SUMMER TRAINING REPORT

BY

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MBA HOSPITAL AND HEALTH MANAGEMENT

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This report has been prepared for the internship that has been done in order to study the practical aspects of the course and implementation of the theory.

The aim of this internship is to be familiar with the practical aspect and uses of theoretical knowledge and clarifying career goals. I have learned a lot of valuable things while working & I realized that learning is never the same when it comes to practice.

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With regards
Shivangi
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ACRONYMS/ ABBREVIATIONS

S.No.	Acronyms	Full Form
1	DALY	Disability Adjusted Life Years
2	IRDA	Insurance Regulatory and Development Authority
3	NRHM	National Rural Health Mission
4	AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy
5	NHSRC	National Health Systems Resource Centre
6	HIS	Health Management Information Systems
7	GDP	Gross Domestic Product
8	MoHFW	Ministry of Health and Family Welfare
9	NFHS	National Family Health Survey

PART-I

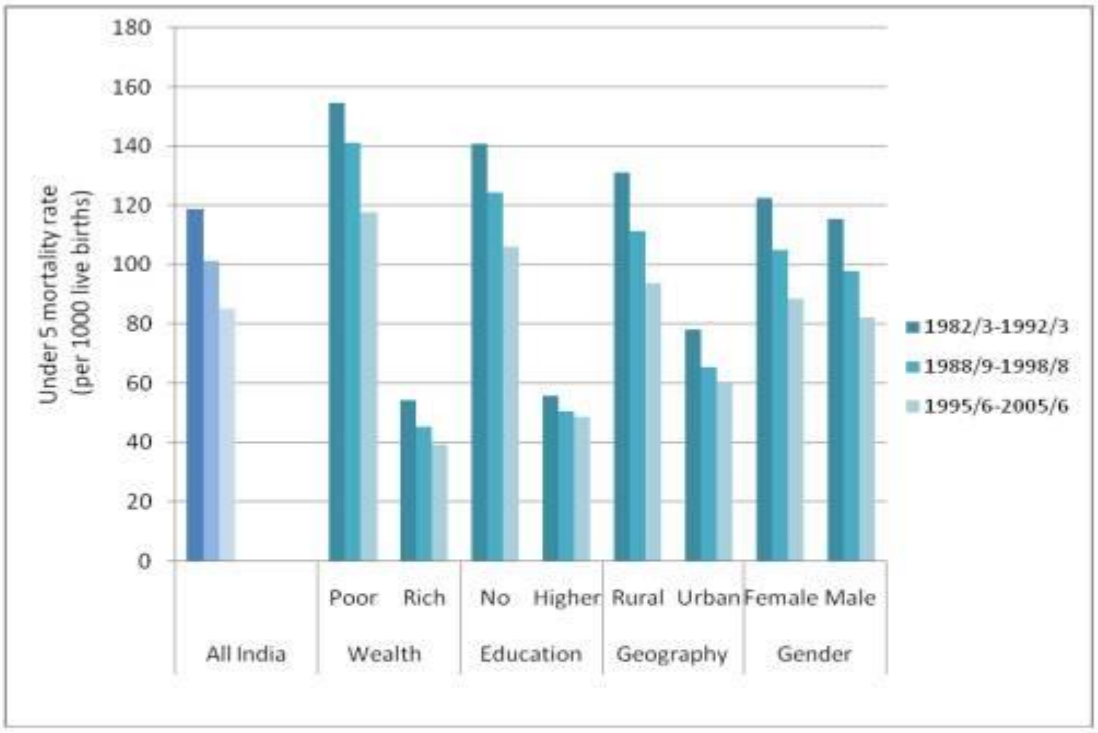
WORK FROM HOME REPORT

HEALTHCARE AND EQUITY IN INDIA

INTRODUCTION

India holds a significant share of the worldwide freight of illness or disease, accounting for About 18% of worldwide demises and then 20% DALY(disability adjusted life years).[1] 53% of deaths (44% part of DALYs) accounts for the rising burden of long-term(chronic) disease, 36% of demises (42% part of DALYs) accounts to infectious diseases, perinatal & maternal state, and nutriment insufficiency suggests a prolonged transformation which is epidemiological.[2] 1/5th of deaths related to mothers(maternal) and child deaths accounts one-quarter globally which occurs in the country like India.[3,4] Expectancy of life at birth was 73.7 years in urban centres & 69 in rural areas for females and 71.2 and 66.4 years for males.[5]

While outcomes of the health has been improved with the progress of time, they are continuing to be firmly figured along the different aspects or dimensions which include caste, gender, geography, education and wealth.[6-8] For instance, among the richest and poorest quintiles of the wealth the infant death rate was observed to be 29.9 deaths per 1,000 live births & 31.5 per 1000 live births in 2018 and 2019, discretely.[9]



Source: NFHS 1992/3, NFHS 1998/9 and NFHS 2005/6

Notes: Under-5 mortality rates for the ten-year period preceding the survey, by selected background characteristics (excludes month of interview from analysis); Inequalities are presented in the following manner: Wealth: poorest quintile vs. richest quintile; Education: no education vs. higher education.

