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Health Care Infrastructure in India: Need for Reallocation and Regulation

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ABSTRACT

It is not the hidden fact that India's health care needs serious attention. In almost all the key health indicators given by World Health Organization (WHO) we lag behind. According to World Health Statistics of 2018 India ranks 145 out of 194 countries. According to NITI Aayog India has a scarcity of 6 lakh doctors, 20 lakh nurses and 2 lakh dental surgeons. Though WHO recommends 1:1000 doctor to patient ratio but in rural India it is 1:11082 and in some states like Bihar It is as low as 1:28391 and UP It is 1:19962 (NHP 2018). Around 80% of India's1.14 million registered doctors of modern medicine(allopathy) work in cities which is home to just 31% of the country's population. same is the case with availability of physical infrastructure i.e. primary health centres (PHCs), community health centres (CHCs), district health centres and hospitals. This study highlights these disparities in health care infrastructure available both in rural and urban India by providing actual status of their availability in the country and need for their reallocation. The main theme of the paper is not only to give actual picture of this infrastructure and find out disparities but also tell measures how to correct these and find out solutions to achieve total health care of 1.3 billion people of the country.

1. Introduction

Health is wealth. Even our Vedas said **"PehlaSukhNirogi Kaya"**. No nation can progress until its people are happy and healthy. Happy and healthy citizens are real wealth of a nation to progress upon. Needless to say, that poor, sick, ill, addict and unhealthy people are a liability to a nation and they swallow a good portion of its GDP in the form of health care. According to World Development Report 1993 (WB, 1993) "Improved health contributes to economic growth in **four** ways. It reduces production losses caused by worker illness, it permits the use of natural resources that had been totally or nearly inaccessible because of diseases, it increases the enrolment of children in schools and makes them better able to learn and it frees alternative uses resources that would otherwise have to be spent on treating illness."

The economic gains are relatively greater for poor people, who spend and suffer a lot due to their ill-health and loose productive days as well as spend a lot to treat illness. For e.g. It has been estimated that 62.6% (HT, India's Health Spending, 2017) of expenses on healthcare in India are out of pocket expenditure but government expenditure is only 1.4% (Sharma N. C., 2019) of GDP which is much lower than the global average of 6%. The government is spending just Rs. 1,112 per capita for health care which means only Rs. 3 per day is spent for the health care of an average Indian. (NHP, 2018) This puts India even lower than nations like Bhutan, Sri Lanka and Nepal who spend 2.5 1.6, and 1.1 of their GDP on health care. Due to lack of health care services approximately 10 lakh people lose their life before time (DJ, 2018). Approximately 7% of population annually plunges below poverty line due to health care costs. (Khandheria, 2018) But before coming to health care infrastructure of India let us come to the basics first. What do we mean by health or health care etc.

Health is not only lack of illness or absence of disease but according to WHO (Callahan, 1973) - "Health is a state of complete physical, mental and social well-being and not merely the absence of disease." According to Oxford dictionary "It is soundness of body and mind that condition in which its functions are duly and efficiently discharged."

Health is considered to be a stock of capital that yields return in the form of healthy days just as wealth is a stock of capital that yields a stream of income. Efficiency of any person/worker depends considerably on his/her health. Workers whose health is not good or who fall sick quite often cannot do their job efficiently and their productivity as well as income declines.

Health care means provision of services to improve health status of individuals. Anything that contributes to producing better health such as nutritious food, clean air, exercise, medical intervention etc. is considered to be health care. Health care infrastructure means an optimum mix of physical structure (building etc.) and human resources as both are required to deliver the desired health services.

2. Literature Review

Shailendra Kumar (Kumar S. , 2016) in his working paper clearly explained How public health care services failed to provide health for all and private sector was promoted and even facilitated to provide health care services to people but failed due to base on profitability, hence created merely inequality and misallocation in spreading of infrastructure facilities in all areas.

Kumar and Gupta (Gupta, 2012) discussed the present scenario of health care facilities and personnel. They suggested a model health care plan which devolves around preparing a long-term strategy for qualitative as well as

quantitative improvements in India's health care infrastructure by focusing on workforce capacity and competency, information and data systems and organizational capacity. They suggest government to take an integrated approach with a decentralized structure based on district level with the help of local people and local level institutions like Panchayats.

