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ROLE INCLUDES CARRYING OUT DAILY ACTIVITIES OF OVERSEEING FINANCES, COMMUNITY RELATIONS, ADMINISTRATION AND MEDICAL POLICIES OF THE ORGANIZATION

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ABSTRACT

A vast variety of medical and non-medical services, including disease prevention and treatment, are under the purview of health policy, which includes its regulation, financing, and provision. The purpose of this study is to investigate the expenditures made by the Municipal Corporation of Greater Mumbai on health-related matters (MCGM). In addition to this, an investigation on the patterns of utilization of public health care services by the residents of Mumbai is being carried out as part of this project. According to the findings, consumption of public health care services is contingent not only on the accessibility of health care services at prices that are affordable but also on the level of care provided by those health care services. Accessibility, availability, and affordability are the primary components of public health care that are responsible for providing fundamental medical services to the underprivileged and the economically disadvantaged members of society. These vulnerable segments of society are reliant on the services offered by the government, and their inability to gain access to public health care facilities frequently compels them to seek treatment in private medical institutions. These out-of-pocket payments can have severe repercussions for these people's finances, and they frequently drive them deeper into debt and poverty as a result.

KEY WORDS: *- Medical, Services*

INTRODUCTION

A vast variety of medical and non-medical services, including disease prevention and treatment, are under the purview of health policy, which includes its regulation, financing, and provision. Due to the difficult nature of the endeavour, it is one of the most intricate and time-consuming areas of public policy. The formulation of effective policies is difficult because of the prevalence of powerful professional interests and autonomies, the high cost of treatments, concerns over equity of access and quality, and rising expenses. Direct democracy, decentralised federalism, liberalism, consensual policymaking, and subsidiarity are some of the philosophical underpinnings of Switzerland's approach to policymaking in the realm of health care. This system provides private actors, voters, and subnational policymakers with a significant amount of access, voice, and influence in the decision-making process pertaining to health policy.

Switzerland is only partially capable of being termed a success story in terms of the macro-indicators that are related to health. The health care system in Switzerland is regarded favourably by the vast majority of the country's inhabitants (FOPH 2010a). Switzerland has a high life expectancy rate at birth (83 as of 2011), a median childhood mortality rate (3.9, 2011), low rates of preventable mortality (159 per 100,000 in 2009), and rather low cancer death rates. These are all positive indicators for the country's health care system (223.5 per 100,000 in 2009). On the other hand, in comparison to other nations in the Organization for Economic Co-operation and Development (OECD), its suicide rate is significantly higher than average (12.2 per 100,000 people in 2009, with an even higher rate historically) (OECD 2010). The most significant obstacle for Switzerland is the ever-increasing prices of medical treatment and long-term care, in addition to problems associated with the unequal distribution of these expenditures. In 2010, Switzerland spent 11.5 percent of its gross domestic product (GDP) on health policy, which is significantly higher than the average of 9 percent for OECD countries. Furthermore, 3.7 percent of these expenditures were made up of out-of-pocket contributions from patients, which is significantly higher than the 2.4 percent average for OECD countries (2010). The majority of healthcare costs are covered by health insurance companies, while the cantons and municipalities of each state are responsible for the largest portion of the state's healthcare costs (FOPH 2011a). The most significant obstacle is the ever-increasing cost of medical care for the population, which is caused by the fact that health insurance premiums are always going up (FOPH 2011b), and a sizeable portion of the population relies on cantonal subsidies to cover the cost of their health insurance premiums (FOPH 2011a).

The health insurance law that was passed in 1994 and has been in effect since 1996 (LAMal; "Loi federale sur l'assurance maladie") serves as the foundation for the national health policy. This law succeeded the statute that had been in place since 1911. The reform that took place in 1994 marked the beginning of the transition from a health insurance system based on voluntary participation to one that is universal and based on forced participation. In comparison to the practises of other European nations, this shift occurred quite late (Uhlmann and Braun 2011). The Federal Office of Public Health (FOPH), which was established in 2009 and was initially responsible for the majority of public health issues, most notably health promotion and sickness prevention, currently holds the primary duty for formulating health policy. The FOPH would not take over responsibility for health insurance until the year 2009. (Trein 2011).

