CHAPTER:1:
AN OVERVIEW OF THE HEALTHCARE SYSTEM IN INDIA

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EXECUTIVE SUMMARY:

In this chapter, the researcher attempts to review the current status of healthcare system in India, Government spending in healthcare, Government schemes and programmes for rural healthcare.

National Health Policy 1983 and National Health Policy 2017 has been assessed, which gives the detailed perspective of the various Government initiatives like Ayushman Bharat, Mission Indradhanush, National Health Mission and Pradhan Mantri Jan Arogya Yojna. The researcher also reviews the way forward for strong framework which is most essential for development of medical services in rural areas. The researcher also reviews the current status of the Primary Healthcare Centers and Community Health Centers and Sub Centers in India. A brief review has been done about the health infrastructure, healthcare funding in the different healthcare programmes, programme wise funding for sustainable development of healthy India. The focus also has been given to the Ayushman Bharat Programme as it has been the game changer for the healthcare sector. The researcher also focus on the importance of health insurance in rural areas as there is not much awareness among the rural people. The brief study has been also done by the researcher for implementation strategy of various programmes of healthcare in rural area.

1.0 Introduction:

Since India's independence, the country's government has prioritised healthcare reforms, drafting and enacting several plans and initiatives in this area. However, health problems persist with rising prosperity. However, the "Millennium Development Goals" and "Universal Health Care" frameworks have not been successful in translating WHO's "Health for All" motto into actual healthcare activities. As a result, the lack of adequate medical services is a severe issue for rural regions.

In India, rural health care is primarily centred on rural Primary Healthcare Centres (PHC), which aim to improve everyone's health. It also seeks to deliver preventative, curative, and rehabilitative health care services as part of its holistic approach. Many Indian health policies and programmes aim to achieve a high standard of healthcare for India (http://shodhganga.inflibnet.ac.in). As a result, the healthcare market might triple by 2022, reaching Rs. 8.6 trillion. The Indian healthcare industry is anticipated to triple in size between the years 2016 and the year 2022, increasing at a CAGR of 22 per cent to reach US$ 372 billion in 2022, up from US$ 110 billion in 2016. Rising money, increased health awareness, lifestyle illnesses, and more insurance access will fuel growth.

India's government wants to make it a worldwide healthcare powerhouse. By 2022, the Indian Government hopes to have increased healthcare spending to 3% of the GDP. By 2030, India would need an additional 2.07 million physicians to reach a doctor-to-population ratio of 1:1000. A vast pool of well-trained medical personnel is available nationwide. From 827,006 in 2010, the number of doctors with recognized medical credentials grew to 1,255,786 in September 2020.

By 2022, the Indian Ayurvedic sector is estimated to be worth $9 billion. The Ministry of AYUSH was given Rs. 2,970 crores in the Budget for 2021, up from Rs. 2,122 crores (US$ 291.39 million) in the former budget. In January 2021, the government placed an order with the Serum Institute of India (SII) for 11 million doses of the Oxford COVID-19 vaccine, Covishield. India intends to start its COVID-19 immunization campaign, the world's largest inoculation campaign, on January 16, 2020, focusing on almost three crore healthcare personnel and frontline workers. (https://www.ibef.org/download/Healthcare-February-2021.pdf.).

It is essential to comprehend how India's healthcare delivery system, particularly in rural India, looks after the health of rural Indians, as well as what initiatives the Indian health sector initiated to accomplish the objective of "Health for All" in India's rural areas.

1.0.1 Trends in India's Health Sector:

The Shift from Communicable to Lifestyle Diseases:

With the rising expansion and modern-day urban living, nearly half of all in-patient beds are used to treat lifestyle illnesses, resulting in a higher demand for specialist treatment. As a result, lifestyle illnesses have replaced traditional health issues in India. High cholesterol, high blood pressure, adiposity, poor nutrition, and alcohol usage, among other factors, cause most illnesses caused by lifestyle.

The Emergence of Telemedicine:

Telemedicine is a rapidly growing industry in India. Major hospitals have embraced telemedicine services (Apollo, AIIMS, Narayana Hrudayalaya), and numerous PPPs have been formed. Since its introduction on December 14, 2010, the Health Ministry's

e-Sanjeevani telemedicine programme has facilitated over one million (10 lacks) teleconsultations, allowing patients to consult with doctors from the comfort of their own homes and doctors to consult with patients (https://www.ibef.org/download/Healthcare-February-2021.pdf.).

Increasing Penetration of Health Insurance:

In FY 2016, health insurance gross direct premium income accounted for 25.4 per cent of total non-life insurance gross immediate premium income. Healthcare insurance premiums reached USD2.8 billion in 2016, growing at a CAGR of 15.36 per cent from FY 2008 to 2016. In FY2020, the health insurance business saw an increase in insurance coverage, according to the Economic Survey 2020-21. In Bihar, Assam, and Sikkim, the number of families having health insurance grew by 89 per cent in FY20 compared to FY16.

Mobile-based Health Delivery:

Tel-Humsafar is a text-messaging-based application for women that helps them better plan their children's health. There are now around 20 mobile healthcare programmes in the country that raise awareness about family planning and other illnesses. The market for healthcare applications is expected to reach $84,817 million in value by the year 2020.

Technological Initiatives:

In India, technology will be a game-changer in the medical sector. However, private players will be the primary driver of technology adoption. Easy accessibility, regardless of geographic location, fewer mistakes, the quick reaction in an emergency, and patient convenience are just a few illustrations of advantages available with technology in healthcare service delivery (https://www.wipro.com).

Healthcare providers are concentrating on the technical component of healthcare delivery to standardize service delivery quality, reduce costs, and improve patient involvement. For example, many medical institutes tried to make their financial transactions paperless by partnering with a mobile wallet firm, MobiKwik (Report IBEF, 2017).

Luxury Offering:

In the healthcare industry, a new emerging trend is related to premium offerings. Over and above meeting basic needs, healthcare professionals are now providing opulent services. For example, private helicopters can pick up and drop off patients, and luxury accommodations can be made for visitors to a patient in the hospital (Report IBEF, 2017).

1.0.1.1 The Public Health System in India: An Introduction and Evolution:

Health is an individual's physical and mental skills that grow in a way that allows them to enjoy life. Thus, the nation's socioeconomic development and the simultaneous and integrated growth of the person and community depend on good health. Wellness, as defined by the World Health Organization, is "a condition of full physical, mental, and social well-being, as opposed to the absence of disease or incapacity." Public health refers to the practise and study of improving the general health of a population, reducing the prevalence of illness, and extending people's lifespans via the coordinated efforts of all members of that population. Access to high-quality healthcare is a way public health improves people's health and quality of life. According to Article 47 of the Indian Constitution's Directive Principles of State Policy, one of the state's primary responsibilities is to improve its citizens' nutrition and standard of living, as well as public health (World Health Organization, Geneva, 1998).

1.0.2 Evolution of Public Health System in India:

The health Government of India have taken various steps to enhance healthcare in their jurisdictions. Over the past years, Government health has experienced many changes and developed many committees for healthcare development.

1.0.3 Expert Committee’s Reports on Healthcare:

A brief discussion about the contribution of some central committees in India related to healthcare is as follows.

Bhore Committee:

The committee stressed the need for public engagement in medical practice to improve environmental health. Plans for rural Primary Health Centers to serve populations of 10,000-20,000 people and to form local health committees to recruit active participation and help implement health initiatives.

Mudaliar Committee:

1959, a committee was formed to enhance district hospitals and strengthen PHC. As a result, an extension of the UGC's responsibilities in medical education, National malaria, smallpox, cholera, leprosy, TB, and filariasis eradication programmes were established. However, except for the needy, those who use hospital services must pay a modest charge.

Chadha Committee:

The committee suggested that all health programmes enhance rural health services, increase medical institution vigilance, and promote multifunctional domiciliary health services.

Mukherjee Committee:

The committee suggested separating family planning from the malaria eradication effort so that it might get undivided attention and upgrading the administrative structure from primary health care to the state level.

Jain Committee:

The committee looked at how different hospitals in the country operate to enhance medical care standards. The main recommendations were to improve the capability and coverage of PHC to offer maternity services and to provide expert medical care at district hospitals.

Kartar Singh Committee:

The committee suggests that every 10,000 to 20,000 persons have access to one Female Health Worker (FHW)/Auxiliary Nurse Midwife (ANM). Therefore, per guidelines, each PHC should care for 50,000 individuals in its catchment area.

Shrivastava Committee:

The committee's main recommendations are to organize general health facilities within the community. The committee also suggested allocating resources toward reorganising medical and health education following national healthcare objectives.

Analysis of Committee Reports:

An analysis of recommendations from a variety of expert groups reflects the evolution and improvement of India's public health care system. The Bhore committee's core structure for the primary health care unit remains the focal point of public health services. The Mudaliar committee's program-based strategy has been implemented to manage major communicable illnesses impacting the population. Following the Mukherjee committee's proposal, family planning is promoted as a distinct activity. The recommendations made by the Kartar Singh Committee centred on hiring female health workers and training professionals with multiple skill sets.

In the early years of independence, the construction of the public health care system was thus founded on the recommendations of these committees, which were constituted regularly.

1.1 A Brief Review of National Health Policy,1983:

The provision of minimal health care services was the driving force for this approach. This plan has addressed population growth and health issues, including primary care, health education, the role of indigenous and other health systems, health insurance, and medical and legal research. Infant mortality, maternal mortality, life expectancy at birth, crude and mortality, adequate marital protection, net protection, family size, pregnant women in prenatal care, and education are all important metrics to track. An obstetrician's use during labour and delivery and the presence or absence of immunity are also included.

1.1.1 Initiatives were undertaken in the National Health Policy, 1983:

- Plan for establishing a structured network of PHC services.
- Placement by “health volunteers” with the necessary expertise and skills.
- A unified system of widely dispersed experts is available to assist with any issue. Incentivize private investment in patients who pay, and restrict free riders' use of public services.

Table No. 1.1 National Health Policy (1983): Health Outcomes in India:

Indicator	1951	1981	2000	2019
Life Expectancy	36.7 Years	54 Years	64.6 Years	68.7 Years
Crude Birth Rate	40.8 per 1000	33.9 per 1000	26.2 per 1000	17.81per 1000
Crude Death Rate	25 per 1000	12.5 per 1000	8.7 per 1000	7.27per 1000
IMR	146 per 1000 Birth	110per 1000 Birth	70per 1000 Birth	28.3per 1000 Birth

Source: Vital Statistics, Sample Registration System

From Table No. 1.1 above, the fertility rate dropped from 40.08 in 1951 to 17.81 in 2019. The declining birthrate shows that people are becoming aware of family planning. In addition, the mortality rate decreased from 25 in 1951 to 7.27 in 2019. Lower mortality offers India's best medical facility. Similarly, the IMR dropped from 146 in 1951 to 28 in 2019.

The life expectancy rate is increasing from the year 1951 to the year 2019. Therefore, the above table indicates that National Health Policy will be a game-changing policy for the health sector.

Smallpox and guinea worm infections were eradicated, polio vaccine coverage was significantly increased, and Kala Azar, Leprosy, and Filariasis were drastically reduced due to these public health measures. However, the morbidity and death rates remained high compared to many other developing nations. In addition, malaria has resurfaced; new infectious illnesses such as HIV/AIDS have arisen as significant dangers; and many other life-threatening diseases.

1.2 Review of National Health Policy, 2017:

This programme targets the pinnacle of health care provision by combining preventive health into various development plans and guaranteeing universal access to excellent medical services free from financial barriers. This is accomplished through expanding availability, enhancing care, and decreasing healthcare expenditures.

1.2.1 Primary Care Services and Continuity of Care:

National Health Policy 2017 marks a significant shift from a highly selective to a comprehensive primary healthcare package that includes senior and mental care services. According to the policy, health facilities should be built based on geographical rather than demographic standards. A matched human resources development plan, an effective logistical support system, and referral backup are all recommended in the policy to offer complete treatment. Upgrading existing sub-centres and reorienting rural PHCs to deliver a full range of preventative, promotive, curative, and rehabilitative services would also be required. It would include providing guaranteed AYUSH healthcare, documentation, and certification of local home and community-based practices. The strategy also promotes the study and validation of traditional tribal remedies. Using digital health`s potential for two-way systemic links across primary, secondary, and tertiary care would ensure continuity of treatment. This policy addresses the proper implementation of grassroots public health systems with appropriate measures and follow-up mechanisms.

1.2.2 Secondary Care Services:

This policy aims to bring secondary care to the county level, which is currently only available in university medical hospitals. The policy pursues the following goals:

a) We will distribute at least two beds per 1,000 residents for immediate contact. This requires a well-functioning emergency transportation infrastructure. This policy also requires the district to have ten categories of talents currently considered unique talents. In addition, at least four professional qualification categories must be accessible at the sub-district level. Strengthening selected groups of district hospitals and hospitals in the right places can contribute to this.
b) Responsive resource allocation is based on the amount, diversity, and quality of caseloads given.
c) After doing due diligence, purchasing treatment from private hospitals is a short-term option until public healthcare systems are improved.

The policy offers a solid structure to oversee the non-government sector purchase of care, ensuring that issues such as care quality, cost escalation, and equitable barriers are appropriately handled. Comprehensive facility development and duties for human resources, particularly specialized demands, must be emphasized to expand the secondary care industry. The policy proposes a programme to enhance human resources and the availability of technical skills.

In district healthcare services safety of blood has been a critical problem. This policy recognizes the need to extend the country's blood bank network to enhance access to the blood bank.

1.2.3 Re-Orienting Public Hospitals:

Public hospitals must be considered part of a single tax-paid medical system with prepaid, low-cost services. This view suggests that quality of care is essential and that public hospitals and institutions are subject to regular quality assessments and accreditations. This strategy proposes that public hospitals provide universal access to more and more free medicines and diagnostics, with sufficient flexibility for states to adapt their programs to their needs.

The policy aims to eliminate the dangers of incorrect treatment by maintaining proper diagnosis and treatment criteria. The strategy recognizes the need for a comprehensive data system with statistics on service availability and utilization in public and private institutions.

1.2.4 Infrastructure and Human Resources/Skill Gaps:

Infrastructure construction and deployment of extra-human resources would be prioritized in districts and blocks with more significant gaps. Outpatient and inpatient attendance and measured use of essential services would be used to fund extra infrastructure or human resources.

1.2.5 Urban Health Care:

National health policies prioritize meeting the city dwellers, especially slams, homeless, shabby pickers, street children, and rickshaws. Pullers, construction workers, sex workers, seasonal immigrants, and other vulnerable populations will also be prioritised. In addition, the city's government provides health care because of the concentration of businesses there. These qualities are also crucial in modern "smart cities." In addition to serving the healthcare requirements of urban dwellers, the National Urban Health Mission (NUHM) will also help those in semi-urban areas. Additionally, the National Urban Health Mission will provide for the early detection and treatment of NCDs, including hypertension and diabetes, which are more prevalent in urban settings (NUHM). A vital component of the programme would be improved secondary prevention. Improved health-seeking behaviour is also a significant component of this strategy, which is influenced by community-based organization capacity building and the creation of an appropriate referral channel. (http://www.thehinducentre.com/multimedia/archive/03145/National_Health_Po_145484a.pdf).

1.2.6 Major Goals of National Health Policy 2017:

NHP 2017 also establishes quantifiable targets in three key areas to measure progress toward policy goals:

1. Raise the average life expectancy at birth from 67.5 to 70 by 2025.
2. TFR reduction to 2.1 at the regional and national levels by 2025.
3. Reduce the under-five mortality rate to 23 by 2025 and the maternal mortality rate to 100 by 2020, both from current levels.
4. By 2019, the newborn mortality rate will be reduced to 28.
5. By 2025, reduce neo-natal death to 16 per cent.
6. By 2025, TB must be eradicated from the world by achieving and maintaining a cure rate of >85% in new sputum-positive patients while reducing the number of new cases.
7. Strive to cut premature deaths by 25% in 2025 from cardiovascular disease, cancer, diabetes, and chronic lung disease.
8. More than ninety per cent of infants will have finished their vaccination series by the time they turn one in 2025.
9. By 2025, the prevalence of stunting in children under the age of five will have decreased by 40 per cent.
10. Ensure the availability of paramedics and physicians in high-priority areas by the Indian Public Health Standard (IPHS) by the year 2020.
11. By 2025, in high-priority areas, increase the ratio of community health volunteers to the population to the IPHS standard.
12. By 2025, establish elementary and secondary care facilities in high-priority regions (based on population and time to meet standards).

(http://employmentnews.gov.in/NewEmp/MoreContentNew.aspx?n=Editorial&k=109).

1.3 Review of the Current Status of the Healthcare Industry in India:

Government and non-government organisations (NGOs) are investing more money and providing more services in the healthcare sector. Analysts project that from 2008 to 2022, the market will expand at a CAGR of 16.28 per cent. By 2022, the overall industry size is anticipated to reach $372 Billion. In India's healthcare business, the private sector has developed as a thriving force, bringing it national and international acclaim. Significant private sector investments are expected to considerably impact the development of India's hospital business, which accounts for around 80 per cent of the entire market. Private healthcare in India accounts for almost 74 per cent of the country's overall healthcare spending. Hospitals and beds are expected to have 74 per cent and 40 per cent of private sector participation, respectively. Proper well-educated, English-speaking medical teams in private-sector hospitals are the two most important factors leading to the rise in medical tourism in India.

1.3.1 Health Care Affordability:

Improvements in affordability and availability of medical treatment have led to increased use of these services in India. According to the most recent National Health Accounts, out-of-pocket spending has dropped from 64.2% of all medical spending in 2013–2014 to 58.7% in 2016–2017. National Health Estimates from 2016 show that 52.1% of India's public health expenditure goes toward primary health care. The National Health Policy for 2017 states that most healthcare dollars should go toward primary care. The world's most significant health insurance programme, Ayushman Bharat, is a giant leap toward making quality healthcare accessible to the poor. The scheme was implemented based on the Socio-Economic Caste Census' deprivation and occupational requirements for rural and urban regions. States have been allocated considerable funding to provide free medications under the Free Drugs Service project. All states and territories have made it a policy to give free critical medicines to health institutions. IT-based Drug Delivery Management Systems have simplified drug procurement, quality control, and distribution in 29 states. States have been allocated considerable funding to provide free medications under the Free Drugs Service project. All states and territories have made it a policy to give free critical medicines to health institutions. In addition, IT-based Drug Delivery Management Systems have simplified drug procurement, quality control, and distribution in 29 states.

1.3.2 Medical Infrastructure:

In India, the doctor-to-populace ratio is 1:1456, compared to the WHO norm of 1:1000. The authorities have undertaken a bold initiative to show district hospitals into scientific colleges to cope with the doctor shortage. In addition, the federal authorities and the states collectively fund a Centrally-sponsored scheme for constructing the latest scientific colleges connected to current district/referral hospitals.

NEET-UG, a standardised entrance exam required for admission to all MBBS programmes in India (including those at AIIMS and JIPMER), is another example of an established order that has led to changes.

The government's persistent efforts in the healthcare sector have led to significant improvements in healthcare infrastructure development and human resource accessibility.

For the most part, the Indian federal government supports individual states' efforts to improve their health care systems under the National Health Mission (NHM). This has led to significant gains in the health infrastructure of public health institutions across the nation.

Table No. 1.2 Current Status of Healthcare Facilities in India:

SC/PHC/CHC	182709 (as of 31.3.2014)	189784 (as of 31.3.2018)
Government Hospital (Rural & Urban areas, including CHC)	20306	25778
AYUSH Clinic & Dispensaries	29733(as on 1.4.2014)	31986(as on 1.4.2018)
Medical Institutions	398(2014-15)	539(2019-20)
Nursing Employees	2621981 (as on 31.12.14)	2966375 (as on 31.12.17)
Chemists	664176 (as of 27.6.2014)	1125222 (as of 27.3.2019)
Doctors (Modern System)	747109(up to 2014)	923749 (up to 31.12.18)
AYUSH Doctors	736538 (as on 1.1.14)	799879 (as on 1.1.18)

Source: National Health Profile 2015 and 2019

Notes 1: SC: Sub Centre, PHC; Primary Health Centre; CHC; Community Health Centre; AYUSH; Ayurveda; Yoga; Unani; Siddha and Homeopathy

2: *Assuming 80 percent of registered doctors are available

In the above-given Table No. 1.2, there are 1,89,784 Health Centres (SC/PHC/CHC) as of March 2018. There are 25,778 Hospitals available in India. There were also 31,986 AYUSH Hospitals, 539 Medical Colleges, and 7,99,879 AYUSH Doctors available in India in 2018. The government also has 10,767 general medical officers, 3,062 professionals, 61,660 registered nurses, 84,077 assistant nurse midwives (ANMs), 42,031 emergency care workers, and 414 public health managers.

Institutions selected by states with limited resources teach MBBS students about emergency obstetric care, basic anaesthesia, and laparoscopic surgery.

In rural and urban areas, the National Health Mission (NHM) employs 10,42 lakh Accredited Social Health Workers (ASHAs) to liaise between local residents and the public health system. As a result, healthcare spending increased per capita due to growing wages, improved access to high-quality healthcare, and increased awareness of personal health and cleanliness.

More than only meeting basic needs, healthcare professionals now provide opulent services. For example, private helicopters can pick up and drop off patients, and luxury accommodations can be made for visitors to a patient in the hospital(https://www.ibef.org/download/Healthcare).

1.4 Economic Survey 2019-2020 (Current Status of Heath Sector in India):

The government currently focuses on four central pillars to address the epidemiological change from infectious to non-communicable—mission-mode initiatives to improve mother and child health, including preventing and treating infectious and no communicable illnesses. Due to the enormous growth in the burden of non-communicable diseases (NCDs), the government is presently concentrating on combating the epidemiological shift from infectious diseases to non-infectious conditions. To combat the rising prevalence of chronic illnesses, including hypertension, diabetes, and heart disease, primary care facilities must implement universal, high-quality screening, preventive, and management programmes.

All 28,005 medical facilities have been up (January 14, 2020). Typical Malignant Neoplasm - We still serve adults and teenagers despite the prevalence of oral cancer, breast cancer, and cervical cancer.

Table No. 1.3 Current Status of India's Health Indicators:

Sr. No.	Parameter	1991	2001	2011	Current level
1.	Crude Birth Rate (per 1000 population)	29.5	25.4	21.8	17.163 (2022)
2.	Crude Death Rate (per 1000 population)	9.8	8.4	7.1	9.1 (2022)
3.	Total Fertility Rate	3.6	3.1	2.4	2.159 (2022)
4.	Maternal Mortality Ratio (per 1,00,000 live births)	NA	301 (2001-03)	167 (2011-13)	97 (2022)
5.	Infant Mortality Rate (per 1000 live births) Rural Urban	80 87 53	66 72 42	44 48 29	31 (2022) 46 32
6.	Child (0-4 years) Mortality Rate (per 1000 children)	26.5	19.3	12.2	32 (2020)
7.	Life Expectancy at Birth Total Rural Urban	(1991-95) 60.3 58.9 65.9	(2001-05) 64.3 63.0 68.6	(2009-13) 67.5 66.3 71.2	(2022) 70.19 68.7 73.4

Source: Sample Registration Survey (SRS) and Register General of India (RGI) retrieved from https://censusindia.gov.in/census.website,/node/294

Table 01.3, presented above, shows the continuous improvement of various health indicators from 1991 to 2022. For example, the fertility rate dropped from 29.50 in 1991 to 17.16 in 2022.