FIGURE 1-Disparities in Under-five deaths along different dimensions in India

Most of these disparities in health is an effect of a comprehensive set of factors like political, economic, and social factors which governs the dispensation of healthcare in a specific population. Rectifying any unfairness in healthcare could be contemplated as major aim of public healthcare programs and have a special and specific part to attain equity with effectiveness, in the health division in the community.[14-16]

Equity in healthcare have been long established concepts which are guiding us with dedication to serve the requirements of deprived sections of the society which are

treated as the major and important to documents of health policy. However, carrying out commitments of policy to healthcare equity still remains a major challenge seeing that India's implementation and institutional capabilities,[21] despite the fact that this is a challenge not only unique to India but the whole global health community facing the same sort of challenge.

OBJECTIVES

1) To study the major challenges to equity in financing and risk protection related to this and the service delivery in India.

2) To study other factors which influence the overall equity which help in implementing of these propositions, in association with the reinforcement of primary healthcare services, providing with an appropriate and trustable process to ensure more healthcare which is equitable for Indian community.

METHODOLOGY

Data from secondary sources through journals and research papers on healthcare and equity in India.

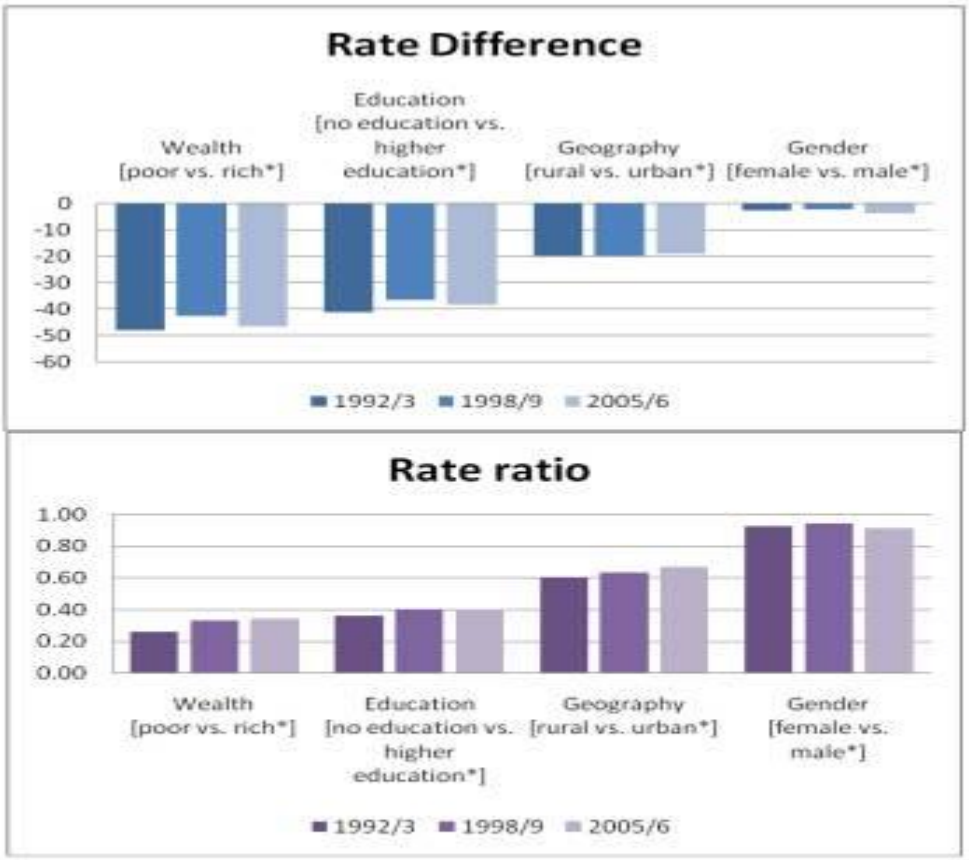
RESULTS AND DISCUSSION

- **INEQUALITIES IN HEALTHCARE**

The contrary care law, by means of which those with the substantial requirement of healthcare have the inordinate difficulty to access the healthcare services and have slightest chances to meet their healthcare needs,[23] is extremely pertinent in country like India.[24-26] It can be considered accessibility as relatedly the capability to acquire a specific facilities, at a quality stage which is specified, subjected to a particularize restriction of cost linked with the inconvenience carried out,[27] and infliction of chosen services of health as a substitute for access. To clearly understand the persevere inequities and inequalities in healthcare in India, we're primarily focusing on the approachability to maternal and child healthcare services, as the burden of disease related to communicable or infectious diseases, maternal and perinatal conditions are conveyed by accessibility to these healthcare services.