Isabelle Joumard and Ankit Kumar (Kumar I. J., 2015) found in their study that health care system in India is a mix of private and public providers and there is a great shortage of health care staff in populous and rural states of north. They suggest that longest gains in health status will come from preventive measures. Improving living conditions and lifestyle habits would have greatest impact as total sanitation campaign (Swachh Bharat Mission) has high effect on reducing young deaths and development disorders in later stage of life. Likewise, better use of drugs would improve quality of health care and reduce out of pocket expenditure.

Chandrakant Lahariya(Lahariya, 2018) discussed health service infrastructure, health education infrastructure and human resources available for health in India and the challenges in this area. It comes out with conclusion that India's vast rural health infrastructure has the capacity and potential to deliver more services than currently it providing. The need is to strengthen them and enable with input mix of facilities, supplies and human resources based upon real time information system.

Pradeep Kr. Chaudhary (choudhury, 2018) in his paper raises questions on the issue of private sector involvement in medical education, the regional variations in the health care services and availability of doctors. It analyses role of private sector in providing medical education, unequal distribution of medical colleges and quality of medical graduates produced from private institutions and suggests the government to correct the geographical imbalances by setting up medical institutions in underserved regions.

Objectives of the Study

1. To find out the current status of health and health care infrastructure of India
2. To find the misallocation in the current health care infrastructure of India
3. To give suggestions to improve this misallocation

Research Methodology

This study is based on secondary data. It uses analytical and descriptive technique to find misallocation in health care infrastructure of India through different research papers, articles, different health reports published by Indian government and world agencies as WHO, World Bank etc. Data from different sources have been culled, analyzed and conclusions drawn.

3. Health Care Infrastructure in India

Ever since India got independence it has worked to check epidemics and enhance general well-being of its people and no doubt it has improved on various health indicators but the rates are still much above the world average and need immediate action. See Table 1

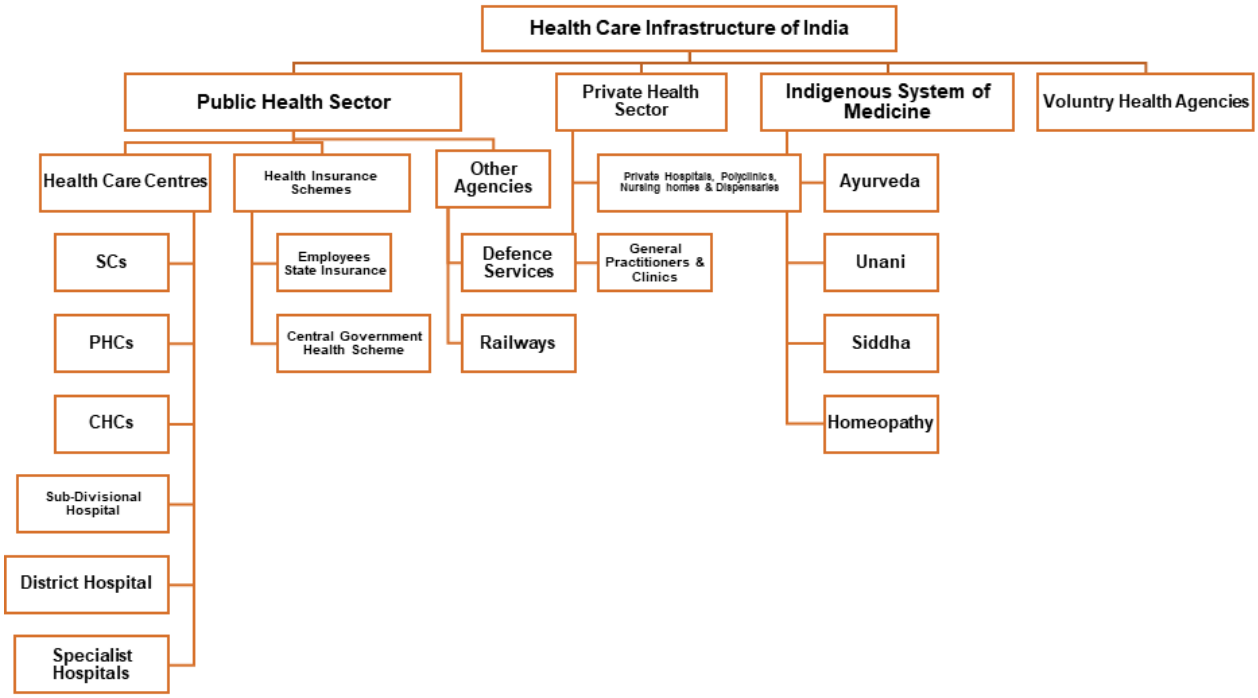
Infrastructure is a prerequisite for delivering any services. Health care system in India is a mix of many sectors public, private, indigenous system of medicine and voluntary agencies. Health care Infrastructure division of India is given in Figure 1

