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AN EVALUATION OF PUBLIC HEALTH SCHEMES IN INDIA: A CASE STUDY OF WEST BEGAL STATE

Minhajuddin Ahmed
Research Scholar, Dept. of Management, Maharaja Agrasen Himalayan Garhwal University

Dr. Vikas Kumar
Professor, Dept. of Management, Maharaja Agrasen Himalayan Garhwal University

ABSTRACT

A priceless gift from nature to mankind, health is one of the most pressing necessities that is impacted by a variety of things, including food, shelter, rudimentary sanitation, safe lifestyles, environmental risks, security, and communicable diseases. The natural state and birthright of man is health, which results from living in accordance with the laws of nature that govern the body, mind, and surroundings. One of the most crucial components of healthy living is quick access to essential services like health care. Nevertheless, it could also be the difference between life and death for someone who is unable to access these services. Hence, without adequate health care services, a crucial component of social sector growth is absent. The state has a sophisticated healthcare system that provides complete medical care to its residents, particularly in remote areas. Major infections like Guinea worm and small pox are under greater departmental control. Leprosy and newborn tetanus have also been eliminated from the province at the same time. The polio vaccination program in Maharashtra has prevented the identification of polio cases since 2011. The ministry has spent more than Rs. 3965.57 crores on public health. The paper includes an introduction, a study of the relevant literature, a discussion of the research techniques and public health initiatives in the state, data interpretation, and suggestions.

KEYWORDS: Communicable Diseases, Health Initiatives, Healthcare System, Public Health

INTRODUCTION

Choice and reasonable longevity to live a healthy life free from illness and disease are important features in the principles of personal comfort for many. Similarly, the phase from a high state of mortality usually leads individuals to longer lives and healthier lives. It is considered desirable and social transformation is appreciated.

Health and longevity indicators are important components of the development process evaluation system in human development strategy, as well as indicators that differentiate the population needs of the population.

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

UNDERSTANDING GOVERNMENT HEALTH SCHEMES

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

SCOPE OF RESEARCH WORK

Each citizen of a nation has a shared interest in health care services and it is in the national interest to spend wisely on health care resources. The government must share scarce resources among competitive uses so that priority sectors are not overlooked. Mainstream economists agree that medical and family care spending is the most efficient expenditure in improving productivity by, on the one hand, promoting and maintaining health and, on the other hand, reducing suffering and ill health. With egalitarianism increasing and healthcare spending increasing gradually, all people should be encouraged to have access to fair arrangements, economists and other social scientists to research healthcare services from various angles. It is not surprising; therefore, that review of health and health systems has become a subject of widespread interest. Therefore, the significance of this study is apparent. There are very few studies in West Bengal that examine the health sector. Health is also one

of the most important needs of our lives today, and comprehensive health knowledge is important to help the State prepare different health programmes. The research is basically restricted to West Bengal and can greatly benefit politicians. It provides a variety of complementary health and health service viewpoints in order to draw on the knowledge base from which economic policymakers will develop effective strategies and actions to resolve and contribute to growth issues. This research focuses on health metrics, health infrastructure, health expenditure, and the issues and challenges of the health sector. In this context, the basic objectives of the study were formulated.

PROBLEM OF STATEMENT

Poverty is a common feature of urban and rural areas in India, creating an inability to meet chronic disease costs. The results of the Centre for Economic and Social Studies study found that 56.1% of rural people are under BPL and 15.80% are in urban areas. At the same time, health statistics are deliberating on inequalities in both sectors. Therefore, the poor are unable to meet the health costs of dangerous diseases.

The State must offer financial security to families residing below the poverty line for the care of major disorders such as cancer, renal failure, cardiac and neurosurgical diseases, etc., requiring hospitalization and surgery. In order to fulfill the state-wide requirement for the treatment of such diseases, there are no requisite facilities for current government hospitals and a specialist pool of physicians. A huge amount of people borrow money, particularly below the poverty line, or sell assets in private hospitals to pay for care. Health insurance may be a method to reduce financial obstacles and improving access to affordable medical services for disadvantaged people, offering financial security against high medical costs and negotiating with providers for higher quality care.

