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HEALTHCARE BUSINESS ENVIRONMENT

MASTER OF BUSINESS ADMINISTRATION
(HOSPITAL ADMINISTRATION)

FIRST YEAR,

SEMESTER-I, PAPER-VI

Lesson writers

Dr. P. Srinivasa Rao
Faculty
Dept. of Hospital Administration
Acharya Nagarjuna University

Dr. B. Sridhar Reddy
Faculty
Dept. of Hospital Administration
Acharya Nagarjuna University

Dr. Sayyed Sadhik
Faculty
Dept. of Hospital Administration
Acharya Nagarjuna University

Editor
Prof. V. Chandra Sekhara Rao
Professor (Retd.)
Department of Commerce & Business Administration
University College of Arts,
Commerce & Law Acharya Nagarjuna University

DIRECTOR, I/c.
Prof. V. Venkateswarlu
M.A., M.P.S., M.S.W., M.Phil., Ph.D.

CENTRE FOR DISTANCE EDUCATION
ACHARYA NAGARJUNA UNIVERSITY
NAGARJUNA NAGAR 522 510
Ph: 0863-2346222, 2346208
0863- 2346259 (Study Material)
Website www.anucde.info
E-mail: anucdedirector@gmail.com

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Director, I/c
Centre for Distance Education,
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FOREWORD

Since its establishment in 1976, Acharya Nagarjuna University has been forging ahead in the path of progress and dynamism, offering a variety of courses and research contributions. I am extremely happy that by gaining 'A+' grade from the NAAC in the year 2024, Acharya Nagarjuna University is offering educational opportunities at the UG, PG levels apart from research degrees to students from over 221 affiliated colleges spread over the two districts of Guntur and Prakasam.

The University has also started the Centre for Distance Education in 2003-04 with the aim of taking higher education to the door step of all the sectors of the society. The centre will be a great help to those who cannot join in colleges, those who cannot afford the exorbitant fees as regular students, and even to housewives desirous of pursuing higher studies. Acharya Nagarjuna University has started offering B.Sc., B.A., B.B.A., and B.Com courses at the Degree level and M.A., M.Com., M.Sc., M.B.A., and L.L.M., courses at the PG level from the academic year 2003-2004 onwards.

To facilitate easier understanding by students studying through the distance mode, these self-instruction materials have been prepared by eminent and experienced teachers. The lessons have been drafted with great care and expertise in the stipulated time by these teachers. Constructive ideas and scholarly suggestions are welcome from students and teachers involved respectively. Such ideas will be incorporated for the greater efficacy of this distance mode of education. For clarification of doubts and feedback, weekly classes and contact classes will be arranged at the UG and PG levels respectively.

It is my aim that students getting higher education through the Centre for Distance Education should improve their qualification, have better employment opportunities and in turn be part of country's progress. It is my fond desire that in the years to come, the Centre for Distance Education will go from strength to strength in the form of new courses and by catering to larger number of people. My congratulations to all the Directors, Academic Coordinators, Editors and Lesson-writers of the Centre who have helped in these endeavors.

Prof. K. Gangadhara Rao
M.Tech., Ph.D.,
Vice-Chancellor I/c
Acharya Nagarjuna University.

MASTER OF BUSINESS ADMINISTRATION
(HOSPITAL ADMINISTRATION)
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PROGRAMME SYLLABUS
1st YEAR – 1st SEMESTER SYLLABUS

106HA26: HEALTHCARE BUSINESS ENVIRONMENT

Unit – I Healthcare systems in India: Types of Healthcare Services, Health Services pyramid, Issues in Healthcare Delivery. Patterns of old Healthcare and New Healthcare; Factors Influencing Change in Healthcare Delivery Systern. Future trends of Indian Health Care system.

Unit – II. History of Hospitals: Hospitals in India; Emergence of healthcare care Delivery System and Hospitals in Independent India; Changing Roles of Hospitals; Role of Hospitals in New Millennium: Globalization of HealthCare;

UNIT - III Administration of Health Services in India: Health committees Appointed by the Government and their influence; International Health Agencies.

UNIT IV Economics of Health Care: Financial Resources for Healthcare Services; Role of Health insurance; Government and Voluntary Health Agencies in India; western Economics of Health Care -Concept of Medicare and Medicaid

UNIT V Emerging Approaches in Hearth Care and Recent trends: Related Ethical and Legal issue; contracting in Health care; Effective Media communication; Robotic 'surgery, Telemedicine; Medical Tourism.

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CONTENTS

LESSON 1: OVERVIEW OF HEALTHCARE SYSTEMS IN INDIA

Lesson Objectives

After studying this lesson, the learner will be able to:

- Understand the concept of a healthcare system
- Identify different types of healthcare services in India
- Distinguish between public and private healthcare systems
- Recognize formal and informal healthcare providers
- Appreciate the relevance of healthcare systems in India's business environment

Structure of the Lesson

- Introduction to Healthcare Systems
- Concept and Meaning of Healthcare System
- Types of Healthcare Services in India
- Public and Private Healthcare Systems
- Formal and Informal Healthcare Providers
- Contemporary Relevance
- Student Activities
- Summary

1.1 Introduction to Healthcare Systems

Healthcare occupies a central position in the economic and social development of any nation. In a developing country like India, the healthcare system is not only a mechanism for treating illness but also a critical determinant of productivity, human capital formation, and inclusive growth. The healthcare system influences demographic indicators such as life expectancy, infant mortality rate, maternal mortality rate, and disease burden, all of which have direct and indirect implications for economic development and business environment.

India's healthcare system has evolved over time in response to changing population dynamics, epidemiological transitions, technological advancements, and policy reforms. With a population exceeding 1.4 billion, wide regional disparities, and a dual burden of communicable and non-communicable diseases, India presents one of the most complex healthcare environments in the world. For students of Hospital Administration, understanding the structure and functioning of the healthcare system is foundational, as hospitals operate within

this broader system and are influenced by its financing, regulation, workforce, and service delivery mechanisms.

From a healthcare business perspective, the system represents a vast service industry involving hospitals, diagnostics, pharmaceuticals, insurance, medical devices, digital health platforms, and allied services. The increasing participation of private players, the expansion of health insurance, and the growing role of technology have transformed healthcare into a major economic sector. Therefore, a comprehensive understanding of healthcare systems is essential for healthcare managers, administrators, and policymakers.

An analysis of the healthcare system must consider not only medical aspects but also organizational structures, governance mechanisms, financing models, human resources, and ethical considerations. This lesson introduces these foundational ideas by explaining the concept of healthcare systems, types of healthcare services, public and private healthcare systems, and the role of formal and informal healthcare providers in India.

Introductory Case: Healthcare Access in India
India has made remarkable progress in healthcare indicators over the last few decades. Life expectancy has increased, infant mortality has declined, and advanced medical technologies are increasingly available. However, access to quality healthcare remains uneven. According to national health surveys, a significant proportion of rural households still depend on primary health centers or private clinics, while urban populations increasingly use corporate hospitals. This dual structure highlights the importance of understanding healthcare systems from both managerial and policy perspectives.

1.2 Concept and Meaning of Healthcare System

A healthcare system can be defined as the organized framework through which a society delivers health services to its population. It comprises all institutions, organizations, people, and resources that are devoted to the promotion, protection, restoration, and maintenance of health. These include hospitals, clinics, diagnostic centers, health professionals, public health institutions, insurance mechanisms, regulatory bodies, and support services such as medical education and research.

The healthcare system is not a single institution but an interconnected network of multiple subsystems. These subsystems work together to ensure that health services are accessible, affordable, acceptable, and of adequate quality. The effectiveness of a healthcare system is often evaluated using indicators such as health outcomes, equity in access, efficiency in resource utilization, responsiveness to patient needs, and financial protection against health-related risks.

From a managerial perspective, the healthcare system can also be viewed as a service delivery system operating under conditions of uncertainty, high information asymmetry, and ethical responsibility. Unlike conventional business sectors, healthcare involves life-and-death decisions, professional autonomy, and social accountability. Therefore, healthcare systems must balance efficiency with equity, innovation with regulation, and profitability with social welfare.

In the Indian context, the healthcare system is characterized by pluralism. It includes modern medicine (allopathy) alongside traditional systems such as Ayurveda, Yoga, Unani, Siddha, and Homeopathy. It also consists of both public and private sectors, as well as formal and informal providers. This pluralistic nature offers patients multiple choices but also poses challenges in terms of regulation, standardization, and quality control.

The healthcare system also encompasses financing mechanisms such as government budgets, out-of-pocket payments, health insurance, and employer-sponsored schemes. These financing arrangements significantly influence access to care and financial risk protection. For hospital administrators, understanding how healthcare systems are financed and regulated is crucial for strategic planning, budgeting, and service delivery.

1.3 Types of Healthcare Services in India

Healthcare services are broadly classified based on their objectives, timing of intervention, and level of care. In India, healthcare services are commonly categorized into preventive, promotive, curative, and rehabilitative services. This classification helps in planning healthcare delivery, allocating resources, and designing health programs.

Preventive Healthcare Services

Preventive healthcare services are aimed at preventing the occurrence of diseases and reducing exposure to risk factors. These services focus on protecting individuals and communities from illness before it occurs. Preventive care is particularly important in a country like India, where a large proportion of the population is vulnerable to communicable diseases due to factors such as overcrowding, poor sanitation, and limited access to clean water.

Preventive services include immunization, vector control, sanitation, food safety, health education, and disease surveillance. National immunization programs have played a significant role in reducing the incidence of diseases such as polio, measles, and diphtheria. Public health initiatives focusing on sanitation and clean drinking water have contributed to a decline in water-borne diseases.

From a business and management perspective, preventive healthcare is increasingly recognized as cost-effective. Preventing disease reduces the need for expensive treatments and hospitalizations. Many hospitals and healthcare organizations now offer preventive health check-up packages as part of their service portfolio, reflecting a shift towards proactive health management.

Promotive Healthcare Services

Promotive healthcare services aim to enhance overall health and well-being by encouraging healthy behaviors and lifestyles. Unlike preventive services, which focus on avoiding disease, promotive services emphasize positive health outcomes and quality of life. These services address social, behavioral, and environmental determinants of health.

Promotive healthcare activities include nutrition education, maternal and child health programs, mental health promotion, physical activity initiatives, and stress management

programs. In recent years, there has been growing emphasis on lifestyle modification to address non-communicable diseases such as diabetes, hypertension, and cardiovascular disorders.

Healthcare organizations, particularly private hospitals and wellness centers, have expanded their promotive services by offering wellness clinics, yoga and fitness programs, and corporate health initiatives. These services not only improve population health but also create new business opportunities in the healthcare sector.

Curative Healthcare Services

Curative healthcare services focus on diagnosing, treating, and managing illnesses and injuries. These services constitute the most visible component of the healthcare system and are primarily delivered through hospitals, clinics, and specialty centers. Curative care ranges from primary-level treatment for common ailments to highly specialized interventions such as organ transplants and advanced surgeries.

India has witnessed rapid growth in curative healthcare services, particularly in the private sector. The expansion of corporate hospitals, availability of advanced medical technologies, and growth of medical tourism have strengthened India's curative care capacity. However, curative services are often expensive, and reliance on out-of-pocket expenditure remains high for many households.

For hospital administrators, curative services involve complex operational challenges, including capacity management, quality assurance, patient safety, and cost control. Effective management of curative services is essential for both clinical outcomes and financial sustainability.

Rehabilitative Healthcare Services

Rehabilitative healthcare services aim to restore functional ability and improve quality of life for individuals who have experienced illness, injury, or disability. These services are particularly important in the context of aging populations, chronic diseases, and increasing survival rates from serious illnesses.

Rehabilitation includes physiotherapy, occupational therapy, speech therapy, mental health rehabilitation, and long-term care services. Rehabilitation services are delivered in hospitals, specialized rehabilitation centers, and community-based facilities.

In India, rehabilitative care has traditionally received less attention compared to curative care. However, growing awareness of disability rights, mental health issues, and post-acute care needs has increased demand for rehabilitation services. Hospitals are increasingly integrating rehabilitation departments into their service offerings, highlighting the evolving nature of healthcare delivery.

1.4 Public and Private Healthcare Systems in India

Public Healthcare System

The public healthcare system in India is funded and operated by the government. It includes sub-centers, primary health centers (PHCs), community health centers (CHCs), district

hospitals, and government medical colleges. The primary objective is to provide affordable and accessible healthcare, especially to vulnerable populations.

Strengths of the public system include wide geographic coverage and subsidized services. However, challenges such as resource constraints, infrastructure gaps, and workforce shortages affect service quality.

Private Healthcare System

The private healthcare system comprises privately owned hospitals, clinics, diagnostic centers, and corporate healthcare chains. It plays a significant role in healthcare delivery, particularly in urban areas.

Private healthcare is often associated with better infrastructure, advanced technology, and shorter waiting times. However, higher costs and limited accessibility for low-income groups raise concerns about equity and affordability.

For hospital administrators, managing efficiency, quality, and ethical standards in both systems is critical.

1.5 Formal and Informal Healthcare Providers

Formal Healthcare Providers

Formal providers are qualified, trained, and regulated professionals such as doctors, nurses, pharmacists, and allied health workers. They operate within recognized institutions and follow standardized protocols.

Informal Healthcare Providers

Informal providers include unqualified practitioners, traditional healers, and local medicine vendors who often serve remote or underserved areas. While they play a role in access, issues related to safety, quality, and regulation remain significant.

Understanding the coexistence of formal and informal providers is essential for healthcare planning and policy formulation.

1.6 Contemporary Relevance

The COVID-19 pandemic highlighted the strengths and weaknesses of healthcare systems worldwide. In India, the role of public health infrastructure, private hospitals, telemedicine, and community-level providers became evident. For healthcare managers, system-level thinking is now more important than ever.

1.7 Student Activities

1. Prepare a comparative chart of public and private healthcare facilities in your district.

Identify examples of preventive and promotive healthcare services offered by a nearby hospital.

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2. Conduct a short survey on healthcare provider preferences among households.

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3. Discuss the role of informal healthcare providers in rural healthcare delivery.

1.8 Summary

This lesson introduced the concept of healthcare systems in India, highlighting their structure, types of services, and key stakeholders. It examined preventive, promotive, curative, and rehabilitative services, compared public and private healthcare systems, and discussed formal and informal providers. Understanding these components is essential for effective healthcare management and policy implementation.

1.9 . Key Words

- Healthcare System: Organized network of institutions and resources delivering health services.
- Preventive Care: Services aimed at disease prevention.
- Promotive Care: Services enhancing health and well-being.

- Curative Care: Treatment-focused healthcare services.
- Rehabilitative Care: Services restoring functional ability.

1.10 . Self-Assessment Questions

A. Short Answer Questions

1. Define a healthcare system.
2. What are preventive healthcare services?
3. Distinguish between promotive and curative care.
4. Mention two features of public healthcare system.
5. Who are informal healthcare providers?

B. Essay Type Questions

1. Explain the concept and components of a healthcare system.
2. Discuss various types of healthcare services in India.
3. Compare public and private healthcare systems in India.
4. Examine the role of formal and informal healthcare providers.
5. Analyze the relevance of healthcare systems for hospital administrators.

C. Multiple Choice Questions

1. Which service focuses on disease prevention?
   a) Curative b) Preventive c) Rehabilitative d) Diagnostic
   Answer: b
2. PHCs are part of which system?
   a) Private b) Corporate c) Public d) Informal
   Answer: c
3. Rehabilitative care mainly aims at:
   a) Diagnosis b) Prevention c) Restoration d) Promotion
   Answer: c
4. Informal providers are mostly:
   a) Regulated b) Qualified c) Unregulated d) Corporate
   Answer: c
5. Promotive healthcare emphasizes:
   a) Surgery b) Lifestyle c) Emergency care d) ICU
   Answer: b

1.11 . Case Study

Case: Balancing Public and Private Healthcare in India

India's healthcare system is characterized by a strong presence of both public and private sectors. In a mid-sized district, government hospitals provide subsidized services, while private hospitals offer advanced treatments at higher costs. During a public health emergency, both sectors were required to collaborate to manage patient load, ensure availability of beds, and provide critical care services.

However, differences in pricing, infrastructure, staffing, and management practices created coordination challenges. Informal healthcare providers continued to serve peripheral villages due to accessibility, raising concerns about quality and safety.

Case Questions

1. What challenges arise in coordinating public and private healthcare systems?
2. How can hospital administrators improve collaboration during emergencies?
3. What role do informal providers play in healthcare delivery?
4. Suggest strategies to strengthen preventive and promotive care.

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LESSON 2: HEALTH SERVICES PYRAMID AND ISSUES IN HEALTHCARE DELIVERY

Lesson Objectives

After completing this lesson, the learner will be able to:

- Understand the concept of the Health Services Pyramid in India
- Distinguish between primary, secondary, and tertiary levels of healthcare
- Explain the structure and functioning of PHCs, CHCs, and tertiary hospitals
- Identify key issues in healthcare delivery in India
- Analyze urban–rural disparities in healthcare access and outcomes

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Structure of the Lesson

- Introduction to Health Services Pyramid
- Primary Healthcare System
- Secondary Healthcare System
- Tertiary Healthcare System
- Structure of PHCs, CHCs, and Tertiary Hospitals
- Issues in Healthcare Delivery
- Contemporary Significance
- Student Activities
- Summary

2.1 Health Services Pyramid in India: Concept and Rationale

The organization of healthcare delivery in India is commonly explained through the concept of the Health Services Pyramid, which represents a hierarchical arrangement of healthcare services based on the level of complexity, specialization, population coverage, and cost of care. This pyramid structure is designed to ensure that healthcare needs of the population are addressed efficiently by delivering services at the most appropriate level, while facilitating referral and continuity of care across different levels of the system.

At the base of the pyramid lies primary healthcare, which caters to the largest segment of the population and addresses the most common health needs. Secondary healthcare occupies the middle level and provides specialized services to patients referred from the primary level. Tertiary healthcare forms the apex of the pyramid and delivers advanced, highly specialized, and technology-intensive medical care. The pyramid structure emphasizes that not all health

problems require high-end hospital care and that an efficient healthcare system depends on a strong foundation of primary healthcare.

In the Indian context, the Health Services Pyramid is particularly important due to the country's vast population, limited resources, and significant regional disparities. Effective functioning of each level of the pyramid and strong referral linkages among them are essential for reducing overcrowding in higher-level hospitals, controlling healthcare costs, and improving overall health outcomes. For hospital administrators, understanding the pyramid is crucial for capacity planning, resource allocation, and system integration.

2.2 Primary Healthcare in India

Primary healthcare represents the first level of contact between individuals and the healthcare system. It focuses on providing essential healthcare services that are universally accessible, affordable, and community-oriented. Primary healthcare emphasizes prevention, early diagnosis, basic treatment, and health promotion, thereby reducing the burden on higher levels of care.

In India, primary healthcare services are delivered through a network of sub-centers, Primary Health Centres (PHCs), and Health and Wellness Centres. These facilities cater primarily to rural and semi-urban populations and play a critical role in addressing common illnesses, maternal and child health needs, immunization, family welfare, nutrition, and control of communicable diseases.

Primary healthcare is central to public health objectives such as disease prevention, health education, and community participation. By addressing health problems at an early stage, primary care reduces the need for costly hospital-based treatment. However, the effectiveness of primary healthcare in India has been constrained by challenges such as inadequate infrastructure, shortage of trained personnel, limited diagnostic facilities, and variable quality of services across regions.

From a management perspective, strengthening primary healthcare is one of the most cost-effective strategies for improving population health. Hospitals, particularly at secondary and tertiary levels, depend heavily on a functional primary care system for appropriate referrals, follow-up care, and continuity of treatment. Weaknesses at the primary level often result in unnecessary patient load at higher-level hospitals, leading to inefficiencies and increased costs.

2.3 Secondary Healthcare in India

Secondary healthcare occupies the intermediate level of the Health Services Pyramid and provides specialist care to patients referred from primary healthcare facilities. It addresses health conditions that require more advanced diagnostic facilities, specialist consultation, and inpatient care but do not necessarily require highly specialized tertiary interventions.

In the Indian healthcare system, secondary care is primarily delivered through Community Health Centres (CHCs), sub-district hospitals, and district hospitals. These institutions are expected to provide services in core specialties such as medicine, surgery, obstetrics and

gynecology, pediatrics, and basic diagnostic services. Secondary healthcare plays a pivotal role in managing complications, conducting routine surgeries, and stabilizing patients before referral to tertiary care when necessary.

The effectiveness of secondary healthcare depends on adequate infrastructure, availability of specialists, diagnostic support, and efficient referral mechanisms. In many parts of India, district hospitals serve as the backbone of secondary care and are often the highest level of healthcare accessible to rural populations. However, shortages of specialists, uneven distribution of resources, and high patient loads continue to challenge the performance of secondary healthcare institutions.

For hospital administrators, secondary healthcare facilities require careful balancing of service demand, workforce deployment, and financial management. Efficient secondary care reduces pressure on tertiary hospitals and ensures that patients receive timely and appropriate treatment closer to their place of residence.

2.4 Tertiary Healthcare in India

Tertiary healthcare represents the highest level of care within the Health Services Pyramid and provides advanced, specialized, and technology-intensive medical services. It includes super-specialty hospitals, medical colleges, and advanced referral centers equipped to manage complex and life-threatening conditions.

Tertiary healthcare institutions offer services such as advanced surgical procedures, organ transplantation, cancer treatment, neurosurgery, cardiac care, and sophisticated diagnostic and therapeutic interventions. These facilities require highly trained specialists, advanced medical technology, and substantial financial investment.

In India, tertiary healthcare is provided by both public and private sector institutions. Public tertiary hospitals play a critical role in providing advanced care at subsidized costs, medical education, and research. Private tertiary hospitals have expanded rapidly, particularly in urban areas, and are often associated with cutting-edge technology and medical tourism. However, access to tertiary care remains limited for large sections of the population due to high costs, geographic concentration, and capacity constraints.

From a healthcare management perspective, tertiary hospitals are complex organizations requiring advanced administrative systems, quality assurance mechanisms, financial sustainability models, and ethical governance. Their effective functioning depends on strong referral linkages with lower levels of care and efficient patient flow management.

2.5 Structure and Functioning of PHCs, CHCs, and Tertiary Hospitals

Primary Health Centres are the cornerstone of rural healthcare delivery in India. Each PHC typically serves a defined population and provides outpatient care, basic inpatient services, maternal and child healthcare, immunization, and implementation of national health programs. PHCs are staffed by medical officers, nurses, and paramedical staff and act as referral units for higher-level facilities.

Community Health Centres function as referral institutions for PHCs and provide specialist services at the secondary level. A CHC is expected to offer services in medicine, surgery, obstetrics, pediatrics, and basic diagnostics. CHCs also play a role in training healthcare workers and supervising primary healthcare activities.

Tertiary hospitals, including medical colleges and super-specialty institutions, function as apex referral centers. In addition to providing advanced clinical care, they are involved in teaching, research, and development of clinical protocols. Their functioning is resource-intensive and requires sophisticated management systems to handle complex operations, large patient volumes, and multidisciplinary teams.

Coordination among PHCs, CHCs, and tertiary hospitals is essential for an effective referral system. Weak referral mechanisms often result in overcrowding of tertiary hospitals and underutilization of primary and secondary facilities, highlighting the need for system-level planning and management.

2.6 Key Issues in Healthcare Delivery in India

Despite significant progress, healthcare delivery in India faces several persistent challenges that affect equity, efficiency, and quality of care. One of the most critical issues is accessibility, which refers to the physical, social, and cultural ease with which healthcare services can be reached. Geographic barriers, poor transportation, and uneven distribution of facilities limit access, particularly in rural and remote areas.

Affordability remains a major concern due to high out-of-pocket expenditure on healthcare. Many households face financial hardship when accessing medical care, particularly for hospitalization and tertiary services. Although health insurance coverage has expanded, gaps in coverage and awareness persist.

Availability of healthcare resources, including facilities, equipment, and trained personnel, varies widely across regions. Shortages of doctors, nurses, and specialists, especially in rural areas, constrain service delivery and increase workload on existing facilities.

Quality of care is influenced by infrastructure, workforce competence, clinical protocols, and patient safety practices. Variations in quality across public and private facilities affect patient outcomes and trust in the healthcare system. Strengthening quality assurance and accreditation mechanisms is therefore a key priority.

Urban–rural disparities cut across all dimensions of healthcare delivery. Urban areas benefit from better infrastructure, specialist availability, and advanced technology, while rural areas often rely on limited primary care services. Addressing these disparities requires targeted investment, workforce incentives, and system integration.

For healthcare administrators, these issues highlight the importance of strategic planning, efficient resource utilization, and coordinated service delivery across all levels of the Health Services Pyramid.

Student Activities

1. Field Observation Activity
   Students may visit a nearby Primary Health Centre (PHC) or Community Health Centre (CHC) and observe its infrastructure, staffing pattern, range of services, and patient flow. Based on the observation, students should prepare a brief report explaining how the facility fits into the Health Services Pyramid and the challenges it faces in delivering healthcare services.

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2. Comparative Analysis Exercise
   Learners may prepare a comparative study of primary, secondary, and tertiary healthcare facilities in their region. The analysis should focus on differences in service scope, level of specialization, availability of resources, and cost of care, and should highlight how these differences contribute to accessibility and quality of healthcare.

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3. Group Discussion and Problem-Solving Activity
   Students may participate in a group discussion on key issues in healthcare delivery, such as affordability, quality of care, or urban–rural disparities. Each group should identify the root causes of one issue and propose feasible administrative or policy-level solutions from a hospital management perspective.

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4. Referral System Mapping Activity
   Learners may map the referral pathway of a patient from a PHC to a tertiary hospital for a specific medical condition. The activity should analyze delays, gaps, or

inefficiencies in the referral process and suggest measures to improve coordination among different levels of the healthcare system.

2.7 Summary of Lesson

In this lesson, you have studied how healthcare services in India are systematically organized through the Health Services Pyramid and the major challenges involved in delivering healthcare effectively. The Health Services Pyramid helps you understand that healthcare is not delivered through hospitals alone, but through a structured system consisting of primary, secondary, and tertiary levels of care, each serving a specific purpose.

You learned that primary healthcare forms the foundation of the healthcare system and acts as the first point of contact for individuals and communities. It focuses on preventive, promotive, and basic curative services and plays a crucial role in early diagnosis, disease prevention, and community health improvement. A strong primary healthcare system reduces unnecessary pressure on higher-level hospitals and improves overall health outcomes.

The lesson further explained the role of secondary healthcare, which provides specialist services and inpatient care for patients referred from primary healthcare facilities. Institutions such as Community Health Centres and district hospitals manage conditions that require medical expertise beyond basic care but do not need advanced super-specialty treatment. Tertiary healthcare, at the top of the pyramid, delivers advanced and highly specialized medical services using sophisticated technology and skilled professionals. These institutions also function as teaching and research centers.

You were introduced to the structure and functioning of PHCs, CHCs, and tertiary hospitals, which helped you understand how healthcare services are delivered at different levels. The importance of an efficient referral system connecting these institutions was emphasized, as poor coordination often leads to overcrowding at tertiary hospitals and underutilization of primary and secondary facilities.

The lesson also highlighted key issues in healthcare delivery in India, such as accessibility, affordability, availability of resources, quality of care, and urban–rural disparities. These challenges affect equity and efficiency in healthcare services and require careful planning and management. Finally, you learned the contemporary significance of healthcare systems, particularly the need for system-level thinking, coordination, and effective administration in a rapidly changing healthcare environment.

Overall, this lesson has helped you understand how healthcare delivery in India functions as an integrated system and why knowledge of the Health Services Pyramid is essential for effective hospital and healthcare management.

2.8 Key Words

- Health Services Pyramid: Hierarchical organization of healthcare services at primary, secondary, and tertiary levels.
- Primary Healthcare: First level of contact between individuals and the healthcare system.
- Secondary Healthcare: Referral-level care providing specialist services.
- Tertiary Healthcare: Advanced and highly specialized medical care.
- Accessibility: Ease with which healthcare services can be reached.
- Affordability: Financial capacity of individuals to utilize healthcare services.
- Availability: Presence of adequate healthcare resources and facilities.
- Quality of Care: Degree to which health services increase desired health outcomes.
- Urban–Rural Disparities: Differences in healthcare access and quality between urban and rural areas.

2.9 . Self-Assessment Questions

A. Short Answer Questions

1. What is meant by the Health Services Pyramid?
2. Define primary healthcare.
3. What role do Community Health Centres play in healthcare delivery?
4. Explain the concept of accessibility in healthcare.
5. What is meant by urban–rural disparity in healthcare?

2.10 Suggested Answers:

1. The Health Services Pyramid refers to the hierarchical organization of healthcare services into primary, secondary, and tertiary levels based on complexity and specialization.
2. Primary healthcare is the first point of contact between individuals and the healthcare system, providing basic preventive and curative services.
3. Community Health Centres function as referral institutions providing specialist care and support to primary healthcare facilities.
4. Accessibility refers to the ease with which individuals can reach and use healthcare services.
5. Urban–rural disparity denotes differences in availability, access, and quality of healthcare services between urban and rural areas.

2.11 Essay Type Questions

1. Explain the concept and significance of the Health Services Pyramid in India.
2. Describe the structure and functioning of Primary Health Centres.
3. Discuss the major issues in healthcare delivery in India.
4. Examine the problem of affordability in the Indian healthcare system.
5. Analyze urban–rural disparities in healthcare delivery.

2.12 Suggested Hints:

- Answers should include definitions, structural explanation, examples, and policy implications.
- Emphasize linkages between different levels of healthcare.
- Use Indian context and healthcare delivery challenges.

2.13 . Multiple Choice Questions

1. The first level of healthcare delivery is:
   a) Tertiary b) Secondary c) Primary d) Super-specialty
   Answer: c
2. CHCs mainly provide:
   a) Basic care b) Preventive care only c) Specialist services d) Home-based care
   Answer: c
3. Accessibility refers to:
   a) Cost of care b) Distance and reachability c) Quality standards d) Technology
   Answer: b
4. Tertiary healthcare is associated with:
   a) Immunization b) OPD care c) Advanced treatment d) Health education
   Answer: c
5. Urban–rural disparities mainly arise due to:
   a) Uniform infrastructure b) Equal workforce c) Unequal distribution of resources d) Same disease burden
   Answer: c

2.14 . Case Study

Case: Referral Overload at a District Hospital

A district hospital in a semi-rural region receives a large number of patients daily, many of whom could have been managed at the primary healthcare level. Due to inadequate functioning of nearby PHCs and lack of trust in primary facilities, patients directly approach secondary and tertiary hospitals. This has resulted in overcrowding, longer waiting times, and strain on hospital resources.

2.15 Case Questions

1. Why are patients bypassing primary healthcare facilities?
2. How does this affect secondary and tertiary hospitals?
3. What role can hospital administrators play in strengthening referral systems?
4. Suggest measures to improve accessibility and quality at the primary level.

2.16 Suggested Answers

- Focus on infrastructure gaps, workforce shortages, and patient perception.
- Highlight referral inefficiencies and system imbalance.
- Emphasize managerial interventions, coordination, and capacity building.

2.17. Reference Text Books

1. Park, K. – Park's Textbook of Preventive and Social Medicine – Banarsidas Bhanot Publishers, Jabalpur, 2021.
2. Goel, S. L. & Kumar, R. – Hospital Administration and Management – Deep & Deep Publications, New Delhi, 2018.
3. Joshi, S. R. – Health Care Management – Oxford University Press, New Delhi, 2019.
4. Roemer, M. I. – National Health Systems of the World – Oxford University Press, New York, 2002.

LESSON 3: EVOLUTION AND FUTURE TRENDS OF INDIAN HEALTHCARE

Lesson Objectives

After studying this lesson, you will be able to:

- Understand the patterns of the old healthcare system in India
- Explain the emergence of the new healthcare system
- Identify key factors influencing changes in healthcare delivery
- Analyze the role of demographic, epidemiological, technological, and policy changes
- Appreciate future trends of the Indian healthcare system

Structure of the Lesson

1. Overview of Healthcare Evolution in India
2. Patterns of the Old Healthcare System
3. Emergence of the New Healthcare System
4. Factors Influencing Change in Healthcare Delivery
5. Future Trends of Indian Healthcare
6. Student Activities
7. Summary

3.1 Overview of Healthcare Evolution in India

The evolution of healthcare in India reflects the broader social, economic, and political transformations experienced by the country over centuries. Healthcare practices in India have moved through multiple stages, beginning with community-based and traditional systems, progressing to state-supported public health structures, and eventually evolving into a complex mix of public, private, and technology-driven healthcare delivery models. This evolution has not been linear; rather, it has been shaped by historical contexts such as colonial administration, post-independence nation-building, economic liberalization, and globalization.

In the early phases, healthcare was largely localized and community-oriented, with families and traditional healers playing a central role in maintaining health and treating illness. With the introduction of Western medicine during the colonial period, institutional forms of healthcare such as hospitals and dispensaries began to emerge, primarily serving urban populations. After Independence, the Indian state assumed a more active role in healthcare delivery, emphasizing public health, disease control, and expansion of healthcare infrastructure to rural areas.

Over time, rising population, epidemiological changes, technological progress, and economic reforms led to the diversification of healthcare delivery. The modern Indian healthcare system today is characterized by the coexistence of traditional medicine, public healthcare institutions, private hospitals, corporate healthcare chains, insurance-based financing, and digital health platforms. Understanding this evolutionary trajectory is essential for healthcare administrators, as it provides insight into current system strengths, persistent gaps, and future opportunities.

3.2. Patterns of the Old Healthcare System

The old healthcare system in India was predominantly characterized by traditional, informal, and community-based modes of healthcare delivery. Prior to the widespread development of modern hospitals and formal public health institutions, healthcare practices were deeply rooted in indigenous knowledge systems and cultural traditions. Ayurveda, Siddha, Unani, and other indigenous systems formed the backbone of healthcare for a large proportion of the population. These systems emphasized holistic treatment, preventive care, and harmony between the individual and the environment.

Healthcare during this period was largely decentralized and depended on local practitioners, family knowledge, and community support. Access to care was determined by geographic proximity, social relationships, and traditional beliefs rather than institutional availability. While these systems provided affordable and culturally acceptable care, they were limited in their ability to manage epidemics, complex diseases, and large-scale public health challenges.

During the colonial era, Western medicine was introduced through hospitals, medical colleges, and public health initiatives, but access remained restricted to urban centers and privileged sections of society. Rural populations continued to rely heavily on traditional and informal providers. The old healthcare system was thus marked by limited institutional coverage, inadequate infrastructure, absence of organized referral systems, and minimal state involvement in comprehensive healthcare delivery.

From a management perspective, the old system lacked standardized protocols, regulatory mechanisms, and organized financing structures. Although it played an important role in meeting basic healthcare needs, it was insufficient to address the demands of a growing population and the changing disease profile of society.

3.3. Emergence of the New Healthcare System

The emergence of the new healthcare system in India can be traced to the post-independence period, when healthcare was recognized as a key component of national development. The government adopted a planned approach to healthcare delivery, focusing on expansion of public health infrastructure, control of communicable diseases, and provision of basic healthcare services to rural and underserved populations. Institutions such as Primary Health Centres, Community Health Centres, and district hospitals became integral components of the healthcare system.

Over subsequent decades, the healthcare system underwent further transformation due to economic growth, urbanization, and increased demand for quality medical services. The liberalization of the Indian economy led to significant private sector participation in healthcare. Corporate hospitals, diagnostic chains, and specialty centers expanded rapidly, particularly in urban areas. The growth of private healthcare introduced advanced medical technology, improved service quality, and expanded treatment options, but also raised concerns regarding affordability and equity.

The new healthcare system is characterized by institutionalization, specialization, and professional management. Healthcare delivery is increasingly supported by health insurance, regulatory frameworks, accreditation systems, and quality standards. Technology has become a central feature, enabling advanced diagnostics, minimally invasive procedures, electronic health records, and telemedicine services.

For healthcare administrators, the new system demands managerial competencies in operations, finance, human resource management, quality assurance, and strategic planning. The shift from purely service-oriented institutions to professionally managed healthcare organizations marks a significant departure from the patterns of the old healthcare system.

3.4. Factors Influencing Change in Healthcare Delivery

Several interrelated factors have influenced the transformation of healthcare delivery in India. One of the most significant factors is demographic change. Rapid population growth, increased life expectancy, and changes in age structure have altered healthcare demand. An aging population has increased the need for chronic disease management, long-term care, and geriatric services, while urbanization has changed patterns of healthcare utilization.

Epidemiological transition has also played a crucial role in reshaping healthcare delivery. India has moved from a disease profile dominated by communicable diseases to one increasingly characterized by non-communicable diseases such as diabetes, cardiovascular diseases, cancer, and mental health disorders. This shift has necessitated changes in healthcare infrastructure, workforce skills, and service delivery models, with greater emphasis on continuous care, specialization, and rehabilitation.

Technological advancement is another major driver of change. Innovations in medical technology, information systems, diagnostics, and treatment methods have transformed healthcare delivery. Telemedicine, digital health platforms, artificial intelligence, and data analytics are redefining how healthcare services are accessed and managed. Technology has improved diagnostic accuracy, expanded access to specialist care, and enhanced operational efficiency, while also increasing the cost and complexity of healthcare management.

Policy reforms have further influenced healthcare delivery by shaping financing mechanisms, regulatory frameworks, and service priorities. Government initiatives aimed at strengthening primary healthcare, expanding insurance coverage, and encouraging public–private partnerships have altered the structure and functioning of the healthcare system. Policy emphasis on universal health coverage and quality improvement reflects a shift towards more inclusive and accountable healthcare delivery.

3.5. Future Trends of Indian Healthcare

The future of the Indian healthcare system is expected to be shaped by continued demographic, technological, and policy-driven changes. One of the most prominent trends is the increasing integration of digital health technologies into routine healthcare delivery. Telemedicine, electronic health records, remote monitoring, and artificial intelligence are likely to become central components of healthcare systems, improving access, efficiency, and patient engagement.

Another important trend is the growing emphasis on preventive and promotive healthcare. Rising awareness of lifestyle-related diseases and the economic burden of curative care are driving a shift towards wellness, early detection, and health promotion. Healthcare organizations are increasingly adopting population health management approaches that focus on long-term health outcomes rather than episodic treatment.

The expansion of health insurance and alternative financing mechanisms is expected to play a significant role in improving affordability and financial protection. Greater private sector participation, combined with regulatory oversight, is likely to continue shaping healthcare delivery models. Medical tourism, specialized care, and integrated care networks may further strengthen India's position in the global healthcare landscape.

For healthcare administrators, future trends highlight the need for adaptive leadership, strategic planning, and system-level thinking. Managing healthcare institutions in a rapidly evolving environment will require balancing technological innovation, financial sustainability, quality of care, and social responsibility.

3.6. Summary of Lesson

In this lesson, you have studied how the Indian healthcare system has evolved over time and how it continues to transform in response to changing social, economic, and technological conditions. The lesson helped you understand that healthcare delivery in India is not static; rather, it is the outcome of a long historical process influenced by population needs, disease patterns, policy decisions, and innovations.

You first learned about the overall evolution of healthcare in India, beginning with community-based and traditional forms of care and progressing towards a more organized and institutional healthcare system. Early healthcare practices were largely informal and rooted in indigenous systems of medicine, with limited infrastructure and minimal state involvement. Over time, especially after Independence, healthcare became an important responsibility of the government, leading to the expansion of public health institutions and organized service delivery.

The lesson then examined the patterns of the old healthcare system, which relied heavily on traditional medicine, informal providers, and localized care. While this system was accessible and culturally acceptable, it lacked standardized treatment protocols, advanced medical technology, and the capacity to manage large-scale public health challenges. These limitations made it inadequate for addressing the health needs of a growing and changing population.

You were then introduced to the emergence of the new healthcare system, which developed through government intervention, institutional expansion, and later private sector participation. The new system is characterized by modern hospitals, professional management, specialization, regulatory frameworks, health insurance, and increasing use of technology. This transformation improved service quality and treatment options but also introduced challenges related to cost, equity, and access.

A major focus of the lesson was on the factors influencing changes in healthcare delivery. You learned how demographic changes, such as population growth, aging, and urbanization, have increased demand for diverse and long-term healthcare services. The epidemiological transition from communicable to non-communicable diseases has reshaped healthcare priorities, requiring continuous care, specialization, and rehabilitation. Technological advancements have transformed diagnostics, treatment, and service delivery, while policy reforms have altered healthcare financing, regulation, and access, aiming to make healthcare more inclusive and efficient.

Finally, the lesson explored the future trends of the Indian healthcare system. You learned that healthcare in India is moving towards greater use of digital technologies, increased focus on preventive and promotive care, expansion of health insurance coverage, and stronger integration of public and private sectors. The future healthcare environment will demand system-level thinking, strategic management, and adaptive leadership from healthcare administrators.

Overall, this lesson has provided you with a comprehensive understanding of how the Indian healthcare system has evolved, why it continues to change, and what these changes mean for the future of healthcare management and hospital administration.

3.7. Student Activities

1. Prepare a brief note comparing the old and new healthcare systems in India.

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2. Identify demographic and epidemiological changes affecting healthcare demand.

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3. Discuss emerging future trends in Indian healthcare in a group setting.

3.8. Key Words

- Old Healthcare System: Traditional and early institutional forms of healthcare delivery.
- New Healthcare System: Modern, organized, and technology-driven healthcare delivery model.
- Demographic Changes: Shifts in population size, age structure, and distribution.
- Epidemiological Transition: Change in disease patterns from communicable to non-communicable diseases.
- Policy Reforms: Government initiatives aimed at improving healthcare delivery and access.

3.9 . Self-Assessment Questions

A. Short Answer Questions

1. What is meant by the old healthcare system in India?
2. Define the new healthcare system.
3. What are demographic changes?
4. What is epidemiological transition?
5. Mention one policy reform influencing healthcare delivery.

3.10 Suggested Answers:

1. The old healthcare system refers to traditional and early institutional healthcare practices that existed before large-scale modernization.
2. The new healthcare system refers to an organized, technology-enabled, and institution-based healthcare delivery model.
3. Demographic changes refer to variations in population size, age composition, and distribution over time.
4. Epidemiological transition is the shift in disease patterns from infectious diseases to chronic non-communicable diseases.
5. Expansion of public health programs.

3.11. Short Essay Questions

1. Describe the key features of the old healthcare system in India.

2. Explain the emergence of the new healthcare system.
3. Discuss how demographic changes influence healthcare delivery.
4. Examine the role of technology in transforming healthcare services.
5. Outline the future trends of the Indian healthcare system.

3.12 Suggested Hints:

- Use historical background and examples
- Highlight institutional growth and modernization
- Link population changes to healthcare demand
- Discuss digital health and medical innovations
- Focus on system-level future developments

3.13. Multiple Choice Questions

1. The old healthcare system in India mainly relied on: a) Super-specialty hospitals b) Traditional practices c) Telemedicine d) Insurance-based care Answer: b
2. The new healthcare system is characterized by: a) Informal care only b) Organized institutions c) Lack of technology d) Limited policy support Answer: b
3. Epidemiological transition refers to changes in: a) Hospital ownership b) Disease patterns c) Medical education d) Health financing Answer: b
4. Which factor has significantly influenced modern healthcare delivery? a) Rituals b) Technology c) Folklore d) Astrology Answer: b
5. A major future trend in Indian healthcare is: a) Decline in technology use b) Digital health expansion c) Reduction in hospitals d) Elimination of public sector Answer: b

3.14 . Reference Text Books

1. Park, K. – *Park's Textbook of Preventive and Social Medicine* – Banarsidas Bhanot Publishers, Jabalpur, 2021.
2. Goel, S. L. & Kumar, R. – *Hospital Administration and Management* – Deep & Deep Publications, New Delhi, 2018.
3. Joshi, S. R. – *Health Care Management* – Oxford University Press, New Delhi, 2019.

LESSON 4: HISTORY OF HOSPITALS

LESSON OBJECTIVES

After studying this lesson, you will be able to:

- Understand the historical evolution of hospitals at the global level
- Explain the origin and development of early hospitals in India
- Identify the role of traditional healthcare institutions in hospital development
- Examine the growth of hospitals during the colonial period in India
- Appreciate the historical foundations of modern hospital systems

STRUCTURE

1. Introduction to the History of Hospitals
2. Evolution of Hospitals Globally
3. Early Hospitals in India
4. Traditional Healthcare Institutions
5. Growth of Hospitals during the Colonial Period
6. Student Activities
7. Summary

4.1 Evolution of Hospitals Globally

The concept of the hospital has evolved gradually across civilizations, shaped by social values, religious beliefs, medical knowledge, and state involvement. In ancient civilizations, care for the sick was largely provided within families or community settings. Organized institutions resembling hospitals first appeared as places of refuge rather than centers of medical treatment. In ancient Greece, healing temples associated with Asclepius provided rest, diet, and spiritual healing. Similarly, in ancient Rome, military hospitals were established to care for injured soldiers, marking one of the earliest examples of institutional medical care.

During the early medieval period, hospitals in Europe were primarily charitable institutions run by religious organizations. Monasteries and churches established hospices to provide shelter and basic care to the sick, poor, pilgrims, and the dying. Medical treatment was limited, and the primary objective was compassion and care rather than cure. Hospitals during this period were often overcrowded and lacked scientific medical practices.

The Renaissance and early modern periods marked a turning point in hospital evolution. Advances in medical knowledge, anatomy, and surgery gradually transformed hospitals into places of treatment. Governments and municipalities began to assume greater responsibility for healthcare institutions, leading to improved organization, funding, and regulation. The

emergence of teaching hospitals in Europe integrated medical education with patient care, laying the foundation for modern hospital systems.

The nineteenth and twentieth centuries witnessed rapid transformation in hospitals due to scientific breakthroughs such as germ theory, anesthesia, antiseptics, and diagnostic technologies. Hospitals became centers of specialized medical care, research, and education. In the modern era, hospitals evolved into complex organizations requiring professional management, standardized protocols, and advanced infrastructure. Globally, hospitals today function not only as treatment centers but also as hubs for innovation, training, and public health response.

4.2 Early Hospitals in India

The history of hospitals in India reflects both indigenous traditions and external influences. In ancient India, organized healthcare institutions existed in the form of charitable establishments supported by rulers and communities. Historical records indicate that hospitals and dispensaries were established during the Mauryan period, where state-supported institutions provided care to the sick and injured. These early hospitals emphasized free treatment, use of medicinal plants, and community welfare.

In addition to state-supported institutions, temples and religious centers played an important role in providing care. These institutions offered shelter, food, and basic treatment to the sick, reflecting the strong ethical and charitable foundations of Indian healthcare traditions. Medical care was closely linked to indigenous systems such as Ayurveda and Siddha, which emphasized holistic treatment and preventive care.

With the arrival of European trading companies and colonial powers, Western-style hospitals began to appear in India, particularly in port cities. Initially, these hospitals primarily served European soldiers, administrators, and merchants. Over time, access expanded to include the local population, especially in urban areas. Early Indian hospitals were thus characterized by a coexistence of indigenous healing practices and Western medical approaches.

These early hospitals laid the groundwork for institutional healthcare in India but remained limited in coverage and accessibility. Rural areas continued to rely heavily on traditional and informal care providers. The development of hospitals during this phase was uneven and largely concentrated in urban centers.

4.3 Traditional Healthcare Institutions

Traditional healthcare institutions in India predate modern hospitals and form an integral part of the country's medical heritage. These institutions were rooted in indigenous knowledge systems such as Ayurveda, Siddha, Unani, and folk medicine. Healthcare delivery was community-based, relying on local practitioners, family knowledge, and natural remedies. Institutions such as gurukuls, ashrams, and temple complexes functioned as centers for medical learning and practice.

Traditional institutions emphasized preventive care, lifestyle regulation, diet, and harmony between body and environment. Treatment was personalized and holistic, addressing physical, mental, and spiritual well-being. Although these institutions lacked modern infrastructure and technology, they provided accessible and culturally acceptable care to large segments of the population.

From an institutional perspective, traditional healthcare centers were not hospitals in the modern sense but served many hospital-like functions, including diagnosis, treatment, recovery, and health education. They played a crucial role in preserving medical knowledge and ensuring continuity of care across generations.

For contemporary healthcare administrators, understanding traditional healthcare institutions is important because they influenced patient expectations, care-seeking behavior, and ethical foundations of healthcare in India. Even today, traditional systems coexist with modern hospitals, contributing to a pluralistic healthcare environment.

4.4 Growth of Hospitals during the Colonial Period

The colonial period marked a significant phase in the development of hospitals in India. British administration introduced Western medical institutions primarily to serve the needs of colonial officials, military personnel, and urban populations. Military hospitals, civil hospitals, and teaching hospitals were established in major cities and cantonment areas.

Colonial hospitals emphasized clinical treatment, disease control, and medical education based on Western scientific principles. Medical colleges were established to train doctors, leading to the professionalization of medical practice. Public health measures such as sanitation, vaccination, and epidemic control were implemented through hospital-based and community interventions.

However, the growth of hospitals during the colonial period was uneven and largely urban-centric. Rural healthcare remained neglected, and access to hospital services was limited for large sections of the Indian population. Hospitals during this period also reflected social hierarchies, with differential access based on race and class.

Despite these limitations, colonial hospitals introduced important structural and organizational features that continue to influence modern healthcare institutions. These include standardized hospital administration, record-keeping, specialization, and integration of teaching and research. The colonial period thus laid the institutional foundation for the post-independence expansion of hospitals in India.

4.5 Summary

In this lesson, you have studied the historical development of hospitals and how they evolved into the complex healthcare institutions that exist today. The lesson helped you understand that hospitals did not emerge suddenly in their modern form; rather, they developed gradually in response to social needs, medical knowledge, religious values, and administrative systems across different periods of history.

You first learned about the global evolution of hospitals, beginning with early forms of institutional care in ancient civilizations. Initially, hospitals functioned mainly as places of shelter and care rather than centers for scientific medical treatment. Religious institutions played a significant role in establishing early hospitals, particularly during the medieval period, when care for the sick, poor, and travelers was viewed as a moral and charitable responsibility. Over time, advances in medical science, such as the understanding of disease causation and improvements in surgical techniques, transformed hospitals into places focused on treatment, education, and research. This global evolution laid the foundation for the modern hospital as a professional, technology-driven organization.

The lesson then examined the early development of hospitals in India, highlighting that organized healthcare institutions existed long before the advent of modern Western medicine. Ancient Indian rulers and communities supported hospitals and dispensaries that provided free treatment using indigenous medical knowledge. Religious and charitable institutions such as temples and monasteries played an important role in offering care, shelter, and basic treatment to the sick. These early hospitals reflected strong ethical values of service and community welfare, although their reach and technological capabilities were limited.

You also studied the role of traditional healthcare institutions in shaping India's healthcare system. Traditional institutions based on systems such as Ayurveda, Siddha, and Unani emphasized holistic care, prevention, lifestyle regulation, and harmony between the body and environment. Although these institutions differed from modern hospitals in structure and technology, they fulfilled many essential healthcare functions and influenced patient expectations and healthcare-seeking behavior. Their continued relevance highlights the pluralistic nature of healthcare in India.

Finally, the lesson focused on the growth of hospitals during the colonial period, which marked a major turning point in institutional healthcare development. Colonial administration introduced Western-style hospitals, medical colleges, and public health measures, primarily to serve administrative, military, and urban needs. While access to hospital care remained uneven and largely urban-centric, this period established important organizational features such as standardized administration, professional medical education, specialization, and record-keeping. These developments formed the institutional base for the expansion of hospitals in post-independence India.

Overall, this lesson has helped you understand how historical forces shaped the structure, functions, and management of modern hospitals. For students of Hospital Administration, this historical perspective is essential for appreciating the ethical foundations, institutional complexity, and evolving role of hospitals within the healthcare system.

