International Journal of Management, IT & Engineering
Vol.10 Issue 3, March 2020,
ISSN: 2249-0558 Impact Factor: 7.119
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

TO STUDY ABOUT THE GOVERNMENT SPONSORED HEALTH SCHEMES IMPLEMENTED IN INDIA

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ABSTRACT

The health position of the population is important for the financialdevelopment of a country for three main reasons. First, it refers to the capacity and progress of the country or its failure to reach the basic needs of the citizen (food, clothing, shelter, and adequate sanitation). The relationship between raw measures such as infant mortality and life expectancy, on the one hand, and per capita income, on the other hand, is very concrete and well known in the financial literature. Second, health as a human resource is an input for the further development of the country. There is enough evidence that health plays a major role in the development and supply of jobs for adults in addition to school attendance and school results. Health improves or health, therefore, promotes learning, reduces absenteeism, improves perception, and helps to improve the economic condition of the feebler sections. Third, high infant and child death are one of the major factors associated with high fertility, which plays an significant role in development.

KEY WORDS: Health position, financial development, Health Schemes, multi-factor functions, health facilities, socio-economic conditions, wages, educationand quality.

1. INTRODUCTION

Choice and reasonable longevity to live a healthylife free from illness and disease are important features in the principles of personal comfort for many. Similarly, the phase from a high state of mortality usually leads individuals to longer lives and healthier lives. It is considered desirable and social transformation is appreciated. Health and longevity indicators are important components of the development process evaluation system in human development strategy, as well as indicators that differentiate the population needs of the population (National Human Development Report, 2015).

Many countries participating in the Bucharest Conference on Population in 1974 strongly supported the notionthat economic growth and health changes were necessary for the decline of infertility. Health has multi-factor functions. Health factors include genetic factors, environmental factors, lifestyle, adequate housing, basic sanitation and socio-economic conditions, wages, education, availability and quality of health facilities, and per capita health expenditure (Park K, 20014). Health status is affected by per capita health and public health expenditure, but does not have a strong impact on reducing infant mortality, which is important in designing public policy to reduce high mortality in developed economies (Kaushik Krishna K, Kurt Kurt). Clean and Lawrence on. Arbenzer, 2011). Studies of nineteenth-century British experience (McCowan, Brown & Record, 1972) and pre-1930 Latin American experience (Ariaga & Davis, 1969) have shown that declining mortality rates are the result of better living conditions than medical success is closely related. However, from 1930 to 1960, it was argued that mortality rates were largely independent of progresses in living standards (Ariaria and Davis, 1969). Per capita income is the most commonly discussed socio-economic decision-maker of deaths, as it is considered the essence of an economy that can meet the needs of its people (Kochen et al., 1980). Well-educated people enjoy good health than the poor, with high levels of self-reported health and physical performance and low levels of illness, disability and mortality (Ross and Wu, 2005). On the other hand, low education has high infectious disease rates, many chronic infectious diseases, self-reported health, short disease prevention, and short life expectancy (Feldman, Mook, Clayman, & Carney-Huntley, 2001); Gralnick, Land, Phillennbaum and Branch, 2003; Morris, 2002).

1.1 UNDERSTANDING GOVERNMENT HEALTH SCHEMES

Every government has to provide affordable and accessible health care to any person in need of its citizens. In addition, to achieve this, governments are launching aextensive range of services for health insurance so that ordinary citizens can use these facilities n they need them most. Similarly, in the hope of providing better health care to all, the Government ofIndia has introduced a number of health plans that offer very low premiums and an adequate amount of insurance.

The present chapter presents a challenge to vide a comprehensive over view of the Indian health landscape concerning essential health indicators, public health infrastructure, and public health expenditure.

