

Structural Challenges and A Role in New Health Policy Management in Future India

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KEYWORDS ABSTRACT

Health, Health care, policy management

The development of the Indian state has not been the leader in health and medical care top focus. Two noteworthy facts illustrate this. One is the health sector's low level of resource allocation and investment throughout time, which has been roughly 1% of GDP with a clear downward trend over the past ten years. Second, the unchecked, extremely quick growth of an unregulated private health industry, particularly in the past 20 years. Health policies are typically thought of as official written papers, regulations, and guidelines that represent the decisions made by legislators regarding the actions required to promote health and fortify the healthcare system. A common misconception about the "policy process" is that it proceeds logically and linearly from formulation to execution. Health policy is formulated through a multifaceted process that is influenced by numerous scientific, economic, social, and political factors. Within the context of the development of the nation's health sector, this study looks at the historical evolution of health policy making in India. Additionally, it assesses the current situation and offers suggestions for the course of future governmental initiatives.

1. Introduction

A policy is more than just an intervention; it serves as the main catalyst for change and the means by which it is brought about. If we look back at the 10 most significant advances in public health over the 20th century, we can see that all of them were the result of changes in policy, whether it was seat belt use requirements or workplace exposure limits. Health policies deal with health issues and specify what, where, when, and how a person can access medical treatments. They are intended to protect and enhance community health, which often requires promoting and enacting legislative changes. In order to improve community health, policy reforms that foster an environment that is conducive to health must be prioritised by practitioners, innovators, and public health scholars [4]. To change the situation, one must first implement health policy [1]. Planners who are creating a policymaking process that addresses multiple components will be impacted by the study. Additionally, states thinking about developing their state health policy will find it useful [2]. Policymakers and planners will be able to apply an organised approach for inclusive and strong policymaking with the support of this study [10]. The current study's objective is to examine the Indian health policy-making process and offer suggestions for creating an open, inclusive system that will enhance the process [18]. To research the process of creating health policies in India, the roles played by important players in this process, and offer recommendations for ways to make the process better [17].

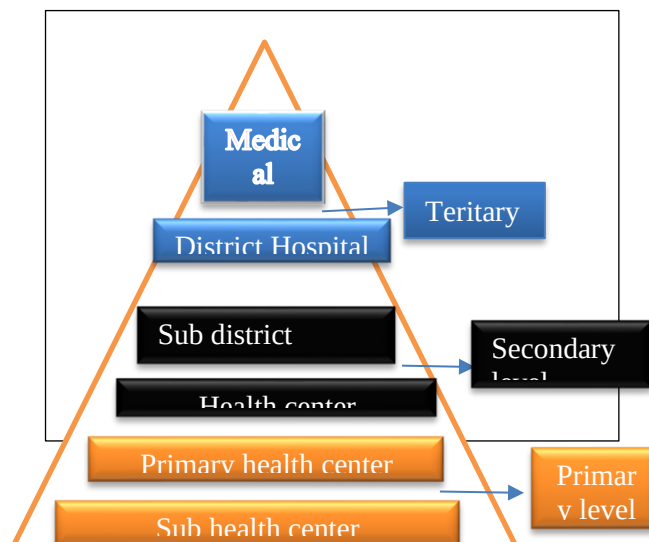


Figure 1. India's Healthcare System

2. Literature Review

Health is wealth. Numerous research conducted worldwide have demonstrated the connection between economic prosperity and good health. Enhancing one's health is crucial to realising one's full potential. In light of this, the governments of many industrialised nations offer social security to their people [3]. But in India, this situation takes on a distinct appearance. Our society's conventional structure assigns social security (the same) to the family or the community [15]. The joint family system is disintegrating as a result of rising urbanisation and industry. Additionally, it has greatly contributed to the decline of family bondage. Therefore, this obligation now requires a different shoulder to be supported.

In addition to several state-run insurance programmes, the government runs a few centrally sponsored social assistance programmes, but the total number of beneficiaries is quite small. A government-funded health program's likelihood of success depends on a number of variables, including income and the composition of the labour market (including both formal and informal work) [11]. Their success is also influenced by the distribution of the population, the administrative framework of the economy, and the ability of the current health infrastructure to provide services [16]. Since taxes are the only source of income for the state, this means that there is a resource restriction [8]. Furthermore, the allocation required in the health sector may not rise to a sufficient level in the near future due to conflicting sectorial demands.