4.6 Student Activities

1. Prepare a brief timeline showing major milestones in the evolution of hospitals globally.

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2. Collect information on any early hospital in India and present its historical significance.

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3. Discuss in groups how traditional healthcare institutions influenced modern hospitals.

4.7 . Key Words

- Hospital: An institution providing medical and nursing care to the sick and injured.
- Infirmary: An early form of hospital primarily for the care of the poor or sick.
- Charitable Hospitals: Hospitals established for providing free or subsidized care.
- Traditional Institutions: Indigenous centers of healing and care before modern hospitals.
- Colonial Period: The phase of British rule in India that influenced institutional healthcare.

4.8 . Self-Assessment Questions

A. Short Answer Questions

1. What is meant by a hospital?
2. What were the early forms of hospitals globally?
3. Mention one feature of early hospitals in India.
4. What role did traditional institutions play in healthcare?
5. Why did hospitals expand during the colonial period?

4.9 Suggested Answers:

1. A hospital is an institution that provides organized medical and nursing care to patients.
2. Early forms included infirmaries and charitable shelters for the sick.
3. Early hospitals in India were mainly charitable and religious in nature.
4. Traditional institutions provided community-based healing and care.
5. Hospitals expanded to meet administrative, military, and public health needs.

4.10. Essay Questions

1. Briefly describe the evolution of hospitals at the global level.
2. Explain the nature of early hospitals in India.
3. Discuss the contribution of traditional healthcare institutions.
4. Examine the impact of colonial rule on hospital development in India.
5. Highlight the significance of hospital history for healthcare administrators.

4.11 Suggested Hints:

- Trace historical stages and purposes of hospitals
- Link religious, charitable, and state roles
- Discuss institutional growth and organization
- Use Indian historical context
- Relate past developments to modern hospitals

4.12 . Multiple Choice Questions

1. Early hospitals globally were mainly associated with: a) Corporations b) Religious institutions c) Insurance companies d) Governments Answer: b
2. Traditional healthcare institutions in India were largely: a) Profit-oriented b) Technology-driven c) Community-based d) Corporate Answer: c
3. During the colonial period, hospitals were expanded mainly to serve: a) Rural villages only b) Industrial workers only c) Administrative and military needs d) Insurance holders Answer: c
4. Infirmaries primarily provided care to: a) Elites b) Soldiers c) The poor and sick d) Tourists Answer: c
5. Understanding hospital history helps administrators to: a) Ignore traditions b) Improve managerial perspective c) Reduce services d) Avoid planning Answer: b

4.13 Case Study

From Charity to Institution – The Historical Transformation of Hospitals in India

Background of the Case

In the early eighteenth century, healthcare in most parts of India was largely non-institutional. Illness was managed within households or by local healers trained in indigenous systems of medicine such as Ayurveda and Unani. Care was personal, community-oriented, and deeply embedded in cultural and religious practices. Organized hospitals, as understood today, were rare and limited in scope. Healing centers attached to temples, monasteries, and charitable trusts provided shelter, food, and basic treatment to the sick, poor, pilgrims, and elderly. These institutions were motivated more by charity and compassion than by systematic medical treatment.

During this period, Indian port cities such as Calcutta, Bombay, and Madras began to experience increased European presence due to trade and colonial expansion. With the arrival of European traders and later British administrators, the need for organized medical facilities became evident, particularly for soldiers, sailors, and colonial officials who were exposed to unfamiliar diseases. This led to the establishment of military hospitals and civil hospitals, which marked the beginning of Western-style institutional healthcare in India.

Initially, these hospitals were exclusive and served primarily European populations. Indian patients were often reluctant to seek treatment in these hospitals due to cultural barriers, distrust of foreign medical practices, and rigid social hierarchies. Over time, however, colonial hospitals expanded their services to the local population, especially in urban areas. Medical colleges were established to train doctors in Western medicine, introducing formal medical education, standardized treatment protocols, and professional medical practice.

By the mid-nineteenth century, hospitals had begun to evolve from mere custodial institutions into centers of diagnosis and treatment. Advances in medical science—such as the understanding of infection, improvements in surgery, and the introduction of anesthesia—transformed hospitals into places where recovery was possible rather than unlikely. Hospitals also became instruments of public health administration, playing a key role in epidemic control, vaccination campaigns, and sanitation efforts.

Despite these developments, hospital growth during the colonial period remained uneven and urban-centric. Rural populations continued to depend largely on traditional healthcare institutions and informal providers. Hospitals reflected social inequalities, with differential access based on race, class, and economic status. Nevertheless, colonial hospitals introduced administrative systems, record-keeping, specialization, and integration of teaching and research that shaped the foundation of modern hospitals in India.

After Independence, India inherited this mixed legacy of traditional healthcare institutions and colonial hospital systems. The post-independence government expanded public hospitals, emphasized universal access, and integrated hospitals into a broader national healthcare framework. Modern hospitals today—whether public or private—are the outcome of this long historical process that combined charitable origins, traditional care practices, colonial institutionalization, and scientific advancement.

This case highlights how hospitals evolved over time and why understanding their historical development is essential for effective hospital administration in the present context.

4.14 Case Questions

1. How did early hospitals differ from modern hospitals in terms of purpose and function?
2. What role did traditional healthcare institutions play before the emergence of modern hospitals in India?
3. In what ways did colonial rule influence the growth and structure of hospitals in India?
4. Why was hospital development during the colonial period uneven across regions and populations?
5. How does an understanding of hospital history help modern hospital administrators?

4.15 Suggested Answers

Answer 1

Early hospitals primarily functioned as charitable and custodial institutions. Their main purpose was to provide shelter, food, and basic care to the sick, poor, and marginalized rather than systematic medical treatment. Modern hospitals, in contrast, are complex organizations focused on diagnosis, treatment, prevention, education, and research, supported by advanced technology and professional management.

Answer 2

Traditional healthcare institutions played a crucial role in providing accessible, community-based care before the emergence of modern hospitals. They emphasized holistic treatment, prevention, and lifestyle regulation using indigenous medical knowledge. These institutions also shaped cultural attitudes toward health and illness and influenced healthcare-seeking behavior, especially in rural areas.

Answer 3

Colonial rule introduced Western-style hospitals, medical education, and public health administration in India. Hospitals were established for military and civil purposes, medical colleges trained doctors in modern medicine, and standardized administrative systems were introduced. These developments transformed hospitals into treatment-oriented institutions and laid the foundation for modern hospital organization.

Answer 4

Hospital development during the colonial period was uneven because it prioritized urban centers, administrative needs, and colonial populations. Rural areas received limited attention, and access to hospital care was influenced by economic status, social hierarchy, and race. As a result, large sections of the population continued to rely on traditional and informal healthcare systems.

Answer 5

Understanding hospital history helps modern hospital administrators appreciate the ethical foundations, institutional complexity, and social responsibilities of hospitals. It provides insight into why hospitals function as they do today, highlights persistent challenges such as access and equity, and supports informed decision-making in planning, management, and policy formulation.

4.16. Reference Text Books

1. Goel, S. L. & Kumar, R. – *Hospital Administration and Management* – Deep & Deep Publications, New Delhi, 2018.
2. Park, K. – *Park's Textbook of Preventive and Social Medicine* – Banarsidas Bhanot Publishers, Jabalpur, 2021.
3. Rosen, G. – *A History of Public Health* – Johns Hopkins University Press, Baltimore, 1993.

LESSON 5: HOSPITALS IN INDEPENDENT INDIA

OBJECTIVES

After studying this lesson, you will be able to:

- Understand the emergence of the healthcare delivery system after Independence
- Explain the expansion of public hospitals in India
- Analyze the growth of private and corporate hospitals
- Examine the role of teaching hospitals in healthcare delivery
- Appreciate the changing hospital landscape in Independent India

STRUCTURE

1. Emergence of Healthcare Delivery System after Independence
2. Expansion of Public Hospitals
3. Growth of Private and Corporate Hospitals
4. Role of Teaching Hospitals
5. Student Activities
6. Summary

Introductory Case: Transformation of Hospital Care in Post-Independence India

In 1947, at the time of Independence, India inherited a limited and unevenly distributed hospital infrastructure. Most hospitals were concentrated in major cities, primarily serving administrative, military, and urban populations. Rural areas, where the majority of Indians lived, had minimal access to institutional healthcare and depended largely on traditional healers and informal providers. Public hospitals were few, understaffed, and poorly equipped, while private hospitals were small in number and limited in scope.

Over the decades following Independence, the Indian government adopted a planned approach to healthcare development. Public hospitals expanded rapidly through Five-Year Plans, with the establishment of district hospitals, medical colleges, and specialty institutions. At the same time, economic liberalization and rising incomes encouraged private investment in healthcare. Corporate hospital chains offering advanced technology and specialized services emerged, particularly in urban centers. Teaching hospitals became central to healthcare delivery by integrating patient care with medical education and research.

Today, India has one of the world's largest hospital networks, comprising public hospitals, private hospitals, corporate healthcare chains, and teaching institutions. This transformation reflects the dynamic evolution of hospitals in Independent India and highlights important managerial, financial, and policy challenges for hospital administrators

5.1 Emergence of the Healthcare Delivery System after Independence

At the time of Independence in 1947, India inherited a fragmented and inadequate healthcare system that was largely urban-centric and colonial in orientation. Hospitals were few in number, unevenly distributed, and primarily designed to serve administrative, military, and urban elite populations. Recognizing health as a crucial component of national development, the newly independent Indian state assumed primary responsibility for organizing and expanding the healthcare delivery system. Healthcare was viewed not merely as a welfare service but as a foundational investment in human capital and socio-economic progress.

The post-independence period marked the beginning of a planned and state-led approach to healthcare delivery. Through successive Five-Year Plans, the government focused on building a three-tier healthcare system comprising primary, secondary, and tertiary levels of care. Hospitals were integrated into this broader framework as key institutions for curative services, disease control, training, and referral support. Emphasis was placed on expanding access to healthcare in rural and underserved regions, correcting the urban bias inherited from the colonial period.

Public hospitals became the backbone of the healthcare delivery system, supporting national health programs, epidemic control, maternal and child health services, and treatment of communicable diseases. Over time, hospitals also assumed a growing role in managing non-communicable diseases, trauma care, and specialized medical services. The emergence of an organized healthcare delivery system after Independence thus represented a shift from selective and exclusionary care towards a more inclusive and population-oriented approach.

5.2 Expansion of Public Hospitals

The expansion of public hospitals was a central feature of healthcare development in Independent India. Government investment focused on establishing and strengthening district hospitals, state-level referral hospitals, and medical college hospitals. These institutions were designed to provide affordable and accessible healthcare services to large sections of the population, particularly the poor and marginalized.

District hospitals emerged as the cornerstone of secondary healthcare, offering inpatient and outpatient services, basic surgical facilities, maternity care, and emergency services. State and central government hospitals provided tertiary care, including specialized medical and surgical services. Medical college hospitals combined patient care with medical education and research, contributing to the development of skilled healthcare professionals.

Public hospitals played a critical role in implementing national health programs, such as immunization, tuberculosis control, and maternal and child health initiatives. They also served as referral centers for primary healthcare facilities. Despite their importance, public hospitals faced persistent challenges related to infrastructure constraints, workforce shortages, overcrowding, and limited financial resources. Nevertheless, they remained essential for ensuring equity and access in the healthcare system.

From a hospital administration perspective, public hospitals in Independent India evolved as large, complex organizations requiring effective management of human resources,

finance, logistics, and service delivery. The need to balance social objectives with operational efficiency became a defining challenge for public hospital management.

5.3 Growth of Private Hospitals and Corporate Hospitals

Alongside the expansion of public hospitals, the private healthcare sector grew steadily in Independent India. Initially, private hospitals were small-scale establishments run by individual practitioners or charitable trusts, catering mainly to urban populations. Over time, rising incomes, population growth, urbanization, and increasing demand for quality healthcare services accelerated the growth of private hospitals.

The economic liberalization of the 1990s marked a turning point in the growth of private and corporate hospitals. Policy reforms encouraged private investment, foreign collaboration, and technological advancement in healthcare. Large corporate hospital chains emerged, offering advanced diagnostic and therapeutic services, specialized care, and improved patient amenities. These hospitals introduced professional management practices, modern infrastructure, and customer-oriented service delivery models.

Corporate hospitals played a significant role in expanding tertiary and super-specialty care, promoting medical tourism, and introducing cutting-edge medical technology. However, their growth also raised concerns regarding affordability, equity, and commercialization of healthcare. High treatment costs and dependence on out-of-pocket payments limited access for economically weaker sections, highlighting the need for regulatory oversight and integration with public health objectives.

For healthcare administrators, the rise of private and corporate hospitals introduced new dimensions of competition, quality benchmarking, financial management, and ethical governance within the healthcare system.

5.4 Role of Teaching Hospitals

Teaching hospitals occupy a unique and vital position in the healthcare system of Independent India. These hospitals are typically attached to medical colleges and serve a dual role by providing healthcare services while simultaneously training medical students, nurses, and allied health professionals. Teaching hospitals have been instrumental in building the country's healthcare workforce and advancing medical knowledge.

In terms of service delivery, teaching hospitals function as major tertiary care centers, handling complex and referral cases that cannot be managed at lower levels of care. They often serve large catchment populations and provide specialized services at relatively subsidized costs, especially in the public sector. Their involvement in research and clinical trials contributes to innovation and improvement in medical practices.

Teaching hospitals also play an important role in shaping standards of care, developing clinical protocols, and promoting evidence-based medicine. From a management perspective, these hospitals are among the most complex healthcare institutions, requiring coordination between academic, clinical, and administrative functions.

In Independent India, teaching hospitals have thus contributed not only to healthcare delivery but also to the sustainability and advancement of the entire health system. Their continued strengthening is essential for addressing future healthcare challenges and ensuring availability of skilled professionals.

5.5 Summary of Lesson 5: Hospitals in Independent India

In this lesson, you have studied how the hospital system in India developed and expanded after Independence, transforming from a limited and urban-centric structure into a large and diverse healthcare network. At the time of Independence, hospitals in India were few in number, unevenly distributed, and largely inherited from the colonial administration. Recognizing the importance of health for national development, the Indian government assumed a central role in building an organized healthcare delivery system that could serve the needs of a growing and diverse population.

The lesson explained the emergence of the healthcare delivery system after Independence, highlighting the planned and state-led approach adopted by the government. Through successive development plans, hospitals were integrated into a three-tier healthcare system and linked with national health programs. Public hospitals became key institutions for providing curative services, controlling communicable diseases, and supporting maternal and child health initiatives. Over time, they also took on the responsibility of managing non-communicable diseases and emergency care.

You also learned about the expansion of public hospitals, which formed the backbone of healthcare delivery in Independent India. District hospitals, state referral hospitals, and medical college hospitals were established across the country to improve access to affordable healthcare. These hospitals played a vital role in ensuring equity and reaching underserved populations, despite challenges such as overcrowding, limited resources, and workforce shortages. From a hospital administration perspective, managing public hospitals required balancing social objectives with efficiency and quality of care.

The lesson further examined the growth of private hospitals and corporate hospitals, particularly after economic liberalization. Private sector participation introduced advanced medical technology, specialized services, and professional management practices. Corporate hospitals contributed to the expansion of tertiary and super-specialty care and enhanced India's position in areas such as medical tourism. At the same time, their growth raised concerns related to affordability, accessibility, and commercialization of healthcare.

Finally, the lesson emphasized the role of teaching hospitals in Independent India. Teaching hospitals combined patient care with medical education and research, making them essential for developing skilled healthcare professionals and advancing medical knowledge. They functioned as major tertiary care and referral centers and played a crucial role in strengthening the overall healthcare system.

Overall, this lesson helped you understand how hospitals in Independent India evolved into complex institutions shaped by public policy, private initiative, and educational needs, and why this evolution is important for effective hospital and healthcare management today.

5.6 Students Activities :

1. **Comparative Study Activity**
   Students may prepare a comparative analysis of a public hospital and a private or corporate hospital in their region. The study should focus on infrastructure, range of services, patient load, cost of treatment, and management practices, and highlight how these hospitals reflect post-Independence healthcare development.

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2. **Policy Review Activity**
   Learners may review one major government initiative or policy that contributed to the expansion of public hospitals after Independence. Based on this review, students should write a brief note explaining how government planning influenced hospital growth and access to healthcare services.

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3. Teaching Hospital Case Exploration
   Students may identify a nearby teaching hospital and examine its dual role in patient care and medical education. The activity should assess how teaching responsibilities influence service delivery, hospital administration, and resource utilization.

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4. Group Discussion and Presentation
   Learners may participate in a group discussion on the impact of private and corporate hospitals on India's healthcare system. Each group should present arguments on both positive contributions and challenges such as affordability and equity, from a hospital management perspective.

5.7 . Key Words

- Public Hospitals: Hospitals funded and managed by the government.
- Private Hospitals: Healthcare institutions owned and operated by private individuals or organizations.
- Corporate Hospitals: Large, professionally managed hospital chains.
- Teaching Hospitals: Hospitals associated with medical colleges for education and research.
- Healthcare Delivery System: Organized arrangement of healthcare services and institutions.

5.8 Self-Assessment Questions

A. Short Answer Questions

1. What was the condition of hospitals in India at the time of Independence?
2. What is meant by public hospitals?
3. Why did private hospitals grow rapidly after economic liberalization?
4. What is a corporate hospital?
5. Mention one role of teaching hospitals.

5.9 Suggested Answers:

1. Hospitals were limited in number, urban-centric, and poorly equipped, with minimal rural coverage.
2. Public hospitals are healthcare institutions funded and managed by the government.
3. Due to rising demand for quality care, higher incomes, and policy support.
4. Corporate hospitals are large-scale, professionally managed hospital organizations.
5. Teaching hospitals provide medical education along with patient care.

5.10 Essay Type Questions

1. Explain the emergence of the healthcare delivery system in India after Independence.
2. Discuss the expansion of public hospitals in post-independence India.
3. Analyze the growth of private and corporate hospitals in India.
4. Examine the role of teaching hospitals in healthcare delivery.
5. Evaluate the challenges faced by hospitals in Independent India.

5.11 Suggested Hints:

- Use historical and policy context
- Highlight Five-Year Plans and government initiatives

- Discuss private sector participation and technology
- Link education, research, and service delivery
- Address access, affordability, and quality issues

5.12 Multiple Choice Questions

1. After Independence, healthcare development in India was mainly guided by: a) Market forces b) Central planning c) Foreign investment d) Insurance companies Answer: b
2. Public hospitals primarily aim to provide: a) Profit-based care b) Luxury services c) Affordable healthcare d) Export services Answer: c
3. Corporate hospitals expanded mainly after: a) 1950 b) 1960 c) 1991 d) 2000 Answer: c
4. Teaching hospitals are closely linked with: a) Insurance firms b) Medical colleges c) Pharmaceutical companies d) NGOs Answer: b
5. One major function of teaching hospitals is: a) Only patient care b) Only research c) Education and training d) Marketing Answer: c

5.13 Case Study: Public and Private Hospital Growth in Post-Independence India

Case Background

After Independence, India faced the challenge of building a healthcare system capable of serving a vast and diverse population. The government invested heavily in public hospitals to improve access, especially in rural and underserved regions. District hospitals and government medical colleges were established across states to strengthen secondary and tertiary care. Over time, limitations in public hospital capacity, quality, and responsiveness created space for private sector growth.

From the 1990s onwards, private and corporate hospitals expanded rapidly, offering advanced medical technology, specialized services, and improved patient amenities. While these hospitals enhanced service quality and attracted medical tourism, concerns emerged regarding affordability, equity, and over-commercialization of healthcare. Teaching hospitals continued to play a dual role by training healthcare professionals and delivering tertiary care, often serving as referral centers for complex cases.

This case highlights the coexistence of public, private, and teaching hospitals in Independent India and the managerial challenges involved in balancing access, quality, and sustainability.

Case Questions

1. Why did the government prioritize public hospital expansion after Independence?
2. What factors contributed to the growth of private and corporate hospitals?
3. How do teaching hospitals differ from other hospitals in their functions?
4. What challenges arise from the coexistence of public and private hospitals?

5. Suggest strategies to improve coordination among different types of hospitals.

5.14 Suggested Answers

1. To ensure equitable access to healthcare and support national development goals.
2. Rising demand for quality care, technological advancement, and economic liberalization.
3. Teaching hospitals integrate education, research, and patient care.
4. Challenges include inequality in access, cost escalation, and resource imbalance.
5. Strengthening referral systems, public–private partnerships, and regulatory oversight.

5.15 Reference Text Books

1. Goel, S. L. & Kumar, R. – *Hospital Administration and Management* – Deep & Deep Publications, New Delhi, 2018.
2. Park, K. – *Park's Textbook of Preventive and Social Medicine* – Banarsidas Bhanot Publishers, Jabalpur, 2021.
3. Joshi, S. R. – *Health Care Management* – Oxford University Press, New Delhi, 2019.

LESSON 6: CHANGING ROLE OF HOSPITALS AND GLOBALIZATION

OBJECTIVES

After studying this lesson, you will be able to:

- Understand the changing roles of hospitals in modern healthcare systems
- Explain hospitals as service-oriented organizations
- Identify key characteristics of hospitals in the new millennium
- Analyze the impact of globalization on healthcare delivery
- Examine the role of international hospital chains and collaborations

STRUCTURE

1. Changing Roles of Hospitals
2. Hospitals as Service Organizations
3. Hospitals in the New Millennium
4. Globalization of Healthcare
5. International Hospital Chains and Collaborations
6. Student Activities
7. Summary

Introductory Case: From Local Hospital to Global Healthcare Brand

In the early 1980s, hospitals in India largely functioned as localized institutions focused on providing curative care to nearby populations. Services were limited in scope, management was primarily clinical in orientation, and patient choice was constrained by geography. Over the past few decades, this situation has changed dramatically. Large hospital groups now operate multi-specialty facilities across several cities and even across national borders. Some Indian hospital chains attract international patients, collaborate with foreign universities, adopt global accreditation standards, and use advanced digital technologies to deliver care.

For example, hospitals that once focused only on inpatient treatment now offer preventive health packages, wellness services, teleconsultations, second-opinion services for overseas patients, and post-discharge continuity of care. Partnerships with international hospital chains, global insurers, and medical technology firms have further transformed hospitals into globally connected service organizations. This shift illustrates how hospitals have moved beyond their traditional roles and become integral players in a globalized healthcare environment.

This lesson examines how and why the role of hospitals has changed, how hospitals function as service organizations, and how globalization has reshaped hospital management and healthcare delivery.

6.1 Changing Roles of Hospitals

The role of hospitals has expanded significantly from their traditional function as places primarily meant for inpatient treatment of acute illness. In earlier periods, hospitals were largely reactive institutions, intervening only after disease had occurred. In the contemporary healthcare environment, hospitals are increasingly proactive and comprehensive institutions that address the entire continuum of care. This includes disease prevention, early diagnosis, treatment, rehabilitation, long-term care, and follow-up services.

Hospitals today are deeply integrated into public health systems and community health initiatives. They actively participate in screening programs for non-communicable diseases, maternal and child health services, immunization campaigns, trauma care systems, and disaster response. The shift in disease burden from communicable diseases to chronic and lifestyle-related conditions has compelled hospitals to adopt multidisciplinary and long-term care approaches rather than episodic treatment models.

In addition, hospitals now play an important role in health education and patient empowerment. Patients are no longer passive recipients of care; they are informed consumers who demand transparency, quality, and participation in decision-making. Hospitals therefore engage in patient counseling, health promotion activities, and shared decision-making processes. From a management perspective, hospitals are accountable not only for clinical outcomes but also for patient satisfaction, safety, and value for money.

6.2 Hospitals as Service Organizations

Hospitals function fundamentally as service organizations, delivering complex, high-contact services where outcomes depend on human interaction, professional judgment, and coordination among multiple departments. Unlike manufacturing organizations, hospitals produce and consume services simultaneously, and the quality of output cannot be separated from the process of delivery. Each patient encounter is unique, making standardization challenging.

As service organizations, hospitals must focus on service quality dimensions such as reliability, responsiveness, assurance, empathy, and tangibles. Patient experience is shaped not only by clinical care but also by waiting times, communication, cleanliness, staff behavior, and administrative processes. Consequently, hospital management increasingly emphasizes patient-centered design, service process mapping, and continuous quality improvement.

Hospitals also rely heavily on teamwork and coordination. Clinical services must be supported by diagnostics, pharmacy, nursing, information systems, logistics, and housekeeping. Inefficiencies in any support function can directly affect clinical outcomes and patient satisfaction. Hospital administrators must therefore manage service capacity, demand variability, and human resources to deliver consistent quality while maintaining cost efficiency.

6.3 Hospitals in the New Millennium

Hospitals in the new millennium operate in an environment characterized by rapid technological advancement, intense competition, regulatory scrutiny, and rising patient expectations. Medical innovations such as minimally invasive surgery, robotic systems, advanced imaging, and personalized medicine have transformed clinical practice. At the same time, digital technologies such as electronic health records, hospital information systems, and data analytics have reshaped hospital administration and decision-making.

Modern hospitals increasingly adopt integrated care models that emphasize coordination across departments and levels of care. Clinical pathways, evidence-based protocols, and performance measurement systems are used to improve outcomes and efficiency. Hospitals are also diversifying service offerings by expanding outpatient care, day-care surgeries, home-based services, and wellness programs, reflecting a shift away from exclusive dependence on inpatient revenue.

The new millennium has also heightened the importance of governance, ethics, and accountability in hospital management. Regulatory requirements, accreditation standards, and patient rights frameworks have increased expectations for transparency and quality. Hospital leaders must balance clinical excellence with financial sustainability, risk management, and social responsibility in a highly dynamic environment.

6.4 Globalization of Healthcare

Globalization has emerged as a powerful force shaping healthcare delivery and hospital operations. Advances in transportation, communication, and information technology have facilitated cross-border movement of patients, health professionals, medical technology, and capital. Hospitals increasingly operate within a global context, adopting international standards and competing in global healthcare markets.

One of the most visible outcomes of globalization is the growth of cross-border patient mobility. Patients travel internationally to access specialized treatments, lower costs, or shorter waiting times. Hospitals responding to this trend have developed international patient departments, multilingual services, and global insurance partnerships. Globalization has also accelerated the spread of medical knowledge, clinical guidelines, and best practices, contributing to improvements in quality and safety.

At the same time, globalization poses significant challenges. Regulatory differences across countries, ethical concerns related to equity and access, and migration of healthcare professionals can strain local health systems. Hospital administrators must navigate these complexities while ensuring that global engagement does not undermine local healthcare priorities.

6.5 International Hospital Chains and Collaborations

International hospital chains and cross-border collaborations represent an advanced stage of globalization in healthcare. Hospital chains operate networks of facilities across regions and

countries, leveraging standardized clinical protocols, brand reputation, and centralized management systems. Such models enable economies of scale, consistent quality standards, and rapid diffusion of innovation.

Collaborations between hospitals and international partners—including universities, research institutions, and technology firms—support knowledge exchange, training, and clinical research. These partnerships enhance institutional capability and global credibility but also require careful governance to manage cultural differences, regulatory compliance, and strategic alignment.

For hospital administrators, international collaborations demand competencies in global strategy, contract management, quality assurance, and cross-cultural leadership. When effectively managed, such collaborations can enhance service quality, innovation, and organizational learning.

Hospitals as Service Organizations

Hospitals are fundamentally service organizations, delivering intangible, people-intensive services characterized by simultaneity of production and consumption, variability, and high information asymmetry. Unlike manufacturing organizations, hospitals cannot standardize outputs completely; care must be tailored to individual patient needs, preferences, and clinical conditions.

Viewing hospitals as service organizations places emphasis on service quality dimensions such as reliability, responsiveness, assurance, empathy, and tangibles. Patient experience, communication, waiting times, and coordination among departments significantly influence perceived quality. Consequently, hospitals invest in service design, patient flow optimization, customer relationship management, and grievance redressal systems.

Service orientation also requires multidisciplinary teamwork and effective coordination among clinical and non-clinical staff. Support services—such as diagnostics, pharmacy, housekeeping, and information systems—are integral to service delivery. Hospital administrators must manage capacity, demand variability, and human resources to ensure consistent service quality while controlling costs.

Hospitals in the New Millennium

Hospitals in the new millennium represent a decisive shift from traditional, facility-centered institutions to complex, knowledge-driven, technology-enabled service organizations operating within dynamic healthcare systems. This transformation has been shaped by advances in medical science, information technology, changing disease patterns, rising patient expectations, regulatory reforms, and globalization. Hospitals today are no longer isolated places of treatment; they function as integrated hubs within broader healthcare networks.

A defining feature of hospitals in the new millennium is the transition from episodic care to continuum-of-care models. Earlier, hospitals primarily focused on acute inpatient treatment. Contemporary hospitals now engage patients across the entire care pathway—ranging from

preventive screenings and early diagnosis to treatment, rehabilitation, home care, and long-term disease management. This shift has been driven largely by the growing burden of non-communicable diseases such as diabetes, cardiovascular disorders, cancer, and mental health conditions, which require sustained and coordinated care rather than one-time interventions.

Technological advancement is central to the modern hospital. Hospitals in the new millennium extensively use advanced medical technologies such as minimally invasive surgery, robotic-assisted procedures, high-resolution imaging, precision diagnostics, and personalized medicine. Alongside clinical technologies, digital health systems—including electronic health records, hospital information systems, telemedicine platforms, and data analytics—have transformed hospital administration and clinical decision-making. These technologies improve care coordination, reduce medical errors, enhance efficiency, and support evidence-based practice.

Another important characteristic is the emphasis on quality, safety, and accountability. Modern hospitals operate under increasing scrutiny from regulators, accreditation agencies, insurers, and patients. Quality indicators, patient safety protocols, clinical audits, and accreditation standards have become integral to hospital operations. Hospitals are expected to demonstrate measurable outcomes, transparency, and continuous quality improvement, moving beyond volume-based service delivery toward value-based care.

Hospitals in the new millennium are also marked by a strong patient-centered orientation. Patients are increasingly informed, empowered, and involved in decisions regarding their care. Hospitals therefore focus on patient experience, effective communication, respect for patient rights, and shared decision-making. Service design, patient feedback systems, grievance redressal mechanisms, and ethical practices are now recognized as essential components of hospital management.

From an organizational perspective, modern hospitals have become professionally managed institutions. Clinical excellence alone is no longer sufficient; hospitals require expertise in finance, human resource management, operations, supply chain management, information systems, and strategic planning. Hospital administrators play a critical role in balancing clinical priorities with financial sustainability, regulatory compliance, risk management, and organizational governance.

Hospitals in the new millennium have also diversified their service portfolios. In addition to inpatient care, many hospitals now offer day-care procedures, ambulatory services, wellness programs, preventive health check-ups, home-based care, and teleconsultation services. This diversification reflects both technological feasibility and changing patient preferences, as well as the need to optimize resource utilization and revenue streams.

Another significant development is the growing importance of integration and collaboration. Hospitals increasingly function as part of integrated delivery systems, collaborating with primary care providers, diagnostic centers, rehabilitation facilities, insurers, and technology partners. Such integration improves continuity of care, reduces duplication of services, and enhances system efficiency.

Finally, hospitals in the new millennium operate within a context of globalization and competition. Adoption of international standards, participation in global healthcare markets,

and collaboration with international institutions have raised expectations regarding quality and innovation. At the same time, hospitals must remain socially accountable, ensuring that technological advancement and global engagement do not compromise equity, affordability, and access.

In summary, hospitals in the new millennium are technology-intensive, patient-centered, quality-driven, and professionally managed organizations. They play a central role not only in treating illness but also in shaping population health, advancing medical knowledge, and sustaining healthcare systems in an increasingly complex and globalized environment.

Globalization of Healthcare

Globalization of healthcare refers to the increasing cross-border flow of patients, health professionals, medical technology, capital, knowledge, and healthcare services, resulting in greater interdependence among national health systems. In the contemporary era, healthcare is no longer confined within national boundaries; hospitals and health systems operate within a global marketplace influenced by international standards, competition, and collaboration. This phenomenon has significant implications for hospital management, healthcare delivery, equity, and policy formulation.

One of the most visible dimensions of healthcare globalization is international patient mobility, commonly referred to as medical tourism. Patients travel across countries to seek medical treatment due to factors such as lower cost, shorter waiting times, access to advanced technology, or specialized expertise. Countries such as India, Thailand, Singapore, Turkey, and Mexico have emerged as major destinations for medical tourism. India, for instance, attracts international patients for cardiac surgery, organ transplantation, oncology, orthopedics, and cosmetic procedures, largely due to comparatively lower treatment costs and availability of skilled medical professionals. Procedures that may cost several tens of thousands of dollars in developed countries are often available at a fraction of the cost in developing economies, while maintaining acceptable quality standards.

Globalization has also facilitated the international diffusion of medical knowledge and technology. Advances in diagnostics, pharmaceuticals, medical devices, and treatment protocols spread rapidly across borders through multinational corporations, research collaborations, conferences, and digital platforms. Hospitals increasingly adopt international clinical guidelines and evidence-based practices, contributing to the standardization of care. Telemedicine and digital health platforms further accelerate globalization by enabling cross-border consultations, second opinions, and remote monitoring of patients.

Another critical aspect of globalization is the movement of healthcare professionals across countries. Doctors, nurses, and allied health workers migrate internationally in search of better training, remuneration, and working conditions. While this mobility contributes to global knowledge exchange and skill enhancement, it also raises concerns about workforce shortages in source countries and ethical issues related to “brain drain.” Hospitals operating in a globalized environment must therefore address workforce planning, retention, and ethical recruitment practices.

Globalization has also influenced healthcare through the internationalization of hospital standards and accreditation systems. Accreditation bodies and global benchmarks have raised

expectations regarding patient safety, quality of care, and organizational governance. Hospitals seeking to attract international patients or collaborate globally often adopt internationally recognized quality frameworks. This has led to improvements in infection control, clinical documentation, patient rights, and risk management. However, compliance with global standards also increases operational complexity and costs.

From an organizational and financial perspective, globalization has encouraged foreign investment and international partnerships in healthcare. Cross-border investments, joint ventures, and public–private partnerships have enabled hospitals to access capital, advanced technology, and managerial expertise. International collaborations with universities and research institutions support clinical research, training, and innovation. At the same time, increased competition from global players pressures hospitals to differentiate themselves through quality, specialization, and service excellence.

Despite its benefits, globalization of healthcare poses several challenges and risks. There are concerns about inequity, as resources may be disproportionately directed toward profitable international patients at the expense of local populations. Regulatory differences across countries create complexities in licensing, malpractice liability, insurance coverage, and data protection. Ethical issues arise regarding prioritization of care, pricing practices, and exploitation of healthcare workers. Additionally, global health crises have demonstrated that interdependence can also increase vulnerability, requiring coordinated international responses.

For hospital administrators, globalization necessitates system-level and strategic thinking. Hospitals must balance global engagement with local health priorities, ensure compliance with diverse regulations, manage cultural diversity among patients and staff, and maintain ethical standards. Effective governance, transparent policies, and alignment with public health goals are essential to harness the benefits of globalization while minimizing its adverse effects.

In conclusion, globalization of healthcare has transformed hospitals into globally connected service organizations operating within an international ecosystem of patients, professionals, technologies, and standards. While globalization enhances access to innovation, quality improvement, and economic opportunities, it also demands careful management to ensure equity, sustainability, and social responsibility. For students and practitioners of Hospital Administration, understanding globalization is essential for managing hospitals in an increasingly interconnected world.

International Hospital Chains and Collaborations

International hospital chains and cross-border collaborations represent one of the most advanced and visible outcomes of the globalization of healthcare. These arrangements involve hospitals or healthcare organizations operating across multiple countries, or forming structured partnerships with foreign institutions for service delivery, education, research, technology transfer, and management support. In the new millennium, hospitals increasingly function not as standalone entities but as parts of global healthcare networks.

Emergence of International Hospital Chains

International hospital chains are healthcare organizations that own, manage, or franchise hospitals in more than one country. Their growth has been driven by rising global demand for

quality healthcare, international patient mobility, and the commercialization and professionalization of hospital management. These chains leverage standardized clinical protocols, centralized governance, brand reputation, and economies of scale to deliver consistent quality across locations.

Globally, several hospital chains have expanded beyond their home countries. Examples include large multi-specialty hospital groups from Asia, the Middle East, Europe, and North America operating facilities or management contracts across continents. Indian hospital groups, for instance, have established hospitals or clinical centers in countries such as Sri Lanka, Bangladesh, Nepal, the Middle East, and parts of Africa, while also attracting patients from Europe, Africa, and West Asia to their Indian facilities. Similarly, hospital groups from Singapore, Thailand, and the Gulf region have expanded internationally through direct ownership or strategic alliances.

International hospital chains typically focus on tertiary and super-specialty care, including cardiology, oncology, orthopedics, organ transplantation, and advanced diagnostics. These services are capital-intensive and benefit from centralized expertise and technology sharing. For patients, global hospital brands signal quality, safety, and reliability, particularly when supported by international accreditation and globally recognized clinicians.

Models of International Expansion

International hospital chains expand through multiple models. One common approach is direct ownership, where the parent organization establishes or acquires hospitals abroad. Another widely used model is management contracts, under which the hospital chain provides clinical governance, operational systems, and branding, while ownership remains local. Franchising and strategic joint ventures are also common, allowing hospitals to share risk, capital, and local market knowledge.

These models enable flexibility and reduce financial exposure while facilitating global reach. From a hospital administration perspective, each model presents distinct challenges related to governance, quality control, cultural adaptation, and regulatory compliance.

International Collaborations in Healthcare

Beyond hospital chains, international collaborations play a crucial role in global healthcare delivery. Collaborations may occur between hospitals, universities, research institutions, technology companies, and insurance providers. Such partnerships focus on clinical training, medical education, research, telemedicine, second-opinion services, and adoption of advanced technologies.

Teaching hospitals frequently collaborate with foreign universities and research centers to strengthen academic programs, faculty exchange, and clinical research. These collaborations enhance clinical standards, promote evidence-based practice, and improve global visibility. Telemedicine-based collaborations allow hospitals to provide cross-border consultations and specialist opinions, particularly in complex cases such as cancer and rare diseases.

Another important area of collaboration is technology and innovation. Hospitals partner with global medical device manufacturers, digital health firms, and pharmaceutical companies to introduce advanced diagnostics, robotic surgery, artificial intelligence–based decision support,

and precision medicine. These collaborations accelerate innovation but also require strong regulatory oversight and ethical governance.

Quality Standards and Accreditation

International hospital chains and collaborations are closely linked to the adoption of global quality and safety standards. Hospitals engaged in international operations often align themselves with internationally recognized accreditation systems to enhance credibility and patient trust. Accreditation encourages standardization of clinical processes, patient safety protocols, infection control, documentation, and governance practices.

Adoption of global standards improves operational discipline and outcomes but also increases costs and administrative complexity. Hospitals must invest in training, infrastructure, and continuous quality improvement to maintain accreditation across multiple locations.

Managerial and Operational Implications

Managing international hospital chains and collaborations requires advanced managerial capabilities. Hospital administrators must handle cross-cultural teams, diverse patient populations, and varying regulatory environments. Differences in legal frameworks, clinical practice norms, labor laws, and reimbursement systems add to managerial complexity.

Human resource management becomes particularly challenging, as hospitals must recruit, train, and retain professionals capable of working in multicultural and international settings. Leadership, communication, and ethical sensitivity are critical competencies in global hospital management.

Financial management is another key concern. International expansion involves significant capital investment, currency risks, pricing challenges, and variations in insurance coverage. Administrators must ensure financial sustainability while maintaining service quality and accessibility.

Equity, Ethics, and Social Responsibility

While international hospital chains and collaborations contribute to quality improvement and innovation, they also raise concerns regarding equity and social responsibility. There is a risk that hospitals may prioritize profitable international patients or premium services at the expense of local populations. Policymakers and hospital leaders must ensure that global engagement does not undermine access, affordability, or public health objectives.

Ethical issues related to pricing, allocation of scarce resources, workforce migration, and patient rights require careful attention. Transparent governance, regulatory oversight, and alignment with national health priorities are essential to address these concerns.

Conclusion

International hospital chains and collaborations have transformed hospitals into globally networked healthcare organizations. They enable access to advanced technology, global expertise, and standardized quality, while fostering innovation and professional development. At the same time, they introduce significant managerial, ethical, and policy challenges. For students and practitioners of Hospital Administration, understanding international hospital

chains and collaborations is essential for managing hospitals in an increasingly interconnected and competitive global healthcare environment

6.6 Student Activities

1. International Hospital Chain Analysis
   Students may select one international hospital chain or global hospital network operating across multiple countries. The activity should analyze the chain's mode of international expansion (ownership, management contract, or collaboration), range of services offered, quality standards followed, and managerial challenges faced in different healthcare systems.

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2. Global Collaboration Case Review
   Learners may examine a cross-border healthcare collaboration (such as hospital–university partnerships, telemedicine collaborations, or technology transfer agreements). The review should focus on objectives of the collaboration, benefits for patients and professionals, and administrative issues related to governance, regulation, and cultural differences.

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3. Debate and Policy Reflection Exercise
   Students may participate in a structured debate on the topic: *"Do international hospital chains and globalization improve healthcare access and quality, or do they increase inequality?"* After the debate, each student should submit a short reflection highlighting managerial and ethical considerations in global hospital operation

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6.7 Summary

Changing Role of Hospitals and Globalization

In this lesson, you have examined how hospitals have evolved from traditional curative institutions into complex, service-oriented and globally connected healthcare organizations. The lesson highlighted that hospitals today perform multiple roles that

extend beyond inpatient treatment, including disease prevention, health promotion, rehabilitation, long-term care, education, and research. This shift reflects changing disease patterns, technological progress, and rising expectations of patients and society.

You learned that modern hospitals function as service organizations, where quality of care is influenced not only by clinical outcomes but also by patient experience, communication, coordination of services, and responsiveness. Hospitals must manage intangible, people-intensive services and ensure consistency, safety, and empathy while dealing with variability in patient needs. As a result, professional management, teamwork, and quality improvement have become central to hospital operations.

The lesson also explored the nature of hospitals in the new millennium, emphasizing the role of advanced medical technologies, digital health systems, integrated care models, and diversified service offerings. Hospitals now operate in competitive and highly regulated environments, requiring strong governance, ethical practices, financial sustainability, and accountability. Patient-centered care and value-based service delivery have emerged as defining features of contemporary hospital management.

A major focus of the lesson was the globalization of healthcare, which has enabled cross-border movement of patients, healthcare professionals, medical knowledge, and technology. Hospitals increasingly adopt international standards, participate in global networks, and serve international patients. While globalization enhances access to innovation and quality improvement, it also introduces challenges related to equity, regulation, workforce migration, and ethical responsibility.

Finally, the lesson discussed international hospital chains and collaborations, which represent an advanced form of global healthcare integration. These networks and partnerships support standardization, specialization, knowledge exchange, and innovation but require careful management to balance global competitiveness with local healthcare needs.

Overall, this lesson has provided you with a system-level understanding of how hospitals operate in a globalized healthcare environment and the managerial skills required to lead hospitals effectively in the new millennium.

6.8 . Key Words

- Service Organization: An organization focused on delivering intangible services to customers.
- Globalization: Integration of economies, services, and institutions across national boundaries.
- Medical Tourism: Travel across borders to obtain medical treatment.
- Accreditation: Formal recognition of quality standards in healthcare institutions.
- International Collaboration: Partnership between organizations across countries.

6.9 Self-Assessment Questions

A. Short Answer Questions

1. What is meant by the changing role of hospitals?
2. Why are hospitals considered service organizations?
3. What is meant by globalization of healthcare?
4. What are international hospital chains?
5. Mention one benefit of international collaboration in healthcare.

6.10 Suggested Answers:

1. It refers to the shift of hospitals from basic care providers to comprehensive service and management-oriented institutions.
2. Because hospitals provide intangible, patient-centered services rather than physical products.
3. Globalization of healthcare refers to cross-border movement of services, patients, technology, and expertise.
4. International hospital chains are hospital groups operating facilities in multiple countries.
5. Access to global expertise and improved quality standards.

6.11. Essay Type Questions

1. Discuss the changing roles of hospitals in modern healthcare systems.
2. Explain hospitals as service organizations with suitable examples.
3. Describe the characteristics of hospitals in the new millennium.
4. Analyze the impact of globalization on healthcare delivery.
5. Examine the role of international hospital chains and collaborations.

6.12 Suggested Hints:

- Highlight transition from curative to comprehensive care
- Discuss service quality, patient experience, and management
- Emphasize technology, specialization, and competition
- Use examples of cross-border healthcare
- Focus on partnerships, quality, and global standards

6.13. Multiple Choice Questions

1. Hospitals today focus mainly on: a) Only inpatient care b) Service integration c) Charity care only d) Traditional healing Answer: b
2. Hospitals are classified as service organizations because they: a) Sell products b) Manufacture equipment c) Deliver patient-centered services d) Export medicines Answer: c
3. Globalization of healthcare includes: a) Local treatment only b) Cross-border patient movement c) Village health services d) Home remedies Answer: b
4. International hospital chains operate: a) In one city only b) Within one country c) Across multiple countries d) Only in rural areas Answer: c
5. Accreditation in hospitals mainly ensures: a) Profit maximization b) Marketing advantage only c) Quality and safety standards d) Higher fees Answer: c

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6.14. Case Study: Globalization and Hospital Transformation

Case Background

A large multi-specialty hospital group in India began as a single tertiary care hospital catering mainly to domestic patients. Over time, it expanded into multiple cities and established collaborations with hospitals and universities abroad. The group adopted international accreditation standards, invested in advanced medical technology, and created specialized departments to attract international patients. Telemedicine services were introduced to provide consultations across borders, and international insurance tie-ups were established.

While globalization improved brand image, quality standards, and revenue streams, it also posed challenges. Hospital administrators had to manage diverse patient expectations, comply with international regulations, ensure ethical practices, and balance global competitiveness with local accessibility.

This case illustrates how globalization has reshaped hospital roles, management practices, and strategic decision-making.

Case Questions

1. How has globalization changed the role of hospitals in this case?
2. What managerial challenges arise from international collaborations?
3. How do accreditation and global standards influence hospital operations?
4. What risks do hospitals face when focusing on international patients?
5. Suggest strategies to balance global expansion with local healthcare needs.

Suggested Answers

1. Hospitals have expanded from local care providers to global service organizations.

2. Challenges include regulatory compliance, cultural differences, and quality management.
3. They improve quality, safety, and international credibility.
4. Risk of neglecting local patients and rising treatment costs.
5. Balanced service mix, strong governance, and inclusive policies.

6.15. Reference Text Books

1. Goel, S. L. & Kumar, R. – *Hospital Administration and Management* – Deep & Deep Publications, New Delhi, 2018.
2. Joshi, S. R. – *Health Care Management* – Oxford University Press, New Delhi, 2019.
3. Shortell, S. M. & Kaluzny, A. D. – *Health Care Management: Organization Design and Behavior* – Delmar Cengage Learning, USA, 2016.

LESSON 7: HEALTH ADMINISTRATION STRUCTURE IN INDIA

OBJECTIVES

After studying this lesson, learners will be able to:

- Understand the multi-tier health administration structure in India
- Identify the roles of Central and State governments in health governance
- Explain the functions of local bodies in healthcare delivery
- Describe the public health administration framework
- Analyse coordination mechanisms across different levels of administration

STRUCTURE

1. Health Administration at the Central Level
2. Health Administration at the State Level
3. Role of Local Bodies in Healthcare Delivery
4. Public Health Administration Framework in India

. Introductory Case (Real-World, Data-Based)

Case Title: COVID-19 Pandemic and India's Health Administration Coordination

In 2020–21, India faced an unprecedented public health emergency due to the COVID-19 pandemic. The crisis tested the health administration structure at all levels—Central, State, and Local.

At the Central level, the Ministry of Health and Family Welfare formulated national guidelines, coordinated vaccine procurement, and issued standard treatment protocols. Flagship programmes such as the National Health Mission were leveraged to strengthen surveillance, testing, and infrastructure. The Central Government also launched the CoWIN digital platform to manage vaccination across the country.

At the State level, governments adapted national guidelines to local contexts. States like Kerala and Tamil Nadu strengthened district health systems, expanded ICU capacity, and mobilised state public health cadres. Differences in administrative capacity across states led to variations in outcomes, highlighting the importance of state-level governance.

At the Local level, municipal corporations, panchayats, and urban local bodies played a critical role in contact tracing, community awareness, quarantine management, and delivery of essential services. For instance, local governments in Odisha and Kerala effectively used grassroots health workers to ensure last-mile service delivery.

According to data from the World Health Organization, India administered over 2 billion vaccine doses by 2023, making it one of the world's largest public vaccination efforts. The pandemic clearly demonstrated that effective public health outcomes depend on coordination across all administrative tiers, not on any single authority.

This case underlines the relevance of understanding India's health administration structure for managing routine healthcare as well as large-scale public health emergencies.

1 Health Administration at the Central Level (India)

1. Introduction

Health administration at the Central level forms the policy, regulatory, financial, and coordinating backbone of India's health system. While health is constitutionally a State subject, the Central Government plays a decisive role in policy formulation, national programme design, inter-state coordination, international health relations, medical education standards, disease surveillance, and financing support.

The Central health administration ensures uniform minimum standards, addresses inter-state and national public health challenges, and supports states in achieving equitable and accessible healthcare.

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2. Constitutional and Legal Basis of Central Health Administration

The role of the Central Government in health administration is derived from:

- Union List: Matters such as international health relations, port quarantine, and regulation of drugs and pharmaceuticals
- Concurrent List: Population control, medical education, prevention of infectious diseases
- Directive Principles of State Policy (Article 47): Obligation of the State to improve public health and nutrition

Although service delivery is largely state-led, the Centre provides legislative leadership, funding support, and technical guidance.

---

3. Apex Authority: Ministry of Health and Family Welfare

The Ministry of Health and Family Welfare (MoHFW) is the nodal ministry responsible for health administration at the national level.

Major Responsibilities

- National health policy formulation

- Design and funding of centrally sponsored health programmes
- Regulation of medical education and professional standards
- Disease surveillance and epidemic preparedness
- International health coordination
- Health research promotion
- Monitoring and evaluation of health outcomes

---

4. Organizational Structure of the Ministry of Health and Family Welfare

The Ministry functions through two main departments:

A. Department of Health and Family Welfare

This department handles public health services, disease control, medical education, and healthcare infrastructure.

Key Functions

- Implementation of national health programmes
- Strengthening primary, secondary, and tertiary care
- Family welfare and reproductive health services
- Disease prevention and control

Major Institutions and Agencies

1. Directorate General of Health Services (DGHS)

The DGHS acts as the technical advisory body to the Government of India.

Functions:

- Technical guidance to states
- Administration of central government hospitals
- Medical education and training
- Public health surveillance

DGHS supervises institutions such as:

- Central Government Health Scheme (CGHS)
- National Centre for Disease Control (NCDC)
- Central Health Education Bureau (CHEB)

2. The National Health Mission (NHM) is the flagship programme of the Central Government.

It integrates:

- National Rural Health Mission (NRHM)
- National Urban Health Mission (NUHM)

Objectives:

- Universal access to equitable, affordable healthcare
- Focus on maternal, child, and adolescent health
- Strengthening health systems and infrastructure

Key Features:

- Flexible funding to states
- Outcome-based monitoring
- Emphasis on primary healthcare
- Deployment of community health workers (ASHAs)

NHM represents a collaborative federal model, where the Centre provides funds and frameworks, and states implement programmes.

