CHAPTER NUMBER ONE

HEALTHCARE SECTOR OF INDIA: AN OVERVIEW

"A Study of Patients' Satisfaction Measurement in Hospital Services of Selected Health Care Facilities"

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HEALTHCARE SECTOR OF INDIA: AN OVERVIEW:

To any community the public health is of supreme importance and it must be given priority. There is a need to enhance and broaden the public health knowledge with new research activities and community based experience. The efforts of Government of India to provide the safer and healthy environment are reflected in the introduction of various programmes, policies, and legislations from time to time by the Government of India. The science of public health need continuously revision from time to time but such changes in the health sector has given rise to many other new challenges in meeting public health goals. Good community health helps to improve labour productivity, human capital and national savings.

An attempt to overview health care sector of India is made by analyzing Government allocations to health sector, infrastructure for health, planning of public health, and legislations related to health, policies.

1.1 A BRIEF REVIEW OF HEALTH STATUS OF INDIA:

Defining the India's health against single set of measures is difficult. Certain selected indicators of health which have improved substantially from1951 to 2001. In 2001, the health of the Indian population has improved significantly. To illustrate, life expectancy has risen to 64 years; the Infant Mortality Rate (IMR) has fallen to 63 per 1,000 populations; crude birth rate has declined to 25 and crude death rate has fallen to 8.1. (J. Kishore, 2006).[1] According to the Report on "Macroeconomics and Health, 2005"[2] of the National Commission, longevity in India has reached to 66 years in 2004; IMR has fallen by over 70 per cent points in 1990. Malaria has been contained at 20 lakh cases; Smallpox and Guinea-warm have been completely eradicated, and leprosy as well as polio has reached to nearly state of elimination. An improvement in the quality of health care has been seen over the years as provided in Table Number 1.1.

Table Number 1.1: Selected Health Indicators in India

Sr. No.	Parameter	1951	1981	1991	Current level
01	Crude Birth Rate (CBR) (per 1000 Population)	40.8	33.9	29.5	23.8 (2005)
02	Crude Death Rate (CDR) (Per 1000 Population)	25.1	12.5	9.8	7.6 (2005)
03	Total Fertility Rate (TFR) (Per Woman)	6.0	4.5	3.6	2.9 (2005)
04	Maternal Mortality Ratio (MMR) (Per 100000 live births)	NA	NA	437 (1992-93) NFHS	301 (2001-2003)
05	Infant Mortality Rate (IMR) (Per 1000 live Births)	146 (1951-61)	110	80	58 (2005)
06	Child (0-4) Mortality Rate (Per 1000 Children)	57.3 (1972)	41.2	26.5	17.0 (2004)
07	Couple Protection Rate (Per cent)	10.4 (1971)	22.8	44.1	48.2 (1998-1999) NFHS
08	Life Expectancy at birth 8.1 Male 8.2 Female	 37.2 36.2	 54.1 54.7	 59.7 (1991-95) 60.9 (1991-95)	 63.87 (2001-2006) 66.91 (2001-2006)

NFHS: National Family Health Survey; NA: Not Available.
Source: The Economic Survey 2006 – 2007.[3]

One can find continuous improvement in various health indicators from 1951. To illustrate, Crude Birth Rate (per 1000 population) has reduced from 40.8 in 1951 to 23.8 in 2005. Crude Death Rate (per 1000 population) has reduced from 25.1 in 1951 to 7.6 in 2005. Similarly, Total Fertility Rate (per woman) has reduced from 6.0 in 1951 to 2.9 in 2005. IMR (Per 1000 live births) has reduced from 146 of 1951 to 58 in 2005. Child (0 – 4) mortality rate (Per 1000 children) was 57.3 in 1972 which has reduced to 17.0 in 2004. The life expectancy at birth for male has increased from 37.2 in years 1951 to 63.87 in years 2001-2006. The life expectancy at birth for female increased from 36.2 of 1951 to 66.91 in 2001-2006 (The Economic Survey, 2006-2007).[3]

During 2000-2005, over 1,00,000 deaths have been averted due to the up scaling of Directly Observed Treatment Short-Course (DOTS). Indian doctors are comparable to the best in the world as they are technically proficient, and capable of performing sophisticated procedures and that too at a fraction of the cost available in the west (Ministry of Health and Family Welfare, 2005).[2]

Apart from improvement in selected health indicators one also finds improvement also in health care infrastructure. Table number 1.2 provides a summarized statistics of the healthcare infrastructure of India.

Table Number 1.2: Trends in the Health Care Infrastructure in India (1951 – 2004)

Sr. No.	Particulars	1951	1981	2005	(Period/Source)
01	SC/PHC/CHC	725	57,353	1,71,608	*
02	Dispensaries and Hospitals (All)	9,209	23,555	27,770	**
03	Beds (Private & Public)	1,17,198	5,69,495	9,14,543	(All types)**
04	Nursing Personnel	18,054	1,43,687	8,65,135	@
05	Doctors (Modern System)	61,800	2,68,700	6,56,111	@

* RHS: Rural Health Statistics, 2006.
** Health information of India, 2004.
@ National Health profile, 2005.
Source: Ibid.[3]

From above table, one can find consistent increase in health infrastructure of India considering the total number of dispensaries and hospitals; beds in the hospitals; doctors and nursing staff (The Economic Survey 2006-2007).[3] The Rural Primary Public Health Infrastructure has recorded an impressive increase consisting of 1, 45,000 Sub-Centers, 23,109 Primary Health Centers, and 3,222 Community Health Centers, catering to a population of 5,000, 30,000 and 1,00,000 respectively as well as 3,000, 20,000 and 80,000 population in tribes and desert areas respectively (Annual Report of Health & Family Welfare Report, 2005 - 2006).[4]

The health expenditure of India can also be analyzed by analyzing trends in expenditure on health as a part of various Five Year Plans of India as shown in the Table number 1.3 given as below.

Table Number 1.3: Trends in Health Expenditure of India (1951 – 2002: Rupees in Millions)

Five Year Plans	Period	Amount	Total Plan Investment (All Development Heads)	Health (Central & States)	
				Outlay/ Expenditure	Per cent of Total Plan
First	1951-1956	Actual	1,960	652	3.33
Second	1956-1961	Actual	4,672	1,408	3.01
Third	1661-1966	Actual	8,576.5	2,259	2.63
Annual	1966-1969	Actual	6,625.4	1,402	2.12
Fourth	1969-1974	Actual	15,778.8	3,355	2.13
Fifth	1974-1979	Actual	39,426.2	7,608	1.93
	1979-1980	Actual	12,176.5	2,231	1.83
Sixth	1980-1985	Outlay	97,500	1,821	1.87
Sixth	1980-1985	Actual	1,09,291.7	20,252	1.85
Seventh	1985-1990	Outlay	1,80,000	33,929	1.88
Seventh	1985-1990	Actual	2,18,729	36,886	1.69
	1990-1991	Actual	61,518	9,609	1.56
	1991-1992	Actual	65,855	10,422	1.58
Eighth	1992-1997	Outlay	4,34,100	75,822	1.75
Ninth	1997-2002	Outlay	8,59,200	51,181	0.6
Tenth	2002-2007	Outlay	15,92,300	-	-

Source: GOI, 1997 (Adapted from Human Development in South Asia, 2004).[5]

It becomes evident that the priority to health sector showed declining trend in terms of expenditure incurred on health as a per cent of total development plans of India.

The amount spent on health sector in the first plan (1951-1956) was 3.33 per cent that has been reduced to 0.6 per cent in the ninth five year plan in India. Further, the year wise details of expenditure by private & public sector on Medical Health & Sanitation are provided in Table number 1.4 as follows.