Table-1
Selected Health Indicators of India

S. No.	Parameter	
1.	Crude Birth Rate (per 1000)	20.4
2.	Crude Death Rate (per 1000)	6.4
3.	Total Fertility Rate (per women)	2.2
4.	Maternal Mortality Rate (per 1,00,000 live births)	130
5.	Infant Mortality Rate (per 1000 live births)	34*
6.	Under 5 Mortality Rate (per 1000 children)	50
7.	Percentage of Deliveries attended by Trained Personnel	79
8.	Immunization covered among children aged 12-23 months	62
9.	Life Expectancy at Birth	68.3

*Source- NFHS survey 4, *NHP 2018, Economic Survey 2017-18*

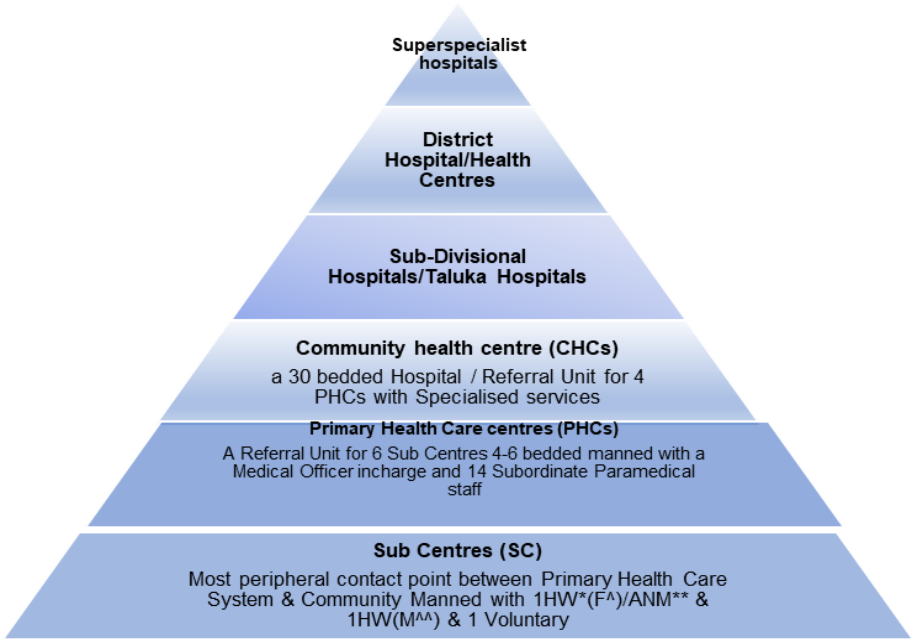
Figure 1Health Care Infrastructure in India



3.1 Public Health Sector Infrastructure

India took a long time almost three and half decades after independence to announce its first National Health Policy (NHP) in 1983 (G.Sen, 2012) in which a holistic (Primary health care) approach was adopted to ensure health for all (HEA) through provisioning of Sub Centres (SCs), Primary Health Centres (PHCs), Community Health Centres (CHCs), district/civil hospitals and medical institutions. The SC is the first and the most peripheral point of contact between the primary health care system and community. One SC covers a population of 3000 in hilly/tribal/difficult area and 5000 in plains. Each SC is required to have at least one female health workers/auxiliary nurse midwife (ANM) and one male health worker. (see Figure 2) SCs have been assigned the task of conducting interpersonal communication in order to bring about behavioural change and provide services in relation to maternal and child health, family welfare, nutrition, immunisation and control of communicable diseases programmes. Above SC are PHC that is the first contact point between village community and the medical officer. One PHC covers 30000 population in plain area while 20000 in hilly/tribal/difficult area. The PHCs are envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of healthcare. At present, a PHC is manned by a medical officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 sub centres. It has 4-6 beds for patients.