1.2 HEALTH INDICATORS

Health is a basic component of human development a therefore it ensures the well-being of society. It is a tool for empowering the backward sections of the society and is, therefore, an important element in the strategy of poverty alleviation. Starting sustainable jobs, improving productivity, and facilitating population transformation. The rights of the prior are strengthened through preventive and protective health care. India's success in providing basic health is highly desirable. In 2004, a UNDP study on human development in South Asia presented a new index called the Health Index (HI) for 177 countries worldwide to determine the overall health status of each population. According to the report, India ranks l40th out 177 countries (with a health index value of 0.476), much lower than other countries such as Japan (21), the United States (10), and Australia (9), Canada (5), Germany (2), Sweden (2).

1.3 HEALTH PLANS LAUNCHED IN INDIA

Indian Health planning dates back to 1943, when the Bhore Committee was appointed to meet India's health and medical needs. The health care system is largely urban and clinic based, providing only preventive care at the time of independence in 1947. Rural health services were started on October 2, 1953 with a primary health center (PHC) in each block with a population of 66,000. In addition to the development of health center campuses to integrate with rural health systems, a number of disease prevention programs have been implemented. India laid the foundation for universal health care services at the end of the Third Five Year Plan. Combining family planning with nutrition services and Maternal and Child health (MCH) is a priority for the next five years. Unity's Net Reproduction Rate (NRR) for Prosperity for Everyone (HFA 2000 A.D.) and 2000 A.D. The Sixth Five Year Plan (1980–85) was implemented. In 1983,the first national health policy was announced. In the Seventh Five Year Plan (1985-90), the integration of the already established health infrastructure was given top priority. Priorities of the Eighth Five Year Plan (1992–97) agreed that health facilities would reach the entire population by the end of the Planning Age.

1.4 REBUILDING PUBLIC HEALTH

In coordination with government health-related work, the Bhore Committee made major reforms. The second section of the study suggests a fascinating peculiarity; On the one hand, the committee noted the disparity between preventive and preventive health services, while on the other hand recommended that they be merged with a single physician. The combination of the Indian health bureaucracy and preventive therapies is a strong departure from the UK's previous priority on health through hygiene, inspection and vaccination. It highlights the role of physicians in public health compared to many other professions for public health. The preventive services provided by doctors have for many years surpassed their place in primary and preventive care and have shifted Indian health policies from public health to health. The Central Government formed the Directorate of Health Services a year after the Bhore Committee Report (DGHS). The Director General of Indian Medical Services (DGIMS) and the Office of the Indian Public Health Commissioner were merged and formed the Directorate of Health Services in 1947. This led to the rejection of the post of Public Health Commissioner, which had successfully held the positions established by the Health Commissioners in the 1860s.

Banerjee argued in 2001 that states had introduced integrated public health and remedial programs to create the Directorate of Health Services. These fusions led to a single health department, usually led by a doctor. For example, on November 1, 1956, when the state of Kerala was formed, the Department of Medical and Public Health joined the former princely states and established the Department of Health Services. It continued with various public health and medical services until 1970 when Maharashtra was merged. At the time of the merger the role of head of public health was abolished and a new position of director of health services was created. This condition is usually treated by a medical professional. Following the merger of the Surgeon General, Bengal and the Director of Public Health Bengal in 1970, the post of Director of Health Services was established in West Bengal, Germany. In many countries, this reorganization has taken a different path, transforming the Department of Public Health into the Department of Water and Sanitation. For example, in 2004, West Bengal transformed its public health department into a water supply and sanitation department. In the field of health policy, solution therapy is given priority in this framework.

1.5 ROLE OF PUBLIC HEALTH SCHEME

With regard to GDP, overall public and private health expenditure is estimated at 3.90%, well below the world average of 9.9%. A fifth of health expenditure is in the public sector.

There are many public insurance programmes including RSBY that cover most diseases health care for those under the poverty line. PT excludes facilities for patients, primary care and tertiary high-level care. The proposed universal health insurance scheme is planned for citizens with two quintals of income. The programme provides annually, for secondary and tertiary care facilities, Rs.500,000 (USD 7,007) per family. The eligibility depends, according to the socio-economic caste census, on the level of homelessness. The programme encompasses almost 100 million vulnerable and impoverished people. Beneficiaries register on the list and may also take advantage of cashless transactions.