Table Number 1.4: Details of Year wise Expenditure on Medical, Health and Sanitation in India

Year	Private Final Consumption Expenditure on health	RVE on Medical, Health & Sanitation (both Central & State)	RVE Increase in Percentages	CPE on Medical, Health & Sanitation (Both Central & State)	CPE Increase in Percentages
	Rs. Crore	Rs. Crore	In Per cent	Rs. Crore	In Per cent
	Expression				
	Level Value	Level Value	Level Value	Level Value	Level Value
Apr-1991	14698	4917.88	-	241.79	-
Apr-1992	16065	5429.15	10.396	296.5	22.627
Apr-1993	17557	6150.49	13.286	269.45	-9.1231
Apr-1994	19543	7234.48	17.624	282.9	4.9916
Apr-1995	27859	8119.05	12.227	391.35	38.335
Apr-1996	32923	7527.1	-7.291	344.62	-11.941
Apr-1997	37341	8693.69	15.499	415.78	20.649
Apr-1998	45899	9985.27	14.857	520.71	25.237
Apr-1999	65389	12203.01	22.21	584.56	12.262
Apr-2000	84359	13765.38	12.803	788.92	34.96
Apr-2001	99338	14872.68	8.0441	681.03	-13.676
Apr-2002	114413	15458.68	3.9401	717.37	5.336
Apr-2003	128303	16151.37	4.4809	779.64	8.6803
Apr-2004	146374	16837.91	4.2507	1095.27	40.484
Apr-2005	-	19821.67	17.72	1379.52	25.953
Apr-2006	-	22192.13	11.959	2054.47	48.926

{lval = level value (it gives growth value also); RVE = Revenue Expenditure; CPE =Capital Expenditure}
Source: www.cmie.com (Centre for monitoring Indian Economy - CMIE). [6]

From above table it is revealed that the private final consumption expenditure on health has increased continuously from Rs.14,698 Crores in April 1991 to Rs.1,46,374 Crores in April 2004. The revenue expenditure on medical, health & sanitation of both Central & State showed improvement of 10.39 per cent from April 1991 to April 1992. It further continued to improve by 13.28 percent in April 1993, and 17.62 per cent in April 1994. But, revenue expenditure has begun to reduce from April 1995 (12.22 per cent) to April 1998 (14.85 per cent). Once again, revenue expenditure had increased by 22.21 percent in April 1999 but after that it has declined continuously and percentage increased in revenue expenditure had reached to 4.25 per cent in April 2004. Revenue expenditure further increased by 17.72 per cent in April 2005 and again reduced to 11.95 per cent in April 2006. This showed that Government of India had focused more in terms of revenue expenditure on medical, health & sanitation at both the levels that is Central & State during 1991 to 1993; from April 1997 to April 1999 and from April 2005 to April 2006. Similar was the case with Government approach towards capital expenditure on medical, health & sanitation that too showed similar trends.

The expenditure on health can also be compared with the total expenditure of Governments, and expenditure incurred on total social sector. Table number 1.5 provides data about trends of social sector expenditure by the Central and State Governments.

Table Number 1.5: Trends of Social Sector Expenditure by General Government (Central and State Government Combined)

Items	2001-2002 Actual	2002-2003 Actual	2003-2004 Actual	2004-2005 Actual	2005-2006 RE	2006-2007 BE
In Rupees Crore						
Total Expenditure	6,44,746	7,04,904	7,96,384	8,69,757	10,09,668	11,14,929
Expenditure on Social sector	1,37,843	1,45,226	1,56,893	1,77,016	2,22,210	2,47,572
Expenditure on Health	28,578	31,457	34,822	39,078	50,164	56.932
In Percentage						
As Percentage of GDP:						
Total Expenditure	28.26	28.77	28.85	27.82	28.30	27.19
Expenditure on Social sector	6.04	5.93	5.68	5.66	6.23	6.04
Expenditure on Health	1.25	1.28	1.26	1.25	1.41	1.39
As Percentage of Total Expenditure:						
Expenditure on Social sector	21.4	20.6	19.7	20.4	22.0	22.2
Expenditure on Health	4.4	4.5	4.4	4.5	5.0	5.1
As Percentage of Social sector Expenditure:						
Expenditure on Health	20.7	21.7	22.2	22.1	22.6	23.0

(RE – Revised Estimates, BE – Budgeted Estimates)

Source: Budget Documents of Union and State Governments/RBI (The Economic Survey 2006-2007). [3]

In terms Governments expenditure on health as a percentage of Gross Domestic Product (GDP), it was 1.25 per cent in 2001-2002, 1.28 per cent in 2002-2003, 1.26 per cent in 2003-2004 and 1.25 per cent in 2004-2005. On an average, it remained near to 1.26 pr cent. But, it showed improvement in 2005-2006 as1.41 per cent and in 2006-2007 as 1.39 per cent respectively.

From the year 2005 onwards Government of India had put more emphasis on improvement of health of Indian population and a percentage of total expenditure on health expenditure had remained between 4.4 to 4.5 per cent from 2001-2002 to 2004-2005. But, it has showed improvement from 5.0 per cent of 2005-2006 to 5.1 per cent in 2006-2007. In terms of health expenditure as a percentage of social sector expenditure for the period from 2001-2002 to 2004-2005, it had remained at lower level of 20.7 per cent and at a higher level of 22.2 per cent. It too had showed improvement from 22.6 per cent of 2005-2005 to 23.0 per cent in 2006-2007 (The Economic Survey 2006-2007).[3]

By making such allocation of funds, the Government of India had put efforts to improve the public health as the national health of India is one of vital component of global health and therefore, public health services provided to the population with the ultimate aim to prevent diseases and maintain good health. Planning of the public health in India thus has long history. An attempt to the public health history has been made as follows.

1.1.1 Public Health Planning In India:

National health planning is the orderly process of defining national health problems, identifying unmeet needs and surveying the resources to meet them, establishing the priority goals that are realistic and feasible and projecting administrative actions to accomplish the purpose of the proposed programme. A health plan is a predetermined course of action that is firmly based on the nature and extent of health problems from which priority goals are devised. Planning for public health services in India have long been a part of history way back to Indus valley civilization, period of Ashoka, and in modern time Bhore committee report etc.

1.1.1.1 The history of planning for public health in India is summarized as follows.

Bhore Committee (1943-1946):

In British India, an effort was made to improve public health in the form of opening of hospitals and medical colleges. A National Planning Commission was set up by the Indian National Congress in 1938. First time in India, in 1943, the British Government appointed the "Health Survey and Development Committee", with Sir Joseph Bhore as Chairman, and committee had submitted elaborate report in 1946. It had offered various recommendations such as setting up of comprehensive primary health system based on smallest service unit for 10,000 to 20,000 population; setting up of 30 bedded hospitals for every two primary health units; formation of village health committee; doctors' should behave as 'social doctor'; formation of district board for each district as well as ensuring suitable housing, sanitary surroundings as well as safe drinking water supply, and elimination of unemployment with emphasis on preventive work. But, after the Independence in 1947, the Government of India set up a Planning Commission in the year 1950 under Indian Constitution, and started Five Year Plans System of planning for socio economic development of India. Besides, the Five Year plans, the Government set up various committees from time to time to examine health situations or any important problem being faced by us to sought suggestions for necessary reforms.

1.1.1.2 Mudaliar Committee (1959-1961):

The Mudaliar Committee was set up under the chairmanship of Dr. A. Lakshmanswami Mudaliar to evaluate the medical and public health services since the submission of report of the Bhore Committee. It recommended for upgrading and strengthening of Public Health Centers (PBHC's); strengthening of district hospitals; offering of mobile service teams rural areas; levy of small fee except poor; long range health insurance policy all citizens; formation of central health cader; inclusion of Medical Colleges under University Grants Commission; Institute of National programs, and improving effectiveness of the Central Council of health.

1.1.1.3 Chadha Committee (1963):

A special Committee under the chairmanship of Dr. MS. Chadha, Director General, (Health Services) was appointed to recommend on details of the requirement related to PHC and maintenance of Malaria Eradication Program. It opined that the maintenance of malaria was the responsibility of the general health services. Its recommendations included vigilance through medical institutions; multipurpose domiciliary health services for all health programs including Malaria, Small-pox, and control of other Communicable Diseases, and emphasis on health education.

