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HEALTH CARE AND HEALTH EXPENDITURE IN INDIA: SPECIAL REFERENCE TO KARNATAKA STATE

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ABSTRACT

India is drawing the world's attention, not only because of its population explosion but also because of its prevailing as well as emerging health profile and profound political economic and social transformation. Healthcare is one of the India's largest sectors in terms of revenue and employment and the sector is expanding rapidly. During the 1990s, Indian health care grew at a compound annual rate of 16 percent. Today the total value of the sector is more than \$34 billion. This translates to \$ 34 per-capita, or roughly percent of GDP by 2012, India's health care sector is projected to grow to nearly \$ 40 billion. Hence this study has attempts to analyses the health facilities in India and Karnataka, to study the health indicators in Karnataka and recent reforms in health care system in the country.

KEYWORDS : NRHM, Health care, Health expenditure.

1) INTRODUCTION:

The role of Government is ensuring that its country's health care system provides optimal services for its population has been greatly emphasized upon (The world's health Report, 2000). Improvement in the

quality of primary health care services apart from increasing accessibility and affordability has become a matter of grave concern for the developing nations in the recent years. However, the meaning quality in healthcare system has been interpreted differently by different researcher. Overview (1992) identified three "stakeholder" components of quality : client, professional, and managerial, from the clients view point, it is the meeting of the patients unique need and want (Atkins, Marshall and javalgi,1996) at the lowest cost (overtviet,1992) provided with

courtesy and on time (Brown et al,1998) while professional quality involves carrying out of techniques and managerial quality entails optimum and efficient utilization of resources to achieve the objectives defined by higher authorities. According to the Institute of medicine (2001), quality in health care is "The degree to which health services for individual and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". Meeting the objectives of both physicians and patient has been equated with the concept of quality In health care by some researcher (Morgan and murgatroyd, 1994) while others have focused on user perception, technical standards and provision of



care (Boller et al ,2003,Hulton, Mathews and stones,2000) Quality of care comprises structure, process and health outcomes and there are eight dimensions of health care service delivery: effectiveness, efficiency, technical competence, interpersonal relations, access to service, safety, continuity and physical aspects of health care(Brown et al, 1998) the concept of quality is multifaceted connoting different meanings to different stake holders such as Government, service provider, hospital administration, and patients.

India has introduced public health care facilities at large scale within the country covering every individual. But because of rapid growing population, development of health care sector has become great challenge. This is a vital area and faces several problems which vast population, scarcity of resources, non availability of personnel, infrastructure, lack of medicine, unaffordable healthcare to the poor.

2) OBJECTIVES OF THE STUDY:

This study based on following objectives

- 1) To study the health facilities in India and Karnataka
- 2) To study the health indicators in Karnataka
- 3) To study the recent reforms in health care system

3) METHODOLOGY OF THE STUDY:

This study based on secondary sources, the secondary sources collected from articles, journals, Books and various government reports.

The health care infrastructure in rural areas has been developed interns of three tier system and is based on the following population norms.

Center	Population Norms
Sub center	5000
Primary Health Center	30,000
Community Health Center	1,20,000

Health care in India has improved in an impressive manner in the recent decades but undoubtedly it has been urban-centric due to the fact that about 75 percent of health infrastructure human resources are concentrated in urban areas where only 27 percent of the population lives.

Health Facilities and Related Parameters in Karnataka

District	Population served per medical institution	No of hospital beds per lakh population	Staff per lakh	Population served per phc(in 000)	Population served per sc (in 000)	One year old children received complt immunization
Bagalkot	26.32	47	26.58	26.81	7.66	64.4
Banglr rural	15.46	51	36.73	20.74	5.29	92.7
Bangr urban	37.19	123	14.23	27.46	6.08	72.1
Belgaum	23.14	50	24.04	24.54	5.58	74.3
Bellary	20.36	91	25.31	25.32	5.28	77.3
Bidar	23.39	67	34.35	28.76	5.23	89
Bijapur	22.15	67	28.11	22.63	4.99	77.3
Chamraj nagar	14.63	86	40.08	15.96	4.11	84.8
Chikmaglur	10.94	113	57.67	18.29	2.84	95.9

Chitrdurga	14.45	88	51.19	22.41	6.23	80.8
Dakshina kannada	20.97	96	37.62	18.68	2.66	93.3
Davangere	15.34	99	31.71	18.33	5.07	93.4
Dharwad	34.12	112	24.75	25.95	4.33	86.3
Gadag	19.69	57	29.94	22.45	5.17	86.9
Gulbarga	19.06	66	26.16	22.66	4.69	81
Hasan	11.02	110	45.13	17.58	3.11	84.4
Haveri	16.39	54	33.01	23.37	3.95	81.2
Kodgu	10.17	234	83.67	16.63	2.96	109.7
Kolar	17.41	99	35.57	23.68	5.24	79.3
Koppal	21.18	51	22.16	24.08	6.16	72.8
Mandya	13.58	91	40.09	20.46	3.97	81.5
Mysore	14.90	137	44.15	17.36	3.49	90.2
Raichur	25.38	58	19.76	26.82	6.25	88.8
Shimoga	13.88	110	44.63	19.38	2.91	109.5
Tumkur	17.40	61	34.01	21.69	5.09	78.4
Udupi	13.10	89	38.75	14.55	3.64	93.8
Uttar kannada	12.51	105	53.04	15.72	3.14	80
Karnataka	18.56	88	26.58	21.42	4.46	81.94

