International Journal of Research in Social Sciences
Vol. 10 Issue 05, May 2020
ISSN: 2249-2496 Impact Factor: 7.081
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

"Health Care Sector in Kashmir Division J&K State (India): an overview"

by

Sumeet Pal Singh Bali
Assistant Prof in Gandhi Memorial College

Dr. Syed Javed Iqbal Kamili
HOD Commerce and Management
Gandhi Memorial College, Srinagar, Kashmir (India)

The maintenance and improvement of physical and mental health, especially through the provision of medical services. (Oxford Dictionaries)

INTRODUCTION:

"Health is wealth". Wealth of the any Nation depends upon the health of its citizens. In the light of this most of the developed countries in the world have more focus on health of their citizens and a larger portion of the budget in developed countries is kept for healthcare sector. The provision of medical care varies across countries and the nature of such Provisioning is determined by the socio-economic and political forces in a given society. Although there is great variety in provisioning, broadly there are three major types. First, there are countries where the state plays a central role in the finance, provision and administration of services but at the same time private interests in the form of individual practice, hospitals and other supportive services coexist. Second, there are countries where the state is the sole provider of medical care and no private interests are allowed. Third, there are countries which rely largely on the market for the provisioning of services. In the aftermath of the Second World War the general consensus in Europe as well as in the newly independent states of Africa and Asia was in favour of a planned economic development. In developing countries on the other hand, the degree to which the state has been involved in the provision of health services has varied somewhat, but the support for universal coverage has been high on the popular agenda. This is related to the fact that in some countries of south Asia (Sri Lanka and India) the initial years of independence witnessed health services taking a large share of planned outlays for investment in development.

As compared to National Health Policy 2002, the Govt. contribution to health sector was 0.9 percent of the GDP not sufficient enough as in India, public expenditure on health was 17.3% of the total health expenditure while in China, the same was 24.9% and in Sri Lanka 45.4% and USA 44.1% . This was the main cause of low health standards in the country as compared to these countries. However, with the continuous efforts on the development of health sector, Presently **India's** expenditure on the **health sector** has risen from 1.2 per cent of the **GDP** in 2013-14 to 1.4 per cent in 2017-18 as per some reports. India is set to increase its public health spending to 2.5 per cent of its gross domestic product (GDP) by 2025 as per new government's policy and initiatives that women, children and the youth will continue to remain at the heart of every policy as per the present government's observations and contemplations. It is observed that India's competitive advantage lies in its large pool of well-trained medical professionals. India is also cost competitive compared to its peers in Asia and Western countries. The cost of surgery in India is about one-tenth of that in the US or Western Europe.

Healthcare in India

Over the last five decades several committees have been set up by the Government to review various aspects of health services development in the country. Prominent among these were the National Planning (Sokhey) Subcommittee of the National Planning Committee (1948) and the Health Survey and Development (Bhore) Committee (1946) which provided the blueprint for development of health services in independent India. India's healthcare system rests on a primary healthcare system that is grossly inadequate and falls woefully short of what it should be to ensure that our people have access to at least basic healthcare

Healthcare has become one of India's largest sectors - both in terms of revenue and employment. Healthcare comprises hospitals, medical devices, clinical trials, outsourcing, telemedicine, medical tourism, health insurance and medical equipment. The Indian healthcare sector is growing at a brisk pace due to its strengthening coverage, services and increasing expenditure by public as well private players.

Some latest Major Initiatives on health sector in India

Some of the major initiatives taken by the Government of India to promote Indian healthcare industry are as follows:

- On September 23, 2018, Government of India launched Pradhan Mantri Jan Arogya Yojana (PMJAY), to provide health insurance worth Rs 500,000 (US$ 7,124.54) to over 100 million families every year.
- In 2018, the Government of India has approved Ayushman Bharat-National Health Protection Mission as a centrally Sponsored Scheme contributed by both center and state government at a ratio of 60:40 for all States, 90:10 for hilly North Eastern States and 60:40 for Union Territories with legislature. The center will contribute 100 per cent for Union Territories without legislature.
- The Government of India has launched Mission Indradhanush with the aim of improving coverage of immunization in the country. It aims to achieve at least 90 per cent immunization coverage by December 2014 which will cover unvaccinated and partially vaccinated children in rural and urban areas of India.