1.1.1.4 Mukherjee Committee (1966):

Under the chairmanship of Union Health Secretary a Committee was appointed to undertake the review of Family Planning (FP) Program in suggesting FP strategy. It recommended administrative set up at different levels from Primary Health Unit to the State Headquarters, and delinking of Malaria maintenance activities from Family Planning Program.

1.1.1.5 Kartar Singh Committee (1972-1973):

Kartar Singh Committee too was set up to study the Family Planning Program, It too recommended in favour of appointment of multipurpose workers for the delivery of health, family welfare and nutrition services. An appointment of one male health workers for a population of 6,000 to 7,000; one PBHC to serve 50,000 population covering 16 sub-centers as well as one female worker for a population of 10,000 to 12,000, and training for all workers in the field of health, family planning and nutrition.

1.1.1.6 Shrivastava Committee (1974-1975):

Under the chairmanship of Dr. J.B. Shrivastava, this Committee made various recommendations such as organization of the basic health services within the community; economic and efficient program of health services; creation of a National Referral Service, and creation of necessary administrative and financial machineries.

1.1.1.7 Bajaj Committee:

This Committee acted as an Expert Review Committee for Health Manpower under the chairmanship of Shri J.S. Bajaj. It focused on health management and recommended several measures to improve the quality of medical education (J. Kishore, 2006).1

Based on various recommendations of various committees, the Government of India took various Initiatives and important action plans.

An attempt has been made to describe in brief various initiatives of the Government of India as follows.

1.1.2 Initiatives of Government of India in Health Sector:

The initiatives in India for the health sector were also based on events took place by events at global level for movement towards health improvement. Two major events for movement of economies in the world towards health improvement includes, Firstly, World Health Organisation (WHO) conference in 1978 at Alma Ata and Second, Millennium Development Goals set up by United Nations Millennium General Assembly, based on the Millennium Summit in September 2000.

Alma Ata Declaration, 1978 focused on health enhancement resolution which stated that, "Health is a State of complete physical, mental and social well being and not merely the absence of disease or infirmity".

It is a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to health sector"(Human Development in South Asia, 2004).[5]

In September 2000, the world leaders from 189 countries attended the United Nations Millennium Summit to adopt the Millennium Development Goals [MDGs] to make collective efforts to overcome poverty, promote equality, peace, and to achieve sustainable development by the year 2015 or earlier. Its main focus area was poverty eradication and health. The MDGs are made up of 08 Goals, 18 targets, and 48 indicators. These 08 MDGs included (i) eradicating extreme poverty and hunger; (ii) achieving universal primary education; (iii) promotion of gender equality and empower women; (iv) reduction of child mortality;(v) improvement maternal health; (vi) combating Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome (HIV/AIDS), Malaria and other diseases; (vii) ensuring environmental sustainability, and (viii) setting up of a global partnership for development.

The first 03 MDGs are directly related to health whereas its 4^{th} to 6^{th} goals deals with basic issues such as maternal health, child mortality and communicable diseases viz., Malaria, Tuberculosis and HIV/AIDS. The 07^{th} MDG focuses upon Environmental Sustainability to make provisions for safe and clean drinking water. Its 08^{th} MDG centered on globally achieving of these MDGs (J. Kishore, 2006 & Human Development in South Asia, 2004).[1 & 5]

An attempt has been made to outline in brief few initiatives of the Government of India as follows.

1.1.2.1 Increase public spending on Health:

The Government of India is committed to raise public spending on health from the current 0.9 per cent to 2.3 per cent of GDP by the year 2010 with a focus on primary health care.

The plan allocation made was Rs. 2,908 Crore for the year 2005-2006 as against the budgeted estimates of Rs. 2,208 Crore for the year 2004-2005. A further step up is visualized in the allocation budgeted for 2006-2007 at Rs. 3328 Crore (Annual Report of Health & Family Welfare, 2005-2006).[4]

1.1.2.2 India Health Vision 2020:

It has been suggested to improve diagnostic services and treatment that can reduce the prevalence and incidence of Tuberculosis (TB) the year by 2020. About 2 million cases of Malaria are reported in India each year.

Restructuring of the "Malaria Workforce" and strengthening of health infrastructure can be helpful in reducing the incidence of TB up to 50 per cent by the year 2010. Another major cause of illness, Childhood Diarrhea is largely preventable through simple community action and public education. Deaths due to Diarrhea are to be eliminated by the year 2010. By projected improvement in living standards; food security; improved educational levels as well as access to health care amongst all levels of population, and substantial progress too be made in reducing the prevalence of severe under nutrition in children by the year 2020 (J. Kishore,2006).[1]

1.1.2.3 Bridging the Gap between Infrastructure & Man Power:

During the tenth Five Year Plan (2002-2007), the main aim of the family welfare programme was to supplement strengthening of infrastructure for service delivery of health programme and bridging the gap in essential infrastructure and manpower.

1.1.2.4 National Population Policy 2000:

The Government of India has brought out the National Population Policy, 2000 which provided a policy framework and the expected level of achievements by the year 2010. Its few achievement included, (i) reduction in IMR to below 30 per 1000 live births; (ii) reduction in Maternal Mortality Rate (MMR) below 100 per 100000 live births; (iii) and achieving of 80 per cent institutional deliveries and 100 per cent deliveries by trained persons.

1.1.2.5 National Rural Health Mission (NRHM):

The NRHM was launched on 12th April, 2005, by Honourable prime Minister of India and it is being overanalyzed from the financial year 2005-2006.

The major purposes of NRHM includes, (i) To provide accessible, affordable, accountable, effective and reliable primary health care facilities for poor section; (ii) To bridge the gap in rural health care services through creation of a cadre of Accredited Social Health Activities (ASHA); (iii) To provide overarching umbrella to the existing programmes of health and family welfare; (iv) To address the related issues of health such as sanitation and hygiene, nutrition, safe drinking water etc.; and (v) To build greater ownership of the health programme among the community through involvement of Panchayati Raj institutions, Non – Government Organistions (NGOs) and other stakeholders at National, State, District and Sub-District level.

The outlay of NRHM for the year 2005-2006 was Rs. 6,731 Crore and the Department of Health and Family Welfare have been merged in to a single department by Government of India to implement this mission.

1.1.2.6 Pradhan Mantri Swasthya Suraksha Yojna (PMSSY):

In order to correct the imbalances in availability of affordable and reliable tertiary level healthcare services, in India in general and to augment facilities for quality medical education in the underserved States the PMSSY in particular was approved in March 2006.

An attempt has been made to describe in brief various Disease Control Programmes of the Government of India as follows.

Disease Control Programmes Mainly Includes Following:

1.1.2.7 National Vector Borne Disease Control Programme (NVBDCP):

Since 2003, in order to prevent and control the vector borne disease such as, Malaria, Filarisis, Kalaazar, Dengue/Dengue hemorrhagic fever, and Japanese Encephalitis, the NVBDCP programme was initiated. Its aim was to reduce mortality on account of Malaria, Dengue, and Japanese encephalitis by 50 per cent and elimination of Kalaazar by 2010 and of Lymphatic Filarisis by the year 2015.

1.1.2.8 National Leprosy Eradication Programme (NLEP):

The National Health Policy, 2002 has kept the goal of Leprosy elimination by the year 2005 through setting up of target as prevalence rate less than 1 case per 10,000 populations. The prevalence rate declined from 57.6 in 1981 to 1.34 in the year 2005 and further came down to 1.07 lakhs giving prevalence rate of 0.95 cases per 10,000 populations in December 2005.

1.1.2.9 Revised National TB Control Programme (RNTCP):

The RNTCP was implemented in a phased manner since 1997, by using Directly Observed Treatment Shortcourse (DOTS) strategy. By October 2005, 1065 million that is 95 per cent of India's population has been covered and more than 49 lakh patients were placed on DOTS treatment which saved about 8.8 lakhs additional human lives.

1.1.2.10 National Programme for Control of Blindness:

An action plan was been prepared during the10th Five Year Plan to implement National Programme for Control of Blindness which focused on development of comprehensive eye care services.