The mortality rate dropped from 9.8 in 1991 to 9.1 in 2022. Similarly, the IMR dropped from 80 in 1991 to 31 in 2022. Life expectancy is increasing year by year.

The above table indicates that doctors are responsibly performing their duties. The child Mortality Rate is also reducing daily, showing that Government is giving more importance to Child Healthcare. The Indradhanush Mission vaccinated 3.39 million children and 87.18 million pregnant women throughout 680 districts (including Gram Swaraj Abhiyan [GSA] and extended GSA). Some of the most recent vaccinations are Measles-Rubella (MR), Pneumococcal Conjugate Vaccine (PCV), Rotavirus Vaccine (RVV), and Inactivated Polio Vaccine (IPV) (IPV). As of December 31, 2019, the MR vaccine has been given to 32.42 million children. Since its inception, a PCV of Rs 2.1896,000 has been administered (as of November 2019). In addition, the Department of Health and Family Welfare banned all activity in e-cigarettes, recognizing the dangers of nicotine addiction among teens and children, which may be spread through gateway products like e-cigarettes.

1.4.1 Progress in Health Infrastructure in Recent Time:

Following table no.1.4 Shows the year-wise progress in the health infrastructure, likewise Sub-centres (SCs), Primary Health Centers (PHCs), Community Health Centers (CHCs), Doctors at PHCs, Total Specialists at CHCs and Paramedical Staff. Since 2014, medical education reform has boosted doctor and staff recruitment. As of June 2022, 13,08,009 allopathic physicians are registered with State Medical Councils and NMC, according to NMC. The country's doctor-population ratio is 1:834, compared to WHO's 1:1000.

Table No.1.4 Year-Wise Progress in Health Infrastructure (as of March each Year):

(Numbers in Thousands)

Indicators	Years				
	2014	2019	2020	2021	2022
Sub-centres (SCs)	152.3	157.4	155.4	156.1	157.9
Primary Health Centres (PHCs)	25.0	24.9	24.9	25.1	24.9
Community Health Centres (CHCs)	5.4	5.3	5.2	5.5	5.5
Doctors at PHCs	27.4	29.8	28.5	31.7	30.6
Total Specialists at CHCs	4.1	3.9	5.0	4.4	4.5
Auxiliary Nurse Midwife at SCs & PHCs	213.4	234.2	212.6	214.8	207.6
Nursing Staff at PHCs & CHCs	63.9	81.0	71.8	79.0	79.9
Pharmacists at PHCs & CHCs	22.7	26.2	25.8	28.5	27.1
Lab Technicians at PHCs & CHCs	16.7	18.7	19.9	22.7	22.8

Source: Rural Health Statistics 2021-22, MoHWF

1.4.2 Overview of Finance (Health Expenditure) in the Healthcare Sector 2019-20:

Public health expenditure in India (total federal and state expenses) has remained between 1.2 and 1.6 per cent of GDP between 2008-2009 and 2019-2020. In comparison to other countries such as China (3.2 per cent), the United States (8.5 per cent), and Germany (9.5 per cent), this expenditure is comparatively low (9.4 per cent).

As a result, the Ministry was given a budget of Rs 67,112 crore for 2020-2021. This is a 3.9 per cent increase above the current predictions for 2019-2020. (Rs 64,609 crore).

Table No. 1.5 Budget Allocation for Ministry of Health and Family Welfare (in Rs Crore):

Item	Budget Estimates 2018-19	Revised Estimates 2019-20	Budget Estimates 2020-21	% Change (Revised Estimate to Budget Estimate)
Health & Family Welfare	52954	62659	65012	3.8%
Health Research	1728	1950	2100	7.7%
Total	**54682**	**64609**	**67112**	**3.9%**

Sources: Department of Health and Family Welfare, Budget 2020-21, PRS.

From the data shown above in Table 1.5, we can determine that the 2018-2019 budget projection for Section 1.4, Department of Health and Family Welfare, is Rs 52,954 crore. In contrast, the Health Research Department puts the figure at Rs 1,728 crore. The projected budget for the Ministry of Health and Family Welfare for 2019-2020 is Rs 62,659 crore.

The Department of Health Research's predicted budget was somewhat surpassed compared to the previous year. The 2020-2021 forecasts are higher in both departments' budgets.

Table No. 1.6 Fund Provided Under Ministry for the Year 2020-21 (in Rs Crore):

Major Heads	Actuals 2018-19	Revised Estimates 2019-20	Budget Estimates 2020-21	% Change (Revised Estimate to Budget Estimate)
NHM (total)	31,045	33,790	33,400	-1%
-NRHM	25,495	27,834	27,039	-3%
-NUHM	868	950	950	0%
-Others	4,682	5,006	5,411	8%
Autonomous Bodies (AIIMS, PGIMER, ICMR)	8,718	10,095	9,616	-5%
Ayushman Bharat: Pradhan Mantri Jan Arogya	1,998	3,200	6,400	100%
PMSSY	3,797	4,733	6,020	27%
National AIDS & STD Control Programme	1,803	2,956	2,900	-2%
Family Welfare Schemes	598	776	831	7%
Rashtriya Swasthya Bima Yojana	227	114	29	-75%
Others	6,497	8,946	7,916	-12%
Total	**54,682**	**64,609**	**67,112**	**4%**

[**Note:** **NHM**- National Health Mission; **NRHM**- National Rural Health Mission; **NUHM**- National Urban Health Mission; **PMSSY**- Pradhan Mantri Swasthya Suraksha Yojana. **AIIMS** - Autonomous Bodies include the All India Institute of Medical Science, **PGIMER**- Post Graduate Institute of Medical Education and Research, **ICMR** - Indian Council of Medical Research, New Delhi]

Sources: Demand No. 42 & 43, Ministry of Health and Family Welfare, Union Budget 2020-21, PRS.

The Indradhanush Mission vaccinated 3.39 million children and 87.18 million pregnant women throughout 680 districts (including Gram Swaraj Abhiyan [GSA] and extended GSA).

Some of the most recent vaccinations are Measles-Rubella (MR), Pneumococcal Conjugate Vaccine (PCV), Rotavirus Vaccine (RVV), and Inactivated Polio Vaccine (IPV) (IPV). As of the end of 2018, 32.42 million youngsters have received the MR vaccination. In addition, a total of Rs 2.1896,000 in PCV have been given out since the program's start. (as of November 2019).

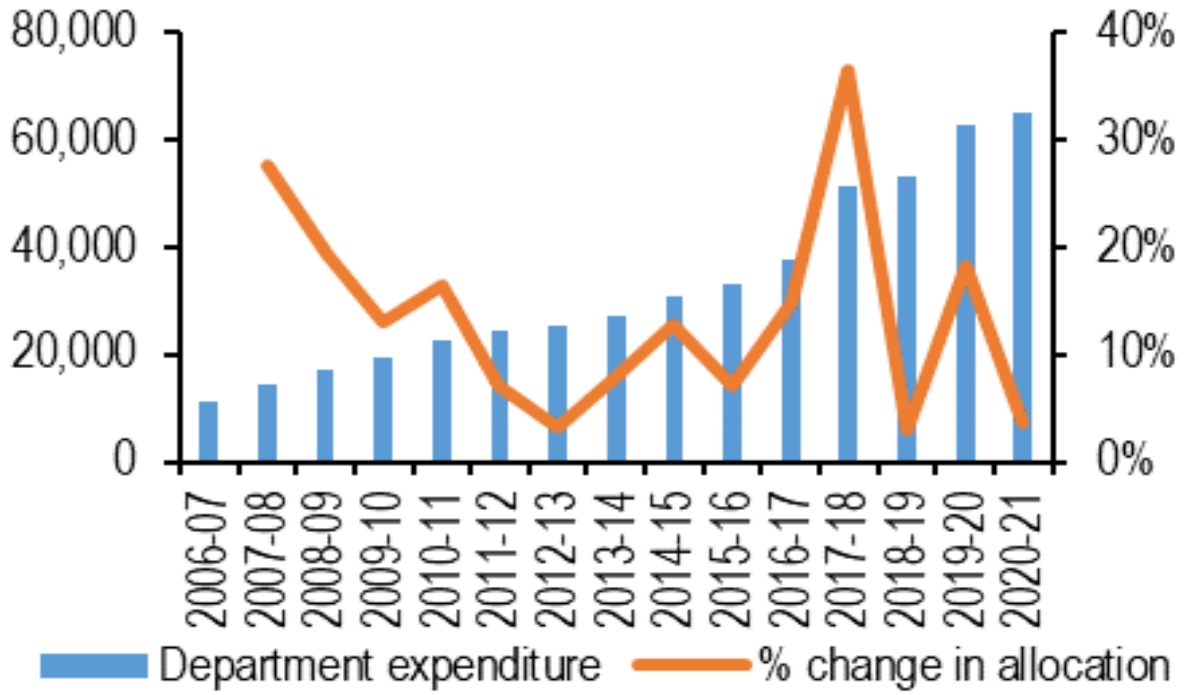
Rather than only the absence of disease or incapacity, "a state of complete bodily, mental, and social well-being." Public health is the study and practise of making a community healthier, reducing the spread of illness, and extending the average lifespan via concerted societal initiatives. The goal is to bridge the gap in community access to low-cost tertiary care services. When medical items such as X-ray equipment are brought into India, a 5% health tax is levied (in addition to customs duties). Money from this tax may be used to improve medical infrastructure and services.

1.4.3 Trends in allocation and expenditure in the Department of Health and Family Welfare:

The spending of the Health and Family Services Department is shown to be on the rise in Figure 1.1. It demonstrates how critically crucial the healthcare industry is in India. In today's scenario, investing

more in the health sector is necessary as India is facing a pandemic situation against COVID-19.

Figure No. 1.1: Fund Provided to the Department of Health and Family Welfare (2006-20) (in Rs crore)



Note: % change in allocation is BE (2020-21) over RE (2019-20) for 2020-21.

Sources: Budget, 2006-07 to 2020-21; PRS

Table No. 1.7 Comparison of Budget estimates and the actual expenditure (2010-20) (in Rs Crore):

Year	BE	Actuals	Actuals/BE
2010-11	23,530	22,765	97%
2011-12	26,897	24,355	91%
2012-13	30,702	25,133	82%
2013-14	33,278	27,145	82%
2014-15	35,163	30,626	87%
2015-16	29,653	30,626	103%
2016-17	37,066	37,671	102%
2017-18	48,853	51,382	105%
2018-19	52,800	52,954	103%
2019-20	62,659	62,659*	100%

Note: BE – Budget Estimates; *Revised Estimates.

Sources: Union Budgets, 2010-20; PRS.

The variance between actual expenditure in the Department of Health and Family Welfare and projected spending is shown in Table No. 1.7. (2010-2020). During the early years of the programme, from the year 2010-2011 to 2014-2015, usage was less than 100 per cent.

However, in the five years after 2014, utilization rose beyond 100%, suggesting that the Department had succeeded where its budget had predicted it would fail. The Department has already attained 100 per cent usage, according to updated forecasts for the year 2019-2020.

1.4.4 Financial Arrangement of National Health Mission:

The National Health Mission aims to enhance the quality of healthcare and public health services in the United States. Many flexible pools, including the RCH Flexible Pool and the Infectious Disease Flexible Pool, support NHM. In addition, elastic pools were established to provide greater financial flexibility and efficient funding to achieve targeted health outcomes. The revised estimate for 2020-2021 (Rs 33,400 crore) for NHM is 1% lower than the previous year's estimate. From 2006–2007, when NHM received 73% of the whole budget, to 2020–2021, when it received 50% of the total budget, NHM's portion decreased dramatically.

Table No 1.8 Vision of National Health Mission:

Targets (2012-17)	Status (as of Dec 2019)
Reduce IMR to 25	IMR was reduced to 35 in 2017.
Reduce MMR to 100/1,00,000 live births	MMR was reduced to 122 in 2017.
Reduce TFR to 2.1	TFR reduced to 2.3 in 2016.
Annual Malaria Incidence to be < .001	The yearly Malaria Rate is 0.02 in 2019.
Less than 1 % microfilaria prevalence in all districts	99 of the 256 districts areas have recorded incidences of less than 1%.
Kala-Azar elimination by 2015, <1 case per 10,000 population in all blocks	In 2019, 92 percent of endemic blocks met the eradication goal.
Reduce yearly frequency and death from Tuberculosis by half	From 300 per lakh in 1990 to 204 per lakh in 2017, the incidence rate has decreased. From 76 per lakh in 1990 to 31 per lakh in 2017, mortality has decreased.

Source: Health and Family Welfare Statistics 2017; Unstarred Question No. 4335, Ministry of Health and Family Welfare, Lok Sabha, December 13, 2019; PRS.

(Note: IMR-Infant Mortality Rate; MMR-Maternal Mortality Rate; TFR-Total Fertility Rate.)

In the above Table No. 1.8, IMR has been reduced to 35, and MMR reduced by 122 in 2017. The status of TFR decreased to 2.3 in the year 2016. The annual malaria incidence is 0.02 in the year 2019. In the case of microfilaria, 99 districts reported less than 1 per cent of incidence until 2018. Ninety-two per cent of blocks have achieved complete elimination from Kala-Azar.

Even though there are decreasing cases of tuberculosis, there is still a need to do over & above to achieve Universal Healthcare. NHM's primary goal is to provide universal access to quality healthcare at little or no cost. The availability of essential resources and the treatment quality may be improved by investment in healthcare workforce education. India's healthcare infrastructure includes the facilities and personnel needed to provide medical treatment to the population. (2019) National Health Mission Annual Report, Department of Health and Family Services.

Table No. 1.9 Public Health Infrastructure Under National Health Mission:

Facility	New Creation		Renewal/Upgradation	
	Approved	Completed	Approved	Completed
Sub Centre	27,573	21,014	18,707	15,345
Primary Health Centre	2,920	2,264	13,324	11,462
Community Health Centre	604	473	6,692	5,771
Sub District Hospital	240	139	1,150	963
District Hospital	172	129	3,201	2,325
Total	31,509	24,019	43,074	35,866

Source: Department of Health & FW (as of 30.6.2019)

Table 1.9 details the Public Health Infrastructure planned to be built as part of the National Health Mission. The Ministry of Health and Family Welfare has funded the construction of 412 hospitals and 27.573 sub-centres, 2.920 rural primary health care centres, 604 community health care centres, and 0 sub-centres. Existing health care facilities may also require the Department of Health and Family Welfare funding to undergo necessary repairs and improvements. They are making an Investment While in Mission-Critical Status The government has launched ambitious programmes, such as the Ayushman Bharat healthcare reform programme, to speed up the country's progress toward the SDGs. The Ayushman Bharat Health & Wellness Centres (AB-HWCs) will adhere to well-established referral and return relationships to ensure patients get consistent care. In addition, teleconsultation would be utilized at all levels to improve referral recommendations and conduct virtual consultations, including case management help from doctors and experts. Several states have also begun employing digital systems such as Echocardiograms (ECHO) to help the primary healthcare team maintain capacity.

Over 7.78 billion individuals have gone to these clinics to be screened for NCDs (NCDs). Two leading causes of death and disability today are blood pressure and diabetes, tested on 2.94 and 2.51 crore individuals, respectively.

In addition to screening for cardiovascular disease, diabetes, and high blood pressure, 1.52 crore individuals will get oral cancer, 92 lakhs for breast cancer, and 92 lakhs for cervical cancer by 11.1.2020. (62 lakhs).

1.5 Current Status of Rural Health Care Services in India:

Due to a growing sick population and an expanding middle class, India's healthcare market reached $81.3 billion in 2013 and is projected to reach 17 per cent by 2020, up from 11 per cent in 1990 (http://www.firstpost.com).

The Government of India has set up several committees and commissions to look into the difficulties and challenges that the health sector is facing. These panels were established to evaluate the present health situation in India and provide suggestions for improving health services for all citizens. India's healthcare sector is rapidly becoming a key contributor to the country's GDP. India's health system has achieved several remarkable triumphs, despite the government's difficulties in providing affordable health care services to the country's rural population. The necessity of investing in and enhancing the public health system was demonstrated during COVID-19 (https://www.indiabudget.gov.in/economicsurvey/doc/echapter_vol2.).

1.5.1 A Brief Scenario of the Rural Healthcare Delivery System of India:

After attaining independence, India has opted for a mixed economy to ensure the implementation of a welfare policy aimed at uplifting millions of Indians mired in poverty who are experiencing poor health care facilities. Therefore, the Government of India adopted the Bhore Committee recommendations (1943), such as improving the Primary Health Care Sector, expanding the workforce and public sector drugs and instrument production units, establishing Health Assistant Training Schools, etc. However, investments in health services have continuously declined after the Third Five-Year Plan, which led to widespread dissatisfaction among rural people. This resulted in the acceptance of the Alma Ata Declaration in 1978, the creation of Community Health Centres in the Sixth Five Year Plan (FYP) (1980-1985), and the launch of the National Rural Health Mission (NRHM) in 2005.

Although the earlier initiatives were commendable on paper, their unsatisfactory performances were primarily due to the absence of adequate infrastructure in rural areas and the segregation of clinical medicine and public health due to the influence of old practices. Due to a lack of medical professionals, many people in rural regions have turned to complementary and alternative medicine practises, including Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy (AYUSH). However, they were also more likely to fall victim to doctors with questionable ethics. In addition, there has been a shift away from the welfare model and toward a more significant role for the private sector in providing healthcare in India following the economic reforms of 1992. However, these changes have generated a rising imbalance between rural and urban communities. Therefore, restructuring the National Rural Health Mission (NRHM) and increasing public sector support for rural medical facilities are necessary to close the gap (http://www.insightsonindia.com/2015).

Three Tire Systems for Healthcare Infrastructure in Rural Areas:

Aside from healthcare indicators, healthcare infrastructure is a critical factor in India's healthcare delivery system. Rural medical infrastructure is designed as a three-tier system based on the demographic criteria listed in Table No. 1.9 below.

Table Number 1.10 Population Norms of Health Care Infrastructure in Rural Areas:

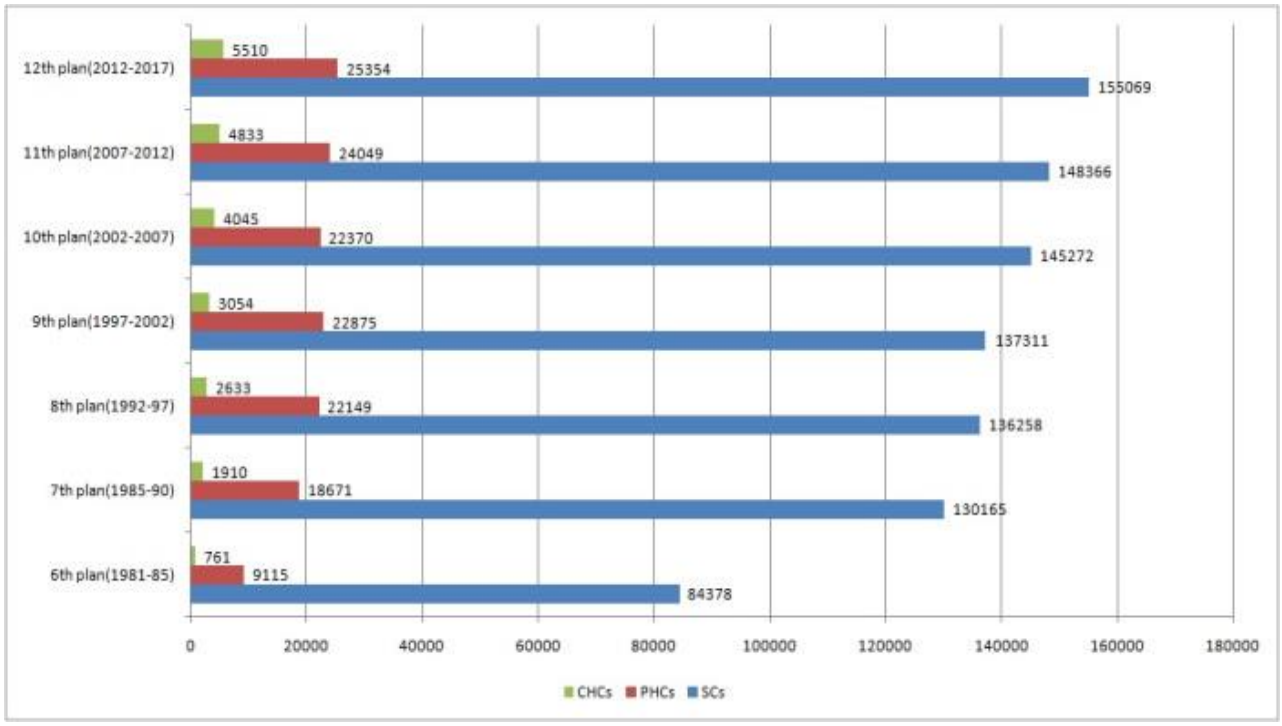
	Population Rules	
Centre	**Plain Area**	**Hilly/Tribal/Difficult Area**
Sub Centre (SC)	5,000	3000
Primary Health Centre (PHC)	30,000	20,000
Community Health Centre (CHC)	1,20,000	80,000

Source: Health Management Information System (Accessed on December 2019).

According to table No. 1.10. one Sub Centre will serve 3000 people in mountainous, tribal, and rugged areas and 5000 people in plain areas.

Each sub-centre must contain at least one medical specialist and one medical specialist. For example, one PHC serves 20,000 people in hills/tribes and 30,000 in flat areas. PHC requires a medical officer and 14 emergency medical personnel, and other specialists. Ultimately, One CHC will serve 80,000 people in hills/tribes / complex areas and 120,000 people in flat areas. The Community Health Center (CHC) requires four board specialists: surgeons, doctors, obstetricians and gynaecologists, paediatricians, emergency medical personnel, and other professionals. (https://nrhm-mis.nic.in).

Figure Number: 1.2: Growth of Sub Centres (SCs), Primary Health Centres (PHCs), and Community Health Centres (CHCs):



Source: RHS 2016 2016, https://pubheal.wordpress.com, Accessed on 28/12/2017.

The number of sub-centres (SCs), Rural Primary Health Centres (PHCs), and Community Health Centres (CHCs) has steadily increased over the years, as shown in Figure Number 1.2. However, these numbers are insufficient to satisfy the population's requirements. The health infrastructure has improved from the 6th Five Year Plan for 1981-1985 to the 12th 2012-2017. However, the effect of infrastructure improvement has been neutralized by population growth. The number of SCs climbed by 6%, the number of rural PHCs by 9%, and the number of CHCs by 65% between 2005 and 2016 (RHS, 2016, https://pubheal.wordpress.com, Accessed on 01/01/2020).