The provision of medical care, the promotion of public and occupational health, and the avoidance of disease

It is somewhat artificial for public health institutions to be kept separate from private organisations that provide medical care (McKee et al., 2010). The phrase "health care public health" refers to the roles that public health institutions (and public health professionals) play to maximise health gains through the delivery of health care to individuals and population groups; however, in the majority of European countries, this role is either not present at all or is severely underdeveloped (McKee et al., 2010). As a method for coordinating preventative and curative care in England, Health and Well-Being Boards were established as a result of the Health and Social Care Act, which was passed in that country. The Boards are created by the local authorities and members include representatives from the National Health Service (NHS), other public health institutions, social services, and child care services.

Institutions of public health are involved in the coordination or implementation of disease prevention and health promotion programmes in the majority of countries across the world. In addition to this, they may have a part to play in the coordination of screening programmes for cancer and inherited metabolic disorders. Providers of health care, particularly at the primary care level, typically play an essential role in the delivery of services

aimed at the promotion of health and the prevention of disease. In some countries, non-governmental organisations (NGOs) also play a role in the provision of services; however, the lack of systematic quality control, a professional public health personnel, and sustainable finance can make their work difficult at times.

OBJECTIVE

1. To do research of the expansion of Mumbai's public health care infrastructure since the year 2009.
2. To investigate the post-independence policies of the government on the provision of public healthcare.

RESEARCH METHODOLOGY

For this particular research study, a number of different aspects of research technique were utilised.

- **Universe**

For the purposes of the current research, the "universe" consists of the whole population of Mumbai as well as all of the public health care facilities that are operated by the MCGM and are located inside Greater Mumbai.

The Rationale Behind Choosing Mumbai as a Research Location

The city of Mumbai, which serves as the commercial centre of India, is home to millions of people who originate not only from the state of Maharashtra but also from the other states of India. As a result, the city features an enormous amount of religious and linguistic variety. Because it is one of the most densely populated cities in the world, Mumbai deals with all of the major issues that are associated with urbanisation. These issues include a growing population, pollution, expanding slums, inadequate health awareness, a lack of health facilities, and a lackadaisical attitude on the part of the government toward the development of health facilities. The population and the number of people living in slums are broken down by ward in the following table, which was compiled using data from the Census in 2011

- **Sample**

The following 10 locations have been submitted to the MCGM Hospitals for the purposes of data collection and analysis in accordance with the data of the ward-wise slum population and the non-slum population according to the Census 2011:

1. (Ward F/S) Parel,

2. (Ward F/N) Sion,

3. (Ward H/W) Kurla (W),

4. (Ward R/S) Kandivali (W),

5. (Ward L) Bandra (W),

6. (Ward N) Ghatkopar (E),

7. (Ward S) Vikhroli (E),

8. (Ward K/W) Vile Parle (W),

9. (Ward H/E) Santacruz (E), and

10. (Ward P/N) Malad (E)

In order to conduct an in-depth investigation and analysis on the public health care facilities provided by the MCGM hospitals in their vicinity, interviews were conducted with a sample of 384 respondents who were selected at random from the various municipal hospitals in the area. This sample consisted of 192 in-patients and 192 out-patients.

Presentation of Data and Analysis of Data

Data collected from primary and secondary sources was presented through tables and for comparison and analytical study. Interpretation of the data was done with the help of various statistical techniques including percentages, graphs, charts etc. to achieve objectives and establish the research questions under consideration.

DATA ANALYSIS AND INTERPRETATION

Tables were used to exhibit the data that was gathered from secondary sources for the purpose of comparison and analytical analysis. The researcher has made use of a variety of statistical methods, such as percentages, graphs, and charts, among others, in order to achieve the goals and establish the research question that is being considered. These methods were utilised in the preparation of the tables, as well as in the analysis of the data and its interpretation.