1.1.2.11 National Cancer Control Programme (NCCP):

The NCCP has aimed to revamp the geographical imbalances in the availability of cancer treatment facilities with the recognition of new Regional Cancer Centers, and strengthening of existing centers.

1.1.2.12 National Mental Health Programme:

The National Mental Health Programme was launched by the Government of India during the 10th five year plan under which 50 new districts were covered in the year 2004-20005 and 94 districts in the year 2005-2006.

1.1.2.13 Integrated Diseases Surveillance Project:

To develop capacity for early identification of important communicable diseases such as, Cholera, Typhoid, Polio, Malaria, TB, HIV/AID, Ministry of health launched Integrated Common Non-Communicable Disease to cover Road traffic accidents in all States and UTs in a phased manner.

1.1.2.14 National AIDS Control Programme (NACP):

The NACP was started in the year 1992 and the Government of India adopted the National AIDS Prevention and Control Policy in April 2002. The budgeted provision was Rs. 259 Crore in the year 2004-2005; Rs. 533 Crore in the year 2005-2006 and the total project cost of NACP phase II was Rs. 2,064.65 Crores (Annual Report of Health & Family Welfare 2005-2006).[4]

Above mentioned Government Initiatives and Public Health Programmes called for successful implementation in form of laws which shall provides coercive power to the Central and State Governments of India. The Government of India needs to make sufficient provisions for protection, promotion and growth of every individual, worker, group and vulnerable population in relation to their health. To achieve these fundamental goals of protection, promotion and growth of every individual various legislations and policies were drafted by the Government of India. Such legislations were introduced for variety of purposes such as, to improve and maintain high standards in the medical education and services; to assess for public registration to mortality and enumeration of population; to prevent public health problems; to achieve Maternal Health and to empower women; to safeguard the children and young; to prevent drug addiction; to protect workers and to provide social security; to protect environmental, and to promote voluntary work.

The list of important Indian Legislation related to health covers, viz., The Indian Medical Council Act, 1956 and Regulations 2002; The Indian Nursing Council Act, 1947; The Dentist Act, 1948; The Pharmacy Act, 1948; The Rehabilitation Council of India Act, 1992; The Indian Medicine Central council Act, 1973; The Consumer Protection Act, 1986; The Registration of Births and Deaths Act, 1969; The Census Act, 1948. the other laws were viz., The Delhi Antismoking & Nonsmoking Health Protection Act, 1996; The Transplantation of Human Organ Act, 1994; The Prevention of Food Adulteration Act, 1954; The Indian Air Craft (Public Health) Act, 1934, and Rules, 1954; The Medical Termination of Pregnancy Act, 1971; The Maternity Benefit Act, 1961; The Prenatal Diagnostic Techniques (Regulation and Prevention of misuse) Act, 1994; The Infant Milk Substitutes, Feeding Bottlers & Infant Foods (Regulation of Production, Supply & Distribution) Act, 1992; The Persons with Disabilities (Equal opportunity, protection of Rights and Full Participation) Act, 1995; The Mental Health Act, 1987; The Narcotic Drugs and Psychotropic Substances Act, 1985; The Drugs and Cosmetics Act, 1940; The Drugs (Control) Act, 1948; The Drugs & Magic Remedies (Objectionable Advertisements) Act, 1954; The Environment (Protection) Act, 1986;The Biomedical Waste (Management & Handling) Rules, 1998; The Municipal Solid Waste (Management & Handling) Rules, 2000; The Hazardous Waste (Management & Handling) Rules, 1989; The Air (Prevention and Control of Pollution Act, 1981; The Water (Prevention and Control of Pollution) Act, 1974; The Atomic Energy Act, 1962; The Insecticides Act, 1988; The Delhi Municipal Corporation Act, 1957; The Motor Vehicle Act, 1988; and The Red Cross Society (Allocation of Property) Act, 1936.

The Government of India under the Constitutional provisions owes its populations social security, health services, safety, environmental protection, equal opportunity, and justice. The methods adopted by the Government of India to deliver these services are framing policies. A few important National Policies include, National Policy & Charter for Children Draft; National Health Research Policy Draft; National Policy on Education; National Water Policy; National Conservation Strategy & Policy Statement on Environment and Development- 1992, National Nutrition Policy- 1993; National Housing and Habitat Policy-1998; National Policy for Old Person-1999; National Population Policy-2000; National policy for the Empowerment of Women-2001; National Blood Policy-2002; National AIDS Prevention and Control Policy-2002, and National Health Policy -2002 (J. Kishore, 2006).[1]

1.2 REVIEW OF NATIONAL HEALTH CARE POLICY (NHP) OF INDIA

An attempt has been made to review in brief the National Health Care Policy as follows.

Various healthcare policies have evolved over a period of time. An attempt to describe it in brief has been made as follows.

1.2.1 National Health Policy: 1983:

In India, the National Health Policy was formulated in 1983 which gave a general exposition of the policies and important policy initiatives under the NHP 1983, its major initiatives were as follows.

(i) Time-bound programme, in different phases under the hope to provide health to all, for comprehensive primary health care services, designed on the ground reality that elementary health problems can be resolved by the people themselves; (ii) intermediation through health volunteers having appropriate knowledge, simple skills and requisite technologies; (iii) establishment of Referral System to ensure that higher levels hierarchy patients, Who afford to pay more, do not become burdened at the decentralized level, where lower level patients are treated; and (iv) encouragement of integrated net-work of speciality and super-speciality services through private investments for patients who can pay, so that the Government's facilities remain limited to those entitled to free use (www.mohfw.nic.in).[7]

Government of India's initiatives in the pubic health sector have recorded some noteworthy successes over time, which are reflected in the progressive improvement of many demographic, epidemiological, and infrastructural indicators as follows.

Table Number 1.6: Achievements in Demographic / Epidemiological / Infrastructural Indicators of Public Health Sector in India

Sr. No.	Selected Indicators	1951	1981	2000
A	**Demographic Changes**			
01	Life Expectancy	36.7	54	64.6(RGI)
02	Crude Birth Rate	40.8	33.9(SRS)	26.1(99 SRS)
03	Crude Death Rate	25	12.5(SRS)	8.7(99 SRS)
04	IMR	146	110	70 (99 SRS)
B	**Epidemiological Shifts**			
01	Malaria (Cases in Million)	75	2.7	2.2
02	Leprosy Cases Per 10,000 Population	38.1	57.3	3.74
03	Small Pox (No of Cases)	>44,887	Eradicated	
04	Guinea worm (No. of Cases)		>39,792	Eradicated
05	Polio		29709	265
C	**Infrastructural Indicators**			
01	SC/PHC/CHC	725	57,363	1,63,181 (99-RHS)
02	Dispensaries &Hospitals (All)	9209	23,555	43,322 (95–96-CBHI)
03	Beds (Private & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
04	Doctors(Allopathy)	61,800	2,68,700	5,03,900 (98-99-MCI)
05	Nursing Personnel	18,054	1,43,887	7,37,000 (99-INC)

Source: National Health Policy 2002, www.mohfw.nic.in.[7]

It becomes evident from the table number 1.6 that smallpox and Guineaworm diseases have been eradicated from India and Polio is on the verge of being eradicated. Leprosy is expected to be eliminated in near future. Despite the impressive public health gains, the morbidity and mortality levels in India are still high.

Out of the communicable diseases Malaria, more deadly Falciparum Malaria, Tuberculosis (TB), and the common water- borne infections such as Gastroenteritis, Cholera, and some form of Hepatitis, have shown significant decline amongst the community. Since the declaration of the NHP 1983, a new and extremely virulent communicable disease "HIV AIDS" has emerged on the health, and as there is no existing therapeutic cure or vaccine for this infection, the HIV AIDS constitutes a serious threat to public health and also to economic development of India. Incidence of macro and micro nutrient deficiencies among women and children is another area in public health domain. The financial resources and public health administrative capacity was possible to marshal by NHP 1983, which was far short of the necessity to achieve such an ambitious and holistic goal of health for all especially for poor and under privileged people of India.