The World Bank has recommended two approaches for mobilising resources for health care: cost control and the cost sharing technique. Health insurance serves as a means of cost distribution [12]. Since HI is one of the finest financial tools for risk management and can keep people with incomes above the poverty line from falling below it, it is becoming a significant policy concern [5]. The government's policy of gradually removing secondary and tertiary medical care is indicative of the current state of health care in the nation. It is thus evident that the health provisioning cannot just be solely dependent on the state. The objectives of the proposed works are,

- To study the various Health Insurance products available in the market with respect to plans, premiums and policies.
- To study the socio-economic aspects of those availing and not availing these plans.
- To have an analytical study of the popularity and general acceptance of the various insurance products offered by the service providers

Strategies Of Policy

Polymaking

Making national health policies is a dynamic, intricate process that differs from nation to nation. A nation's vision, priorities, financial choices, and plan of action for enhancing and preserving the health of its citizens are determined in large part by its national health policies, strategies, and plans. For decades, the majority of nations have been creating national health policies, strategies, and plans to provide guidance and consistency to their endeavours aimed at enhancing health.

Everywhere there is a shift in the policy-making process. Politicians, bureaucrats, and interest groups comprised the government or public sector apparatus that was the subject of the policy study in the past. And as researchers in policy and policymaking have noted, this has changed throughout time. The private sector is one of the new stakeholders joining the growing list of those active in the policy-making process [6]. Organisations from the civil community are also essential in developing healthcare policy. In addition to the global civil society, public-private partnerships had an impact on policy formulation. Technology is expanding the scope of how it can affect policy [13].

Policy-Making Process

The entire process of initiating, formulating, or specifying policies, organising them, communicating them, carrying them out, and evaluating them is included in the Policy-Making Process (PMP). Upon

examination of the literature pertaining to the policymaking process, it becomes evident that the field has primarily remained theoretical, with a particular emphasis on agenda-setting and the processes that initiate policy change—aptly referred to as "triggering events"—as key components. The following elements of the process/outcome model of policymaking are undoubtedly present: agenda-setting, politics, triggering mechanisms, and the ensuing consequences.

Using the stage heuristic approach is the most popular way to understand the PMP. In order to do this, the approach method must be broken down into steps, and it must be acknowledged that this is theoretical and does not accurately reflect reality [7]. However, it is imperative to examine policymaking because it involves the subsequent phases:

- **Problem Identification:** Look into how issues are covered in the policy agenda and the reasons behind the exclusion of certain subjects.
- **Policy Formulation:** Looks at who is involved, how approaches are debated and chosen, and how decision-makers subsequently share their findings with one another.
- **Policy Implementation:** Often disregarded, this stage of the policy-making process is thought to be separate from the preceding two stages. Drafting the implementation framework with goals connected to initiatives to accomplish the goals outlined in the health policy is part of this process.
- **Policy Evaluation:** Confirming the successes, results, or shortcomings of a policy. This makes a distinction between what happens after a strategy is put into practice and what happens after it is being monitored, regardless of whether the approach succeeds or has unintended consequences. At this point, methods are changed or abandoned, and new regulations are put into place.