Figure 2.Public Health Sector Hierarchy in India



**Health Worker, **Auxiliary nurse midwife, ^Female, ^^Male*

The activities of PHC include curative, preventive, promotive and family welfare services. Above PHC are CHC. they are being established and maintained by state government under MNP/BMS programme. One CHC has to cover 1,20,000 population in plain area while 80,000 in hilly/tribal/difficult area. One CHC has 4 medical specialists surgeon, physician, gynaecologist and paediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs and also provide facilities for obstetric care and specialist consultations. Above CHCs comes sub-divisional hospitals (SDH), District hospitals, super-specialist hospitals. Table 2 gives actual number of these centres in India till March 2017.

Table 2Health Care Infrastructure in India on March 31, 2017

Health centres	Number
Sub Centres	1,56,231
Primary Health Centres	26,650
Community Health Centres	5,624
Sub-divisional Hospitals (SDHs)	1,108
District Hospitals	779
Mobile Medical Units	1,589
Medical Colleges and associated Hospitals	476
Dental Colleges	313
General Nursing Midwives Institutions	3,215
Pharmacy Colleges	777
Total Hospitals	23,582
Rural Areas	19,810
Urban Areas	3,772
Total Beds	7,10,761
Total beds in Rural Hospitals	2,79,588
Total beds in Urban Hospitals	4,31,173
Licensed Blood Banks	2903
Allopathic Doctors	1,14,969
Dental Surgeons	7,239
AYUSH Doctors	773668
Pharmacists	907,132
Nurses	28,78,182

Source- National Health profile 2018

3.1.1 Health Insurance Schemes:

- **Employee State Insurance Scheme:** The ESI Scheme introduced in 1948 is based on the principle of contribution by employer and employee. It provides medical care in cash and kind, benefits in the contingency of sickness, maternity and employment injury.
- **Central Government Health Scheme (CGHS):** CGHS was first introduced in 1954 to provide comprehensive medical care to central Government employees, pensioners and their dependents residing in CGHS covered cities. At present CGHS has health facilities in 37 cities having 287 allopathic dispensaries and 85 AYUSH dispensaries in the country with 10,82,913 registered cards/families. (NHP, 2018)

3.1.2 Other Agencies:

Besides these defence services have their own organization for medical care under the banner “Armed Forces Medical Services”. Likewise, the railways provide comprehensive Health care services to its employees.

3.2 Private sector Infrastructure

India has a large and unregulated private sector, both in formal and informal sectors which provide health services to people on payment basis. Private sector health care infrastructure can be divided in two parts

a. Private Hospitals, Polyclinics, Nursing Homes and Dispensaries
b. General Practitioners and Clinics

Authentic data about private informal sector is not available while the majority of super specialist hospitals and doctors’ practise in urban areas.

3.2.1 Private Non-profit Sector

The private non-profit sector includes health care services provided by voluntary organisations, Non-Profit organizations (NGOs), Charitable institutions, missions and charitable trusts. These organizations provide health care services on voluntary basis without any cost or with minimal costs. General public especially poor people are great beneficiaries of these low-cost service providers.

3.3 Indigenous System of Medicine

In addition to these India has its own indigenous system of medicine. Ayurveda, Siddha, Unani, Homeopathy, Naturopathy are some examples of it. The government of India and many state governments have taken steps to formalize and initiate standardization of these systems. Even a new ministry AYUSH ministry has been opened to promote and develop these indigenous systems of medicine. In India AYUSH infrastructure is given in Table 3

Table 3
Registered AYUSH Practitioners in India

AYUSH Dispensaries	27,698
AYUSH hospitals	3,943
Ayurveda	428,884
Unani	49,566
Siddha	8,505
Naturopathy	2,242
Homoeopathy	284,471
Total AYUSH Doctors	**773,668**

Source- National Health profile 2018

AYUSH has maximum number of registered Ayurvedic doctors (55.44%), followed by registered homeopathy doctors (36.77%) in India.