As of March 31, 2019, of the total of 157,541 SCs (HWCSCs) servicing rural areas of the country, 7,821 SCs have recently been upgraded to Health and Wellness Center Sub-Centres. Tamil Nadu (985), Maharashtra (939), Gujarat (813), Uttar Pradesh (726), Chhattisgarh (650), Assam (628), Andhra Pradesh (612), and Karnataka (612) are the states that have been upgraded from SC to HWCSC. There was a containment of it (571). Rajasthan (3,000), Gujarat (1,892), Karnataka (1,615), Madhya Pradesh (1,352), Chhattisgarh (1,387), Jammu and Kashmir (1,146), Orissa (761), and Tripura (364) all have large subcenters (433). Increased. The percentage of subcenters run by state entities has risen from 43.8% in 2005 to 75.3% in 2019.

There were 24 855 rural PHCs in rural regions as of March 31, 2019. (16613 PHCs and 8242 HWC-PHCs). 8242% of rural PHCs, formerly HWC-PHCs, are now full-fledged PHCs.

An impressive number of rural PHCs have been upgraded to HWCPHCs in the states of Andhra Pradesh (1145), Uttar Pradesh (946), Orissa (827), Gujarat (772), Tamil Nadu (716), and Telangana (636). Significant growth in primary healthcare centre (PHC) numbers may be seen in the states of Karnataka (446), Gujarat (406), Rajasthan (369), Assam (336), Jammu and Kashmir (288), and Chhattisgarh (275). The number of PHC services served by government agencies has increased significantly from 69% in 2005 to 94.5% in 2019.

As of March 31, 2019, 5335 Community Health Centers (CHCs) were operating in rural regions around the country. Uttar Pradesh has increased by 293 per cent, Tamil Nadu by 350 per cent, West Bengal by 253 per cent, Rajasthan by 245 per cent, Odisha by 146 per cent, Jharkhand by 124 per cent, and Kerala by 124 per cent (121). From 2005 to 2019, the percentage of CHCs in government buildings has risen from 91.6% to 99.3% (https://vikaspedia.in/health/health-directory/rural-health-care-system-in-india).

Table No. 1.11: Number of Sub-Centers, PHCs and CHCs Functioning:

Sr. No.	State/UT	2005			2016		
		Sub- Centre	PHCs	CHCs	Sub- Centre	PHCs	CHCs
01	Andhra Pradesh	12,522	1,570	164	7,659	1,075	193
02	Arunachal Pradesh	379	85	31	304	143	63
03	Assam	5,109	610	100	4,621	1,014	151
04	Bihar	10,337	1,648	101	9,729	1,802	148
05	Chhattisgarh	3,818	517	116	5,186	790	155
06	Goa	172	19	5	212	22	4
07	Gujarat	7,274	1,070	272	8,801	1,314	322
08	Haryana	2,433	408	72	2,576	474	110
09	Himachal Pradesh	2,068	439	66	2,071	518	79
10	Jammu & Kashmir	1,879	334	70	2,805	637	84
11	Jharkhand	4,462	561	47	3,953	327	188
12	Karnataka	8,143	1,681	254	9,332	2,353	206
13	Kerala	5,094	911	106	4,575	824	225
14	Madhya Pradesh	8,874	1,192	229	9,192	1,171	334
15	Maharashtra	10,453	1,780	382	10,580	1,811	360
16	Manipur	420	72	16	421	85	17
17	Meghalaya	401	101	24	431	109	27
18	Mizoram	366	57	9	370	57	9
19	Nagaland	394	87	21	396	126	21
20	Odisha	5,927	1,282	231	6,688	1,305	377
21	Punjab	2,858	484	116	2,951	427	150
22	Rajasthan	10,512	1,713	326	14,408	2,080	571
23	Sikkim	147	24	4	147	24	2
24	Tamil Nadu	8,682	1,380	35	8,712	1,368	385
25	Telangana				4,863	668	114
26	Tripura	539	73	10	1,033	94	20
27	Uttarakhand	1,576	225	44	1,847	257	59
28	Uttar Pradesh	20,521	3,660	386	20,521	3,497	773
29	West Bengal	10,356	1,173	95	10,369	909	349
30	A& N Islands	107	20	4	123	22	4
31	Chandigarh	13	0	1	17	3	2
32	Dadra & Nagar Haveli	38	6	1	56	11	0
33	Daman & Diu	21	3	1	26	4	2
34	Delhi	41	8	0	26	5	0
35	Lakshadweep	14	4	3	14	4	3
36	Puducherry	76	39	4	54	24	3
	All India/ Total	**1,46,026**	**23,236**	**3,346**	**1,55,069**	**25,354**	**5,510**

Source: RHS, 2016, https://pubheal.wordpress.com, Accessed on 28/12/2017

To see how many Sub-Centers, rural Primary Health Care Centers and Community Health Centers have been established since 2005, we may look at Table No. 1.11. This data demonstrates an increase in both the number of sub-centres and rural primary health centres, but one that is slower than the pace of overall population growth. A medical officer must operate a PHC with the help of 14 paramedical and other staff.

Rural PHCs can engage two extra staff nurses on a contract basis under NRHM. It contains 4-6 patient beds and is a referral centre for six sub-centres. PHC offers curative, preventive, promotional, and family welfare (https://main.mohfw.gov.in/sites/default /files/Final%20RHS%202018-19_0.pdf).

Table No. 1.12 Number of Sub-Centers, PHCs & CHCs Functioning as of 31st March 2019:				
Sr. No.	**State / UT**	**(As of 31st March 2019)**		
		Sub Centre SCs + HWC-SCs	**PHCs + HWC – PHCs**	**CHCs**
1	Andhra Pradesh	7,437	1,145	140
2	Arunachal Pradesh	385	143	63
3	Assam	4,643	946	177
4	Bihar	9,949	1,899	150
5	Chhattisgarh	5,205	792	170
6	Goa	219	24	5
7	Gujarat	9,166	1,476	362
8	Haryana	2,604	379	115
9	Himachal Pradesh	2,089	586	87
10	Jammu & Kashmir	3,025	622	84
11	Jharkhand	3,848	298	171
12	Karnataka	9,758	2,127	198
13	Kerala	5,380	848	227
14	Madhya Pradesh	10,226	1,199	309
15	Maharashtra	10,668	1,828	364
16	Manipur	490	90	23
17	Meghalaya	477	118	28
18	Mizoram	370	59	9
19	Nagaland	433	126	21
20	Odisha	6,688	1,288	377
21	Punjab	2,950	416	89
22	Rajasthan	13,512	2,082	571
23	Sikkim	176	29	2
24	Tamil Nadu	8,713	1,422	385
25	Telangana	4,744	636	85
26	Tripura	972	108	18
27	Uttarakhand	1,847	257	67
28	Uttar Pradesh	20,782	2,936	679
29	West Bengal	10,357	908	348
30	A& N Islands	124	22	4
31	Chandigarh	0	0	0
32	Dadra & Nagar Haveli	71	9	2
33	Daman & Diu	23	4	0
34	Delhi	12	5	0
35	Lakshadweep	14	4	3
36	Puducherry	54	24	2
	All India	**1,57,411**	**24,855**	**5,335**

Source:https://main.mohfw.gov.in/sites/default/files/Final%20RHS%202018-19_0.pdf

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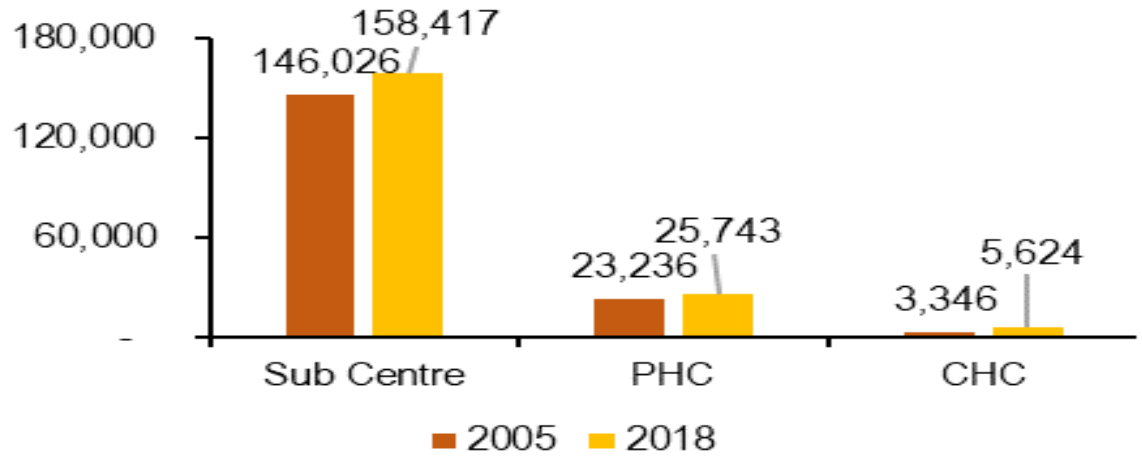
The 2019 statistics for SCs and rural PHCs include the number of Health and Wellness Centres at the SC and PHC levels. Table No. 1.12 shows 24,855 rural PHCs throughout the country as of March 31, 2019. Compared to 2005, there will be 1619 more rural PHCs in the United States in 2019. Karnataka (446), Assam (336), Rajasthan (369), Jammu & Kashmir (288), and Chhattisgarh (275) all saw significant increases in the number of rural PHCs during 2005. (251).

On March 31st, 2019, there were 5,335 CHCs around the country. Uttar Pradesh (293), Tamil Nadu (350), West Bengal (253), Rajasthan (245), Odisha (146), Jharkhand (124), Kerala (121), Gujarat (90), and Madhya Pradesh have all seen significant increases in the number of CHCs since 2005. (80). From 2005 to 2019, the number of CHCs housed in public buildings has grown. However, there was a shortage of experts of 81.6% compared to what was required by current CHCs. As of March 31, 2019, there were 1, 57,411 sub-centres in operation nationwide.

Figure No. 1.3: Number of Sub-centers, PHCs, and CHCs (2005 and 2018):



Source: Comparative Statement, Health Management Information System; PRS 2018-2019.

Figure 1.3 indicates that the SC, PHC, and CHC have increased. Many other parts of the healthcare system are paying attention to it as well. There is a need for 32,900 more SCs in addition to the 6,430 rural PHCs and 2,188 CHCs that are currently unavailable.

The Ministry of Defense has determined that the present SC suffers from a similar funding and physical facilities shortage. Several rural PHCs have employed SCs with just one room, and many SCs have been using outbuildings. Under NRHM, states might develop the necessary infrastructure.

NHM supports the provinces in strengthening public health care facilities. Since 2018, India has had 25,778 government clinics (including regional health care clinics). In addition, the state was 258 new district hospitals and renovated 3,288. HEG (2011) recommends the same functional bed access for secondary and tertiary treatment.

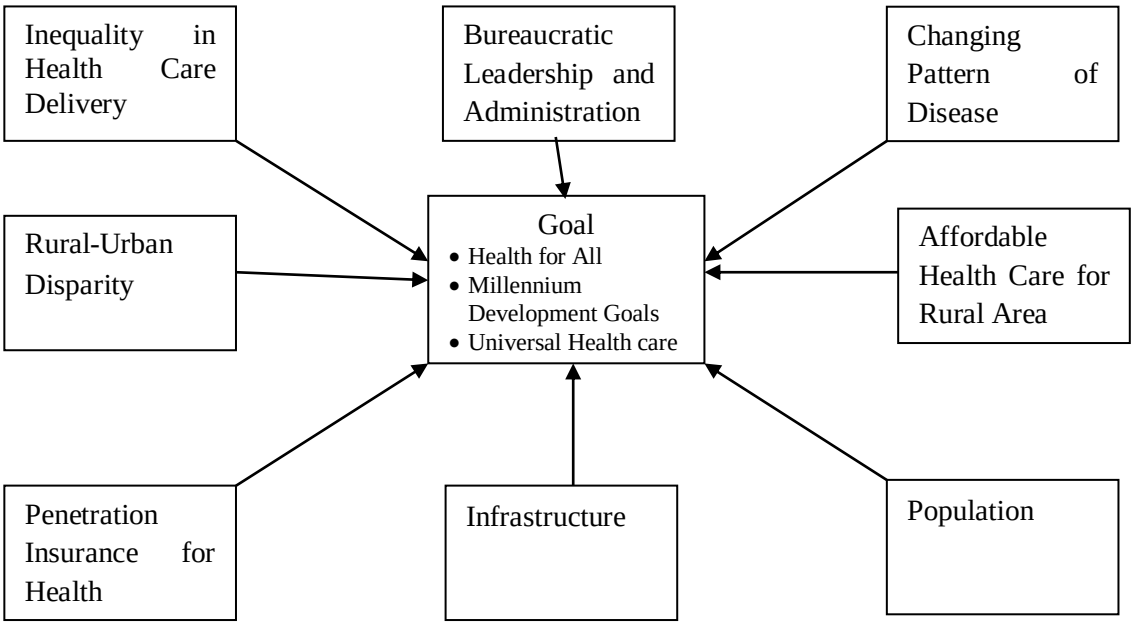
According to the World Health Organization, India counts an average of 3.4 beds worldwide, which is the lowest. By 2022, the annual functional bed capacity forecast will increase to 2 beds per 1000 people.

As the first point of contact between the community and the primary health care system in the case of SCs and the first point of contact between a medical officer and the community in the case of rural PHCs, the inadequate number of SCs and rural PHCs isn't enough to meet the needs of the rural population (RHS, 2016, https://pubheal.wordpress.com, Accessed on (04/01/2020).

1.5.2 Factors Affecting Delivery of Rural Health Care Services:

The challenges surrounding the delivery of rural health care services have been projected in Figure 1.4, taking into account the eight crucial elements necessary for the system designed for the delivery of rural health care services to be implemented successfully.

Figure Number: 1.4: Model of Factors Affecting Rural Health Care Delivery System:



Source: Adapted from Panagariya, Ashok (2014) and http://www.firstpost.com, Accessed on 28/12/2017.

The qualitative assessment of the professional abilities of staff, management skills of administrators, Best practices in healthcare delivery services, and quality of students taught at medical schools can all be blamed for inequity in the delivery of health care services.

The bureaucratic leadership type of India's healthcare system includes a lack of clear vision, inclusive solutions, motivation, hunger, and excitement, as well as a failure of bureaucratic leadership. Administrative reforms are required to enhance the administrative machinery, which must be restructured and integrated.

The Medical, Health, and Education Departments must collaborate to attain the goal of general health improvement. Deep-seated corruption impedes the system's efficient operation, particularly the timely acquisition of medical equipment and diagnostics.

The Directorate of Medical and Health, India's primary administrative and regulatory agency for medical and health, requires revamping due to a lack of technical knowledge. The change has increased stress, diabetes, and coronary heart disease, as well as infections and undernutrition in the elderly, among other indicators of a shifting pattern of illness. Swine flu, dengue fever, and scrub typhus have all surfaced, increasing the number of diseases. The availability of affordable medical care in rural areas depends on how much the costs of diagnosis and treatment are.

Biomedical scientists from hospitals, research institutes, and other organizations may combine their expertise into cheap medical products to help push the indigenous manufacturing of medical equipment, medicines, surgical instruments, and diagnostics. (Panagariya, Ashok, 2014). India's healthcare business confronts challenges due to the country's growing population, which has increased from 760 million in 1985 to an expected 1.3 billion in 2015. India's central and state governments provide universal health care, economic treatment, and vital pharmaceuticals through government hospitals.

On the other hand, their hospitals are understaffed and underfunded, forcing patients to seek treatment from private doctors and hospitals. Another stumbling point in India is the low percentage of people with health insurance.

The cost of healthcare per person is among the lowest in India. However, the fact that 76 per cent of Indians lack health insurance makes the hefty out-of-pocket costs even worse. Another issue that influences how rural health care services are delivered is the rural-urban divide.

The three-tiered rural health care infrastructure is made up of a Sub-Center, rural Primary Health Centers (PHCs), and Community Health Centers (CHCs) (http://www.firstpost.com).

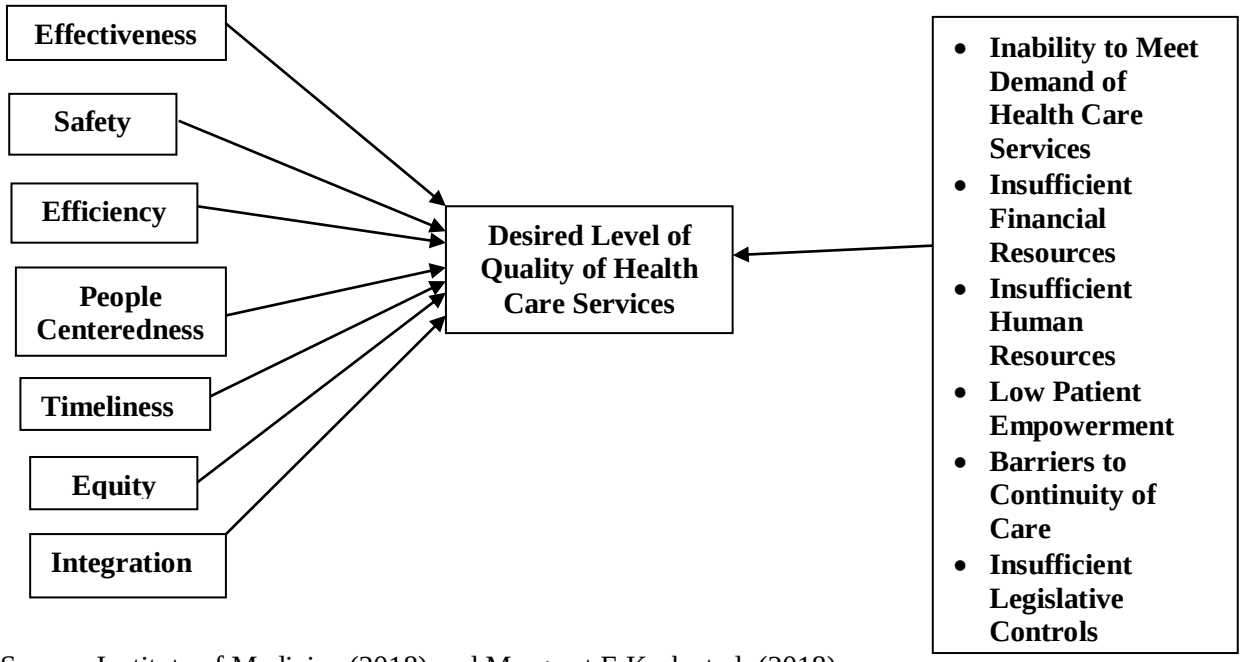
In a remote community, providing excellent health care requires more than guaranteeing the cohabitation of infrastructure, medical supplies, and health care professionals. Instead, it calls for a deliberate emphasis on healthcare quality, including providing prompt, equitable, integrated, and effective healthcare services that are safe, secure, and patient-centred.

1.5.3 Elements of Quality of Health Care Services: Interplay of Restraining and Facilitating Forces:

Healthcare quality is the level to which medical interventions for people and groups increase the probability of desired health outcomes and align with current professional knowledge. Quantifying healthcare quality to enhance health rather than just growing health service inputs or streamlining system operations is possible. Figure 1.5 depicts the restraining and facilitating force affecting the quality of health care services.

Figure Number: 1.5: Restraining and Facilitating Forces Affecting Quality of Health Care Services: An Interplay:

FACILITATING FORCES **RESTRAINING FORCES**



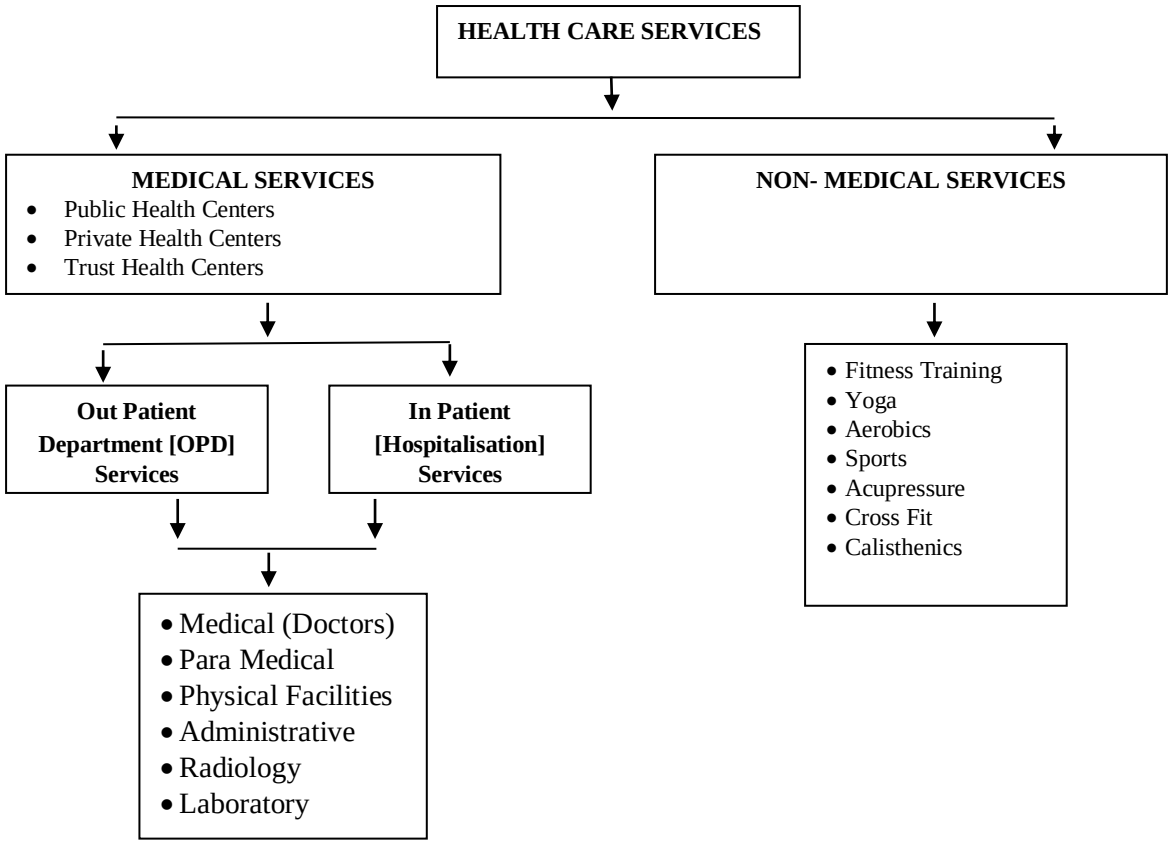
Source: Institute of Medicine (2018) and Margaret E Kruk et al. (2018).

Multiple quality elements affect medical services, including viz., Effectiveness, Safety, People-Centeredness, Timeliness, Equity, and, Integration of efficient healthcare services. These factors are ingredients for realizing the benefits of quality health care. The restraining forces that constrain the effectiveness of the Delivery of Healthcare Services can be categorized as reasons, including, viz., Inability to meet the demand for Health Care Services, Lack of Finance, Lack of Human Resources, low patient Ratio and Insufficient Judicial Controls, respectively.

1.6: Comprehensive Model of Health Care Services:

The following model provides a comprehensive picture of health care services provided to the community to cure and prevent the health of the public at large.

Figure Number: 1.6: Comprehensive Model of Health Care Services:



Source: Compiled and Conceived by Research Scholar Based on Review of Literature

To give a thorough picture of the health care services offered to individuals in India to treat and prevent illnesses, the researcher conducted a quick study of the literature. Following is a short introduction of the Model and a summary of its essential components as they apply to different health care services.