- **INEQUALITIES IN PREVENTIVE HEALTHCARE**

Administration of preventive healthcare facilities like prenatal care & immunizations endures negligible, with significant variability in the administration of such type of facilities in terms of geography, gender and socioeconomic status. Years between 2005–2006, the overall immunisation coverage of India was seen at 44%. Disparities in vaccination subsist with the household wealth & education, with definite & comparative inequalities shows indication of depletion over the time. Inequalities subsist by caste in the year between 2005–2006, immunization coverage amid SCs and STs was 39.7% and 31.3% consecutively in comparison with 53.8% amongst different social class with definite disparities betwixt these social classes escalating over the time-period. Coverage is observed exorbitant in urban zones that is 58% in comparison to the rural zones that is 39%, even though definite and comparative rural & urban dissimilarities have been depleting over the time-period. As years passed by, the definite gap between gender has escalated with a definite 2.6% gap between gender in 1992–1993 escalating to 3.8%s gap seen in the year 2005–2006.



Source: NFHS 1992/3, NFHS 1998/9 and NFHS 2005/6

Notes: The immunization coverage represents percentage of children aged 12-23 months who had received full immunization consisting of BCG, measles, and three doses each of DPT and polio vaccines (excluding Polio 0).
* represents the reference group.

FIGURE 2-Trends in disparities in immunization coverage along different proportions indicated in rate difference (definite disparities) and rate ratio (comparative disparities)

Similarly, related specifications in disparities has been observed for coverage of prenatal care. Years between 2005–2006, it was seen that 77% of the population of Indian women at the time of their gestation period encountered some formation of prenatal care in the time period of 3 years preceding to the survey, in spite of the fact that only 52% have been going for the suggested three or more than three visits. Altogether, progression in the coverage of antenatal has escalating over the time.

- **<u>INEQUALITIES IN CURATIVE HEALTHCARE</u>**

Insufficient ingress to pertinent maternal services in health still remains a significant determining factor for maternal mortality rate. Even though the charges of delivery which

are institutional have escalated over a certain period of time. There subsists a 6-fold differentiation between the poorest and richest sections of the society in institutional delivery (Figure 2). Even though this comparative deviation in inequity has diminished over certain period of time, the definite percentage variation in the prevalence of institutional deliveries between the richest and poorest has been observed that it has been increased from 38.7% to 78.9% in the span of 10 years till 2015-16, as per National Family Health Survey (NFHS-4).

Even though the impoverished are more expected to be on the lookout for health care in the civil section, the advantaged section seize more of the part of the share of civil facilities since they are more expected to make use of these kind of facilities, and besides be on the lookout for health care in high-level services.[29] The advantages sections of the society are also more expected to be admitted to the hospital, and have prolonged inpatient visits in the civil section.[30] Earlier probe of health services in civil section exhibited that the preventative healthcare facilities of antenatal and immunisation visits reveals a more impartial dispensation than the curative care.[29]

Although progression has been observed, disparity go on to persevere in ingress to facilities. There is distinctive shift in absolute and relative disparities proposing distinctive access and uptake to facilities by divergent sections and recognising these modulated sequences which has scheme consequences for finer positioning of facilities to disadvantaged sections.

- **FACTORS TO ACHIEVE EQUITY IN HEALTHCARE**

Attaining fairness in approach to healthcare call for conquering various factors that stand against equity in delivery of service, and equity of financing in health. These factors need to be inspected through an interlinked demand-supply structure for healthcare facilities (Figure 3). With the supply side, the issues which are examined are correlated to attain fairness in service delivery which confirms access to a certain level of well-equipped services, and on the demand side we are trying to investigate financial equity in health and risk-protection financially and contemplate how the prices of looking for healthcare may restrict the usage, mainly when expenditure which are out of pocket are tremendously high-level.