1.2.2 National Health Policy, 2002:

The changed circumstances relating to the health sector of India have generated a situation in which it felt necessary to review the field, and to formulate a new National Health Policy, 2002.

The NHP, 2002 was an attempt to set out a new policy framework to accelerate achievement of the public health goals considering the socio- economic circumstances of India (Ibid).[7]

Ministry of Health & Family Welfare, Government of India promulgated the National Health Policy (NHP) 2002 after a gap of 18 years. The reason behind recognizing the need to make changes in the National Health policy was related with the demographic changes, epidemiological transition including newer public health challenges; technological advancements, rising aspirations of the community and increasing globalization.

The main broad objective and emphasis of NHP, 2002 were viz., to achieve an acceptable standard of good health amongst the general population of the country; to increase access of the people to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions; emphasis given to increasing the aggregate public health investment through an increased contribution by the Central Government which further strengthens the capacity of the public health administration at the State level; emphasis on enhancing the contribution of the private sector in providing health services, for the population group which can afford to pay for services, and emphasis laid on rational use of drugs within the allopathic system and increased access to tried and tested systems of traditional medicine.

Within these broad objectives, the NHP 2002 was endeavor to achieve the following time-bound goals given as below.

Table Number 1.7: Time Bound Goals to be achieved under NHP by 2000-2015 in India

Sr. No.	Particulars	Year
01	Eradicate Polio and Yaws	2005
02	Eliminate Leprosy	2005
03	Eliminate Kala Azar	2010
04	Eliminate Lymphatic Filariasis	2015
05	Achieve Zero level growth of HIV/AIDS	2007
06	Reduce Mortality by 50 Per cent on Account of TB, Malaria and Other Vector and Water Borne Diseases	2010
07	Reduce Prevalence of Blindness to 0.5 Per cent	2010
08	Reduce IMR to 30/1000 And MMR to 100/Lakh	2010
09	Increase Utilization of Public Health Facilities from Crrent Level of <20 to >75 Per cent	2010
10	Establish an Integrated System of Surveillance, National Health Accounts and Health Statistics.	2005
11	Increase Health Expenditure By Government As a Per cent of GDP From The Existing 0.9 Per cent to 2.0 Per cent	2010
12	Increase Share of Central Grants to Constitute at Least 25 Per cent of Total Health Spending	2010
13	Increase State Sector Health Spending From 5.5 Per cent To 7 per cent of The Budget Further Increase To 8 Per cent	2005 2010

Source: Ibid.[7]

The major prescriptions of the NHP, 2002 against scenario before NHP, 2002 are described as follows.

The public health investment in India over the years as a percentage of GDP had declined from 1.3 per cent in the year 1990 to 0.9 per cent in the year 1999. The aggregate expenditure in the health sector was 5.2 per cent of the GDP. The Central Budgetary allocation for health, during the period of 1990 to 1999, as a percentage of the total central budget, was stagnant at 1.3 per cent, while at the state level it had declined from 7.0 per cent to 5.5 per cent. Under the constitutional structure, the responsibility and principal contribution for the funding of public health services is to be from resources of the States with some supplementary contribution about 15 per cent from Central resources.

The key policy provisions of the NHP 2002 were as follows.

To overcome the difficult fiscal position of State Government, the emphasis was laid down on role of Central Government in augmenting public health investments. Under the policy, the plan was to increase the health sector expenditure to 6 per cent of GDP with 2 per cent of GDP being contributed as public health investment by the year 2010. The State Government was expected to increase their commitment to health sector by the year 2005 in the first phase of their resources to 7 per cent of the budget and by the year 2010, in the second phase, to 10 per cent of budget. In case of public health investment Central Government contribution shall rise to 25 per cent from the existing 15 per cent by the year 2010.

Despite the focus of centralized planning in the development process was on an equitable regional distribution. The following Table indicates the attainment of health indices which is uneven across the rural – urban divide.

Table Number 1.8: Differentials in Health Status Among States

Sr. No.	Sector	Population BPL (per cent)	IMR(infant Mortality)/ Per 1000 Live Births (1999-SRS)	<5Mort-ality per 1000 (NFHS II)	Under Weight For Age-per cent of Children Under 3 years (<-2SD)	MMR/ Lakh (Annual Report 2000)	Leprosy cases per 10000 population	Malaria +ve Cases in year 2000 (in Thousands)
A	**India**	**26.1**	**70**	**94.9**	**47**	**408**	**3.7**	**2200**
01	Rural	27.09	75	103.7	49.6	-	-	-
02	Urban	23.62	44	63.1	38.4	-	-	-
B	**Better Performing States**							
01	Kerala	12.72	14	18.8	27	87	0.9	5.1
02	Maharashtra	25.02	48	58.1	50	135	3.1	138
03	TN	21.12	52	63.3	37	79	4.1	56
C	**Low Performing States**							
01	Orissa	47.15	97	104.4	54	498	7.05	483
02	Bihar	42.60	63	105.1	54	707	11.83	132
03	Rajasthan	15.28	81	114.9	51	607	0.8	53
04	UP	31.15	84	122.5	52	707	4.3	99
05	MP	37.43	90	137.6	55	498	3.83	528

Source: Ibid.[7]

It becomes clear that the attainment of health indices has been very uneven across the rural urban divide and it also brought out the wide differences between the attainments of health goals in the better – performing states as compared to the low – performing States. The public health systems have been very uneven between the better – endowed and the more vulnerable sections of society. The health indices on account of socio-economic inequality are given as follows.

Table Number 1.9: Differentials in Health Status Among Socio-Economic Groups

Sr. No.	Selected Indicators	Infant Mortality/1000	Under 5 Mortality/1000	Percentages of Children Underweight
A	**India**	**70**	**94.9**	**47**
B	**Social Inequity**			
01	Scheduled Castes	83	119.3	53.5
02	Scheduled Tribes	84.2	126.6	55.9
03	Other Disadvantaged	76	103.1	47.3
04	Others	61.8	82.6	41.1

Source: Ibid.[7]

The key policy prescriptions of NHP, 2002 indicated that in order to reduce the various types of inequalities and imbalances, in the inter-regional; across the rural-urban divide; and between economic classes, the NHP, 2002 Policy set out the most cost – effective method which suggested to increase allocation of 55 per cent of the total public health investment for primary health sector, 35 per cent for secondary and 10 per cent for tertiary health sectors. The policy projected that the increased aggregate outlays for the primary health sector will be utilized for strengthening existing facilities and also for opening additional public health service outlets.

In terms of delivery of National Public Health Programmes, the scenario before introduction of NHP, 2002 is discussed in brief as follows.

In view of wide variety of socio – economic settings in India, National Health Programmes need to be designed with enough flexibility to permit the State public health administrators to craft their own customized programme. The technical and managerial expertise belonging to Central Government shall be gainfully utilized in designing of national health programmes for its implementation across the various States. Over the last decade, that is from the year 1990 to 1999 for the major disease programmes, the Government of India had relied upon a vertical implementation structure and was able to make a substantial dent in reducing the burden of specific diseases. But, such structure requires independent manpower for each diseases programme, is expensive and difficult to sustain. It is a wide spread perception that the rural health staff has become a vertical structure exclusive for the implementation of family welfare activities. The outcome is that there is no identifiable service delivery system for these public health programmes where there is no separate vertical structure.

The key policy prescriptions of NHP 2002 indicated the key role of the Central Government in designing National programmes with the active participation of the State Governments. The policy highlighted the need for developing the capacity within the state public health administration for scientific designing of public health projects, suited to the local situation (Ibid).[7]

1.3 REVIEW OF GUJARAT HUMAN DEVELOPMENT REPORT: 2004:

An attempt has been made to review in brief the Gujarat Human Development Report, 2004 as follows.

Various attempts have been made over a period of time by State Government of Gujarat. An attempt to describe it in brief has been made as follows.