---

3. National Disease Control Programmes

The Central Government designs and funds major disease-specific programmes, including:

- Tuberculosis elimination
- HIV/AIDS control
- Malaria eradication
- Non-communicable disease prevention

These programmes ensure uniform strategies, pooled procurement, and national monitoring.

---

4. Central Government Health Scheme (CGHS)

CGHS provides comprehensive healthcare services to:

- Central government employees
- Pensioners
- Members of Parliament

It demonstrates direct service provision by the Central Government in urban areas.

B. Department of Health Research

This department promotes medical and public health research and strengthens evidence-based policymaking.

Indian Council of Medical Research

The Indian Council of Medical Research (ICMR) is the apex biomedical research body in India.

Roles:

- Conducting medical research
- Supporting epidemiological studies
- Advising government during health emergencies
- Clinical trials and ethical guidelines

During the COVID-19 pandemic, ICMR played a crucial role in:

- Testing strategy formulation
- Vaccine research coordination
- National sero-surveys

---

1. Central Institutions for Tertiary Healthcare and Medical Education

The Central Government directly manages premier institutions to:

- Set benchmarks in medical education
- Provide advanced tertiary care
- Promote research and innovation

Examples include:

- All India Institute of Medical Sciences (AIIMS) network
- Postgraduate medical institutes
- Central universities with medical faculties

These institutions act as centres of excellence and training hubs for specialists.

---

2. Regulation of Medical Education and Health Professionals

The Central Government ensures standardisation and quality control in medical education and practice through statutory bodies such as:

- National Medical Commission (NMC)
- National Nursing and Midwifery Commission (proposed)

- Pharmacy Council of India

Functions:

- Curriculum standards
- Accreditation of institutions
- Licensing and ethics
- Workforce planning

This regulatory role is essential to maintain national uniformity in healthcare quality.

---

3. Drug and Medical Device Regulation

The Central Government regulates pharmaceuticals and medical devices through agencies under MoHFW.

Key Functions:

- Approval of drugs and vaccines
- Regulation of clinical trials
- Ensuring safety and efficacy
- Control of counterfeit medicines

This function became critically important during vaccine development and emergency approvals.

---

4. Health Financing and Budgetary Role

The Central Government:

- Allocates funds through Union Budget
- Provides centrally sponsored scheme funding
- Supports infrastructure through capital grants
- Funds research and innovation

Although health expenditure as a percentage of GDP is modest, central funding plays a catalytic role in reducing inter-state disparities.

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5. Role in Public Health Emergencies

The Central Government acts as the command and coordination authority during national health crises.

COVID-19 Pandemic Example

- National lockdown decisions
- Vaccine procurement and distribution
- Issuance of treatment protocols
- International coordination

Agencies such as World Health Organization collaborated closely with Indian authorities, reflecting the Centre's role in global health diplomacy.

---

6. International Health Relations

The Central Government:

- Represents India in global health forums
- Engages with WHO, UNICEF, World Bank
- Participates in international disease surveillance
- Provides medical assistance to other countries

India's vaccine diplomacy during COVID-19 showcased the strategic importance of central health administration.

---

7. Monitoring, Evaluation, and Digital Health Governance

The Centre increasingly relies on:

- Health Management Information Systems (HMIS)
- National surveys
- Digital health platforms
- Performance-linked funding

Initiatives such as national digital health records and telemedicine guidelines are centrally driven reforms.

---

8. Significance of Central-Level Health Administration

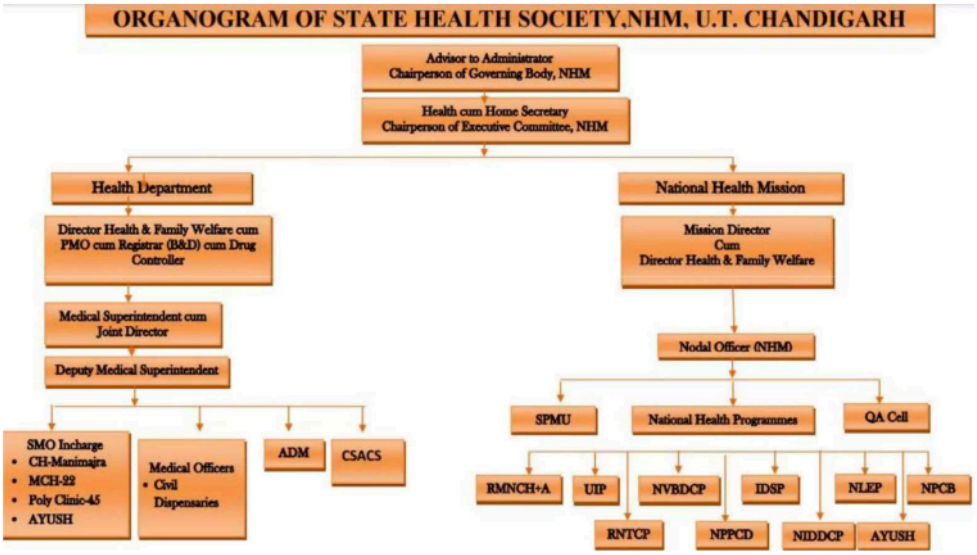
Central health administration:

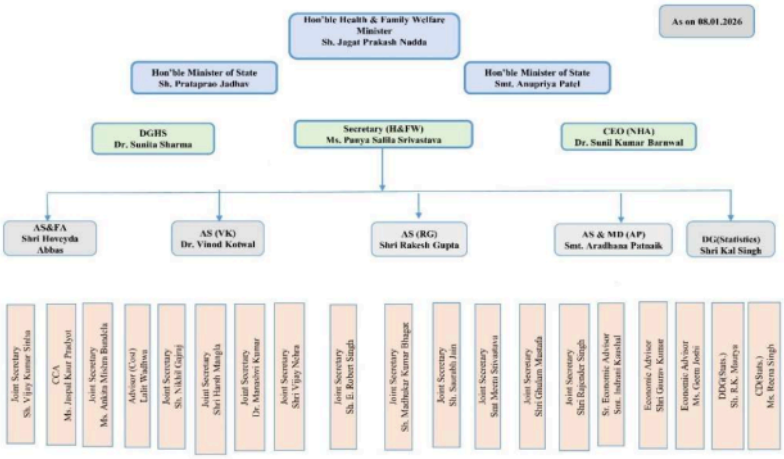
- Ensures policy coherence and national standards
- Addresses inter-state inequalities
- Manages large-scale public health risks

- Mobilises resources during emergencies
- Strengthens India's global health role

While states remain primary service providers, the Central Government functions as the strategic architect and stabiliser of India's health system.

7.2 Health Administration at the State Level (India)





1. Introduction

Health administration at the State level represents the operational core of India's health system. Although national policies and programmes are largely framed by the Central Government, actual delivery of healthcare services to the population is primarily the responsibility of State Governments.

Under India's federal structure, public health and sanitation, hospitals, and dispensaries are State subjects, making state governments the principal implementers, managers, and regulators of healthcare services. The effectiveness of India's health outcomes therefore depends substantially on the administrative capacity, financial commitment, and governance quality of individual states.

---

2. Constitutional Position of States in Health Administration

Health administration at the state level is rooted in the Indian Constitution:

- State List (List II):
  - Public health and sanitation
  - Hospitals and dispensaries
- Concurrent List (List III):
  - Prevention of infectious diseases
  - Population control and family welfare
  - Medical education

This constitutional framework empowers states to design, finance, and manage health services, while coordinating with the Centre for nationally significant concerns.

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3. State Health Department: Apex Administrative Authority

Each state has a Department of Health and Family Welfare, headed politically by the Health Minister and administratively by the Principal Secretary / Secretary (Health).

Key Responsibilities

- Formulation of state health policies
- Implementation of national and state-specific health programmes
- Management of public health infrastructure
- Recruitment and management of health personnel
- Regulation of private healthcare institutions
- Disease surveillance and epidemic control

The State Health Department functions as the nodal agency linking the Centre, districts, and local bodies.

---

4. Directorate of Health Services (DHS)

Most states operate through a Directorate of Health Services, which serves as the technical and executive wing of the Health Department.

Functions of DHS

- Supervision of government hospitals and health institutions
- Implementation of public health programmes
- Monitoring service delivery standards
- Training and deployment of medical staff
- Data collection and reporting

In many states, DHS is further divided into:

- Directorate of Public Health
- Directorate of Medical Education
- Directorate of Family Welfare

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5. Directorate of Medical Education (DME)

The Directorate of Medical Education manages:

- Medical colleges
- Teaching hospitals
- Nursing and paramedical institutions

Key Roles

- Medical education planning
- Clinical training of doctors and nurses
- Tertiary healthcare delivery
- Coordination with national regulatory bodies

Institutions under DME often serve as referral centres for complex cases.

---

6. State-Level Implementation of National Health Programmes

States are the primary implementers of centrally sponsored schemes such as the National Health Mission.

State Health Society

Each state establishes a State Health Society to:

- Receive central and state funds
- Prepare Programme Implementation Plans (PIPs)
- Monitor district performance
- Ensure financial accountability

This institutional mechanism enables cooperative federalism in health governance.

---

7. District Health Administration

The district is the critical operational unit of state health administration.

District Health Officer / Chief Medical Officer

- Overall in-charge of district health services
- Coordinates hospitals, PHCs, and outreach programmes
- Reports to state authorities

District Health Society

- Integrates multiple health programmes
- Facilitates decentralized planning
- Ensures community participation

District-level administration bridges policy intent and ground-level service delivery.

---

8. Public Health Infrastructure under State Control

States are responsible for maintaining a three-tier healthcare system:

Primary Level

- Sub-Centres
- Primary Health Centres (PHCs)
- Community outreach through health workers

Secondary Level

- Community Health Centres (CHCs)
- District Hospitals
- Sub-divisional hospitals

Tertiary Level

- Medical college hospitals
- Specialty hospitals

The quantity, quality, and accessibility of these facilities vary significantly across states.

---

9. Human Resources for Health at State Level

States manage the largest segment of India's public health workforce, including:

- Doctors
- Nurses
- Pharmacists
- Public health managers
- Frontline health workers

Recruitment is conducted through:

- State Public Service Commissions
- Medical recruitment boards
- Contractual appointments under NHM

Human resource availability is a major determinant of state health performance.

---

10. State Role in Disease Surveillance and Epidemic Control

States are responsible for:

- Early detection of disease outbreaks
- Implementation of containment measures
- Coordination with central agencies

State surveillance units work closely with national institutions such as the Indian Council of Medical Research and the National Centre for Disease Control.

During COVID-19, state governments:

- Established testing and treatment facilities

- Managed quarantine and isolation centres
- Enforced public health regulations

---

11. Regulation of Private Healthcare at State Level

States regulate:

- Private hospitals and clinics
- Diagnostic laboratories
- Nursing homes

Key regulatory areas include:

- Licensing and registration
- Quality standards
- Pricing of services (in some cases)
- Enforcement of public health laws

Effective regulation is essential, as the private sector accounts for a significant share of healthcare delivery.

---

12. Health Financing at State Level

State governments finance healthcare through:

- State budgets
- Central transfers
- Externally aided projects

Expenditure patterns differ widely:

- Southern states generally allocate higher health spending
- Economically weaker states rely more on central support

State-level financial commitment is closely associated with health outcomes and equity.

---

13. Innovations and Best Practices by States

Several states have pioneered innovative health administration models:

- Kerala: Strong public health system and community participation
- Tamil Nadu: Efficient drug procurement and hospital management

- Odisha: Disaster-resilient health infrastructure
- Andhra Pradesh: Digital health records and doorstep services

These experiences highlight the autonomy and creativity possible at the state level.

---

14. Coordination with Central and Local Governments

State health administration functions as a linking layer:

- Implements central policies
- Guides and supervises local bodies
- Provides feedback for national planning

Effective coordination determines the success of programmes such as immunisation, maternal health, and disease control.

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15. Challenges in State Health Administration

Key challenges include:

- Regional disparities
- Shortage of skilled personnel
- Infrastructure gaps
- Financial constraints
- Weak regulatory enforcement

These challenges necessitate continuous reforms and capacity building.

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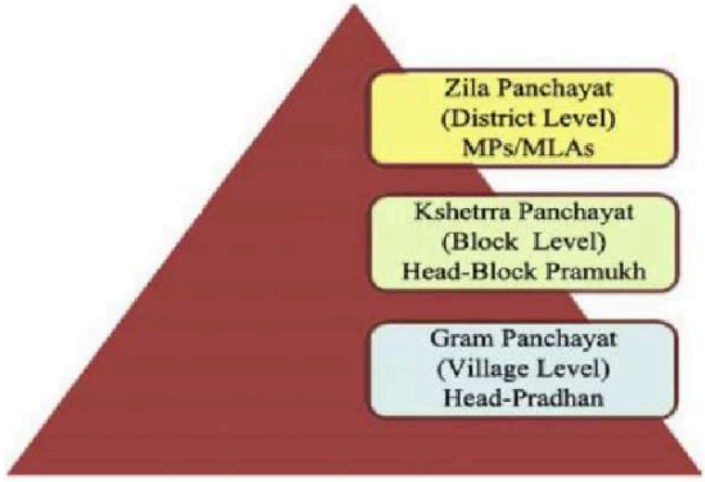
16. Significance of State-Level Health Administration

State health administration:

- Converts policy into practice
- Ensures accessibility and continuity of care
- Responds rapidly to local health needs
- Shapes population health outcomes

States are therefore the cornerstone of India’s public health system.

7.3 Role of Local Bodies in Healthcare Delivery (India)



1. Introduction

Local bodies constitute the grassroots foundation of India's healthcare delivery system. They are the closest administrative units to the community and play a vital role in ensuring accessibility, equity, responsiveness, and community participation in health services.

With the adoption of decentralised governance, especially after the 73rd and 74th Constitutional Amendments, local self-governments have emerged as key actors in public health delivery, particularly in primary healthcare, sanitation, nutrition, disease prevention, and health awareness.

Local bodies act as the implementation arm of state and central health policies and are critical for achieving universal health coverage.

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2. Constitutional and Legal Basis of Local Bodies in Health

The role of local bodies in healthcare is constitutionally supported by:

- 73rd Constitutional Amendment Act (1992) – Panchayati Raj Institutions (PRIs)
- 74th Constitutional Amendment Act (1992) – Urban Local Bodies (ULBs)

These amendments mandate the devolution of functions, funds, and functionaries to local governments.

Eleventh Schedule (Rural Local Bodies)

Includes:

- Health and sanitation
- Family welfare
- Women and child development
- Drinking water
- Nutrition

Twelfth Schedule (Urban Local Bodies)

Includes:

- Public health
- Sanitation and solid waste management
- Urban poverty alleviation
- Slum improvement

This constitutional framework legitimises the active role of local bodies in healthcare delivery.

---

3. Types of Local Bodies Involved in Healthcare

Local healthcare delivery in India operates through two broad categories:

A. Rural Local Bodies (Panchayati Raj Institutions)

Three-Tier Panchayati Raj Structure

1. Gram Panchayat (Village Level)
2. Panchayat Samiti / Block Panchayat (Intermediate Level)
3. Zilla Parishad (District Level)

Each tier contributes to healthcare delivery in a graded and complementary manner.

---

4. Role of Gram Panchayats in Healthcare

The Gram Panchayat is the most crucial institution for primary healthcare delivery in rural India.

Key Functions

- Supervision of Sub-Centres and Primary Health Centres (PHCs)
- Support to frontline health workers (ASHAs, ANMs, Anganwadi Workers)
- Promotion of sanitation, hygiene, and safe drinking water
- Monitoring maternal and child health services
- Organising Village Health, Sanitation and Nutrition Committees (VHSNCs)

Village Health Planning

Gram Panchayats participate in:

- Village health plans
- Identification of vulnerable households
- Local monitoring of service delivery

This ensures community ownership of health programmes.

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5. Block and District Panchayat Role

Block Level (Panchayat Samiti)

- Coordination of PHCs and CHCs
- Consolidation of village health plans

- Monitoring programme implementation

District Level (Zilla Parishad)

- Oversight of district health infrastructure
- Integration with District Health Society
- Budget allocation and performance review

District-level panchayats act as intermediaries between state health departments and villages.

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6. Urban Local Bodies (ULBs) and Healthcare

Urban healthcare delivery is managed by municipal institutions, including:

- Municipal Corporations
- Municipal Councils
- Nagar Panchayats

Urban local bodies face unique challenges such as population density, slums, migration, and environmental health risks.

---

7. Functions of Urban Local Bodies in Healthcare

ULBs are primarily responsible for public health and preventive services.

Key Responsibilities

- Urban primary health centres and dispensaries
- Sanitation and waste management
- Control of communicable diseases
- Health services in slums and informal settlements
- Registration of births and deaths

ULBs play a central role in urban disease surveillance and outbreak control.

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8. Local Bodies under National Health Programmes

Local bodies function as last-mile delivery agents for centrally sponsored programmes such as the National Health Mission.

Examples of Local-Level Responsibilities

- Immunisation drives
- Maternal and child health outreach

- Nutrition supplementation
- Non-communicable disease screening
- Health awareness campaigns

Programme success depends heavily on local administrative efficiency and community trust.

---

9. Role of Community-Level Health Workers

Local bodies support and coordinate the work of frontline health workers, including:

- ASHA (Accredited Social Health Activist)
- Auxiliary Nurse Midwife (ANM)
- Anganwadi Worker

These workers:

- Act as health educators
- Facilitate institutional deliveries
- Ensure immunisation coverage
- Provide basic health services

Local governance structures ensure accountability and community integration of these workers.

---

10. Local Bodies and Public Health Surveillance

Local bodies are the first responders in detecting:

- Disease outbreaks
- Environmental health hazards
- Nutrition deficiencies

They collaborate with district and state surveillance units and national agencies such as the National Centre for Disease Control.

Early detection at the local level significantly reduces health risks and mortality.

---

11. Role During Public Health Emergencies

During disasters and epidemics, local bodies perform critical functions:

- Enforcement of public health regulations
- Community mobilisation and awareness

- Management of quarantine and isolation facilities
- Distribution of medicines and relief materials

During the COVID-19 pandemic, local governments played a decisive role in contact tracing, home isolation monitoring, and vaccination mobilisation in coordination with state and central authorities and guidance from the World Health Organization.

---

12. Financial Role of Local Bodies in Healthcare

Local bodies finance health-related activities through:

- Grants from state and central governments
- Local taxes and user charges
- Programme-specific untied funds

Village Health Funds

Funds such as untied grants enable local solutions for:

- Minor repairs
- Health awareness activities
- Emergency support

Financial autonomy enhances local responsiveness.

---

13. Community Participation and Accountability

Local bodies institutionalise community participation through:

- Gram Sabha meetings
- Ward committees
- Health and sanitation committees

These platforms:

- Promote transparency
- Enable grievance redressal
- Improve service quality

Community oversight strengthens social accountability in healthcare.

---

14. Best Practices and State Experiences

Several states have demonstrated effective local health governance:

- Kerala: Strong decentralised planning and local health committees
- Odisha: Community-led nutrition and maternal health programmes
- Tamil Nadu: Urban local body–managed primary care models
- Maharashtra: Robust village health monitoring systems

These experiences show that empowered local bodies can significantly improve health outcomes.

---

15. Challenges Faced by Local Bodies

Despite their importance, local bodies face challenges such as:

- Inadequate financial resources
- Limited technical capacity
- Uneven devolution of powers
- Dependence on higher administrative levels
- Urban slum health complexities

Addressing these challenges is essential for effective decentralised healthcare.

---

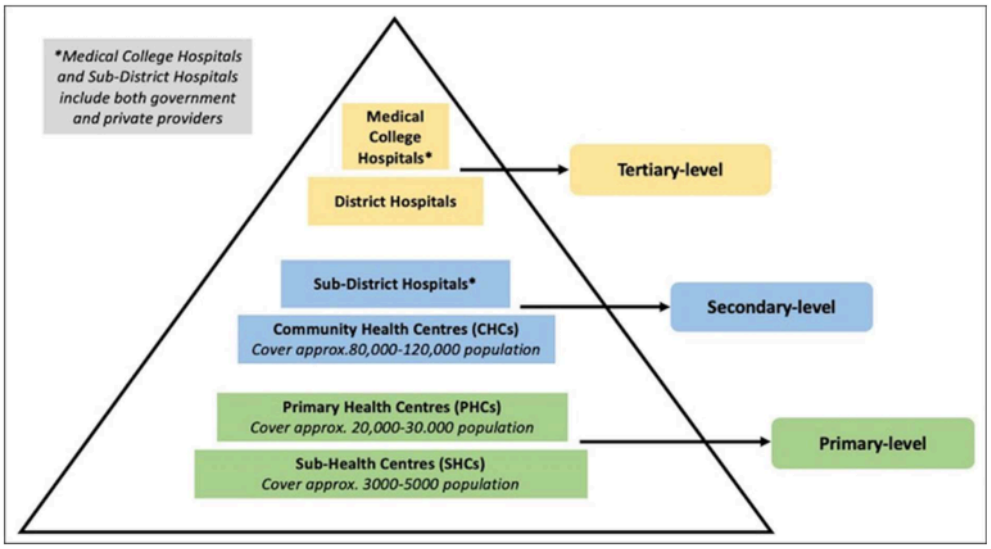
16. Significance of Local Bodies in Healthcare Delivery

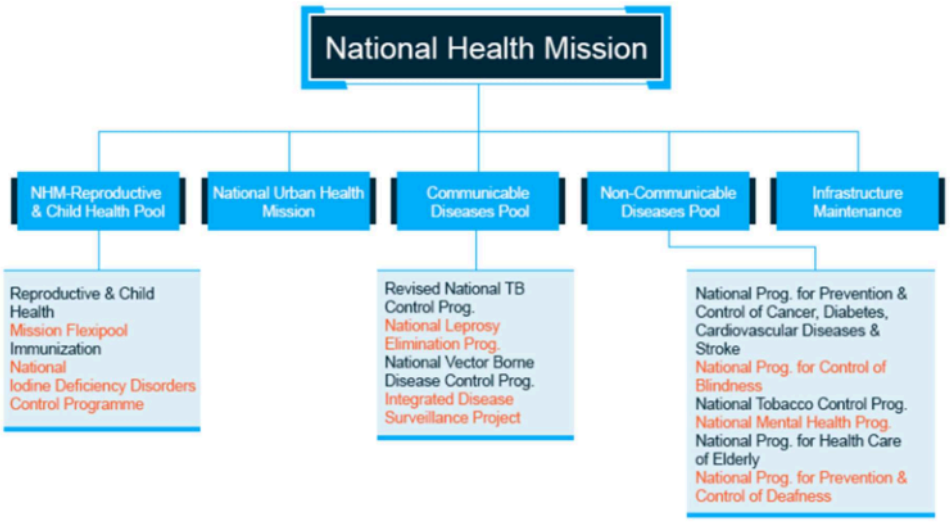
Local bodies:

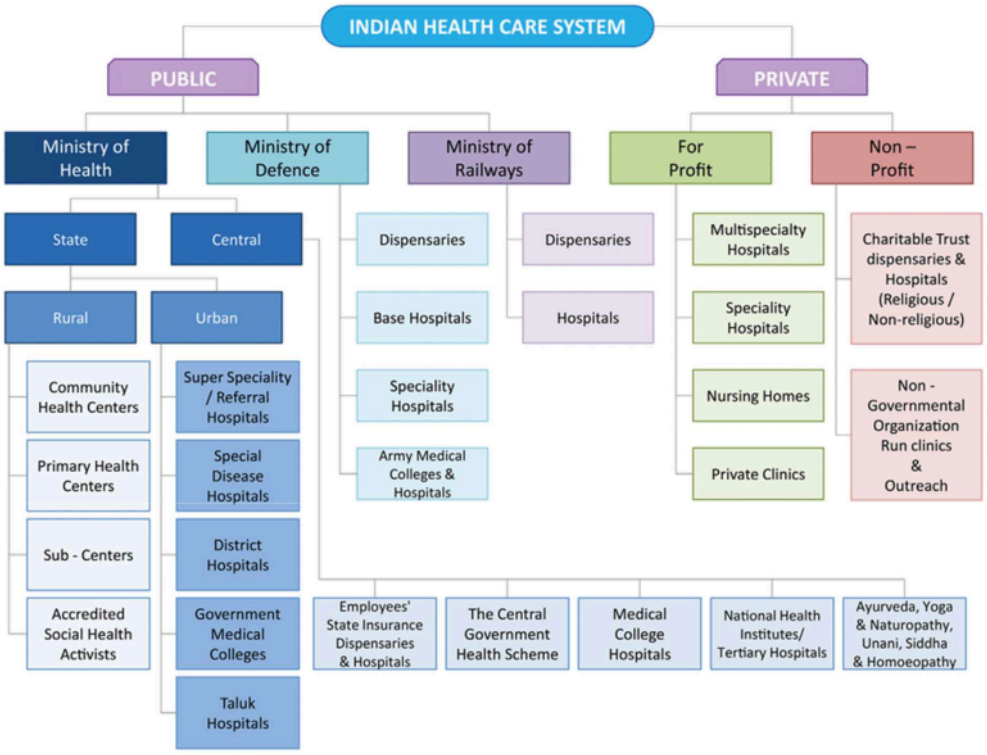
- Ensure last-mile service delivery
- Address local health needs
- Promote preventive and promotive healthcare
- Enhance community trust
- Strengthen public health resilience

They represent the human face of the health system and are indispensable for sustainable health development.

7.4 Public Health Administration Framework in India







1. Introduction

The Public Health Administration Framework in India represents the institutional, legal, and operational system through which the State protects, promotes, and improves the health of the

population. Unlike curative healthcare, public health focuses on prevention, promotion, protection, and preparedness at the population level.

India's public health framework is multi-layered, decentralised, and cooperative, involving the Central Government, State Governments, and Local Bodies, supported by statutory institutions, professional bodies, and international organisations. This framework addresses communicable and non-communicable diseases, maternal and child health, nutrition, sanitation, environmental health, and emergency preparedness.

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2. Concept and Scope of Public Health Administration

Public Health Administration refers to:

- Planning and implementation of public health policies
- Organisation and management of health services
- Disease prevention and health promotion
- Surveillance, regulation, and emergency response

Scope

- Epidemiology and disease control
- Environmental and occupational health
- Nutrition and food safety
- Maternal, child, and adolescent health
- Health education and behaviour change
- Disaster and epidemic preparedness

Public health administration aims to maximise population health outcomes with optimal use of public resources.

---

3. Constitutional and Policy Framework

Constitutional Basis

- Article 47 (DPSP): Duty of the State to improve public health and nutrition
- State List: Public health and sanitation
- Concurrent List: Prevention of infectious diseases

Policy Framework

Key national policies guiding public health administration include:

- National Health Policy

- Population Policy
- Nutrition Policy
- Disaster Management Policy

These policies provide strategic direction and priorities for public health action.

---

4. Institutional Framework of Public Health Administration

India's public health administration operates through four interconnected levels:

A. Central-Level Public Health Institutions

The Ministry of Health and Family Welfare provides policy leadership, financing, regulation, and coordination.

Key Central Public Health Institutions

1. Directorate General of Health Services (DGHS)

- Technical advisory body
- Supervises national public health programmes
- Coordinates disease surveillance and emergency response

2. Indian Council of Medical Research

The Indian Council of Medical Research supports:

- Epidemiological research
- Evidence-based policy
- Clinical and operational research

3. National Centre for Disease Control

The National Centre for Disease Control is the apex body for:

- Disease surveillance
- Outbreak investigation
- Epidemic preparedness

4. National Health Mission

The National Health Mission integrates public health service delivery across rural and urban areas.

B. State-Level Public Health Administration

States are the primary executors of public health functions.

State Institutions

- Department of Health and Family Welfare
- Directorate of Public Health
- State Surveillance Units
- State Health Societies

Functions

- Implementation of disease control programmes
- Regulation of public and private health services
- Health workforce management
- Monitoring and evaluation

State-level capacity largely determines public health performance across regions.

C. District-Level Public Health Administration

The district is the operational nucleus of public health administration.

Key Structures

- District Health Officer / Chief Medical Officer
- District Health Society
- Integrated Disease Surveillance Units

Functions

- Programme implementation
- Disease surveillance
- Supervision of health institutions
- Community mobilisation

Districts translate policy objectives into ground-level action.

D. Local-Level Public Health Administration

Local bodies ensure last-mile delivery of public health services.

Key Roles

- Sanitation and waste management
- Health education and awareness
- Nutrition and maternal health
- Early outbreak detection

Local administration ensures community participation and accountability.

---

5. Public Health Service Delivery Framework

India follows a three-tier service delivery model:

Primary Level

- Preventive and promotive services
- Immunisation, nutrition, health education

Secondary Level

- Curative services
- District hospitals and CHCs

Tertiary Level

- Specialised and referral care
- Teaching hospitals and national institutes

Public health administration emphasises strong primary healthcare as the foundation.

---

6. Disease Surveillance and Epidemiological Framework

India operates a structured surveillance system involving:

- Routine reporting
- Sentinel surveillance
- Laboratory networks

Institutions such as the World Health Organization collaborate with Indian authorities to align surveillance with global standards.

Effective surveillance enables:

- Early outbreak detection
- Evidence-based decision-making
- Rapid response

7. Legal and Regulatory Framework

Public health administration is supported by:

- Epidemic control laws
- Food safety regulations
- Environmental health standards
- Occupational health laws

Regulation ensures population safety, quality control, and ethical standards.

8. Public Health Financing Framework

Public health financing involves:

- Central and state budget allocations
- Centrally sponsored schemes
- External aid and partnerships

Funding supports:

- Infrastructure development
- Human resources
- Disease control programmes

Efficient allocation and utilisation are critical for health equity.

9. Role of Intersectoral Coordination

Public health outcomes depend on sectors beyond health:

- Drinking water
- Sanitation
- Education
- Housing
- Environment

Public health administration promotes Health in All Policies (HiAP) approach.

10. Public Health Emergency and Disaster Management

India's public health framework includes:

- Preparedness planning
- Emergency response protocols
- Inter-agency coordination

During COVID-19, the framework demonstrated:

- Central coordination
- State-level execution
- Local-level community engagement

This highlighted the importance of institutional readiness and resilience.

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11. Digital Public Health Governance

Digital tools are increasingly integral:

- Health Management Information Systems
- Disease dashboards
- Telemedicine platforms
- Digital vaccination systems

Digital governance improves efficiency, transparency, and real-time monitoring.

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12. Challenges in Public Health Administration

Key challenges include:

- Unequal capacity across states
- Workforce shortages
- Urban–rural disparities
- Emerging disease threats
- Climate-related health risks

Addressing these challenges requires systemic reforms and sustained investment.

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13. Significance of India's Public Health Administration Framework

The framework:

- Protects population health

- Prevents epidemics
- Promotes equity and inclusion
- Supports sustainable development
- Strengthens national resilience

A strong public health administration is essential for economic growth and social stability.

7.5 Student Activity

Student Activity 1: Health Administration Structure Chart

Task: Prepare a neat chart / flow diagram showing:

- Central level health administration
- State level health administration
- Role of local bodies
- Public health administration framework

Instructions:

- Mention 2 key functions at each level
- Show how the levels are linked and coordinated

Outcome:
Students understand the overall structure and division of responsibilities in India's health administration.

Student Activity 2: Short Case-Based Analysis

Task:Read the following situation and answer briefly:

A disease outbreak occurs in a district. Hospitals are overcrowded and community awareness is low.

Questions to Answer:

1. What actions should be taken by the Central Government?
2. What role should the State Health Department play?

3. What responsibilities should local bodies perform?

Outcome:
Students learn to apply administrative roles to real-life public health situations.

Student Activity 3: State-Level Health Administration Review

Task: Choose any one Indian state and write a short note (1–2 pages) on:

- Structure of health administration in the state
- Role of the state government in healthcare delivery
- Role of local bodies in public health

Outcome:
Students develop analytical understanding of state-level health governance.

7.6 Summary:

Health Administration Structure in India

India's health administration system is a multi-level, decentralised framework designed to address the diverse health needs of a large and heterogeneous population. The system operates through Central, State, and Local levels, integrated within a comprehensive public health administration framework that emphasises prevention, promotion, and protection of health.

At the Central level, the Government of India provides policy leadership, national planning, regulation, funding support, and coordination. The Ministry of Health and Family Welfare is the apex authority responsible for framing national health policies, designing centrally sponsored programmes, regulating medical education and drugs, managing international health relations, and coordinating responses to public health emergencies. Institutions such as the Indian Council of Medical Research and the National Centre for Disease Control support research, disease surveillance, and evidence-based decision-making. The Central Government plays a crucial role in ensuring uniform standards and inter-state coordination, especially during epidemics and disasters.

The State level forms the operational backbone of healthcare delivery in India. Health being primarily a State subject, state governments are responsible for planning, financing, managing,

and delivering health services. State Health Departments, Directorates of Health Services, and Directorates of Medical Education oversee public hospitals, health institutions, workforce management, and implementation of national and state-specific programmes. States also regulate private healthcare institutions and adapt national policies to local needs. Variations in state capacity and investment explain differences in health outcomes across regions.

Local bodies—including Panchayati Raj Institutions in rural areas and Urban Local Bodies in cities—ensure last-mile delivery of healthcare services. Empowered by the 73rd and 74th Constitutional Amendments, local governments play a vital role in primary healthcare, sanitation, nutrition, disease prevention, health awareness, and community participation. They support frontline health workers, manage local health facilities, detect outbreaks early, and mobilise communities during public health emergencies. Effective local governance strengthens accessibility, accountability, and trust in the health system.

The Public Health Administration Framework in India integrates all these levels into a coherent system focused on population health rather than only curative care. It encompasses policy, institutions, service delivery, surveillance, regulation, financing, intersectoral coordination, and emergency preparedness. Public health administration addresses communicable and non-communicable diseases, maternal and child health, nutrition, environmental health, and disaster response, with strong emphasis on preventive and promotive healthcare.

In essence, India's health administration structure relies on cooperative federalism and decentralisation. The Central Government acts as the strategic architect, states function as primary implementers, and local bodies serve as the community-facing delivery agents. Their coordinated functioning is essential for achieving equitable, efficient, and resilient healthcare, making health administration a cornerstone of India's social and economic development.

7.7 . Key Words with Explanation

- Health Administration – The organisation, planning, implementation, and monitoring of health services by public authorities.
- Public Health – The science and practice of preventing disease and promoting health at the population level.
- Decentralisation – Transfer of administrative and financial powers to state and local governments.
- Primary Healthcare – First level of contact between individuals and the health system, focusing on preventive and basic curative services.
- Health Governance – Decision-making processes and accountability mechanisms in the health system.
- Intergovernmental Coordination – Collaboration among central, state, and local authorities for policy implementation.

7.8. Self-Assessment Questions

A. Short Questions (with Answers)

1. What is health administration?
   It refers to the planning, organisation, and management of healthcare services by public authorities.
2. Which ministry is responsible for health at the central level?
   The Ministry of Health and Family Welfare.
3. What role do state governments play in healthcare?
   They manage public hospitals, implement health programmes, and regulate health services.
4. Name one function of local bodies in healthcare.
   Delivery of primary healthcare and sanitation services.
5. What is public health administration concerned with?
   Population-level disease prevention, health promotion, and control of epidemics.

B. Essay Questions (with Hints)

1. Explain the health administration structure at the central level in India.
   Hints: Role of ministries, national programmes, policy formulation, funding.
2. Discuss the responsibilities of state governments in health administration.
   Hints: Hospitals, medical education, public health regulation.
3. Analyse the role of local bodies in healthcare delivery.
   Hints: Panchayats, municipalities, primary health centres.
4. Describe India's public health administration framework.
   Hints: Preventive care, surveillance, coordination.
5. Evaluate the importance of coordination among different levels of health administration.
   Hints: Pandemic response, resource sharing, efficiency.

C. Multiple Choice Questions (with Answers)

1. Health is primarily a subject under which list of the Indian Constitution?
   a) Union List
   b) State List
   c) Concurrent List
   d) Residuary List
   Answer: b) State List
2. The apex body for health policy at the central level is:
   a) NITI Aayog

b) State Health Directorate
c) Ministry of Health and Family Welfare
d) WHO
Answer: c) Ministry of Health and Family Welfare

3. Primary healthcare is mainly delivered through:
   a) Tertiary hospitals
   b) Private clinics
   c) Primary Health Centres
   d) Medical colleges
   Answer: c) Primary Health Centres

4. Local bodies mainly focus on:
   a) Medical research
   b) Community-level healthcare
   c) International health policy
   d) Defence health services
   Answer: b) Community-level healthcare

5. Public health administration mainly emphasises:
   a) Curative care
   b) Preventive care
   c) Corporate healthcare
   d) Medical tourism
   Answer: b) Preventive care

D. Comprehensive Case Study

Case: Strengthening Primary Healthcare through Decentralisation

A rural district in Madhya Pradesh reported high maternal mortality and low immunisation coverage. While the Central Government provided funds under national health programmes, implementation depended on state health departments and local panchayats. Due to weak coordination, funds were underutilised and health outcomes remained poor.

After decentralising decision-making, district authorities empowered local bodies to manage sub-centres, hire contractual health workers, and conduct village health meetings. Within three years, institutional deliveries increased by 40%, immunisation coverage crossed 90%, and maternal deaths declined significantly.

Issues for Analysis:

- Role of each administrative level
- Importance of decentralisation
- Coordination between state and local bodies
- Lessons for public health administration

7. Standard Textbooks and Reference Materials

Textbooks (Purchasable by Students)

1. Park, K. – *Park's Textbook of Preventive and Social Medicine*
2. Goel, S. L. – *Health Care Administration in India*
3. Basu, D. – *Introduction to Health Policy, Planning and Management*
4. WHO – *Public Health Administration: Principles and Practices*
5. Gulati, S. C. – *Health Administration in India*

7.9 Reports & Other References

- World Health Organization – World Health Reports
- NITI Aayog – Health Index Reports
- Ministry of Health and Family Welfare – National Health Policy documents
- World Bank – Health Systems in India reports

LESSON 8: HEALTH COMMITTEES IN INDIA

OBJECTIVES

After studying this lesson, learners will be able to:

- Understand the need for health committees in India
- Identify major health committees appointed by the Government of India
- Explain key recommendations of health committees
- Assess the impact of committee reports on the healthcare system
- Analyse the role of committees in health policy and planning

STRUCTURE

1. Need for Health Committees in India
2. Major Health Committees Appointed by the Government of India
3. Key Recommendations of Important Health Committees
4. Impact of Health Committees on the Indian Healthcare System
5. Influence of Committees on Health Policy and Planning

Introductory Case (Real-World, Data-Based)

Case Title: From Bhore Committee to Ayushman Bharat – The Evolution of Health Planning in India

In the mid-1940s, India faced severe public health challenges—high infant mortality, low life expectancy (around 32 years), widespread communicable diseases, and inadequate healthcare infrastructure. To address these issues, the colonial government appointed the Bhore Committee in 1943.

The committee's landmark report (1946) recommended a state-funded, comprehensive health service with emphasis on primary healthcare, preventive services, and integration of curative and preventive care. Many of its ideas later influenced India's post-independence health planning.

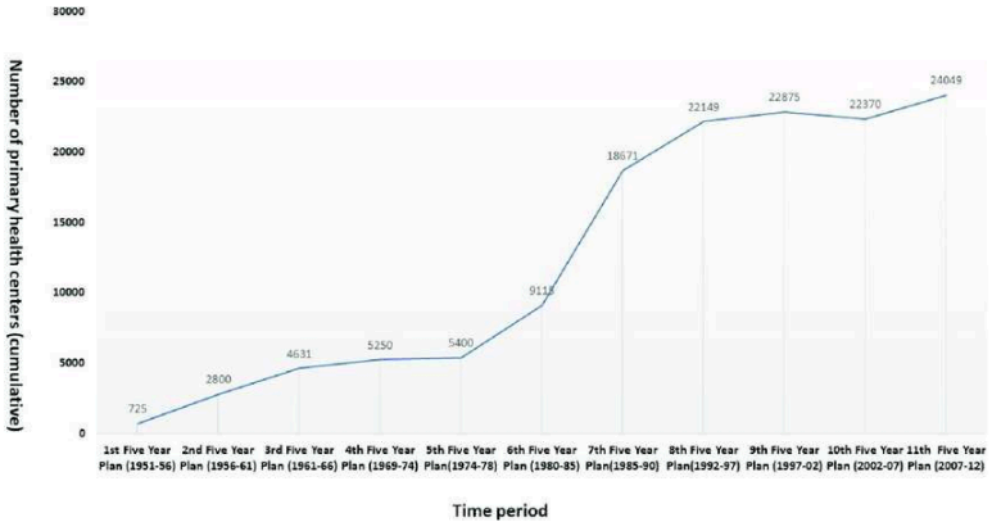
Decades later, India continued to rely on expert committees to address emerging challenges such as population growth, epidemiological transition, and rising healthcare costs. Committees like the Mudaliar Committee, Kartar Singh Committee, and Shrivastav Committee shaped rural health infrastructure, workforce design, and community participation.

In recent years, expert groups and committees supported reforms such as the National Health Policy, National Health Mission, and Ayushman Bharat, contributing to improved indicators—

life expectancy increased to over 69 years, and institutional deliveries exceeded 88% nationwide.

This case highlights how health committees have consistently guided India's health policy, planning, and system reforms, making them central to health administration.

8.1 Need for Health Committees in India



1. Background and Rationale

India's health system has evolved in response to changing demographic, epidemiological, and socio-economic conditions. At Independence, the country faced high mortality, widespread communicable diseases, limited infrastructure, and acute manpower shortages. Over time, new challenges emerged—population growth, urbanisation, non-communicable diseases, technological change, and rising costs.
In this complex context, Health Committees became essential instruments for systematic assessment, expert guidance, and long-term planning.

2. Complexity and Diversity of Health Needs

India's vast geographic and cultural diversity produces uneven health needs and outcomes across regions. Health committees help:

- Diagnose region-specific and system-wide problems
- Balance preventive, promotive, and curative care
- Recommend context-sensitive solutions rather than ad-hoc measures

3. Need for Evidence-Based Policy and Planning

Health committees are constituted to:

- Undertake scientific assessment of health conditions
- Use data, field studies, and international experience
- Provide evidence-based recommendations to governments
  This approach reduces reliance on short-term political considerations and strengthens policy credibility.

4. Integration and Coordination of Services

Historically, India's health services suffered from fragmentation, especially through vertical disease control programmes. Committees were needed to:

- Promote integration of preventive and curative services
- Improve coordination between levels of government
- Rationalise health workforce deployment

5. Health Workforce and Infrastructure Planning

India has faced persistent shortages and maldistribution of health personnel. Committees examined:

- Optimal doctor–population and nurse–population ratios
- Design of multipurpose health worker models
- Strengthening of Primary Health Centres (PHCs) before expansion
  Such planning ensured efficient use of limited resources.

6. Responding to Epidemiological Transition

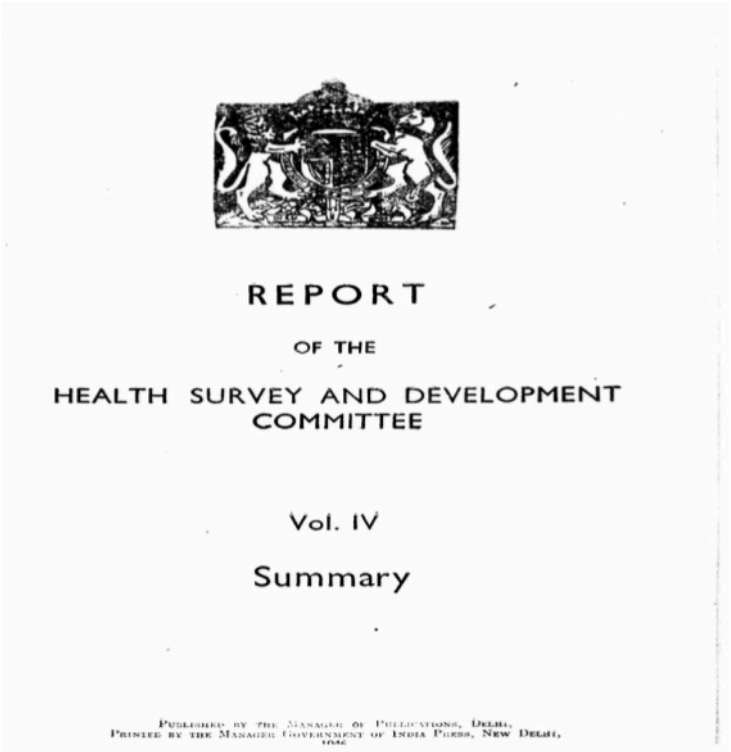
As India moved from a disease profile dominated by infections to one with growing non-communicable diseases, health committees helped:

- Reorient health systems toward chronic care and prevention
- Recommend health promotion and lifestyle interventions
- Update policy priorities in line with changing disease patterns

7. Long-Term Vision and Continuity

Health committees provide a long-term vision for health development that transcends political cycles. Many foundational reforms—primary healthcare focus, decentralisation, and community participation—originated from committee recommendations and continue to guide policy.

8.2 Major Health Committees Appointed by the Government of India



REPORT

OF THE

HEALTH SURVEY AND DEVELOPMENT COMMITTEE

Vol. IV

Summary

Published by the Manager of Publications, Delhi,
Printed by the Manager, Government of India Press, New Delhi,
1946

1. Bhore Committee (1943–1946)

Chairperson: Sir Joseph Bhore

Context:
Appointed during the pre-independence period to survey India's health conditions comprehensively.

Major Recommendations:

- Health as a state responsibility
- Integrated preventive and curative services
- Strong network of Primary Health Centres
- Emphasis on public health and medical education reform

Significance:
Laid the foundation of India's public health system and strongly influenced post-independence health planning.

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2. Mudaliar Committee

Chairperson: Dr. A. L. Mudaliar

Context:
Reviewed progress after Independence and assessed weaknesses in implementation.

Major Recommendations:

- Strengthening existing PHCs before expanding coverage
- Improvement in quality of services
- Focus on medical education standards

Significance:
Shifted emphasis from rapid expansion to consolidation and quality improvement.

---

3. Kartar Singh Committee (1973)

Chairperson: Kartar Singh

Context:
Addressed manpower shortages and inefficiencies due to vertical programmes.

Major Recommendations:

- Introduction of Multipurpose Health Workers (male and female)
- Integration of disease control activities

- Rationalisation of supervisory structures

Significance:
Revolutionised grassroots health service delivery and improved outreach efficiency.

---

4. Shrivastav Committee

Chairperson: Dr. J. B. Shrivastav

Context:
Focused on rural health services and community involvement.

Major Recommendations:

- Creation of community health volunteers
- Closer linkage between medical education and rural health
- Emphasis on people's participation

Significance:
Introduced the concept of community-oriented primary healthcare in India.

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5. Bajaj Committee (1986)

Focus:
Medical education and health manpower planning.

Key Contributions:

- Review of medical education quality
- Recommendations for aligning training with national health needs

---

6. HLEG on Universal Health Coverage (2011)

Appointed by: Planning Commission

Key Recommendations:

- Universal access to essential health services
- Increased public health spending
- Strengthening primary healthcare

Significance:
Influenced recent reforms aimed at universal health coverage.

---

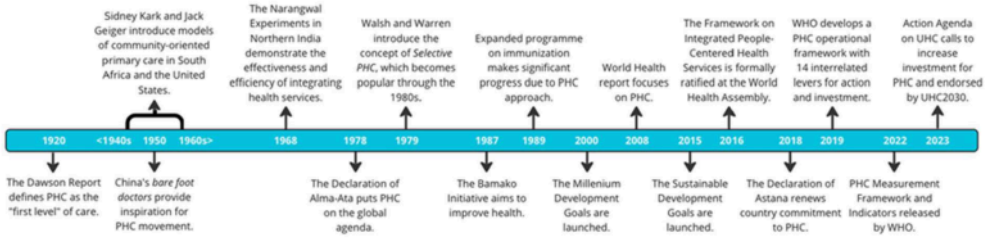
7. Overall Contribution of Health Committees

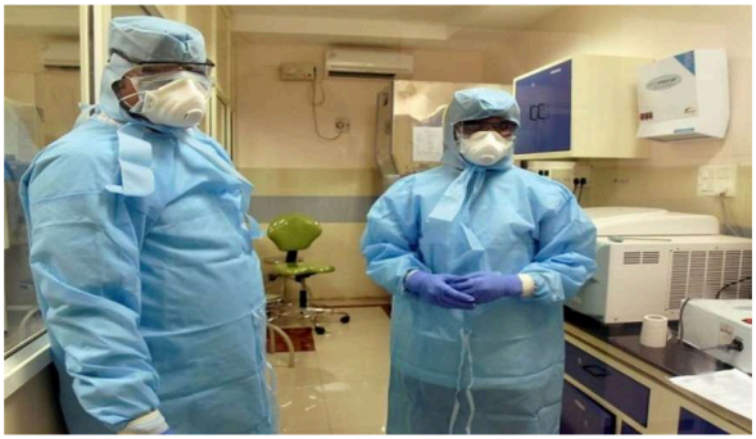
Collectively, these committees:

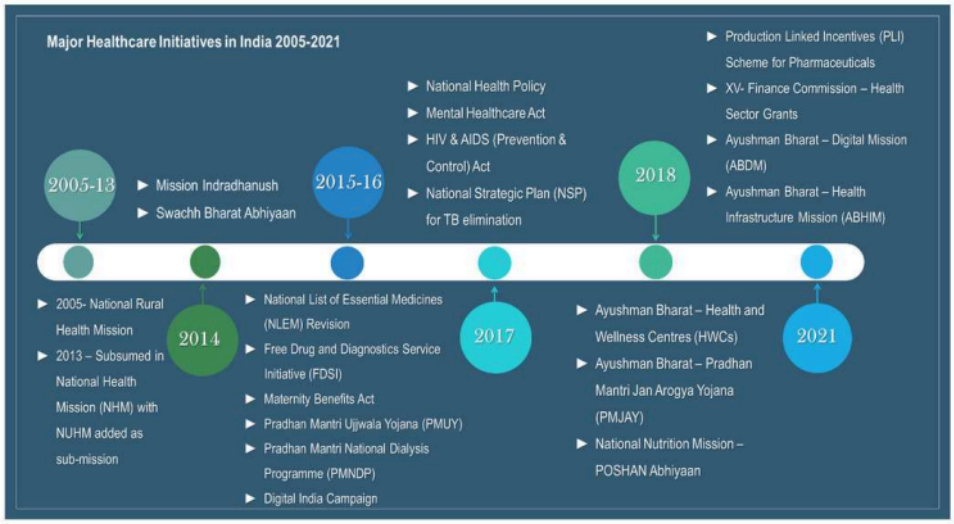
- Provided diagnostic insight into system weaknesses
- Guided policy formulation and health planning
- Shaped primary healthcare orientation
- Strengthened human resource planning
- Influenced landmark programmes and policies

They demonstrate how expert-driven advisory mechanisms have been central to the evolution and reform of India's health system.

8.3 Recommendations and Impact on the Healthcare System







1. Introduction

The recommendations of health committees in India have played a decisive role in shaping the structure, philosophy, and functioning of the healthcare system. These committees did not merely identify problems; they proposed system-wide reforms covering healthcare delivery, workforce planning, infrastructure development, community participation, and policy orientation. Over time, many of these recommendations were translated into programmes, institutions, and policies, leaving a lasting impact on India's health system.

2. Core Recommendations of Major Health Committees

Although each committee operated in a different historical context, their recommendations show strong continuity and cumulative influence.