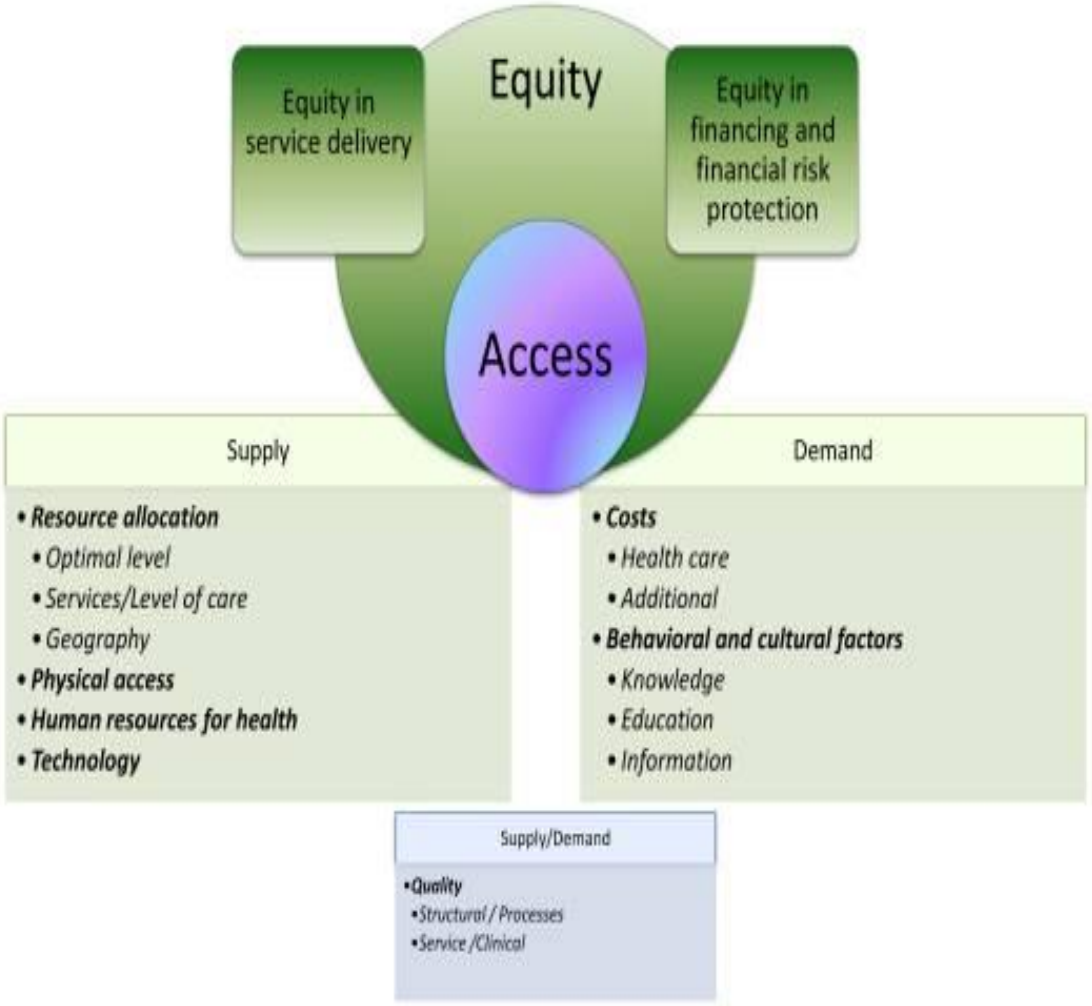


FIGURE 3-Definitional model to understand challenges to equity in healthcare

- **FACTORS FOR SUPPLY SIDE**

Suboptimal and inequitable resource allocation- The systematic allotment of resources between contrasting levels of services and between separate geographical sections is evaluative in ensuring the physical accessibility of the pertinent level of sufficiently resourced healthcare facilities.[15] India's total expenditure on health was estimated at 3.6% of the Gross Domestic Product (GDP) in 2019–20, Private dissipation on health have still remains high over the past decade, with India is having one of the largest share of household out-of-pocket expenses on healthcare in the world, approximated at 65.8% in urban and 68.3% in rural areas. There is also broad variation in expenditures of state on healthcare, with a 7-fold distinction between the

major states. As for example, public expenditures per capita on healthcare in Bihar is estimated at Rs 100 in contrast to Rs 447 per capita on health in Tamil Nadu as in 2004–2005.[31] The private division dominates facility provision of high end curative facilities, and reports from national household surveys(NFHS) exhibits the widening role of the private division over the past two decades arising as the predominant contributor of inpatient care.[34]

Physical access

Physical access is a major obstacle to both curative and preventive healthcare facilities for India's substantial rural section population i.e., >70%. The number of government hospital beds in urban areas is twice the number or even more than that in comparison to rural areas,[35] and the prompt development of the private division in urban areas has ensued in an unequal and unplanned geographical dispersion of facilities.[36] As substantial distance to services is a key factor for access,[37,38] overcoming this through extend or finer roads, transport and communication system is mandatory for reaching out to impoverished and physically secluded groups, such as SCs and STs. Furthermore, physical access of facilities does not necessarily insure practical and effective use since the prices correlated with seeking care also hinder uptake, even when facilities are physically accessible.