1.6 GOVERNMENT SPONSORED HEALTH SCHEMES IN INDIA

A notable trend in health policy in India is the growth of government-funded health insurance schemes. These include the purchase of health services by private providers of healthcare and the purchase of medical benefits by health insurance companies. From their historical context, we deliver new visions into these trends in this article. The origins of Indian health policy lie in the British Indian policies that underpin public health. Overall, public health and not health care became the priority. In British India, the legislative and administrative system centered mainly on public health and played an important role for sub-national governments (states, cities). It reiterated this design in large part when the Indian Constitution was framed. The changes came from two sources after independence. In practice, power was transferred to the Union government while the Constitution envisaged a federal arrangement. The union government designed programmes for the execution of these programmes, and funded state governments. Consequently, political thinking and implementation in state and local governments have been atrophied. It affected many aspects of Indian public policy. In this case, the public health effects are negative because most of the public health is created with local public goods. The Bhore Committee (1943) was the most influential document focusing on public health and leading physicians in health policies. This document was approved in the commission plan and translated into plans and expenses over the next decades. A big effort has been made to build a public health system. This policy - the weak position in local government, the weak

position in public health, the emphasis on public health care, the dominance of physicians - has been a prime example of Indian health policy for decades. Some policymakers began questioning this structure in the early 1980s. By the 1990s there had been many evidence and literature criticizing this approach. Public health weaknesses gave a high burden of disease. In addition, the public health organization was not efficient. An unregulated private health care organization was developed to meet citizens' needs. While the mainstream health policy creation proposed to intensify its efforts in this paradigm, politicians increasingly worried that the paradigm produced poor results by spending more money on it. It was evident on the ground that the private sector's health insurance was the prevailing characteristic of Indian health care. This contributed to the proposal of public financing of health insurance providers for the purchase of private health care. This approach was appealing as tax expenditures appeared to be more specifically converted into concrete public benefits. This policy innovation started in Maharashtra in 1997 and spread rapidly across the country. As of early 2018, there are 48 health insurance plans (GFHIS) with federal funding. We argue that four areas are concerned about this strategy. The first problem is the lack of focus on public health. The most important public policy initiatives in the health sector are public health products. First, it is a high disease burden and it is not appropriate to create a healing layer on it. Secondly, there is concern that the increasingly unregulated private health sector operates, contributing to bad outcomes for people. This calls for a health sector regulatory policy. Thirdly, the shortcomings in consumer security and precautionary control of health insurance providers are of concern, resulting in disappointing outcomes for residents. This calls for the oversight of health insurance providers to be reformed. Finally, there are major fiscal risks along this route. When voters are accustomed to freedom, it is difficult politically to revoke them. Population-scale health care is costly, particularly in the context of deficiencies in public health that put a large burden on the disease. In the construction of these programmes, further fiscal analysis and caution are needed.

2. RESEARCH METHODOLOGY

The study is based on primary and secondary data. Secondary data has been accumulated from various issues of the Indian Statistical Abstract and Economic Survey in between 2001 and 2018. Several mathematical tools were used to describe the data. Data were also illustrated and clarified with graphs, bar charts, and pie charts. Basic data for 2018-19 were

collected in this survey. The sample scheme is based on a comprehensive survey and a random sampling approach. Nadia selected a sample of 200 houses based on the rural-urban population ratio according to 2018 census, of which 120 were rural and 80 were urban. Model design also includes in rural areas:

1. Block selection

2. Choose Town

3. Choose Homes

2.1 BLOCK SELECTION

There are 16 development blocks in Nadia district. The Borda score's final ranking shows the level of development of these blocks for ten socio-economic models. Block growth rate indicators are literacy rate, population density, population SC population percentage in the population, total employee population percentage, intensity of cultivation, number of tractors per 1.000 hectares, population per medical institution. , Population per room, population per bank and population per school. Blocks are defined as blocks formed, half-developed and less developed. On the basis of the results, Chapra, Hanskali and Tehta-1 were found to be semi-developed and relatively underdeveloped by Nadia, Chakda and Nakshipara, Kaliganj and Krishnanagar-I. From each of the built, semi-developed and underdeveloped blocks, namely nadia, kaliganj and chapra, the developed block is randomly selected.