A. Emphasis on Primary Healthcare

One of the most consistent and influential recommendations came from the Bhore Committee, which proposed that:

- Healthcare should be state-funded and universally accessible
- Primary Health Centres (PHCs) should form the backbone of the health system
- Preventive and curative services must be integrated

Impact

- Establishment of a nationwide PHC network

- Long-term prioritisation of primary healthcare in national planning
- Alignment with global principles later reflected in the Alma-Ata Declaration

This recommendation fundamentally shifted India away from a hospital-centric model to a community-oriented health system.

B. Strengthening and Consolidation of Existing Infrastructure

The Mudaliar Committee observed that rapid expansion without quality compromised service delivery.

Key Recommendations

- Strengthen existing PHCs before opening new ones
- Improve quality of services and supervision
- Enhance medical education standards

Impact

- Greater focus on quality improvement rather than numerical expansion
- Better utilisation of existing health facilities
- Recognition of the need for standardisation and supervision

This marked a transition from quantitative growth to qualitative consolidation.

C. Integration of Health Services and Workforce Rationalisation

Fragmentation caused by vertical disease control programmes led to inefficiencies. The Kartar Singh Committee addressed this issue directly.

Key Recommendations

- Introduction of Multipurpose Health Workers (MPHWs)
- Integration of disease-specific activities
- Rational supervisory structures

Impact

- Improved efficiency of grassroots health delivery
- Reduced duplication of services
- Enhanced outreach, especially in rural areas

The MPHW scheme remains a cornerstone of India’s primary healthcare workforce.

D. Community Participation and Decentralisation

The Shrivastav Committee emphasised that health systems cannot succeed without people's involvement.

Key Recommendations

- Community health volunteers
- Greater role for local bodies
- Linkage between medical education and rural health needs

Impact

- Foundation for community-based health programmes
- Later development of ASHA and village-level health committees
- Strengthened decentralised health governance

This recommendation reshaped health administration to be participatory rather than purely bureaucratic.

E. Health Manpower and Medical Education Reforms

Committees such as the Bajaj Committee examined mismatches between health needs and medical training.

Key Recommendations

- Align medical education with national health priorities
- Promote public health orientation among medical graduates
- Improve standards and accreditation

Impact

- Reforms in medical curricula
- Recognition of public health and community medicine
- Expansion of paramedical and nursing education

Human resource planning became a central component of health system development.

F. Universal Access and Equity in Healthcare

In the post-liberalisation era, expert groups such as the HLEG on Universal Health Coverage revisited earlier committee ideas in a modern context.

Key Recommendations

- Universal access to essential health services
- Increased public health expenditure
- Strong primary healthcare and financial protection

Impact

- Renewed focus on universal health coverage
- Policy direction for large-scale health reforms
- Strengthening of publicly financed healthcare mechanisms

These recommendations addressed inequities and rising out-of-pocket expenditure.

---

3. System-Wide Impact on the Indian Healthcare System

Collectively, committee recommendations produced transformational changes:

A Structural Impact

- Creation of a three-tier healthcare system
- Institutionalisation of PHCs, CHCs, and district hospitals

B Administrative Impact

- Integration of preventive and curative services
- Strengthened coordination across administrative levels

C Workforce Impact

- Development of multipurpose and community-based health workers
- Expanded training and deployment of paramedical staff

D Policy Impact

- Evidence-based health policies
- Long-term strategic planning instead of ad-hoc decisions

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4. Limitations and Gaps in Implementation

While committee recommendations were visionary, their implementation faced challenges:

- Financial constraints
- Uneven state capacity
- Administrative bottlenecks
- Political and institutional resistance

As a result, outcomes varied across states, highlighting the importance of governance and capacity.

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5. Overall Significance

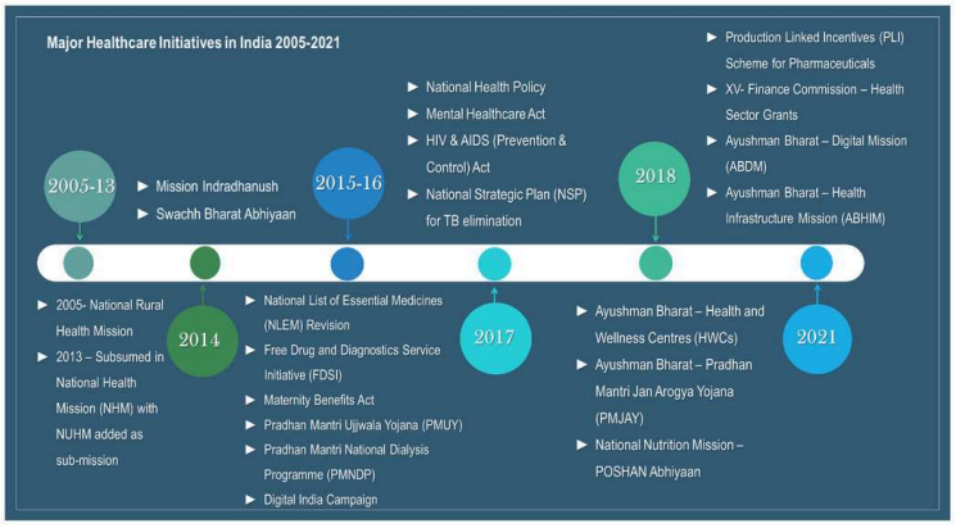
Health committees have acted as:

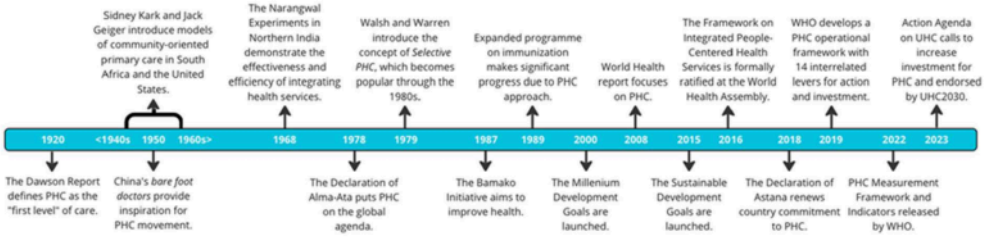
- Think tanks for health reform
- Bridges between evidence and policy
- Instruments of continuity in health planning

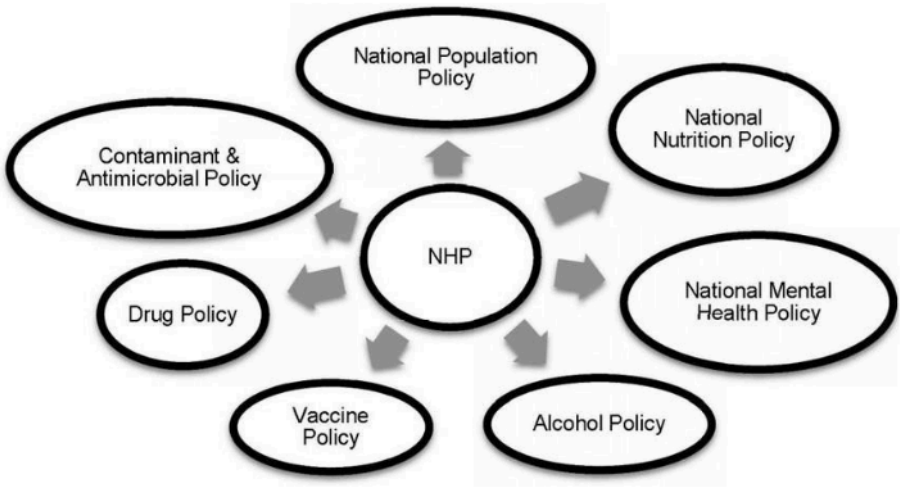
Their recommendations continue to influence:

- National health programmes
- Public health administration frameworks
- Long-term health sector reforms

8.4 Influence of Health Committees on Health Policy and Planning in India







1. Introduction

Health committees in India have functioned as strategic advisory mechanisms that bridge ground realities, scientific evidence, and governmental decision-making. Their influence extends beyond individual recommendations to shaping the philosophy, priorities, and instruments of health policy and planning over time. By providing expert, non-partisan, and long-term perspectives, committees have ensured continuity and coherence in India's health sector reforms.

2. Committees as Foundations of Health Policy Vision

The earliest committees laid down the normative vision of India's health system. The Bhore Committee articulated principles that became enduring pillars of health policy:

- State responsibility for health
- Universal access to health services
- Primary healthcare as the foundation
- Integration of preventive and curative care

Policy Influence

These principles were reflected in:

- Post-independence Five-Year Plans
- Expansion of public health infrastructure
- Emphasis on publicly funded healthcare

Even decades later, national policies continue to reaffirm these foundational ideas.

3. Shaping National Health Policies

Health committees have directly and indirectly influenced successive National Health Policies by identifying system gaps and proposing corrective strategies.

Key Areas of Influence

- Shift from hospital-centric care to primary healthcare
- Focus on equity and access for rural and vulnerable populations
- Recognition of public health as distinct from clinical medicine
- Emphasis on preventive and promotive care

These themes recur consistently in policy documents, indicating the enduring intellectual imprint of committee recommendations.

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4. Influence on Health Planning and Five-Year Plans

Health committees have significantly shaped health sector planning, especially during the Five-Year Plan era.

Planning Contributions

- Defining norms for PHCs, CHCs, and district hospitals
- Guiding allocation of resources between infrastructure, workforce, and programmes
- Advising on sequencing of reforms (strengthening before expansion)

The Mudaliar Committee influenced planners to prioritise quality and consolidation, preventing unbalanced expansion.

---

5. Workforce Planning and Policy Orientation

Health committees deeply influenced health manpower policies.

Examples

- The Kartar Singh Committee reshaped policy by:
    - Integrating vertical programmes
    - Introducing multipurpose workers
    - Improving efficiency and outreach
- The Shrivastav Committee:
    - Brought community participation into policy discourse
    - Highlighted the need to align medical education with public health goals

Policy Outcomes

- Development of community-based health worker models
- Recognition of public health and community medicine as core disciplines
- Policies encouraging decentralisation and local engagement

---

6. Influence on Programme Design and Reforms

Committee ideas often translated into major national programmes.

Examples of Influence

- Integration of services → comprehensive health missions
- Emphasis on primary care → strengthening of sub-centres and PHCs
- Focus on equity → targeting of underserved populations

Expert advice helped ensure that programmes were:

- Evidence-informed
- System-oriented rather than disease-specific
- Aligned with long-term goals rather than short-term targets

---

7. Equity, Access, and Universalism in Policy Thinking

In the contemporary period, expert groups such as the HLEG on Universal Health Coverage reinforced earlier committee ideas within modern contexts.

Policy Influence

- Renewed emphasis on universal health coverage
- Greater attention to financial protection
- Recognition of health as a social investment

These ideas influenced planning approaches aimed at reducing out-of-pocket expenditure and improving access for the poor.

---

8. Committees and Evidence-Based Policymaking

Health committees institutionalised the practice of evidence-based policymaking by:

- Conducting surveys and field studies
- Analysing international best practices
- Linking data with policy options

Institutions such as the Ministry of Health and Family Welfare continue to rely on expert committees to:

- Evaluate reforms
- Propose mid-course corrections
- Respond to emerging health challenges

---

9. Long-Term Continuity and Policy Stability

One of the most important influences of health committees has been policy continuity.

- Committee reports act as reference documents across decades
- Core ideas—primary care, prevention, equity—persist despite political changes
- Planning becomes incremental and cumulative rather than disruptive

This continuity has been essential for building large-scale health systems in a diverse country like India.

---

10. Limitations of Committee Influence

Despite their impact, committee influence faces constraints:

- Recommendations are advisory, not binding
- Implementation depends on political will and resources
- Variations in state capacity affect outcomes

Nevertheless, even partial adoption of recommendations has produced system-wide improvements.

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11. Overall Significance

Health committees have:

- Shaped India's health policy philosophy
- Guided strategic health planning
- Strengthened evidence-based governance
- Promoted equity, prevention, and community orientation
- Ensured continuity and coherence in health reforms

They function as the intellectual backbone of India's health policy and planning process.

8.5 Student Activity

Student Activity 1: Committee–Contribution Match

Task:
Match each health committee with its major contribution.

Health Committee	Major Contribution
Bhore Committee	_____
Mudaliar Committee	_____
Kartar Singh Committee	_____
Shrivastav Committee	_____

Outcome:
Students recall key committees and their core recommendations.

Student Activity 2: Short Application Exercise

Task:
Answer briefly (3–4 sentences):

Why does the Government of India appoint health committees before introducing major health reforms?

Points to Cover (Hints):

- Expert advice
- Evidence-based planning
- Long-term vision

Outcome:
Students understand the need and relevance of health committees in policy-making.

Student Activity 3: Policy Link Identification

Task:
Identify one recommendation of any health committee and mention one health policy or programme influenced by it.

Example Format:

- Committee: _____
- Recommendation: _____

- Policy / Programme Influenced: _____

Outcome:
Students link committee recommendations with real-world health policies.

8.6 Summary:

Health Committees in India

Health committees have played a pivotal role in the evolution of India's healthcare system by providing expert guidance for health policy formulation, planning, and system reform. Given the size, diversity, and complexity of India's health challenges, governments have consistently relied on expert committees to study prevailing conditions, identify gaps, and recommend long-term solutions based on evidence and experience.

The need for health committees in India arises from multiple factors: wide regional disparities in health outcomes, changing disease patterns, limited resources, workforce shortages, and the necessity for coordinated action across levels of government. Health committees enable evidence-based decision-making, reduce ad-hoc policy responses, promote integration of services, and provide a long-term vision that goes beyond political cycles. They also help align healthcare delivery with broader social goals such as equity, prevention, and universal access.

Several major health committees appointed by the Government of India have left a lasting imprint on the health system. The Bhore Committee laid the foundation of India's public health system by advocating state responsibility for health, universal access, strong primary healthcare, and integration of preventive and curative services. The Mudaliar Committee shifted attention to strengthening and consolidating existing health infrastructure, emphasising quality over rapid expansion. The Kartar Singh Committee addressed manpower constraints by recommending multipurpose health workers and integration of vertical disease programmes. The Shrivastav Committee highlighted the importance of community participation, decentralisation, and linking medical education with rural health needs. Later expert groups further reinforced concerns related to equity, access, and universal health coverage.

The recommendations of these committees significantly transformed India's healthcare system. They led to the establishment of a three-tier health structure, expansion and strengthening of Primary Health Centres, rationalisation of health manpower, promotion of community-based health services, and increased focus on preventive and promotive care. Many committee ideas were translated into national programmes, workforce policies, and administrative reforms, though implementation varied across states due to financial and governance constraints.

Health committees have also exerted strong influence on health policy and planning. Their ideas shaped successive national health policies, guided health sector priorities in planning exercises, and institutionalised evidence-based policymaking. Core principles such as primary healthcare, equity, decentralisation, and prevention have shown remarkable continuity in India's health policy discourse, reflecting the enduring influence of committee recommendations.

In conclusion, health committees function as the intellectual backbone of India's health system reforms. By systematically linking evidence, expertise, and policy action, they have ensured

that India's health planning remains structured, forward-looking, and socially oriented, making them indispensable to the development of a resilient and equitable healthcare system.

8.7. Key Words with Explanation

- Health Committee – An expert body appointed to study health conditions and recommend reforms.
- Health Policy – A set of decisions and plans to achieve specific healthcare goals.
- Primary Healthcare – Essential healthcare based on practical and community-oriented methods.
- Preventive Care – Measures taken to prevent diseases before they occur.
- Health Planning – Systematic assessment and allocation of health resources.
- Expert Committee – A group of specialists constituted to provide technical guidance.

8.8 . Self-Assessment Questions

A. Short Questions (with Answers)

1. What is a health committee?
   A health committee is an expert body appointed to examine health issues and recommend reforms.
2. Why are health committees needed in India?
   To provide expert advice for health planning and policy-making.
3. Name the first major health committee in India.
   The Bhore Committee.
4. Which committee emphasised strengthening PHCs before expansion?
   The Mudaliar Committee.
5. What is the main role of health committees in policy-making?
   To provide evidence-based recommendations.

B. Essay Questions (with Hints)

1. Explain the need for health committees in India.
   Hints: Diversity, expert advice, planning, reforms.
2. Discuss the recommendations of the Bhore Committee.
   Hints: Primary healthcare, preventive care, state responsibility.
3. Examine the contribution of post-independence health committees.
   Hints: Mudaliar, Kartar Singh, Shrivastav Committees.

4. Analyse the impact of health committees on healthcare delivery.
   Hints: Infrastructure, workforce, service integration.
5. Evaluate the influence of health committees on health policy and planning.
   Hints: National Health Policy, NHM, Ayushman Bharat.

C. Multiple Choice Questions (with Answers)

1. The Bhore Committee was appointed in:
   a) 1935
   b) 1943
   c) 1952
   d) 1960
   Answer: b) 1943
2. Which committee recommended integration of preventive and curative services?
   a) Mudaliar Committee
   b) Kartar Singh Committee
   c) Bhore Committee
   d) Shrivastav Committee
   Answer: c) Bhore Committee
3. The Kartar Singh Committee focused on:
   a) Medical education
   b) Health financing
   c) Multipurpose health workers
   d) Urban health
   Answer: c) Multipurpose health workers
4. Health committees mainly assist in:
   a) Judicial review
   b) Policy formulation
   c) Tax collection
   d) Defence planning
   Answer: b) Policy formulation
5. Which area is NOT directly influenced by health committees?
   a) Health policy
   b) Health planning
   c) Workforce design
   d) Foreign trade
   Answer: d) Foreign trade

D. Comprehensive Case Study

Case Title: Role of Health Committees in Strengthening Rural Health Systems in India

Background

After Independence, India inherited a weak and fragmented healthcare system, particularly in rural areas where nearly 70% of the population resided. Rural regions were characterised by:

- High infant and maternal mortality
- Prevalence of communicable diseases such as malaria, tuberculosis, and diarrhoeal diseases
- Shortage of trained doctors and nurses
- Poor infrastructure and accessibility

To systematically address these challenges, the Government of India relied on expert health committees to assess ground realities and propose long-term solutions. These committees were composed of public health experts, administrators, and medical professionals, and their recommendations formed the backbone of India's health planning.

One such state (hypothetical but representative of many Indian states in the 1960s–70s) had:

- One Primary Health Centre (PHC) covering nearly 1 lakh population
- Severe shortage of doctors and paramedical staff
- Vertical disease control programmes working in isolation
- Minimal community involvement in healthcare

Health indicators in the state reflected these weaknesses:

- Infant Mortality Rate (IMR): above 120 per 1,000 live births
- Maternal Mortality Ratio (MMR): extremely high
- Immunisation coverage: below 30%
- Institutional deliveries: less than 20%

8.9 Policy Intervention Based on Health Committee Recommendations

The State Government undertook a comprehensive review of its health system by referring to national-level committee reports such as:

- The Bhore Committee, which recommended state responsibility for health services, emphasis on primary healthcare, and integration of preventive and curative care
- The Mudaliar Committee, which stressed strengthening existing PHCs before expanding infrastructure
- The Kartar Singh Committee, which proposed the multipurpose health worker scheme to optimise limited manpower

- The Shrivastav Committee, which highlighted community participation and linkage between health services and medical education

Drawing from these recommendations, the state implemented the following reforms:

1. Reorganisation of Health Workforce
    - Vertical disease workers were merged into multipurpose health workers
    - Greater focus on maternal and child health, immunisation, and health education
2. Strengthening of Primary Health Centres
    - PHCs were upgraded with better infrastructure and essential drugs
    - Referral linkages with Community Health Centres (CHCs) were improved
3. Community Participation
    - Village-level health committees were formed
    - Local leaders and volunteers were involved in awareness campaigns
4. Administrative Integration
    - Preventive and curative services were brought under a unified administrative structure
    - Better coordination between state and district health authorities

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8.10 Outcomes Observed Over Five Years

Following the implementation of committee-based reforms, measurable improvements were observed:

- Immunisation coverage increased from 30% to over 75%
- Institutional deliveries rose to nearly 60%
- IMR and MMR showed a steady decline
- Utilisation of PHCs increased significantly
- Community trust in public health facilities improved

These outcomes demonstrated that expert committee recommendations, when adapted and implemented effectively, can bring substantial improvements in healthcare delivery.

8.11 Issues for Analysis

Students are required to analyse the case using the following guiding questions:

1. Why were health committees necessary for identifying problems in rural healthcare?
   (Hint: complexity of health issues, need for expert assessment, evidence-based planning)
2. Which committee recommendations were most relevant to the reforms undertaken by the state?
   (Hint: Bhore Committee – PHC focus; Kartar Singh Committee – workforce reorganisation)
3. How did multipurpose health workers improve service delivery at the grassroots level?
   (Hint: efficiency, integration of services, outreach)
4. What role did community participation play in improving health outcomes?
   (Hint: awareness, acceptance, accountability)
5. What lessons can current health planners learn from the impact of these committee recommendations?
   (Hint: relevance of expert advice, long-term planning, adaptability)

8.12. Standard Textbooks and Reference Materials

Textbooks (Purchasable by Students)

1. Park, K. – *Park's Textbook of Preventive and Social Medicine*
2. Goel, S. L. – *Health Care Administration in India*
3. Basu, D. – *Health Policy, Planning and Management*
4. Banerji, D. – *Health and Family Planning in India*
5. Gulati, S. C. – *Health Administration in India*

Reports & Other References

- Ministry of Health and Family Welfare – National Health Policy documents
- World Health Organization – Health systems and policy reports
- NITI Aayog – Health index and policy reports
- Planning Commission of India – Health sector reports

LESSON 9: INTERNATIONAL HEALTH AGENCIES

OBJECTIVES

After studying this lesson, learners will be able to:

- Understand the concept and role of international health agencies
- Identify major international health organizations and their functions
- Explain the nature of technical and financial assistance to India
- Analyse the influence of international agencies on national health programs
- Appreciate the relevance of global health agencies in health policy and planning

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STRUCTURE

1. Concept and Role of International Health Agencies
2. Major International Health Organizations
3. Technical and Financial Assistance to India
4. Influence of International Health Agencies on National Health Programs

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Introductory Case (Real-World, Data-Based, Learner-Engaging)

Case Title: How International Health Agencies Supported India During COVID-19

In early 2020, India faced one of the largest public health crises in its history due to the COVID-19 pandemic. With a population exceeding 1.4 billion, the country needed massive support in disease surveillance, testing, vaccination, logistics, and public health communication.

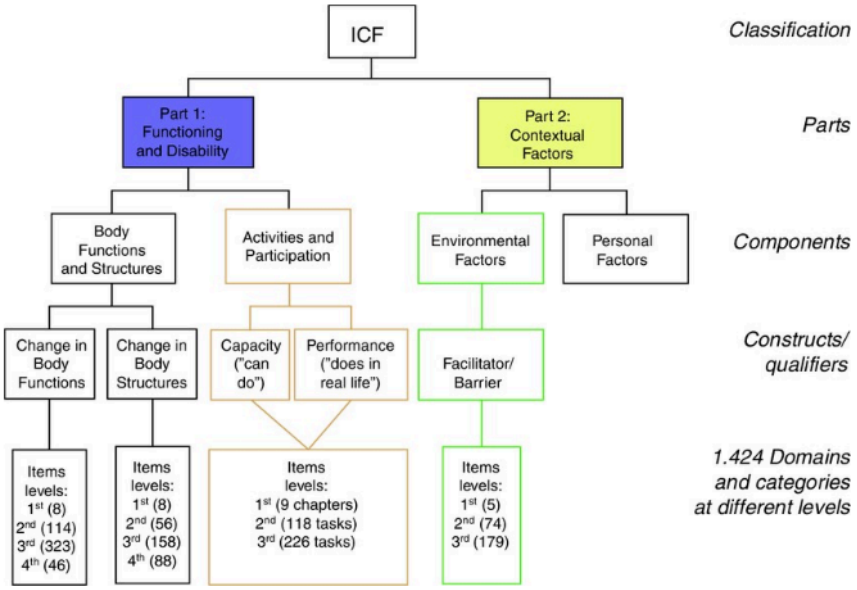
The World Health Organization worked closely with India's Ministry of Health to provide technical guidance on surveillance, testing protocols, clinical management, and infection prevention. WHO-supported training programs helped rapidly scale up testing laboratories across states.

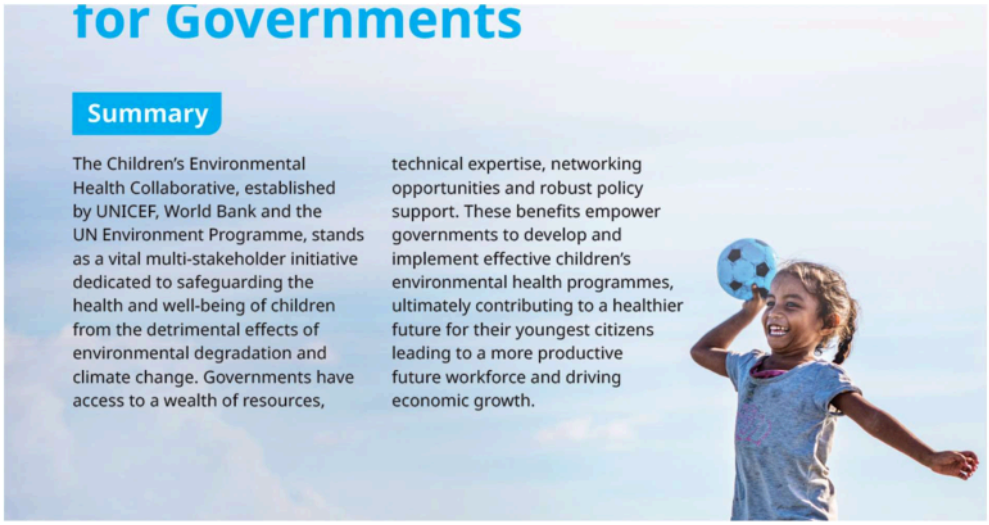
The UNICEF played a crucial role in risk communication, vaccine cold-chain logistics, and public awareness campaigns, especially targeting children, women, and vulnerable populations. UNICEF supported India's immunization infrastructure to manage one of the world's largest vaccination drives, administering over 2 billion vaccine doses.

The World Bank extended emergency financing and health system strengthening support, enabling procurement of medical equipment, PPE, oxygen infrastructure, and capacity building at state and district levels.

This coordinated global support demonstrated how international health agencies influence national health responses, strengthen health systems, and shape public health programs. The case highlights the strategic importance of international health agencies in India's healthcare business and policy environment.


Global Governance for Health
• Health in the context of global organisations in other sectors
• Starting point for the social, economic, and political determinants of health
Global Health Governance
• Governance of dedicated health organisations and thier interface
• Starting point for health equity and disease control
Governance for Global Health
• Governance at national and regional levels in support of global health agendas
• Starting point for global health strategies


ICF
Classification
Part 1: Functioning and Disability
Part 2: Contextual Factors
Parts
Body Functions and Structures
Activities and Participation
Environmental Factors
Personal Factors
Components
Change in Body Functions
Change in Body Structures
Capacity ("can do")
Performance ("does in real life")
Facilitator/ Barrier
Constructs/ qualifiers
Items levels: 1st (8) 2nd (114) 3rd (323) 4th (46)
Items levels: 1st (8) 2nd (56) 3rd (158) 4th (88)
Items levels: 1st (9 chapters) 2nd (118 tasks) 3rd (226 tasks)
Items levels: 1st (5) 2nd (74) 3rd (179)
1.424 Domains and categories at different levels



9.1. Concept and Role of International Health Agencies

A.Concept of International Health Agencies

International Health Agencies (IHAs) are intergovernmental or multilateral organizations established to promote, protect, and improve health across national boundaries. These agencies function within the framework of global health governance, addressing health issues that transcend national borders, such as pandemics, communicable diseases, malnutrition, environmental health risks, and health inequities.

Unlike national health systems, international health agencies:

- Operate across multiple sovereign states
- Work through technical cooperation rather than authority
- Focus on collective global action

They do not replace national governments but support, guide, finance, and coordinate national health systems.

B.Rationale for the Emergence of International Health Agencies

The need for international health agencies arose due to:

1. Transnational Nature of Diseases
   Infectious diseases such as plague, cholera, influenza, HIV/AIDS, and COVID-19 demonstrated that diseases do not respect political boundaries.
2. Global Inequalities in Health
   Wide disparities in healthcare capacity between developed and developing countries required international solidarity and assistance.
3. Need for Standardization
   Uniform standards for:
   - Disease surveillance
   - Drug safety
   - Vaccines
   - Health statistics

4. Shared Global Risks
   Climate change, migration, urbanisation, and antimicrobial resistance demand coordinated global responses.

C. Definition of International Health Agencies

International health agencies may be defined as:

"Organizations operating at international or regional levels that promote health, prevent disease, and strengthen health systems through technical expertise, financial assistance, research, and policy guidance."

D. Core Roles of International Health Agencies

The roles of international health agencies can be grouped into six major functional domains:

---

1 **Technical Advisory Role**

International agencies provide:

- Evidence-based guidelines
- Standard treatment protocols
- Disease classification systems
- Public health best practices

This role is especially critical for:

- Disease outbreaks
- New vaccines and medicines
- Health system reforms

---

2 **Norm-Setting and Standardization Role**

Agencies establish international norms and standards, such as:

- International Health Regulations (IHR)
- Vaccine quality standards
- Essential medicines lists
- Disease coding and reporting systems

These standards ensure comparability, safety, and coordination across countries.

---

3 **Capacity Building and Human Resource Development**

International agencies support:

- Training of health professionals
- Strengthening public health institutions
- Leadership development
- Knowledge transfer

This role is crucial for low- and middle-income countries, including India.

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4 **Financial Assistance and Resource Mobilization**

Some agencies provide:

- Grants
- Soft loans
- Emergency funding
- Infrastructure financing

Funding is often linked with:

- Health system strengthening
- Disease-specific programs

- Health sector reforms

---

5 Research, Data, and Knowledge Generation
International health agencies:

- Conduct global health research
- Publish health statistics and reports
- Support surveillance systems
- Generate comparative health data

These outputs guide policy formulation and planning at national and global levels.

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6 Coordination and Global Health Diplomacy
International agencies act as:

- Platforms for international cooperation
- Mediators during health emergencies
- Coordinators of multi-country initiatives

They play a central role in health diplomacy, balancing health priorities with political and economic realities.

E. Relevance of International Health Agencies for India
For a country like India:

- Large population
- Regional diversity
- Epidemiological transition
- Resource constraints

International health agencies provide:

- Technical expertise
- Financial support
- Global best practices
- Support during emergencies

They significantly influence India's health policies, national programs, and health business environment.

9.2. Major International Health Organizations

4

A. World Health Organization (WHO)

World Health Organization

Establishment and Background

- Established: 1948
- Headquarters: Geneva, Switzerland
- Specialized agency of the United Nations

Vision and Mandate

WHO's objective is:

"The attainment by all peoples of the highest possible level of health."

Functions of WHO

1. Normative and Standard-Setting Functions
    - International Health Regulations (IHR)
    - Essential Medicines List
    - Disease classification (ICD)
2. Technical Assistance
    - Disease surveillance
    - Outbreak response
    - Health system strengthening
3. Health Policy Guidance
    - National health policies
    - Universal health coverage strategies
    - Public health reforms
4. Emergency Response
    - Pandemic preparedness
    - Emergency health operations
5. Research and Knowledge Dissemination
    - World Health Reports
    - Global health statistics

WHO and India

WHO has supported India in:

- Polio eradication
- Tuberculosis control
- COVID-19 response
- Surveillance strengthening

WHO's country office works closely with the Ministry of Health and Family Welfare.

B. United Nations Children's Fund (UNICEF)

UNICEF

Establishment and Background

- Established: 1946
- Mandate: Child survival, development, and protection

Functions of UNICEF

1. Maternal and Child Health
    - Immunisation
    - Nutrition
    - Neonatal care
2. WASH (Water, Sanitation, Hygiene)
    - Safe drinking water
    - Sanitation infrastructure
    - Hygiene promotion
3. Health Communication
    - Behaviour change campaigns
    - Community engagement
4. Supply and Logistics
    - Vaccine procurement
    - Cold chain systems

UNICEF and India

UNICEF has played a major role in:

- Universal Immunisation Programme
- Pulse Polio Campaign
- Nutrition missions
- COVID-19 vaccination logistics

C. World Bank (Health Sector Role)

World Bank

Nature and Mandate

- International financial institution
- Focus on development financing

Functions in Health Sector

1. Financial Assistance
    - Loans and credits
    - Emergency funding
    - Health infrastructure projects
2. Health System Strengthening
    - Institutional reforms
    - Health financing reforms

- Digital health systems

3. Policy Advisory Role
   - Health economics
   - Cost-effectiveness analysis
   - Sector reforms

World Bank and India
World Bank has supported:

- Health system modernization
- Disease control programs
- COVID-19 emergency response
- State-level health reforms

D. International Labour Organization (ILO)
International Labour Organization
Health-Related Functions

- Occupational health and safety
- Social security and health insurance
- Labour welfare standards

ILO influences:

- Workplace health policies
- Employee health benefits
- Social protection systems

E. United Nations Development Programme (UNDP)
United Nations Development Programme
Health-Related Contributions

- Health governance
- HIV/AIDS programs
- Health system capacity building
- Sustainable development goals (SDGs)

UNDP integrates health with:

- Poverty reduction
- Gender equality
- Environmental sustainability

F. Other International Health Organizations (Brief Overview)

- Global Fund – HIV/AIDS, TB, Malaria financing
- GAVI – Vaccine alliance
- FAO – Nutrition and food security
- UNFPA – Reproductive and population health

These agencies complement WHO and UNICEF in targeted health interventions.

G. Comparative Perspective of Major Agencies

Agency	Core Role	Nature of Support
WHO	Technical leadership	Guidelines, norms
UNICEF	Child & maternal health	Logistics, outreach
World Bank	Financing	Loans, reforms

Agency	Core Role	Nature of Support
ILO	Worker health	Standards
UNDP	Health & development	Capacity building

9.3 Technical and Financial Assistance to India

CITY
UNIVERSITY OF LONDON
EST 1894

Healthcare Financing System in India: RSBY

Lead: Dr Sharanya Rajan

Dr Mina Maallah
Adriana Desoto
Ana Milena Quintero
Anoosha Anoosha
Marya Salhab

(Plasman, 2016)

1

1 Introduction

India's healthcare system, given its population size, regional diversity, epidemiological transition, and resource constraints, has historically benefited from technical and financial assistance provided by international health agencies. Such assistance has played a critical role in:

- Strengthening public health infrastructure
- Enhancing human resource capacity
- Supporting national health programs
- Responding to public health emergencies
- Advancing health system reforms

International assistance does not substitute national responsibility; instead, it acts as a catalyst, accelerating reforms, introducing global best practices, and bridging gaps in finance, technology, and expertise.

2 Concept of Technical and Financial Assistance

a Technical Assistance

Technical assistance refers to non-financial support provided by international agencies to strengthen national health systems.

It includes:

- Policy advice and strategic guidance
- Development of clinical and public health guidelines
- Capacity building and training
- Research, data systems, and surveillance support
- Technology transfer and digital health solutions

Technical assistance focuses on knowledge, skills, systems, and governance.

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2 Financial Assistance

Financial assistance includes:

- Grants
- Concessional loans
- Emergency financing
- Project-based funding

This assistance supports:

- Infrastructure development
- Procurement of equipment and medicines
- Program implementation
- Health system reforms

Financial assistance is often conditional, linked to reforms, accountability, and performance.

---

3 Rationale for International Assistance to India

International agencies support India due to:

1. Global Health Security
   Diseases in India can have global implications, making international cooperation essential.
2. Equity and Development Goals
   India hosts a large share of the world's poor and vulnerable populations.
3. Scale and Replicability
   Successful health interventions in India offer global learning value.
4. Health System Transformation Needs
   Large-scale reforms require external expertise and financing.

---

4 Technical Assistance to India by Major International Health Agencies

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1 Technical Assistance by the World Health Organization (WHO)

World Health Organization is the principal source of technical guidance for India.

Key Areas of Technical Support

a) Disease Surveillance and Control

- Establishment and strengthening of surveillance systems
- Outbreak investigation and response
- Pandemic preparedness planning

WHO has supported India in:

- Polio eradication surveillance
- Tuberculosis notification systems
- COVID-19 surveillance and laboratory networks

---

b) Norms, Standards, and Guidelines

WHO provides:

- Treatment protocols
- Public health standards
- Vaccine safety guidelines
- International Health Regulations (IHR) compliance

These norms ensure uniformity and scientific rigor in India's health programs.

---

c) Health Policy and System Strengthening
WHO advises on:

- National Health Policy formulation
- Universal Health Coverage (UHC) strategies
- Primary healthcare reforms
- Health governance frameworks

WHO's technical inputs influence long-term policy orientation.

---

d) Capacity Building

- Training of health professionals
- Leadership development programs
- Public health education initiatives

WHO-supported training enhances institutional capacity at central and state levels.

.2 Technical Assistance by UNICEF
UNICEF focuses on maternal, child, adolescent health, and nutrition.
Major Technical Contributions
a) Immunisation Systems Strengthening

- Cold-chain design and management
- Vaccine logistics and supply chain
- Monitoring and evaluation tools

UNICEF's technical expertise has been central to:

- Universal Immunisation Programme
- Pulse Polio Campaign
- COVID-19 vaccination rollout

---

b) Behaviour Change Communication (BCC)
UNICEF designs:

- Health awareness campaigns
- Nutrition education programs
- Maternal and child health messaging

BCC interventions improve service utilisation and outcomes.

---

c) WASH Technical Support

- Safe drinking water systems
- Sanitation models
- Hygiene promotion

This support links environmental health with disease prevention.

---

3 Technical Assistance by the World Bank
World Bank provides policy-oriented technical assistance.
Key Areas

- Health financing reforms
- Cost-effectiveness analysis
- Institutional restructuring
- Digital health systems

The World Bank integrates economic analysis with health planning, improving efficiency and sustainability.

---

4 Technical Assistance by UNDP
United Nations Development Programme supports health as part of human development.
Key Contributions

- Governance and institutional capacity
- HIV/AIDS and communicable disease programs
- SDG-aligned health planning
- Gender and equity mainstreaming

UNDP strengthens the developmental foundations of health systems.

---

5 Technical Assistance by ILO
International Labour Organization contributes through:

- Occupational health standards
- Workplace safety norms
- Social health protection models

ILO guidance influences employee health benefits and insurance systems.

---

5 Financial Assistance to India by International Health Agencies

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1 World Bank Financial Assistance
The World Bank is the largest external financier of India's health sector.
Nature of Assistance

- Long-term concessional loans
- Emergency health financing
- State-level health reform funding

Areas Supported

- Hospital infrastructure
- Public health laboratories
- Health information systems
- Pandemic response mechanisms

World Bank funding has enabled system-wide modernization.

---

2 UNICEF Financial Support
UNICEF provides:

- Program-specific grants
- Support for immunisation and nutrition
- Emergency child health funding

Financial support complements technical assistance, especially in vulnerable regions.

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3 Global Health Financing Mechanisms
Other agencies providing financial support include:

- Global Fund (HIV/AIDS, TB, Malaria)
- GAVI (vaccines and immunisation)

These mechanisms focus on targeted disease control and prevention.

---

4 Emergency Financial Assistance
During crises such as COVID-19:

- Rapid financing supported procurement of PPE, oxygen, and vaccines
- Emergency funds strengthened surveillance and response capacity

Emergency assistance improves health system resilience.

6 Channels of Assistance Flow to India

International assistance reaches India through:

- Central Government ministries
- State governments
- National health missions
- Autonomous institutions
- Public–private partnerships

This multi-channel approach ensures scalability and reach.

7 Impact of Technical and Financial Assistance on India's Health System

1 Infrastructure Development

- Expansion of hospitals and laboratories
- Improved cold-chain and logistics

2 Health Workforce Strengthening

- Training and capacity building
- Skill development

3 Program Effectiveness

- Improved immunisation coverage
- Better disease surveillance
- Enhanced maternal and child health outcomes

4 Policy and Governance Improvements

- Evidence-based policymaking
- Improved accountability and monitoring

8 Critical Assessment of International Assistance

Advantages

- Access to global expertise
- Additional financial resources
- Faster adoption of best practices

Limitations

- Dependence risks
- Conditionalities
- Alignment challenges with local priorities

India increasingly emphasizes country ownership and sustainability.

9.4. Influence of International Health Agencies on National Health Programs

Year	*Programme*	*Year*	*Programme*
1952	National Family Planning Programme	2002	National Programme for Control of Blindness
1955	National Leprosy Control Programme	2003	Cigarettes and Other Tobacco products Act (COPTA)
1955–1962	Filaria (later became part of NVBDCP)	2003–2004	National Vector Borne Disease control programme (NVBDCP)
1958	National Programme on Malaria (later became part of NVBDCP)	2004	Integrated Disease Surveillance Project
1962	National TB Control Programme	2005	National Rural Health Mission/ Programme
1962	National Iodine Deficiency Disorders Control Programme (rechristened in 1992)	2005	National Programme on Janani Suraksha Yojna
1962–1963	Mid-Day Meal Programme, earlier initiated in 1923, 1946 and 1956	2005	Japanese Encephalitis (a part of NVBDCP)
1972	National Nutritional Anaemia Prophylaxis Programme	2005, 2012	National Program for Palliative Care
1972–1973	National Rural Drinking Water Programme	2006	National Programme for Rehabilitation of Persons with Disabilities
1975	Integrated Child Development Scheme	2006–2007	National Programme for


Key Interventions for
Maternal Health
In India
pib
RESEARCH UNIT
1
Institutional Deliveries on the Rise
✓ 88.6% of all births now take place in health institutions (NFHS-5, 2019–21), including among tribal women – a major win under the National Health Mission.
2
Janani Suraksha Yojana (JSY)
✓ Conditional cash transfer scheme (since 2005) to boost institutional deliveries.
✓ 36.77 Lakh women benefited (April–Sept 2024).
3
Janani Shishu Suraksha Karyakaram (JSSK)
✓ Ensures completely free care for pregnant women and sick infants – covering delivery (including C-section), transport, diagnostics in public hospitals.
4
Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)
✓ Free, quality antenatal care on the 9th of every month since 2016.
✓ Over 6 crore women examined as of April 2025.
5
Extended PMSMA Strategy
✓ Focus on high-risk pregnancies with financial incentives for extra 3 visits + ASHA support till safe delivery.
6
SUMAN (2019)
✓ Assures zero-cost, respectful and quality care for all women and new borns in public health facilities.
✓ 41,519 facilities onboarded as of Dec 2024.
7
LaQshya (2017)
✓ Aims to improve labour room and maternity OT quality in public hospitals.
✓ 1,106 Labour Rooms and 809 Maternity OTs certified by Dec 2024.

4

1 Introduction

National Health Programs (NHPs) in India are not designed or implemented in isolation. Over several decades, international health agencies have significantly influenced the formulation, design, implementation, monitoring, and evaluation of these programs. Their influence operates through technical guidance, financial support, global norms, research evidence, and policy dialogue.

While the Government of India retains sovereign control over health policy, international agencies act as knowledge partners, financiers, and catalysts, ensuring that Indian health programs align with global best practices while addressing national priorities.

2 Pathways of Influence on National Health Programs

International health agencies influence national health programs through multiple interconnected pathways:

1. Policy framing and agenda setting
2. Program design and structuring
3. Implementation support and capacity building
4. Monitoring, evaluation, and accountability
5. Innovation and reform orientation

These pathways collectively shape both the content and execution of national health initiatives.

3 Influence on Health Policy Frameworks

1 Shaping National Health Policy Orientation

International agencies—particularly the World Health Organization—have influenced the philosophical foundations of India's health policies.

Key global principles promoted include:

- Primary healthcare as the foundation
- Universal health coverage (UHC)
- Equity and social justice
- Prevention and health promotion
- Health systems strengthening

These principles are reflected in India's National Health Policy frameworks, which emphasise:

- Strengthening public health systems
- Reducing out-of-pocket expenditure
- Improving access for vulnerable populations

Thus, international agencies shape the strategic direction of health programs even before program-level design begins.

4 Influence on Design of Major National Health Programs

1 National Immunization Programs

India's immunisation initiatives have been deeply influenced by global technical and operational standards.

Role of International Agencies

- UNICEF: cold-chain systems, vaccine logistics, community communication
- World Health Organization: vaccine safety, surveillance, monitoring protocols
- Global partners: financing and innovation support

Impact on Program Design

- Standardised immunisation schedules

- Robust surveillance for vaccine-preventable diseases
- High-quality cold-chain infrastructure

As a result, India successfully implemented large-scale immunisation campaigns, including eradication and elimination initiatives.

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2 Disease Control Programs (TB, HIV/AIDS, Malaria)

National disease control programs in India reflect international epidemiological models and guidelines.

Influence Mechanisms

- Global treatment protocols
- Surveillance and reporting standards
- Outcome-based program monitoring

Agency Contributions

- WHO: technical standards and monitoring
- UNDP: governance and capacity building
- Global financing mechanisms: targeted funding

These influences improved:

- Treatment success rates
- Surveillance accuracy
- Program accountability

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3 Maternal, Child, and Nutrition Programs

Programs addressing maternal and child health reflect strong international influence.

Key Areas of Influence

- Antenatal and postnatal care standards
- Nutrition supplementation strategies
- Behaviour change communication

Role of UNICEF

UNICEF has shaped:

- Program design for maternal and child nutrition
- Communication strategies for service uptake
- Monitoring frameworks for child survival indicators

These inputs improved service utilisation and outcome tracking.

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5 Influence on Program Implementation Mechanisms

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1 Strengthening Delivery Systems

International agencies influence how programs are delivered, not just what they aim to achieve.

Key contributions include:

- Logistics and supply chain design
- Human resource training models
- Digital tracking and reporting systems

For example, WHO and UNICEF inputs strengthened:

- Last-mile service delivery
- Program supervision mechanisms

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2 Capacity Building and Skill Development

International agencies invest heavily in:

- Training of health workers

- Program managers
- Policy planners

This has resulted in:

- Improved managerial capacity
- Better program execution
- Professionalisation of public health administration

Capacity building ensures sustainability beyond project cycles.

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6 Influence on Monitoring, Evaluation, and Accountability

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1 Evidence-Based Monitoring Frameworks

International agencies promote:

- Indicator-based monitoring
- Outcome and impact evaluation
- Data-driven decision-making

National programs increasingly rely on:

- Standardised indicators
- Independent evaluations
- Transparent reporting

This improves program effectiveness and credibility.

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2 Data Systems and Surveillance

Support for:

- Disease surveillance systems
- Health Management Information Systems
- Digital dashboards

has enabled:

- Real-time monitoring
- Early detection of gaps
- Evidence-based mid-course corrections

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7 Influence on Health Financing and Program Sustainability

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1 Financial Design of Programs

International agencies—especially the World Bank—influence:

- Cost-effective program design
- Resource allocation priorities
- Health financing reforms

This results in:

- More efficient use of public funds
- Focus on value for money
- Integration of economic evaluation in program planning

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2 Sustainability and Transition Planning

Agencies encourage:

- Gradual transition from donor dependence
- Increased domestic financing
- Institutionalisation of successful interventions

This ensures that national programs remain viable in the long term.

8 Influence During Public Health Emergencies

International agencies play a critical role during crises.

Examples of Influence

- Emergency guidelines and protocols
- Rapid financing and procurement support
- Risk communication strategies

During COVID-19:

- WHO guided surveillance and clinical management
- UNICEF supported logistics and communication
- Financial institutions supported emergency health spending

This reinforced the importance of international–national coordination.

9 Critical Evaluation of International Influence

Positive Contributions

- Access to global expertise
- Improved program quality
- Faster adoption of innovations
- Strengthened accountability

Limitations

- Risk of external agenda-setting
- Alignment challenges with local needs
- Administrative complexity

India increasingly follows a model of partnership rather than dependence.

10 Relevance to Healthcare Business Environment

For MBA (HA) students, understanding this influence is vital for:

- Health project planning
- Public–private partnerships
- Consulting and advisory roles
- Health program management
- International health collaborations

National health programs increasingly operate within a global health ecosystem, affecting financing, procurement, technology, and governance.

11 Overall Significance

International health agencies have:

- Shaped the design philosophy of national programs
- Improved implementation efficiency
- Strengthened monitoring and accountability
- Encouraged evidence-based policymaking
- Enhanced health system resilience

Their influence has transformed national health programs from isolated initiatives into integrated, globally informed interventions.

9.5 Summary:

International Health Agencies

International Health Agencies (IHAs) play a crucial role in the global health ecosystem by addressing health challenges that transcend national boundaries, such as pandemics, communicable diseases, malnutrition, environmental health risks, and health inequities. These agencies operate within the framework of global health governance, supporting countries through technical expertise, financial assistance, research, standard-setting, and coordination, while respecting national sovereignty. For a populous and diverse country like India, international health agencies have been strategic partners in strengthening health systems, shaping policies, and improving program outcomes.

The concept and role of international health agencies are rooted in the recognition that health is a global public good. Diseases and health risks do not respect borders, making international cooperation essential. International health agencies provide norms and standards, technical guidance, capacity building, and platforms for health diplomacy. Their roles include policy advisory support, standardisation of health practices, surveillance and data generation, emergency response, and coordination among countries. For India, these agencies have been instrumental in introducing global best practices, strengthening institutional capacity, and supporting large-scale health reforms.

Several major international health organizations are central to India's health sector engagement. The World Health Organization provides technical leadership, global norms, disease surveillance support, and policy guidance, influencing areas such as primary healthcare, universal health coverage, and epidemic preparedness. UNICEF focuses on maternal and child health, nutrition, immunisation, WASH, and behaviour change communication, playing a critical role in strengthening India's immunisation and child health programs. The World Bank supports the health sector through financial assistance, health system strengthening, policy advisory services, and large-scale infrastructure and reform projects. Other agencies such as UNDP, ILO, and global financing mechanisms complement these efforts by linking health with development, labour welfare, and targeted disease control.

Technical and financial assistance to India from international health agencies has significantly enhanced the capacity and performance of the health system. Technical assistance includes policy advice, development of clinical and public health guidelines, training and capacity building, surveillance systems, and digital health support. Financial assistance takes the form of grants, concessional loans, emergency funding, and project-based financing for infrastructure, equipment, medicines, and program implementation. Together, these forms of assistance have strengthened health infrastructure, improved workforce skills, enhanced disease surveillance, and supported emergency responses, while also promoting efficiency, accountability, and evidence-based decision-making.

International health agencies have also had a strong influence on national health programs in India. Their influence operates through policy framing, program design, implementation support, monitoring and evaluation, and financing strategies. Global principles such as primary healthcare, prevention, equity, and universal health coverage are reflected in India's national health policies and programs. Agencies have shaped immunisation programs, disease control initiatives, maternal and child health schemes, nutrition programs, and emergency health responses by providing technical standards, operational models, and monitoring frameworks.

They have also strengthened data systems, accountability mechanisms, and sustainability planning, ensuring that programs are both effective and resilient.
In conclusion, international health agencies function as knowledge partners, financiers, and catalysts in India's healthcare system. Their engagement has helped transform national health programs into globally informed, evidence-based, and system-oriented interventions. For MBA (HA) students, understanding the role and influence of international health agencies is essential to analysing the healthcare business environment, health policy, program management, financing, and international collaborations in an increasingly interconnected world.

9.6 Students Activity:

Activity 1: Agency–Role Identification
Task:
Select any one international health agency discussed in the lesson (e.g., WHO, UNICEF, or World Bank) and list:

- Two key functions
- One example of its support to India

Purpose:
To help learners understand the practical role of international health agencies in India's health system.

Activity 2: Program Influence Mapping
Task:
Choose one national health program (such as immunisation, disease control, or maternal health) and identify:

- One international health agency associated with it
- The type of assistance provided (technical or financial)

Purpose:
To enable learners to connect international agencies with real national health programs.