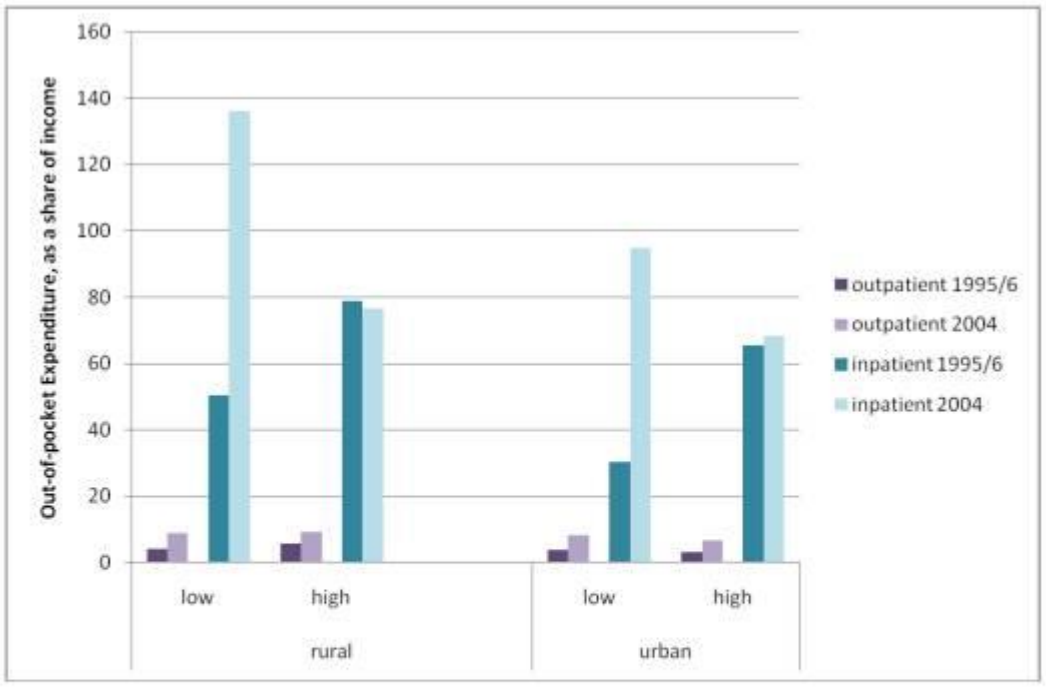
Human resources for health

India faces the challenge of bearing suitable level, skillset mix, distribution of human resources and quality for healthcare, beyond states and mainly in impoverished rural areas. Rural areas are assisted by more than million rural health practitioners, many of whom are not even formally given training or have license.[40] Since the most underprivileged are more expected to receive treatment from less qualified and unskilled healthcare providers, India's human resources for health challenge represents a further obstruction for insuring healthcare equity.

- **FACTORS FOR DEMAND SIDE**

- **Economical constraints**

Decreased levels of funding coming from public, Absence of a broad risk pooling system, and top-level out of pocket expenses in the subject of rising health prices are key factors influencing financing in health and risk protection in equity. Evidences from national expenses studies indicates that disparities in financing of healthcare have augmented over the past two decades.[34] Comprehensive insurance accessed the Indian market after passing of the bill which was IRDA (Insurance Regulatory and Development Authority) Bill in the year 1999. Public-based healthcare insurance programs for the unorganised section which persuades risk pooling coverage lower than 1% of the whole population.[52,57] Therefore out of pocket expenses and the integrated disparities dominate. Out of pocket expenses on healthcare, as a portion of household expenses, has been rising as the time passes by, in both urban and rural areas.[34,55] Expenses on both outpatient and inpatient healthcare are constantly inflated in public services in comparison to private services; and the expenditure of non-infectious disorders outdo that of infectious disorders.[60] In particular, the portion of expenses which is being expended on healthcare has risen incrementally for the impoverished households.



Source: NSSO 52nd, 60th rounds, adapted from Yip W, Mahal A. The Health Care Systems Of China And India: Performance And Future Challenges. Health Aff. 2008 July 1, 2008; 27(4):921-32)

Notes: Annual income per capita (accounts for household size and standardized to 1993 Rupees). 'Low' indicates the lowest quintile, and 'high' the highest quintile income group. Outpatient episode is per outpatient visit, and inpatient episode is per hospital admission.