REVIEW OF LITERATURE

Shreedevi (2014) conducted an investigation into 'The Rajiv Aarogyasri Scheme Assessment in Andhra Pradesh and Patient Feeling Survey.' The goal, work, achievements and impact of Aarogyasri are captured by this investigation. Depending on patient information, the investigation was conducted for the period from April 2007 to December 2013. For example, straightforward instruments such as recurrence checks, rates, proportions, midpoints, and so on were used to understand insurance mode productivity and measure the presentation of the scheme.

'Health Care Policy and Administration: A Case Study of Rajiv Aarogyasri Health Insurance in Andhra Pradesh' was considered by **Mallikarjuna, K (2014)**. He pointed out that the Aarogyasri model is a comprehensive way of dealing with healthcare, ensuring that people are kept an eye on by 100 doctors and 1,600 paramedics who handle around 53,000 calls per day without receiving health checks by the system hospitals and 24 hour help line. Ambulance services 108 and 104 will be constantly available to patients at their doorsteps by means of a simple telephone call from the general population. Since the inclusion of ailments under Aarogyasri was limited, he travelled; countless patients continued to seek help from the Chief Minister's Relief Fund for the treatment of various diseases. The Aarogyasri Health Scheme vouches slanted requirements for the State Governments. It allows only 500 out of the 20,000 odd patients admitted to the Network Hospitals every day in the express, both in the private and public segments. It is necessary for the remainder of the patients to bring about pocket consumption.

Rajesh K Yadav and Sarvesh Mohania (2014) found that 'Health Insurance Portability is a baseline set by IRDA where, at their own choice, an individual is allowed to switch between safety net providers without stressing their no-case reward and spread of previous illnesses.' The investigation aims to include the reason for transmitting capacity, a structure that allows the policyholder to move the policy from one insurance organisation to the next. The Indian health insurance part of the overall industry is a blend of compulsory Social Medical Insurance (SHI), deliberate private health insurance, and Community Based Medical Insurance if there should be a disappointment with regard to the current policy or services or to switch over to an inventive/other product that could be accessible elsewhere in health insurance services (CBHI).

RESEARCH METHODOLOGY

The study is based on primary and secondary data. Secondary data has been accumulated from various issues of the Indian Statistical Abstract and Economic Survey in between 2001 and 2018. Several mathematical tools were used to describe the data. Data were also illustrated and clarified with graphs, bar charts, and pie charts. Basic data for 2018-19 were collected in this survey. The sample scheme is based on a comprehensive survey and a random sampling approach. Nadia selected a sample of 200 houses based on the rural-urban population ratio according to 2018 census, of which 120 were rural and 80 were urban. Model design also includes in rural areas:

1. Block selection
2. Choose Town

3. Choose Homes

COLLECTING DATA AND PRIMARY SURVEY MATERIAL

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

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

RESULTS AND DATA INTERPRETATION

The family structure of respondents is presented in Table 1. In rural areas (7.08), the average household size is higher than in urban areas (6.38). Furthermore, the average number of women in households is 3.25. Males (3.71) in urban and rural areas outnumbered (3.37) women and urban women (3.37) outnumbered women (3.25). (June 3rd). In addition, the total number of workers is higher than the number of staff and thus the dependency ratio is 64.24. Their figures are more rural than urban areas. The dependence ratio (67.72) was therefore found to be higher in rural areas than in urban areas (58.45).

Table-1 Family Structure of the Sampled Households

Family Structure	Rural	Urban	Average
Men	3.71	3.25	3.48
Women	3.37	3.13	3.25
Total	7.08	6.38	6.73
Jobholders	2.64	2.83	2.74
Dependent Member	4.44	3.56	4.00
Dependent Ratio	67.72	58.45	64.24

Home size also determines the demand and use of health care services. The distribution of sample houses according to family size is shown in Table 2. Of the total households in the sample, 101 (50.0%) household sizes were only 4 persons, followed by 92 (46%) 5 to 8 family households and very few (i.e. 7) urban households. In rural and urban areas, 45% of households in rural areas are 5 to 8 people and in urban areas 58.75% of households are four to 49.17%, and in urban areas 41.25%, and in rural areas 5.83% of households are very small shape families.