Activity 3: Short Policy Reflection
Task:
Write a brief note (5–6 sentences) on:
How international health agencies support India during public health emergencies.
Purpose:
To encourage learners to apply lesson concepts to real-world health policy and management situations.

9.7. Key Words with Explanation

- International Health Agency – An organization operating at global or regional level to promote health, prevent disease, and support countries.
- Global Health Governance – Collective international action to address transnational health challenges.
- Technical Assistance – Expert support such as guidelines, training, research, and advisory services.
- Financial Assistance – Grants, loans, or funding support for health programs and infrastructure.
- Health Diplomacy – Negotiation and collaboration among nations to improve global health outcomes.
- National Health Program – Government-led initiative to address specific health priorities.

9.8. Self-Assessment Questions

A. Short Questions (with Answers)

1. What is an international health agency?
   An international health agency is an organization that works across countries to improve health and prevent disease.
2. Name one major international health agency associated with the United Nations.
   World Health Organization (WHO).
3. What type of support do international agencies provide to India?
   Technical assistance, financial aid, and policy guidance.
4. Which agency focuses primarily on child and maternal health?
   UNICEF.
5. How do international agencies influence national health programs?
   Through funding, technical guidance, and policy recommendations.

B. Essay Questions (with Hints)

1. Explain the concept and role of international health agencies.
   Hints: Global health issues, coordination, expertise, disease control.
2. Discuss the functions of major international health organizations.
   Hints: WHO, UNICEF, World Bank, UN agencies.
3. Examine the technical and financial assistance provided to India by international agencies.
   Hints: COVID-19, immunization, health infrastructure.

4. Analyse the influence of international agencies on India's national health programs. *Hints: Policy design, implementation support.*
5. Evaluate the importance of international health agencies in a globalized world. *Hints: Pandemics, equity, global cooperation.*

C. Multiple Choice Questions (with Answers)

1. WHO is a specialized agency of:
   a) World Bank
   b) United Nations
   c) IMF
   d) WTO
   Answer: b) United Nations
2. UNICEF mainly focuses on:
   a) Trade and health
   b) Child and maternal health
   c) Industrial development
   d) Health insurance
   Answer: b) Child and maternal health
3. Which organization provides major health sector loans to India?
   a) WHO
   b) UNICEF
   c) World Bank
   d) ILO
   Answer: c) World Bank
4. Technical assistance includes:
   a) Only cash grants
   b) Policy advice and training
   c) Tax collection
   d) Military aid
   Answer: b) Policy advice and training
5. International health agencies mainly aim to:
   a) Maximize profits
   b) Control national governments
   c) Improve global health outcomes
   d) Promote private hospitals
   Answer: c) Improve global health outcomes

D. Comprehensive Case Study

Case: International Health Agencies and Strengthening India's Immunization Program

India's Universal Immunization Programme (UIP) faced challenges such as uneven coverage, cold-chain gaps, and vaccine hesitancy, especially in remote regions. To address these issues, the Government of India collaborated with international health agencies.

The World Health Organization provided technical expertise in disease surveillance and vaccine safety monitoring. UNICEF supported cold-chain logistics, training of health workers, and community awareness campaigns. The World Bank offered financial assistance for infrastructure strengthening and digital monitoring systems.

As a result:

- Immunization coverage improved significantly
- Surveillance and reporting systems strengthened
- Vaccine delivery became more efficient

Issues for Analysis:

- Role of international agencies in program design
- Types of assistance provided
- Impact on national health outcomes
- Advantages and limitations of external support

9.9. Standard Textbooks and Reference Materials

Textbooks (Purchasable by Students)

1. Park, K. – *Park's Textbook of Preventive and Social Medicine*
2. Basu, D. – *Health Policy, Planning and Management*
3. Goel, S. L. – *Health Care Administration in India*
4. Janovsky, K. – *Health Policy and Systems Development*
5. Merson, M. H. et al. – *Global Health: Diseases, Programs, Systems, and Policies*

Reports, Web Resources & Other References

- World Health Organization – www.who.int
- UNICEF – www.unicef.org
- World Bank – Health sector reports
- Ministry of Health and Family Welfare – National Health Program documents
- National Health Policy of India – Government of India


National Consultative Workshop on
"National Pandemic Preparedness Plan
for Respiratory Viruses"
8 – 9 December 2023 | New Delhi

LESSON 10: HEALTHCARE FINANCING AND COURSE:

OBJECTIVES

After studying this lesson, learners will be able to:

- Understand the concept of healthcare economics
- Identify major financial resources for healthcare services
- Distinguish between public and private financing of healthcare
- Analyse the nature and impact of out-of-pocket expenditure
- Evaluate healthcare financing issues in the Indian health system

STRUCTURE

1. Concept of Healthcare Economics
2. Financial Resources for Healthcare Services
3. Public Financing of Healthcare
4. Private Financing of Healthcare
5. Out-of-Pocket Expenditure in Healthcare

Introductory Case

Case Title: Why Do Indian Families Spend So Much from Their Own Pocket on Healthcare?

India is one of the fastest-growing healthcare markets in the world, yet a significant proportion of healthcare spending comes directly from households. According to estimates reported by the World Health Organization, nearly 45–50% of total health expenditure in India is borne by individuals as out-of-pocket expenditure (OOPE).

A middle-income family in a semi-urban district of Andhra Pradesh faced a sudden medical emergency when a family member required surgery. Although treatment was available in a private hospital, the cost exceeded ₹2.5 lakhs. With limited insurance coverage and long waiting times in public hospitals, the family relied on personal savings and borrowed money, pushing them into financial stress.

At the national level, studies supported by the World Bank indicate that millions of Indians fall below the poverty line each year due to healthcare expenses. This situation has drawn policy attention to the structure of healthcare financing, the balance between public and private spending, and the need to reduce catastrophic health expenditure.

This case highlights why understanding healthcare financing and financial resources is essential for healthcare administrators, policymakers, and managers operating in India's healthcare business environment.

10.1Concept of Healthcare Economics

Main Body

1 What is healthcare economics? (Short definition)
Healthcare economics is the application of economic principles to health and healthcare: it studies how scarce resources are allocated to produce, distribute and consume health goods and services; it examines efficiency, equity, financing, demand and supply, and the economic incentives that shape behaviour of patients, providers and payers.

2 Core questions addressed by healthcare economics

- What to produce? (Which services and public health interventions should the system prioritise?)
- How to produce? (Efficient organisation and use of inputs — workforce, drugs, equipment.)
- For whom to produce? (Distributional/equity choices — who gets access?)
- How to pay? (Financing, pooling, provider payment mechanisms.)

These four questions (often called the *WHO four questions* in economics of health) form the basis for policy design and managerial decisions.

3 Key concepts and tools (short primers)
Scarcity & Opportunity Cost — resources (money, staff, beds) are limited; spending on one service means less for another.
Demand & Supply in healthcare — demand is influenced by prices, insurance coverage, perceived need; supply by provider capacity and regulation.
Market failures in healthcare — information asymmetry (doctor knows more than patient); externalities (vaccination benefits others); public goods (disease surveillance). These failures justify public intervention and collective financing.
Costing & Cost-effectiveness — microeconomic evaluation tools: cost–benefit, cost–effectiveness, cost–utility analyses used to prioritise interventions (e.g., selecting vaccines or screening programs).
Risk pooling & insurance — spreading financial risk across a population to protect households from catastrophic spending.
Provider incentives & payment methods — fee-for-service, capitation, salaries, DRG/episode payments — each has implications for volume, quality and cost-control.

4 Why healthcare economics matters for MBA (HA) students

- Policy influence: Understanding economics helps interpret national budgets, program design, and reforms.
- Managerial decisions: Pricing, capacity planning, negotiations with payers, financial sustainability.
- Strategic planning: Evaluating investments (new specialty, diagnostics), public–private partnership (PPP) options, and risk management.
- Performance measurement: Using cost, utilisation and outcome metrics to improve value (health outcomes per rupee spent).

10.2. Financial Resources for Healthcare Services

Overview: Financing a health system involves three inter-linked functions: revenue raising, pooling of funds, and purchasing of services. Each function shapes incentives, access and financial protection.

1 Major sources of healthcare finance — an Indian perspective

India's Total Health Expenditure (THE) is financed from multiple sources: government (centre + states + local), households (out-of-pocket payments), private health insurance, employer financing, and external/donor funds. Recent National Health Accounts (NHA) show important trends:

- Total Health Expenditure (THE) and share of GDP: THE in 2020–21 was estimated at ≈ 3.73% of GDP (per NHA 2020–21). .
- Government share rising: Government Health Expenditure (GHE) share in THE rose from ~29% (2014–15) to ~48% in 2021–22; this indicates growing public financing. .
- Out-of-Pocket Expenditure (OOPE): OOPE's share has declined but remains substantial — NHA 2019–20 reported OOPE ≈ 47.1% of THE (and NHA 2020–21 / 2021–22 show downward trends toward ~39–40% as government share increased). OOPE in absolute terms was large (e.g., Rs. 3,08,727 crores in 2019–20). .
- Private health insurance: Still a small share of THE (~6–8% range in recent NHAs), indicating limited depth of risk pooling by insurance. .

(Caveat: THE and shares vary year-by-year; always consult the latest NHA release for up-to-date figures.)

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2 Detailed breakdown of financing channels

A. Public financing (tax-based + social insurance + earmarked funds)

Components

- Union (Central) Government budgets: funding for national programs (NHM/NHM variants, vertical programs), tertiary care institutes, and conditional grants to states. In the NHA 2020–21, Union share of Current Health Expenditure was explicitly quantified (e.g., Union Government CHE share Rs. 81,772 crores = 12.33% of CHE). .
- State Governments: largest chunk of public spending on health — states implement public facilities and pay staff (State share of CHE in 2020–21 was ~20.94% per NHA). .
- Local bodies: municipal and panchayat-level health activities, sanitation, and primary care financing.
- Government-financed insurance schemes (e.g., central schemes and large state schemes including Ayushman Bharat — PMJAY at national level, and various state health insurance schemes). These pool some risk and pay hospitals for inpatient care.

Finance instruments

- General taxation (income taxes, GST-derived transfers) — main progressive source.
- Earmarked taxes and cesses (occasionally used for health initiatives).
- Borrowing (for capital projects), and external loans/grants (e.g., World Bank financing for health system strengthening).

Implications

- Advantages: potential for equity, progressive financing, and macro-level redistribution.
- Challenges in India: fragmentation between centre and states, variable state capacities, bottlenecks in public service capacity, and limited per-capita public spending historically.

(Data note: Government share increase 2014–15 → 2021–22 and OOPE decline are documented by MoHFW NHA summaries.)

B. Private financing

Components

- Out-of-pocket payments (OOPE): direct payments at point of service for consultations, diagnostics, drugs and hospitalisation. Historically the dominant financing source. NHA 2019–20 reported OOPE ≈ 47% of THE; this share has been declining but remains large. .
- Private health insurance: growing but still limited—covers inpatient care to some extent; indemnity and cashless hospitalisation products. Private insurance spending was ~6–7% of THE per recent NHAs. .
- Employer-based financing: formal sector employers provide services/insurance to employees; small share relative to OOPE.
- Outfront philanthropy / charitable hospitals / CSR: grants and subsidised services in pockets.

Implications

- Private financing enables access to a large private provider network, but high OOPE causes catastrophic expenditure and impoverishment risks for households (policy concern). It also fragments purchasing and weakens bargaining power of payers.

C. External / donor financing

Components

- Grants and concessional loans from bilateral donors, multilateral lenders (World Bank, Global Fund, GAVI), and UN agencies (WHO, UNICEF) for targeted programs (e.g., polio eradication historically, TB, HIV, COVID response).
- External flows are a small share of THE but strategically important for targeted programs and technical support.

Implications

- Useful for targeted scale-up and innovation; sustainability requires domestic financing transition planning.

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3 Pooling and risk-sharing arrangements

Pooling means collecting prepaid funds to spread risk across individuals. Key Indian pooling mechanisms:

- Tax-based pooling: government budgets pool tax revenue and finance public services (universal/public goods).
- Social/Statutory insurance: relatively limited; some schemes cover formal sector workers (ESI) and specific populations.
- Publicly financed-insurance schemes: e.g., Ayushman Bharat—Pradhan Mantri Jan Arogya Yojana (PMJAY) pools central funds to pay for secondary/tertiary hospitalization for identified poor families (example of purchaser-style pooling).
- Private insurance pools: private insurers pool premiums from clients, but penetration is low relative to population.

Key managerial points

- Well-designed pooling reduces OOPE and financial catastrophe.
- Fragmented pools (many small schemes) reduce cross-subsidisation and bargaining power; consolidating purchasers can improve efficiency.

(Note: Specific program names such as PMJAY are widely known; see central program sources for scheme design.)

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4 Purchasing: how funds are used (provider payment mechanisms)

Purchasing is the process of paying providers for services. Major methods in India:

- Line-item budgets / input-based financing: public hospitals paid via budgets — limited incentives for efficiency. Common at primary and many secondary public facilities.
- Case-based payments / package payments (e.g., DRG-like, AB PMJAY packages): used in insurance schemes for hospitalisation—creates incentives to standardise prices but may encourage upcoding if not monitored.
- Fee-for-service: common in private providers — can increase volume and cost.
- Mixed payments and performance-based incentives: e.g., result-based financing in some projects.

Implications for providers

- Payment method influences behaviour: fee-for-service increases service volume; capitation encourages cost containment; case rates encourage efficiency but require strong quality oversight.

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5 Flow diagram (conceptual) — how financing reaches services

1. Revenue raising — taxes, premiums, premiums/grants/loans →
2. Pooling — consolidated government funds / insurance pools / private pools →
3. Purchasing — budgets, contracts, case rates →
4. Providers — public hospitals, private hospitals, clinics, pharmacies →
5. Service delivery & households — utilisation, OOP for uncovered items →
6. Feedback/Monitoring — M&E, audits, performance reporting (informs future allocation)

(Managers should map local flows in their hospitals — e.g., how PMJAY payments reach facilities; what share of revenue is cash vs. prepayment.)

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6 Recent Indian trends and their implications (evidence-backed)

- Rising public share of THE (2014–15 → 2021–22): government share rising to ~48% of THE suggests stronger public financing and potential reductions in OOPE. This shift reflects policy emphasis (e.g., increased health budgets, scheme rollouts). . *Managerial implication:* greater public spending can mean more government patients, need to comply with public program billing/quality rules, and opportunities for public–private contracting.
- Declining OOPE but still high in absolute terms: OOPE declined from ~62.6% (2014–15) to ~39–47% in recent NHAs, but many households still face catastrophic payments. .

  Managerial implication: providers should design affordable outpatient packages, rational drug supply (free medicines lists), and negotiate government scheme tariffs.
- Limited penetration of private insurance: insurance remains a small share of THE (~6–8%); majority of population still uninsured or underinsured. . *Managerial implication:* market growth opportunity for insurers and hospitals; hospitals must build insurance billing capabilities and manage claim denials.
- Programmatic shift to primary care: increased share of primary healthcare in Current Government Health Expenditure (CGHE) suggests strategic emphasis on prevention and PHC. .

Managerial implication: hospital chains may need to invest in outreach, diagnostics, and tie-ups with primary care networks.

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7 Financing instruments and innovations (practical options)

- Sin taxes / earmarked levies (tobacco/alcohol taxes) — can raise resources for health.
- Health cess / social health funds — used in some contexts to finance specific programs.
- Public–Private Partnerships (PPPs) — build infrastructure (diagnostic centers, specialized hospitals) under long-term contracts.
- Performance-based financing / results-based grants — link funding to outcomes (useful in donor-funded projects).
- Digital payments & e-governance — reduce leakage and speed reimbursements (e.g., digital claim portals for PMJAY).

(Policy makers weigh revenue potential vs. political feasibility and equity.)

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8 Implications for healthcare businesses and managers (practical takeaways)

Revenue management

- Diversify revenue streams: combine government contracts, private pay/premium services, and insurance receipts.
- Build robust billing & claims systems to process government insurance (e.g., PMJAY) and private insurer claims quickly.

Cost control & efficiency

- Adopt clinical protocols and standard cost-of-care pathways to control variability.
- Use economies of scale (group purchasing) for drugs and consumables to lower unit costs.

Negotiations & contracting

- Strengthen negotiation capacity with payers; provide cost-data and outcomes to support tariffs.
- Consider risk-sharing contracts (e.g., bundled payments) with insurers/ governments carefully.

Quality & accreditation

- Improve quality metrics and accreditation (NABH/NQAS) to attract insurers and PPP contracts and to secure higher payment rates.

Strategic partnerships

- Partner with primary care networks and telemedicine providers to capture upstream patient flows.
- Engage with government programs (e.g., as empanelled facility under PMJAY) to access government-funded patient streams.

Financial planning

- Maintain liquidity to bridge delayed reimbursements from public payers; set aside cash reserves.
- Model payer mixes (OOPE vs insurance vs government) and stress-test scenarios (e.g., increase in government patients, lower private demand).

10.3. Public Financing of Healthcare

1 Concept of Public Financing

Public financing of healthcare refers to the mobilisation and allocation of financial resources by the government to fund health services for the population. These resources are raised primarily through general taxation, supplemented by cesses, duties, social insurance

contributions, and external assistance, and are used to finance public health programs, public healthcare facilities, and government-sponsored insurance schemes.
Public financing is considered the most equitable method of health financing, as it allows risk pooling, redistribution of resources, and protection of households from catastrophic medical expenses.

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2 Sources of Public Health Financing in India
Public financing in India flows through multiple governmental levels:

1. Central Government
    - Union Budget allocations to health
    - Centrally Sponsored Schemes (CSS)
    - Funding for national institutions and tertiary hospitals
    - Transfers to states through Finance Commission and scheme-based grants
2. State Governments
    - Largest contributors to public health expenditure
    - Responsible for running public hospitals, PHCs, CHCs, and district hospitals
    - Salaries of health workforce and operational costs
3. Local Governments
    - Urban Local Bodies and Panchayati Raj Institutions
    - Financing of sanitation, primary care, and preventive services
4. External Public Sources
    - Concessional loans and grants from international agencies such as the World Bank
    - Programmatic assistance through multilateral initiatives

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3 Trends in Public Health Financing in India
According to National Health Accounts (NHA) estimates:

- Government Health Expenditure (GHE) as a share of Total Health Expenditure (THE) increased from around 29% in 2014–15 to nearly 48% in 2021–22
- Government Health Expenditure as a percentage of GDP rose steadily, reflecting increased policy focus on health
- Share of primary healthcare in Current Government Health Expenditure also increased, signalling a shift towards preventive and promotive care

These trends indicate a gradual strengthening of public financing, though India's public health spending remains lower than many middle-income countries.

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4 Uses of Public Health Funds
Public funds are utilised for:

- Operation and maintenance of public healthcare facilities
- National health programs (maternal health, immunisation, disease control)
- Public health infrastructure development
- Medical education and research institutions
- Government-sponsored health insurance schemes
- Free or subsidised medicines and diagnostics

Public financing also supports population-wide public goods such as disease surveillance, epidemic control, and health promotion.

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5 Advantages of Public Financing

- Equity: Enables redistribution from rich to poor and healthy to sick

- Financial protection: Reduces dependence on out-of-pocket payments
- Universal access: Promotes healthcare as a social right
- Public health orientation: Supports preventive and promotive services
- System stability: Provides predictable funding for essential services

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6 Limitations and Challenges

Despite its importance, public financing in India faces several challenges:

- Overall level of public spending remains modest relative to needs
- Inter-state disparities in fiscal capacity and health outcomes
- Inefficiencies in fund utilisation and delays in disbursement
- Infrastructure and human resource constraints in public facilities

These challenges necessitate better governance, efficiency, and accountability in public health spending.

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7 Public Financing and Healthcare Business Environment

For healthcare managers:

- Public financing creates large patient volumes but lower margins
- Compliance with government pricing and quality norms is essential
- Opportunities exist in public–private partnerships, outsourcing, and empanelment under government schemes
- Strategic alignment with public programs can ensure volume stability and social legitimacy

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10.4. Private Financing of Healthcare

1 Concept of Private Financing

Private financing of healthcare refers to non-governmental sources of funds used to pay for health services. These include household spending, private health insurance, employer-based financing, and charitable contributions.

In India, private financing has historically played a dominant role, particularly due to the extensive presence of private healthcare providers.

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2 Components of Private Healthcare Financing

2.1 Household Expenditure

- Direct payments made by individuals for consultations, diagnostics, medicines, and hospitalisation
- Includes both insured and uninsured payments

2.2 Private Health Insurance

- Indemnity-based and managed care products
- Covers mainly inpatient care
- Penetration remains limited, especially in rural and informal sectors

2.3 Employer-Based Financing

- Health benefits provided by employers to employees
- Concentrated in organised sector

2.4 Charitable and Voluntary Contributions

- Trust hospitals, NGOs, CSR funding
- Important but limited in scale

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3 Role of Private Sector in Healthcare Delivery
Private financing supports:

- Over 60% of hospitalisations in India
- Majority of outpatient care
- Advanced diagnostics and specialty services

The private sector fills gaps where public capacity is limited, but often at higher cost.

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4 Advantages of Private Financing

- Expands service availability and choice
- Encourages innovation and investment
- Reduces fiscal burden on government
- Improves responsiveness and perceived quality

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5 Limitations of Private Financing

- Leads to inequitable access based on ability to pay
- Increases out-of-pocket expenditure
- Fragmented risk pooling
- Cost escalation and supplier-induced demand

These limitations highlight the need for regulation and strategic purchasing.

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6 Private Financing and Healthcare Business Strategy
For healthcare organisations:

- Private financing offers higher margins but demand volatility
- Strong insurance management and pricing strategies are critical
- Reputation, quality, and patient experience influence demand
- Balancing private revenue with public empanelment reduces risk

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10.5. Out-of-Pocket Expenditure (OOPE)

1 Meaning and Definition
Out-of-pocket expenditure (OOPE) refers to direct payments made by households at the point of service utilisation, excluding any reimbursement from insurance or government schemes.
OOPE includes spending on:

- Consultation fees
- Medicines
- Diagnostics
- Hospital charges
- Informal payments

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2 Magnitude of OOPE in India
India has historically recorded one of the highest OOPE levels globally.
Key observations from National Health Accounts:

- OOPE constituted over 60% of THE in early 2000s
- Declined to around 47% in 2019–20
- Further reduction observed with rising public expenditure, though OOPE remains substantial in absolute terms

Medicines account for the largest share of OOPE, especially in outpatient care.

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3 Impact of High OOPE

High OOPE leads to:

- Catastrophic health expenditure
- Medical impoverishment of households
- Delayed or foregone treatment
- Increased inequality in health access

According to estimates referenced by the World Health Organization, millions of Indians face financial hardship annually due to healthcare expenses.

---

4 Factors Contributing to High OOPE

- Limited insurance coverage
- High dependence on private providers
- Inadequate public facility availability
- Cost of medicines and diagnostics
- Chronic disease burden

---

5 Policy Measures to Reduce OOPE

Strategies adopted in India include:

- Expansion of public financing
- Free medicines and diagnostics initiatives
- Government-sponsored insurance schemes
- Strengthening primary healthcare
- Price regulation of drugs and medical devices

These measures aim to enhance financial protection.

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6 OOPE and Healthcare Management Implications

For healthcare managers:

- Transparent pricing improves trust and utilisation
- Bundled packages reduce patient uncertainty
- Participation in insurance and government schemes lowers patient financial risk
- Ethical billing practices enhance institutional credibility

---

10.6. Integrative Perspective

India's healthcare financing system is mixed in nature, combining:

- Public financing for equity and public health
- Private financing for capacity and innovation
- OOPE as a residual but problematic component

The challenge lies in rebalancing the mix towards greater public financing and effective pooling, while leveraging private sector efficiency under appropriate regulation.

10.7 Summary

Healthcare Financing and Financial Resources

Healthcare financing is a central pillar of the healthcare business environment, as it determines how resources are mobilised, pooled, and used to deliver health services while ensuring efficiency, equity, and financial protection. Healthcare economics provides the analytical framework for understanding these processes by applying economic principles—such as scarcity, opportunity cost, demand and supply, and efficiency—to health systems. It addresses

key questions of *what services to provide, how to provide them, for whom, and how to pay*, and highlights market failures in healthcare that justify public intervention and collective financing. India's healthcare system is financed through a mixed model involving public financing, private financing, and household out-of-pocket expenditure (OOPE). Financial resources for healthcare services are raised from government budgets (central, state, and local), households, private health insurance, employers, and limited external assistance. Financing operates through three core functions: revenue raising (taxes, premiums, contributions), pooling (spreading financial risk across populations), and purchasing (paying providers through budgets, case-based payments, or fees). Recent National Health Accounts show a positive trend of rising government share in total health expenditure and a gradual decline in OOPE, although private spending remains significant.

Public financing of healthcare refers to government mobilisation and allocation of funds for health services and public health programs. In India, state governments account for the largest share of public health spending, while the central government supports national programs, tertiary institutions, and transfers to states. Public financing promotes equity, universal access, and financial protection, and supports public goods such as disease surveillance, prevention, and health promotion. However, challenges remain in terms of adequacy of spending, inter-state disparities, and efficiency of fund utilisation. From a healthcare management perspective, public financing creates opportunities for large patient volumes, public–private partnerships, and scheme-based empanelment, albeit with tighter pricing and compliance requirements.

Private financing of healthcare includes household spending, private health insurance, employer-based benefits, and charitable contributions. The private sector plays a dominant role in service delivery, especially in outpatient care and hospitalisation, offering greater choice, responsiveness, and innovation. At the same time, private financing can increase inequality and cost escalation due to limited risk pooling and high dependence on direct payments. For healthcare organisations, private financing offers higher margins but also demand volatility, making insurance management, pricing strategies, and quality differentiation critical.

Out-of-pocket expenditure (OOPE) refers to direct payments made by households at the point of care. Although OOPE as a share of total health expenditure has declined in recent years, it remains substantial in absolute terms and is a major cause of catastrophic health expenditure and medical impoverishment, particularly due to medicine and diagnostic costs. Reducing OOPE is a key policy objective, pursued through increased public spending, free medicines and diagnostics, insurance expansion, and strengthening of primary healthcare. For healthcare managers, transparent pricing, ethical billing, and participation in pooled financing mechanisms are essential to reduce patient financial risk and build trust.

In summary, India's healthcare financing system reflects a dynamic balance between public responsibility, private participation, and household contribution. For MBA (HA) learners, understanding this balance is crucial for analysing health markets, designing sustainable healthcare organisations, managing payer mix, and contributing to policy and strategic decisions that improve both financial sustainability and health outcomes.

10.8 Students Activity:

Activity 1: Identify Financing Sources
Task:
List the different sources of healthcare financing for a nearby hospital (public or private). Classify them as:

- Public financing
- Private financing
- Out-of-pocket payments

Purpose:
To help learners understand the real-world mix of healthcare financing at the provider level.

Activity 2: Patient Cost Analysis
Task:
Select any common medical service (e.g., normal delivery, appendectomy, diabetes treatment) and note:

- Cost in a public hospital
- Cost in a private hospital
- Portion paid out-of-pocket by the patient

Purpose:
To develop awareness of cost differences and financial burden on patients.

Activity 3: Financing Impact Reflection
Task:
Write a short note (5–6 sentences) on:
How increased public financing can reduce out-of-pocket expenditure in healthcare.
Purpose:
To encourage learners to apply lesson concepts to health policy and management decision-making.

10.9 Key Words with Explanation

- Healthcare Economics – Study of allocation, efficiency, and utilisation of resources in healthcare.
- Health Financing – Methods of raising, pooling, and allocating funds for healthcare services.
- Public Financing – Healthcare funding provided by government through taxes and budgets.
- Private Financing – Healthcare funding from individuals, private insurance, and employers.
- Out-of-Pocket Expenditure (OOPE) – Direct payments made by households for healthcare services.
- Catastrophic Health Expenditure – Health spending that severely affects household financial stability.

10.10. Self-Assessment Questions

A. Short Questions (with Answers)

1. What is healthcare economics?
   It is the study of how healthcare resources are allocated and utilised efficiently.
2. Name two sources of healthcare financing.
   Public financing and private financing.
3. What is public financing of healthcare?
   Healthcare expenditure funded by government budgets and taxes.
4. What is private financing of healthcare?
   Healthcare expenditure funded by individuals, private insurance, and employers.
5. Define out-of-pocket expenditure.
   Direct payments made by households at the point of receiving healthcare.

B. Essay Questions (with Hints)

1. Explain the concept of healthcare economics.
   Hints: Scarcity, efficiency, allocation, demand and supply.
2. Discuss various financial resources for healthcare services.
   Hints: Government budgets, insurance, private spending.
3. Examine the role of public financing in healthcare delivery.
   Hints: Equity, access, public hospitals.
4. Analyse private financing of healthcare in India.
   Hints: Private hospitals, insurance, employer contribution.
5. Evaluate the impact of out-of-pocket expenditure on households.
   Hints: Poverty, catastrophic expenditure, access issues.

C. Multiple Choice Questions (with Answers)

1. Healthcare economics mainly deals with:
   a) Profit maximisation

b) Allocation of health resources
c) Medical ethics
d) Hospital architecture
Answer: b) Allocation of health resources

2. Public financing of healthcare is mainly through:
   a) User fees
   b) Donations
   c) Government budgets
   d) Employer payments
   Answer: c) Government budgets
3. Which of the following is a form of private healthcare financing?
   a) Tax revenue
   b) Government grants
   c) Private health insurance
   d) Municipal funding
   Answer: c) Private health insurance
4. Out-of-pocket expenditure refers to:
   a) Insurance premium
   b) Direct household payments
   c) Government subsidy
   d) Employer contribution
   Answer: b) Direct household payments
5. High OOPE often leads to:
   a) Improved equity
   b) Reduced health risk
   c) Financial hardship
   d) Increased government revenue
   Answer: c) Financial hardship

D. Comprehensive Case Study

Case: Healthcare Financing Choices and Household Financial Risk

A district-level survey revealed that a majority of patients preferred private hospitals due to better perceived quality and shorter waiting times. However, public hospitals were underutilised despite offering subsidised services. Data showed that nearly 60% of healthcare spending in the district came from out-of-pocket payments.

Households with chronic illness patients reported selling assets or borrowing money to finance treatment. While some families had private insurance, coverage limits and exclusions reduced its effectiveness. Government-sponsored schemes helped a section of low-income families but did not fully cover outpatient and medicine costs.

10.11 Analytical Questions and Plausible Answers

1. Why do households rely heavily on out-of-pocket payments?
   Answer: Limited insurance coverage, preference for private care, and gaps in public services.

2. How does public financing help reduce financial risk?
   Answer: By providing subsidised or free services and expanding access to public facilities.
3. What role does private financing play in healthcare delivery?
   Answer: It expands service availability but may increase inequality.
4. How can insurance reduce catastrophic health expenditure?
   Answer: By pooling risk and covering major treatment costs.
5. What lessons can policymakers draw from this case?
   Answer: Need to strengthen public financing, insurance coverage, and cost control.

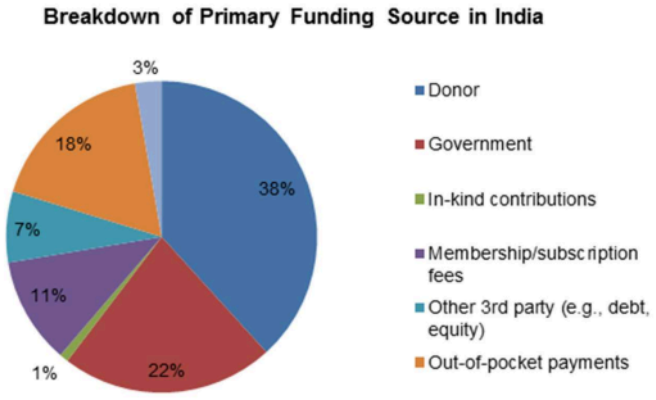
10.12. Standard Textbooks and Reference Materials

Textbooks (Purchasable by Students)

1. Park, K. – *Park's Textbook of Preventive and Social Medicine*
2. Folland, S., Goodman, A., & Stano, M. – *The Economics of Health and Health Care*
3. Basu, D. – *Health Policy, Planning and Management*
4. Goel, S. L. – *Health Care Administration in India*
5. McPake, B., et al. – *Health Economics: An International Perspective*

Reports, Web Resources & Other References

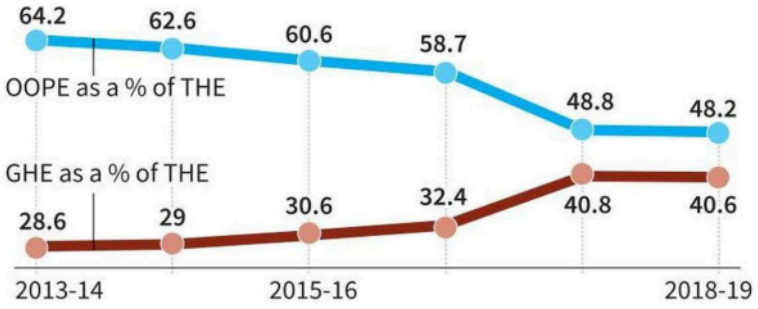
- World Health Organization – Global Health Expenditure Database
- World Bank – Health financing reports
- Ministry of Health and Family Welfare – National Health Accounts
- National Health Policy – Government of India
- NITI Aayog – Health sector financing reports



Health Care Provision	Health Care Provided Through	Health Care Beneficiaries	Health Care Financing
A. GOVERNMENT AGENCIES			
1. Government Administration			
Central, State, Union Territory and Local Governments	1. Public hospitals 2. DHCs, CHCs, PHCs SCs, etc.	All people (Rationing by queue); but mostly poor and weaker sections	Tax and non-tax receipts, capital receipts deficit financing, foreign aid, gifts, and fees for services rendered
Public Enterprises and Autonomous Institutions (Fully or Partially Funded by Government	1. Hospitals owned by them 2. Reimbursement for treatment obtained in private hospitals	Restricted to their employees	Profits, grants from governments, gifts, fees for services rendered
2. Social Insurance			
CGHS	CGHS clinics, government hospitals and some private hospitals	Restricted mainly to Central government employees and others	Employees' contribution and Central government revenues
ESIS	ESIS hospitals and dispensaries	Restricted to workers registered with ESIC, drawing below Rs. 6,000 per month	Employee, employer and government contributions
B. Non-Government Agencies			
1. Private hospitals	Owned hospitals by individuals/groups of individuals	Open to all	Fees for the services (Households)
2. Private dispensaries	Owned hospitals by individuals/groups of individuals	Open to all	Fees for the services (Households)
3. Physician consultants	Owned consultancy clinics and private hospitals	Open to all	Fees for the services (Households)
4. Charitable hospitals/ research labs	Hospitals owned by individuals/ trusts/ philanthropists	Open to all	Contributions from philanthropists / fees the services on no profit basis (Households)
5. Private corporations (Joint Stock Companies)	Hospitals owned by them and reimbursements	Restricted to their employees	Profits, tax concessions, grants from government, and fees

Health spending

The chart shows government health expenditure (GHE) and out-of-pocket expenditure (OOPE) as a share of total health expenditure (THE). OOPE still remains high



LESSON 11: HEALTH INSURANCE AND ROLE OF AGENCIES

OBJECTIVES

After studying this lesson, learners will be able to:

- Understand the concept and importance of health insurance
- Identify different types of health insurance in India
- Explain the role of government health agencies in insurance delivery
- Describe the role of voluntary health agencies in healthcare financing
- Analyse public–private partnerships (PPPs) in healthcare and insurance

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STRUCTURE

1. Concept and Importance of Health Insurance
2. Types of Health Insurance in India
3. Role of Government Health Agencies
4. Role of Voluntary Health Agencies
5. Public–Private Partnerships in Healthcare

Introductory Case (Real-World, Data-Based, Learner-Engaging)

Case Title: Health Insurance as Financial Protection for Indian Households

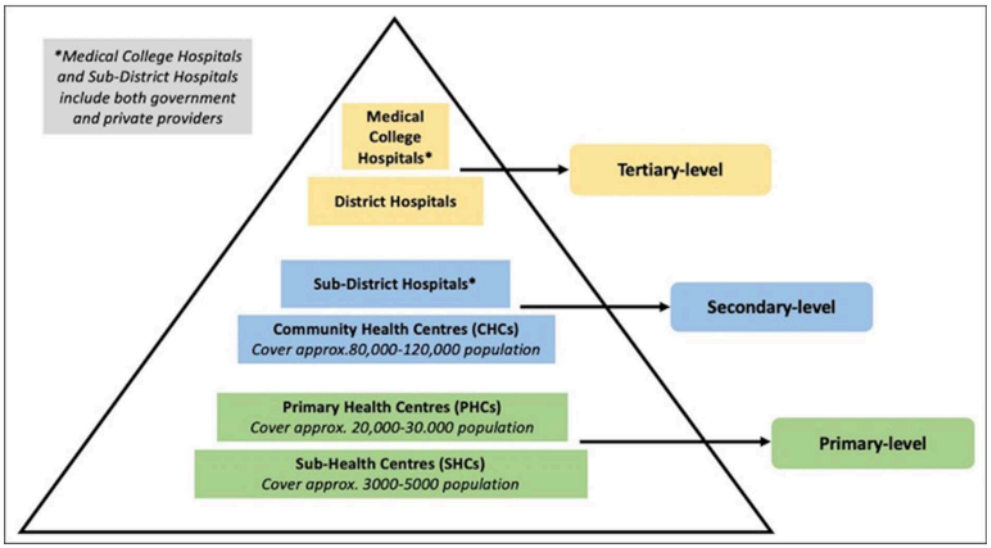
India's healthcare system is characterised by a high reliance on private healthcare services and significant out-of-pocket expenditure (OOPE). Despite improvements in public financing, many households continue to face catastrophic health expenditure when serious illness occurs.

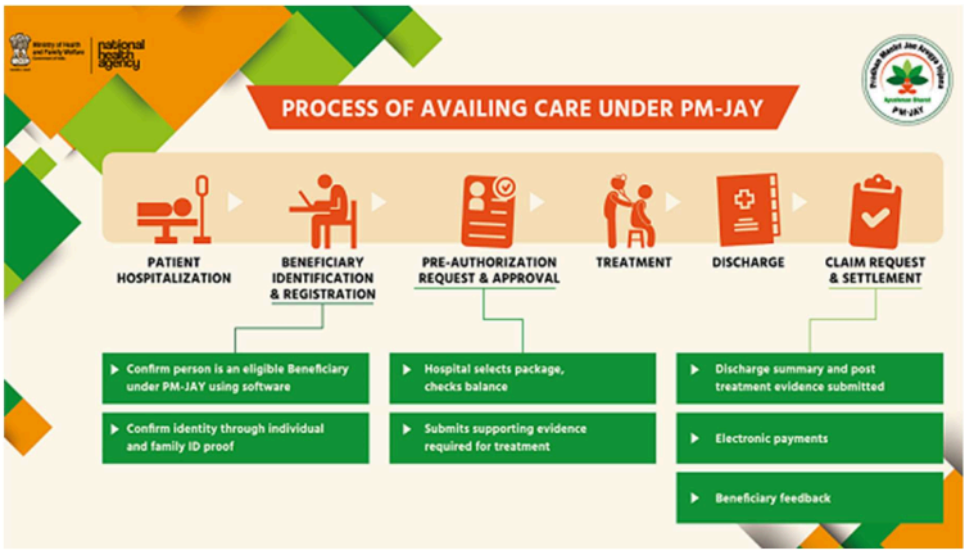
A daily-wage worker's family in Telangana required emergency cardiac treatment in a private hospital. The total cost exceeded ₹4 lakhs. Without insurance, the family would have faced severe financial distress. However, the patient was covered under Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana, which covered most of the hospitalisation expenses.

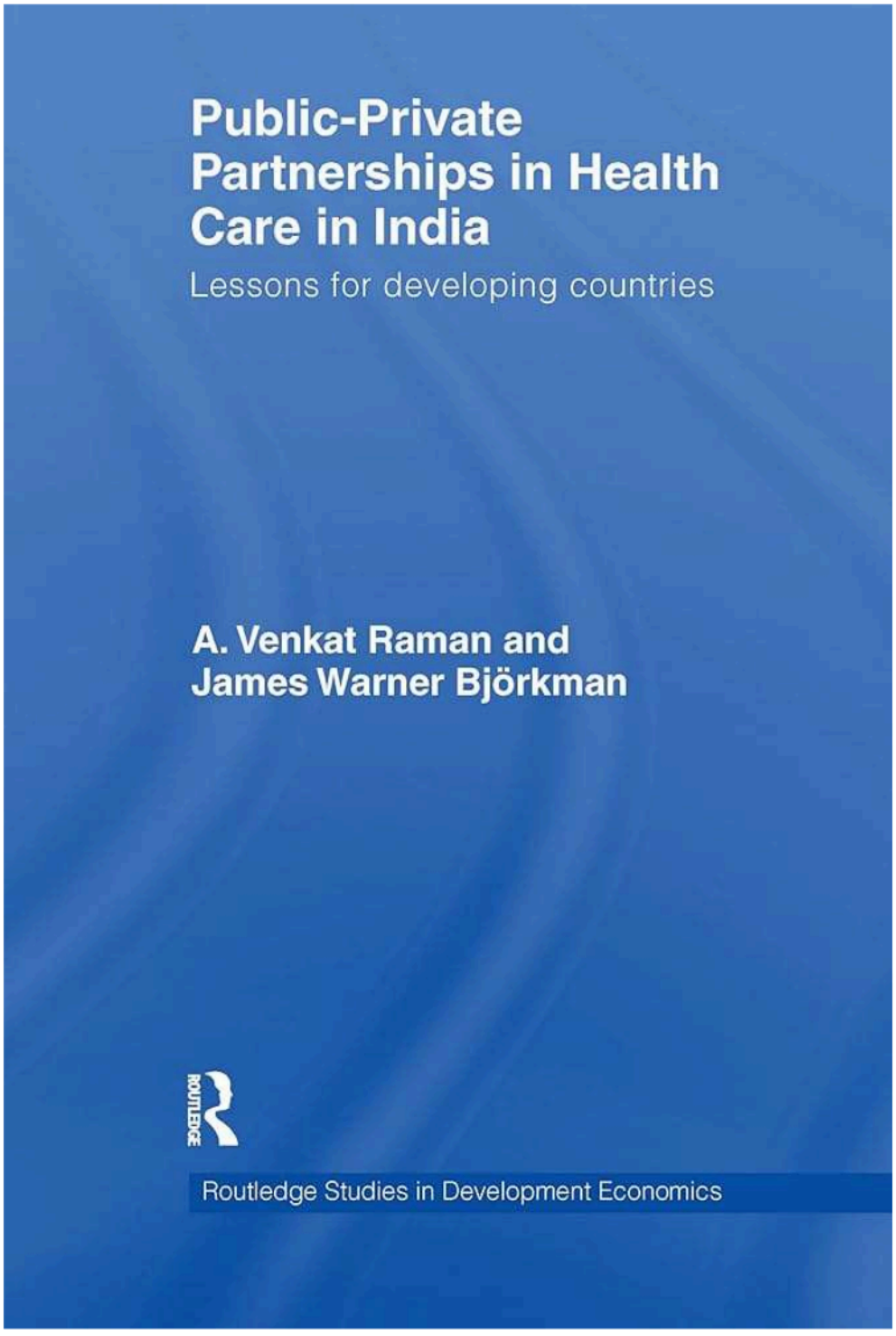
According to reports referenced by the World Health Organization, expansion of health insurance coverage is a key strategy to reduce OOPE and improve access to healthcare in low- and middle-income countries. In India, the growth of both government-sponsored and private health insurance has reshaped the healthcare business environment, influencing hospital revenues, service pricing, and public–private collaboration.

This case highlights the critical role of health insurance and supporting agencies in ensuring financial protection and system sustainability.

Main Body


*Medical College Hospitals and Sub-District Hospitals include both government and private providers
Medical College Hospitals*
District Hospitals
Tertiary-level
Sub-District Hospitals*
Community Health Centres (CHCs)
Cover approx.80,000-120,000 population
Secondary-level
Primary Health Centres (PHCs)
Cover approx. 20,000-30.000 population
Sub-Health Centres (SHCs)
Cover approx. 3000-5000 population
Primary-level


PROCESS OF AVAILING CARE UNDER PM-JAY
PATIENT HOSPITALIZATION
BENEFICIARY IDENTIFICATION & REGISTRATION
PRE-AUTHORIZATION REQUEST & APPROVAL
TREATMENT
DISCHARGE
CLAIM REQUEST & SETTLEMENT
Confirm person is an eligible Beneficiary under PM-JAY using software
Confirm identity through individual and family ID proof
Hospital selects package, checks balance
Submits supporting evidence required for treatment
Discharge summary and post treatment evidence submitted
Electronic payments
Beneficiary feedback


Public-Private Partnerships in Health Care in India
Lessons for developing countries
A. Venkat Raman and James Warner Björkman
ROUTLEDGE
Routledge Studies in Development Economics

11.1. Concept and Importance of Health Insurance

1 Concept of Health Insurance

Health insurance is a financial risk-sharing mechanism through which individuals or households protect themselves against high and unpredictable healthcare costs. Under health insurance, a large number of people contribute premiums into a common pool, and the pooled resources are used to pay for healthcare services required by members who fall ill.

Health insurance is based on the principles of:

- Risk pooling
- Risk sharing
- Prepayment
- Financial protection

Unlike direct out-of-pocket payments, insurance spreads the financial burden across the insured population, thereby reducing individual hardship.

---

2 Importance of Health Insurance

Health insurance plays a crucial role in the healthcare system due to the following reasons:

2.1 Financial Protection

In India, where healthcare costs can be catastrophic for households, insurance reduces:

- Out-of-pocket expenditure
- Medical impoverishment
- Dependence on borrowing or asset sales

2.2 Improved Access to Healthcare

Insurance encourages:

- Timely utilisation of healthcare services
- Access to secondary and tertiary care
- Use of private healthcare facilities when public capacity is limited

2.3 Risk Pooling and Equity

By pooling risks:

- Healthy individuals subsidise the sick
- Higher-income groups subsidise lower-income groups (in public schemes)
- Equity in healthcare access is improved

2.4 System Efficiency

Insurance introduces:

- Standardised pricing and packages
- Accountability through empanelment
- Incentives for quality and efficiency

---

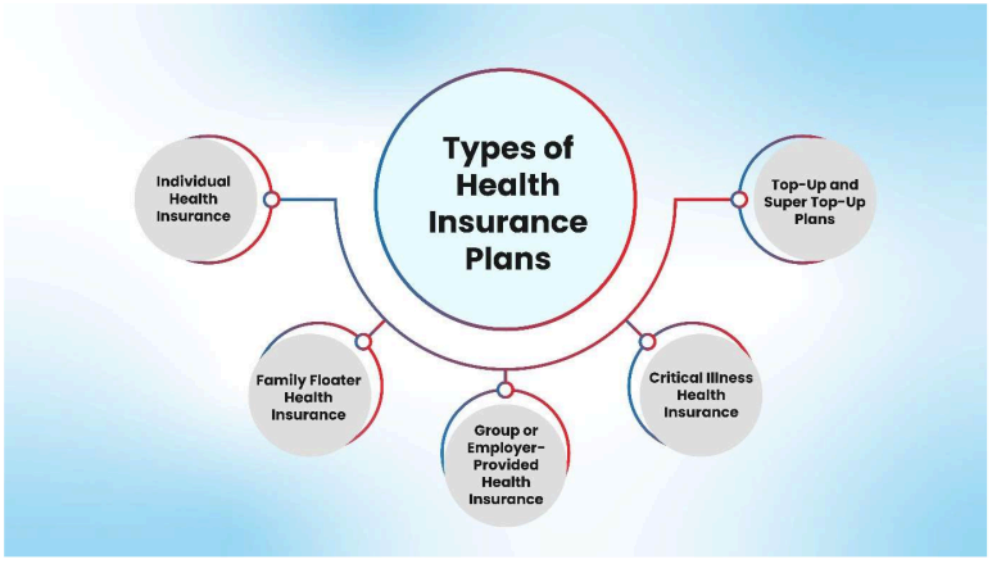
3 Relevance in the Indian Context

India historically relied on out-of-pocket expenditure as the dominant mode of health financing. The expansion of health insurance—both public and private—has been a strategic response to:

- High disease burden
- Rising healthcare costs
- Dominance of private healthcare providers

Health insurance has thus become a core pillar of India's healthcare financing architecture.

11.2. Types of Health Insurance in India



Health insurance in India can be broadly classified into public (government-sponsored) and private forms.

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1 Government-Sponsored Health Insurance Schemes

Government health insurance schemes aim to provide financial protection to vulnerable populations.

1.1 Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY)

The Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana is the largest publicly funded health insurance scheme in the world.

Key Features:

- Coverage up to ₹5 lakh per family per year
- Cashless and paperless hospitalisation
- Coverage for secondary and tertiary care
- Target population: poor and vulnerable households

Business Perspective:

- Large patient volumes for empanelled hospitals
- Lower margins but assured payments
- Strong influence on hospital pricing and billing systems

1.2 Employees' State Insurance Scheme (ESIS)

ESIS provides health insurance to:

- Workers in the organised sector
- Their dependents

It combines:

- Medical care
- Cash benefits during sickness and disability

1.3 State Government Health Insurance Schemes

Several states operate their own schemes (e.g., Aarogyasri, CMCHIS), often integrated with or aligned to PMJAY.

---

2 Private Health Insurance

Private health insurance is offered by:

- Public sector insurance companies
- Private insurance firms

Types of Private Insurance

- Individual health insurance
- Family floater plans
- Group insurance (employer-based)
- Senior citizen plans

Characteristics:

- Premium-based coverage
- Focus on hospitalisation
- Coverage limits and exclusions apply

Business Perspective:

- Higher reimbursement rates than public schemes
- Increased administrative requirements
- Importance of claims management and negotiation

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3 Employer-Based Health Insurance

Employers provide health insurance as part of:

- Employee welfare
- Retention and motivation strategies

This form is significant in:

- Corporate hospitals
- Urban healthcare markets

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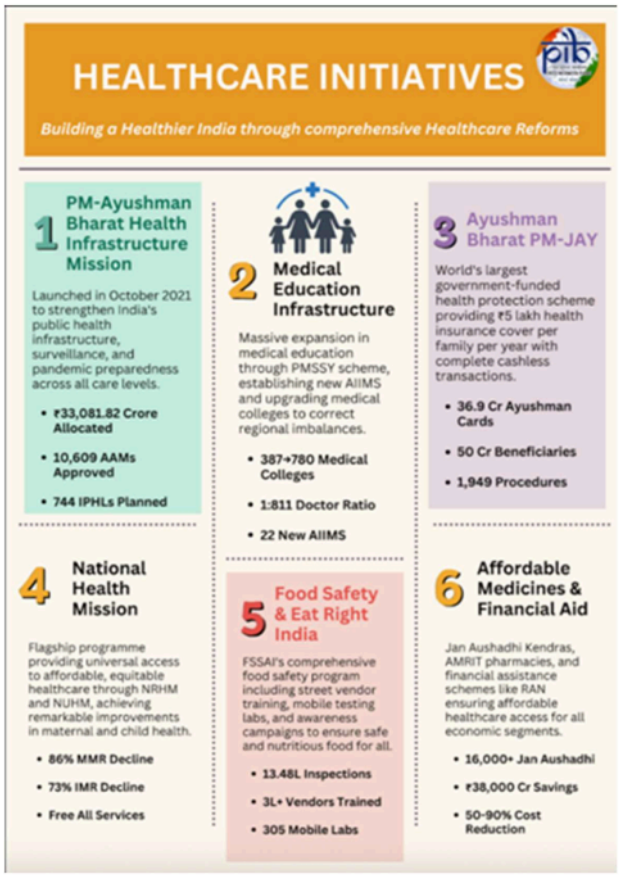
4 Community-Based and Micro-Insurance

Community-based insurance schemes:

- Operate at local or cooperative levels
- Target informal sector workers
- Have limited coverage but improve access

11.3. Role of Government Health Agencies



Government health agencies play a central role in policy, financing, regulation, and implementation of health insurance.