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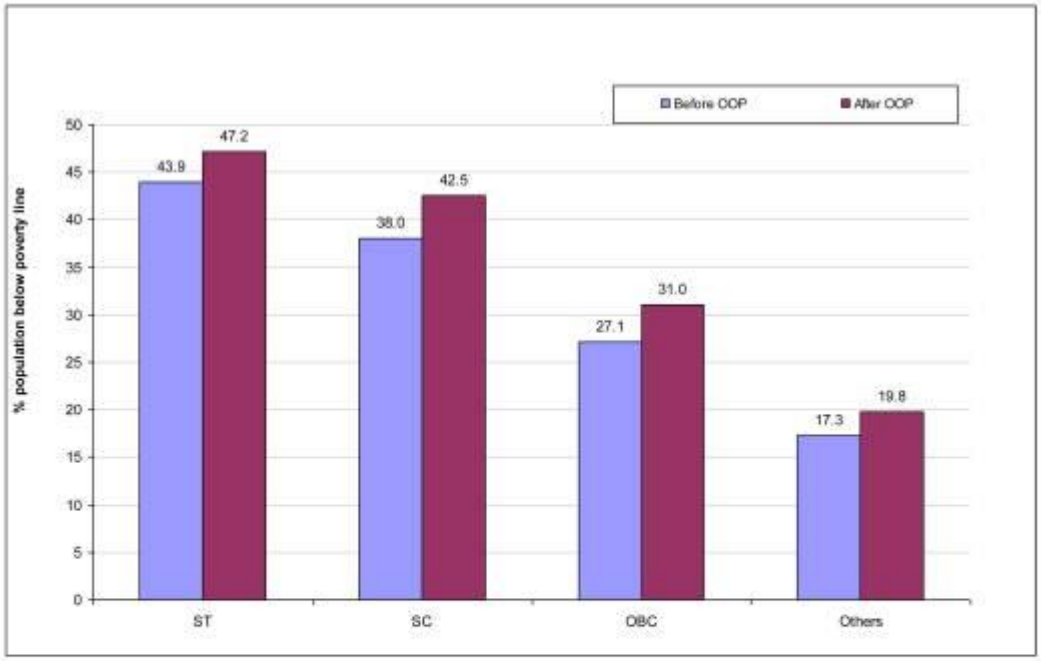
FIGURE 4-Trends in out-of-pocket health expenditures in households per episode, as a share of income by income group and residence



Source: Authors' calculations based on Consumer Expenditure Surveys 1993-94 (50th Round), 1999-2000 (55th Round) and 2004-5 (61st Round), NSSO

Notes: In India, official poverty lines are based on a calorie norm of 2,400 calories per capita per day for rural areas and 2,100 calories per capita per day for urban areas. The proportion of population with monthly per capita expenditure (MPCE) less than the specified poverty line (calorie norm) are considered below poverty. Before and after OOP refers to a situation where before OOP is percent population below poverty without taking into consideration OOP, while the latter denotes percent population below poverty after taking into account OOP.

FIGURE 5-Impact of out-of-pocket payments (OOP) on poverty ratios in India

- **Health spending inflation**

Health spending inflation is another essential factor restricting ingress to healthcare facilities and financial equity. Although prices have been increased in both the private and public sector, this rise has been much rapid (above 100%) in the private sector.[34] Rise in expenses has been rapid for rural inpatient facilities.[65] Expenses on drugs have been rising with time, and drug prices constitutes a much bigger proportion of expenditures which are out-of-pocket for the impoverished as compared

to the rich sections. Current drawbacks in the adequacy and effectiveness of drug cost control, regulating the pharmaceutical market, and distributions and procurement mechanisms aggravate inequitable ingress to economical quality drugs.[66,67] The portion of drugs under cost control has diminished markedly; whereas in and around about 90% of drugs were under cost control in the year 1970s, only about is 10% are today.[66] Moreover, analysis of modifications in drug costs shows that between the years 1996-2006, medicines in a selected basket of drugs increased by 40%; whereas the costs of drugs on the essential drugs list increased by 15%, drugs not on the list of essential drug and not cost controlled increased by 137%.[67]

- **PRINCIPLES TO ACHIEVE EQUITY IN HEALTHCARE**

The obstacles faced by the health care system in its pursuit for healthcare equity in are significant. These obstacles are further intricated by the interplay of these obstacles which act distinctively at state, local and individual stage, diversity in the scale, which call for contextually pertinent solutions. In the past few years India has been making substantial improvement, with various examples of innovative programmes and initiatives which are operated in the private and public sector with the most notable initiative which is government-led being the NRHM (National Rural Health Mission) which was started in 2005. This initiative has initiated the rejuvenation and repositioning of the public healthcare network. To support and complement and support these, here we are proposing the following supportive principles to help attain healthcare equity.