1.6.1 Medical Services:

(i) Public Health:

Public health is defined as the "art and science of preventing illness, extending life, and promoting health by the concerted efforts of society." The main objective is to enhance Integrated Public Health Services, reduce inequities, and promote health and well-being over the long term. The Alma Ata Declaration states that the public health approach comprises working with medical professionals and other sectors to address the more significant determinants of health and that primary care physicians may play an essential role in disease prevention and health promotion (http://www.euro.who.int).

(ii) Private Health Centers:

Private Health Centers are Non-Government organizations that provide medical services. The term "private health care" is more commonly used in countries with a publicly-funded healthcare system, such as Canada, Japan, or the United Kingdom, and refers to medical services that the government does not cover, such as ambulance rides, private hospital rooms, cosmetic surgeries, and a variety of other benefits. "Private Medicine" is another name assigned to Private Health Centers (https://www.superbrokers.ca).

(iii) The Trust Health Center:

The Trust Health Center aims to improve the lives of its customers by providing high-quality care that addresses their physical, emotional, and social well-being in one place. The partner organizations collaborate closely to assist clients with medical facilities (https://www.achch.org).

(iv) Out-Patient Department [OPD]:

The services provided by an out-patient department (OPD) are those in which a patient receives a diagnosis or treatment but is not admitted to a hospital for the night (https://www.merriam-webster.com/dictionary/outpatient).

(v) In-Patient:

In-Patient [Hospitalization] Services in which a hospital patient receives treatment, lodging, and food (https://www.merriam-webster.com).

(vi) Medical:

The medical word refers to illnesses and injuries, as well as how to cure or avoid them (https: //www. collinsdictionary.com/dictionary/English/medical).

(vii) Paramedical Services:

Services and professions that augment and assist medical work but do not need a fully certified doctor are referred to as paramedical services. Nursing, radiography, emergency first aid, physiotherapy, dietetics, and other services are included (https://en.oxforddictionaries.com/definition/paramedical).

(viii) Physical Activity:

It is any form of exercise or physical movement of Individuals(http://www.who.int/kobe_centre/ageing /the _vol5_glossary.pdf).

(ix) Administration:

The term "administration" refers to the tasks involved in planning and overseeing an organization or institution's operations (https://www.collinsdictionary.com/administration).

(x) Radiology:

It is a branch of medicine that deals with diagnosing and treating disease using radioactive or radiant radiation (such as X-rays) (https://www.merriam-webster.com/dictionary/radiology).

(xi) Laboratory:

A laboratory is a location for conducting, conducting, and analyzing scientific experiments (https://www.merriam-webster.com/dictionary/laboratory).

(xii) Research Laboratory:

A site that permits experimentation, observation, or practice in a field of study might be used to characterize it in general (https://www.merriam-webster.com/dictionary/laboratory).

1.6.2 Non-Medical Services

(i) Fitness Training:

It is the activity of exerting your muscles in various ways to keep fit (https://www.thefreedictionary.com/Fitness+training).

(ii) Yoga:

It is a form of exercise that involves moving your body into various postures to enhance your fitness or flexibility, improve your breathing, and calm your thoughts (https://www.collinsdictionary .com/dictionary/English/yoga).

(iii) Aerobics:

It's a set of vigorous physical activities that strengthen the heart, lungs, and muscles while increasing the amount of oxygen in the blood. It's usually done with a group of people to music (https://dictionary.cambridge.org/dictionary/english/aerobics).

(iv) Sports:

It is a kind of entertainment in which an individual or a team competes against another or others via physical endurance and talent (https://en.oxforddictionaries.com/definition/sport).

(v) Acupressure:

It's a type of traditional Chinese medicine bodywork based on acupuncture principles. It involves the application of pressure to particular spots on the body rather than needles to manage symptoms such as pain or nausea (https://www.medicinenet.com/ script/main/art.asp? article key=10920).

(vi) Calisthenics:

It is described as a set of methodical, rhythmic body exercises generally conducted without equipment (https://www.merriam-webster.com/dictionary/calisthenics).

(vii) Cross fit:

It's a high-intensity training programme that incorporates components from a variety of sports and workouts (https://www.google.com.crossfit+definitionoqcrossfit+definition&gs_l=psy-).

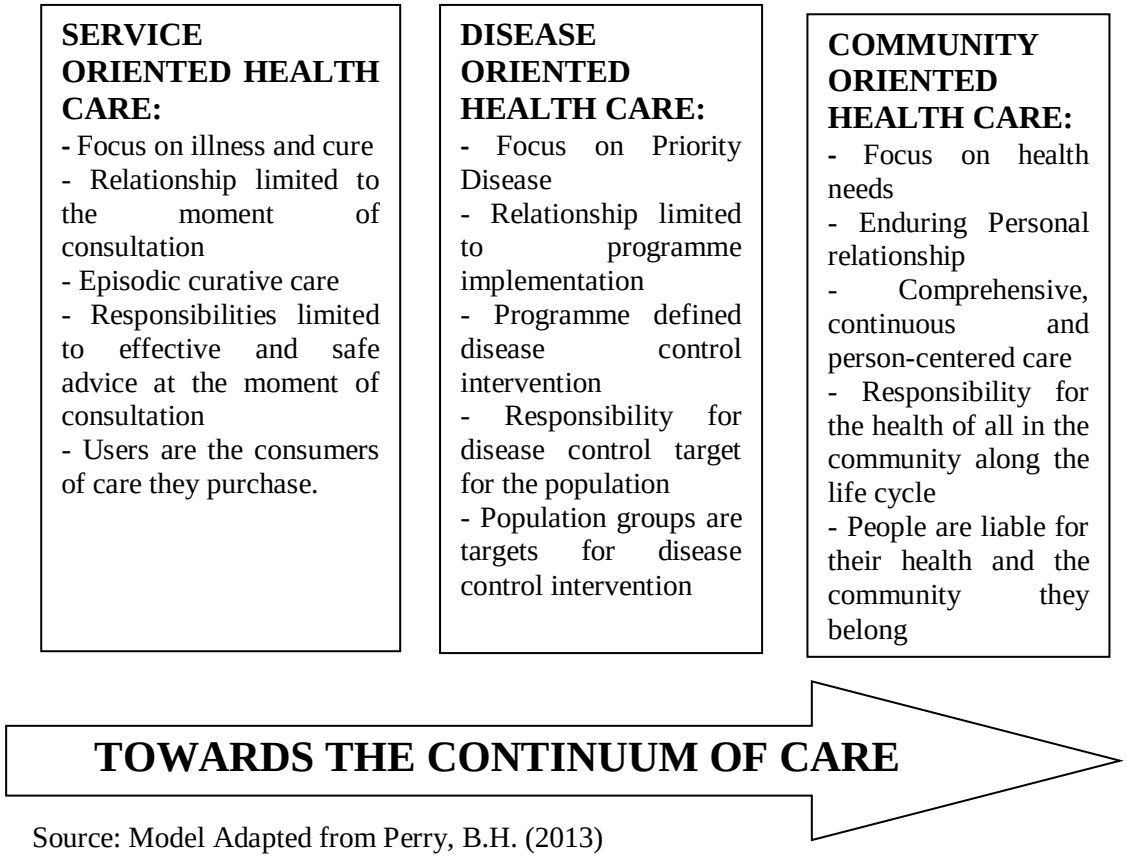
1.7 Emerging Role of Primary Health care in India:

The main goal of primary healthcare is to provide patients with comprehensive, ongoing care. Additionally, it promotes patients' accessibility to various social care and public health services offered by governmental bodies and other groups. Providing first-rate medical and social services to underprivileged individuals is another important goal of rural primary health clinics. Furthermore, primary health care serves community members by giving first-level professional care to patients through preventative strategies, including numerous preventive interventions, chronic illness management, and self-care promotion. Increase. Furthermore, primary health care allows the population greater access to the advanced healthcare system, resulting in better health outcomes and the avoidance of delays.

A committed team of healthcare experts provides the most excellent medical services in all primary healthcare clinics. They offer a well-coordinated approach to healthcare delivery with the most qualified healthcare professionals. (https://ccchclinic.com/low-income-clinics/importance-benefits-primary-health-care/).

Service-based healthcare, disease-based healthcare, and community-based healthcare are the three basic healthcare models that overlap. Service-oriented care is an outpatient treatment offered in a clinic or outpatient facility, focusing on a single relapse. In India, it is the most common type of healthcare.

Figure No. 1.7 Showing the Emerging Role of Primary Health care:



Source: Model Adapted from Perry, B.H. (2013)

Disease-focused health care targets a significant ailment like polio, malaria, or HIV/AIDS. Low-income nations have provided the most effective funding and expertise. Disease-oriented health care is "Top-Down". Usually with the fundamental health framework (Perry, 2013).

Community-oriented health involves quickly and thoroughly meeting the health needs of diverse communities. Yet, it gets the least attention in conventional healthcare (Priya Anant et al. 2016).

1.7.1 Components of Primary Health Care:

World Health Organization endorsed the Alma-Ata Declaration in 1978. Almaty, Kazakhstan, hosts the organization's Almaty Declaration on universal healthcare. The 1978 Alma Ata Declaration, signed by 137 nations, including India, called for "Health for All by 2000". According to this view, the integrated health service should include primary health care. PHC is vital for healthcare because it uses practical, scientifically correct, and socially acceptable procedures and practices that are broadly accessible to people and families via participation.

Public Education:

The first and most crucial component of primary health care is public education. The WHO educates and encourages individuals to prevent and manage health issues to prevent illness from spreading.

Nutrients:

Another important aspect of health care is nutrition WHO aims to prevent hunger, famine, and various illnesses and ailments.

Clean Water and Sanitation:

Clean drinking water and basic waste, sewage, and water sanitation may enhance public health and prevent numerous illnesses.

Maternal and Child Health Care:

Primary health care includes appropriate medical facilities for children and women, pregnant and not. The World Health Organization [WHO] helps future generations flourish and contribute worldwide by caring for individuals who are most vulnerable to health concerns.

Immunization:

WHO strives to eradicate major infectious illnesses by giving universal vaccinations, substantially enhancing global health.

Local Disease Control:

Primary health care requires disease prevention and management. Diseases vary by location. Consider these diseases and avoid them to lower infection rates.

Accessible Treatment:

One of primary care's most crucial elements is ensuring people have access to the resources they need to be healthy. In addition, by attending to injuries and illnesses as quickly as possible, careers may help avoid consequences and the need for more extensive medical treatment.

Drug Provision:

Caregivers can assist in avoiding illness escalation by giving critical medications to people who need them, such as antibiotics, to patients suffering from infections. This keeps the community safer since illnesses are less likely to spread (https://pocketsense.com/8-components-of-primary-health-care-12378089.html).

1.7.2 Concept of Community Health Centers:

Community health centres provide the best medical care to the public based on their specific needs. In addition, CHCs often provide primary and preventative care to those medically underserved or uninsured. The criteria for health centre programs are based on federal legislation and regulation. In addition, they cover governance, needs, services, finance, and administration, all of which combine to create a distinctive, patient- and community-centred approach.

1.7.3 Role of Community Health Centers in India:

Community Governed:

The health centre idea is built on the requirement that at least 51 per cent of a health centre's governing board be active patient users, ensuring that health centre activities are responsive to community needs and interests. This governance structure is far more potent than advisory boards since it oversees all elements of health centre operations, including the appointment and dismissal of directors.

Locate in or serve Medically Underserved areas:

The Health Resources and Services Administration (HRSA) has categorized these sectors. They are also concerned with the following: There is a high need for health care services, widespread health disparities, and poor results in these regions.

Serve all without regard to Insurance Status of ability to pay:

Anyone who passes through the doors of a health facility can receive services. They provide discounts to uninsured patients in need, with rates modified according to the patient's financial situation.

Provide Comprehensive, Co-ordinated Primary and Preventive Care Services:

Health care facilities must provide a variety of primary and preventive treatments and "enabling services" to help patients get care. Mental health, dental, vision, and pharmaceutical services are also encouraged or required in certain health facilities. Even though many locations lack extensive referral networks, health clinics are intended to communicate with other local health and social care providers.

Provide Culturally Competent Care:

Primary care clinics are expected to respect and respond to the cultural preferences of their patients.

Conduct ongoing needs and Quality Improvement (QI) Assessments:

QI and quality assurance systems must be in place at health centres, and regular, formal evaluations of community needs must be.

Report Data:

The federal Health Resources and Services Administration (HRSA) requires yearly reporting on patients, services, quality, and finances (http://www.nachc.org/wp-content/uploads/2015/06/Module-1-An-Introduction-to-the-Community-Health-Center-Model.pdf).

1.7.4 Weaknesses of the Primary Healthcare Model in India:

India's public health system has both substantial limitations and untapped promise.

Inability to Deliver Cost-Effective Care:

Effective screening, diagnosis, and referral to hospital treatments are not a top priority in the system, with a few notable exceptions. Financially, they are crucial to a healthy community. Even if the absence of generic medicine distribution drives the price of treating common acute ailments like pneumonia and chronic ones like hypertension, this is still an ideological and global strategy.

Inadequate Human Resources for Health:

The healthcare system's ability to attract, train, and retain high-quality employees is severely limited. In remote and difficult-to-reach areas, these restrictions are increased. A significant portion of the shortfall is due to a lack of interaction with medical staff.

High Out-of-Pocket Expenditures and Medical Inflation:

Few people in India have access to health insurance or participate in a risk pool. Healthcare is both expensive and unequal for the great majority of people. More than 40 million individuals fall into poverty annually due to rising medical expenditures, notably those associated with the private sector and medicines. Ineffective regulation contributes to the spiralling costs of healthcare.

Poor Regulation and Enforcement of Quality Standards:

In a widely scattered and pluralistic health system, the Government cannot control, enforce, or monitor quality. As a result, the delivery of high-quality healthcare is neither differentiated nor valued in current financial structures.

Absence of Public Engagement:

There are few institutional pathways for boosting community health literacy, such as educating people about the hazards of overmedication or more actively incorporating communities in service delivery so that services are more responsive to communities.

The problem of Authority:

The system suffers from weak governance and leadership when it comes to management and clinical procedures. For instance, healthcare systems lack cross-sector and cross-institutional access to integrated information technology that would allow for better oversight, planning, and policymaking. The current situation of government health delivery leaves room for experimentation and innovation. The excellent quality of medical treatment offered in chosen institutions, which may serve as a model for increasing access to larger populations, is one of the most important possibilities to enhance India's primary care system. Simultaneously, the presence of sizable health staff, albeit with different credentials, may be leveraged to transfer tasks and to improve representation in remote regions

(https://accessh.org/wp-content/uploads/2016/05/Primary-Care-Landscape_ACCESS-Health-International.pdf).

1.7.5 Role of Human Resources in the Healthcare Sector:

The number of registered doctors grew by 24 per cent between 2014 and 2018, rising from 7,47,109 to 9,23,749. However, it's worth noting that, despite the rise, the shortage of physicians, specialists, and surgeons has continued to grow. In 2018, major medical facilities in India were short 46% of general practitioners and 82% of specialists, including surgeons, obstetricians, gynaecologists, physicians, and paediatricians. Poor working conditions, low salaries to promote migration to other countries and employment in the private sector, recruiting delays, and insufficient planning to immediately replace vacancies all contribute to government agencies' scarcity. Position. It is estimated that 16 states will spend 0.6% of GDP to address workforce shortages.

Table No. 1.13 Number of Health Professionals in India:

Number of Public Health Professionals in India (2014-18)			
Profession	**2014**	**2018**	**% increase**
Allopathic Doctors	7,47,109	9,23,749	24%
AYUSH Doctors**	7,36,538	7,99,879	9%
Nurses and Pharmacists	32,86,157	40,91,597	25%

Notes: **includes Ayurveda Unani Siddha Naturopathy Homeopathy.

Source: Economic Survey 2019-20; PRS.

From the above-given Table No. 1.13, there are increasing numbers of health professionals in India. In 2014 Allopathic Doctors were 7,47,109, which grew to 9,23,749 in 2018. Ayush Doctors were 7,36,538 in the year 2014, whereas there were 7,99,879 in the year 2018. Nurses and Pharmacists were 40, 91,597 in 2018, 25 per cent higher than in 2014.

1.7.6 Brief Review of the National Medical Commission Act, 2019:

The authority has legislated the creation of a medical regulator to check on the quality of medical schools and practitioners. The Indian Medical Council has been superseded by the National Health Commission Act of 2019. The 1956 Act created MCI to set and enforce a uniform medical education and practice standard. The legislation ensures that there will always be enough qualified doctors to go around, that they will always accept the newest medical findings, that hospitals and clinics will be regularly inspected, and that there will always be a system in place for people to file complaints against doctors. Build a structure for the study of medicine (https://prsindia.org/budgets/parliament/demand-for-grants-2020-21-analysis-health-and-family-welfare).

1.7.7 Health Research:

There is a considerable, continuous, and repeating difference between the Department of Health Research's predicted funds and the actual scenario. The budget for 2020-2021 has been increased to Rs 2,100 crore, up 7.7% from the revised expectations for 2019-2020. However, the Committee recommended that there was a budget shortfall for project execution as well as an underutilization of funds available. The disparity between requested and available money has influenced the approval of new laboratories, the provision of recurrent grants to continuing programmes, and the upgrading of health research infrastructure. This has implications in terms of medical research output as well (http://164.100.47.5/newcommittee/reports/EnglishCommittees/Committee%20on%20Health%20and%20Family%20Welfare/100.pdf).

1.7.8 Drug Regulation:

The 1940 Drugs and Cosmetics Act governs federal and state drug regulators. DCA oversees pharmaceutical import, production, sale, and distribution. The state enforces DCA, federal legislation. Expert groups provide numerous solutions to national drug management issues. The new, autonomous, and professionally run Central Pharmacy categorises conditions by industrial size and reports directly to the Department of Health and Family Welfare, which invests in regulation appropriately. Increase drug application, clinical trial, import drug registration, and domestic drug registration costs. (https://prsindia.org/budgets/parliament/demand-for-grants-2020-21-analysis-health-and-family-welfare).

1.7.9 Quality of Drugs:

The incidence of low-quality pharmaceuticals is about 7-8 per cent, with non-standard drugs outnumbering spurious drugs.

Between 2014 and 2016, 3.2 per cent of medications in the National Drug Survey were of "non-standard quality." The percentage of spurious drugs was 0.02 per cent throughout the same time. The Mashelkar Commission is responsible for verifying the medicines, monitoring the quality of medications stored by suppliers and registered physicians, and increasing and improving the number of drug inspectors. In addition, the state recommends that more samples be taken(ibid).

1.7.10 Drug Pricing:

Schedule I drugs under 2013's Drug Price Control Order will have their pricing determined by NPPA when the agency receives a notice based on the National Essential Medicines List. In 2015, 3,754 medications were produced. Manufacturers that charge more than the NPPA-mandated pricing will have their reports thoroughly reviewed. Over 2,038 warning letters have been issued to drug firms since NPPA's inception in 1995 for charging customers prices that are too high (https://prsindia.org/budgets/parliament/demand-for-grants-2020-21-analysis-health-and-family-welfare).

Table No. 1.14 Allocations of the Ministry of Health and Family Welfare for 2020-21 (in Rs Crore):

Major Heads	2018-19 Actuals	2019-20 BE	2019-20 RE	2020-21 BE	% Change RE (2019-20)/Actuals (2018-19)	Change between RE 2019-20 and BE 2020-21
Department of Health Research	**1,728**	**1,900**	**1,950**	**2,100**	**13%**	**7.7%**
Department of Health and Family Welfare	**52,954**	**62,659**	**62659**	**65,012**	**18%**	**3.8%**
Pradhan Mantri Swasthya Suraksha Yojana	3,797	4,000	4,733	6,020	**25%**	**27%**
Family Welfare Schemes	598	950	776	831	**30%**	**7%**
National AIDS and STD Control Programme	1,803	2,500	2,956	2,900	**64%**	**-2%**
National Health Mission	**31,045**	**32,995**	**33,790**	**33,400**	**9%**	**-1%**
-National Rural Health Mission	25,495	27,039	27,834	27,039	**9%**	**-3%**
-National Urban Health Mission	868	950	950	950	**9%**	**0%**
-Tertiary Care Programs	289	550	300	550	**4%**	**83%**
-Strengthening of State Drug Regulatory System	179	206	206	175	**15%**	**-15%**
-Human Resources for Health and Medical Education	4,214	4,250	4,500	4,686	**7%**	**4%**
Infrastructure Development for Health Research	103	160	153	170	**48%**	**11%**
Rashtriya Swasthya Bima Yojna	227	156	114	29	**-50%**	**-75%**
Pradhan Mantri Jan Arogya Yojana	1,998	6,400	3,200	6,400	**60%**	**100%**
Autonomous Bodies	8,718	9,920	10,095	9,616	**16%**	**-5%**
Others	6,394	7,478	8,793	7,745	**38%**	**-12%**
Total	**54,682**	**64,559**	**64,609**	**67,112**	**18%**	**3.9%**

Sources: Demand for Grants, Ministry of Health and Family Welfare, Union Budget, 2020-21; PRS.

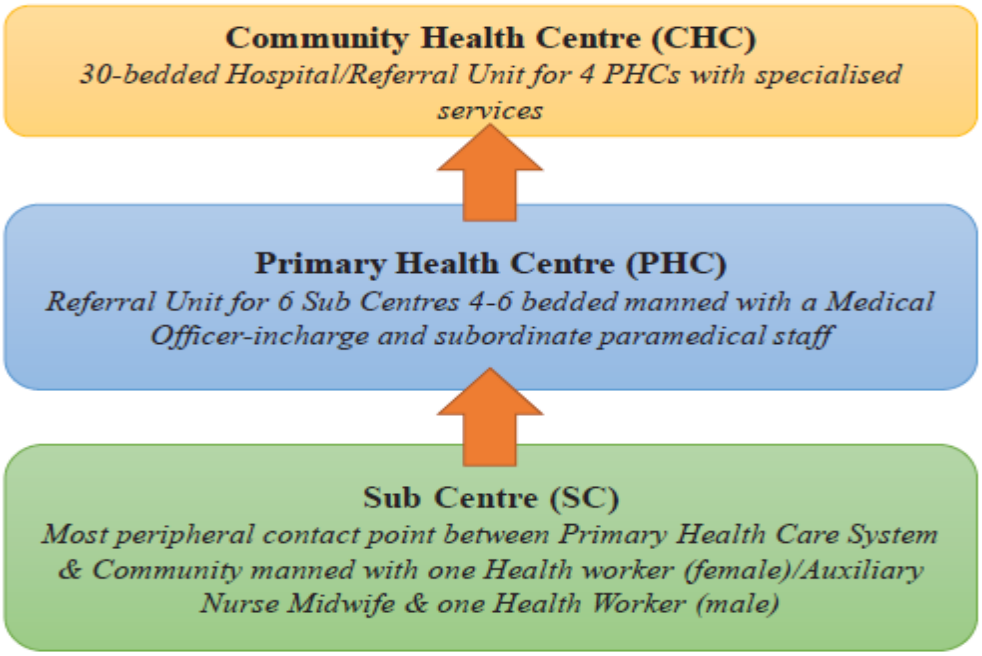
Table 1.14 shows that funding In every critical programme in the year 2020-2021 increased comparatively in 2018-2019. The government spent the most on Pradhan Mantri Jan Arogya Yojna that year. Pradhan Mantri Swasthay Bima Yojna and Tertiary Care Programmes provided 27 per cent and 83 per cent higher funding in 2020-2021 compared to 2019-2020. Even the Government is giving more importance to innovation in the healthcare sector in the year 2020-2021.