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1 Ministry of Health and Family Welfare (MoHFW)

The Ministry of Health and Family Welfare:

- Designs national health insurance policies
- Oversees implementation of PMJAY
- Coordinates with states and agencies

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2 NITI Aayog

The NITI Aayog:

- Provides policy guidance
- Evaluates insurance schemes
- Recommends reforms for universal health coverage

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3 State Health Agencies (SHAs)

At the state level:

- Implement and manage public insurance schemes
- Empanel hospitals
- Monitor claims and service quality

---

4 Insurance Regulatory and Development Authority of India (IRDAI)

IRDAI:

- Regulates private health insurance market
- Protects consumer interests
- Standardises insurance products

Business Perspective:

- Compliance with IRDAI norms is mandatory
- Influences product design and pricing

11.4. Role of Voluntary Health Agencies

VOLUNATARY ORGANIZATION:

- A voluntary organization is a non-governmental ,autonomous, non- profit making organization supported mainly by voluntary contributions in cash and kind from the general public or certain segments of the public, specialized to carry out a number of functions related to development, aid and emergency relief.

Vakilkaro

Understanding Insurance Requirements

for NGOs in India

1 Meaning of Voluntary Health Agencies

Voluntary health agencies are non-government, non-profit organisations involved in:

- Healthcare delivery
- Health financing support
- Community mobilisation

2 Functions of Voluntary Health Agencies

- Awareness creation about health insurance
- Assisting enrolment of beneficiaries
- Supporting access to healthcare services
- Advocacy for vulnerable populations

Examples include NGOs working in:

- Maternal and child health
- Tuberculosis and HIV programs
- Community insurance models

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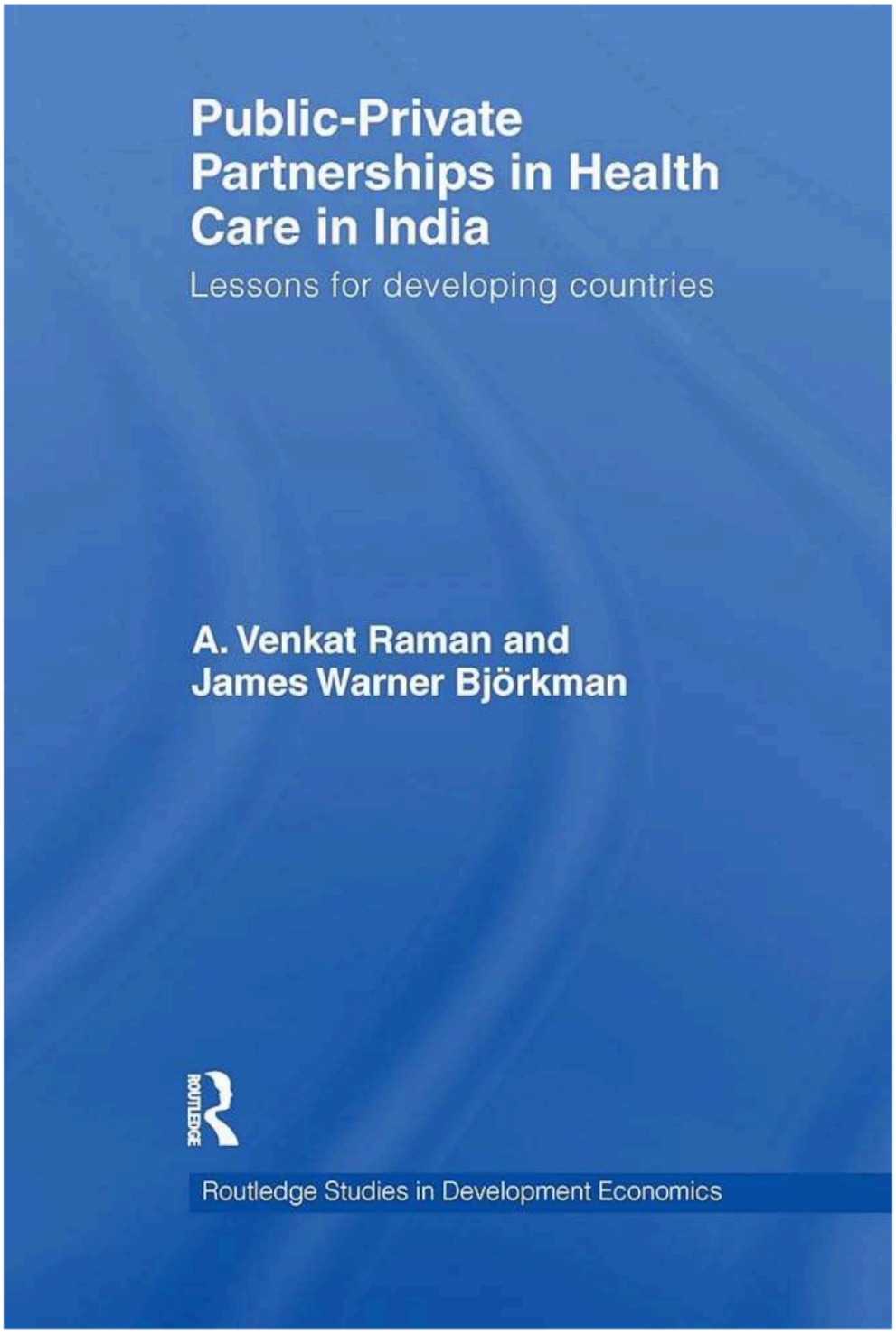
3 Importance in Healthcare Financing

Voluntary agencies:

- Bridge gaps between communities and formal systems
- Improve reach of government schemes
- Enhance social accountability

11.5. Public–Private Partnerships (PPPs) in Healthcare


Public-Private Partnerships in Health Care in India
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1 Concept of Public–Private Partnership

A Public–Private Partnership (PPP) is a collaborative arrangement where:

- Government provides financing, policy, or risk coverage
- Private sector delivers healthcare services

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2 PPPs in Health Insurance

In India:

- Government finances insurance schemes
- Private hospitals provide services
- Insurance companies or trust models manage claims

This model combines:

- Public financing
- Private sector efficiency

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3 Advantages of PPPs

- Expanded service availability
- Improved efficiency and quality

- Optimal utilisation of private infrastructure
- Reduced burden on public hospitals

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4 Challenges in PPPs

- Claim delays
- Cost control issues
- Quality monitoring
- Alignment of public and private objectives

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5 Business Implications of PPPs

For healthcare organisations:

- Stable patient inflow
- Need for compliance with package rates
- Investment in IT and claims processing
- Reputation and accreditation become critical

11.6. Integrative Perspective

Health insurance in India operates through:

- Government schemes for equity
- Private insurance for choice and capacity
- Voluntary agencies for outreach
- PPPs for system expansion

Together, these actors form a multi-agency health insurance ecosystem.

11.7. Relevance to Healthcare Business Environment

For MBA (HA) graduates:

- Health insurance shapes hospital revenue models
- Determines payer mix and pricing strategy
- Influences capacity planning and service offerings
- Requires strong coordination with agencies and regulators

11.8 Summary:

Health Insurance and Role of Agencies

Health insurance is a financial risk-sharing mechanism designed to protect individuals and households from high and unpredictable healthcare costs. It operates on the principles of risk pooling, prepayment, and financial protection, thereby reducing dependence on out-of-pocket expenditure and preventing medical impoverishment. In the Indian context—where private healthcare dominates service delivery and treatment costs can be catastrophic—health insurance has emerged as a core pillar of healthcare financing and the healthcare business environment.

The importance of health insurance lies in its ability to improve access, equity, and efficiency in healthcare delivery. Insurance coverage encourages timely utilisation of services, enables access to secondary and tertiary care, and introduces standardisation in pricing and service delivery. For the health system, insurance facilitates better resource allocation, accountability through empanelment, and a shift from direct payment to pooled financing.

India has a diverse health insurance landscape. Government-sponsored health insurance schemes aim to provide financial protection to poor and vulnerable populations. The flagship scheme, Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana, provides cashless hospitalisation cover for secondary and tertiary care and has significantly expanded insurance coverage. In addition, schemes such as Employees' State Insurance and various state-specific insurance programs cover organised sector workers and targeted population groups. Private health insurance, offered by public and private insurers, caters mainly to middle- and higher-income groups and employer-based coverage, providing greater choice but with premiums, exclusions, and limits. Community-based and micro-insurance schemes play a supplementary role, especially in the informal sector.

Government health agencies play a central role in the health insurance ecosystem. They are responsible for policy formulation, financing, regulation, and implementation of insurance schemes. Central and state health authorities design schemes, empanel hospitals, monitor service quality, and manage claims, while insurance regulators oversee private insurers to protect consumer interests. Through these functions, government agencies shape both access to healthcare and the operational environment for healthcare providers.

Voluntary health agencies, including non-government and non-profit organisations, complement government efforts by creating awareness, facilitating enrolment, supporting service access, and advocating for vulnerable groups. Their community presence helps bridge gaps between formal insurance systems and beneficiaries, improving utilisation and social accountability.

Public–Private Partnerships (PPPs) are a defining feature of health insurance delivery in India. Under PPP models, the government finances insurance coverage, while private hospitals deliver services and insurers or trusts manage claims. PPPs expand service capacity, leverage private sector efficiency, and reduce pressure on public facilities. However, challenges such as claim delays, cost control, and quality assurance require strong regulation and coordination.

In summary, health insurance in India functions through a multi-agency ecosystem involving government bodies, private insurers, voluntary organisations, and healthcare providers. For MBA (HA) learners, understanding this ecosystem is essential to analysing hospital revenue models, payer mix, pricing strategies, compliance requirements, and public–private collaboration in a rapidly evolving healthcare business environment.

11.9 Learner Activities (Aligned with UGC–DEB Guidelines)

Activity 1: Insurance Scheme Identification

Task:
Identify any one health insurance scheme (government or private) available in your state. Write a short note on:

- Target beneficiaries
- Type of coverage provided
- Role of government or private agencies

Learning Outcome:
Understanding different types of health insurance and agency roles.

Activity 2: Hospital Perspective Exercise

Task:
Visit or study a nearby hospital (public or private) and list:

- Health insurance schemes accepted
- Benefits of insurance for the hospital
- Challenges faced in claim settlement

Learning Outcome:
Linking health insurance with healthcare business operations.

Activity 3: PPP Reflection Note

Task:
Write a brief note (5–6 sentences) on:

How public–private partnerships in health insurance improve access to healthcare.

Learning Outcome:
Applying lesson concepts to real-world policy and management scenarios.

11.10 Key Words with Explanation

- Health Insurance – A financial arrangement that provides coverage for healthcare costs in exchange for a premium.
- Risk Pooling – Sharing health risks across a large population to reduce individual financial burden.
- Premium – Amount paid periodically to maintain insurance coverage.
- Claim Settlement – Process of reimbursement or cashless payment for covered healthcare services.
- Government Health Agency – Public body responsible for financing, regulating, or implementing health insurance schemes.
- Voluntary Health Agency – Non-government organisation supporting healthcare delivery and financing.
- Public–Private Partnership (PPP) – Collaborative arrangement between government and private sector for healthcare services.

11.11 Self-Assessment Questions

A. Short Questions (with Answers)

1. What is health insurance?
   It is a mechanism to protect individuals from high healthcare costs by pooling risk.
2. Why is health insurance important in India?
   It reduces out-of-pocket expenditure and improves access to healthcare.
3. Name one government-sponsored health insurance scheme in India.
   Ayushman Bharat – PMJAY.
4. What is the role of government health agencies in insurance?
   They finance, regulate, and implement public health insurance schemes.
5. What is a public–private partnership in healthcare?
   A collaboration between government and private sector to deliver health services.

B. Essay Questions (with Hints)

1. Explain the concept and importance of health insurance. *Hints: Risk pooling, financial protection, access.*
2. Discuss different types of health insurance available in India. *Hints: Government schemes, private insurance, employer-based.*
3. Examine the role of government health agencies in health insurance delivery. *Hints: Financing, regulation, implementation.*
4. Analyse the contribution of voluntary health agencies to healthcare financing. *Hints: NGOs, community support, outreach.*
5. Evaluate the role of public–private partnerships in healthcare. *Hints: Efficiency, access, shared responsibility.*

C. Multiple Choice Questions (with Answers)

1. Health insurance primarily aims to:
   a) Increase hospital profits
   b) Provide financial protection
   c) Replace public healthcare
   d) Promote medical tourism
   Answer: b) Provide financial protection
2. PMJAY is implemented under:
   a) National Health Mission
   b) Ayushman Bharat
   c) Employees' State Insurance
   d) National Insurance Scheme
   Answer: b) Ayushman Bharat
3. Which of the following is a private health insurance provider?
   a) MoHFW
   b) WHO
   c) National Insurance Company
   d) NITI Aayog
   Answer: c) National Insurance Company
4. Voluntary health agencies are mainly:
   a) Profit-oriented
   b) Government departments
   c) Non-government organisations
   d) Insurance regulators
   Answer: c) Non-government organisations
5. PPP in healthcare involves:
   a) Only government funding

b) Only private hospitals
c) Joint participation of public and private sectors
d) Foreign aid only
Answer: c) Joint participation of public and private sectors

D. Comprehensive Case Study

Case: Integrating Public and Private Players in Health Insurance Delivery

A state government implemented a publicly funded health insurance scheme to improve access to tertiary care. While financing and beneficiary identification were managed by the government, private hospitals were empanelled to deliver services. Voluntary organisations assisted in community awareness and enrolment.

Over time, utilisation of hospital services increased, and OOPE declined for insured households. However, challenges such as claim delays, hospital compliance, and awareness gaps remained.

11.12 Analytical Questions and Plausible Answers

1. Why did the government adopt a health insurance approach?
   To provide financial protection and expand access to healthcare.
2. What role did private hospitals play?
   They provided healthcare services under empanelment.
3. How did voluntary agencies support the scheme?
   By creating awareness and assisting beneficiaries.
4. What benefits did PPP bring to healthcare delivery?
   Expanded capacity, improved access, shared responsibility.
5. What improvements are needed for sustainability?
   Better regulation, timely payments, stronger monitoring.

11.13 . Standard Textbooks and Reference Materials

Textbooks (Purchasable by Students)

1. Park, K. – *Park's Textbook of Preventive and Social Medicine*
2. Basu, D. – *Health Policy, Planning and Management*
3. Goel, S. L. – *Health Care Administration in India*
4. Folland, S., Goodman, A., & Stano, M. – *The Economics of Health and Health Care*
5. McPake, B. et al. – *Health Economics: An International Perspective*

Reports, Web Resources & Other References

- World Health Organization – Health financing and insurance reports
- Ministry of Health and Family Welfare – Health insurance and Ayushman Bharat documents
- NITI Aayog – Health policy and PPP reports
- Insurance Regulatory and Development Authority of India (IRDAI) – Health insurance data

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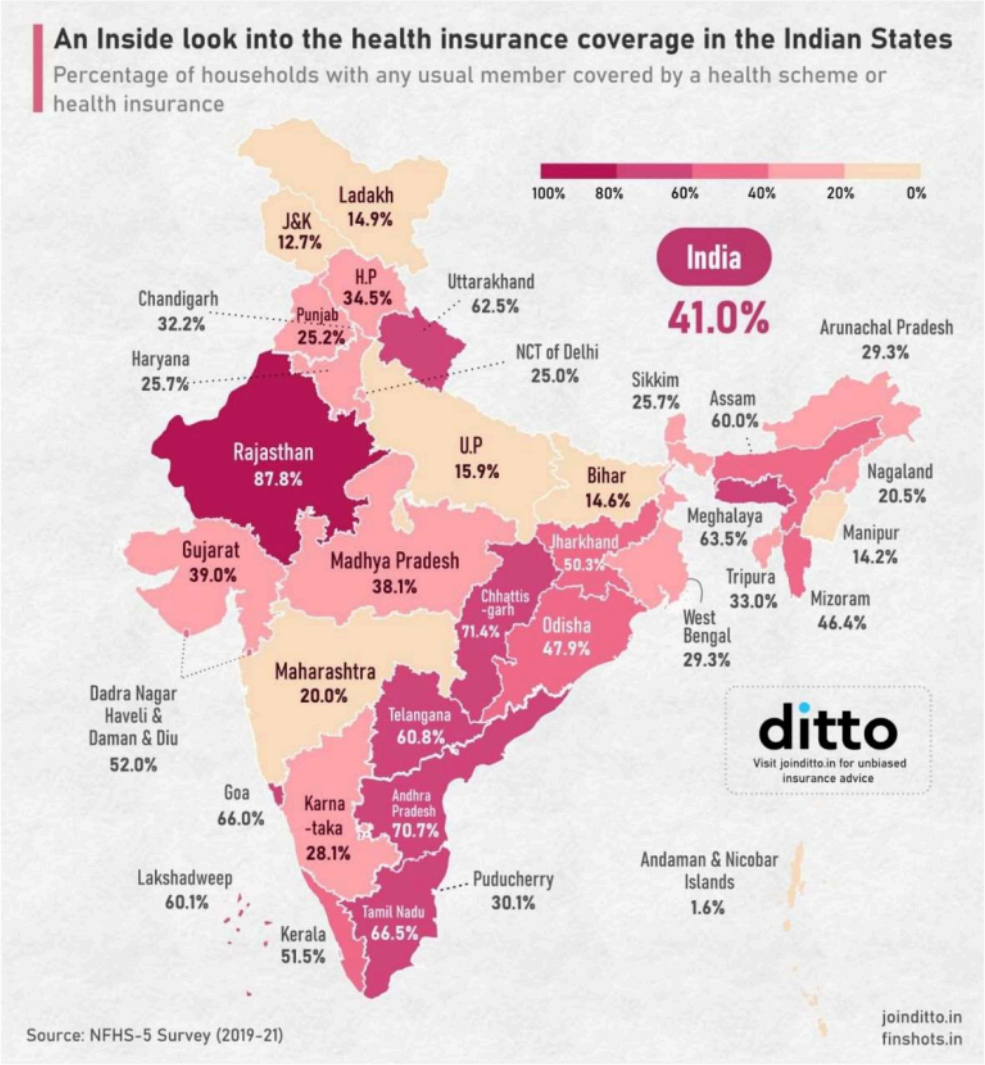
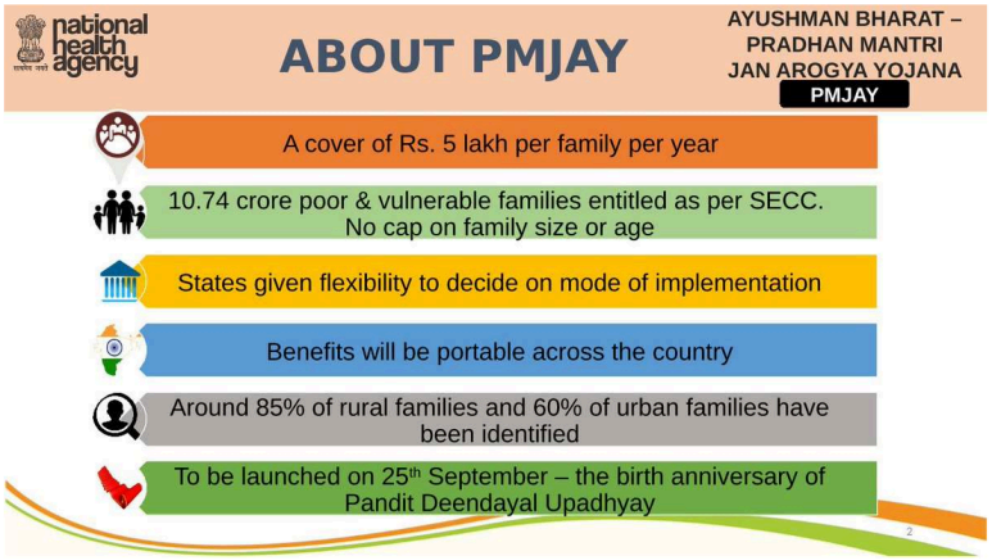
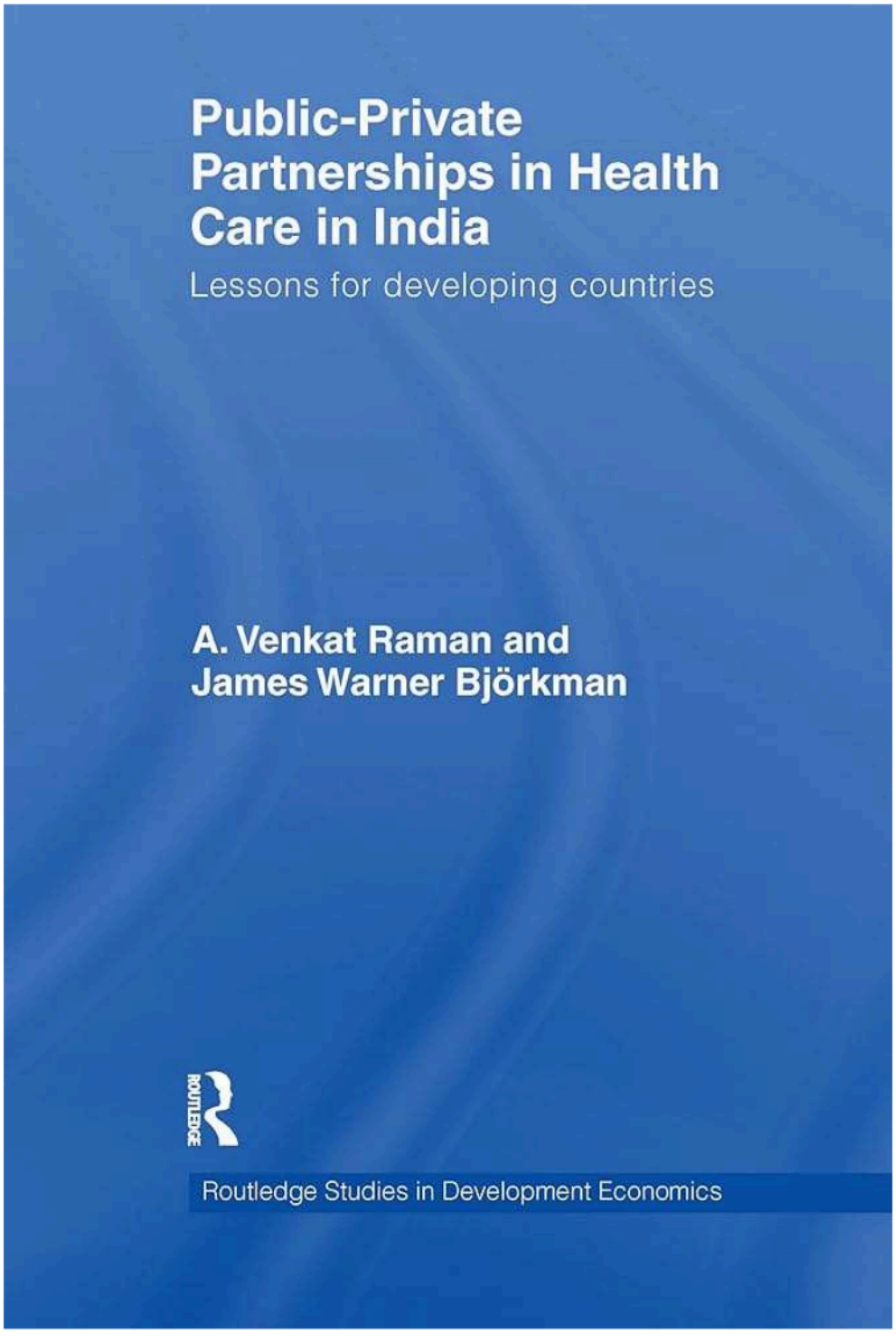
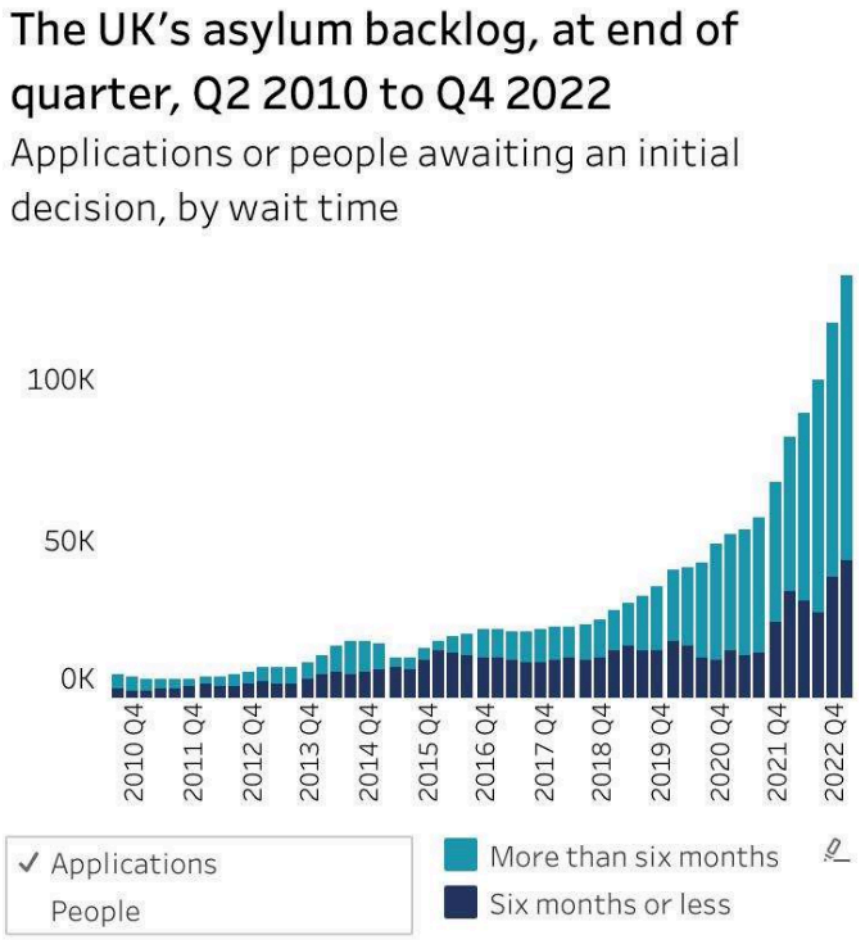



national health agency
ABOUT PMJAY
AYUSHMAN BHARAT – PRADHAN MANTRI JAN AROGYA YOJANA
PMJAY
A cover of Rs. 5 lakh per family per year
10.74 crore poor & vulnerable families entitled as per SECC. No cap on family size or age
States given flexibility to decide on mode of implementation
Benefits will be portable across the country
Around 85% of rural families and 60% of urban families have been identified
To be launched on 25th September – the birth anniversary of Pandit Deendayal Upadhyay

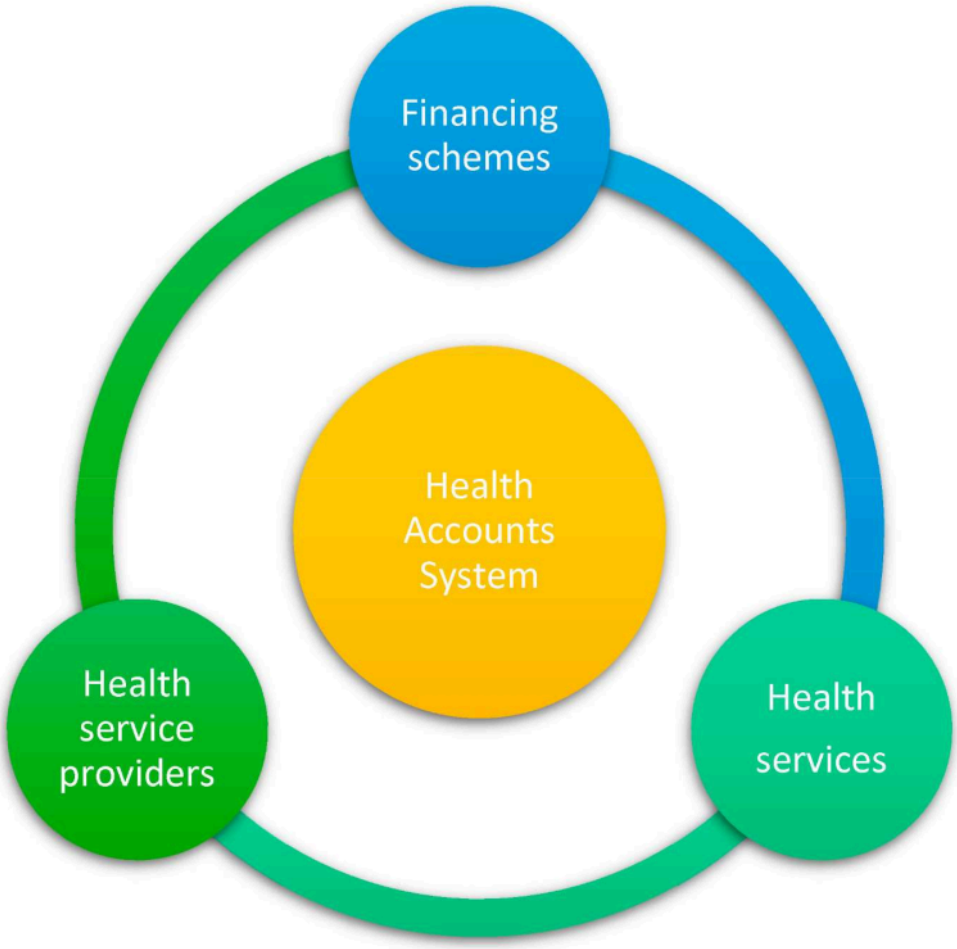

Public-Private Partnerships in Health Care in India
Lessons for developing countries
A. Venkat Raman and James Warner Björkman
ROUTLEDGE
Routledge Studies in Development Economics

LESSON 12: WESTERN ECONOMICS OF HEALTH CARE



Source: Home Office immigration statistics quarterly release, year ending December 2022, Asylum applications awaiting a decision, Asy_D03.

Notes: Includes only applications submitted since 1 April 2006. End of Q1 = 31 Mar; Q2 = 30 Jun; Q3 = 30 Sep; Q4 = 31 Dec.



OBJECTIVES

After studying this lesson, learners will be able to:

- Understand the structure of healthcare systems in western countries
- Explain the concept and functioning of Medicare
- Explain the concept and functioning of Medicaid
- Compare western healthcare financing models with India
- Analyse implications of western health economics for healthcare management

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STRUCTURE

1. Overview of Healthcare Systems in Western Countries

2. Concept of Medicare
3. Concept of Medicaid
4. Comparison with Indian Healthcare Financing System

Introductory Case (Real-World, Data-Based, Learner-Engaging)

Case Title: Why Does Healthcare Cost More in the West but Offer Greater Financial Protection?

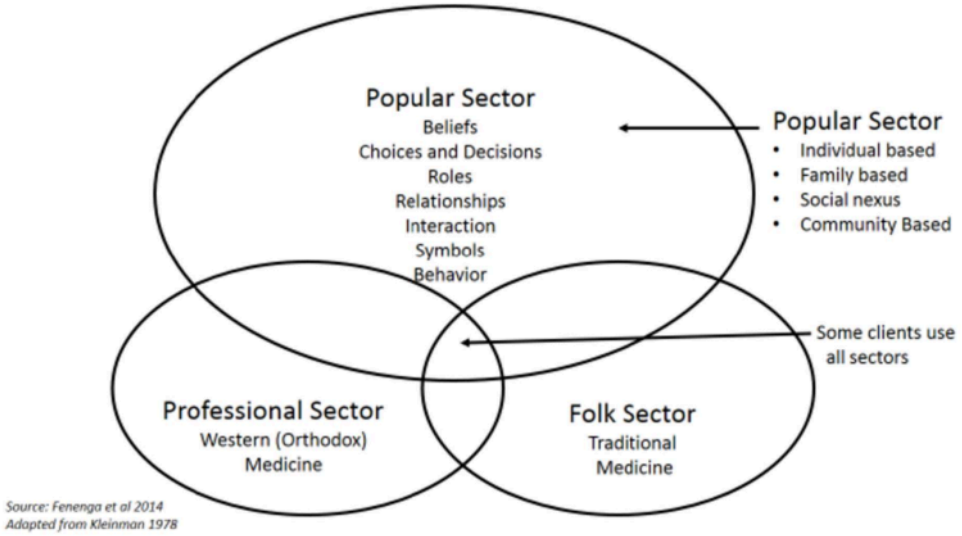
A 67-year-old retired teacher living in the United States underwent knee replacement surgery. The total hospital bill exceeded USD 40,000, but most of the cost was covered through Medicare, leaving the patient with limited out-of-pocket payment.

In contrast, a similar patient in India undergoing the same procedure in a private hospital paid nearly ₹3–4 lakhs largely from personal savings or insurance, while a public hospital offered the service at much lower cost but with longer waiting periods.

According to data published by the Organisation for Economic Co-operation and Development, western countries such as the United States, United Kingdom, Germany, and Canada spend 10–17% of GDP on healthcare, with strong public or social insurance systems providing financial protection. India, on the other hand, spends around 3–4% of GDP, with a historically high reliance on out-of-pocket expenditure.

This contrast raises important questions about healthcare economics, financing models, equity, efficiency, and sustainability, which form the foundation of this lesson.

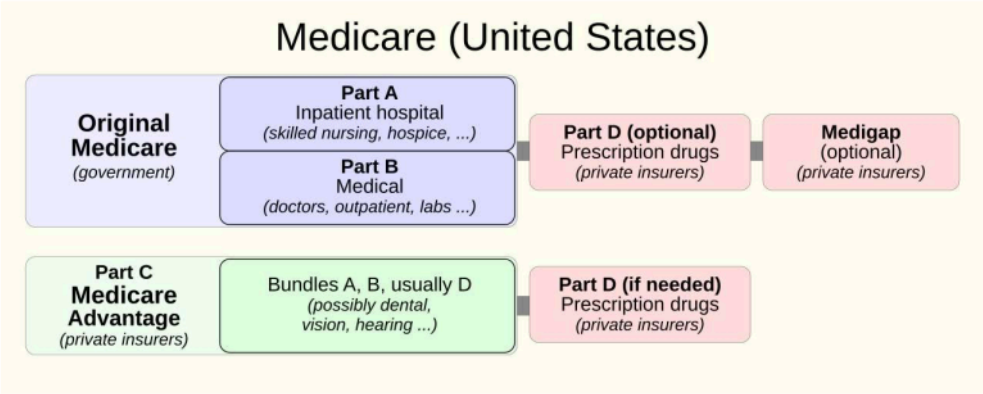
Main Body



Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).



12.1. Overview of Healthcare Systems in Western Countries

1 Meaning and Scope of Western Healthcare Systems

Western healthcare systems refer to the healthcare delivery and financing models adopted by developed countries such as the United States, United Kingdom, Canada, Germany, France, and other OECD nations. These systems are shaped by advanced economic structures, high public expenditure, strong regulatory frameworks, and widespread insurance coverage.

A defining characteristic of western systems is the central role of public financing or social insurance, aimed at ensuring financial protection, equity, and universal access.

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2 Common Features of Western Healthcare Systems

Despite differences among countries, western healthcare systems share several common features:

1. High Healthcare Expenditure
   Western countries typically spend 10–17% of GDP on healthcare, reflecting greater investment in health infrastructure, workforce, and technology.
2. Strong Risk Pooling Mechanisms
   Financing is largely based on:
   - General taxation (e.g., UK, Canada)
   - Social health insurance (e.g., Germany, France)
   - Public insurance programs (e.g., Medicare, Medicaid in the USA)
3. Universal or Near-Universal Coverage
   Most western countries ensure that the majority of their population is covered by public or mandatory insurance schemes.
4. Limited Out-of-Pocket Expenditure
   Household payments form a small share of total health expenditure, reducing catastrophic health spending.
5. Strong Regulation and Accountability
   Governments regulate pricing, quality, and provider behaviour to control costs and ensure patient safety.

---

3 Types of Western Healthcare Models

Western healthcare systems are often classified into four broad models:

3.1 Beveridge Model

- Financed through general taxation
- Healthcare provided largely by government
- Examples: United Kingdom, Spain, Scandinavian countries

3.2 Bismarck Model

- Financed through payroll-based social insurance
- Multiple non-profit insurance funds
- Examples: Germany, France, Netherlands

3.3 National Health Insurance Model

- Single-payer public insurance
- Providers may be private

- Examples: Canada

3.4 Market-Oriented Model (with Public Safety Nets)

- Mix of private insurance and public programs
- Examples: United States

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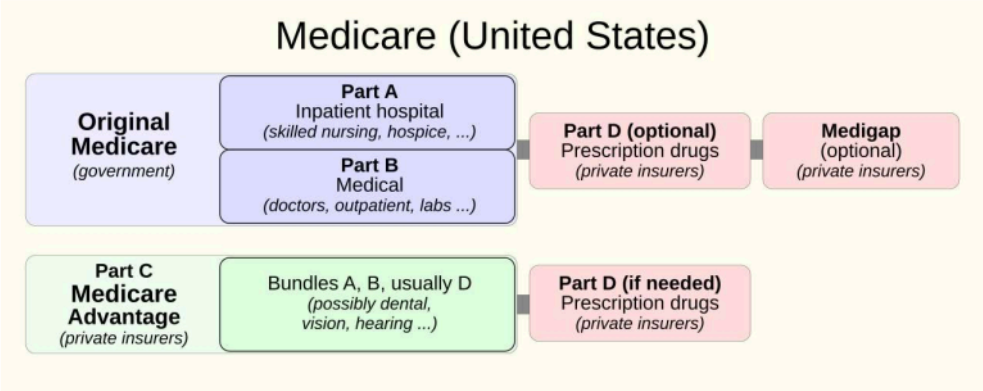
4 Economic Rationale of Western Health Systems

Western healthcare economics emphasises:

- Health as a social investment
- Equity and redistribution
- Prepayment and risk pooling
- Cost control through regulation and purchasing

Healthcare is viewed not merely as a commodity, but as a public good with significant externalities.

12.2. Concept of Medicare



1 Meaning of Medicare

Medicare is a federally funded public health insurance program in the United States, primarily designed to provide healthcare coverage to:

- Persons aged 65 years and above
- Certain younger people with disabilities
- Patients with end-stage renal disease

Medicare was introduced in 1965 as part of social security reforms to protect the elderly from high medical costs.

2 Objectives of Medicare

- Ensure financial protection for elderly citizens
- Improve access to hospital and medical services
- Reduce poverty and insecurity among older adults
- Standardise healthcare coverage nationwide

3 Structure of Medicare

Medicare is divided into four parts:

1. Part A – Hospital Insurance
   Covers inpatient hospital care, skilled nursing facilities, and limited home health care.

2. Part B – Medical Insurance
   Covers outpatient services, physician fees, diagnostics, and preventive services.
3. Part C – Medicare Advantage
   Managed care plans offered by private insurers under government regulation.
4. Part D – Prescription Drug Coverage
   Covers outpatient prescription medicines.

4 Financing of Medicare

Medicare is financed through:

- Payroll taxes
- General federal revenues
- Premiums paid by beneficiaries

The system ensures large-scale risk pooling and redistribution.

5 Impact of Medicare

- Significant reduction in elderly poverty due to medical costs
- Increased utilisation of healthcare services among seniors
- Improved health outcomes and longevity

6 Limitations of Medicare

- Rising fiscal burden due to ageing population
- Cost escalation and sustainability concerns
- Coverage gaps leading to supplementary insurance needs

12.3. Concept of Medicaid

Eligibility Requirements for Medicaid

In order to qualify for Medi-Cal, California's Medicaid program, **you must meet these eligibility requirements:**

Over the age of 65

In a nursing or immediate care home

Under the age of 21

Blind or disabled

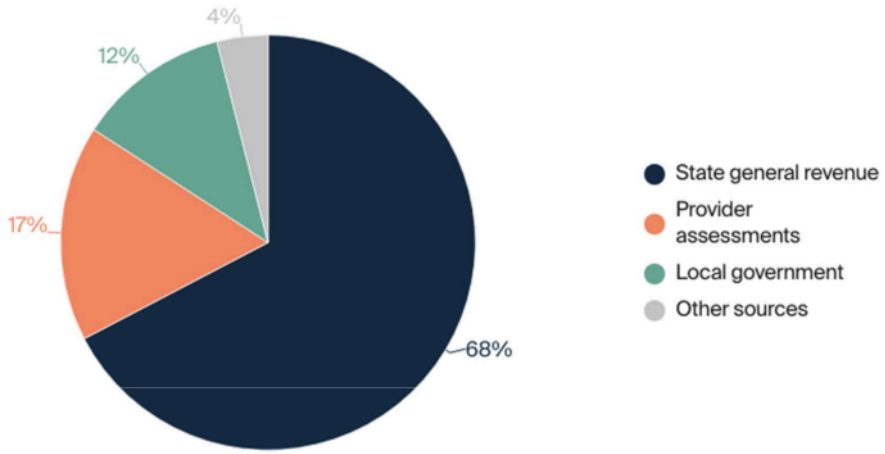
Pregnant

To receive Medi-Cal benefits in California, **you must be a U.S. citizen**, a state resident of California, a permanent U.S. resident, a legal alien or a U.S. national.

Contact **Healthcare of California** for more information.

HEALTH *for* CALIFORNIA
INSURANCE CENTER

State Medicaid Funding Sources, 2018



Data: U.S. Government Accountability Office, *Medicaid: CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight* (GAO, Dec. 2020).

Source: Akeiisa Coleman, "How Do We Pay for Medicaid?" (explainer), Commonwealth Fund, Mar. 14, 2025. https://doi.org/10.26099/t28v-s666

1 Meaning of Medicaid

Medicaid is a means-tested public health insurance program in the United States designed to provide healthcare coverage to low-income individuals and families.

Unlike Medicare, Medicaid eligibility depends on income and socio-economic status.

2 Objectives of Medicaid

- Provide healthcare access to economically vulnerable groups
- Reduce health inequalities
- Act as a social safety net
- Support maternal, child, and disability care

3 Financing and Administration

Medicaid is jointly financed by:

- Federal Government

- State Governments

States have flexibility in:

- Eligibility criteria
- Benefit packages
- Provider payment methods

---

4 Services Covered Under Medicaid

- Hospital and physician services
- Maternal and child healthcare
- Long-term care services
- Preventive and rehabilitative services

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5 Impact of Medicaid

- Improved healthcare access for low-income populations
- Reduced infant and maternal mortality
- Enhanced financial protection for the poor

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6 Limitations of Medicaid

- Variations in coverage across states
- Lower provider reimbursement rates
- Administrative complexity

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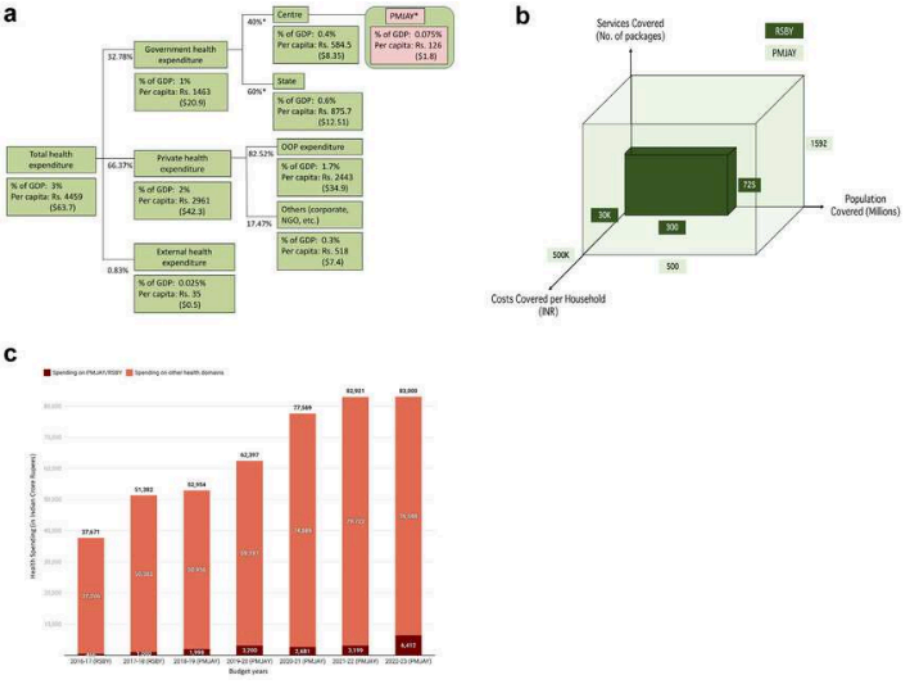
12 4. Comparison with Indian Healthcare Financing System



Name of the Treatment	*Approximate Cost in India ($)**	*Cost in the major healthcare ($)*	*Approximate waiting periods in USA/UK (in months)*
Open heart Surgery	4,500	>18,000	9-11
Cranio facial surgery and skull base	4,300	>13,000	6-8
Neuro-Surgery with hypothermia	6,500	>21,000	12-14
Complex spine Surgery with implants	4,300	>13,000	9-11
Simple spine Surgery	2,100	>6,500	9-11
Simple brain tumour	1,000	>4,300	6-8
Biopsy Surgery	4,300	>10,000	6-8
Parkinsons Lesion	2,100	>6,500	9-11
DBS	17,000	>26,000	9-11
Hip replacement	4,300	>13,000	9-11

* These costs are an average and may not be the actual to be incurred.
Source: The Guardian News, Feb. 1, 2005.

1 Healthcare Financing in India: An Overview

India's healthcare financing system is mixed, involving:

- Public financing through taxation
- Government-sponsored health insurance
- Private health insurance
- High out-of-pocket expenditure

Public health expenditure in India is around 3–4% of GDP, significantly lower than western countries.

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2 Key Differences Between Western Systems and India

Aspect	Western Countries	India
Health spending (% of GDP)	10–17%	~3–4%
Coverage	Universal / near-universal	Partial
Financing	Tax / social insurance	Mixed
OOPE	Low	High
Risk pooling	Strong	Limited

---

3 Medicare/Medicaid vs Indian Health Insurance

- Medicare and Medicaid provide entitlement-based coverage
- Indian schemes like PMJAY are targeted and scheme-based
- Western systems rely on institutionalised risk pooling
- India is transitioning towards broader insurance coverage

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4 Lessons for India from Western Healthcare Economics

- Increase public health expenditure
- Strengthen insurance-based risk pooling
- Reduce dependence on out-of-pocket payments
- Improve regulation and purchasing mechanisms
- Invest in preventive and primary healthcare

---

5 Indian Contextual Constraints

- Large informal sector
- Fiscal capacity constraints
- Inter-state disparities
- Infrastructure and workforce shortages

These factors require adaptation rather than direct replication of western models.

12.5. Relevance to Healthcare Business Environment

For healthcare administrators:

- Western systems illustrate structured financing and payment models
- Medicare and Medicaid influence provider reimbursement strategies
- Comparative analysis informs policy, pricing, and hospital planning
- Lessons guide sustainable healthcare financing reforms

Western healthcare systems demonstrate that strong public financing, risk pooling, and regulation are essential for achieving universal health coverage and financial protection. Medicare and Medicaid represent two complementary pillars—age-based and income-based insurance models—ensuring equity and access.

India's healthcare system, while improving, continues to rely heavily on private spending and OOPE. A gradual shift toward western-style risk pooling and public financing, adapted to Indian realities, is critical for sustainable health system development.

Summary: Lesson 12 – Western Economics of Health Care

Western economics of healthcare refers to the financing, organisation, and delivery of health services in developed (western) countries, particularly members of the Organisation for Economic Co-operation and Development. These countries view healthcare as a social investment rather than a private commodity, and therefore emphasise public financing, risk pooling, insurance coverage, and strong regulation to ensure equity and financial protection.

A common feature of western healthcare systems is high healthcare expenditure, usually ranging between 10–17% of GDP, supported by either general taxation or social health insurance. Most western countries provide universal or near-universal health coverage, which significantly reduces reliance on out-of-pocket expenditure (OOPE). Governments play a strong role in regulating prices, provider behaviour, and quality of care. Based on financing and organisation, western systems are commonly classified into the Beveridge model (tax-funded, government-provided care), Bismarck model (social insurance-funded care), National Health Insurance model (single-payer insurance), and market-oriented models with public safety nets.

In the United States, two major public health insurance programs illustrate western health economics in practice. Medicare is a federally funded health insurance program primarily for people aged 65 years and above, as well as certain disabled groups. Introduced in 1965, Medicare is structured into multiple parts covering hospital care, outpatient services, managed care options, and prescription drugs. It provides financial protection to the elderly, improves access to healthcare, and reduces poverty caused by medical expenses, although it faces sustainability challenges due to rising costs and population ageing.

Medicaid, on the other hand, is a means-tested program designed to cover low-income individuals and families. It is jointly financed by the federal and state governments and functions as a social safety net, ensuring access to healthcare for economically vulnerable groups. Medicaid has played a crucial role in improving maternal and child health outcomes and reducing health inequalities, though coverage and provider payments vary across states.

When compared with western healthcare financing systems, India's healthcare system shows significant differences. India spends around 3–4% of GDP on healthcare, relies on a mixed financing model, and continues to have relatively high OOPE, despite recent improvements. While government schemes such as Ayushman Bharat have expanded insurance coverage, risk pooling remains limited compared to Medicare and Medicaid. Western systems demonstrate the advantages of institutionalised insurance, higher public spending, and strong regulation, while India faces constraints such as a large informal sector, fiscal limitations, and regional disparities.

In conclusion, western healthcare economics highlights the importance of public responsibility, insurance-based financing, and financial protection. Although India cannot directly replicate western models, key lessons—such as strengthening public financing, expanding risk pooling,

and reducing OOPE—are highly relevant for the future development of India's healthcare business environment.

12.6 Learner Activities (Aligned with UGC–DEB Guidelines)

Activity 1: System Comparison Exercise

Task:
Prepare a short comparison (one page) between any one western healthcare system (USA, UK, or Canada) and the Indian healthcare financing system based on:

- Source of financing
- Coverage
- Out-of-pocket expenditure

Learning Outcome:
Helps learners understand structural differences in healthcare financing systems.

Activity 2: Medicare–Medicaid Mapping

Task:
Prepare a simple table showing:

- Target population
- Source of funding
- Type of coverage
  for Medicare and Medicaid.

Learning Outcome:
Builds clarity on age-based and income-based insurance models in western healthcare.

Activity 3: Policy Reflection Note

Task:
Write a brief note (5–6 sentences) on:

What lessons India can learn from western healthcare financing systems to reduce out-of-pocket expenditure.

Learning Outcome:
Encourages learners to apply comparative health economics concepts to Indian policy and management contexts.

12.7 . Key Words with Explanation

- Western Healthcare System – Health systems prevalent in developed countries, characterised by strong public financing, insurance coverage, and regulation.
- Medicare – A publicly funded health insurance program primarily for elderly citizens in the United States.
- Medicaid – A government-funded health insurance program for low-income groups in the United States.
- Universal Health Coverage (UHC) – Ensuring all people receive needed health services without financial hardship.
- Social Health Insurance – Insurance funded through payroll contributions shared by employers and employees.
- Healthcare Financing – Methods of raising and allocating funds for healthcare services.