- **EQUITY METRICS**

Equity metrics needs to be consolidated into all healthcare system policies and assigning strategies, and at each and every level of any reform procedure. Advised by the Commission on Social Determinants and others,[14,77,78] this involves applying an approach which is totally equity focused to the use, collection, and application of data on health result or outcomes and means of healthcare, and performance of health systems during monitoring and evaluation. This requires a self-regulating system built

across the health system nexus, comprising the private and public sector, and non-allopathic medicine AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy) and allopathic medicine, placed with international standards and principles for health equity metrics.[79]

- **SUSTAINABLE DEVELOPMENT FOR HEALTH SYSTEMS AND HEALTH EQUITY RESEARCH**

There needs to be a combined effort to boost the base of the knowledge of healthcare systems research and healthcare equity research.[81] India is in the position to take a foremost role in boosting our knowledge of healthcare systems probe at the worldwide level. Given that much of the execution and resolutions are made at the state and local stage, there is the chance to actively acquire knowledge from the multitude of distinct refinement. Although, it is imperious at the conception that optimal data management network and research design are put in place, so to capitalize on acquiring knowledge from the arbitration and understanding which scheme and interventions work and how they influence equity in healthcare. This is even more mandatory, given the constant rolling out and scaling up these reforms, which is guided by where resources should be most effectively conducted to boost up the possibility of success.[79] However there have been unconventional and internal analysis of the NRHM,[74-76 ,82] both of particular programs and in specified states, there is the acute need for further unconventional big scale evaluations.[75]

The NHSRC (National Health Systems Resource Centre) is well in position to provide the important framework to facilitate this, and support the ongoing growth of HIS (Health Management Information Systems). In this way, India can promote to the limited base of knowledge of operative research in healthcare systems in countries which are developing and support the **'knowledge-action'** gap in strengthening of healthcare systems.[85,86]

- **Contemplative process to achieve equity in healthcare**

There is need for more significant determinant and growth of the regulatory approach related to achieve healthcare equity. The challenges of mapping out and executing pro-equity healthcare schemes when resources are restricted needs a contemplative approach. This call for taking into deliberation the repercussions and threats of those resolutions, with observing and checking the progress of how such resolutions will influence healthcare equity. Additionally, with India's elderly population call for consideration of inter-generational equity in the assigning of finite resources within distinct age-groups.

It is suggested to review and formalize the procedure of resources assigning resolution and planning of service delivery, which includes striking the stability within the three tiers centre, state and local financing, and horizontal and vertical assigning effectiveness, which is based on the best available proof, and directed by equity issues. This could be included in adopting of a system such as **'BENCHMARKS FOR FAIRNESS'** which is seen to be successfully attuned for use in various developing countries like Colombia, Pakistan and Thailand.[87]

- **<u>Stakeholder accountabilities & responsibilities</u>**

Multilaterals, civil sector, NGOs, pharmaceutical industry, local government, national, research and academic institutions all have distinct roles and responsibilities to play part in insuring the successfulness of attaining equity in healthcare and undeniably finer health governance.[88] This call for importunate transparency, accountability, and finer partnership and leadership within the healthcare mechanism, altogether with structured analysis and assessment of healthcare governance. Since healthcare scheme and execution clearly is operating within the comprehensive political factor, specifying iterative approach for major players to preserve legislative primacy for the equity in healthcare plan is mandatory to promote this matter. This is specifically necessary because the dormant assignee depict a less organised influential groups, who are consequently inadequate to impact the refinement.[89] It is needed to specifically emphasize the duty of civic society, and the necessity to empower, captivate, and capacity building within the community to behest equity in healthcare and finer healthcare quality at rational costs. Even though the proof to sustain this may be deficient, examples such as experience of China's where it was seen public discontent with the integrity of its healthcare system, exhibits how civic society can affect the changes in healthcare refinement.[10]

- **Investment in primary care and public health: Backbone for equity in health**

Eventually, prime concern should be to invest in primary care and public healthcare. To improve the subsisted disintegrated perspective to public health facilities through creating a solid foundation in public health emulated by boosting up of the primary healthcare system would go a very long way in insuring a more equitable health care in India.[91] To build the capacity and capability to design and execute public health facilities from and within the MoHFW(Ministry of Health and Family Welfare) will allow for a more collaborative strategy to effectively safeguard the community health.[91] Plausible partnerships and engagement, both within and outside the government, are in need for improvement public healthcare framework and it is better to safeguard the most pregnable from unfair subjection to unwretched risks. Such kind of financing in public health, in link with reinforcement of primary healthcare facilities and specific policies for reaching out to those disadvantaged sections is a key course of action towards rectifying the health disparities that prevail in India.[92] Primary healthcare is conceivably more complicated and indecisive in comparison at the time when Alma Ata declaration was made but to build a receptive desegregated primary healthcare facility which insures universal health coverage is also one way to control prices.[93]