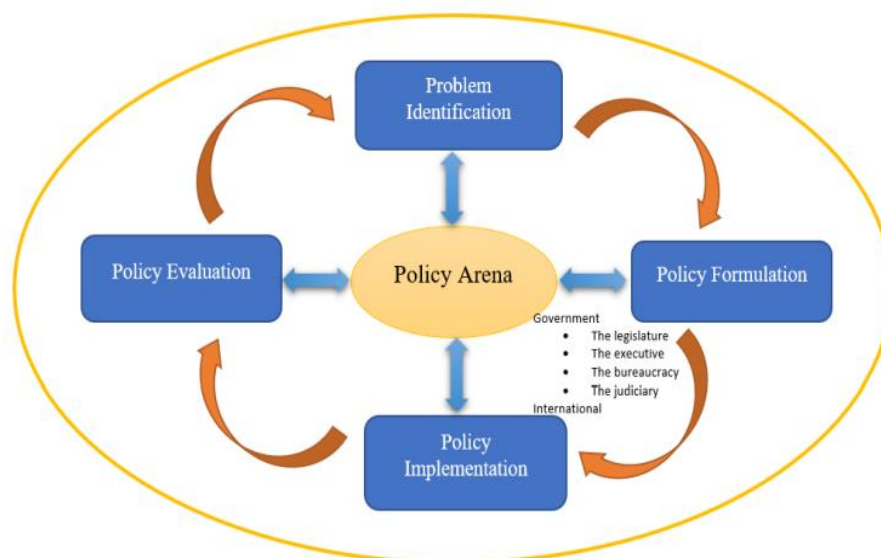


Figure 1. Policy Making Cycle

Healthcare Policies

Health policy interventions were developed to address disparities related to a person's socioeconomic and geographic status as well as to provide high-quality healthcare services and protect people from financial risk by making healthcare cheap [14]. The Royal Commission on the "Sanitary State of the Army in India" issued its report in 1859, citing the following factors as the root causes of the high death rate among British soldiers in India. This was one of the oldest reviews of healthcare in India, and it occurred 162 years ago:

- Inadequate sewerage

- Water supply
- Poor drainage
- ventilated and overcrowded barracks

So, the start in terms of policy planning in its most primitive form started in India with the Royal Commission Report in 1859. Even though it is a worldwide community health concern rather than a specific one for India, the execution of equitable policy remains challenging given India's institutional and implementation capacity.

Table 1. Development of Health infrastructure in India 2021-2024

			2016	2017	2018	2019	2020	2021	2022	2023	2024
1	Hospitals		2924	3175	3396	6915	11355	16700			18175
		% Rural	41	47	55	59		67			
		%Private				43	57	68			
2	Hospital & dispensary beds		190105	229634	348655	504538	664135	870161			950000
		% Rural	29	31	39	41		47			
		%Private				28	32	36			
3	Dispensaries		6715	9506	13180	16845	28431	29225			
		% Rural	81	85	79	63		45			
		% Private				23	69	75			
4	PHCs		915	2795	5215	5715	22543	21993	22917	22746	24620
5	Sub-centres				22543	21993	131098	131900	134931	136379	
6	Doctors	Allopaths	60840	83070	153000	266140	395600	459670	475780	503950	522634
		All Systems	156000	184606	450000	665340	920000			1100000	1155000

3. Results and discussion

Equity and universal coverage for primary healthcare are acknowledged and frequently stated objectives. It is frequently cited as an essential human right. Equity and universal coverage are intertwined. Curative services are the primary focus of the private health industry, as was previously indicated. Eighty percent of private health providers are general practitioners, who treat common illnesses [9–11]. According to the 1987 National Sample Survey on Morbidity and Utilisation of Health Services, a startling 96% of these experts, who have degrees from a range of medical systems, practise modern medicine.

As a result, neither professional associations nor the government exercise any oversight, control, or regulation over private medical practitioners. In actuality, there exist a sizable, uncountable number of unqualified practitioners, particularly in places where it is hard to get qualified physicians. In both rural and urban settings, general practitioners together manage more than three-fourths of all outpatient cases. While still relatively small, the private sector's influence in hospital treatment is growing quickly.

The private sector provides healthcare without taking into account social concern, reason, or quality, while the public health sector lacks the resources to meet the needs of the populace. Public opinion, as demonstrated by the numerous utilisation surveys already mentioned, suggests that characteristics such as proximity, availability hours, wait times, individualised attention, and medication availability are significant drivers of preference for private health care providers. When public health facilities benefit

from these elements, their usage significantly increases. Therefore, certain considerations must be made while organising the delivery of healthcare.

- Services provided by family physicians and general practitioners for individual health care.
- Primary specialty and first-level referral hospital care, including ophthalmology and dental services.
- Immunisation services against diseases that can be prevented by vaccines.
- Epidemiological services, such as laboratory services, ongoing survey-based surveillance and major disease control, information management, and public health initiatives.
- Services for ambulances.
- Women's health services.
- Health instruction.

4. Conclusion and future scope

When considering the future of our healthcare delivery system, it's critical to remember that high satisfaction ratings and excellent care don't always go hand in hand. greater patient satisfaction was linked to greater overall healthcare costs and higher mortality, according to a nationwide survey. A comprehensive structure of nested health missions, programmes, projects, acts, and statutes enshrines the overarching purpose of guaranteeing everyone's health and welfare. The numerous barriers stand in the way of achieving objectives. Coordinated efforts and diligent research are still not yielding the intended outcomes. Due to the size and complexity of the health sector, extensive reality checks and a careful review of all previous committee reports and recommendations are necessary. The role of the government needs to be increased in addition to this. For the health sector to succeed, the government's role must be expanded in conjunction with increased funding provision.

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