The Various Public Authorities Conducted an Analysis of the Data Regarding the Public Health Expenditures

The expenditures made on public health by the various concerned public authorities on the national, state, and municipal levels are the focus of the first three goals of the study, which are all related to the aims of the study. As a result, this study makes an effort to conduct an analysis of the health-related expenditures made by the Central Government of India, the State Government of Maharashtra, and the Municipal Corporation of Greater Mumbai (MCGM). The objectives have been formulated with the help of information obtained from a wide variety of secondary sources.

To investigate the post-independence policies of the government on the provision of public health care

The improvement of both public health and medical infrastructure are among the most crucial preconditions for economic growth in any nation. The current state of a country's health infrastructure can serve as an indicator for gaining a better understanding of the health care policy and welfare mechanism that are in place in that nation. This is because the current state of health infrastructure demonstrates the investment priority given by the relevant authorities toward the creation of health care facilities.

Planning for health care is essential if we are to improve the overall health of the people, and this is especially true in India, which has one of the world's largest populations and is also plagued by widespread poverty. The Health Survey and Development Committee Report, also commonly referred to as the Bhore Committee Report, was the first step in the process of health planning in India. This report was compiled on the eve of India's independence in 1946, making it the most comprehensive health policy and plan document that had

ever been prepared in India. The recommendations of the Bhore Committee demanded the implementation of structural changes in the existing health care system at the time. If these changes had been implemented in a timely manner, it would have had a significant impact on the access to health care as well as the health status of the general population of India, particularly the rural population living in rural areas. Although the significance of the development of health services and health infrastructure as a key to improving the health of the population has been duly recognised in the various five year plans drafted by the Planning Commission, it has not been fully implemented due to the financial constraints and changing priorities faced by the central government. Despite this, the Planning Commission has duly recognised the significance of the development of health services and health infrastructure as a key to improving the health of the population.

For the purpose of this study, the following levels of spending in the social sector were analysed in terms of their respective trends: (a) the central government, and (b) the Maharashtra state government. There are three different approaches to analysing the trends in expenditures in the social sector. In the first scenario, social sector expenditure is viewed as a percentage of gross domestic product (GDP). In the second scenario, it is calculated as a percentage of total government expenditure. Finally, in the third scenario, health expenditure is viewed as a percentage of social sector expenditure. Spending on medical care, public health, and the welfare of families, as well as spending on health, nutrition, water supply, and sanitation, all fall under the category of "health expenditures."

The following chart shows the trends in India's social sector expenditure from 2009-10 to 2010-11.

Although the majority of issues pertaining to the social sector are considered to come under the jurisdiction of the states, the central government has maintained its support for various social programmes over the years. Despite the fact that there has been a steady increase in Social Sector Expenditure by the government, spending on the social sector by the government has decreased over the course of the past few years as a result of the adverse fiscal circumstances in the country that have arisen as a result of the impact of the global financial crisis that occurred in 2009-2010 and the euro area crisis that occurred in 2010-2011.

The total expenditure made by the general government as well as the expenditure made on social services

The following table presents information regarding the Total Expenditure incurred by the General Government (combined expenditures of the Central and State Governments) beginning in 2009–2010. Additionally, the table presents information regarding the expenditures incurred regarding Social Services during this time period.

The following table provides information regarding the Total Expenditure and Social Services Expenditure that the General Government incurred from 2009-10 to 2010-11.