CONCLUSION

There is a compelling social, moral, and economic argument for investment to achieve equity in the healthcare of Indian population. Recent prompt economic expansion accord for a distinctive opportunity to elevate financial covenant to sustain the public healthcare system and healthcare systems research. India can also extract the knowledge resource of its flourishing technology section to strengthen and innovate the evolution of HIS (health information systems). Moreover, there is the opportunity to mobilize the ability of the local pharmaceutical industry by procuring it to take bigger responsibility to deliver equity in healthcare. The next course of action is to translate these into actual and practical schemes and effectively executing them. Still, this prioritizing the role of the healthcare mechanism needs to be put in place within the bigger and broader context of the social factors of health, and addressing the root inducement of socially disadvantaged sections of the society. In this manner, a healthcare mechanism is built on a rock-solid foundation of public healthcare and primary healthcare must be cooperated with public schemes that improve intersectoral propositions. Better sanitation and water, poverty reduction, food security and changes being made to other systematic factors, which is being augmented by a more equitable healthcare framework, which will help insure additional equitable health care for beyond than a billion number of people all over the country.

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PART-II

REPORT ON ONLINE COURSE

NAME OF THE COURSE

ESSENTIALS OF GLOBAL HEALTH

COURSE DESCRIPTION

Essentials of Global Health is a comprehensive introduction to global health. It is meant to introduce to this topic in well-structured, clear and easy to understand ways. Much of this course is focused on five questions: What do people get sick, disabled and die from; Why do they suffer from these conditions? Which people are most affected? Why should we care about such concerns? What can be done to address key health issue, hopefully at least cost, as fast as possible, and in sustainable ways? The course is global in coverage but with a focus on low and middle income countrymate health of the poor, and health disparities. Particular attention is paid throughout the course to health systems issue, the linkages between health and development, and health matters related to global interdependence. The course will cover key concepts and frameworks but be practical in orientation.

COURSE OBJECTIVES

1) Articulate key public health concepts related to global health
2) Analyse the key issues in global health from a number of perspectives
3) Discuss with confidence the burden of disease in various regions of the world; how it varies by sex, age and location; key risk factors for this burden; how the disease burden can be addressed in cost-effective ways
4) Assess key health disparities, especially as they relate to the health of low-income and marginalised people in low- and middle-income countries
5) Outline they key factors and organisations in global health and the manner in which they cooperate to address critical global health concerns
6) Review key global health challenges that are likely to arise in the coming decades,

COURSE CONTENTS

MODULE 1

INTRODUCTION

- Course overview and getting started
- Key perspectives on Global Health
- The global health context and who plays

MODULE 2

THE BURDEN OF DISEASE

- The state of World's health
- Demography and Global Health
- The burden of disease-The DALY
- What do people get Sick, Disabled, and Die from?
- Key risk Factors for deaths and DALYs

MODULE 3

HEALTH SYSTEMS AND VALUE FOR MONEY IN HEALTH

- Value for money in global health
- The organisation and aims of Health Systems
- Health Expenditure, the Quest for UHC and Pharmaceuticals

MODULE 4

CROSS-CUTTING THEMES IN GLOBAL HEALTH-PART I

- Health Disparities
- The environment and health and climate change and health
- Nutrition and Global health

MODULE 5

CROSS-CUTTING THEMES IN GLOBAL HEALTH-PART II

- Women's health
- Child health
- Childhood Immunisation

MODULE 6

CROSS-CUTTING THEMES IN GLOBAL HEALTH-PART III

- Adolescent health
- Complex Humanitarian Emergencies

MODULE 7

CRITICAL CAUSES OF ILLNESS AND DEATH-PART I

- Emerging and Remerging ID and Anti-microbial Resistance
- HIV
- Tuberculosis (TB)
- Malaria

MODULE-8

CRITICAL CAUSES OF ILLNESS AND DEATH-PART II

- Neglected Tropical diseases
- Overview of Non-communicable, Cardiovascular diseases
- Cancer and Diabetes

MODULE 9

CRITICAL CAUSES OF ILLNESS AND DEATH-PART III

- Tobacco and Alcohol
- Mental Health
- Injuries

MODULE 10

LOOKING FORWARD

- Intersectoral approaches to enabling better health
- Science and Technology for Global Health
- Key challenges for the future

LEARNING METHODOLOGY

VIDEO LECTURES

READING MATERIAL

KEY LEARNINGS

1) Learned about basic concepts of global health, and a number of key perspectives for considering global health issues.
2) Examined what people get sick, disabled and die from and what risk factors and determinants these conditions can be attributed.
3) Reviewed how health systems in different parts of the world are organised, issues they face in effectively and efficiently providing appropriate services of acceptable quality.
4) Studied the relationship between the environment and health, complex humanitarian emergencies and natural disasters and health, nutrition.
5) Assessment of health of women, children and adolescents and childhood immunisation.
6) Examined communicable diseases, such as emerging infectious diseases, HIV, TB, Malaria.
7) Key issues in non communicable diseases such as heart disease, stroke, cancer and diabetes.
8) How science and technology can be harnessed through collective action, to address those challenges.