1.8 Rural health care – strengthening of infrastructure and human resource:

The state of a country's health infrastructure may tell you a lot about its healthcare system and its social safety net. Some have called public health infrastructure "the nerve centre of the public health system" since it provides the backbone for delivering services to the final recipient. Health-related human resources are also recognised as an essential component of the healthcare infrastructure.

Medical doctors, nurses, pharmacists, midwives, dentists, allied health professionals, community health workers, social health workers, and other health care providers, as well as health management and support staff, all fall under this category.

Figure No.1.8 Rural Health Care System in India:



1.9 Review of Government Programmes for Healthcare:

1.9.1 National Health Mission:

It's important to note that the National Health Mission encompasses the National Rural Health Mission and the National Urban Health Mission, both of which were recently founded. The main focuses of the programme include infectious and non-communicable illnesses; enhancement of local and urban health systems; and maternal, newborn, and adolescent reproductive health (RMNCH + A). NHM's goal is to ensure that everyone, no matter where they live, has access to health care that is both effective and within their means (https://www.thehinducentre.com/resources /article29841374.ece/binary/8603321691572511495.pdf).

1.9.2 National Rural Health Mission (NRHM) (2005):

The National Rural Health Mission was founded in April 2005 and became the National Health Mission in 2013. Rural residents, particularly the poor, get fair, inexpensive, and high-quality healthcare through NRHM. The mission is fully functional, with cross-sectoral convergence to address health factors, including water, sanitation, education, nutrition, society, and gender equality. They were establishing a community-owned decentralized healthcare system (ibid).

1.9.3 National Urban Health Mission (NUHM) (2013):

On May 1, 2013, the National Health Mission proposed creating the National Urban Health Mission. We work to satisfy the medical requirements of urban residents, emphasising the underprivileged in urban areas, by increasing access to fundamental primary health care and lowering out-of-pocket expenses(https://www.thehinducentre.com/resources/article29841374.ece/binary/8603321691572511495.pdf).

1.9.4 National Programme for Prevention & Management of Burn Injuries (NPPMBI) (2014):

The main goal of this program is to prevent burns, provide prompt and appropriate care in the event of a burn, reduce mortality, complications, and consequent disability, and be effective when a disability is established. The primary purpose is to reduce the incidence, mortality, morbidity, and disability of burns in the general public and vulnerable groups. (ibid).

1.9.5 National Mental Health Policy (2014):

In October 2014, the federal government unveiled a new policy to improve mental health services. The goal of the national mental health policy is to ensure that all citizens have access to high-quality, affordable, and accessible social care throughout their lives, regardless of their socioeconomic status or the stage of life in which they experience mental health difficulties, and to reduce stigma and discrimination associated with mental health issues (https://www.thehinducentre.com/resources/article29841374.ece/binary/8603321691572511495.pdf).

1.9.6 National Vector Borne Disease Control Programme (NVBDCP):

This program is a comprehensive initiative to prevent and manage disease-borne diseases. Malaria, Dengue fever, Chikungunya, Filariasis, Kala-Azar, and Filariasis are all included in the plan. As a result, the NVBDCP sees a self-sufficient, knowledgeable, and healthy India, free of vector-borne diseases, with equal access to high-quality healthcare facilities near people's homes (ibid).

1.9.7 National AIDS Control Programme (1992):

In 1992, India initiated the world's first national effort to combat the spread of HIV/AIDS. Reducing HIV transmission has replaced earlier priorities, such as education and the involvement of non-governmental organisations and support groups. To lessen the severity of AIDS-related illness and death nationally, the United States government has established the National AIDS Control Program (https://www.thehinducentre.com/resources/article29841374.ece/binary/8603321691572511495.pdf).

1.9.8 Janani Suraksha Yojna:

The program was established in April 2005. Yojana promotes safe motherhood. Encourage pregnant women to give birth in the hospital and reduce mother and newborn mortality(ibid).

1.9.9 Janani Shishu Suraksha Karyakram (JSSK):

The Indian government introduced it to encourage those who still prefer home births to choose institutional deliveries.

It's an endeavour in which governments are expected to step up and ensure that every impoverished pregnant woman who visits a government facility receives benefits under the JSSK(https://www.thehinducentre.com/resources/article29841374.ece/binary/8603321691572511495.pdf).

1.9.10 Mission Indradhanush:

The mission started on December 25, 2014. Indradhanush's mission is to vaccinate all unvaccinated or partially immunized children in 2020 against vaccine-preventable diseases (http://vikaspedia.in/health/nrhm/national-health-programmes-1).

1.9.11 Pradhan Mantri Swasthaya Suraksha Yojna:

The goals of the Yojana are to improve access to quality, cost-effective healthcare throughout India and to expand medical education opportunities, particularly in underserved communities. In March 2006, the plan was accepted (ibid).

1.9.12 National Ayush Mission:

The Government of India sent the National AYUSH Mission (NAM) to the States/UTs during the Twelfth Plan. The primary objective of NAM is to improve AYUSH clinical frameworks through the implementation of practical AYUSH administrations, the reinforcement of instructive frameworks, the assistance in the performance of value control of Ayurvedic, Siddha, Unani, and Homeopathic medicines, and the provision of readily available ASU and H crude materials.

Nationally and locally, the NAM hopes to develop a purpose (http://vikaspedia.in/health/nrhm/national-health-programmes-1).

1.9.13 National Programme for Health Care Elderly:

This program's primary objective is to detect health issues among the elderly and to provide suitable community health treatments backed by solid referral resources. The program also provides referral services to older patients through county hospitals and community medical institutions (http://vikaspedia.in/health/nrhm/national-health-programmes-1).

1.9.14 Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A):

The primary goal of these initiatives is to improve women's and children's health by reducing preventable deaths and removing barriers to treatment. It always deals with scorecards to track health and uses the National Iron + Initiative to address anaemia in individuals of all ages. It also includes innovative initiatives such as intervention (ibid).

1.9.15 Rashtriya Bal Swasthya Karyakram (RBSK):

Congenital disabilities, deficiencies, diseases, and developmental delays, including disability, were the primary concentrations of the program's early detection and intervention efforts for children aged 0-18. Conditions, such as deficits, may be mitigated, or even prevented entirely, with early diagnosis and treatment (http://vikaspedia.in/health/nrhm/national-health-programmes-1

1.9.16 The Rashtriya Kishor Swasthya Karyakram:

Every teenager in India has a better chance of realising their full potential because this effort provides them with the information, tools, and guidance they need to make healthy lifestyle choices. In addition, a government-sponsored vaccine programme called Pulse Polio aims to eradicate polio in India by protecting all children under five years old (ibid).

1.9.17 Integrated Child Development Service:

The primary goal of these initiatives is to improve women's and children's health by reducing preventable deaths and removing barriers to treatment. Comprehensive early screening for birth abnormalities, diseases, and deficits in children and adolescents, as well as the use of scorecards to monitor health, are also part of the programme. It also includes innovative initiatives such as intervention(https://www.oxfamindia.org/blog/15-healthcare-schemes-india-you-must-know-about).

1.9.18 Immunisation:

Diphtheria, Pertussis, Tetanus, Polio, Measles, Rubella, a severe form of Childhood Tuberculosis, Rotavirus diarrhoea, Hepatitis B, and others are vaccinated free under the Universal Immunisation Programme (UIP). Mission Indradhanush (MI) was established in December 2014 to boost child immunisation coverage to 90% and maintain it. It targets unvaccinated and partly vaccinated kids. One hundred ninety districts/urban areas began intensified MI in October 2017. In FY23, Intensified MI 4.0 covered children and pregnant women who missed regular immunisation during the COVID-19 pandemic in 416 districts (75 under Azadi Ka Amrit Mahotsav) in 32 states/UTs. Until December 2022, 11 stages of MI have vaccinated 4.5 crore children and 1.1 crore pregnant women in 701 districts.

1.9.19 eSanjeevani:

eSanjeevani, an innovative, indigenous, cost-effective, and integrated cloud-based telemedicine system application, allows patient-to-doctor teleconsultation to provide continuity of care and accessible health services to all individuals in their homes. All Indian states and UTs have eSanjeevani. On 17 January 2923, eSanjeevani enabled 1,12,553 rural HWCs and 15,465 Hubs in tertiary hospitals and medical colleges in the states. This revolutionary method has benefited 9.3 crore people nationwide and serves 4 lakh patients daily. eSanjeevani—National Telemedicine Service of India is the world's most effective outpatient services system.

1.10 Brief Review of the Ayushman Bharat Programme:

Prime Minister Narendra Modi introduced Ayushman Bharat as part of the 2017 National Health Policy to attain Universal Health Coverage. The scheme will be funded with a 60 per cent contribution from the Centre and the remaining from the state. According to the most recent socio-economic caste census data, the plan targets impoverished, underprivileged rural households and defines an occupational group of urban worker's families.

Benefits are available at Government and listed private hospitals for those who qualify. Ayushman Bharat has placed India on an unstoppable route to universal healthcare. The system will continue to evolve, considering the evidence gathered during its implementation. Given the most significant political support for these measures, this programme has little chance of failing.

Ayushman Bharat plans to include innovative pharmaceuticals in its coverage of primary, secondary, and tertiary care for the public's health. Health and wellness centre construction and the Pradhan Mantri Jan Arogya Yojana are two parts of Ayushman Bharat's continuum of care strategy. (PM-JAY). PMJAY would provide yearly health insurance coverage of Rs. 5 lakhs per family to 50 crore individuals from 10.74 crores "deficient" households defined by SECC data. In addition, 18,550 hospitals are empanelled under the Government's flagship health insurance scheme. Of this, 54 per cent are private hospitals, and the rest are public. However, private hospitals cater to over 60 per cent of beneficiaries under the scheme, which has recorded over 50 lakh hospital admissions within a year of its launch.

1.10.1 Establishment of Health and Wellness Centers:

The most crucial part is the establishment of 150,000 Health and Wellness Centers, which will bring medical facilities closer to people's homes. Comprehensive Essential Social Insurance will be provided in these clinics, covering various medical needs, including prenatal and pediatric care, treatment for non-communicable diseases, distribution of essential pharmaceuticals at no cost, and provision of demonstration services.

1.10.2 A Brief Review of Pradhan Mantri Jan Arogya Yojana (PM-JAY):

Goal 3 of the Sustainable Development Agenda is to ensure that all people may enjoy physical, mental, and social well-being by 2030. PM-JAY represents a significant step in that direction (SDG3). In this context, "insurance" refers to providing health coverage for low-income and otherwise vulnerable families to protect them financially during a catastrophic health event. The Pradhan Mantri Jan Arogya Yojana (PM-JAY) is expected to help 10.74 crores of low-income, below-poverty-line (BPL), and urban worker families become financially stable, according to data from the 2011 Socio-Economic and Caste Census. It would need to provide each family in India with Rs. 500,000 in aid every year. As a general rule, for all methods of secondary and tertiary consideration. It will cover therapy and hospitalization expenditures. PM-JAY has identified 1,350 therapeutic packages, including drugs, diagnostics, transportation for medical procedures, and therapeutic and childcare pharmaceuticals.

The approach would be cashless and paperless at government hospitals and private medical clinics. The grantees will not be responsible for any fees associated with their hospitalization. Pre- and post-hospitalization expenditures are also included in the benefit. (https://economictimes.indiatimes.com/wealth/insure/ayushman-bharat-how-to-check-entitlement-and-eligibility/articleshow/65422257.cms).

By December 2022, 1,50,000 Sub Health Centers (the initial point of contact between the health system and the community) and rural Primary Health Centers (the referral unit for sub-centres) would be transformed into Health and Wellness Centers under the Ayushman Bharat plan. These clinics will provide free medications, diagnostics, and general care.

Table No. 1.15 Status of Implementation of Ayushman Bharat (as of January 2020):

Indicators	India
families that are part of the program (in lakhs)	1363
% Claims have been settled.	63%
The number of hospitals that have been approved as empaneled	19,752
Health and Wellness Centres	29,572

Sources: Ministry of Health and Family Welfare, answered on November 22, 2019; HWC

Table No. 1.15 shows that many families have already been covered under the Pradhan Mantri Jan Arogya Yojna, and 63 per cent of claims have already been paid to the beneficiaries. Currently, there are 19,752 Hospitals and 29,572 Health and Wellness Centres working and providing medical facilities to the general public.

1.10.3 Ayushman Bharat and COVID-19:

Recently, the National Health Authority has been working feverishly to prepare a particular COVID-19 plan as part of the game-changing programme in the medical domain. The Ayushman-PMJAY plan now covers hospitalization packages for critical care units and regular wards but does not cover preventative healthcare. The Ayushman Bharat plan, which provides yearly coverage of 5 lahks per household to disadvantaged individuals, does not include isolation wards. Because isolation wards are a need for patients infected with COVID-19, the expense to be borne by PMJAY will be considerably increased. COVID-19 coverage under the Ayushman Bharat Scheme is projected to help reduce the coronavirus's effect in India.

Table No. – 1.16 State-wise Allocation of Funds for Ayushman Bharat-Health and Wellness Centres (AB-H&WCs) under the National Health Mission (NHM) in India (2019-2020):

(Rs. in Crore)

States/UTs	Health system strengthening under NRHM(AB-HWC under NRHM)	NUHM FlexiblePool(AB-HWCunder NUHM)
Andaman and Nicobar Islands	1.36	0.07
Andhra Pradesh	42.65	15.29
Arunachal Pradesh	14.15	0.48
Assam	81.03	10.82
Bihar	116.39	5.64
Chandigarh	0.41	0.53
Chhattisgarh	44.58	4.84
Dadra and Nagar Haveli	1.23	0.02
Daman and Diu	0.73	0.02
Delhi	1.19	8.08
Goa	1.23	0.17
Gujarat	48.68	11.45
Haryana	19.21	5.57
Himachal Pradesh	21.77	0.19
Jammu and Kashmir	42.39	2.09
Jharkhand	44.16	3.04
Karnataka	51.53	13.04
Kerala	18.44	6.27
Lakshadweep	0.32	-
Madhya Pradesh	103.47	15.26
Maharashtra	83.99	37.19
Manipur	8.57	1.12
Meghalaya	9.17	2.32
Mizoram	4.41	2.64
Nagaland	6.22	2.57
Odisha	60.64	4.58
Puducherry	0.31	0.54
Punjab	20.91	5.56
Rajasthan	105.23	8.49
Sikkim	2.17	0.92
Tamil Nadu	50.40	19.46
Telangana	30.49	12.07
Tripura	9.27	4.14
Uttar Pradesh	213.31	23.78
Uttarakhand	24.98	1.70
West Bengal	65.00	20.05
India	1350.00	250.00

Abbr. : NHUM: National Urban Health Mission.

Source: Lok Sabha Unstarred Question No. 3301, dated 12.07.2019.

https://www.indiastat.com/table/economy-data/8/national-rural-health-mission-nrhm-2004-2020/20779/1284219/data.aspx

Ayushman Bharat's state budget allocations to health and wellness facilities are outlined in Table 1.16. These allocations are made following the National Rural Health Mission and the National Urban Health Mission. Under the National Rural Health Mission, the states of Uttar Pradesh and Bihar bring in the most money, with a total of 213.31 and 116.39 crores, respectively, for the development of rural healthcare. The minimum amount of money available in Pondicherry is 310,000 Rs. With a total of 23.78 and 19.46 crores, respectively, Uttar Pradesh and Tamil Nadu are the states that will get the highest funding from the National Rural Health Mission to construct robust urban health and health infrastructure. On the other hand, under the National Urban Health Mission, the states of Dadar Nagar Haveli and Daman and Diu get the least amount of funds.

Table No. 1.17 State-wise Funds Released under Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) in India (2018-2019 and 2019-2020- up to 25-11-2019:

(Rs. in Crore)		
States/UTs	2018-2019	2019-2020^
Andaman and Nicobar Islands	0.15	0.41
Andhra Pradesh	182.85	107.12
Arunachal Pradesh	2.31	-
Assam	21.08*	82.21
Bihar	88.27	-
Chandigarh	0.68	1.5
Chhattisgarh	217.43	23.54
Dadra and Nagar Haveli	3.25	-
Daman and Diu	1.02	-
Goa	0.64	0.04
Gujarat	77.5	212.33
Haryana	26.81	50.36
Himachal Pradesh	17.18	13.61
Jammu and Kashmir	20.64#	19.26
Jharkhand	170.17	-
Karnataka	159.31*	85.9
Kerala	25	36.28
Lakshadweep	0	-
Madhya Pradesh	72.57	84.6
Maharashtra	266.32	162.03
Manipur	7.18	7.18
Meghalaya	15.57	14.78
Mizoram	17.48	2.58
Nagaland	4.72	-
Puducherry	1.52	-
Punjab	2.24	23.95
Rajasthan	0	-
Sikkim	1.03	-
Tamil Nadu	304.98*	-
Tripura	12.81	5.6
Uttar Pradesh	85.01	72.49
Uttarakhand	12.54	7.96
West Bengal	31.28	-
India	1849.54	1013.76

Note : *: The above information relates to beneficiaries supported under PM-JAY in alliance with state schemes.
#: Including Ladakh.
^ : Upto 25.11.2019.
Source: Lok Sabha Unstarred Question No. 1185, dated 28.06.2019, Lok Sabha Unstarred Question No. 952, dated 22.11.2019 & Lok Sabha Starred Question No. 170, dated 29.11.2019.

Ayushman Bharat's Pradhan Mantri Jan Arogya Yojna allocation per state is shown in Table 1.17. The conditions of Gujarat and Maharashtra get the most cash under the Pradhan Mantri Jan Arogya Yojana, receiving 212.33 and 162.03 crores, respectively, to bolster their health care systems. Among all Union Territories in India, Goa's 4-million-rupee allocation to the Pradhan Mantri Jan Arogya Yojana is the lowest. Due to their refusal to participate in PMJAY, Telangana, Odisha, and Delhi, states were automatically disqualified. Since January this year, the West Bengal State Government has not participated in the programme.

1.11 Brief Review of Poshan Bharat Abhiyaan:

The Government will implement the POSHAN Abhiyaan to solve India's malnutrition problems. It is the objective of the POSHAN Abhiyaan to enhance the nutritional condition of children under the age of six, pregnant women, and nursing mothers during the next three years (2017-2019). The mission aims to gradually eliminate malnutrition in the country by applying a synergistic, results-oriented strategy with a lifecycle approach. In addition, the task ensures timely service delivery, intense monitoring, and intervention infrastructure.

Table No. 1.18 Objectives of Poshan Bharat Abhiyaan:

Sr. No	Objective	Target
1.	Stunting in children should be avoided and reduced (0-6 years)	By 6% to 2% p.a.
2.	Prevent and decrease childhood malnutrition (underweight prevalence) (0-6 years)	By 6% to 2% p.a.
3.	Reduce the number of children under the age of five who are anemic (6-59 months)	By 9% to 3% p.a.
4.	Reduce the prevalence of anemia among women and teenage girls aged 15 to 49 years.	By 9% to 3% p.a.
5.	Low Birth Weight Reduced (LBW).	By 6% to 2% p.a.

In above-given Table No. 1.18 shows the significant objectives and targets set under the Poshan Bharat Abhiyan. The target is set to reduce Stunting in children by 6 per cent to 2 per cent. Under the Poshan Bharat Abhiyan, another significant target is minimising low birth weight, lowering anaemia prevalence among children, and reducing undernutrition. The Mission aims to decrease the worldwide prevalence of stunting in children under the age of six from 38.4 per cent in 2016 to 25 per cent by 2022 (https://wcd.nic.in/sites/default/files/EOI-Engagement-of-Services-POSHAN-Abhiyaan_1.pdf).

1.11.1 Components of Poshan Bharat Abhiyaan:

Convergence:

Services for Children in Need, or Anganwadi Programs, Pradhan Mantri Matru Adolescent girls in this province may participate in a Vandana Yojana programme. Swachh Bharat Mission of the Ministry of Drinking Water Hygiene; Janani Suraksha Yojana, National Health Mission. National Rural Employment Guarantee Program of the Mahatma Gandhi Administration for Rural Development.

The goal should be achieved through department-level meetings with relevant ministers, joint ministerial conferences chaired by the Chief Cabinet Secretary, standard rules at each level, typical inspection visits, and decentralization plans.

Technology:

In the case of technology, frontline personnel can easily collect data using the mobile app, and a 6-level dashboard provides monitoring and action. CAS replaces 8.2kg paper files with 173g smartphones. It allows for automatically charting a growth chart on the mobile application, allowing for tracking children's growth.

Capacity Building:

POSHAN Abhiyaan, or "Step-by-Step Learning Methods," includes capacity building for integrated Child Development Services (ICDS). The Incremental Learning Approach (ILA) comprises 21 thematic modules for training SRGs, DRGs, and BRGs at the state, regional, and local levels (BRGs).

E-ILA (Learning and Management Solution):

The e-ILA program was created as a comprehensive web-based learning site for fieldworker training and evaluation. This helps ensure the long-term viability of ILA by introducing a mechanism that makes it easy to monitor learning outcomes using an e-learning platform.

Community Mobilization and Behavioral Change:

The effects of malnutrition may be seen for generations, despite efforts to improve newborn feeding practices, immunization, institutional delivery, early childhood development, fortification, access to clean drinking water and good sanitation, and nutritional diversity. It is affected by various factors, such as. Cause. Dealing with stunting, being underweight, and wasting, especially in adolescence, requires multifaceted strategies at the grassroots level, synergies, and sustained efforts that require convergence(ibid).

1.12 Review of Government Programmes for Nutrition and Healthcare:

1.12.1 Pradhan Mantri Matru Vandana Yojana:

This programme's primary purpose is to provide monetary incentives as part of the wage loss compensation so that the mother may get enough rest before and after the birth of the first alive child. In addition, pregnant women and lactating mothers would be more likely to seek medical help if given a monetary incentive (https://vikaspedia.in/social-welfare/women-and-child-development/women-development-1/pradhan-mantri-matru-vandana-yojana).

1.12.2 The Bal Sakha Scheme:

Many moms in Gujarat die while giving birth to their 12,000,000 annual offspring. Significant issues impacting mother and child health include malnutrition and a lack of access to appropriate maternity and child care. In addition, poor newborn development, a lack of proper and timely maintenance, and insufficient nutrition contribute to the early deaths of thousands of infants in the State each year.

These are significant mother and child health issues that need to be addressed immediately with the help of the Bal Sakha Scheme (https://nrhm.gujarat.gov.in/bal-sakha-yojana.htm).

