are in the swing. The private health care in many modernized hospitals in Indian cities are comparable to their counterparts in developed countries. However, the public health care system, except for the teaching hospitals, is often not as good or fast as the private hospitals. But the private players charges exorbitant amount for the same treatment as compared to a Public hospital for maintaining their corporate status. Despite of paying high amount patients are either not Happy with the Hospital Services, may be the staff, Doctors treatment or the infrastructure etc.

3.12 **Healthcare Economics**: Health care economics consists of a complicated relationship between a number of participants; the consumer, insurance companies or third party administrators, employers, medical professionals, and various government entities. An essential feature of health care economics is the spreading of risk,
since the cost of health care for catastrophic illness can be prohibitive. This risk may be spread by private insurance companies (who seek to make a profit), or by government involvement in the health care market. The health care market can suffer from a number of problems which can be summarized as follows:

a. Adverse selection in insurance markets occurs because those providing insurance wish to limit insurance payouts, thus providing a profit. In simple terms, those with poor health will apply for insurance, raising the cost of providing insurance; those with good health will find the cost of insurance too expensive, raising costs further. Private insurers are economically incentivized to spend substantial sums on investigating the health history of prospective clients and proving those in need to be uninsurable while charging higher premiums for unhealthy individuals, which they may not be able to afford in order to provide a "profit margin".\(^{43, 44}\)

b. Moral Hazard in insurance markets occurs when the insured behave in a riskier manner than they would if they were not insured. This argument is significantly weakened when speaking of health care which becomes more prevalent with age for example, regardless of other factors.

Among the potential solutions posted by economists are:

Various forms of universal health insurance, such as requiring all citizens to purchase insurance, limiting the ability of insurance companies to deny insurance to individuals or may vary price between individuals. Compulsory universal health insurance is a common thread, although there is no requirement that the insurance or medical services be provided by government, no accountability amongst insurers, and no protection against rising health insurance costs.
Decreased government regulation: Conservative Republican US Senator Bill Frist argued (45) that the free market will keep costs down, because individuals who have to pay for their own health care will make wiser decisions and not spend money on unneeded or inefficient care. However, as this cuts down on the routine maintenance of care and penalizes the afflicted who can least afford to pay for care, the overall health statistics of the country decline. The US currently (2007) has the most expensive health care of any OECD country and also has the highest percentage of costs paid privately with some of the worst health statistics in the free world. (46)

Providers: A health care provider or health professional is an organization or person who delivers proper health care in a systematic way professionally to any individual in need of health care services. A health care provider could be government, the health care industry, a health care equipment company, an institution such as a hospital or medical laboratory, physicians, dentists, support staff, nurses, therapists, psychologists, pharmacists, chiropractors, and optometrists.

3.13 Implication for the Study

Healthcare Upcoming Set - up

What then can we conclude about the prospects of health care in India in 2020? An optimistic scenario will be premised on an average 8% rate of economic growth during this decade and 10% per annum thereafter. If so, what would be the major fall out in terms of results on the health scene? In the first place, longevity estimates can be considered along the following lines. China in 2000 had a life-expectancy at birth of 69 years (M) and 73(F) whereas India had respectively 60 (M) and 63 (F). More importantly, healthy life
expectancy at birth in China was estimated in the World Health Report 2001 at 61 (M) and 63.3 (F) whereas in Indian figures were 53 (M) and 51.7 (F). If we look at the percentage of life expectancy years lost as a result of the disease burden and effectiveness of health care systems, Chinese men would have lost 11.6 years against Indian men losing 12.7 years. The corresponding figures are 13.2 for Chinese women and 17.5 for Indian women. Clearly, an integrated approach is necessary to deal with avoidable mortality and morbidity and preventive steps in public health are needed to bridge the gaps, especially in regard to the Indian women. Taking all the factors into consideration, longevity estimates around 20-25 could be around 70 years, perhaps, without any distinction between men and women.