1.3.1 Health and Human Development:

Health is important in the process of human development and the member's country of WHO has also given importance at global level in the Alma-Ata Conference in 1978. Since the Alma-Ata Conference of 1978, it declared health as a fundamental human right, health and nutrition have been accepted as important national concern by developed and the developing countries. Another important event at global level was the declaration adopted by 189 countries at U.N. Millennium Summit in September 2000, in which world leaders promised to meet concrete targets for advancing development and reducing poverty by the year 2015 or earlier. The Major eight goals which were agreed upon amongst world leaders included viz., Goal 1: eradicate extreme poverty and hunger; Goal 2: achieve universal primary education; Goal 3: promote gender equality and empower women; Goal 4: reduce child mortality; Goal 5: improve maternal health; Goal 6: combat HIV/AIDS, malaria, and other diseases; Goal 7: ensure environmental sustainability; Goal 8: develop a global partnership for development. Three of these goals are directly health-related to health.

Goals four, five and six were expected to deal with basic health issues like maternal health, child mortality and communicable diseases like malaria, tuberculosis and HIV/AIDS. Even the first goal of eradication of poverty and hunger lead to better health of an individual as the poor health is both a cause and result of poverty and hunger. For achieving these goals of human development, the public action by the Government of India related to its social sectors which includes health, nutrition, education, public distribution system, social welfare system and other social services (Human Development Report 2003).[8] In the Indian Federal System, health is the concern of State Governments, though some of the important health programmes are funded by the Central Government of India (Gujarat Human Development Report 2004).[9]

1.3.2 Government Expenditure on Social Sectors:

For achieving higher levels of human development public action is an important component. The size and composition of public expenditure, particularly the expenditure on social sectors, determine the nature and extent of human development and is likely to influence the status of human development in several ways. There is a need to analyze how public spending on human development can be designed and monitored (Ibid).[9]

In order to analyze and measure public expenditure on human development the Human Development Report 1991 (UNDP 1991) had suggested four expenditure ratios in order to enable monitoring and planning of the public spending on Human Development. The four ratios were: viz., First, Public Expenditure Ratio (PER) that is, percentage of national income that goes into public expenditure. Second, Social Allocation Ratio (SAR) that is, percentage of total expenditure earmarked for social services. Third, Social Priority Ratio (SPR), that is, percentage of social expenditure devoted to human priority concerns, such as elementary education, preventive healthcare (water supply and sanitation), and nutrition. Fourth, Human Expenditure Ratio (HER), that is, percentage of national income devoted to human priority concerns. It is expressed as the product of the three previous ratios. According to the HDR 1991, HER should be around 5 per cent if a country wishes to do well in human development. This can be achieved if PER is around 25 per cent, SAR around 40 per cent, and SPR more than 50 per cent (Human Development Report, - UNDP-1991).[10]

1.3.2.1 Expenditure Ratios in the State of the Gujarat:

Prabhu and Chatterjee (1993) had computed the four ratios for the 15 major States of India for four years, 1974-1975; 1980-1981; 1985-1986, and 1990-1991. The performance against Public Expenditure Ratio (PER), found a good amount of progress at all India level, with the ratio increased from 15.29 in the year 1974-1975 to 24.79 in the year 1990-1991, but the ratio was still below the norm of 25.00. The performance of Gujarat was less than satisfactory with the ratio increased from 18.23 in the year 1974-1975 to 22.18 in the year 1990-1991. The performance against Social Allocation Ratio (SAR) it was found that there was marginal improvement at the All-India level, from 31.56 in the year 1974-1975 to 32.99 in the year 1990-1991, still, lower than the norm of 40. In Gujarat, there was an overall decline from 33.51 in the year 1974-1975 to 31.40 in 1990-91, only three States – Kerala, Bengal, and Tamil Nadu met the norm of 40.00 in the year 1990-1991 and Gujarat was ranked 9th among the 15 large States of India. The performance against Social Priority Ratio (SPR) was found that for the most States and for the country, SPR had remained far below the norm. There was only a marginal increase during the period 1974-1975 to 1990-91 (from 36.83 to 38.39). Gujarat's performance had been slightly better than that of the country, the value increased from 31.26 in the year 1974-75 to 38.79 in the year 1990-1991. The performance against Human Expenditure ratio (HER) it was found that the India as a whole did show improvement in HER from 1.79 in the year 1974-1975 to 3.21 in the year 1990-1991. Gujarat State showed relatively less improvement, with the ratio moved up from 1.91 in the year 1974-75 to just 2.70 in the year 1990-91, a 42 per cent improvement (Gujarat Human Development Report 2004).[9]

The ratios did not show any radical improvement in the post-reform period. The data of expenditure ratios in the State of the Gujarat from the year 1990-1991 to the year 2001-2002 are given as follows.

Table Number 1.10: Expenditure Ratios in the State of the Gujarat

Year	PER	SAR	SPR	HER
1990-1991	22.18	31.70	38.79	2.72
1991-1992	29.80	25.84	40.74	3.13
1992-1993	25.02	24.61	41.09	2.53
1993-1994	23.70	26.94	41.71	2.66
1994-1995	20.08	30.16	41.04	2.48
1995-1996	21.86	31.21	41.95	2.77
1996-1997	19.48	27.92	50.26	2.73
1997-1998	20.08	29.52	46.95	2.78
1998-1999	21.44	30.78	-	-
1999-2000	24.85	30.69	35.24	2.69
2000-2001	33.81	28.19	36.61	3.49
2001-2002	62.78	13.02	25.05	2.05
HDR 1991 norms	25.00	40.00	50.00	5.00

PER – Public Expenditure Ratio, SAR – Social Allocation Ratio, SPR – Social Priority Ratio, HER – Human Expenditure Ratio.

Source: Ibid.[9]

As per Table Number 1.10, PER shows wide year-to-year fluctuations and a long term increasing trend from 22.18 in the year 1990-91 to 62.78 in the year 2001-02. SAR also showed wide fluctuations as this ratio declined from 31.70 in the year 1990-1991 to 13.02 in the year 2001-2002. SPR showed an increasing trend up to 1996-1997 (ratio reached the norm of 50.00). But, after that the ratio has declined sharply to 46.95 in the year 1997-1998. HER had remained almost constant with figures going slightly above or below 2.70 against the norm of 5.00 till the year 1999-2000. The Gujarat state has not met any of the norms set up by the UNDP with regard to social sector and public expenditure ratios either before or after the reforms.

What kind of priority was given to social services in the Five Year Plans in the State of the Gujarat ? There was a clear decline from in the Fourth Plan. Although in the Fifth Plan, an increase was observed. In the Sixth and Seventh Plan, once again, there was a decline. However, some improvements were observed in the Eighth Plan with social services get a share of 19.00 per cent. Finally, in the Ninth Plan serious efforts towards social development were observed, with an increase in the outlay to the social sector. Composition of actual expenditure on various components of the social sector was very useful and the proportions of expenditure on health and education sectors were provided in table number 1.11.

Table Number 1.11: Trends in Expenditure on Health and Education in the State of the Gujarat

Year	As a Percentages of Expenditure on Social Services			
	Health		Education	
	Revenue	Capital	Revenue	Capital
1986-1987	30.66	3.94	48.14	1.70
1990-1991	25.49	2.78	56.75	4.92
1995-1996	21.82	2.62	59.79	11.51
1996-1997	22.07	3.41	59.90	5.18
1997-1998	27.32	6.64	54.00	6.19
1998-1999	23.45	7.61	57.47	3.36
1999-2000	26.38	5.68	54.47	2.76
2000-2001	35.61	2.41	47.59	1.17
2001-2002	44.97	1.60	42.19	0.63

Source: Ibid.[9]

From the above mentioned, it can become evident that the health sector expenditure showed a consistent decline in terms of its percentage share. In the case of expenditure on education, one did not observe any clear increase in capital account, as there were year-to-year wide fluctuations. In the case of the health sector the composition of expenditure had changed in such a way that a relatively higher amount was spent on medical side given as follows.