1.12.3 Kasturba Poshan Sahay Yojana (KPSY):

The "Kasturba Poshan Sahay Yojana - The government of Gujarat launched a conditional Cash Transfer" programme to reduce malnutrition and anaemia among the state's BPL mothers. Cash assistance of Rs. 6000/- is offered to all BPL women to ensure proper nutrition throughout pregnancy. (http://www.nari.nic.in/schemes/financial-assistance-pregnant-women).

1.12.4 Doodh Sanjivani Yojna:

The Gujarat State Government established it to improve children's health in tribal regions. To enhance and enrich the nutrition of tribal primary school kids, the State Government also distributes milk with their noon meal to the tribal taluka's primary school children. The major goal of this programme is to reduce school dropout rates, ensure regular attendance in Government primary schools, and combat childhood malnutrition. This initiative benefits 30 lakh people by providing flavoured milk to children from Aanganwadi centres, primary schools, and nursing moms. (https://govinfo.me/doodh-sanjeevani-yojana-childrens-gujarat/).

1.13 Role of Primary Health Care in Covid-19:

Patients with respiratory symptoms are separated from those with COVID-19, early diagnosis is provided, and susceptible individuals are assisted in coping with their fear of the virus as part of the primary care provided for COVID-19. Supportive treatment and primary care services for individuals suspected of or proven to have COVID-19 at the primary care level are outlined in this document for use by national and local health care managers. Provides interim guidance for direct care workers—primary care when COVID-19 occurs(https://apps.who.int/iris/handle/10665/331921).

1.13.1 Primary Health Care in the Face of the Crisis:

Dengue, Zika, yellow, chikungunya, and COVID-19 pandemics make PHC essential. Emphasizing primary care essentials like monitoring vulnerable households and following up on suspected mild cases will help limit the outbreak and prevent Covid 19 instances from turning severe. Degeneration or onset of psychiatric disorders, domestic violence, alcoholism, and chronic illnesses are difficult to predict and require continuous, comprehensive treatment, all treated by primary care (https://doi.org/10.3399/bjgpopen20X101041).

Delivering proper treatments requires data-driven planning, trend-based service restructuring, financial allocation, and specific action steps to address the current pandemic (https://doi.org/10.3399/bjgpopen20X101041). These include healthcare professionals trained to meet the needs of quality people, and some steps have already been taken in this direction. For example, many diagnostic tests will be done if bulk testing is selected.

Appropriate facility for accommodating suspicious cases received by medical services. Drug inventory; more. Well-defined work (https://www.saude.gov.br/images/pdf/2020 /marco/20/20200318-ProtocoloManejo-ver002.pdf). Since primary health care effectively reduces health inequality, it has spread nationwide and their living conditions (https://doi.org/10.1371/journal.pmed.1002306).

1.13.2 Telehealth as a Care Option:

Telemedicine services attract service users because the virus is vulnerable to people, is likely to spread to confined spaces such as hospitals and emergency rooms, and needs to avoid abuse of medical services in the early stages of the epidemic. Enable critical care strategies to enable timely and accurate information on how to proceed individually (https://doi.org/10.1016/S0140-6736(20)30424-4). Proper implementation of these technologies will enhance the capabilities of healthcare systems to meet their needs, increase access to accurate advice, reduce congestion at PHC and other levels of healthcare, and bring designs to life. Improves the flow of people through the healthcare system for organizing. Furthermore, because many health personnel may be forced to miss work due to the pandemic, telehealth allows them to work remotely. Patients with chronic diseases who are currently followed up at health facilities benefit from this strategy's ability to improve access, comprehensiveness, the scope of treatment, service user convenience, and monitoring if applied at this level of care.

1.13.3 Linkages of Primary Health Care, Universal Health Care, and Sustainable Development Goals:

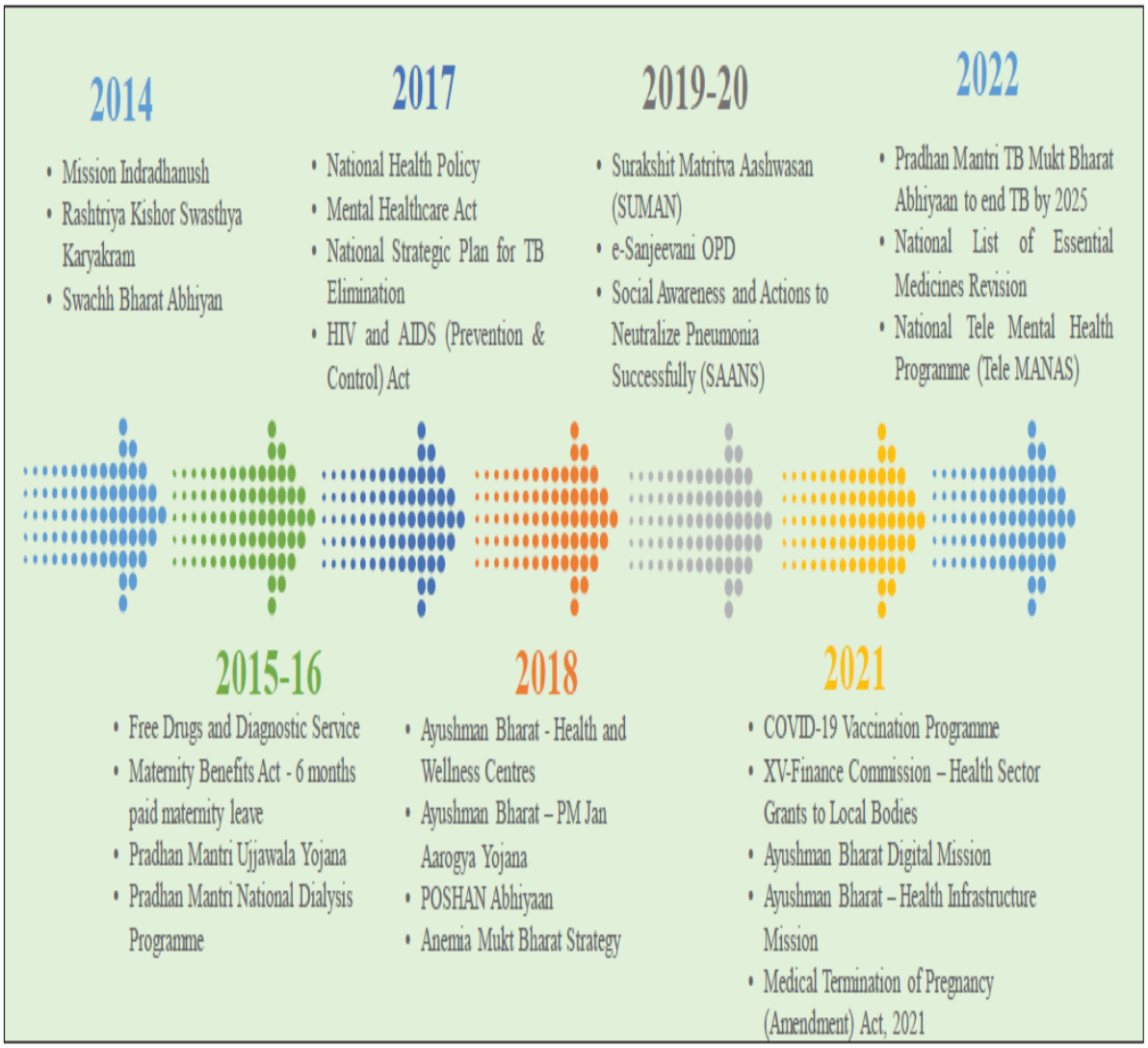
PHC provides a crucial basis for these endeavours. One of the primary areas of attention for the worldwide community is achieving UHC. UHC has multiple dimensions, including expanding access to quality services, medications, and vaccinations and enhancing financial protection (thereby decreasing household health expenditures). By addressing the underlying determinants of health and prioritizing population-level interventions that prevent disease and promote well-being, PHC plays a critical role in lowering family health expenditures. This minimizes the need for personalized treatment while preventing health problems from becoming more complex and costly. People and groups with more authority are more likely to push for increased financial protection for health care. Focusing on PHC is the best-value approach for countries toward universal access since it is a cost-effective means of delivering healthcare. Including empowered people and communities as co-developers of services enhances cultural sensitivity and patient satisfaction, leading to increased utilization and better health outcomes. Furthermore, there is substantial evidence that health systems focused on first-contact, continuous, comprehensive, integrated, and people-cantered primary care services offer superior health outcomes.

Moreover, the PHC's concentration on community-based care is the only method to reach rural and disadvantaged communities in most countries (https://www.who.int/docs/default-source/primary-health/vision.pdf).

1.14 Quality and Affordable Health for All:

The Government places a high value on guaranteeing access to high-quality healthcare for its inhabitants. The goal should be achieved with a wide range of efforts to improve the public's health as a whole that have been initiated and are continuing to be pursued.

Figure No.1.9 Major Initiatives from 2014 to 2022 for Better Overall Health:



The National Health Mission is the Government's deliberate endeavour to provide excellent healthcare to all citizens at a cost they can afford. This goal will be achieved by collaborating with all relevant sectors and stakeholders.

1.14.1 Presents Position of Health-Indicators:

Indian hospitals and clinics are now among the world's most enormous. In addition, health indicators have shown considerable improvement due to the implementation of sound health policies and programmes.

Table No.1.19 Progress in Health Related Indicators:

INDICATORS	NFHS-4 (2015-16)	NFHS-5 (2019-21)
Households with any usual member covered under a health insurance/ financing scheme (per cent)	28.7	↑ 41.0
Total fertility rate (children per woman)	2.2	↓ 2.0
Current Use of Family Planning Method- Any Method (per cent)	53.5	↑66.7
Mothers who had at least 4 antenatal care visits (per cent)	51.2	↑58.1
Institutional births (per cent)	78.9	↑88.6
Neonatal mortality rate (per 1000 live births)	29.5	↓24.9
Infant mortality rate (per 1000 live births)	40.7	↓35.2
Under-five mortality rate (per 1000 live births)	49.7	↓41.9
Children age 12-23 months fully vaccinated based on information from either vaccination card or mother's recall (per cent)	62.0	↑76.4
Children under age 6 months exclusively breastfed (per cent)	54.9	↑63.7
Children under 5 years who are stunted (height-for-age) (per cent)	38.4	↓35.5
Children under 5 years who are wasted (weight-for-height) (per cent)	21.0	↓19.3
Children under 5 years who are underweight (weight-for-age) (per cent)	35.8	↓32.1
Children under 5 years who are overweight (weight-for-height) (per cent)	2.1	↑3.4
Women who are overweight or obese (BMI≥25.0 kg/m2) (per cent)	20.6	↑24.0
Men who are overweight or obese (BMI≥25.0 kg/m2) (per cent)	18.9	↑22.9
Women age 15-24 years who use hygienic methods of protection during their menstrual period (per cent)	57.6	↑77.3

Source: National Family Health Surveys (NFHS) 2015-16 and 2019-21, MoHFW

India has improved mother and child health via the Reproductive, Maternal, Newborn, Child, and Adolescent Health Plus Nutrition (RMNCAH+N) approach. According to Sample Registration System (SRS) statistics, India has met the 2020 National Health Policy 2017 goal of reducing the Maternal Mortality Ratio (MMR) to below 100 per lakh live births by lowering it to 97 per lakh in 2018-20 from 130 per lakh in 2014-16. In addition, eight states have met the 2030 SDG objective of reducing MMR to 70 per lakh live births. Kerala (19), Maharashtra (33), Telangana (43), Andhra Pradesh (45), Tamil Nadu (54), Jharkhand (56), Gujarat (57), and Karnataka (57). (69). NFHS-5 indicates a 14.4% rise in Full Immunisation Coverage (FIC) over NFHS-4 and an increase in 30 states/UTs.

1.14.2 Present Status of Mortality Indicators:

Infant Mortality Rate (IMR), Under Five Mortality Rate (U5MR), and Neonatal Mortality Rate (NMR), which had been on a steady decline, have now fallen even more as a result of national efforts to expand access to healthcare services through improving service delivery, quality assurance, RMNCAH+N, human resources, community processes, information and knowledge, drugs and diagnostics, supply chain management, etc.

Table No.1.20 Trends in Mortality Indicators:

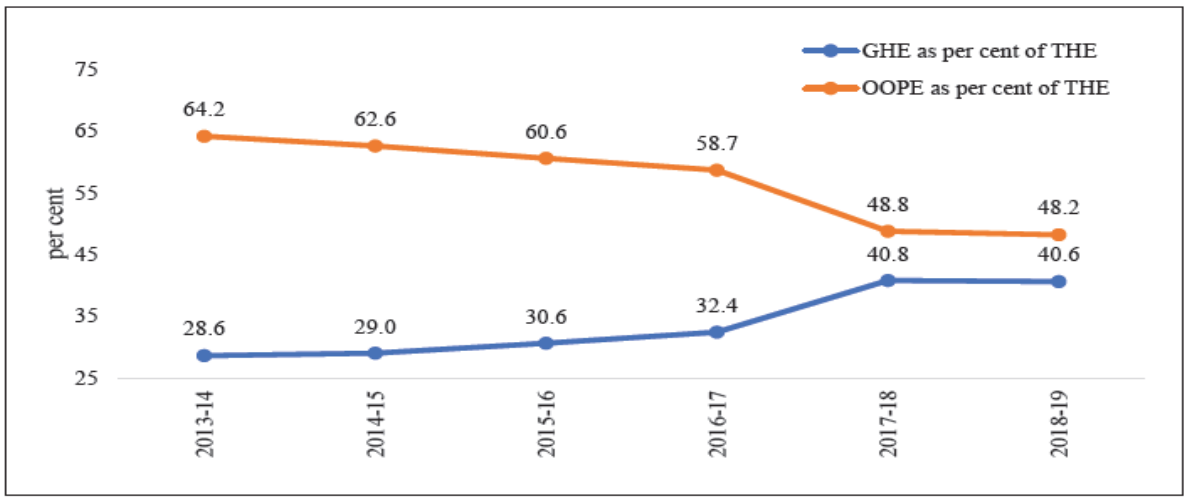
Indicators	Years			
	2014	2016	2018	2020
Maternal Mortality Ratio (per lakh live births)	167 (2011-13)	130 (2014-16)	113 (2016-18)	97 (2018-20)
Infant Mortality Rate (per 1000 live births)	39	34	32	28
Neonatal Mortality Rate (per 1000 live births)	26	24	23	20
Under 5 Mortality Rate (per 1000 live births)	45	39	36	32
Early Neonatal Mortality Rate – 0- 7 days (per 1000 live births)	20	18	18	15

Source: Sample Registration System

1.14.3 Health Expenditure Estimates:

The newest National Health Account (NHA) for FY19 emphasises the growing significance of public healthcare and social security in achieving universal health coverage. According to NHA estimates, Government Health Expenditure (GHE) in GDP rose from 1.2 per cent in FY14 to 1.3 per cent in FY19. The percentage of GHE to THE has similarly increased over time, from 28.6% in FY14 to 40.6% in FY19. As a result, the total expenditure on healthcare in India is expected to reach Rs. 5,96,440 crores in FY19 (3.2 per cent of GDP and Rs. 4,470 per capita). The current health spending is Rs. 5,40,246 crores (90.6 per cent of THE), while the current capital expenditure is Rs. 56,194 crores (9.4 per cent of THE). A total of 64.7% of GHE is funded by the state governments, while the federal Government contributes 34.3%.

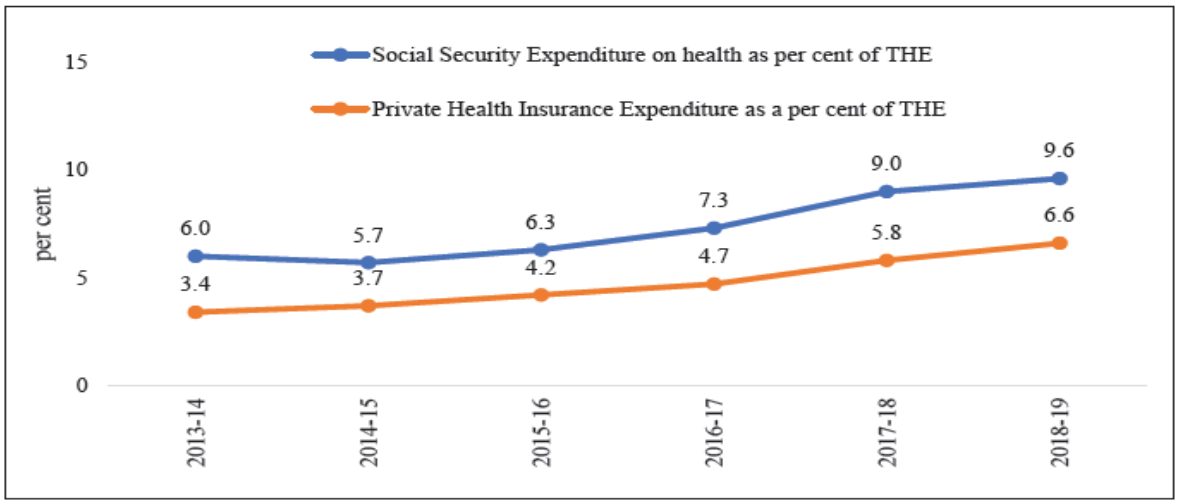
Figure No.1.10 Government Health Expenditure (GHE) and Out of Pocket Expenditure (OOPE) as per cent of Total Health Expenditure (THE):



Source: National Health Accounts, MoHFW

Primary healthcare spending has grown from 51.1 per cent in FY14 to 55.2 per cent in FY19, aligning with the National Health Policy 2017's proposal to provide healthcare to everyone. This improves primary care and minimises the need for secondary and tertiary treatment. As a result, primary and secondary care in the GHE rose from 74.4 to 85.7 per cent between FY14 and FY19. However, private health spending on primary and secondary care has dropped from 82.0 per cent to 70.2 per cent.

Figure No.1.11 Social Security Expenditures and Private Health Insurance Expenditures as per cent of Total Health Expenditure (THE):



Source: National Health Accounts, MoHFW

Primary healthcare spending has grown from 51.1 per cent in FY14 to 55.2 per cent in FY19, aligning with the National Health Policy 2017's proposal to provide healthcare to everyone. This improves primary care and minimises the need for secondary and tertiary treatment. As a result, primary and secondary care in the GHE rose from 74.4 to 85.7 per cent between FY14 and FY19. However, private health spending on primary and secondary care has dropped from 82.0 per cent to 70.2 per cent.

Figure No.1.12 Out of Pocket Expenditure as per cent of Total Health Expenditure wise for 2018-19

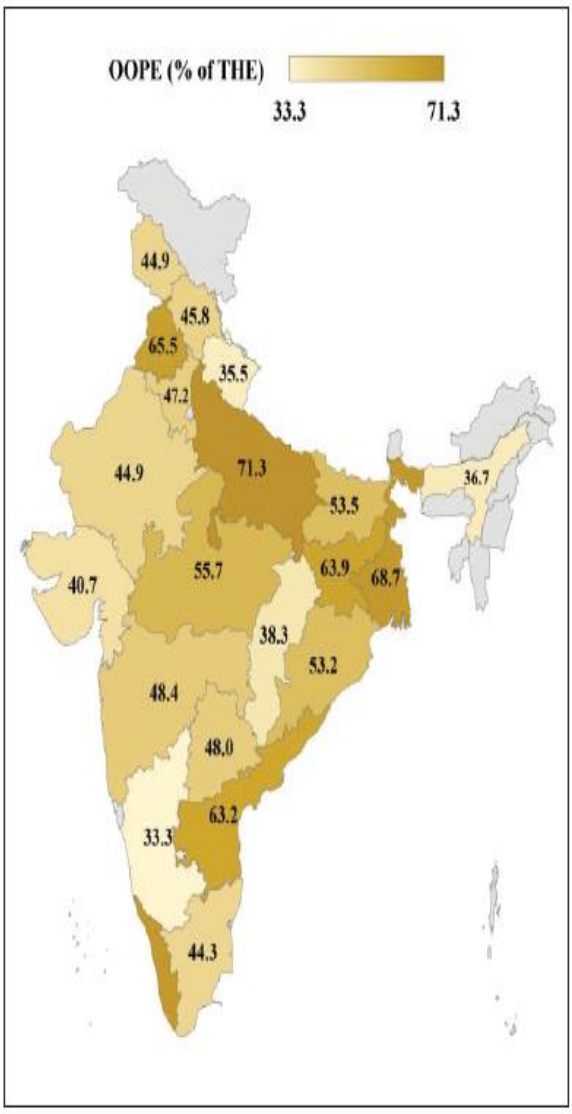
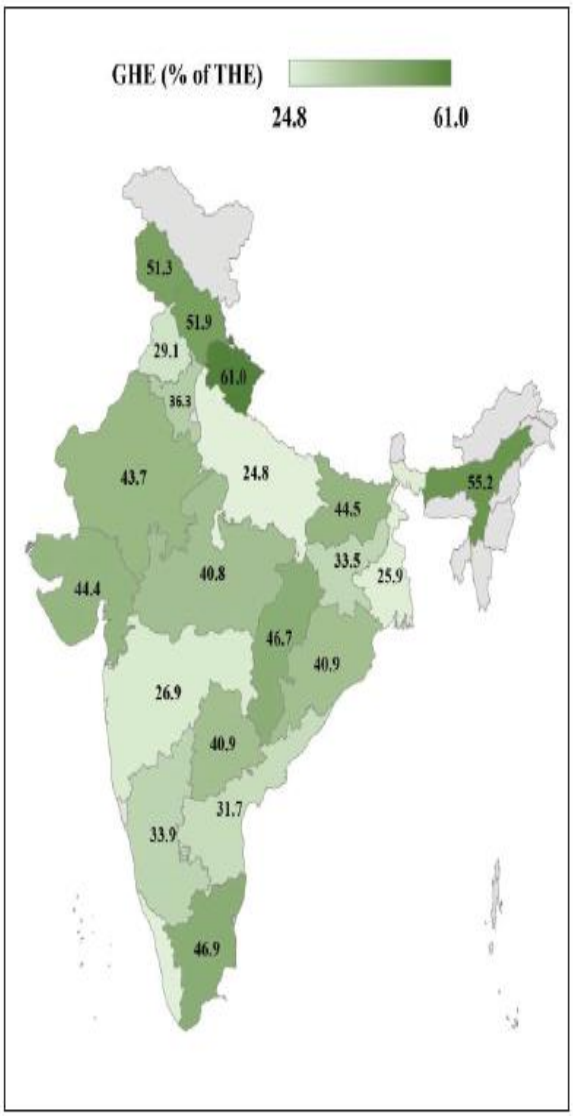


Figure No.1.13 Government Health Expenditure as per cent of Total Health Expenditure State State wise for 2018-19



Source: National Health Accounts 2018-19, MoHFW

Note: Jammu and Kashmir represents the erstwhile J&K including Ladakh

Recent changes in India's healthcare system have focused on improving its public health facilities and the quality of its medical workforce.

The growing availability of medical professionals and facilities in rural regions, including an increase in the number of Sub-centres, Primary Health Centres, and Community Health Centres, shows this. As part of the Ayushman Bharat initiative, existing SCs and PHCs are being upgraded to Health and Wellness Centres (HWCs) one at a time so that they may provide Ayushman Bharat's promised complete Primary Healthcare services. By the end of 2022, almost 1.5 million HWCs will have been installed.