This leads us to the second question of the remaining disease burden in communicable and non-communicable diseases, the effective of interventions, such as, immunization and maternal care and the extent of vulnerability among some groups. These issues have been dealt with in detail earlier. Clearly an optimistic forecast would envisage success in polio, yaws, leprosy, kalazar, malaria and blindness. As regards TB it is possible to arrest further growth in absolute numbers by 2010 and thereafter to bring it to less than an million within internationally accepted limits by 2020. With regard to Malaria, the incidence can be reduced by a third or even up to half within a decade. In that case, one can expect near freedom from Malaria from most of the countries by 2020. As regards AIDS, it looks unlikely that infection can be leveled off by 2007. The prognosis in regard to the future shape of HIV / AIDS is uncertain. However, it can be a feasible aim to reduce maternal mortality from the present 400 to 100 per lac population by 2010 and achieve world standards by 2020. What is important is the chance of two thirds decline in moderate
malnutrition, and abolition of serious malnutrition completely by 2015 in the case of Cancer, it is feasible to set up an integrated system for proper screening, early detection, self care and timely investigation and referral. In the matter of disease burden as a whole, it is feasible to attempt to reach standards comparable to China from 2010 onwards.

Taking the third aspect viz fairness in financing of health care and reformed structure of health services, an optimistic forecast would be based on the fact that the full potential of the vast public health infrastructure would be fully realized by 2020. Its extension to urban areas would be moderated to the extent substantial private provision of health care is available in urban areas, concentrating on its sensible and effective regulation. A reasonably wide network of private voluntary health insurance cover would be available for the bulk of the employed population and there would be models of replicable community based health insurance available for the unorganized sector. As regards the private sector in medicine, it should be possible in the course of this decade to settle the public role of private medical practice - independent or institutional. For this purpose, more experiments are to be done for promoting public private partnerships, focusing on the issue of how to erect on the basis of shared public health outcome as the key basis for the partnership. A sensible mixture of external regulation and professional self-regulation can be device in the consultation with the profession to ensure competence, quality and accountability. The future of plural systems in medical understanding and evaluation of comparative levels of competence and reliability in different systems - a task in which, the separate department for Indian systems of medicine and homeopathy will play
a leading role in inducting quality into the indigenous medical practices.

The next issue relates to the desirable level of public expenditure towards health services. China devotes 4.5% to its GDP as against India devoting 5.1%. but this hides the fact that in China, public expenditure constitutes 38% whereas in India, it is only 18% of total health expenditure. An optimistic forecast would be that the level of public expenditure will be raised progressively such that about 30% of total health expenditure would be met out of public funds by progressively increasing the health budget in states and the central and charging user fees in appropriate cases. The figure mentioned would perhaps correspond to the proportion of the population which may still need assistance is social development.

Finally it is proper to remember that health is at bottom an issue in justice. It is in this context that we should ask the question as to how far and in what way has politics been engaged in health care? The record is disappointing. Most health sector issues figuring in political debate are those that affect interest groups and seldom central to choices in health care policy. For instance conditions of service and reward systems for Government doctors have drawn much attention often based on inter service comparison of no wider interest. Inter-system problems of our plural medical care have drawn more attention from courts than from politics. Hospital management and strikes, poor working of the MCI and corruption in recognition of colleges, dramatic cases of spurious drug supply etc have been debated but there has been no sustained attention on such issues as why malaria recrudescence is so common in some parts of India or why complaints about absence of informed consent or frequent in testing on women, or on the variations in prices and availability of essential drugs or for combating epidemic attacks in deprived areas
seldom draw attention. The far reaching recommendations made by the Hathi Committee report and or the Lentin Commission report, have been implemented patchily.

The role to be assigned to private sector in healthcare management is to provide quality healthcare treatment and infrastructure and thereby win the hearts of the general public in ensuring Good Customer Relationship Management. Hence the need to study the marketing of Healthcare services and its implication on Customer Relationship Management

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