Table Number 1.12: Expenditure Pattern in Health Sector of the State of the Gujarat

Year	Percentages of Expenditure on			
	Medical	Public Health	Water & Sanitation	Family Welfare
1985-1986	41.40	16.30	24.80	17.60
1990-1991	51.10	11.60	24.60	12.70
1995-1996	53.65	15.19	17.86	13.29
1996-1997	56.50	15.51	15.64	12.34
1997-1998	57.22	14.10	22.06	06.62
1999-2000	37.48	08.31	41.32	12.89
2000-2001	30.39	05.70	57.04	06.87
2001-2002	49.17	09.34	32.73	08.76

Source: Ibid.[9]

It was found that the pattern of composition of expenditure in health sector focused more on medical side i.e. 41.40 per cent in the year 1985-1986 to 49.17 per cent in the year 2001-2002, which was higher than the expenditure on public health, water & sanitation and family welfare. Expenditure on public health as a percentage of total health budget showed a noticeable decline while expenditure on family welfare had drastically decreased. The share of water and sanitation in the health sector has increased, which was a very welcome development. The pattern of expenditure on the social sector in the State of the Gujarat did not reflected consistency in proportionate allocations to the components of this sector. The normative level of expenditure is a necessary, but not sufficient, condition for improving social sector development.

There is no doubt that the allocation to public health showed a less emphasis but health is a fundamental right and has been accepted as important national concerns in the developing countries (Ibid).[9]

1.3.3 Health Status of the State of the Gujarat:

The IMR in the Gujarat State came down from 145 to 63 deaths per thousand live births during the year 1973-1999. However, the state was far behind Kerala whose IMR was 14. Maternal Mortality Rate (MMR) in the state was 3.89 in the year 1992-1993, which was high as compared to Kerala's figure (0.87) per 1000. Total Fertility Rate (TFR) had declined from around 6 to 3 during 1951-98. The population policy intends to bring it down to 2.1 by the year 2010. The Couple Protection Rate (CPR) had increased from 10.4 per cent to 44 per cent in the year 1999. Gujarat's performance was compared against all India aggregates with regard to important Health indicators, which is given as follows.

Table Number: 1.13 Health Status Indicators of the State of the Gujarat and India

Sr. No.	Health Status Indicators	Gujarat	India
01	Crude Birth Rate, 2001*	24.90	25.40
02	Crude Death Rate, 2001*	07.80	08.40
03	Maternal Mortality Rate1992-1993*	03.89	04.58
04	Infant Mortality Rate, 2001*	60.00	66.00
05	Life Expectancy at Birth,1996-2001-Male*	61.53	62.36
06	Life Expectancy at Birth,1996-2001-Female*	62.77	63.39
07	Neo-natal Mortality Rate 1998**	44.00	45.00
08	Peri-natal Mortality Rate1998*	38.00	42.00
09	Post Neo-natal Mortality Rate1998**	21.00	27.00
10	Child Mortality Rate (0-5 years) 1998*	85.10	94.90
11	General Fertility Rate 1998*	98.70	106.50
12	Total Fertility Rate 1998*	03.00	03.20
13	Gross Reproduction Rate 1998*	01.40	01.50

Note: Data given by the health department of Government of Gujarat.
Source: Ibid.[9]

Gujarat's performance was better than all India aggregates with regard to important Health indicators. IMR had dramatically declined in India and Gujarat during the year 1971 and the year 2001. In the case of India, it had declined from 200-225 per 1000 live births at the time of Independence to 129 in the year 1971 and to 66 in the year 2001. In the case of Gujarat, it had declined much faster, from 145 in the year 1971 to 60 in the year 2001.

Inter State comparison puts Gujarat State in the middle order among the major 15 states as far as important health indicators are concerned, are given in table number 1.14.

Table Number 1.14: Interstate Comparison of Health Status of India

Sr. No.	States	CBR, 2001			CDR, 2001			IMR, 2001		
		Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
01	Kerala	17.2	17.4	16.6	06.6	06.8	06.1	11.0	12.0	09.00
02	Maharashtra	20.6	21.0	20.1	07.5	08.5	05.9	45.0	55.0	27.0
03	Punjab	21.2	22.1	18.7	07.0	07.2	06.4	51.0	55.0	37.0
04	Tamil Nadu	19.0	19.6	17.8	07.6	08.4	06.0	49.0	54.0	35.0
05	Karnataka	22.2	23.6	19.0	07.6	08.2	06.4	58.0	69.0	27.0
06	**Gujarat**	**24.9**	**26.6**	**21.5**	**07.8**	**08.8**	**05.6**	**60.0**	**67.0**	**42.0**
07	West Bengal	20.5	22.8	13.8	06.8	07.0	06.4	51.0	53.0	38.0
08	Haryana	26.7	27.8	22.8	07.6	07.6	07.4	65.0	68.0	54.0
09	Andhra Pradesh	20.8	21.3	19.6	08.1	08.9	05.6	66.0	74.0	39.0
10	Assam	26.8	27.8	18.5	09.5	09.8	06.6	73.0	76.0	33.0
11	Madhya Pradesh	30.8	32.8	23.0	10.0	10.8	07.2	86.0	92.0	53.0
12	Rajasthan	31.0	32.3	24.7	07.9	08.3	06.2	79.0	83.0	57.0
13	Orissa	23.4	23.9	19.6	10.2	10.7	06.8	90.0	94.0	60.0
14	Uttar pradesh	32.1	33.2	27.0	10.1	10.6	07.8	82.0	86.0	62.0
15	Bihar	31.2	32.3	23.4	08.2	08.5	06.3	62.0	63.0	52.0
16	**INDIA**	**25.4**	**27.1**	**20.2**	**08.4**	**09.0**	**06.3**	**66.0**	**72.0**	**42.0**

CBR – Crude Birth Rate, CDR – Crude Death Rate, IMR – Infant Mortality Rate.
Source: Ibid.[9]

It becomes evident that Gujarat State stood ninth with respect to CBR (24.9) in 2001 as against 25.4 in India. Gujarat State was ranked seventh in the overall IMR, with IMR at 60 in 2001. It ranked seventh in rural IMR (67) and ninth in urban IMR (42). It was worth noting that though the Gujarat State was at the top on urban Crude Death Rate (CDR), it ranked far below at ninth rank in the urban IMR among the large states. Information of some of the health indicators by districts in the Gujarat state that were available mainly based on the 1991 Census showed that there was a high disparity among the districts in the State of the Gujarat given as follows.

Table Number 1.15: Morbidity Indicators in the State of the Gujarat

Sr. No.	Morbidity Indicators	Gujarat	India
A	Morbidity Rate Per 1000 Population (Rural)		
01	- Total	75.8	106.7
02	- Male	71.6	105.5
03	- Female	80.8	108.1
B	Morbidity Rate Per 1000 Population (Urban)		
01	- Total	84.3	103.0
02	- Male	95.0	098.2
03	- Female	74.5	108.4
C	Prevalence Of Illness by Type (Rural)		
05	- serious communicable diseases	21.0	015.6
06	- Acute Illness	49.6	077.9
07	- Chronic Illness	05.2	013.2
D	Prevalence Of Illness by Type (Urban)		
01	- Serious Communicable Diseases	18.8	014.0
02	- Acute Illness	52.8	070.6
03	- Chronic Illness	12.7	018.4

Notes: Reference period is one year. All India figures include State /Union Territories of Goa, Meghalaya, Pondicherry, Chandigarh and Delhi Rural.
Source:Ibid.[9]

The Morbidity Rate per 1000 Population in both rural and urban areas was high in India Compared to Gujarat State. The prevalence rates of serious communicable diseases were rated higher in Gujarat (Rural Rate 21.0 & Urban Rate 18.8) compared to All India Rate (Rural Rate 15.6 & Urban Rate 14.0), and that of Acute diseases and chronic diseases were lower in Gujarat than the respective rates for rural and urban areas in India as a whole.

Further, the data on different diseases reported in Gujarat over time were collected by the Health Commissionerate are given as below.