TABLE-2: SAMPLED HOUSEHOLDS ACCORDING TO FAMILY SIZE

Family Size	Rural	Urban	Total
Upto 4 members	53 (44.17)	48 (60.00)	101 (50.50)
5 to 8 members	60 (50.00)	32 (41.25)	92 (46.00)
More than 8 members	7 (5.83)	0 (0.00)	7 (3.50)
Total	120 (100)	80 (100)	200 (100)

Education is not only a major growth variable, but also an important population quality indicator. Household members with a good school level can be expected to adopt health-related practices and have a satisfactory understanding of health services, illnesses and health services. Table 3 Distributes home models according to the educational level of the head of the household.

TABLE -3: FAMILY HEAD QUALIFICATION LEVEL

Qualification	Rural	Urban	Total
10^{th}	52 (43.33)	25 (31.25)	77 (38.50)
12^{th}	38 (31.67)	14 (17.5)	52 (26.00)
Under Graduate	11 (10.00)	5 (6.25)	16 (8.00)
UG	12 (9.17)	27 (33.75)	39 (19.50)
PG	7 (5.83)	9 (11.25)	16 (8.00)
Total	120 (100)	80 (100)	200 (100)

It indicates that of the total sampled household 77 (38.5%) whose heads studied under metric, followed by 52 (26%) whose heads studied up to metric, and 39 (19.5%) whose heads received education up to graduation. There were 16 households, i.e. 16 (each 8%) with undergraduates and postgraduates in charge. Significant differences

were found when comparing the educational levels of the heads of model homes in rural and urban areas. Heads of households in rural areas who achieved education levels up to metric level (44.17%), metric level (32.50%) and graduates (10%) suffered significantly compared to urban areas, for these 30 people, respectively. % Are. , 16.25% and 5%, with higher rates in urban areas having higher education levels up to graduation (36.25%), indicating that sample households from urban areas have a better educational status than those in rural areas. This discrimination in the education of domestic leaders undoubtedly affects their knowledge of the symptoms of various diseases, their treatment and their needs.

TABLE – 4: ANNUAL HEALTH EXPENDITURE INCURRED BY THE RESPONDENTS

Health Expenditure Item	From Rural Area	From Urban Area	Total
Consultation Fee	835 (9.91)	903 (8.07)	857 (8.99)
Medicines	3228 (38.33)	4243 (37.92)	3652 (38.33)
Surgery	869 (10.32)	1391 (12.43)	1068 (11.21)
Hospitalization	1130(13.42)	2210 (19.75)	1586 (16.64)
Laboratory Tests	908 (9.59)	1324 (11.83)	1054 (11.06)
Transportation	991 (10.78)	621 (5.55)	846 (8.88)
Various Expenditure	461 (5.47)	498 (4.45)	466 (4.89)
Total	8422 (100)	11190 (100)	9529 (100)

Rs. 8422 and Rs. 11190 on average were the annual health expenditure incurred by the households sampled in urban and rural areas. In addition, it was found that the proportion of medical and injected expenditure (39.40%), transport (11.65%), consultation/doctoral expenditure (9.56%) and miscellaneous expenditure (5.37%) was higher in rural regions than in urban regions (37.92 per cent, 5.55 percent, 8.07 percent and 4.45 percent respectively). On the other hand, in urban areas, the proportion of hospitalization costs (19.75 percent), surgery (12.43 percent), laboratory tests/x-rays, etc. (11.83 percent) was higher than in rural areas, where the figures were 13.42 percent, 10.32 percent, 9.59 percent, respectively. The analysis above showed that most of the health costs were spent on medicinal products and injections (in both urban and rural areas).