According to the Economic Survey 2009-10, only 13 per cent of the rural population has access to a primary healthcare centre with 33 per cent having access to a sub- centre, 9.6 per cent to a hospital and 28.3 per cent to a dispensary or clinic. India has a rudimentary network of public hospitals – there was a shortage of 4,504 primary health centres and 2,135 community health centres in 2009. India also carries the world's largest burden of maternal, newborn and child deaths. At the beginning of this Millennium in year 2000, 189 countries and 23 international health agencies had pledged to reduce child under-5 mortality by two-third (Millennium Development Goals 4) and to reduce maternity mortality by three fourths (Millennium Development Goal 5) by 2015.

Access to healthcare in India

There are 1.4 million doctors in India. Yet, India has failed to reach its Millennium Development Goals related to health. The definition of 'access is the ability to receive services of a certain quality at a specific cost and convenience. The healthcare system of India is lacking in three factors related to access to healthcare: provision, utilization, and attainment. Provision, or the supply of healthcare facilities, can lead to utilization, and finally attainment of good health. However, there currently exists a huge gap between these factors, leading to a collapsed system with insufficient access to healthcare. Differential distributions of services, power, and resources have resulted in inequalities in healthcare access. Access and entry into hospitals depends on gender, socioeconomic status, education, wealth, and location of residence (urban versus rural). Furthermore,

inequalities in financing healthcare and distance from healthcare facilities are barriers to access. Additionally, there is a lack of sufficient infrastructure in areas with high concentrations of poor individuals. Large numbers of tribes and ex-untouchables that live in isolated and dispersed areas often have low numbers of professionals. Finally, health services may have long wait times or consider ailments as not serious enough to treat. Those with the greatest need often do not have access to healthcare. Indian healthcare delivery system is categorized into two major components - public and private. The Government, i.e. public healthcare system comprises limited secondary and tertiary care institutions in key cities and focuses on providing basic healthcare facilities in the form of primary healthcare centre (PHCs) in rural areas. The private sector provides majority of secondary, tertiary and quaternary care institutions with a major concentration in metros, tier I and tier II cities.

Public healthcare

India's constitution guarantees free healthcare for all its citizens, but in practice the private healthcare sector is responsible for the majority of **healthcare in India**, and most healthcare expenses are paid out of pocket by patients and their families, rather than through insurance. All government hospitals are to provide healthcare free of cost. Public healthcare is free for those, who are below the poverty line. The public health sector encompasses 18% of total outpatient care and 44% of total inpatient care. Middle and upper class individuals tend to use public healthcare less than those with a lower standard of living. Additionally, females and elderly use public services more. The public health care system was originally developed in order to provide a means to healthcare access regardless of socioeconomic status. However, reliance on public and private healthcare sectors varies significantly between states. Several reasons are cited for relying on the private rather than public sector; the main reason at the national level is poor quality of care in the public sector, with more than 57% of households pointing to this as the reason for a preference for private health care. Most of the public healthcare caters to the rural areas; and the poor quality arises from the reluctance of experienced healthcare providers to visit the rural areas. Consequently, the majority of the public healthcare system catering to the rural and remote areas relies on inexperienced and unmotivated interns who are mandated to spend time in public healthcare clinics as part of their curricular requirement.

Other major reasons are distance of the public sector facility, long wait times, and inconvenient hours of operation.

Different factors related to public healthcare are divided between the state and national government systems in terms of making decisions, as the national government addresses broadly applicable healthcare issues such as overall family welfare and prevention of major diseases, while the state governments handle aspects such as local hospitals, public health, promotion and sanitation, which differ from state to state based on the particular communities involved. Interaction between the state and national governments does occur for healthcare issues that require larger scale resources or present a concern to the country as a whole.

To take the health care system standards at the global level government recently unveiled plans for a nationwide universal health care system known as the National Health Assurance Mission, which would provide all citizens with free drugs, diagnostic treatments, and insurance for serious ailments..