3.4 Voluntary Health Agencies

Voluntary health agencies play an important role in community health programmes. They collect fund and spend according to the need of the society. India has vast number of voluntary health agencies as Indian Red Cross Society, Bharat SevakSamaj, All India Blind Relief Society, Professional bodies like Indian Medical Association (IMA), All India Dental Association etc., International Agencies like Ford Foundation, Bill and Milinda Gates Foundation etc.

Besides these Auxiliary Nurse Midwife plays a very crucial role in providing health care services. They have wider linkages with ASHA workers, Anganwadi workers of ICDS and other development sectors like education, water supply and sanitation. Table 4 gives Registered number of ANM, GNM and LHV.

Table- 4Nurses Registered in India

ANM (Auxiliary Nurse Midwives)	841,279*
GNM (General Nurse Midwives)	1,980,536*
LHV (Lady Health Visitors)	56,367*
Nursing Institutions	3,215**
Production capacity of Nursing Institutions	1,29,926**

Source- National Health profile 2018
**Till 31-12-16, **Till 31st October, 2017*

4. Problems with Health Care Infrastructure of India

Despite so many hospitals, clinics, dispensaries and health centres both in public and private sectors and even NGOs and charitable institutions in health care, India's health care services failed to provide a satisfactory level of health care to its 1.3 billion population. Every year in India new public health challenges are emerging due to demographic and epidemiological transitions, environment degradation, emerging infectious diseases and anti-microbial resistance. India's health care infrastructure however, is unable to respond these new challenges as the delivery system is not functioning optimally and it is not based on the current needs of the community. The main problems of Indian Healthcare infrastructure are -

- **Shortage of Staff and Equipment's**

Though Indian Government both central and state have created a vast network of health care infrastructure in India but it is insufficient to provide proper health care to common people in a cost-effective manner. The government Rural Health Survey reveal that only 55.6% of CHCs have functional X-ray machine while only 18% of specialists required (surgeon, physician, gynaecologist and paediatrician) are in place. (Alexender, 2018) Northern States of India are not only poorly equipped but have shortage of staffs also. At least 4 specialists are expected to be available at each CHC in India. However, against a requirement of 22,496 specialist doctors only 4,156 were available at 5,624 CHCs across in India at the end of March 2017 (Lahariya, 2018). Overall there was a shortfall of 86.5% surgeons; 74.1% obstetricians &gynaecologists; 84.6% general physicians and 81% paediatricians at CHCs in the country. According to rural Health Statistics in March 2018 only 8% subcentres, 12% PHCs and 13% CHCs met Indian Public Health Standards (Alexender, 2018). In addition to doctors and specialists there is shortage of other category of health staff. There was shortfall of nearly 10,000 ANM and Health worker (F) at SCs and PHCs. Of total 31,274 PHCs and CHCs, there was a shortfall of 12,511 laboratory technicians; 7052 pharmacists, 13,194 nursing staff and 3629 radiographers.