Source; Government of Karnataka (2006)

Health indicators in Karnataka

Divisions	Birth rate 1991-92	2001-02	Death rate 1991-92	2001-02	Life expectancy 1991-92	2001-02
Banglr division	27.3	20.4	7.4	6.9	63.7	65.9
Belbum division	29.2	23.5	9.5	8.5	60.3	63.0
Gulbarga	30.4	27.4	9.1	8.3	60.7	63.9
Mysore	27.4	18.5	8.4	7.8	62.4	64.8
Karnataka	27	22.4	8.6	7.5	62.1	64.4

Source: High power committee for redressed of regional imbalances, final report, june 2002, Government of Karnataka

After 54 years of independence a number of urban and growth orientated developmental progress having been implemented, nearly 72 percent of the total population, half of which are below poverty line (BPL) continue to fight a hopeless and constantly losing battle for survival and health.

The policies implemented so far, which concentrate only on growth of economy not an equity and equality, have widened the gap between urban and rural haves and have not nearly 70 percent of deaths from communicable diseases, occurred among the poorest 20 percent of the population.

Rural India faces a lot of problems including under serviced medical delivery due to a lack or misallocation of resources, both in terms of money and labour, ever exploding health care cost, lack of specialty services, lack of available technology for treatment of disease and many such issues.

4) HEALTH EXPENDITURE IN INDIA:

In India public expenditure contributes a significantly small percent in health care expenditure. Healthcare expenditure refers to states expenditure and does not include central governments allocation for family welfare programmes. The expenditure on health also does not include budgetary allocations to water supply and sanitation. The government of India has set a goal of increasing government health spending to 2-percent of Gross Domestic Product over the next five years, even with optimistic assumptions; it cannot meet the stated goal. Health expenditure in India is around RS 646,055 millions with more than 70 percent consisting of private expenditure in the year 2002. Average per-capita health expenditure is an indicator of how much public and household expenditure is made on health care, which comes to about RS 617. However, average per-capita health expenditure is far less than household per capita expenditure. (RS 641). Share of public expenditure within plan and non-plan component of the budget stands in the ratio of 1:3 which shows that recurring expenditure like salary etc. Constitutes an over whel mingly large proportion of states expenditure while the capital investment in total public expenditure is about 4.4 percent, the share of public expenditure on social and development expenditure of states are about 14.5 percent and 7.9 percent respectively.

5) RECENT REFORMS OF HEALTH CARE

Improving the health of individuals, particularly those belonging to socially and economically those belonging to socially and economically disadvantaged groups, is a key objective of the Indian government and a major consequence of a constitution that repeatedly directs the state to this end. Moreover, the Indian government has, at various points in time, embraced the objective of the poor and the disadvantaged units policy statements and actions, one being its signing of the a alma ata declaration of 1978, emphasizing "health for all (LOk sabha secretarial 1985) In its national health policy statement of 1983 ,the government stated that " the highest priority would ... require to be devoted to efforts at launching special programmes for the improvement of maternal and child health, with a special focus on the less privileged sections of society."

1. A Series of policies have been formulated since 2000, important among them are the revised National Health Policy on Indian system of medicine and homeopathy (2002) and national pharaceutical policy (2002)
2. To accelerate the decline of infant mortality essential new born care has been included in Reproductive and child health (RCH) programme
3. Instead of campaign mode, routine immunization is being strengthened.A project on Hepatitis B Immunization and infection safety has also been initiated.
4. The Government has launched a National Rural Health Mission to improve the availability ofand access, to quality healthcare by the people, especially those residing in rural areas, the poor women and vchildren. Under this scheme, eachvillagewill have a female Accredited Social Health Activist (ASHA) who will be the interface between the community and the public health system.
5. The ministry has constituted a task force under the chairmanship of the Director General of Health Services to reviewand streamline the health information with feedback mechanism keeping in view the objectives of the National Rural Health Mission.
6. Recognising the need for evidence based information about various initiatives under taken and their assessment as a part of the health sector reforms process, the ministry of health and family welfare, in collaboration with WHO country office. India has undertaken a review and documentation of health sector initiatives.
7. The government has created and has maintained a web based Health sector policy reforms option database (HS PROD), which shares information about Indian good practices, innovations and reforms has already, documented more than 200 reform options.
8. In 2004, the central Bureau Of Health Inelegance, the agency for health information in India made recommendations in consultations with the states and union Territories for improving and strengthening health information in the country.

6) CONCLUSION:

Health sector is complex with multiple goals, multiple products, and different beneficiaries. Peter berman (1995) health sector reforms as “sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector. The implementation of large scale health system reform demands political sensitivity strategic thinking and management capacity of a high order. In practice, the application of health system reforms takes a wide variety of shapes by combining different components into different configurations.

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