Considering the goal of obtaining universal health care, scholars request policy makers to acknowledge the form of healthcare the many are using. Scholars state that the government has a responsibility to provide health services that are affordable, adequate, new and acceptable for its citizens. Public healthcare is very necessary, especially when considering the costs incurred with private services. Many citizens rely on subsidized healthcare. The national budget, scholars argue, must allocate money to the public health sector to ensure the poor are not left with the stress of meeting private sector payments.

Private healthcare

After 2005, most of the healthcare capacity added has been in the private sector, or in partnership with the private sector. The private sector consists of 58% of the hospitals in the country, 29% of beds in hospitals, and 81% of doctors.

According to National Family Health Survey-3, the private medical sector remains the primary source of health care for 70% of households in urban areas and 63% of households in rural areas. The study conducted by IMS Institute for Healthcare Informatics in 2013, across 12 states in over 14,000 households indicated a steady increase in the usage of private healthcare facilities over the last 25 years for both Out Patient and In Patient

services, across rural and urban areas. In terms of healthcare quality in the private sector, a 2012 study by Sanjay Basu et al., published in *PLOS Medicine*, indicated that health care providers in the private sector were more likely to spend a longer duration with their patients and conduct physical exams as a part of the visit compared to those working in public healthcare.

However, the high out of pocket cost from the private healthcare sector has led many households to incur Catastrophic Health Expenditure (CHE), which can be defined as health expenditure that threatens a household's capacity to maintain a basic standard of living. Costs of the private sector are only increasing. One study found that over 35% of poor Indian households incur CHE and this reflects the detrimental state in which Indian health care system is at the moment. With government expenditure on health as a percentage of GDP falling over the years and the rise of private health care sector, the poor are left with fewer options than before to access health care services. Private insurance is available in India, as are various through government-sponsored health insurance schemes. According to the World Bank, about 25% of India's population had some form of health insurance in 2010. A 2014 Indian government study found this to be an over-estimate, and claimed that only about 17% of India's population was insured. Private healthcare providers in India typically offer high quality treatment at unreasonable costs as there is no regulatory authority or statutory neutral body to check for medical malpractices. In Rajasthan, 40% of practitioners did not have a medical degree and 20% have not completed a secondary education. On 27 May 2012, the popular actor Aamir Khans program Satyamev Jayate did an episode on "Does Healthcare Need Healing?" which highlighted the high costs and other malpractices adopted by private clinics and hospitals.

Objectives of this study

1. To study the health sector in India in the light of the recent developments in the contemporary world

2. To study and compare the private and public health in India

3. To make analysis of health sector in Kashmir Division in J&K State, India

4. To make suggestion on the bases of the study.

Research methodology:

Collection of data: The study was based on , various **secondary sources** which included studies conducted and published in various academic and research journals and reports, besides relevant information available in the magazines , news papers, Government websites ,international agencies (the likes of world health organisation, world bank etc) and other published and unpublished data

Health Sector in Kashmir Division of J&K State India: An overview

SNo.	Name of Institution	Anar	Budg	Band	Baran	Karg	Gan	Kulga	Kupwa	Leh	Pulwar	Shopi	Srg	Total Centre
1	**Provincial Hospital**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2	**District Hospital**	**1**	**1**	**0**	**1**	**1**	**0**	**1**	**2**	**1**	**1**	**0**	**1**	**10**
3	**General Hospital**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
4	**Sub District Hospita**	**6**	**9**	**3**	**6**	**4**	**4**	**2**	**6**	**0**	**3**	**2**	**1**	**46**
5	**Emergency Hospita**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
6	**Primary Health Cer**	**27**	**36**	**6**	**28**	**2**	**29**	**19**	**31**	**14**	**21**	**6**	**9**	**228**
7	**Allopathic Dispensa**	**14**	**9**	**6**	**21**	**14**	**4**	**9**	**8**	**3**	**17**	**4**	**16**	**125**
8	**Urban Centre/Evening Cli**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
9	**District TB Centre**	**1**	**0**	**0**	**1**	**1**	**0**	**0**	**1**	**1**	**1**	**0**	**1**	**7**
10	**Medical Aid Centre**	**11**	**3**	**5**	**13**	**100**	**4**	**5**	**41**	**86**	**6**	**5**	**1**	**280**
11	**Mobile Medical Aid**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
12	**Sub Centres**	**123**	**121**	**39**	**126**	**33**	**84**	**70**	**154**	**24**	**80**	**44**	**41**	**939**
13	**MCH**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
14	**Maternity Hospital**	**0**	**0**	**0**	**0**	**0**	**6**	**0**	**0**	**0**	**0**	**0**	**3**	**9**
15	**Leprosy Hospital**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**
		184	179	59	**196**	155	131	106	**243**	129	129	61	74	1646