- **Health care infrastructure is heavily skewed in favour of urban areas**

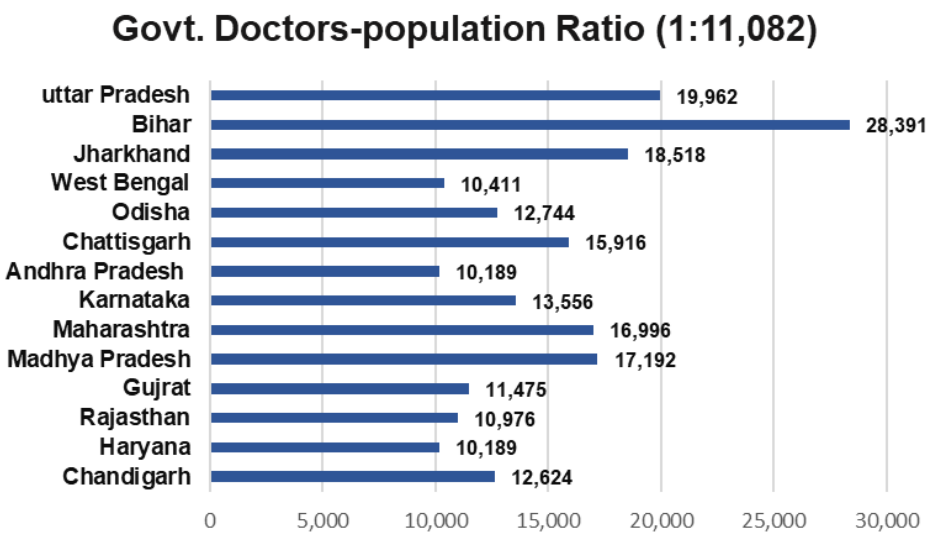
The evidence show that private health care market occupies a large share of hospitals (75%), hospital beds (50.7%) and medical institutions (54.3%) largely located in urban areas. The growth of private sector has been urban and metro centric. (S.K.Hooda, Private sector in Health Care Delivery Market in India: Structure, Growth and Implications, 2015) With regards to the spread of organised hospital care, the IMS Health survey conducted in 62 Indian cities in the year 2012 covering 14121 hospitals reflects that out of the total hospitals surveyed, almost half (48%) of the large private hospitals and two-thirds of corporate hospitals are located in five million plus cities in India. Mumbai alone has 16% of all hospitals in organised healthcare. (Mukhopadhyay, 2015)

Of the total 1.14 million allopathic doctors registered with medical council of India by December 2017, around 80% work in urban areas while 69% of rural India is heavily dependent on public health system where allopathic doctor population ratio is 1:11,082 while World Health Organization recommends a ratio of 1:1000. (Sharma S. , 2018) Delhi is best served with one government doctor per 2,203 people while Bihar is the worst with one doctor for 28,391. Figure 3 gives state-wise allocation of doctor population ratio.

Six states Delhi, Karnataka, Kerala, Tamil Nadu, Punjab and Goa have more doctors (Nagrajan, 2018) than WHO norm of 1:1000 but most of these doctors are located in urban areas and may be rural areas of these states see dearth of qualified doctors. Besides, most doctors from these states are unwilling to move states like Bihar or UP that suffer from acute shortage. This again raises question whether producing more doctors can address the crunch in rural areas.

Moreover, due to concentration in urban and in posh areas these doctors have started malpractices to woo the patients. According to Dr. Prabhakar president of Karnataka Branch of IMA "40% of doctors in Karnataka are in Bangalore. In rural areas there is still a shortage. Bangalore issaturated, even for specialists. So, they don't get jobs. Doctors salaries are coming down… we need to focus on producing doctors for the periphery. Just producing more doctors won't not work." (Nagrajan, 2018)Around 90% of dentists and 80% of practitioners of Ayurveda, yoga and naturopathy, unani, siddha and homeopathy (AYUSH) are also in private sector. Nurse are more evenly distributed, with half the number of nurse and midwives in public sector.

Figure 3
State–wise Allopathic doctor- population Ratio in India



Source- National Health profile 2018

- **Inter-State and Intra-state variations**

There is high variation in the availability of health care facilities across the states and within the state. In a few states such as Kerala, Tamil Nadu and Delhi public health facilities play their intended role of being the first point of care and proactively delivering essential services while in some states like Uttar Pradesh, Bihar, Jharkhand primary health care is not available to masses and they are highly dependent on private sector with their own expenditure. These states also suffer from lack of doctors and nurses.

Not only among the states but within a state there is a wide variation in availability of health care facilities. In his study Hooda found (S.K.Hooda, 2017) public health facilities (estimated covering availability of SCs, PHCs, CHCs, sub-divisional and district hospitals per 1,00,000 population) also shows high inequality in the provision of public Health Facilities across Districts. He found while the private facility is highly urban centric covering a few districts of India, there is dearth of both public and private health care facilities in many of the districts and there are many parts/areas/districts where no one is to serve people.