12.8. Self-Assessment Questions

A. Short Questions (with Answers)

1. What is meant by western healthcare systems?
   They are healthcare systems in developed countries with strong public or insurance-based financing.
2. Who is eligible for Medicare?
   Primarily citizens aged 65 years and above in the USA.
3. What is Medicaid?
   A health insurance program for low-income individuals and families in the USA.
4. Name one feature common to western healthcare systems.
   High level of public or insurance-based financing.
5. How does India differ from western countries in healthcare financing?
   India relies more on out-of-pocket expenditure.

B. Essay Questions (with Hints)

1. Describe the key features of healthcare systems in western countries.
   Hints: Public financing, insurance, regulation, equity.
2. Explain the concept of Medicare and its significance.
   Hints: Elderly care, public insurance, financial protection.
3. Discuss Medicaid as a social safety-net program.
   Hints: Low-income groups, joint funding, access.
4. Compare western healthcare financing models with India.
   Hints: Spending levels, coverage, OOPE.
5. What lessons can India learn from western healthcare economics?
   Hints: Risk pooling, public spending, insurance expansion.

C. Multiple Choice Questions (with Answers)

1. Medicare is mainly meant for:
   a) Children
   b) Elderly population
   c) Unemployed youth
   d) Migrant workers
   Answer: b) Elderly population
2. Medicaid primarily covers:
   a) High-income groups
   b) Government employees
   c) Low-income population
   d) Private sector workers
   Answer: c) Low-income population
3. Western countries generally spend:
   a) Less than 2% of GDP on health
   b) 3–4% of GDP on health
   c) 10–17% of GDP on health
   d) More than 25% of GDP on health
   Answer: c) 10–17% of GDP on health
4. Universal Health Coverage mainly aims at:
   a) Increasing profits
   b) Reducing public spending
   c) Financial protection and access
   d) Privatising healthcare
   Answer: c) Financial protection and access
5. A key difference between India and western countries is:
   a) Disease pattern

b) Population size
c) Financing mechanism
d) Medical technology
Answer: c) Financing mechanism

D. Comprehensive Case Study

Case: Comparing Western and Indian Healthcare Financing Models

A comparative study of healthcare systems shows that countries like the USA, UK, Germany, and Canada rely heavily on insurance-based or publicly financed healthcare systems, ensuring wide coverage and financial protection. Programs such as Medicare and Medicaid cover elderly and low-income populations respectively.

In India, although government schemes such as Ayushman Bharat have expanded coverage, a significant portion of healthcare expenditure still comes from households. Western systems demonstrate strong risk pooling, higher public spending, and regulated pricing, while India faces challenges related to limited public expenditure and high OOPE.

12.9 Analytical Questions and Plausible Answers

1. Why do western countries have higher healthcare spending?
   Due to higher public financing, insurance coverage, and advanced medical technology.
2. How does Medicare improve financial protection?
   By covering major healthcare costs for the elderly.
3. What role does Medicaid play in equity?
   It ensures access to healthcare for low-income populations.
4. What is the main weakness of India's healthcare financing?
   High dependence on out-of-pocket expenditure.
5. What policy lesson can India adopt from western systems?
   Strengthening public financing and insurance-based risk pooling.

12.10. Standard Textbooks and Reference Materials

Textbooks (Purchasable by Students)

1. Folland, S., Goodman, A., & Stano, M. – *The Economics of Health and Health Care*
2. Santerre, R. E. & Neun, S. P. – *Health Economics: Theory, Insights, and Industry Studies*
3. Park, K. – *Park's Textbook of Preventive and Social Medicine*

4. Basu, D. – *Health Policy, Planning and Management*
5. McPake, B. et al. – *Health Economics: An International Perspective*

Reports, Web Resources & Other References

- World Health Organization – Global Health Expenditure Database
- Organisation for Economic Co-operation and Development – OECD Health Statistics
- World Bank – Health system financing reports
- Ministry of Health and Family Welfare – National Health Accounts

LESSON 13: EMERGING APPROACHES AND ETHICAL–LEGAL ISSUES

OBJECTIVES

After studying this lesson, learners will be able to:

- Understand emerging approaches in healthcare delivery
- Identify major ethical issues in healthcare practice and management
- Explain legal issues relevant to healthcare administration
- Describe patient rights and responsibilities
- Analyse ethical–legal challenges in the contemporary healthcare business environment

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STRUCTURE

1. Emerging Approaches in Healthcare Delivery
2. Ethical Issues in Healthcare
3. Legal Issues in Healthcare Management
4. Patient Rights and Responsibilities

Introductory Case (Real-World, Data-Based, Learner-Engaging)

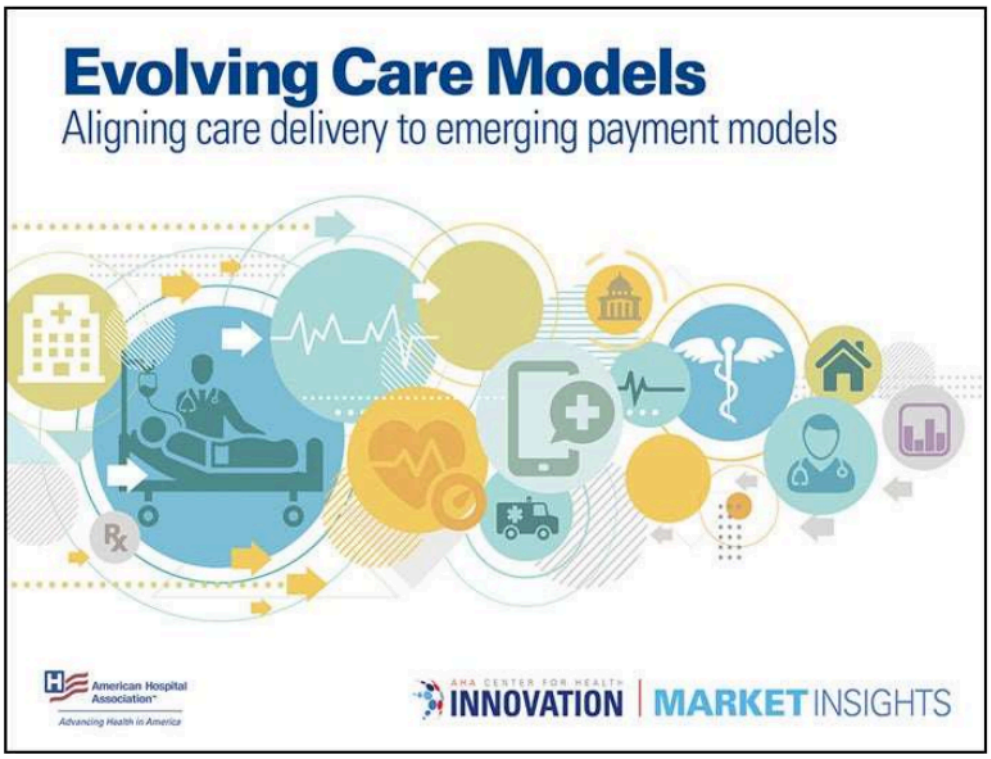
Case Title: Digital Healthcare, Ethical Dilemmas, and Legal Accountability

A multi-specialty hospital in India introduced telemedicine, electronic health records (EHRs), and AI-based diagnostic support systems to improve access and efficiency. During the COVID-19 pandemic, teleconsultations increased rapidly, helping patients in remote areas receive timely medical advice.

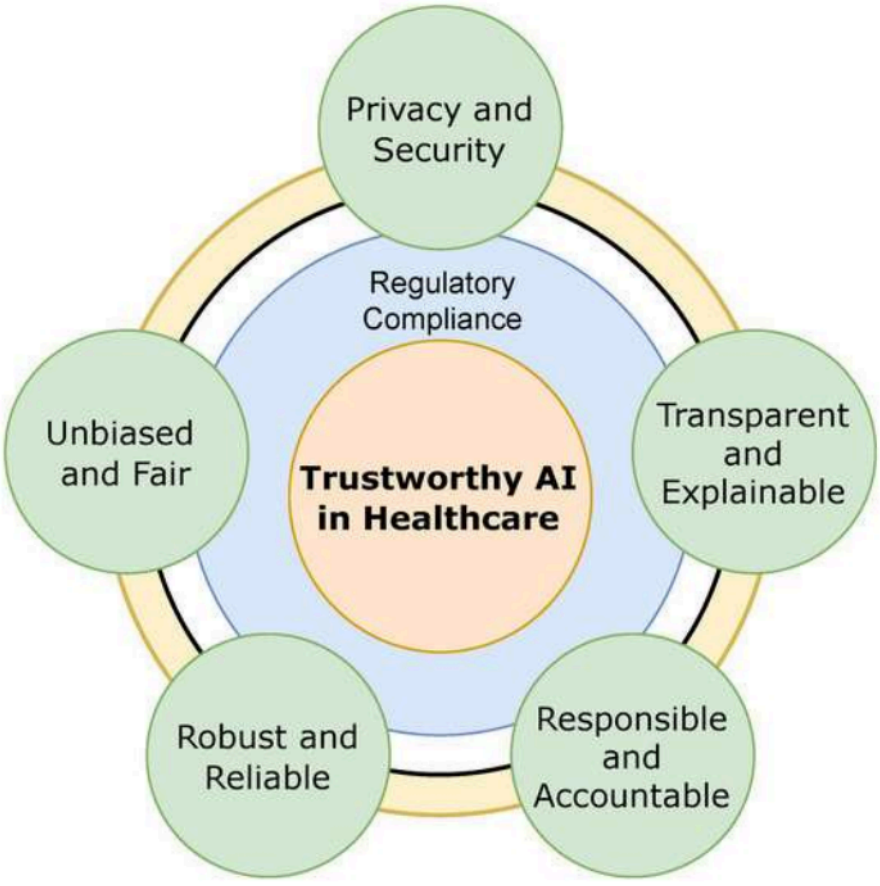
However, a patient later alleged that a misdiagnosis during an online consultation led to delayed treatment. Questions were raised regarding data privacy, professional liability, informed consent, and patient rights. The hospital administration had to respond to legal notices while also addressing ethical concerns about quality of care and confidentiality.

According to guidelines issued by the Ministry of Health and Family Welfare, telemedicine and digital health services must comply with ethical standards, legal frameworks, and patient rights protections. This case highlights how emerging healthcare approaches bring new opportunities along with ethical and legal challenges, making governance and compliance critical in healthcare management.

Main Body




NATIONAL DIGITAL HEALTH MISSION (NDHM)
Aims to offer Universal Health Coverage
Accessible
Inclusive
Timely
Safe
VISION
Universal Health Coverage
Efficient
Affordable
www.ndhm.gov.in


Privacy and Security
Regulatory Compliance
Unbiased and Fair
Trustworthy AI in Healthcare
Transparent and Explainable
Robust and Reliable
Responsible and Accountable

13.1. Emerging Approaches in Healthcare Delivery

1 Introduction

Healthcare delivery systems across the world are undergoing rapid transformation due to advances in technology, changing disease patterns, rising patient expectations, cost pressures, and policy reforms. Traditional hospital-centric models are increasingly being replaced or supplemented by patient-centred, technology-enabled, and integrated care approaches. These emerging approaches aim to improve access, efficiency, quality, and continuity of care, while controlling costs.

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2 Digital Health and Telemedicine

Digital health refers to the use of information and communication technologies in healthcare delivery. It includes:

- Telemedicine and teleconsultation
- Electronic Health Records (EHRs)
- Mobile health (mHealth) applications
- Artificial Intelligence (AI) and data analytics

Telemedicine enables remote consultation, diagnosis, and follow-up, especially benefiting rural and underserved populations. In India, telemedicine expanded significantly during the COVID-19 pandemic and is now an integral part of healthcare delivery under national digital health initiatives guided by the Ministry of Health and Family Welfare.

Managerial relevance:
Digital health improves operational efficiency, optimises clinician time, and expands market reach, but also requires investment in IT infrastructure, cybersecurity, and staff training.

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3 Integrated and Continuum-of-Care Models

Emerging healthcare systems emphasise integration of services across:

- Primary, secondary, and tertiary care
- Preventive, promotive, curative, and rehabilitative services

Integrated care models focus on continuity of care, particularly for chronic diseases such as diabetes, cardiovascular disorders, and cancer. Coordination among hospitals, clinics, laboratories, pharmacies, and home-care services reduces duplication and improves outcomes.

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4 Patient-Centred and Value-Based Care

Modern healthcare delivery increasingly prioritises:

- Patient experience and satisfaction
- Shared decision-making
- Outcome-based performance

Value-based healthcare shifts focus from volume of services to value delivered, measured in terms of health outcomes relative to cost. This approach encourages quality improvement, accountability, and cost containment.

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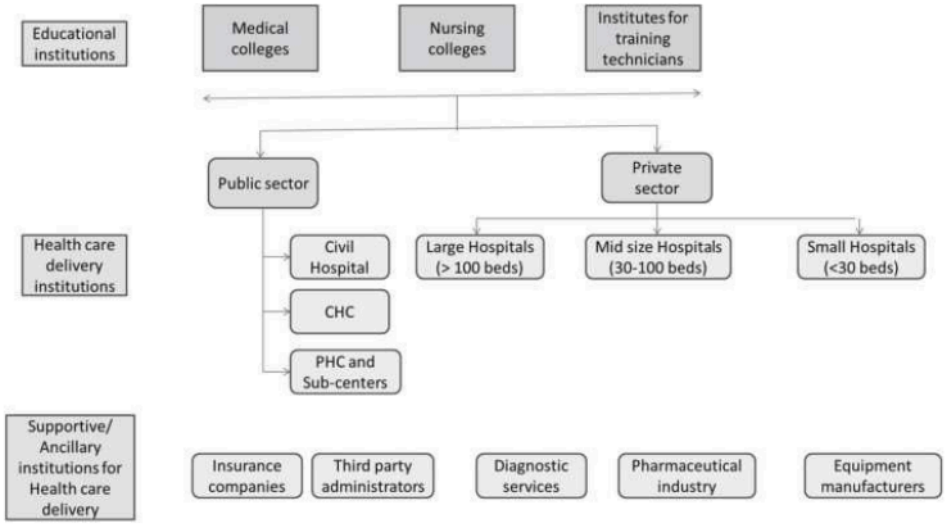
5 Public–Private and Community-Based Approaches

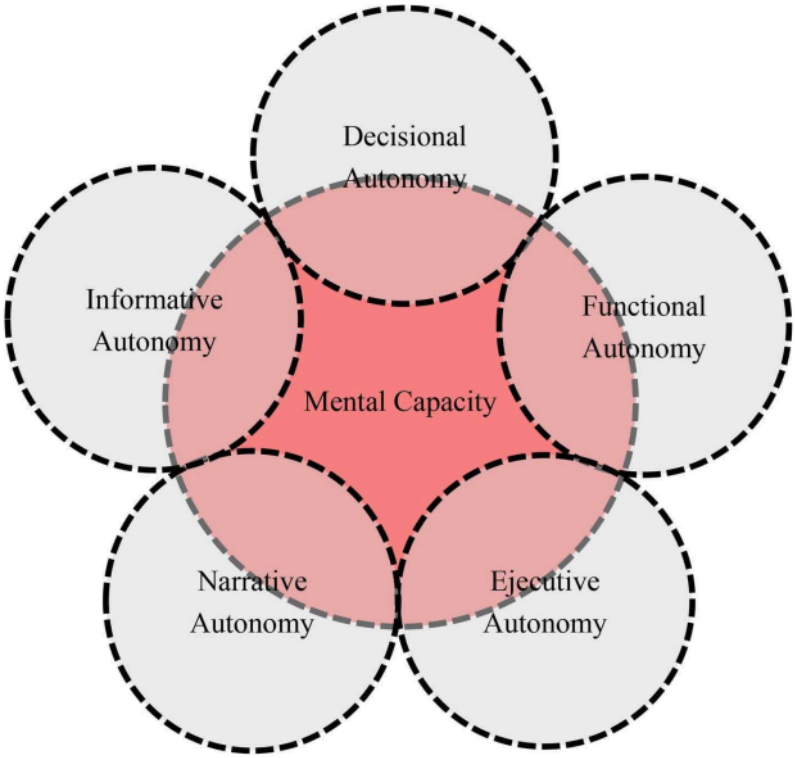
Emerging delivery models also include:

- Public–Private Partnerships (PPPs)
- Community-based healthcare delivery
- Home-based and long-term care services

These approaches leverage private sector efficiency and community participation to address gaps in public healthcare infrastructure.

13.2. Ethical Issues in Healthcare





1 Meaning and Importance of Medical Ethics

Medical ethics refers to the application of moral principles and values to healthcare practice and decision-making. Ethical issues arise due to:

- Life-and-death decisions
- Power imbalance between provider and patient
- Rapid technological change
- Commercialisation of healthcare

Ethics ensures that healthcare delivery remains humane, fair, and patient-oriented, even in complex and resource-constrained environments.

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2 Core Principles of Medical Ethics

Healthcare ethics is commonly based on four fundamental principles:

1. Autonomy – Respecting the patient's right to make informed decisions
2. Beneficence – Acting in the best interest of the patient
3. Non-maleficence – Avoiding harm ("do no harm")
4. Justice – Fair and equitable distribution of healthcare resources

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3 Major Ethical Issues in Healthcare Practice

3.1 Informed Consent

Patients must be adequately informed about:

- Nature of treatment
- Risks and benefits
- Alternatives

Failure to obtain informed consent violates patient autonomy and ethical norms.

3.2 Confidentiality and Privacy

Healthcare professionals are ethically bound to protect patient information. Digital records and telemedicine have increased the risk of data breaches, making confidentiality a critical ethical concern.

3.3 Equity and Access

Ethical dilemmas arise when limited resources force prioritisation among patients, especially in public hospitals.

3.4 End-of-Life Care

Decisions related to life support, palliative care, and dignity of dying raise complex ethical questions.

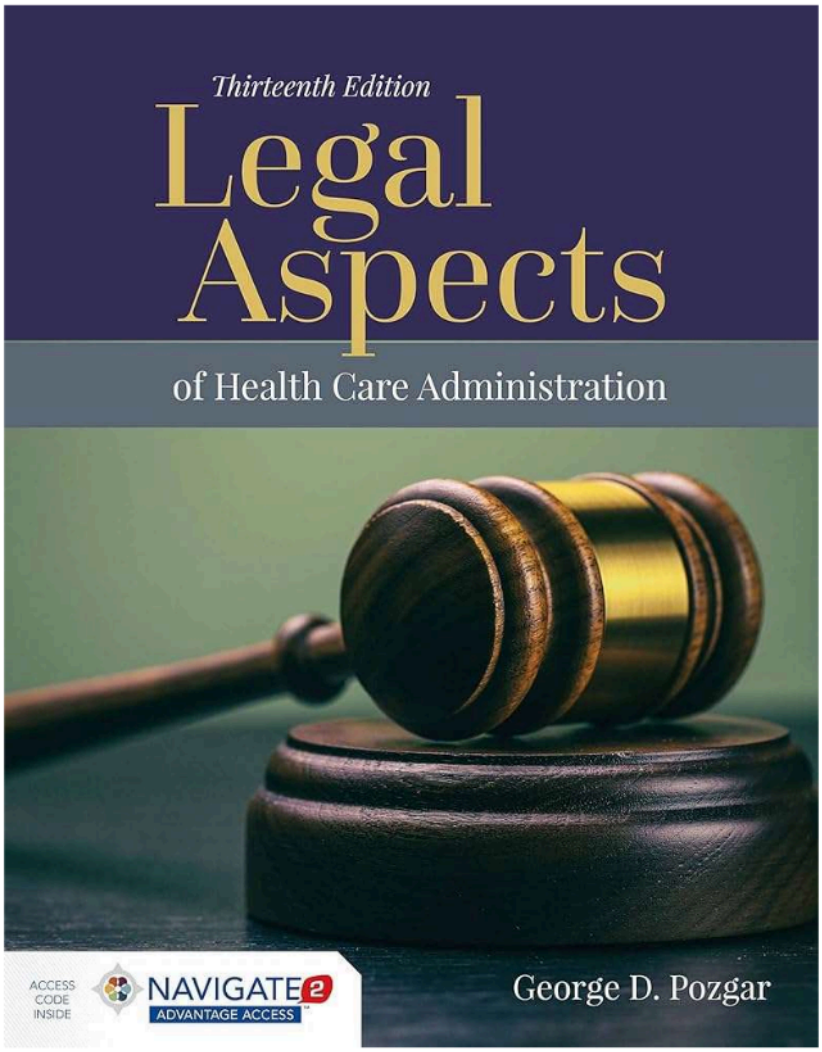
4 Ethical Challenges from Emerging Technologies

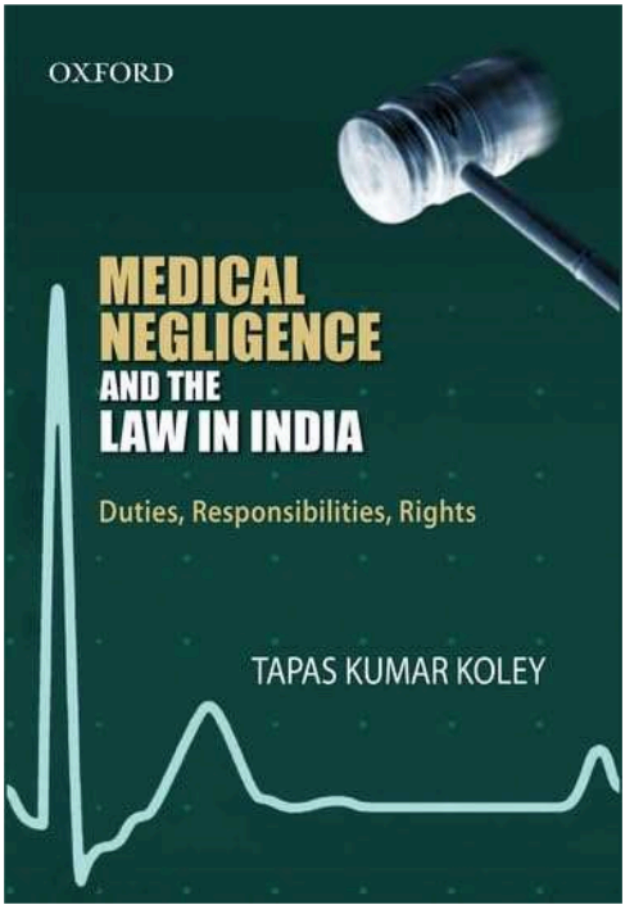
AI-driven diagnostics, genetic testing, and digital health tools raise concerns about:

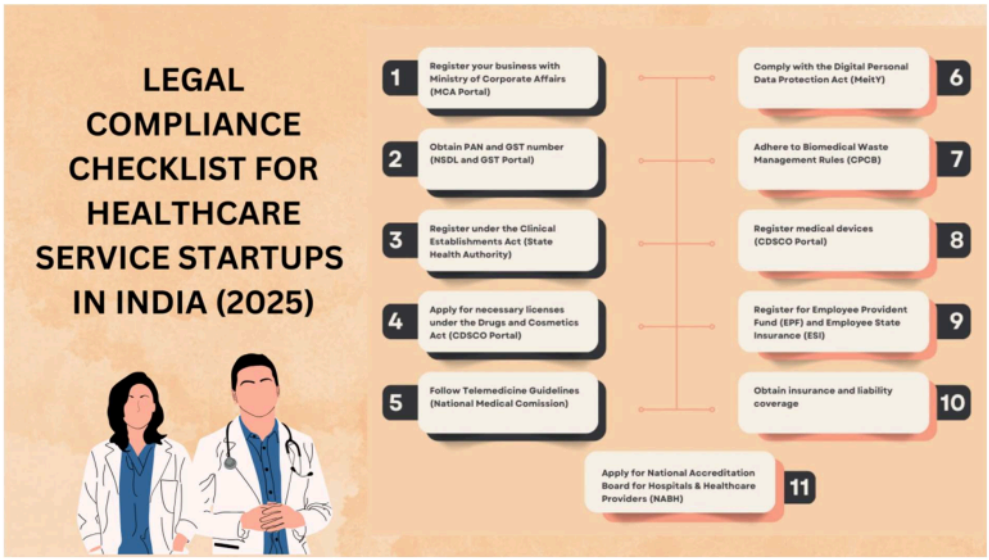
- Transparency in decision-making
- Accountability for errors
- Bias in algorithms
- Consent for secondary data use

Healthcare managers must balance innovation with ethical safeguards.

13.3. Legal Issues in Healthcare Management




OXFORD
MEDICAL NEGLIGENCE AND THE LAW IN INDIA
Duties, Responsibilities, Rights
TAPAS KUMAR KOLEY


LEGAL COMPLIANCE CHECKLIST FOR HEALTHCARE SERVICE STARTUPS IN INDIA (2025)
1 Register your business with Ministry of Corporate Affairs (MCA Portal)
2 Obtain PAN and GST number (NSDL and GST Portal)
3 Register under the Clinical Establishments Act (State Health Authority)
4 Apply for necessary licenses under the Drugs and Cosmetics Act (CDSCO Portal)
5 Follow Telemedicine Guidelines (National Medical Comission)
6 Comply with the Digital Personal Data Protection Act (MeitY)
7 Adhere to Biomedical Waste Management Rules (CPCB)
8 Register medical devices (CDSCO Portal)
9 Register for Employee Provident Fund (EPF) and Employee State Insurance (ESI)
10 Obtain insurance and liability coverage
11 Apply for National Accreditation Board for Hospitals & Healthcare Providers (NABH)

1 Nature of Healthcare Law

Healthcare law consists of statutes, regulations, judicial decisions, and professional codes that govern:

- Healthcare institutions
- Medical professionals
- Patient rights
- Standards of care

Legal compliance is a core responsibility of healthcare administrators.

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2 Medical Negligence and Liability

Medical negligence arises when a healthcare provider:

- Breaches the standard of care
- Causes harm to the patient

Hospitals may face vicarious liability for acts of employed doctors and staff. Consumer protection laws in India allow patients to seek compensation for deficient services.

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3 Consent and Legal Validity

Consent is not only an ethical requirement but also a legal necessity. Inadequate or invalid consent can result in legal action, even if treatment outcomes are favourable.

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4 Legal Issues in Digital and Corporate Healthcare

Emerging delivery models raise new legal challenges:

- Data protection and cybersecurity
- Telemedicine liability
- Compliance with accreditation and licensing norms
- Contractual disputes with insurers and partners

Healthcare managers must establish robust legal risk management systems.

13.4. Patient Rights and Responsibilities

CHARTER OF PATIENTS RIGHTS

1. RIGHT TO ACCESS HEALTH CARE
Patients have a right to equal access to health services ***without any discrimination*** as regards class, caste, gender, HIV status or any other such factor.

2. RIGHT TO EMERGENCY TREATMENT
As per Supreme Court Directive, a ***patient should get emergency treatment*** irrespective of any legal or financial considerations.

3. RIGHT TO INFORMATION
3.1 The patient or designated representative should be provided with the necessary information about the likely cause of the illness, the investigations & treatment being planned, it's cost, expected outcomes including likely complications, alternatives available and consequences of not taking treatment.
3.2 The patient should have access to his/her clinical records at all times.
3.3 On admission, the patient shall be informed about the treating doctor, rules and regulations of the nursing home, approximate expenses that would be incurred.
3.4 At the time of discharge the patient should get a discharge card containing the summary of clinical findings, investigations, diagnosis, treatment, state of his/her health at the time of discharge and follow-up advice.

4. RIGHT TO PRIVACY
All examination should be carried out in a private environment with any person present on the request of the patient. In case of a woman a female attendant must be present at the time of examination.

5. RIGHT TO CONFIDENTIALITY
All the records of patients must be kept restricted to only the team treating the patient. This information can be disclosed to any person only with patient's consent.

6. RIGHT TO AUTONOMY AND DECISION MAKING
6.1 An ***informed consent*** should be taken before giving anesthesia, blood or blood product transfusions and any invasive / high-risk procedures / treatment.
6.2 In case of minor, or unconscious patient, consent should be obtained from close relative.
6.3 The patient has a ***right to refuse treatment.***
6.4 Patient has ***a right to a second*** opinion. The current physician should co-operate by providing necessary information to the second physician and the second opinion should be in writing.

7. RIGHT TO QUALITY CARE
Every patient should receive good quality care, which reflects satisfactory levels of technical performance and care that reflects consideration for personal values, beliefs and optimise comfort and dignity.

8. RIGHT TO SEEK REDRESSAL
Every patient has the right to complain about any aspect of service provided and get it investigated by a competent authority if any. Every nursing home should display the information on such competent authority prominently.

9. IN CASE OF NURSING HOME UNDERTAKING CLINICAL RESEARCH
Documented policies and procedures should guide all research activities in compliance with the National and International Guidelines.

10. IN CASE OF A HIV POSITIVE PATIENT
No person suffering from HIV should be denied care only on the basis of the HIV status. Not having a Voluntary Testing and Counseling Centre cannot become grounds to refuse care. *For management of patient who is HIV positive, the nursing home would follow guidelines circulated from time to time by NACO (National AIDS Control Organization).*

Every patient has the following responsibilities:

- To provide all personal and family health information.
- To participate in making decisions about the treatment, and comply with the plan of care.
- To enquire about the related costs of treatment and arrange for payment.

(Adapted from the Draft Rules framed under the BNMRA 2008)
Printed by Cohai for JSA E-mail : jsanurshi@gmail.com

Patients Rights & Responsibilities
रुग्णांचे अधिकार आणि जबाबदाऱ्या

NINE PEARLS HOSPITAL

रुग्णांचे अधिकार

- जात/धर्म यांचा विचार न करता उत्तम उपचार मिळणे तसेच जीवरक्षक प्रणालीचे उपचार आर्थिक परिस्थितीचा विचार न करता मिळण्याचा अधिकार डॉक्टर निवडण्याचा अधिकार.
- आदरपूर्वक उपचार मिळण्याचा अधिकार.
- उपचार स्विकारण्याचा व नाकारण्याचा अधिकार तसेच पूर्ण माहिती घेऊन निर्णय घेण्याचा अधिकार.
- हॉस्पिटलमधील डॉक्टरांसह सर्व स्तरातील कर्मचाऱ्यांकडुन आदरपूर्वक तसेच कोणत्याही भेदभाव न करता उपचार मिळण्याचा अधिकार.
- दुसऱ्या डॉक्टरांचे मत घेण्याचा अधिकार.
- रुग्णसेवेशी निगडीत वैद्यकिय व्यक्तिचे नाव जाणुन घेण्याचा तसेच उपचारांबाबत शंका विचारण्याचा अधिकार.
- स्वत:च्या वैद्यकिय उपचारांची कागदपत्रे जाणुन घेण्याचा तसेच त्याची प्रत मिळवण्याचा अधिकार.
- हॉस्पिटल तसेच सेवा पुरवणाऱ्या व्यक्तिबद्दलच्या तक्रारीची योग्य दखल घेतली जाण्याचा अधिकार.
- आवश्यक त्या कायदेशिर बाबींची पुर्तता केल्यानंतर हॉस्पिटल सोडण्याचा अधिकार.
- बिलाचा अंदाज तसेच तपशिल मिळण्याचा अधिकार.
- शारीरीक गैरवर्तन आणि दुर्लक्ष करण्यापासुन संरक्षणाचा अधिकार.

रुग्णांच्या जबाबदाऱ्या

- हॉस्पिटलशी प्रामाणिक राहणे, उपचारकर्त्या व्यक्तींना तुमचा वैद्यकिय पुर्व इतिहास तसेच सद्य स्थितीची माहिती देणे.
- उपचार अथवा दिलेल्या सुचना बद्दल शंका असल्यास हॉस्पिटलच्या उपचारकर्त्यांना सांगणे.
- हॉस्पिटल कर्मचाऱ्यांशी प्रक्षोभक वर्तन न करणे, शाब्दिक/शारीरिक गैरवर्तन न करणे.
- हॉस्पिटलच्या सर्व नियमांचे पालन करणे.
- उपचारासंबधीच्या निर्णय प्रक्रिये मध्ये सहभागी होणे तसेच त्याबबतचे शंकानिरसन करुन घेणे.
- इतर रुग्ण तसेच हॉस्पिटल कर्मचाऱ्यांचा अधिकाराचा आदर राखणे.
- हॉस्पिटलने सांगितलेल्या उपचार नियमावलीचे पालन करणे.
- उपचारासाठीच्या बिलांची पूर्तता तत्परतेने करणे.
- वैयक्तिक गोष्टी / मौल्यवान वस्तुंची जबाबदारी पूर्णपणे रुग्ण अथवा नातेवाईकांवर राहील.

PATIENT'S RIGHTS

- Right to personal dignity & to receive care without any form of Stigma & discrimination.
- Right to receive medical care & information on the expected cost of treatment.
- Information about medical problem, treatment & procedure, staff Information on hospital Rules & regulation.
- Right to seek second opinion on his / her medical condition.
- Privacy during examination and treatment.
- A documented procedure for obtaining informed consent of their Medical care.
- Protection from the physical abuse and neglect.

PATIENT'S RESPONSIBILITIES

- To Participate To Their Best of the Ability In Making Decisions about their treatment and to comply with the agreed plan of care.
- To ask question of the physician or any other Health care provider when they do not understand any information or Instruction.
- To be considerate to other receiving and providing care and also observe facility policies and procedures including those regarding smoking, Noise and number of visitors.
- Accept financial Responsibility for Healthcare received and settle bills promptly.
- Patient & Relative shall Take care of their valuables. Hospital will not Responsible for the loss of It.

1 Concept of Patient Rights

Patient rights are legal and ethical entitlements that ensure dignity, safety, and fairness in healthcare. In India, patient rights are articulated through policy documents and regulatory guidelines.

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2 Major Patient Rights

Key patient rights include:

- Right to information and transparency
- Right to informed consent
- Right to privacy and confidentiality
- Right to quality and safe care
- Right to grievance redressal

Recognition of patient rights promotes trust and accountability in healthcare systems.

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3 Patient Responsibilities

Along with rights, patients also have responsibilities, such as:

- Providing accurate health information
- Following medical advice
- Respecting healthcare staff and facilities
- Complying with hospital rules

Balanced recognition of rights and responsibilities ensures effective healthcare delivery.

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4 Managerial Implications of Patient Rights

Healthcare administrators must:

- Institutionalise patient rights policies
- Train staff in ethical and legal compliance
- Establish grievance redressal mechanisms
- Ensure transparency in billing and care processes

13.5. Integrative Perspective

Emerging healthcare approaches have transformed healthcare delivery, but they also intensify ethical and legal complexities. Ethical principles guide professional conduct, while legal frameworks ensure accountability. Patient rights act as a bridge between ethics and law, placing the patient at the centre of the healthcare system.

13.6. Relevance to Healthcare Business Environment

For MBA (HA) professionals:

- Ethical conduct enhances organisational reputation
- Legal compliance reduces risk and liability
- Patient-centred care imp*roves service utilisation and trust*

13.7 Summary:

Emerging Approaches and Ethical–Legal Issues

The healthcare sector is undergoing rapid transformation due to technological advancements, changing patient expectations, epidemiological transitions, and cost pressures. These changes have led to the emergence of new approaches in healthcare delivery that move beyond

traditional hospital-centric models toward patient-centred, integrated, and technology-enabled systems. Emerging approaches such as telemedicine, digital health platforms, electronic health records, artificial intelligence, and integrated care networks aim to improve access, efficiency, quality, and continuity of care, particularly for chronic and long-term conditions.

Digital health and telemedicine have become especially significant in India, enabling remote consultation, diagnosis, and follow-up care for populations in rural and underserved areas. Integrated and continuum-of-care models emphasise coordination across primary, secondary, and tertiary levels of care, reducing fragmentation and duplication of services. At the same time, healthcare delivery is increasingly guided by value-based and patient-centred care principles, where emphasis is placed on health outcomes, patient experience, and cost-effectiveness rather than the volume of services provided.

Alongside these developments, ethical issues in healthcare have gained greater prominence. Medical ethics provides the moral framework for healthcare practice and is grounded in the principles of autonomy, beneficence, non-maleficence, and justice. Ethical challenges commonly arise in areas such as informed consent, confidentiality and privacy, equitable access to care, allocation of scarce resources, and end-of-life decision-making. The adoption of digital technologies and artificial intelligence has further intensified ethical concerns related to data privacy, transparency, accountability, and potential bias in clinical decision-making.

Legal issues in healthcare management are closely linked to ethical concerns and have become increasingly complex with the corporatisation and digitisation of healthcare. Healthcare administrators must ensure compliance with laws and regulations governing medical negligence, professional liability, consent, patient safety, data protection, accreditation, and licensing. Failure to comply with legal requirements can result in litigation, financial penalties, and reputational damage. Effective legal risk management is therefore a critical component of modern healthcare administration.

Patient rights and responsibilities form the cornerstone of ethical and legal healthcare delivery. Patient rights include the right to information, informed consent, privacy and confidentiality, safe and quality care, and grievance redressal. At the same time, patients have responsibilities such as providing accurate information, following medical advice, and respecting healthcare personnel and institutional rules. For healthcare managers, institutionalising patient rights, strengthening grievance mechanisms, and fostering ethical–legal awareness among staff are essential for building trust and accountability.

In conclusion, emerging approaches in healthcare delivery offer significant opportunities to enhance efficiency and access, but they also bring ethical and legal challenges that must be carefully managed. Sustainable healthcare systems require a balanced integration of innovation, ethical values, legal compliance, and patient-centred governance, making these dimensions central to the contemporary healthcare business environment.

13.8 **Learner Activities (**Aligned with UGC–DEB Guidelines)

Activity 1: Emerging Healthcare Model Identification

Task:
Identify any one emerging healthcare delivery approach (such as telemedicine, integrated care, or home-based care) implemented in India. Write a brief note on:

- Its key features
- One ethical or legal issue associated with it

Learning Outcome:
Enhances understanding of innovation and its ethical–legal implications.

Activity 2: Ethics and Law Scenario Analysis

Task:
Read a short news report or case related to medical negligence, data privacy, or patient consent. Identify:

- The ethical issue involved
- The possible legal implications

Learning Outcome:
Develops analytical and critical thinking related to healthcare ethics and law.

Activity 3: Patient Rights Reflection

Task:
Prepare a short note (5–6 sentences) on:

Why patient rights and responsibilities are essential for quality healthcare delivery.

Learning Outcome:
Reinforces the importance of patient-centred care and ethical governance.

13.9. Key Words with Explanation

- Emerging Healthcare Approaches – New models and technologies such as telemedicine, digital health, AI, and integrated care systems.

- Medical Ethics – Moral principles guiding healthcare practice, including autonomy, beneficence, non-maleficence, and justice.
- Healthcare Law – Legal rules governing healthcare delivery, institutions, and professional conduct.
- Informed Consent – Voluntary agreement by a patient after understanding risks, benefits, and alternatives.
- Patient Rights – Entitlements ensuring dignity, privacy, information, and quality care.
- Professional Liability – Legal responsibility of healthcare professionals for negligence or malpractice.
- Confidentiality – Ethical and legal obligation to protect patient information.

13.10. Self-Assessment Questions

A. Short Questions (with Answers)

1. What are emerging approaches in healthcare delivery?
   New models and technologies aimed at improving access, efficiency, and quality of healthcare.
2. What is medical ethics?
   A set of moral principles guiding healthcare practice.
3. Name one ethical issue in healthcare.
   Patient confidentiality.
4. What is informed consent?
   Patient's voluntary agreement after receiving adequate information.
5. Mention one patient right.
   Right to privacy.

B. Essay Questions (with Hints)

1. Explain emerging approaches in healthcare delivery.
   Hints: Digital health, telemedicine, integrated care.
2. Discuss major ethical issues in healthcare management.
   Hints: Autonomy, confidentiality, equity.
3. Analyse legal issues faced by healthcare managers.
   Hints: Negligence, compliance, regulation.
4. Describe patient rights and responsibilities.
   Hints: Information, consent, cooperation.
5. Evaluate ethical–legal challenges arising from digital healthcare.
   Hints: Data privacy, accountability.

C. Multiple Choice Questions (with Answers)

1. Telemedicine mainly aims to:
   a) Increase hospital costs
   b) Improve access to healthcare
   c) Replace doctors
   d) Reduce regulation
   Answer: b) Improve access to healthcare

2. Which principle means “do no harm”?
   a) Autonomy
   b) Justice
   c) Beneficence
   d) Non-maleficence
   Answer: d) Non-maleficence

3. Informed consent relates to:
   a) Hospital finance
   b) Patient decision-making
   c) Insurance claims
   d) Staff recruitment
   Answer: b) Patient decision-making

4. Patient confidentiality is mainly an:
   a) Administrative rule
   b) Ethical obligation
   c) Financial norm
   d) Marketing practice
   Answer: b) Ethical obligation

5. Legal liability in healthcare often arises from:
   a) Innovation
   b) Negligence
   c) Teamwork
   d) Training
   Answer: b) Negligence

D. Comprehensive Case Study (Expanded – Textbook Style)

Case: Ethical and Legal Challenges in a Digitally Enabled Hospital

A tertiary-care hospital adopted AI-assisted diagnostics, electronic medical records, and teleconsultation platforms to enhance efficiency and patient reach. While these innovations reduced waiting times and improved documentation, they also introduced new ethical and legal concerns.

A patient undergoing remote consultation alleged that sensitive health data was accessed by unauthorised staff, raising issues of confidentiality and data protection. Another patient questioned whether adequate informed consent was obtained before using AI-based decision-

support tools. Meanwhile, hospital administrators faced uncertainty about legal liability in cases where clinical decisions involved digital platforms.

Indian healthcare regulations and professional guidelines increasingly emphasise patient rights, ethical medical practice, and legal accountability, particularly in technology-driven care models. The hospital had to revise its policies, strengthen consent procedures, and train staff on ethical–legal compliance.

13.11 Analytical Questions and Plausible Answers

1. What ethical issues are highlighted in this case?
   Confidentiality, informed consent, and accountability.
2. What legal risks does the hospital face?
   Data breaches, negligence claims, and regulatory non-compliance.
3. How do emerging healthcare approaches increase ethical complexity?
   By introducing new technologies that affect privacy and decision-making.
4. What role should hospital management play?
   Ensure compliance, training, and ethical governance.
5. How can patient rights be better protected?
   Through transparent policies, consent mechanisms, and data security.

13.12 . Standard Textbooks and Reference Materials

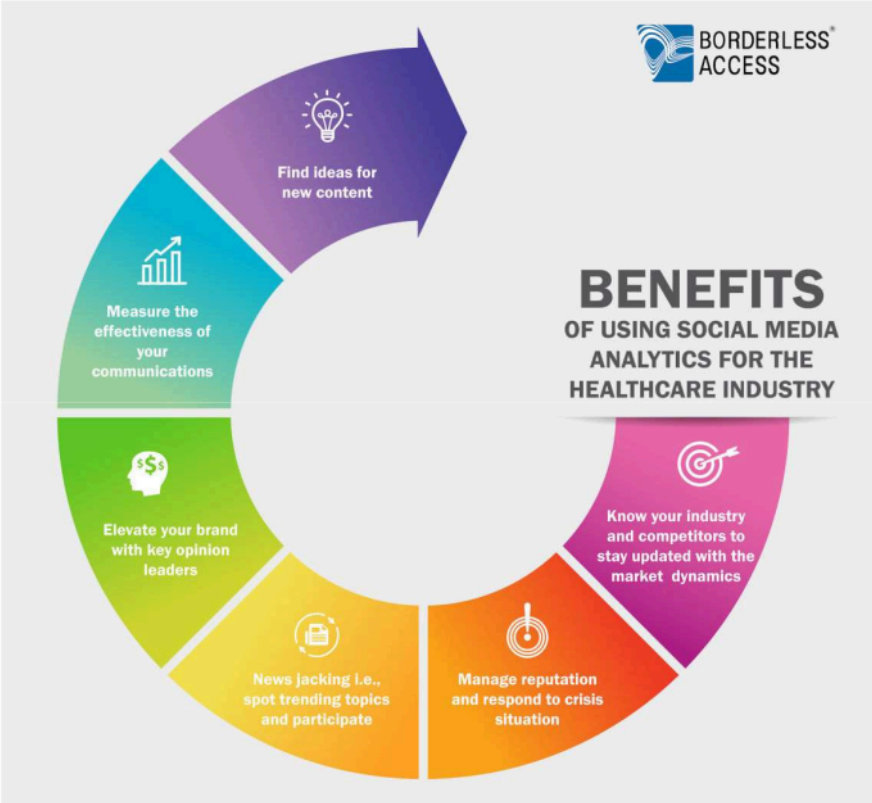
Textbooks (Purchasable by Students)

1. Park, K. – *Park's Textbook of Preventive and Social Medicine*
2. Basu, D. – *Health Policy, Planning and Management*
3. Goel, S. L. – *Health Care Administration in India*
4. Beauchamp, T. L. & Childress, J. F. – *Principles of Biomedical Ethics*
5. McPake, B. et al. – *Health Economics: An International Perspective*

Reports, Legal & Other References

- World Health Organization – Ethics and digital health guidelines
- Ministry of Health and Family Welfare – Telemedicine and digital health guidelines
- National Medical Commission (India) – Professional conduct regulations
- Patient Rights Charter – Government of India

LESSON 14: CONTRACTING AND MEDIA COMMUNICATION IN HEALTHCARE



OBJECTIVES

After studying this lesson, learners will be able to:

- Understand the concept and importance of contracting in healthcare
- Identify various types of healthcare contracts
- Explain the role of outsourcing in hospital management
- Analyse the importance of effective media communication in healthcare
- Examine the role of healthcare marketing and public relations

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STRUCTURE

1. Concept of Contracting in Healthcare
2. Types of Healthcare Contracts
3. Outsourcing in Hospitals

4. Role of Effective Media Communication
5. Healthcare Marketing and Public Relations

Introductory Case (Real-World, Data-Based, Learner-Engaging)

Case Title: Contracting, Outsourcing, and Media Management in a Modern Hospital

A large multi-specialty hospital in an Indian metropolitan city outsourced its housekeeping, security, diagnostics, and cafeteria services to specialised agencies through formal contracts. This helped the hospital reduce operational costs and focus on core clinical services. However, a dispute arose when the housekeeping contractor failed to maintain hygiene standards, leading to a hospital-acquired infection incident that was widely reported in the media.

The hospital administration had to simultaneously:

- Review contractual obligations and service-level agreements
- Take corrective action against the outsourcing agency
- Manage adverse media coverage and public perception

Healthcare experts note that ineffective contracting and poor media handling can damage a hospital's reputation, patient trust, and financial sustainability. According to advisories and best-practice guidelines referenced by the Ministry of Health and Family Welfare, hospitals must ensure robust contracting mechanisms and transparent communication strategies to maintain quality and accountability.

This case highlights how contracting, outsourcing, and media communication are interlinked and critical components of healthcare management.

Main Body

14.1. Concept of Contracting in Healthcare

1 Meaning of Contracting in Healthcare

Contracting in healthcare refers to the formal, legally binding agreements entered into by healthcare organisations with individuals, firms, or institutions for the provision of goods or services. These agreements clearly define roles, responsibilities, performance standards, payment terms, duration, and legal obligations of the contracting parties.

In the healthcare sector, contracting is essential because hospitals and health systems rely on multiple external entities for:

- Clinical support services
- Non-clinical and support services
- Infrastructure, technology, and logistics
- Insurance and third-party administration

2 Rationale for Contracting in Healthcare

Healthcare organisations increasingly adopt contractual arrangements due to:

- Growing complexity of healthcare delivery
- Need for specialised services
- Cost containment pressures
- Focus on core clinical competencies
- Regulatory and quality requirements

Contracting enables hospitals to optimise resources, ensure accountability, and improve operational efficiency.

3 Essential Elements of Healthcare Contracts

A well-designed healthcare contract typically includes:

- Scope of work and service specifications
- Service-Level Agreements (SLAs)
- Performance indicators and reporting mechanisms
- Payment and penalty clauses
- Confidentiality and data protection clauses
- Dispute resolution and termination provisions

4 Contracting and Hospital Governance

Effective contracting strengthens:

- Transparency and accountability
- Risk allocation and control
- Compliance with regulatory standards

For healthcare administrators, contract management is a core managerial competency.

14.2. Types of Healthcare Contracts

DRAFT COPY OF AGREEMENT WITH NETWORK PROVIDER (HOSPITALS)

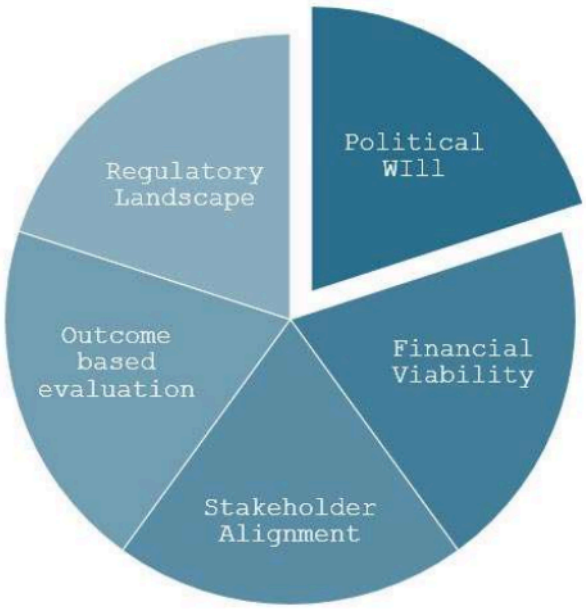
AGREEMENT BETWEEN THE **PARK MEDICLAIM TPA PVT. LTD.** INCORPORATED UNDER THE COMPANIES ACT 1956 AT NEW DELHI SITUATED AT **702, RAJENDRA PLACE, NEW DELHI – 110008.**

FOR PROVIDING HOSPITALIZATION AND / OR OUT PATIENT CARE TO AN INDIVIDUAL COVERED WITH **PARK MEDICLAIM TPA PVT. LTD.**

This Agreement made at _____Delhi _____on the_____ of_____between **Park Mediclaim TPA Pvt. Ltd.**, a company duly registered under the Companies Act. 1956, having its Head Office at **702, Rajendra Place, New Delhi – 110008**. (hereinafter referred to as company, which expression shall unless it be repugnant to the context or meaning thereof shall mean and include its successors and assignees).

AND

_____(Name of the Hospital)_____Located at_____
(hereinafter referred to as Participating Provider Hospital, which expression shall unless it be repugnant to the context or meaning thereof shall mean and include its successors and assignees).



Healthcare contracts vary depending on purpose and scope.

1 Service Contracts

Service contracts are used for:

- Housekeeping
- Security
- Laundry
- Catering
- Biomedical waste management

These contracts define service quality, staffing norms, and hygiene standards.

---

2 Supply and Procurement Contracts

These contracts relate to:

- Medicines and pharmaceuticals
- Medical equipment and consumables
- Surgical supplies

They emphasise pricing, quality specifications, delivery schedules, and warranties.

---

3 Professional and Consultancy Contracts

Such contracts involve:

- Visiting consultants and specialists
- Diagnostic service providers
- IT and health information system vendors

---

4 Insurance and Third-Party Administrator (TPA) Contracts

Hospitals enter into agreements with:

- Government insurance schemes
- Private insurance companies
- Third-party administrators

These contracts govern reimbursement rates, claim procedures, and compliance requirements.

---

5 Public–Private Partnership (PPP) Contracts

PPP contracts involve collaboration between government and private sector for:

- Diagnostic services
- Dialysis centres
- Emergency services

PPP contracts are long-term and focus on risk-sharing and performance outcomes.