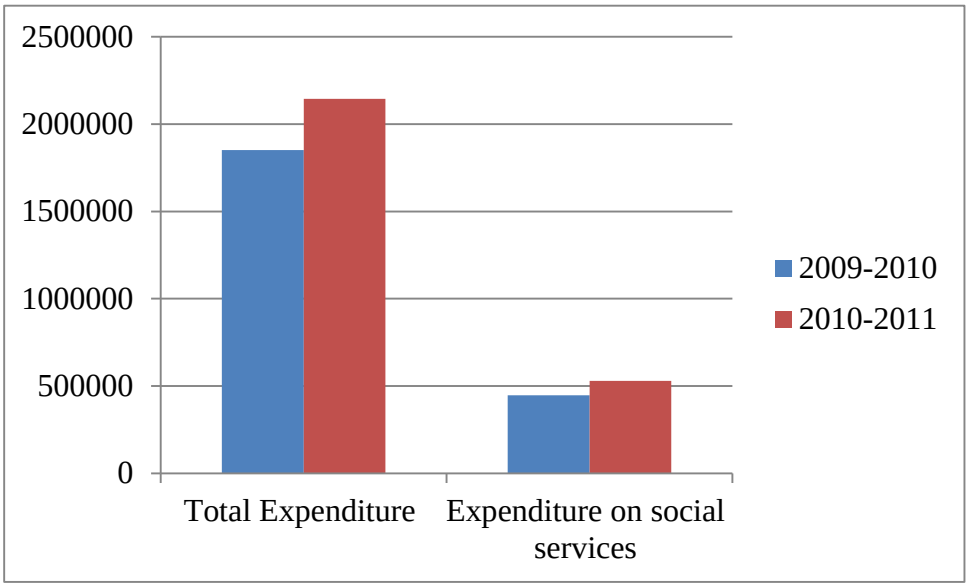
TABLE .1 OVERALL EXPENDITURES AS WELL AS EXPENDITURES MADE BY THE GENERAL GOVERNMENT ON SOCIAL SERVICES

Years	Total Expenditure	Expenditure on social services
2009-2010	1852119	446382
2010-2011	2145145	529398

Source: Documents Relating to the Budgets of the Union and the States, Prepared by the RBI

The total amount spent by the general government on social services and rural development, including Plan and non-Plan expenditures, has climbed from ₹202672 crores in 2009-2010 to ₹868476 crores in 2010-11.

FIGURE .1 OVERALL EXPENDITURES AS WELL AS EXPENDITURES MADE BY THE GENERAL GOVERNMENT ON SOCIAL SERVICES



It is evident from the various tables given that during the period under study, beginning in 2009-10 and continuing onward, there is a steady rise in absolute social sector expenditure by the General Government (at both the centre and state levels), and the Euro area crisis that occurred in 2010-11.

Developments in the Amount Spent Overall and on Social Services proportion of total expenditure to gross domestic product

In recent years, there has been an increase in the amount of money spent by the General Government (the Centre and the States together) on social services. This is a reflection of the important role that this industry plays in the cultivation of human resources in the country. The following table shows the total expenditure as a percentage of the Gross Domestic Product (GDP), which declined from 26.76 percent in 2009-10 to 25.83 percent in 2010-11. The social expenditure of India is reported as a proportion of the Gross Domestic Product (GDP). After that, it gradually climbed to a high of 28.6 percent in 2009-10, having reached a low of 26.27 percent in 2010-11. The total amount spent on social services as a proportion of the GDP rose from 5.65 percent in the 2009-2010 fiscal year to 6.9 percent in the 2010-2011 fiscal year.

The adverse financial circumstances in the country, such as the global monetary crisis and the crisis in the euro area in 2009-10, resulted in a reduction in government spending on the social sector, which brought it down to 27.5 percent and 27.4 percent respectively in 2009-10 and 2010-11. It was found that the expenditure on social services as a share of GDP went down to 6.8 percent in 2010-11 and 6.6 percent in 2011-12. This reduction was directly correlated with the growth of the GDP. In the fiscal year 2009–2010, overall expenditures represented 27 percent of GDP, while expenditures on social services represented 6.6 percent of GDP. Both figures are expressed as a percentage. The overall expenditure as a proportion of the GDP was 28.4% in the

2009–10 fiscal year, but by the 2010–11 BE fiscal year, this number had dropped to 27.0%. (Budget Estimates). However, during this same time period, expenditures on social services as a share of GDP increased from 6.5 percent in 2009–10 to 6.7 percent in 2010–11, as seen in the table shown above.

The following table provides a percentage breakdown, by category, of both total expenditures and expenditures on social services relative to GDP.