1.14.4 Advantages of Primary Health Care in Covid-19:

- A national crisis to a virus epidemic or disaster such as COVID-19 begins with a strong PHC. Therefore, it is essential to use diagnosis, surveillance, and immunization to effectively and equitably limit the transmission of the disease while meeting the overall needs of the people.

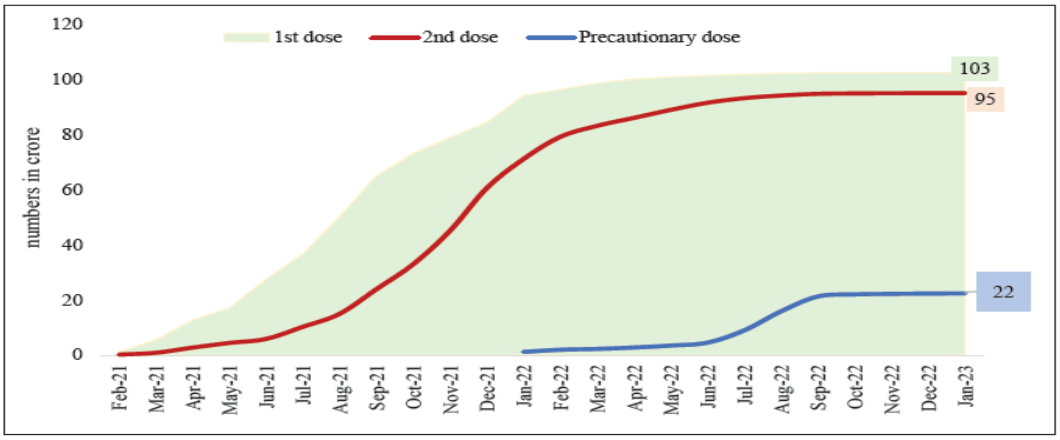
- PHC provides a strong foundation of a functional healthcare system that can provide high-quality, essential, and routine medical services to prevent future preventable illnesses and deaths during and after the epidemic.
- PHC staff and infrastructure improve COVID-19 immunity by improving vaccine access to vulnerable populations, providing essential and accurate vaccine safety and efficacy information, and building community trust.

- Governments and donors invest in primary health care (PHC) to achieve universal health insurance, recover from COVID-19, and build a resilient community in preparation (https://improvingphc.org/sites/default/files/COVID19%20and%20Primary%20Health%20Care_Key%20Messages.pdf).

1.14.5 National Covid-19 Vaccination Programme:

India's National Covid-19 Vaccination Programme, the world's biggest, started on 16 January 2021, intending to reach the adult population as quickly as feasible. Accordingly, the preventive dosage was increased to encompass all 12+-year-olds and 18+-year-olds. Test-Track-Treat-Vaccinate and Covid-appropriate behaviour remain the tested Covid management plan.

Figure No.1.14 Number of Covid-19 vaccinations:



Source: Ministry of Health and Family Welfare[47]

Research and development for new Covid vaccines, training of over 2.6 million vaccinators and 4.8 million other vaccination team members, optimal use of the available vaccine, hard-to-reach population, and the need to ensure all essential health services alongside scaling up of vaccination programme were all obstacles to the introduction of Covid-19 vaccines. It was also noted that there were certain logistical hurdles, such as storing and dispersing vaccines across 29,000 cold chain sites, increasing hard chain capacity, and building an IT infrastructure for identifying vaccination recipients and delivering vaccines. However, the programme overcame these obstacles and met its objectives quickly. India has administered about 220 crores of Covid vaccination doses since 6 January 2023. Approximately 90% of eligible individuals have received two doses of Covid-19 vaccination. On 16 March 2022, 12-14-year-olds were vaccinated; on 10 April 2022, 18-59-year-olds received the precautionary dosage. Over 4.2 crore adolescents have received the first Covid-19 vaccination and 22.4 crore preventive doses.

1.14.6 Community-Based Healthcare:

Community-based health care refers to services provided by a broad definition of community health care workers. This includes a wide range of public and professional, formal and informal, paid and unpaid healthcare professionals, and staff of institutions. All communities have local actors, connections, and processes that interact with the healthcare sector to provide quality, human-centric healthcare and build resilience for healthcare systems. Community health workers enjoy good relationships with these groups because they are trusted community members (https://apps.who.int/iris/rest/bitstreams/1277158/).

1.14.7 Community-based Delivery of Essential Health Services:

Nationally approved primary care programmes must provide capacity for avoiding morbidity and death via basic medical facilities to fulfil continuing population health requirements and minimize the consequences of the COVID-19 epidemic, such as Vaccination, chemoprevention, vector control, and treatment of infectious diseases; Taking specific steps to safeguard vulnerable groups such as pregnant and breastfeeding mothers, small children, and the elderly; managing emergencies that necessitate quick response and keeping referral systems up and running. Relevant community-based activities and consultations with appropriate community health workers are national and quasi-national processes to identify critical services, coordinate with COVID-19 response plans, and optimize health workers and service delivery. Must be included in (ibid).

1.14.8 Outreach and Campaign-based Prevention Services:

All triggered outreach services and epidemic responses are examples of community-based preventative efforts used to contain new health threats. While these measures can save lives, they also increase the risk of COVID-19 transmission between communities, medical professionals, and the general public. The influence of COVID-19 communication, the pace of illness recurrence, and the implications of not intervening should all be considered when deciding whether to continue, alter, or postpone these actions. Once COVID-19 infection was confirmed, the mass vaccination campaign was discontinued. However, oral vaccines given in single-dose vials, such as cholera and polio, can be safely self-administered or administered by caregivers during home visits when healthcare professionals are monitoring from a mile away Vaccine-preventable disease (VPD) outbreaks and deal with high pressure on the medical system and require risk and benefit analysis. Event-based (basishttps://apps.who.int/iris/rest/bitstreams/1277158/).

1.14.9 Time-Sensitive Conditions and Community-Based Acute Care:

Most acute and emergency medical services must continue throughout the COVID-19 pandemic due to their highly time-sensitive nature and ability to prevent death and harm at all stages of life. An increase in severely ill patients is expected, especially among patients with respiratory failure associated with COVID-19 and patients with other urgent medical conditions indirectly related to the pandemic environment. Individual community members and community health workers, especially those organized in the Community Based First Aid Responder (CFAR) program, can safely provide easy, inexpensive, effective first aid. Robust community-based acute and emergency services reduce excessive morbidity and mortality during and after the COVID-19 pandemic, enable a return to comprehensive service delivery, and develop more resilient systems. (ibid).

1.15 Conceptual Framework of Perception:

The layman’s Perception is the act of being aware of "one's environment through bodily feeling, which signifies an individual's capacity to comprehend" (Chambers Dictionary).

1.15.1 The Nature and Importance of Perception:

Perception is a multifaceted cognitive process that generates each individual's own, sometimes inaccurate, the mental image of the world. An employee's viewpoint may be regarded as a filter regarding organizational conduct. Because perception is mainly acquired, and no two people have the same learnings and experiences, each person has their filter, and identical situations/stimuli can result in quite different emotions and behaviours. One example is managers' general perception that employees always seek promotions, whereas, in reality, many are psychologically pushed to accept a promotion policy. As a result, managers seldom inquire whether the promotion should be provided, and occasionally, associates are unaware. In other words, the manager's perception of the world differs considerably from the associate's perception of the world (Buckingham, M.A R.C.U. S & Coffman, C. U. R. T, 1999).

1.15.2 Sensation versus Perception:

There are five senses: sight, sound, touch, smell, and taste. Quite a few "sixth senses" exist. However, psychologists do not wholly embrace any sixth sense, such as intuition. Numerous impulses from the outside and inside always overwhelm the senses. External stimuli include, but are not limited to, electromagnetic waves, mechanical energy in the form of pressure, and the chemical energy of olfactory and gustatory items. Muscular energy, digesting food, and the release of hormones from glands that modulate behaviour are all examples of internal stimuli. These instances illustrate how emotions mainly concern fundamental behaviours, primarily governed by physiological processes. According to one molecular expert, "the brain performs the smelling," not the nose (Shannon Brownlee with Traci Watson, “The Senses,” U.S. News and World Report, 1997). This is how we perceive the world in hues, shades, shapes, volumes, tones, temperatures, aromas, and flavours.

Perception is a far more complicated and broad concept than feeling. A complex combination of selection, organization, and interpretation might be characterized as the perceptual processor filter. Although raw data is primarily based on the senses, the cognitive process filters modify or alter this input. For example, the individual presumably detects that the item is moving by gently shifting their gaze to the other side of the object. On the other hand, the individual considers the thing immovable. The individual "sees" the item as immobile because the perceptual process has triumphed over the sensory process. Put another way, the perceptual process augments and diminishes the “real” sensory reality. Here are several organizational examples are following:

1. The administrative buy the programme they feel is the best, not the one recommended by the software developer.

2. A team member may be seen as a hard worker by one colleague and a lazy one by another.

3. The design team may consider a product to be of excellent quality, but a consumer may consider it to be of poor quality.

1.15.3 Perception Process:

The sensory organs (including the eyes, ears, nose, mouth, and fingers) instantly react to natural stimuli (such as light, colour, odour, texture, and sound) in a perception process. Everyone perceives stimuli in a way that matches their tastes, desires, and experiences. Perception consists of three phases: exposure, attention, and interpretation, as shown in Figure 08.

Figure No. 1.15 Perception Route:

Perception involves choosing, organising, and interpreting information to enhance consumer decision-making. The information input is the sensation that our sensory organs (i.e., sight, taste, hearing, smell, touch) receive during exposure; for example, information is submitted when you see, hear, smell, or touch an advertisement. Perception is the term used to describe all of these processes (Madichie, Nnamdi. 2012).

1.15.4 Steps Involved in Perception Process:

The following is the process of perception:

Exposure:

Exposure occurs when the stimulus reaches sensory receptors (visual, olfactory, or tactile). Consumers can choose to focus on some inspirations and ignore other stimuli or avoid specific signals.

Attention:

When the stimuli exceed the range of human sensory receptors, they are exposed (visual, olfactory, or tactile). Consumers may choose to focus on some inspirations and ignore others. Alternatively, we may take essential steps to avoid receiving specific signals. This depends on the stimulus (in this case, the lecture) and the recipient (your state of mind at the time). Consumers often experience sensory overload. When it comes to marketing, we are constantly being hit by marketing stimuli from commercial sources, resulting in endless competition to get our attention.

Interpretation:

The meaning we give to sensory input is called interpretation. Different people perceive stimuli and have different meanings for those stimuli. The two can see and hear the same thing, but depending on their expectations of the trigger, their interpretation can be as different as day and night. Ideas that we find attractive determine the interpretation we give them. Many marketing choices depend on choosing and motivating the proper schema to decide how people assess a product, packaging, or message (https://www.researchgate.net/publication/328676646).

1.15.5 Sensory Systems:

The perception process is driven by the raw data received by our five senses. For instance, while taking in information about the environment via one's ears, such as a music clip on Radio, the song evokes the first encounter with a young man's wife and the scent of her perfume when they finally meet the court. As it produces, it produces an internal sensory experience. The unique sensory quality of the product helps the brand stand out from the crowd, especially when it makes a special connection to the occasion. The five senses are shown in the table and show how they affect our perception.

Table No. 1.21 Perception and the Use of Senses:

Sense	Illustration
Smell	Aroma—deodorant and/or coffee smells that are sweet.
Sound	The music used in TV advertisements can have an impact on how the message is received and pleasant music tends to arouse positive emotions
Taste	The value of the brand image is frequently demonstrated in blind testing (Coca-Cola blind tests are a classic in this regard). On the flavor characteristics of Nigerian Guinness.
Touch	This is especially crucial for brick-and-mortar shops, but it may be difficult for internet retailers. Fabric samples are increasingly being included in publications by marketers.
Vision	Color influences our senses—consider how red and yellow signify speed, as seen in Kodak and McDonald's packaging.

Smell:

Smell, whether pleasant or unpleasant (i.e. fragrance or odour), can elicit strong emotions or have a soothing influence, particularly on the occasion of smells. As in the case of aromatherapy, they can also evoke memories or ease tension. According to the report, consumers exposed to flower and chocolate scents while watching flower and chocolate ads may spend a lot of time digesting product information and looking for other options within each product category. In addition, many customers want to regulate the smells in their surroundings. This rising desire has resulted in many new items being developed and re-created in recent years.

Sound:

Sound influences brand experiences and perceptions since it relates to emotions and feelings. It is not by chance that the sound of music constantly assaults us. In today's consumerist culture, our senses, particularly vision, do not appear to function in isolation. Consider how radio ads lag behind their television counterparts in terms of ad expenditure.

Taste:

Our taste receptors play a role in how we perceive various items. So-called "flavour houses" always concoct new combinations to appeal to consumers' shifting tastes. Scientists are close behind them as they create new instruments to evaluate these tastes. Coca-Cola and Pepsi use the tongue to assess the quality of corn syrups, and pharma companies like Roche have been known to develop medications that don't taste bitter. (Tagliabue, J. 2002). Changes in our society have an impact on the flavours we find appealing. Consumption of spicy meals has risen due to consumers' growing enjoyment of various ethnic dishes. For example, Chatkazz. Chasswala Business in Dairy Products.

Touch:

Although researchers haven't done much to examine tactile sensations' role in shaping consumer behaviour, it's evident that this sense is crucial. In response to requests from US bottlers for a soft drink container that could be easily seen in the dark, the now-iconic contoured Coca-Cola bottle was developed. Touches of all kinds, from the warm hands of a masseuse to the brisk air of a winter wind, may profoundly affect our well-being. There is evidence that physical contact may influence business transactions (Ellison, S., & White, E. 2000).

Vision:

Advertising, shopping planning, and packing are the most important visual aspects. They use colour, size, and layout to express meanings on the optical channel. Philips makes their gadgets slimmer and more colourful to give them a more youthful appearance.

Colours may even have a more direct impact on our emotions. Some colours (especially red) are thought to elicit arousal and promote hunger, whereas others (such as blue) elicit feelings of relaxation. (ibid).

1.15.6 Service Quality GAP Model (Parasuraman et al., 1985):

According to Parasuraman et al. (1985) "Service quality is a function of the gaps between expectations and performance across the quality dimensions. They developed a service quality model based on gap analysis". Detailed discussions in the model are as follows:

Gap1: "Difference between consumer expectations and management's perceptions of those expectations, i.e., not knowing what customers anticipate".

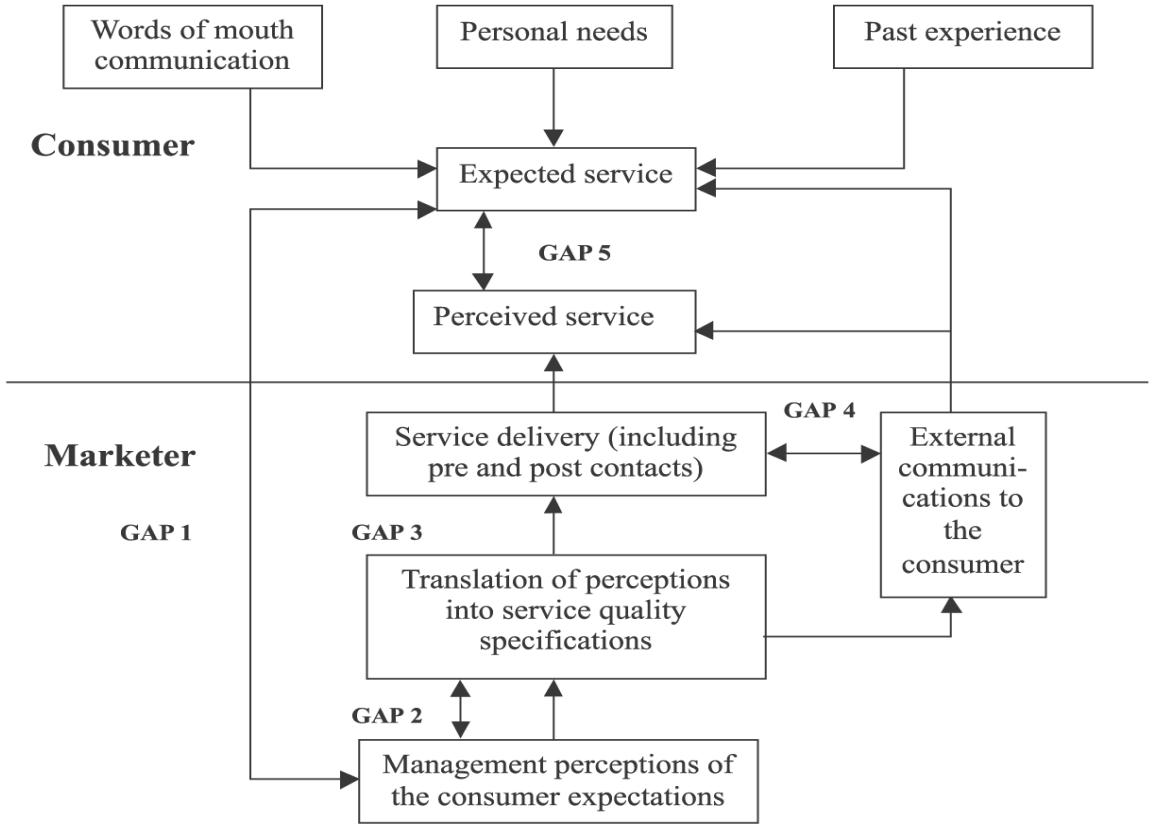
Gap2: "Difference in management's beliefs of customer expectations and service quality criteria, resulting in poor service quality standards".

Gap3: "The discrepancy between the service quality requirements and the service delivered is known as the service performance gap".

Gap4: "Is there a distinction between service delivery and customer service delivery communications, i.e., if promises are kept?"

Gap 5: "The disconnect between what customers expect and how they see service. The amount and direction of the four gaps associated with the marketer's delivery of service quality determine this gap".

Figure No. 1.16: Service Quality GAP Model:



Source: Parasuraman *et al*. (1985)

This preliminary study evolved into the SERVQUAL scale, which measures consumers' views of service quality. (Parasuraman and colleagues, 1988). Reliability, responsiveness, specificity, self-confidence, and empathy have been considered for service quality.

1.15.7 Sub-Processes of Perception:

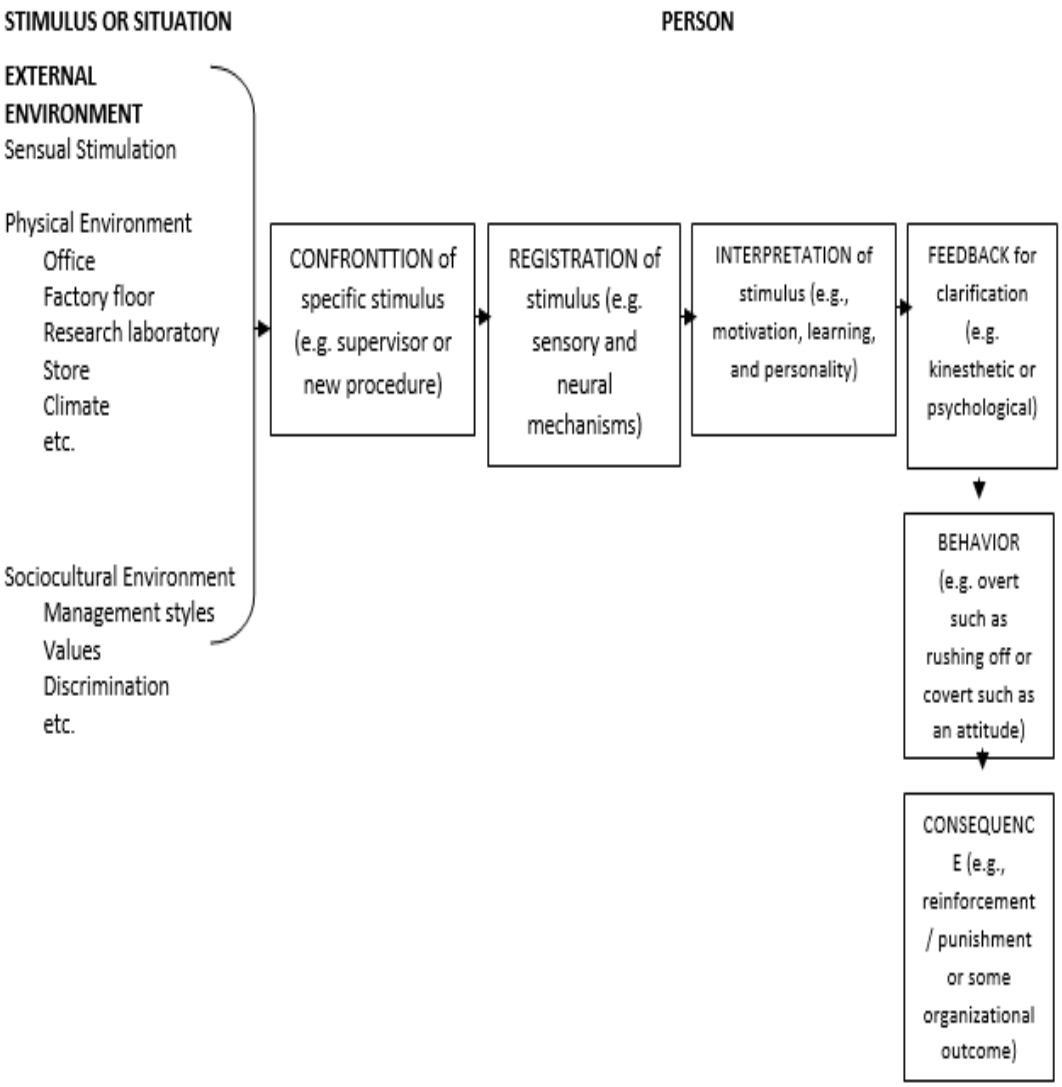
Perception's complexity and interactive character may be seen in several sub-processes. The stimulus or condition that is present is the first significant sub-process. When a person is exposed to a stimulus or circumstance, perception starts. Examples are bosses and employees facing the overall formal organizational environment.

Any or all of these factors can trigger an employee recognition process. For example, a cognitive function includes internal recording, interpretation, feedback, and external environmental and interpersonal interactions. In addition, physiological systems will be impacted during the registration phenomenon, altering how we hear, see, and perceive it.

Psychological feedback may take the form of a manager's altered eyebrow position or tone of voice, which can significantly impact an employee's worldview. In addition, studies show facial expressions (Carroll, J. M., & Russell, J. A. 1996).

The term "cognitive-behavioural cessation" describes any overt or covert response or activity needed when thinking is seen as a behavioural event, as it is in the context of organizational behaviour. For example, employees can move quickly or slowly and perform perceptual self-assessment (covert behaviour).

Figure No. 1.17: The Sub-Processes of Perception:



These different aspects of perception align with the social cognitive framework, as seen in Figure 1.10. The first condition is the presence of stimulation or the surrounding environment. The individual's mental process performs the functions of registration, interpretation, and feedback. The effects on the surrounding environment follow the ensuing conduct (Kim, M. S., & Hunter, J. E. 1993).