14.3. Outsourcing in Hospitals

Module 8

Outsourcing of Non-clinical Services in Hospitals

8.1. Objective of the Training

1. Explain the objective of outsourcing of non-clinical services
2. Understand the preconditions to outsource non-clinical services
3. Explain the administrative process required to outsource non-clinical services
4. Understand lists of services to be outsourced
5. Understand different alternatives available to

1 Concept of Outsourcing

Outsourcing refers to the practice of delegating non-core hospital functions to external specialised agencies under contractual arrangements. The hospital retains oversight while the vendor performs operational tasks.

---

2 Areas Commonly Outsourced in Hospitals

Hospitals commonly outsource:

- Housekeeping and sanitation
- Security services
- Laundry and linen management
- Biomedical waste disposal
- Dietary and cafeteria services
- IT and facility maintenance

Clinical outsourcing is limited and carefully regulated.

---

3 Advantages of Outsourcing

- Cost reduction and budget predictability
- Access to specialised expertise
- Improved operational efficiency
- Allows management focus on core clinical services

---

4 Risks and Challenges of Outsourcing

- Quality control issues
- Dependency on vendors
- Labour disputes and compliance risks
- Patient safety concerns

These risks necessitate strong monitoring, SLAs, and performance audits.

---

5 Managerial Role in Outsourcing

Healthcare managers must:

- Select vendors carefully

- Monitor performance continuously
- Enforce contractual terms
- Integrate outsourced services into quality management systems

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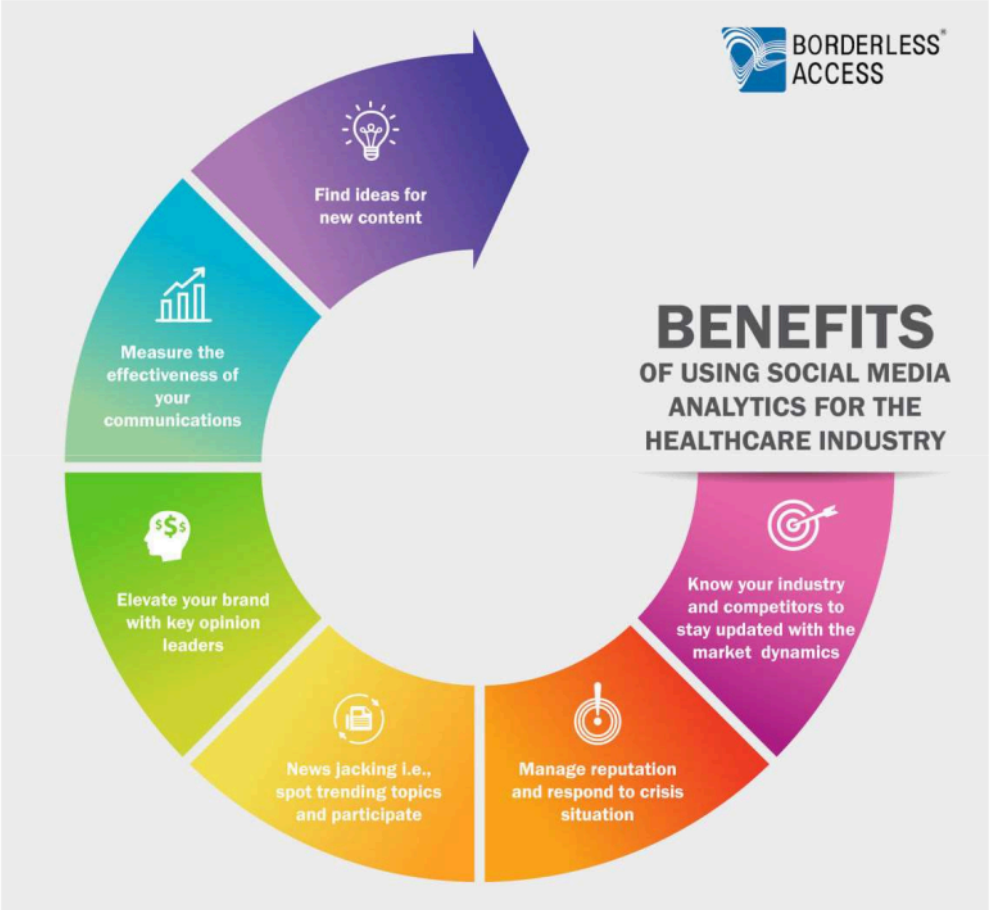
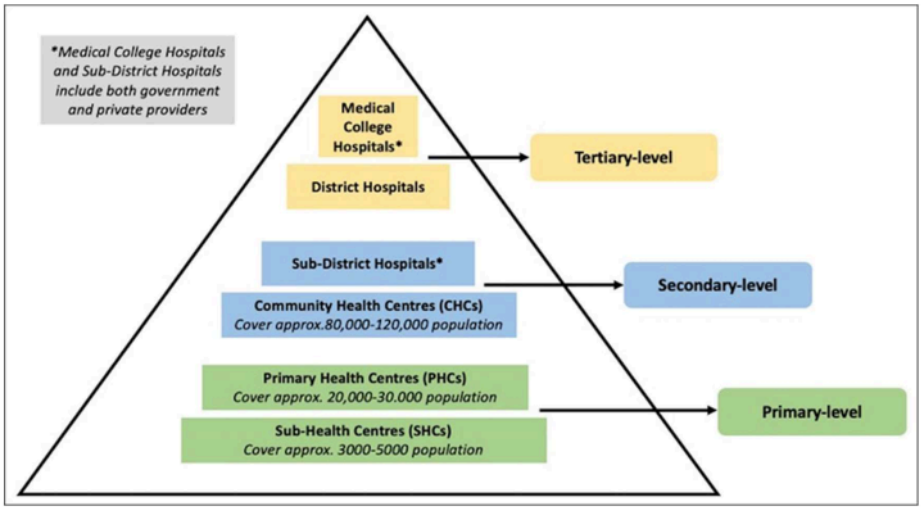
14.4. Role of Effective Media Communication





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1 Meaning of Media Communication in Healthcare

Media communication refers to structured interaction between healthcare organisations and:

- Print media
- Electronic media
- Digital and social media

Its purpose is to disseminate accurate information, build public trust, and manage organisational image.

---

2 Importance of Media Communication

Effective media communication:

- Enhances transparency
- Builds credibility and public confidence
- Supports health awareness and education
- Manages crises and misinformation

---

3 Media Communication During Healthcare Crises

During events such as:

- Medical negligence allegations
- Infection outbreaks

- Public health emergencies

Hospitals must adopt:

- Timely and truthful communication
- Single authorised spokesperson
- Clear messaging aligned with ethical standards

---

4 Ethical and Legal Dimensions of Media Communication

Healthcare communication must respect:

- Patient confidentiality
- Legal constraints
- Professional ethics

Irresponsible media handling can result in legal action and reputational damage.

14.5. Healthcare Marketing and Public Relations

1 Concept of Healthcare Marketing

Healthcare marketing involves planned activities aimed at:

- Creating awareness of services
- Building institutional image

- Communicating value to patients and stakeholders

Unlike commercial marketing, healthcare marketing must be ethical, patient-focused, and compliant with professional standards.

---

2 Objectives of Healthcare Marketing

- Inform patients about available services
- Build trust and reputation
- Promote preventive healthcare
- Strengthen patient relationships

---

3 Tools of Healthcare Marketing

Common tools include:

- Health education programs
- Digital marketing and websites
- Community outreach
- Media campaigns
- Branding and corporate identity

---

4 Public Relations (PR) in Healthcare

Public relations focuses on maintaining positive relationships with:

- Patients and families
- Media
- Government and regulators
- Community and civil society

PR activities support:

- Reputation management
- Crisis response
- Stakeholder engagement

---

5 Ethical Boundaries in Healthcare Marketing

Healthcare marketing must avoid:

- Misleading claims
- Unethical advertising
- Exploitation of patient vulnerability

Ethical marketing enhances credibility and long-term sustainability.

14.6. Integrative Perspective

Contracting, outsourcing, media communication, and healthcare marketing are interconnected managerial functions. Poor contracting can lead to service failures; ineffective media handling can amplify crises; unethical marketing can damage trust. An integrated approach ensures quality, accountability, and organisational reputation.

14.7 Summary:

Contracting and Media Communication in Healthcare

Modern healthcare organisations operate in a complex business environment that requires effective coordination with multiple external stakeholders. Contracting in healthcare refers to formal, legally binding agreements entered into by hospitals and health systems for procuring services, supplies, and professional expertise. Well-designed contracts clearly define the scope of work, service-level standards, payment terms, accountability, and dispute resolution mechanisms. Contracting enables healthcare organisations to optimise resources, manage risks, ensure compliance, and focus on their core clinical functions.

Healthcare contracts take various forms, including service contracts for housekeeping and security, supply and procurement contracts for medicines and equipment, professional contracts with consultants and specialists, insurance and third-party administrator contracts, and public–private partnership (PPP) contracts. Each type of contract serves a specific managerial purpose and directly influences service quality, cost control, and operational efficiency. Effective contract management is therefore a critical competency for healthcare administrators.

Outsourcing in hospitals is a strategic extension of contracting, involving the delegation of non-core services to specialised external agencies. Commonly outsourced services include housekeeping, laundry, security, biomedical waste management, catering, and facility maintenance. Outsourcing helps hospitals reduce costs, access specialised expertise, and concentrate on patient care. However, inadequate monitoring and weak service-level enforcement can compromise quality and patient safety. Hence, outsourcing must be supported by robust vendor selection, clear SLAs, and continuous performance monitoring.

Alongside operational management, media communication plays a vital role in shaping a hospital's public image and credibility. Healthcare organisations interact with print, electronic, and digital media to disseminate information, educate the public, and respond to crises. Effective media communication promotes transparency, builds public trust, and helps manage

reputational risks during adverse events such as infection outbreaks or allegations of negligence. Ethical and legal considerations—particularly patient confidentiality and accuracy of information—must guide all media interactions.

Healthcare marketing and public relations (PR) are essential tools for building awareness, trust, and long-term relationships with patients and other stakeholders. Healthcare marketing focuses on informing patients about services, promoting preventive care, and communicating organisational values, while PR emphasises reputation management and stakeholder engagement. Unlike commercial marketing, healthcare marketing must adhere to ethical standards, avoiding misleading claims or exploitation of patient vulnerability.

In conclusion, contracting, outsourcing, media communication, and healthcare marketing are interconnected managerial functions that significantly influence service quality, cost efficiency, and organisational reputation. For healthcare administrators, integrating these functions through ethical practices, strong governance, and strategic planning is essential for achieving sustainable and patient-centred healthcare delivery.

14.8 Learner Activities (Aligned with UGC–DEB Guidelines)

Activity 1: Contract Identification Exercise

Task:
Identify any one contract used in a hospital (e.g., housekeeping, security, or insurance contract). Write a short note on:

- Purpose of the contract
- Key responsibilities of the service provider

Learning Outcome:
Understanding practical applications of healthcare contracting.

Activity 2: Outsourcing Analysis

Task:
List three services commonly outsourced in hospitals and mention:

- One advantage
- One potential risk
  for each service.

Learning Outcome:
Develops insight into outsourcing decisions and quality implications.

Activity 3: Media and PR Reflection

Task:
Write a brief note (5–6 sentences) on:

Why ethical media communication and public relations are important for hospitals.

Learning Outcome:
Enhances awareness of reputation management and stakeholder communication in healthcare.

14.9 . Key Words with Explanation

- Healthcare Contracting – Formal agreements between healthcare organisations and other parties for delivery of goods or services.
- Service-Level Agreement (SLA) – A contract defining performance standards and responsibilities.
- Outsourcing – Delegation of non-core hospital services to external agencies.
- Vendor Management – Process of managing and monitoring contracted service providers.
- Media Communication – Interaction between healthcare organisations and media to disseminate information.
- Healthcare Marketing – Activities aimed at promoting healthcare services and organisational image.
- Public Relations (PR) – Strategic communication to build and maintain positive relationships with stakeholders.

14.10. Self-Assessment Questions

A. Short Questions (with Answers)

1. What is contracting in healthcare?
   It is a formal agreement for procuring services or goods in healthcare.
2. Name one type of healthcare contract.
   Service contract.

3. What is outsourcing in hospitals?
   Delegating non-clinical services to external agencies.
4. Why is media communication important for hospitals?
   It shapes public perception and trust.
5. What is healthcare marketing?
   Promotion of healthcare services and organisational image.

B. Essay Questions (with Hints)

1. Explain the concept of contracting in healthcare.
   Hints: Formal agreements, accountability, efficiency.
2. Discuss different types of healthcare contracts.
   Hints: Service, supply, PPP contracts.
3. Analyse the advantages and risks of outsourcing in hospitals.
   Hints: Cost, quality control, dependency.
4. Examine the role of media communication in healthcare organisations.
   Hints: Crisis communication, transparency.
5. Evaluate healthcare marketing and public relations strategies.
   Hints: Branding, patient engagement.

C. Multiple Choice Questions (with Answers)

1. A Service-Level Agreement mainly defines:
   a) Hospital vision
   b) Performance standards
   c) Medical ethics
   d) Insurance benefits
   Answer: b) Performance standards
2. Outsourcing is commonly used for:
   a) Surgery
   b) Nursing care
   c) Housekeeping services
   d) Diagnosis
   Answer: c) Housekeeping services
3. Media communication mainly affects:
   a) Clinical outcomes
   b) Public perception
   c) Medical education
   d) Drug pricing
   Answer: b) Public perception

4. Healthcare marketing focuses on:
   a) Only profit
   b) Patient awareness and image building
   c) Medical research
   d) Legal compliance
   Answer: b) Patient awareness and image building

5. PR in healthcare aims to:
   a) Hide information
   b) Build trust and goodwill
   c) Increase litigation
   d) Reduce staff
   Answer: b) Build trust and goodwill

D. Comprehensive Case Study (Expanded – Textbook Style)

Case: Contract Management, Outsourcing Failure, and Media Crisis in a Hospital

A tertiary-care hospital entered into multiple contracts with private vendors for housekeeping, biomedical waste management, and diagnostic services. While outsourcing reduced costs initially, lack of monitoring led to service quality deterioration. A sanitation-related infection outbreak occurred, which attracted extensive media attention.

The media questioned the hospital's contracting practices, regulatory compliance, and patient safety standards. Social media amplified public concern, forcing the hospital management to issue press statements, suspend the vendor, and revise outsourcing contracts with stricter SLAs.

The incident demonstrated that contracting decisions, vendor performance, and media communication are interdependent. Effective hospital management requires not only well-drafted contracts but also proactive communication and crisis management strategies.

14.11 Analytical Questions and Plausible Answers

1. What were the weaknesses in the hospital's contracting approach?
   Inadequate monitoring and weak service-level enforcement.

2. How did outsourcing contribute to the problem?
   Poor vendor performance affected service quality.

3. What role did media play in the case?
   It influenced public opinion and accountability.

4. How should hospital management respond to such crises?
   Strengthen contracts, enforce SLAs, communicate transparently.

5. What lessons can healthcare managers learn?
   Integrated approach to contracting, quality control, and media management.

14.12. Standard Textbooks and Reference Materials

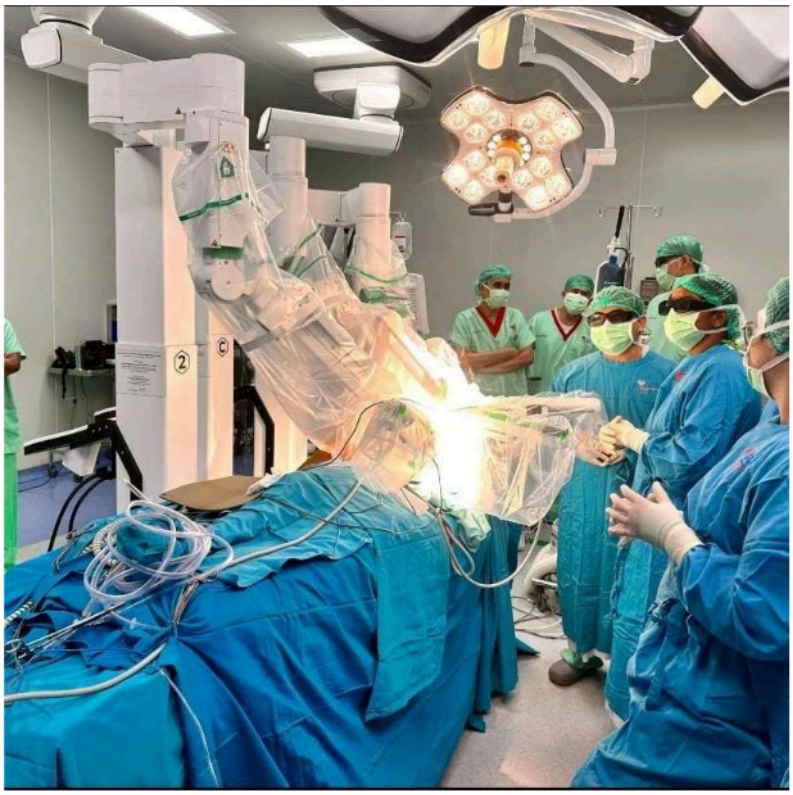
Textbooks (Purchasable by Students)

1. Goel, S. L. – *Health Care Administration in India*
2. Basu, D. – *Health Policy, Planning and Management*
3. Gapenski, L. C. – *Healthcare Finance: An Introduction to Accounting and Financial Management*
4. Kotler, P. & Keller, K. L. – *Marketing Management* (Healthcare Applications)
5. George, B. – *Healthcare Marketing*

Reports, Web Resources & Other References

- Ministry of Health and Family Welfare – Hospital standards and advisories
- National Health Systems Resource Centre (NHSRC) – Contracting and PPP guidelines
- World Health Organization – Health service management resources
- Press Council of India – Media ethics and communication standards

LESSON 15: TECHNOLOGY, INNOVATION, AND MEDICAL TOURISM



OBJECTIVES

After studying this lesson, learners will be able to:

- Understand the role of technology and innovation in modern healthcare
- Explain the concepts of robotic surgery, telemedicine, and e-health
- Analyse digital transformation in healthcare delivery and management
- Examine the growth and characteristics of medical tourism
- Assess India's position as a global healthcare destination

STRUCTURE

1. Robotic Surgery
2. Telemedicine and E-Health
3. Digital Transformation in Healthcare
4. Medical Tourism
5. India as a Global Healthcare Destination

Introductory Case (Real-World, Data-Based, Learner-Engaging)

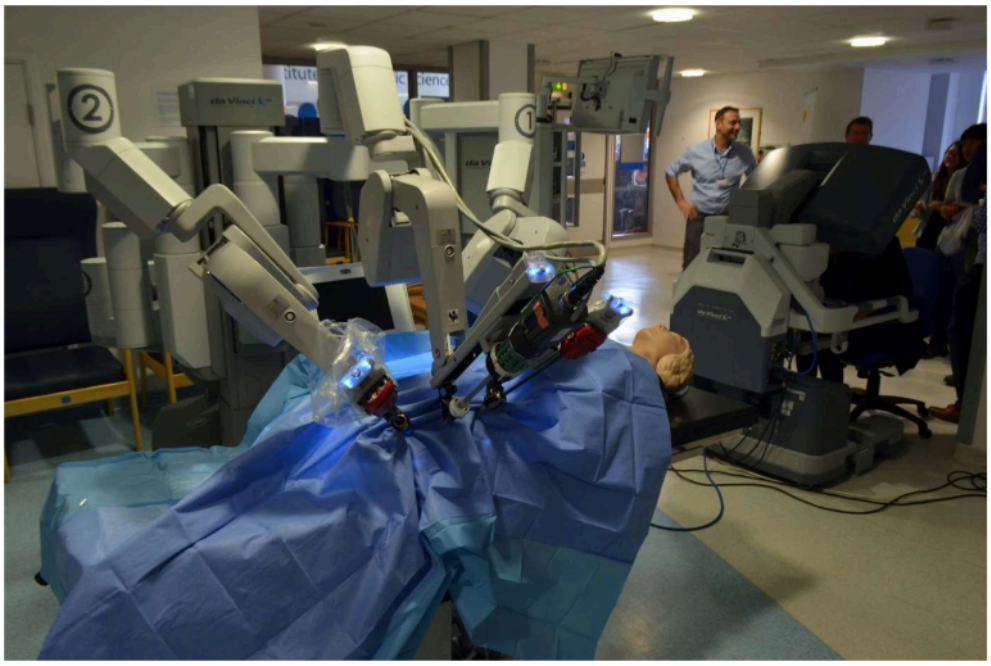
Case Title: Technology-Driven Healthcare and India's Rise as a Medical Tourism Hub

A 58-year-old patient from East Africa travelled to India for a robot-assisted cardiac procedure at a corporate hospital in Chennai. The surgery was performed using advanced robotic systems, followed by digital monitoring and tele-consultations after discharge. The total cost of treatment—including surgery, hospital stay, and follow-up—was nearly one-third of the cost in the patient's home country.

India has emerged as a preferred destination for medical tourism, offering advanced technology, skilled medical professionals, internationally accredited hospitals, and cost-effective treatment. According to reports referenced by the Ministry of Health and Family Welfare and the World Health Organization, the integration of digital health, telemedicine, and innovation has strengthened India's healthcare ecosystem and enhanced global patient confidence.

This case highlights how technology, innovation, and medical tourism are interconnected and increasingly shape the healthcare business environment in India.

Main Body




RADIX
Digital
Transformation
in Healthcare
www.radixweb.com

15.1. Robotic Surgery

1 Meaning and Concept

Robotic surgery refers to the use of computer-assisted robotic systems to aid surgeons in performing complex procedures with enhanced precision, flexibility, and control. The surgeon operates from a console, controlling robotic arms that translate hand movements into precise micro-movements inside the patient's body.

Robotic surgery does not replace the surgeon; rather, it augments human capability by reducing hand tremors, improving visualisation through high-definition 3D imaging, and enabling minimally invasive techniques.

---

2 Applications of Robotic Surgery

Robotic surgery is increasingly used in:

- Cardiac surgery
- Orthopaedics
- Urology (e.g., prostate surgery)
- Gynaecology
- Oncology and general surgery

In India, several tertiary and corporate hospitals have adopted robotic systems for advanced procedures, particularly in urban centres.

---

3 Advantages of Robotic Surgery

Robotic-assisted procedures offer multiple benefits:

- Greater surgical precision
- Smaller incisions and minimal blood loss
- Reduced post-operative pain
- Shorter hospital stay and faster recovery
- Lower risk of infection

These advantages improve clinical outcomes and patient satisfaction.

---

4 Limitations and Challenges

Despite its benefits, robotic surgery faces several challenges:

- High capital and maintenance costs

- Requirement of specialised training
- Limited accessibility in public hospitals
- Ethical concerns regarding overuse and cost escalation

---

5 Managerial and Business Perspective

For healthcare administrators:

- Robotic surgery enhances hospital brand value
- Attracts medical tourists and high-end patients
- Requires careful cost–benefit analysis
- Demands skilled workforce planning and utilisation optimisation

Robotic surgery is therefore both a clinical innovation and a strategic business decision.

---

2. Telemedicine and E-Health


Online Registration System (ORS)
Patient Registration (OPD & Casualty)
IPD
Clinics
Store & Pharmacy
Dietary
NIC Hospital
Laundry
OT Management
Radiology
Billing
Lab
e-BloodBank

1 Concept of Telemedicine

Telemedicine is the delivery of healthcare services using information and communication technologies (ICT) when distance separates patients and providers. It includes teleconsultation, tele-diagnosis, tele-follow-up, and telemonitoring.

Telemedicine has become a vital component of healthcare systems, especially in geographically large and demographically diverse countries like India.

---

2 E-Health: Scope and Components

E-health is a broader concept encompassing:

- Electronic Health Records (EHRs)
- Health information systems
- Mobile health (mHealth) applications
- E-prescriptions
- Telemedicine platforms

E-health integrates clinical, administrative, and managerial processes through digital tools.

---

3 Role of Telemedicine and E-Health in India

Telemedicine in India has expanded rapidly, supported by national digital health initiatives guided by the Ministry of Health and Family Welfare. It has been particularly effective in:

- Improving rural and remote healthcare access
- Providing specialist consultation
- Reducing patient travel and waiting time
- Supporting continuity of care

---

4 Benefits of Telemedicine and E-Health

- Enhanced access to healthcare services
- Cost-effective service delivery
- Improved efficiency and documentation
- Better disease monitoring and follow-up
- Strengthened public health surveillance

---

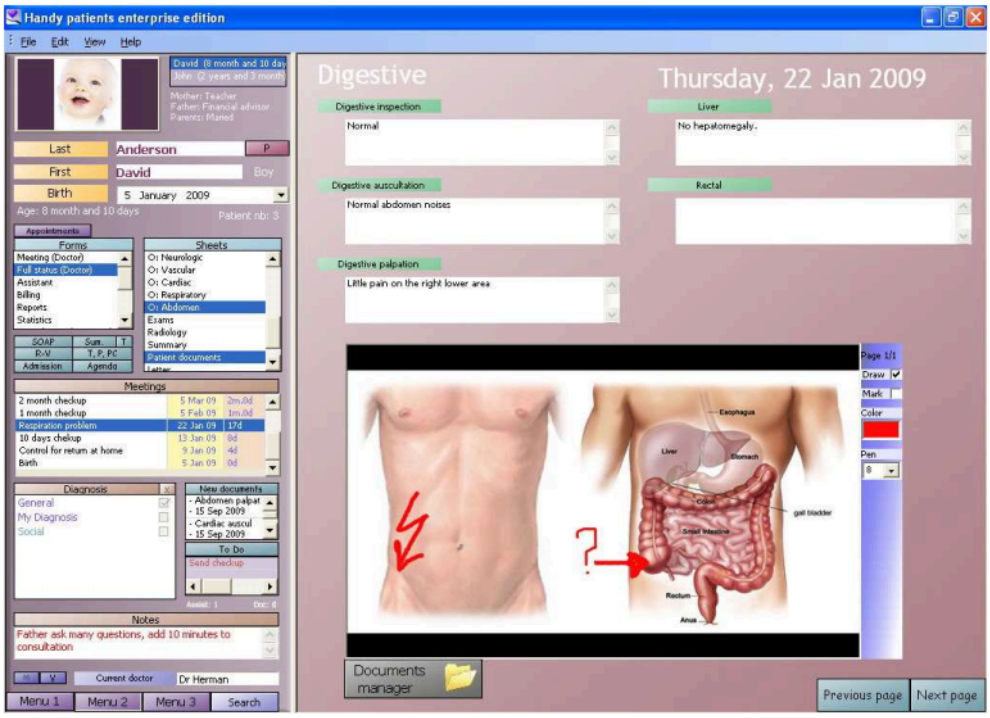
5 Challenges and Ethical–Legal Concerns

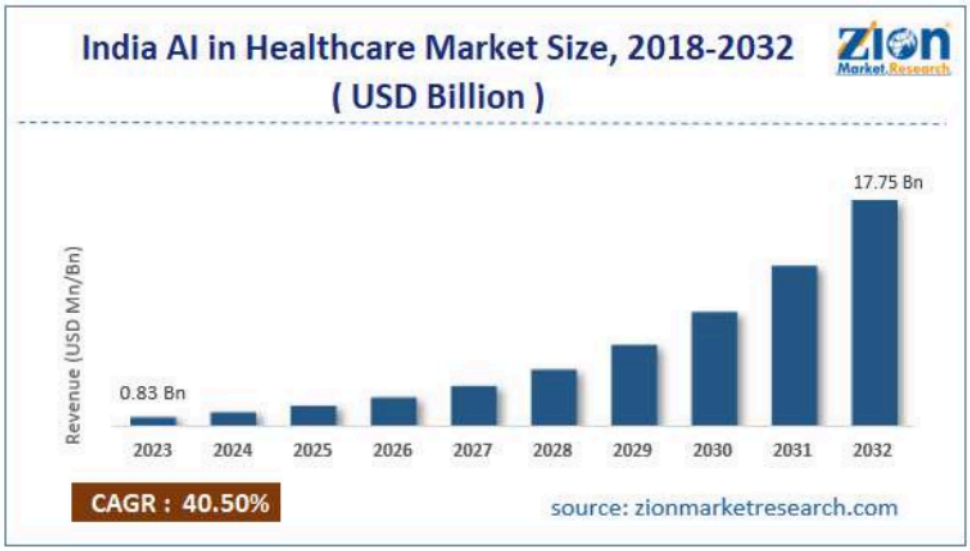
Key challenges include:

- Digital divide and connectivity issues
- Data privacy and cybersecurity risks
- Quality assurance and clinical accountability
- Legal clarity regarding liability

Healthcare managers must balance innovation with ethical and regulatory compliance.

15.3. Digital Transformation in Healthcare





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1 Meaning of Digital Transformation

Digital transformation in healthcare refers to the systematic integration of digital technologies into all aspects of healthcare delivery and management, resulting in fundamental changes in how services are delivered, decisions are made, and value is created.

It goes beyond digitisation of records and involves process re-engineering, data-driven decision-making, and patient-centric models.

---

2 Key Elements of Digital Transformation

- Electronic Health Records (EHRs)
- Hospital Information Systems (HIS)
- Artificial Intelligence and analytics
- Digital billing and insurance platforms
- Patient portals and mobile applications

---

3 Impact on Healthcare Delivery

Digital transformation enables:

- Integrated and coordinated care
- Real-time access to patient information

- Evidence-based clinical decisions
- Improved operational efficiency
- Enhanced patient engagement

---

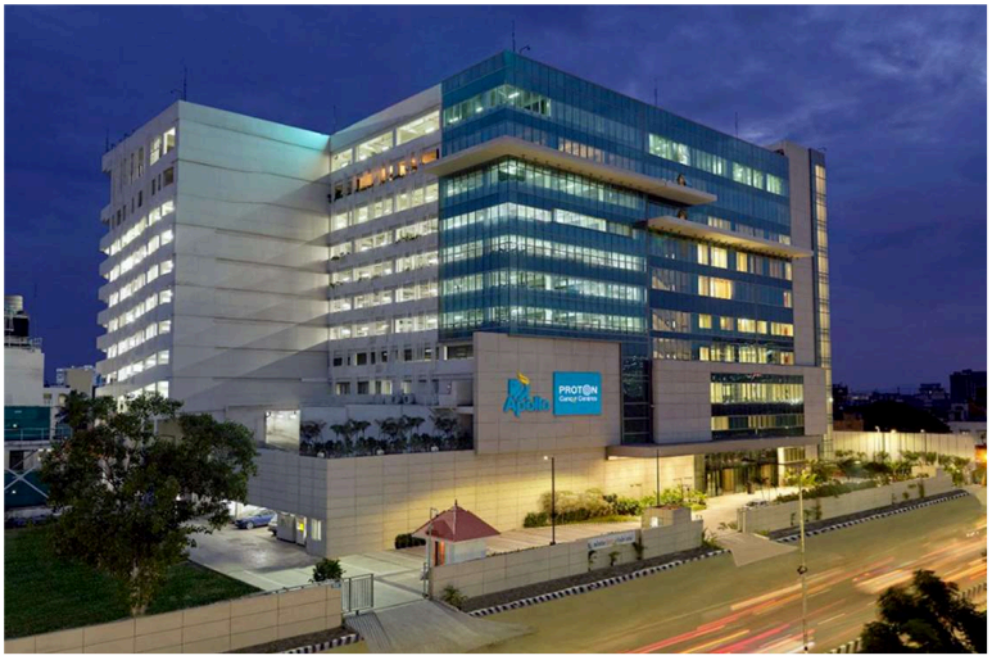
4 Organisational and Managerial Implications

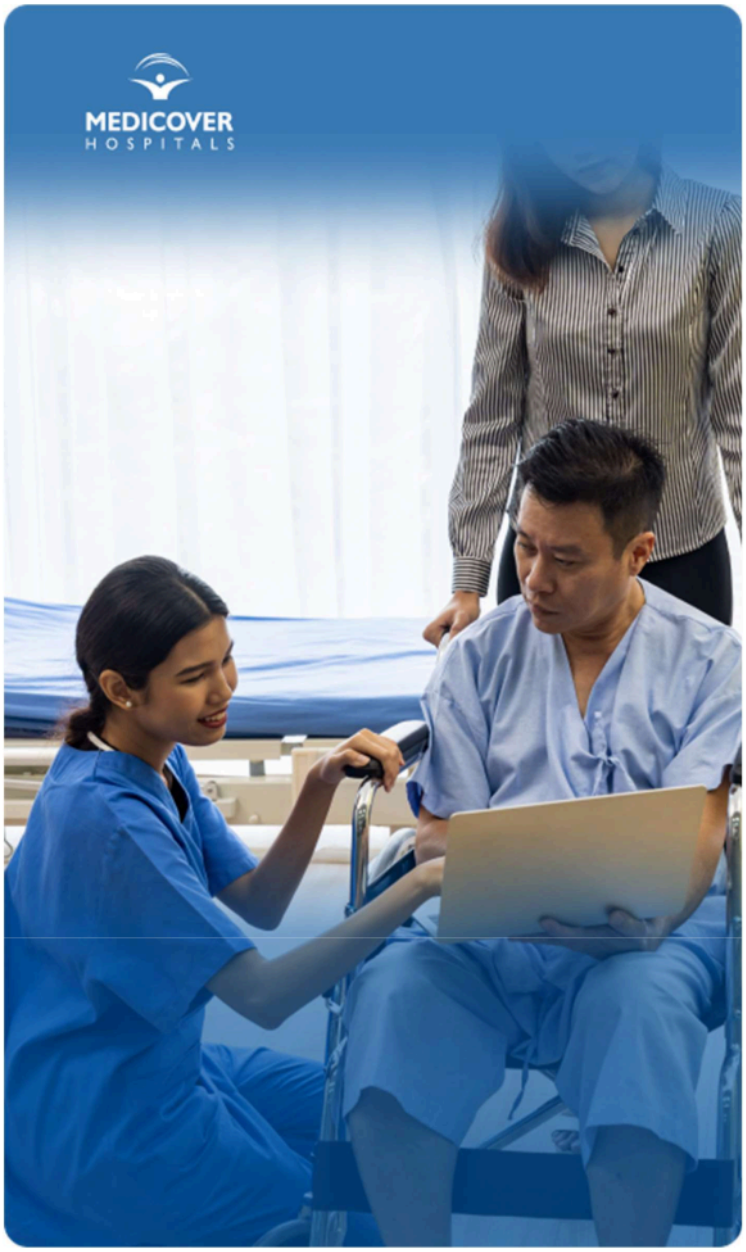
For healthcare organisations:

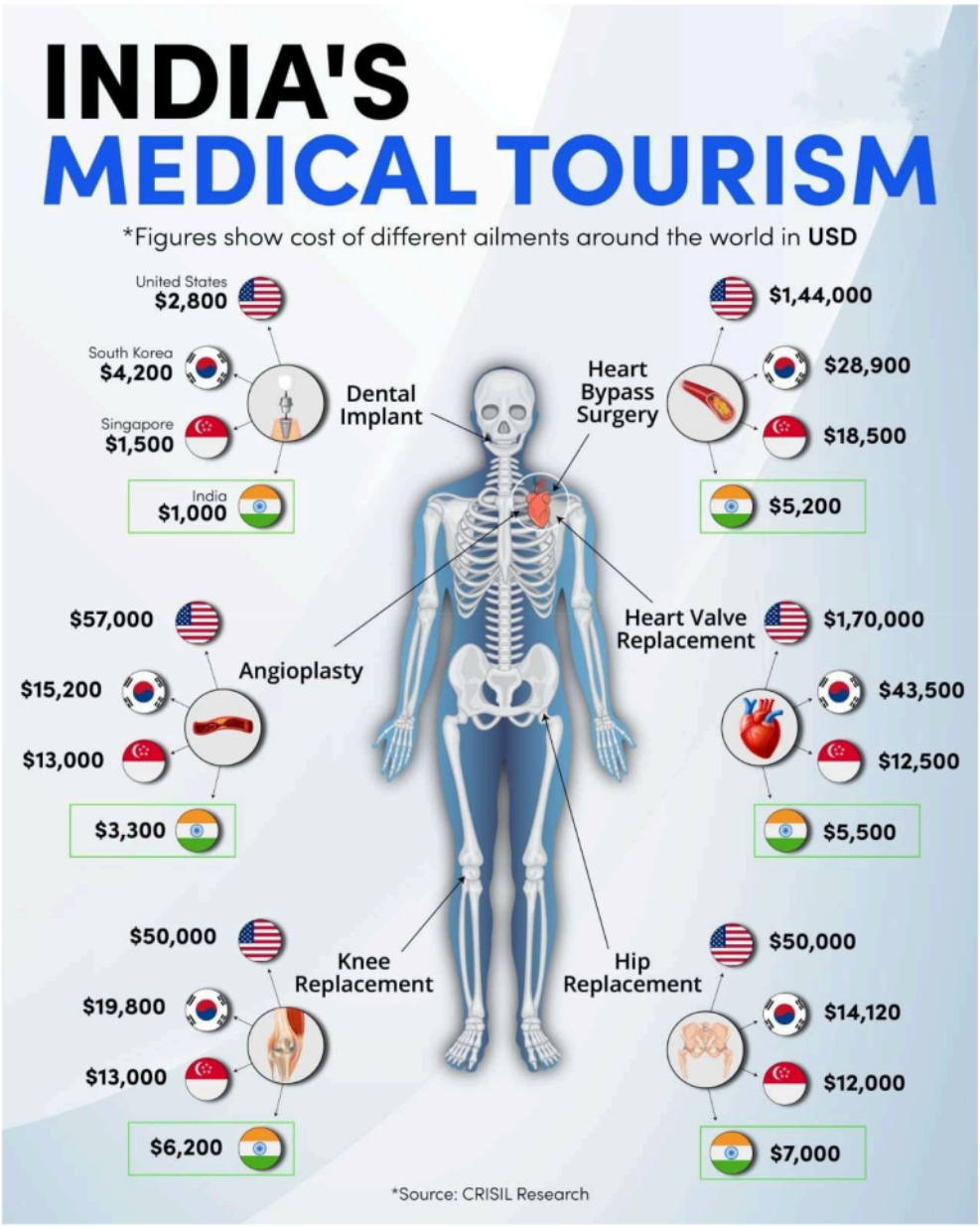
- Requires change management and staff training
- Involves investment in IT infrastructure
- Demands data governance and cybersecurity frameworks
- Supports performance monitoring and quality improvement

Digital maturity is increasingly viewed as a competitive advantage in the healthcare market.

15.4. Medical Tourism




MEDICOVER
HOSPITALS



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1 Concept of Medical Tourism

Medical tourism refers to the practice of travelling across national borders to obtain medical treatment. Patients seek care abroad due to:

- Lower cost of treatment

- Better quality or advanced technology
- Shorter waiting times
- Availability of specialised procedures

---

2 Growth of Medical Tourism

Medical tourism has grown rapidly due to:

- Globalisation of healthcare services
- Improved international connectivity
- Growth of corporate hospitals
- International accreditation and quality standards

---

3 Types of Medical Tourism Services

Common services sought by medical tourists include:

- Cardiac surgery
- Orthopaedic procedures
- Oncology treatments
- Cosmetic and elective surgery
- Organ transplantation (where legally permitted)

---

4 Economic and Business Significance

Medical tourism contributes to:

- Foreign exchange earnings
- Growth of private healthcare sector
- Employment generation
- Development of allied services such as hospitality and travel

---

5 Challenges in Medical Tourism

- Ethical concerns and equity issues
- Regulatory and legal compliance
- Continuity of post-treatment care

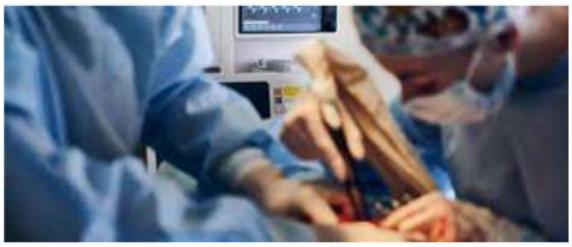
- International competition

Healthcare managers must balance commercial opportunity with ethical responsibility.

15.5. India as a Global Healthcare Destination

NABH Accredited Hospitals

S No.	Accr. No.	Name	Valid Form	Valid Upto
1	H-2006-0001	B.M. Birla Heart Research Centre, Kolkata	October 30, 2009	October 29, 2012
2	H-2006-0002	MIMS Hospital (MIMS Ltd.), Calicut	October 30, 2009	October 29, 2012
3	H-2007-0003	Kerala Institute of Medical Science, Thiruvananthapuram	February 06, 2010	February 05, 2013
4	H-2007-0004	Max Super Speciality Hospital, New Delhi	February 06, 2010	February 05, 2013
5	H-2007-0005	Max Super Speciality Hospital (A Unit of Devki Devi Foundation), New Delhi	February 06, 2010	February 05, 2013
6	H-2007-0006	Moolchand Hospital, New Delhi	March 19, 2010	March 18, 2013
7	H-2007-0007	Narayana Hrudayalaya, Bangalore	June 05, 2010	June 04, 2013
8	H-2007-0008	Dr. L. H. Hiranandani Hospital, Mumbai	September 14, 2010	September 13, 2013
9	H-2007-0009	Fortis Hospital, Noida	December 19, 2010	December 18, 2013
10	H-2007-0011	Columbia Asia Medical Centre - Hebbal, Bangalore	December 20, 2010	December 19, 2013
11	H-2008-0012	Manipal Hospital, Bangalore	Feb 11, 2011	Feb 10,2014
12	H-2008-0013	Nethradhama Superspeciality Eye Hospital, Bangalore	May 27, 2011	May 26, 2014
13	H-2008-0015	Baby Memorial Hospital Calicut , ACCREDITATION KEPT IN ABEYANCE	June 16, 2008	June 15, 2011
14	H-2008-0016	Escorts Heart Institute And Research Centre, New Delhi	June 16, 2011	June 15, 2014
15	H-2008-0017	Sir Ganga Ram Hospital, New Delhi	June 16, 2011	June 15, 2014
16	H-2008-0018	Fortis Escorts Hospital, Jaipur	June 16, 2011	June 15, 2014
17	H-2008-0019	Fortis Hospital, Mohali	June 16, 2011	June 15, 2014
18	H-2008-0023	Dharamshila Hospital and Research Centre, Delhi	November 21, 2011	November 20, 2014



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1 Factors Supporting India’s Global Position

India has emerged as a preferred medical tourism destination due to:

- Highly skilled medical professionals
- Advanced medical technology

- Internationally accredited hospitals
- Cost-effective treatment (often 30–70% lower than Western countries)
- English-speaking healthcare workforce

---

2 Role of Technology and Innovation

Technology and digital health strengthen India's global appeal by:

- Supporting advanced procedures like robotic surgery
- Enabling tele-follow-up for international patients
- Enhancing transparency and trust through digital records

---

3 Government and Institutional Support

Policy support and promotion initiatives by agencies such as the Ministry of Health and Family Welfare and international recognition by bodies like the World Health Organization have contributed to India's reputation.

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4 Strategic Implications for Healthcare Managers

For hospital administrators:

- Medical tourism requires international marketing and branding
- Compliance with global quality and ethical standards is essential
- Integration of clinical excellence, hospitality, and digital services is critical

---

15.6 Integrative Perspective

Technology, innovation, and medical tourism are mutually reinforcing components of the modern healthcare business environment. Robotic surgery and digital health enhance clinical outcomes, telemedicine ensures continuity of care, digital transformation improves efficiency, and medical tourism expands global reach.

15.7. Relevance to Healthcare Business Environment

For MBA (HA) professionals, these developments:

- Shape competitive strategies
- Influence investment and capacity planning
- Require ethical, legal, and managerial oversight
- Position healthcare organisations in global markets

15.8. Concluding Note

The future of healthcare lies in responsible adoption of technology and innovation, supported by strong governance and patient-centred values. India's growing role in medical tourism demonstrates how technology-enabled healthcare can contribute to both national economic development and global health service delivery.

15.9 Summary:

Technology, Innovation, and Medical Tourism

Rapid advances in technology and innovation have transformed healthcare delivery, management, and global competitiveness. Modern healthcare systems increasingly rely on advanced medical technologies, digital platforms, and innovative service models to improve clinical outcomes, efficiency, access, and patient experience. These developments are particularly relevant in the contemporary healthcare business environment, where quality, cost, and global reach determine organisational success.

Robotic surgery represents a major technological innovation in healthcare. By using computer-assisted robotic systems, surgeons can perform complex procedures with greater precision, minimal invasiveness, and enhanced visualisation. Robotic surgery has been widely adopted in specialties such as cardiac surgery, orthopaedics, urology, gynaecology, and oncology. Its advantages include reduced blood loss, shorter hospital stays, faster recovery, and improved patient satisfaction. However, high capital costs, maintenance expenses, and the need for specialised training pose managerial and economic challenges, requiring careful cost–benefit analysis by hospital administrators.

Telemedicine and e-health have emerged as critical tools for improving healthcare access, especially in geographically diverse countries like India. Telemedicine enables remote consultation, diagnosis, follow-up, and monitoring through information and communication technologies. E-health encompasses a broader digital ecosystem, including electronic health records, mobile health applications, e-prescriptions, and health information systems. These technologies enhance continuity of care, reduce patient travel and waiting time, and support public health surveillance. At the same time, issues such as data privacy, cybersecurity, digital literacy, and legal accountability must be addressed to ensure ethical and effective use.

Digital transformation in healthcare goes beyond simple digitisation of records and involves the comprehensive integration of digital technologies into clinical, administrative, and managerial processes. Hospital information systems, data analytics, artificial intelligence, and digital insurance platforms enable evidence-based decision-making, operational efficiency, and patient-centred care. Digital transformation requires strong leadership, change management, workforce training, and robust data governance frameworks. For healthcare organisations, digital maturity has become a key source of competitive advantage.

Medical tourism refers to the movement of patients across national borders to seek medical treatment. It has grown rapidly due to globalisation, improved connectivity, and disparities in healthcare costs and waiting times across countries. Patients often seek complex procedures such as cardiac surgery, orthopaedics, oncology, and cosmetic treatments. Medical tourism

contributes significantly to economic growth through foreign exchange earnings, employment generation, and development of allied sectors.

India has emerged as a global healthcare destination due to its combination of highly skilled medical professionals, advanced medical technology, internationally accredited hospitals, English-speaking workforce, and cost-effective treatment—often at a fraction of the cost in Western countries. The integration of robotic surgery, digital health, and telemedicine has further strengthened India's global appeal. For healthcare managers, success in this domain requires balancing technological excellence, ethical responsibility, regulatory compliance, and international patient expectations.

In summary, technology, innovation, and medical tourism are interconnected forces reshaping healthcare delivery and business strategies. Their effective integration is essential for achieving quality, efficiency, global competitiveness, and sustainable growth in the healthcare sector.

15.10 Learner Activities (Aligned with UGC–DEB Guidelines)

Activity 1: Technology Mapping Exercise

Task:
Identify any one healthcare technology (robotic surgery, telemedicine, or digital health system) used in an Indian hospital. Write a brief note on:

- Its purpose
- One clinical or managerial benefit

Learning Outcome:
Helps learners understand practical applications of healthcare technology.

Activity 2: Digital Health Reflection

Task:
Write a short note (5–6 sentences) on:

How telemedicine and e-health can improve healthcare access in rural India.

Learning Outcome:
Encourages application of digital health concepts to real-world challenges.

Activity 3: Medical Tourism Analysis

Task:
List three reasons why international patients choose India for medical treatment and mention one challenge faced by hospitals in managing medical tourists.

Learning Outcome:
Develops insight into medical tourism as a healthcare business strategy.

15.11. Key Words with Explanation

- Robotic Surgery – Use of computer-assisted robotic systems to perform precise surgical procedures.
- Telemedicine – Delivery of healthcare services using information and communication technologies over distance.
- E-Health – Use of electronic processes and digital tools in healthcare delivery and management.
- Digital Transformation – Integration of digital technologies to improve healthcare processes, outcomes, and efficiency.
- Medical Tourism – Travel across borders to receive medical treatment.
- Health Innovation – Development and application of new technologies, processes, or services in healthcare.
- Global Healthcare Destination – A country offering internationally competitive healthcare services.

15.12. Self-Assessment Questions

A. Short Questions (with Answers)

1. What is robotic surgery?
   A technology-assisted surgical method using robotic systems.
2. Define telemedicine.
   Provision of healthcare services remotely using ICT.
3. What is meant by digital transformation in healthcare?
   Adoption of digital technologies to improve healthcare delivery.
4. What is medical tourism?
   Travel to another country for medical treatment.

5. Why is India popular for medical tourism?
   Quality care at affordable cost with skilled professionals.

B. Essay Questions (with Hints)

1. Explain the role of robotic surgery in modern healthcare.
   Hints: Precision, outcomes, technology.
2. Discuss telemedicine and e-health initiatives in India.
   Hints: Access, digital platforms, rural care.
3. Analyse digital transformation in healthcare organisations.
   Hints: EHRs, efficiency, decision-making.
4. Examine the concept and growth of medical tourism.
   Hints: Globalisation, cost, quality.
5. Evaluate India's position as a global healthcare destination.
   Hints: Infrastructure, accreditation, competitiveness.

C. Multiple Choice Questions (with Answers)

1. Robotic surgery mainly improves:
   a) Hospital marketing
   b) Surgical precision
   c) Insurance coverage
   d) Medical tourism visas
   Answer: b) Surgical precision
2. Telemedicine primarily helps in:
   a) Increasing hospital stay
   b) Remote healthcare delivery
   c) Drug manufacturing
   d) Medical education only
   Answer: b) Remote healthcare delivery
3. E-health mainly involves:
   a) Paper records
   b) Electronic health systems
   c) Manual billing
   d) Physical referrals
   Answer: b) Electronic health systems
4. Medical tourism depends largely on:
   a) Climate
   b) Political system
   c) Cost and quality of care

d) Language only
Answer: c) Cost and quality of care

5. India's advantage in medical tourism is:
   a) High cost
   b) Limited specialists
   c) Affordable advanced care
   d) Restricted technology
   Answer: c) Affordable advanced care

D. Comprehensive Case Study (Expanded – Textbook Style)

Case: Digital Innovation and Medical Tourism in an Indian Corporate Hospital

A NABH-accredited hospital in India invested heavily in robotic surgery platforms, telemedicine units, electronic health records, and digital patient management systems. These innovations reduced surgical complications, improved recovery time, and enabled remote follow-up consultations for international patients.

The hospital attracted patients from Africa, the Middle East, and South-East Asia for orthopaedic, cardiac, and oncology treatments. Marketing through international facilitators and transparent pricing enhanced trust. However, the hospital also faced challenges related to data security, technology costs, and regulatory compliance.

This case demonstrates how technology adoption and digital transformation support medical tourism while creating managerial challenges.

15.13 Analytical Questions and Plausible Answers

1. How did technology enhance patient outcomes?
   Through precision surgery and digital monitoring.
2. Why did international patients prefer India?
   High quality care at lower cost.
3. What role did digital health play in follow-up care?
   Enabled remote consultations and continuity of care.
4. What managerial challenges emerged?
   Technology investment, data protection, compliance.
5. What lessons can healthcare managers learn?
   Strategic technology adoption and global patient focus.

15.14. Standard Textbooks and Reference Materials

Textbooks (Purchasable by Students)

1. Goel, S. L. – *Health Care Administration in India*

2. Basu, D. – *Health Policy, Planning and Management*
3. Gapenski, L. C. – *Healthcare Finance*
4. Shortliffe, E. & Cimino, J. – *Biomedical Informatics*
5. Porter, M. E. – *Redefining Health Care*

Reports, Web Resources & Other References

- World Health Organization – Digital health and innovation reports
- Ministry of Health and Family Welfare – Digital health initiatives
- NITI Aayog – Medical tourism and innovation reports
- Medical Tourism Association – Global medical tourism data

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