ANALYSIS OF THE INTER-CLASS

An interclass analysis of the average annual health expenditure incurred by the households sampled for only one year, i.e. 2018-19, reflects the figures in Table 5. As we have progressed from the lowest income to the highest income category, the table shows that the average health expenditure has increased. In both urban and rural areas, it was found that this pattern was the same. Furthermore, the analysis showed that in all income categories, the average health expenditure incurred in urban regions was higher than in rural areas. In urban areas, low, medium and high incomes resulted in higher health expenditure, i.e. the health expenses incurred by the respective categories of income in rural areas are Rs.5310, Rs.12091 and Rs.16278, i.e. Rev. 4781, revised 11221; revised 13769.

TABLE-5: AVERAGE ANNUAL HEALTH EXPENDITURE OF THE RESPONDENTS

Income Categories	Rural	Urban	Total
Low	4781	5310	10091
Middle	11221	12091	23312
High	13769	16278	30047

Accordingly, the above analysis shows that in rural areas, the average annual income was higher than in urban areas, and that the proportion of households belonging to the low and medium income categories was higher than in urban areas, whereas in urban areas, the proportion of households belonging to the high income category was higher than in rural areas. The consumer pattern of households sampled showed that the maximum share of total consumer expenditure followed by services, durable goods and marriages and other social ceremonies was non-sustainable consumption expenditure. When the consumption of services was observed, it was revealed that healthcare accounted for the major amount of consumption, followed by education, transport, rent and entertainment, while urban areas accounted for the major proportion of education and healthcare, transport, rent and entertainment.

CONCLUSION

It is hard to argue that good health and adequate food, clothing and shelter are important for people to enjoy their lives. As an internal and important aspect of human life, the level of health in society increases with economic development, if not proportionately. Due to the rapid economic development of West Bengal, other aspects of human life can also be expected to improve. But unfortunately, it is not. Since 2000, the number of public health institutions in West Bengal has not increased significantly. A large number of vacant, accepted roles of medical,

paramedical and district health officials assess the dire condition of public health institutions. Posts approved in the West Bengal Health Ministry will be deliberately left vacant by enforcing the new recruitment ban, not because of the unavailability of qualified health workers, but mainly due to pressure on the state's global economic policy and resource scarcity. Empirical research has shown that public health facilities are low compared to actual public health standards, with a lack of some basic facilities, a shortage of health workers, and a shortage of physicians in health care facilities, health facilities and other services. Health. As globalization gained importance and became inevitable in India in 2000, reforms were implemented in the health sector to lead to strategic and positive changes in the health care system. The West Bengal government has implemented two changes in health policy. First is the inauguration of the private corporate sector of health services; Second, in 2006-07, the World Bank Sponsored State Health System Development Project II was built by the West Bengal Health System Corporation (WBHS) by 150 government agencies. However, these two measures failed miserably. The stat-health plan is a basic requirement for the state health plan. The health policy should capture the comprehensive vision of the state health, define needs and objectives, set goals and see to it that the resources allocated according to the capabilities and limitations of the health system are used appropriately. The Government of West Bengal should focus on promoting more productive use of public health facilities. The health policy should keep a proper record on the prevention items as well as the prevention items. Offer some fixing services such as simple, tail-free access, long-term service availability, clean premises, drug facility, non-profit diagnostic services under a single roof with significant discounts for economically and vulnerable areas. Policy regulation by the public and private sectors is important. Mandatory registration for private health sector, monitoring of services, regulation of fees and ratings are mandatory, rationalization of posts, strict deputation guidelines and priority setting for rural posts are required for the public sector. In addition, the rising cost of public and private health care guarantees a viable health insurance program. Government spending in the health sector should be well expanded, and the health investment scheme for poor areas and communities should not be distorted. Ensure proper utilization of health workers and services in the health policies of West Bengal, increase the availability of primary health care and paramedic personnel, develop policies to address the increasing stress on tertiary health institutions and raise awareness about improved environmental and occupational health quality in health.

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