TABLE 2

Expenditures of money for many kinds of social services, such as education, healthcare, and others

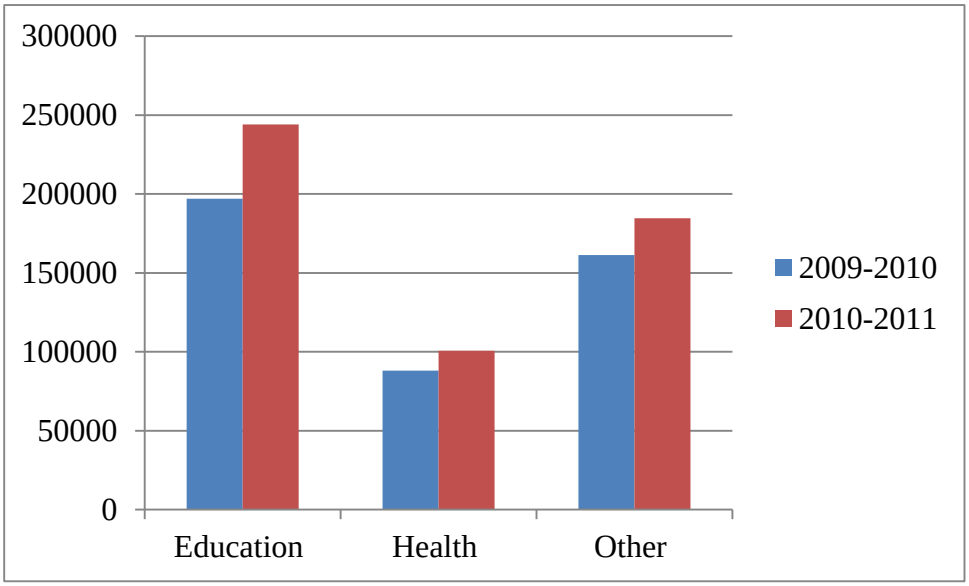
Year	Education	Health	Other
2009-2010	197070	88054	161258
2010-2011	244156	100576	184,666

Source: Documents Concerning the Budgets of Both the Union and the States, in Addition to Those of the Reserve Bank of India

The following figure provides an illustration of the rise in expenditures that were made in social sectors such as education and health, amongst other areas, over the time period that is under consideration, commencing in 2009–2010 and continuing onward, respectively. The graphic shows that the percentage of money spent on education is increasing at a higher rate, while the percentage of money spent on healthcare is increasing at a rate that is substantially slower.

FIGURE.2

MONETARY OUTLAYS FOR DIFFERENT ASPECTS OF SOCIAL SERVICES, INCLUDING EDUCATION, HEALTHCARE, AND OTHERS



It is evident from the various tables given that during the period under study, beginning in 2009-10 and continuing onward, there is a steady rise in absolute social sector expenditure by the General Government (at

both the centre and state levels) and the Euro area crisis that occurred in 2010-11. During this time period, the total expenditure went from ₹959855 crores to ₹3895541 crores, and during this same time period, the expenditure on social services climbed from ₹202672 crores to ₹868476 crores.

CONCLUSION

The condition of the population in terms of its resources is of critical importance to the process of socioeconomic advancement. The purpose of this study is to investigate the expenditures made by the Municipal Corporation of Greater Mumbai on health-related matters (MCGM). In addition to this, an investigation on the patterns of utilisation of public health care services by the residents of Mumbai is being carried out as part of this project. According to the findings, consumption of public health care services is contingent not only on the accessibility of health care services at prices that are affordable but also on the level of care provided by those health care services. Accessibility, availability, and affordability are the primary components of public health care that are responsible for providing fundamental medical services to the underprivileged and the economically disadvantaged members of society. These vulnerable segments of society are reliant on the services offered by the government, and their inability to gain access to public health care facilities frequently compels them to seek treatment in private medical institutions. These out-of-pocket payments can have severe repercussions for these people's finances, and they frequently drive them deeper into debt and poverty as a result.

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