2.2 SELECTION OF TOWNS

Selection of villages will begin next. About 10 towns and 85,380 households are in Nadia area. Kaliganj block has two towns and approximately 28,000 people; it also has 28,684 households. There are two villages to be opted from every block.The villages have been picked because they are located as far as possible away from the Primary Health Centre (PHC). A village that is within the diameter of 2.5 kilometres from the PHC and another village that is beyond this radius. Collectively, the villages and settlements chosen from Nadia are Kalyani and Taherpur; from Kaliganj, Adampur and Basatpur; from Chapra, Alfa and Dukria.

2.3 SELECTION OF HOUSEHOLDS

The list of residents of each selected village has been listed, and finally the list of household has been randomly selected. In this way, 120 households are chosen from the rural areas.

The sampling procedures for a human population in an urban region consist of the following two stages:

1. The issue of the study was to establish a representative sample of towns in Nadia. It was observed that within the city of Nadia four villages have been selected and further data has been gathered from two wards of every town.
2. A random selection of households has been made from all the households of the selected wards, and this list has been compiled to signify every stratum. This way, 80 households from the urban region were selected.

2.3 COLLECTING DATA AND PRIMARY SURVEY MATERIAL

An opinion poll was usedto collect primary data. Because the interviewees were declared that the study was purely academic, they were not concerned about its implications. The questionnaire was segmented into five sections for better results.

1. Household Identity Particulars
2. Particulars of Members of the Household
3. Sources of Expenditure on Income and Consumption
4. Family Members with Mild Illness
5. Members of the Household with Major Illness

3. RESULTS AND DISCUSSION

3.1 CENTRAL GOVERNMENT HEALTH SCHEME (CGHS)

The Government of India (Allocation of Business) Rules, 1961 was depended the obligation of giving medical consideration to the Central Government Servants, to the Department of Health and Family Welfare, Ministry of Health and Family Welfare. At Sr.

No. 14 of the rundown of business apportioned to the Department of Health and Family Welfare, it gives as under: -

"Concession of medical participation and treatment for Central Government Servants other than (i) those in Railway Services (ii) those paid from Defense Service Estimates (iii) officials represented by the All-India Services (Medical Attendance) Rules, 1954 and (iv) officials administered by the Medical Attendance Rules, 1956" CGHS was established vide Ministry of Health's OM dated 1.5.1954. As per Para 6 of the said Office Memorandum, CGHS offices are allowable to all the Central Government workers who are paid their compensation/benefits from the Civil Estimates of the Central Government.

Central Government Health Scheme (CGHS) is a health scheme for serving/resigned Central Government workers and their families. The scheme was begun in 1954 in Delhi. The scheme was expected to be just for serving Central Government representatives who experienced issues in getting repayment by virtue of OPD medicines (today CGHS dispensaries are giving OPD medicines). The way that there were relatively few private medical clinics by then of time was likewise one reason for beginning the scheme. This was not conceived to be an all-India scheme. Truth be told, the stretch of this scheme to 25 urban communities throughout the years has put a heavy strain on restricted assets accessible for the reason.

The Central Government Health Scheme (CGHS), a health care facility scheme provides complete health services to more than 30 lakh beneficiaries in 37 cities. The medical facilities are delivered through more than 1000 empanelled healthcare organizations in different states of India, which include Wellness Centers (previously referred to as CGHS dispensaries/polyclinics under Allopathic, Ayurveda, Yoga, Unani, Sidha and Homeopathic) systems of medicines.

CGHS offers cashless facilities like OPD treatment, medical consultation and dispensing of medicines, specialist consultation at polyclinic/govt. hospitals, family welfare, maternity and child health services. The reimbursement of expenses for treatment availed in any govt. /private hospitals are also allowed under emergency or in view of demand of these beneficiaries where private hospitals/ diagnostic centres /the facilities found in inadequate for beneficiaries with the prior permission of the Ministry/ Department.