Source: DRDA

Finding and Analysis:

The table above reveals that out 1646 various types of health care facilities in Kashmir Division of J&K State, Kupwara has the highest number of hospitals viz 243 followed by, 196 in Bandipora ,184 in Anathnag, 155 in Kargil, 129 in Leh while as Bandipora has the lowest number of hospitals viz 59 followed by 61 in shopian and 74 in District Srinagar

The table shows that the Kashmir has total of **228 PHC**, out of which 36 are in budgam that is maximum 02 in Kargil that is minimum , 31 in kupwara , 27 in Anantnag, 21 in Pulwama and rest are shared by other districts. Table above reveals that District **hospital** Kupwara has **2 District Hospitals** whereas all the rest has 1 District hospital each except Bandipora, ganderbal, shopian which have no **district hospital** out of total of 10 District Hospitals in Kashmir Division of J&K State. The table above depicts Out 0f 46 **SDH** Budgam has the highest number of **SDH** i.e 09 whereas Srinagar has 0nly 01 **SDH** and Lrh has no Table above exhibits that SDH in Kashmir has total of 125 Allopathic Dispensaries, out of which 21 are in Baramulla, 17 in Pulwama, 16 in Srinagar, 14 in Kargil , 03 in Leh and rest in other districts. Table reveals that there are total 07 **TB centres** in Kashmir Division out of which 01 **TB Centre** each is present in Anantnag, Baramulla, kargil, Kupwara, Leh, Pulwama, Srinagar and it's absent in other districts. Table shows that Out of total of **280 Medical Aid** centres Kargil has maximum number of MAC i.e. 100 whereas Srinagar has 01 MAC only it is reveals in this table that **Kashmir division** has total of **939 sub centres** out of which **Kupwara** has a maximum **of 154 sub centres** and district Leh has only 24 that is minimum. Table reveals that Out of Total of only **09 maternity hospitals** District Ganderbal has 06 and district Srinagar has 03 maternity hospitals. Rest there is absence of Maternity hospitals in every remaining district where in all the maternity related activities are carried out in respective District Hospitals. It shows in the table that Kashmir division has only **01 Leprosy Hospital** that is present **in Srinagar District** only.

Conclusion: The health sector in India as compared to developed countries is still lagging behind including the State of Jammu and Kashmir and in Kashmir Division in some districts Hospitals are not equally poised in respect to Medical facilities which puts a huge burden on City hospitals .

References:

1. "National Health Policy 2002, Ministry of Health and Family Welfare, 2002.

2. “National Health Policy 2017, Ministry of Health and Family Welfare, 2017

3. Thayyil, Jayakrishnan; Jeeja, MathummalCherumanalil (2013). "Issues of creating a new cadre of doctors for rural India". International Journal of Medicine and Public Health. 3 (1), Jan-Mar, 2013, ISSN-2230-8598

4. International Institute for Population Sciences and Macro International (September 2007). "National Family Health Survey (NFHS-3), 2005 –06". Ministry of Health and Family Welfare, Government of India. pp. 436–440.

5. Ramya Kannan (30 July 2013). "More people opting for private healthcare". Chennai, India: The Hindu.

6. Basu, Sanjay; Andrews Jason; Kishore Sandeep; Panjabi Rajesh etc (19 June 2012). "Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review" ISSN 1549-1676

7. *Worldbank.org*, "Government-Sponsored Health Insurance in India: Are You Covered?" 11 October 2012

8. Balarajan, Y; Selvaraj, S; Subramanian, SV (5 February 2011). "Health care and equity in India". *The Lancet*. 377 (9764): 505–515.

9. JK.health.org