1.15.8 Perceptual Selectivity and Organization:

Everyone is continuously bombarded with a variety of stimuli. The sound of the air conditioner or computer printer and outside noises from automobiles, planes, or street maintenance work are just a few of the inspirations that affect the senses - not to mention the overall impact on the environment. Subliminal perception occurs when stimuli are delivered below a person's conscious threshold.

1.15.9 Attention Factors in Selectivity:

Various external and internal attention variables influence perceptual selectivity. Impacts on the external environment, such as strength, size, contrast, repetition, movement, novelty, and familiarity, are examples of external variables.

1. **Intensity:**

   The eye depth principle states that the more powerful an external signal is, the more likely it is to be perceived. More attention will be drawn to loud noise, pungent odour, or spectacular light than a quiet noise, weak smell, or dim light. Advertisers employ depth to pique the interest of their target demographic. Bright packaging and tv advertisements that are louder than the standard programme are examples. To draw attention, supervisors may raise their voices. This last case demonstrates how additional, more complicated psychological factors may outperform a single external variable. Instead of attracting their attention, the supervisor may be turning them off by speaking loudly. All parts of the perceptual process are affected by these sorts of problems.

2. **Size**:

   Instead of attracting their attention, the supervisor may be turning them off by speaking loudly. All parts of the perceptual process are affected by these sorts of problems. While undoubtedly important, the concept of strength is just a minor component of the perceptual process, which is only a portion of the cognitive function and a fraction of what goes into human behaviour.

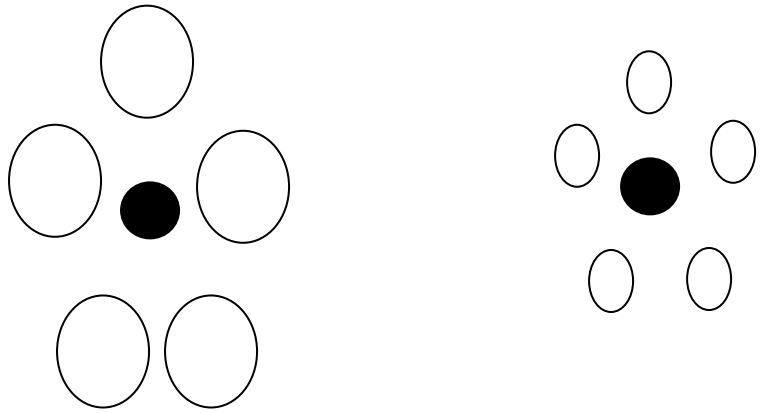
3. **Contrast**:

   The contrast principle says people notice things that stick out or are unexpected. The illustration depicts this perception. The background circles make the right black ring look more prominent than the left. Black circles are equal. A 5-foot 2-inch, the 120-pound boss may get the same attention as a 6-foot 5-inch, 250-pound supervisor. An experienced worker scarcely notices the manufacturing floor's loud noise. The noise level would change immediately if one or more machines stopped.

4. **Repetition:**

   The repetition principle states that a stimulus has to be shown several times before it is noticed. Workers tend to "hear" better when given repeated instructions for a tedious task. This theory helps to explain why supervisors have to repeat instructions for even the simplest of jobs. Workers' interest in a tedious activity may be diminishing, and the only way they can hear instructions is for supervisors to repeat themselves multiple times. Advertisers seeking to establish a distinct image for a product undifferentiated from its rivals – such as aspirin, soap, and deodorant – depend heavily on repetition.

Figure No. 1.18: The Contrast Principle of Perception: Which black circle is more prominent?:



5. **Motion**:

   According to the principle of movement, people will pay more attention to objects moving in the field of view than to stationary objects. For example, production line workers may not be aware of relatively comfortable working conditions because they focus on the line of slow-moving products they are working on. Advertisers are leveraging this idea by designing signage with moving components. An example of an ad is in Las Vegas at night.

6. **Novelty and Familiarity**:

   It argues that an attention-getter might be either a fresh or an ordinary external circumstance. The perceiver's attention will be drawn to new items or events in a familiar environment and familiar objects or occurrences in a new one. This idea is demonstrated via job rotation. Research shows that job rotation boosted attention at a big pharmaceutical company and improved employees' acquisition of new abilities. (Campion, M. A., Cheraskin, L., & Stevens, M. J. 1994). Changing workers' jobs regularly encourage them to pay more attention to the task. According to a recent meta-analysis, culture substantially influences perceptual judgments. Collectivist countries, for example, had higher levels of compliance than individualist countries. (Bond, R., & Smith, P. B. 1996).

   As a result, people will choose from the environment stimuli or circumstances that appeal to and are suitable to their learning, motivation, and personality. Recent fundamental research, for example, suggests that language and education influence how people see colours. For example, African languages have five colour terms, but Russian has the same number as English, plus one more type of blue. “Learning new colour categories causes modest but significant changes in how people see those colours,” researchers discovered (Benson, E. 2002 and Waller, M. J., Huber, G. P., & Glick, W. H. (1995).

Some employees have learned to view the world around them similarly in the workplace. One study revealed that a sample of managers' functional backgrounds (e.g., accounting, finance, marketing, human resources, and research and development) substantially impacted how they evaluated changes in their businesses' performance. (Waller, M. J., Huber, G. P., & Glick, W. H. 1996).A recent study has discovered the opposite results of a primarily negative link between functional experience and perceptions (Janice M, Beyer, Prithviraj Chattopadhyay, Elizabeth George, William H. Glick, at Ogilvie and dulce Pugliese 1997). A single statement, "I cannot recommend this young guy too highly," was copied and given to various managers in the same organization in another research. Even though this remark is vague and confusing, all managers considered it a favourable recommendation. They'd all learned to interpret this phrase the same way — positively. (Swanda, J. R. 1979).

1.15.10 Perceptual Organization:

Perceptual organization is concerned with what happens after the information from the scenario is absorbed. For example, an individual rarely perceives colour, light, or sound patches. Instead, the person will see well-organized patterns of stimuli as well as entirely different things. For example, when a college student is shown a basketball, the student does not usually perceive it as brown, as gain-leather in texture, or as the odour of leather. Instead, the student perceives a basketball with, in addition to the characteristics named, a potential for giving the perceiver fun and excitement as either a participant or a spectator. Put another way, the person's perceptual process arranges the incoming data into a coherent whole. The perceptual organization has numerous principles similar to selectivity.

1.15.11 Figure-Ground:

The most fundamental kind of perceptual structure is typically thought to be figure-ground. The figure-ground principle essentially states that seeing things stand out as distinct from their surroundings. It can be proven effective by reading this text. On the other hand, the reader does not see it that way. Instead, the reader sees black shapes displayed against a white backdrop, such as letters, words, and phrases.

1.15.12 Perceptual Grouping:

The perceptual organization's grouping principle argues that there is a propensity to group many inputs into a recognized pattern. This is a fundamental idea that may be substantially inborn. In the grouping, there are certain underlying uniformities. For example, when people are presented with essential stimuli, they categorize them according to closure, continuity, closeness, or resemblance.

Closure:

The Gestalt school of psychology is strongly associated with the closure concept of grouping. A fundamental gestalt principle is that a person may see a whole even when one does not exist.

The person's perceptual process will fill in the blanks left by sensory data. Participants in the formal organization may see a whole when none exists or be unable to fit the pieces together to make a whole that does exist. For example, the leader of a project team may mistakenly believe that all team members agree on a specific project while, in reality, many members are opposed. In this case, the team leader filled in the gaps and gave the impression of total agreement when there was none. An example of the other side of the coin is the adage of being unable to see the forest (whole) because of the trees (parts). The extreme specialization of functionally oriented managers has led them to lose track of the organization's overarching objectives on several occasions. Specialists may become so engrossed in their expertise and responsibilities that they lose sight of the larger purpose. As a result, they cannot join their parts with the others to perceive the whole. Because of this issue, most businesses today encourage inter-functional architectures emphasising horizontal rather than conventional vertical hierarchical organizational structures.

Continuity:

Continuity is closely related to the closure. Some psychologists do not even bother to distinguish between the two grouping principles. There is, nevertheless, a distinction. The continuity principle states that a person will likely see continuous lines or patterns, whereas closure provides missing inputs. Organizational participants may become inflexible or noncreative due to this type of consistency. Only the most evident, long-term patterns or correlations will be seen. For example, a new design for a production process or product may be restricted to clear flows or continuous lines—ideas for a seamless organizational structure that are new and unique.

Proximity:

A set of stimuli that are close together will be seen as a complete pattern of components belonging together, according to the concept of proximity or nearness. For example, a group of workers working on a single procedure may be viewed as a single entity. However, suppose the production is poor, and the supervisor receives numerous complaints from the group. In that case, management may mistakenly believe that all of the workers in this process are troublemakers while, in reality, some of them are loyal and devoted employees. Despite this, departments or workgroups are sometimes viewed as a single unit due to their physical proximity. As teams grow more frequently in today's workplaces, this closeness concept will aid in identifying them as a single unit.

Similarity:

The principle of similarity states that stimuli will be interpreted as a unit when their degree of similarity is maximized. Similarly, although it is theoretically connected to proximity, it is usually stronger than proximity. While it's easy to generalize about a company's blue-collar workers, it's important to remember that behind every uniform is a unique person. Similarity also applies to minorities and women. Unfortunately, there is a tendency to perceive minority and women employees as a single group. This can lead to stereotyping problems, discussed in a later section.

1.15.13 Perceptual Constancy:

One of the most advanced types of perceptual structure is consistency. It provides a sense of security in an ever-changing world. This idea allows an individual to maintain consistency in a highly changeable and complicated environment. Learning is considerably more critical than figure-ground or grouping phenomena.

Regardless of the information acquired by the senses, an object's size, shape, colour, brightness, and position remain broadly consistent. It should be pointed out that perceptual constancy results from patterns of cues. Mostly, these patterns are learned, but each situation is different, and there are interactions between the inborn and learned tendencies within the entire perceptual process.

The world would be highly chaotic and unorganized for the person if consistency were not there at work. An organizational example is a worker who must choose a material or tool of the correct size from a large assortment situated at varied distances from a workstation. Without perceptual constancy, everything would change sizes, shapes, and colours as the worker moved, making the task practically impossible.

1.15.14 Perceptual Context

In context, the highest and most complex kind of perceptual organization. Simple stimuli, things, events, circumstances, and other people in the environment are given meaning and worth by it. The visual stimuli are meaningless on their own.

The corporate culture and structure provide the fundamental context in which employees and managers see. A verbal instruction, an email message, a new policy, a suggestion, a raised eyebrow, or a pat on the back take on new meaning and importance in the workplace.

1.16 Social Perception:

Because social elements of perception are so essential in organizational behaviour, they get a lot of attention. For example, ‘How one person views other people is strongly related to social perception’.

1.16.1 Characteristics of Perceiver and Perceived:

A review of classic study findings given the features:

1. Having a good understanding of oneself makes it simpler to view others.
2. One's attributes impact the traits that others are likely to exhibit.
3. People who accept themselves are more inclined to notice the positive qualities in others.
4. Accuracy in perceiving others is not a single skill (Zalkind, S. S., & Costello, T. W. 1962).

According to the concept of motion, viewers give their attention to whatever is now moving inside their field of vision. Because of their intense concentration on the slow-moving items in front of them, production line employees may be oblivious to the pleasant working circumstances around them. Advertisers are leveraging this idea by designing signage with moving components. An example of an ad is in Las Vegas at night (Luthans, F., & Avolio, B. J., 2003).

The person's traits also affect social perception:

1. The perceived status of the individual will have a significant impact on how others see the person.
2. To make the viewer's perceptual processes more accessible, the individual being viewed is generally divided into groups. Status and role are two frequent categories.
3. The outward characteristics of the individual viewed will have a significant impact on how others perceive the person. (Zalkind, S. S., & Costello, T. W, 1962).

These qualities of the perceiver and the perceived suggest the complexity of social perception. Participants in an organization need to understand that their beliefs about others are greatly influenced by their qualities and traits. For example, if a leader has strong self-esteem and others are well-characterized and distant, the leader may be watching them. On the other hand, management with low self-esteem and an arrogant salesman might generate a terrible impression. People's social views and subsequent conduct are heavily influenced by their attributions of others. Many complicated elements influence social perception, but the issues connected with stereotyping, the halo effect, and the cognitive process of causal attribution, which will be discussed next, are the most significant.

Stereotyping:

Stereotypes are the tendency to categorise people into groups. Typographers use the phrase for a printing plate made from a pre-composed type. Walter Lippmann coined the term "perception" in 1922. Since then, the word "stereotyping" has come to be used to characterize perceptual mistakes. It is instrumental in the study of bias. Stereotyping may assign positive or negative qualities to the stereotyped individual, which is not often accepted. Most of the time, a person is stereotyped since the perceiver only knows the broad group to which the individual belongs. However, because each person is unique, the person's actual characteristics will usually differ significantly from what the stereotype suggests.

There may be consensus on the traits that members of diverse groups share. Individual distinctions and a considerable degree of diversity exist among members of this and all other groups, on the contrary. Despite this, other organisation members frequently form broad judgments and act accordingly. One study found that one of General Motors' key issues is the company's standardized set of managerial ideas regarding consumers, workers, international rivals, and the Government.

These attitudes enable GM's top brass to point fingers at the stereotypical rather than admit that the company's problems lay inside its own corporate culture and seek to change it from the ground up (O'toole, J. 1999). According to Steele, C. M. G (1997), Long-term exposure to unfavourable stereotypes has also been linked to inferiority anxiety and reduced expectancies. There is a slew of additional academic papers and daily instances that relate to stereotyping and the issues it causes in the workplace. (Jackson, L. A., Sullivan, L. A., & Hodge, C. N. 1993).

The Halo Effect:

Stereotyping is quite similar to the halo effect in social perception. However, the halo effect differs from stereotyping in that it perceives a person based on a single attribute rather than a single category. This is called a halo if the evaluator makes a mistake in assessing an individual's overall personality or performance based on a single superior character, such as intelligence, attractiveness, credibility, or willingness to cooperate. Whatever the single feature is, it has the potential to overcome all other qualities in creating a person's perspective. For example, when deciding to hire or assess an individual's performance, the individual's appearance and clothing may take precedence over all other factors. Complete opposition may be shown in cases of the "horn effect," in which a person is degraded for a single unfavourable attribute or occurrence (Angelo S. DeNisi and Ricky W. Griffin. 2001).

1.17 Attribution:

Attribution is the process of explaining the roots of someone else's conduct. It's the conceptual process through which people infer elements that impact or excuse one another's behaviour (McCabe, D. L., & Dutton, J. E. 1993). In social cognition, people create two types of attribution. Human conduct may be explained by disposition attribution when considering internal elements like character, motivation, and talent or by situation attribution when considering external factors like resources and social influences—influence (Spencer A. Rathus 1990).

1.17.1 Attribution Theory:

"The cognitive process through which a person recognizes that conduct is created by a specific aspect of the environment involved is important to attribution theory," writes renowned social psychologist Harold Kelley. The idea is that most of the causes, properties, and "reasons" are invisible, so humans need to rely on cognition, especially perception. In addition, people are naturally curious and driven by a need for knowledge, say proponents of the attribution theory.

1.17.2 Locus of Control Attributions:

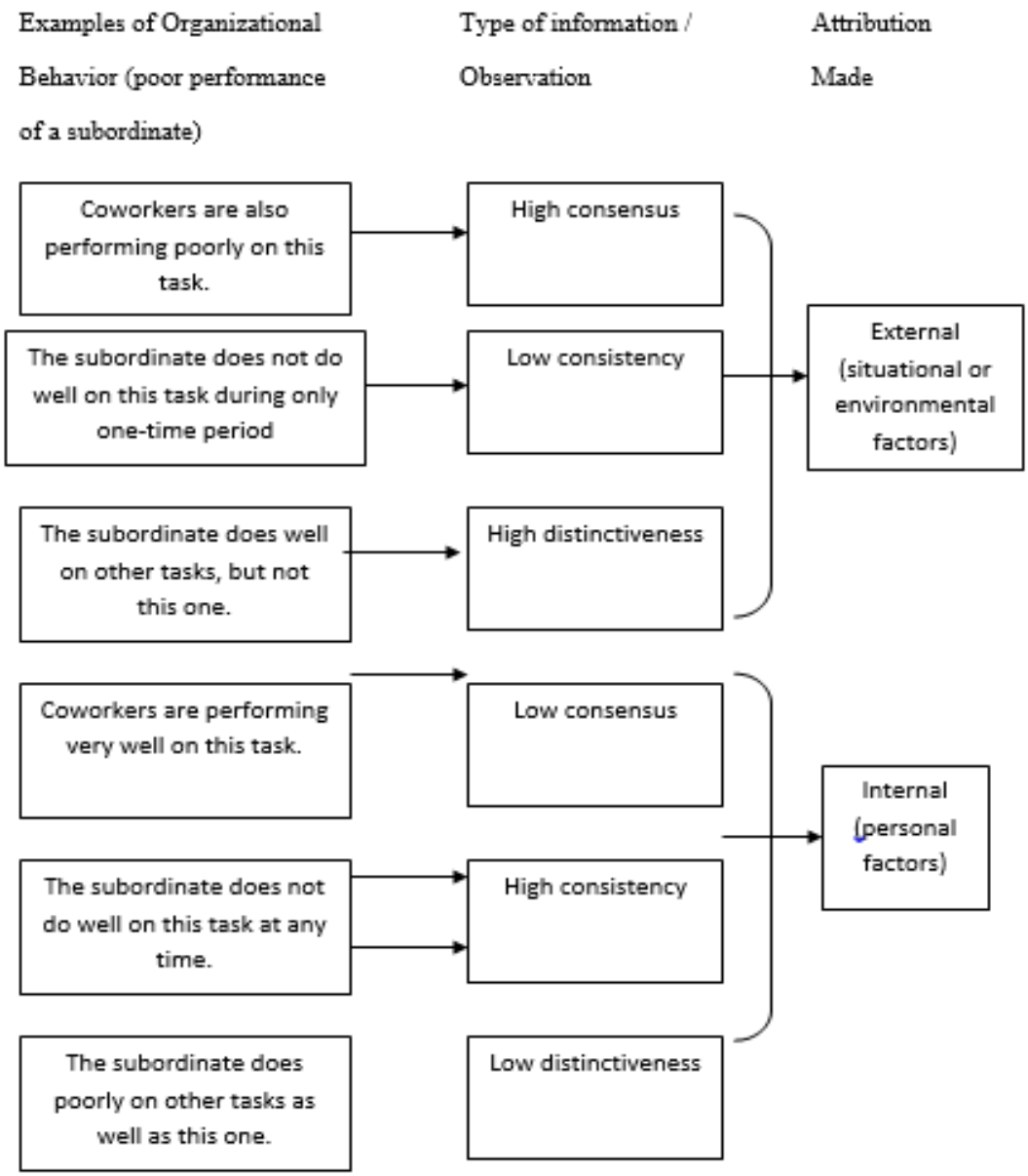
According to the theory of where control lies, workers will act differently based on whether or not they feel accountable for the outcomes of their efforts. Workers who experience internal control think they can make a difference through their skills and efforts. Employees who believe they are under the influence of other factors B. The luck and difficulty of work, they believe their consequences are beyond their control. Their performance and enjoyment can be affected differently depending on the location of their perceived power. There has been a lot of progress in the research of attribution and other organizational behaviour factors. Recent research suggests that an individual's locus of control mediates the connection between motivation and incentives, affecting their performance and job satisfaction (Spector, P. E. 1982 and Krenl, L. 1992).

Further states that attribution is linked to the symbolism of an organization and that understanding an organization requires understanding its symbolic character. (Frost, P. J. 1985). According to this theory, attributions, rather than facts, provide the basis for most forms of organization (Moussavi, F., & Evans, D. A. 1993). In addition, research shows that symbols influence psychological perceptions (Ornstein, S. 1986).

1.17.3 Other Attributions:

Attribution theory improves organizational behaviour comprehension. Bernard Weiner suggested recognizing stability (fixed or changeable) (Bernard, W. 1972). Experienced employees will likely have a constant internal attribution about their skills but a variable one regarding effort. These workers may attribute luck and job difficulties differently. As demonstrated in Figure 1.12, external or context/environmental elements may cause it to be unanimous, inconsistent, and unique. For example, external attribution might be that the job is too complicated or that family or work demands limit performance. However, internal or personal factors of behaviour might create common consensus, high consistency, and low distinctiveness. When a supervisor makes an internal attribution, they may infer that the subordinate lacks competence, is not putting up the appropriate effort, or lacks the drive to work effectively.

Figure No. 1.19 Kellye's model of attribution:



1.17.4 Attribution Errors:

When people make attributions, social psychologists identify two powerful biases. The fundamental attribution mistake is the first. According to research, individuals tend to overlook strong situational influences while describing other people's conduct. Instead, people prefer to attribute the behaviour of others to their characteristics, even when it is clear that an individual has reacted like themselves due to an event or situation. Another attribution bias the survey has shown is that people prefer an optimistic view. People can quickly become aware of their success, but failure is often attributed to external situational variables such as bad luck or the inherent "impossible" of the problem. For example, athletes often attribute their wins to themselves but tend to blame the loss for something else, such as running.

Standards: bad breaks, bad leadership, or tremendous effort from other teams (Mullen, B., & Riordan, C. A. 1988). When anything goes wrong at work, the supervisor sometimes blames the employees' ineptitude or bad attitude, even when it's their responsibility. Subordinates are the opposite. They blame their problems on the situation, yet they make a personal accusations against their employer. If all goes well, the boss assigns a person's attribution to himself and a situational attribution to his subordinates.

In contrast, the subordinate gives a person's attribution to himself but assigns a situational attribution to his boss. In other words, corporate managers and subordinates typically have the opposite attribution bias (Johns, G. 1999). Theorists and researchers recommend strengthening interpersonal connections, opening communication channels and workshops, and reducing attribution mistakes to lower party perceptions and promote more effective partnerships. You must conduct a team-building session (Kottke, J. L. 1994).

1.18 Perception Towards Healthcare:

Finding strategies to make health services in developing nations more client-centred is a significant problem. Indifferent treatment of patients, unofficial payments to doctors, a lack of patient privacy, and insufficient medicine and supply deliveries are all too prevalent. Yet, standard quality evaluation techniques seldom recognize these. Assessing patient views gives users a voice, which, if given systematic attention, can make services more responsive to people's wants and expectations, critical components of improving the effectiveness of health systems. In addition, customer happiness determines service quality, a vital part of an employer's brand. In this setting, the healthcare industry's primary objective is to offer the best medical facilities to its patients to remain competitive (Pramanik A. 2016).

1.18.1 Patient Perceptions and Expectations from Primary Healthcare:

The quality of medical treatment for most people significantly indicates social development and a country's health. Primary healthcare services must meet the criteria viz; They must be efficient in terms of cost, methods, and organization; they must be readily available to people who need them and be acceptable to the community served at an affordable price. Persons should be able to get quality healthcare at an affordable price, in a manner and language appropriate for the community and the people receiving the service, and in a way that respects local traditions and customs. Patient satisfaction is correlated with treatment adherence, clinical results, service availability, and risk management. Thus, patient satisfaction is a crucial measure of the quality of treatment provided and a vital indication in the assessment and improvement of medical services (Ardey, R., & Ardey, R. 2015).

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