- **No proper regulatory mechanism and monitoring-**

Not only there is shortage of doctors but there are many practitioners in the private sector who are actually not qualified doctors or Jholachapp in local language. According to WHO report published in 2016 Only one in five doctors in rural India is qualified to practice medicine. The report said that 31.4% of those calling themselves allopathic doctors were educated only up to class 12 and 57.3% doctors did not have a medical qualification. (HT, 2017)

Due to poor regulatory mechanism and monitoring, private health care services and doctors are following unethical, greedy practices treating medical services as a business and hospitalisation as a source of profit, writing unnecessary diagnostic tests, high rate medicines instead of generic one, organ theft (kidney racket) etc. even denying treatment to poor people though getting land from government on a subsidised rate. In addition, Shailaja Chandra in her study (Chandra, 2017) noticed that Indian citizens (rich or poor) have no protection against medical exploitation or malpractice. Regulators like Medical Council of India and state Medical Council rarely react to medical malpractices. This is why there is no check on greed and malpractices of doctors and hospitals.

5. Recommendations

Based on this study following recommendations can be given

1. Primary health Centres needs to be strengthened as 80-90% health needs of a person in a life time can be provided by primary health care centres that ranges from maternity to child care, disease prevention through immunisation, management of seasonal and life style diseases like flu, cold, fever, hypertension, diabetes etc., supporting care to aging people who have multiple diseases. For this in urban areas Mohalla clinics can be a good alternative while in villages SCs and PHCs should be strengthened.
2. Increase the expenditure on health from current 1.4% to 2.5% as envisaged NHP 2017 to improve infrastructure in health centres. as in health there is a problem of underfunding and not inefficiency. If government can ensure a perfect combination of physical and human infrastructure by spending adequate amount of money on health, the results will be different. It is proved that public health care sector has never been given a chance to do better, the sector has always been lacking from flow of meagre funds. Wherever it has been provided with funds it has done much better for e.g. in case of AIIMS, PGI Chandigarh or JIPMER
3. To meet shortage and availability of trained staff at PHCs and CHCs preference should be given to local people. To solve problem of abstaining from leaves or resistance to live in rural areas local people should be trained and posted in SCs, PHCs and CHCs of

difficult/ tribal and hilly areas. Skills of good performing ASHA, ANM workers and nurses should be upgraded and they should be posted in their own rural and remote areas of PHCs and CHCs.

4. To remove misallocation of medical colleges maximum in urban areas new medical colleges whether it is private or public should be opened strictly only in rural and remote areas. Special focus should be on large populous northern states or backward states.
5. There should be proper regulation and monitoring against all the malpractices prevalent in health area. Stringent laws and punishment should be there for all those who do unethical practices in this field as health is a service not business to fulfil the greed of the people.
6. Use of technology can help a lot to reduce the cost as well as improving facilities in health area. On line monitoring of all the facilities of a health centre as well as use of tele-conferencing, tele-medicine and tele-radiology, mobile hospital and mobile ambulance in remote, rural, hilly and tribal areas can help a lot to bring down the cost of establishing health centres over there.
7. Overall help of community people should be sought for providing health care to all because no programme can be successful without active involvement of community. Kerala is a good example for it that took help of educated youth and Panchayati Raj Institutions for implementing her health programmes.

6. Conclusion

Though government has done a lot in last few years and many steps have been taken to improve infrastructure in health sector. New AIIMS and medical colleges have been opened. To remove regional differences and bring equitability government has made a policy to open a medical college covering 3 parliament constituency. Tablets are being provided to ANM and ASHA workers. After the launch of Ayushman Bharat SCs and PHCs are being converted into health and wellness centres. As one of the components of this program is to upgrade 1,50,000 SCs and PHCs into health and Wellness Centres (HWCs) by 2022. This should be taken as an opportunity and the attention should be ensuring of providing the right mix of facilities, supplies and human resources to enable them to deliver servicers. This should be linked with real time information system as is being done by National Health Resource Repository (NHRR) Programme that aims to collect information on existing health facilities, providers and services available at the facilities in the urban area. The area of this programme should be extended to all health and wellness centres to do real time monitoring of the services provided by these centres. Thus, lot is to be done as health is the right of every individual and to ensure that government has to adopt an integrated approach in which help of all stake holders public, private, NGOs, voluntary organisation etc. should be taken to provide health care to all. As no health programme can be successful without active involvement of the community so Active involvement of community and educated youth should be ensured to achieve goal of Health for all and like ‘Swachh Bharat Mission’ ‘**Swasth Bharat'** should be our new slogan.

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