Although, the CGHS provides complete healthcare services, there are certain limitations:

- Beneficiary incurs OOP health cost at the time of availing services.
- The Empanelled private healthcare organizations are not satisfied with agreement of CGHS particularly the delay payments and very low packages rates compared to market rates.
- Misappropriation or fraud can take multiple forms and prompt disciplinary action is very important as a deterrent to fraudulent in claim settlement. There is lack of robust management information systems in CGHS.

From the table…..represents that total 1,678 number of Healthcare Organizations (HCOs) have been empanelled in 24 States including Union Territories, out of which around 60% Healthcare providers are empanelled in only three states/UTs namely Maharashtra, Union Territory/National Capital Territory (NCT) of Delhi and Uttar Pradesh respectively.

Table-1. State wise Empanelled Hospitals/Nursing Homes, and Diagnostic Centres under CGHS.

Sl	States/UTs	Empanelled Hospitals/Nursing Homes	Empanelled Diagnostic Centres	Total
1	Andhra Pradesh	35	2	37
2	Assam	5	4	9
3	Bihar	35	3	38
4	Chhattisgarh	6	-	6
5	Gujarat	45	7	52
6	Haryana	9	1	10
7	Union Territory of Jammu and Kashmir	2	-	2
8	Jharkhand	12	1	13
9	Karnataka	37	9	46
10	Madhya Pradesh	70	5	75
11	Maharashtra	225	16	**241**
12	Meghalaya	2	1	3

Sl	States/UTs	Empanelled Hospitals/Nursing Homes	Empanelled Diagnostic Centres	Total
13	Odisha	13	-	13
14	Punjab	60	-	60
15	Rajasthan	8	-	8
16	Rajasthan	62	4	66
17	Tamil Nadu	37	7	44
18	Telangana	83	7	90
19	Union Territory/National Capital Territory (NCT) of Delhi	463	98	**561**
20	Uttar Pradesh	184	17	**201**
21	Uttarakhand	17	7	24
22	West Bengal	21	16	37
23	Union Territory Chandigarh	27	10	37
24	Union Territory Pondicherry	5	-	5
	Grand Total	**1,463**	**215**	**1,678**

Source: Data from Central Government Health Scheme Ministry of Health & Family Welfare Government of India web site compiled by author

From the table total number of Card Holders and Beneficiaries in 32 States/UTsare 13,32,570 and 38,78,685 respectively. Among these 32 State/UTs, three of them i.e Maharashtra, Union Territory/National Capital Territory (NCT) of Delhi and Uttar Pradesh have covered more 62 % of total enrollment whereas the rest of the 29 States have covered only other 48 % of enrollment.

4. SUMMARY AND CONCLUSIONS

In addition to the social appeal of improved health, population health is of paramount importance to the country's economic growth. Improved population health is a relative indicator of a country's stability and prosperity. Improving health status has become one of the major national priorities and foundations for maintaining and stimulating the proper economic performance and growth of the country. There is ample evidence that improving health and health care in developing and developing countries has greatly contributed to economic well-being and development. The people of a country are interested in health services and it is in the national interest to spend money efficiently on health care. The

government should spend less resources on competitive uses so as to ignore priority sectors. Mainstream economists agree that health and family welfare expenditure is the most effective expenditure, on the one hand increases labor productivity by promoting and maintaining health – related health, and on the other hand reduces the pain and misery caused by illness. The steady increase in health spending, along with the equilibrium priority, has led economists and other sociologists to conduct research in health systems from different angles, suggesting that everyone should have reasonable access to systems. It is therefore not surprising that the study of the health care system has become a topic of widespread interest. Therefore, the significance of this study is clear. There are no serious studies in the field of health in West Bengal. Welfare is one of the most essential needs in the world today, so accurate health statistics that help the state develop various health services are important. This study is mainly confined to the state of West Bengal and it is very helpful for politicians.

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