Table Number 1.16: Year wise Cases of Different Diseases in the State of the Gujarat

Year	Diseases							
	Gastro Enteritis	Scabies	Tuberculosis	Cataract	Hepatitis	Leprosy	Malaria	Cholera
1988	69615	48127	139435	83425	7793	11249	460683	1207
1989	23096	30944	145272	93793	11939	11782	598653	274
1990	23413	44843	139863	94001	8095	9697	515926	144
1991	25071	53548	157303	112239	6817	11082	404735	107
1992	32389	59675	158928	124898	4407	11338	348532	246
1993	33600	132789	159471	153255	8825	13911	304109	265
1994	42035	-	165254	187332	7701	10278	248624	572
1995	25164	-	149376	229596	4780	11514	191028	65
1996	33173	-	153872	248681	6282	14303	143817	200
1997	23081	-	103621	274243	5824	15567	159652	49
1998	30966	-	126769	291030	5523	12778	106825	121
1999	24067	-	137494	-	-	-	64130	81
2000	37481	-	197910	-	-	-	36712	181
2001	33858	-	62779	-	-	-	84131	118

Source: Ibid.[9]

It becomes evident that from the year 1988 to the year 2001 the most widely prevalent disease in Gujarat State was Malaria. The second most prevalent disease was Tuberculosis. Scabies too was widely prevalent.

1.3.3.1 Sanitation:

Sanitation facilities are also considered as important factor affecting Health Status of People. The Census of India has brought out two publications in the year 1981 and the year 1991 on housing, electricity and toilet facilities. While the 1981 Report provided information for urban areas, the 1991 Report was for both urban and rural areas. National Sample Survey (NSS) Survey in 1998 estimated rural sanitation coverage in the State of the Gujarat to 20 per cent and urban coverage at 79 per cent. Mahadevia and Sarkar (2003), using NSS data, observed that in the year 1998 (NSS 54th Round which was on facilities), 17.4 per cent of households in urban areas in the State of the Gujarat had no access to drainage facility, while this figure for all India was 20.6 per cent (Ibid).[9]

The Government of Gujarat had introduced the Gokul Gram Yojna, by realizing the importance of sanitation, under which individual latrines are constructed in Gokul Grams villages. The Gujarat Municipalities Act, 1963, prescribed that each municipality shall provide latrines and urinals in municipal limits for public use.

Though per capita healthcare expenditure in the State is much lower than that for the country, the Gujarat State had much higher level of health facilities given as follows.

Table Number 1.17 Health Facilities in Rural and Urban Gujarat and India

Sr. No.	Facilities Per lakh Population	Gujarat	India
01	Hospitals - Total	04.34	01.32
	- Rural	00.70	00.57
	- Urban	11.26	03.51
02	Dispensaries - Total	15.22	03.25
	- Rural	09.33	01.86
	- Urban	17.78	05.38
03	Primary Health Centers	03.24	03.55
04	Sub-Centers	26.41	20.90
05	Beds - Total	145.76	78.70
	- Rural	31.34	22.26
	- Urban	363.95	241.96
06	Doctors	52.98	47.19
07	Nurses	59.00	36.88

Source: Ibid.[9]

The number of hospitals and dispensaries in 1991 in the State of the Gujarat (4.34) as per lakh population was more than three times the national average (01.32). But, the difference between the State of the Gujarat and India was not high when the health sub-centres (26.41 in Gujarat and 20.90 in India), per lakh population and doctors (52.98 in Gujarat and 47.19 in India) and nurses (59.00 in Gujarat and 36.88 in India), per lakh population were to be considered. With respect to Primary Health Centres (PHCs), Gujarat's (3.24) performance was lower than national average (3.55). Thus, Gujarat's performance was better in high order health facilities, which were generally located in urban areas. Urban-rural difference in high order health facilities was quite high in the State compared to all-India figures. The number of hospitals per lakh population in urban areas for the State of Gujarat (Urban 11.26 and rural 0.70) was 16 times higher than in rural areas. For India (Urban 3.51 and Rural 0.57) the difference was only near to six times. With respect to beds per lakh population, urban-rural difference was that urban facilities were 11 times more for the State of the Gujarat as well as for India (Ibid).[9]

A study conducted by National Council of Applied economic Research (NCAER) in 1994 on utilization of health care facilities in the State of the Gujarat, compared the utilization of health facilities in India given in table number 1.18.

Table Number 1.18: Utilisation of Health Facilities, Gujarat and India

Sr. No.	Particulars		Gujarat		India	
			Public	Private	Public	Private
A	Out patient Treatment					
01	Rural	Male	36.8	62.2	40.2	54.4
		Female	36.7	59.8	43.3	50.8
02	Urban	Male	38.7	57.7	34.7	58.9
		Female	31.6	63.2	33.2	60.9
B	Hospitalisation					
01	Rural		32.2	67.8	62.0	38.0
02	Urban		27.2	72.8	60.1	39.9

Source: Ibid.[9]

It was found that people, both males and females, depended more on private facilities in rural and urban areas. Dependence on the private sector for hospitalization cases was a common feature in the Gujarat State. This was contrary to the all India trend as well as the general understanding about the utilization of health care facilities. Hospitalization involved higher expenditure than outpatient treatment. For outpatient treatment, people were likely to reject public facilities. Long waiting period, non-availability of medical staff on time, and non-availability of quick treatment in Government hospitals and dispensaries discourages people from using public facilities. They, therefore, turned to the private sector. Dependence on public facilities was likely to be high in cases of prolonged treatment of chronic illnesses as well as for hospitalization that was expensive in private hospitals. The higher use of private hospitals in the State of the Gujarat can be explained by the fact that Gujarat probably has a large number of charitable trust hospitals providing hospitalization at reasonable prices, which makes them more popular than Government owned hospitals. One reason for the low utilization of public health care facilities in the State of the Gujarat was the large number of staff vacancies in Community Health Centers (CHCs), Public Health Centers (PBHCs) and Sub Health Centre (SHCs). At the lower end, with respect to paramedical staff, there was not much difference between the staff required and position sanctioned, but there was a significant gap in the case of doctors between positions sanctioned and positions filled (Ibid).[9]

The State of the Gujarat had improved its performance vis-à-vis India in the long run. In the early 1970s, the situation was very bad, but the Gujarat State had made better progress. IMR was lower than that for the country but far behind that of Kerala. Expenditure on health as a proportion of total budgetary allocations had improved since the year 1997-1998 and in the year 2000-2001 and the year 2001-2002, there was a marked improvement. However, a large part of the population uses private health care facilities in rural and urban areas. In spite of increased expenditure on the health sector, the poor and specific sections of the marginal population remained outside the purview of public health facilities. An emerging area of concern for health problems in the State of the Gujarat includes, first of all, Gujarat faced the problem of groundwater in quantitative as well as qualitative terms.

Excess salinity, excess fluoride, and excess nitrite are responsible for diseases like fluorosis, leprosy, trachoma, and conjunctivitis. Leprosy and scabies were also very common in Gujarat. Conjunctivitis erupts during certain seasons. Industrialization in the State of the Gujarat was dominated by pollution-prone industries such as chemicals and petrochemicals, dyes and pharmaceuticals, etc. Many of the chemicals used or produced in the State are hazardous. The health impact of chemical pollution has not yet been investigated much and needs to be taken seriously (Ibid).[9]

For this, monitoring of environmental health problems is essential. Gujarat is under the threat of diseases such as HIV/ AIDS, since it is a migrant receiving state.

1.3.3.2 Spending of People of Gujarat on Health:

The survey titled 'How Indian earns, Spends, and Saves' carried out by Max New York Life Insurance (MNYLI) and National Council of Applied Economic Research (NCARE) covered 342 towns and nearly 2,000 villages across 250 districts and 2,255 wards. The sample size included 63,016 households equally divided between rural and urban areas. The findings indicated that burgeoning health expenditure are severely denting household income in the Gujarat State as people are incurring nearly 24 per cent of their annual income on health related expenses. The Gujarat State stood at number five in medical expenditure ranking with a health index of 0.70 slightly higher than National Index Score of 0.547. Among the households in the Gujarat State those faced major sickness, 63.0 per cent had exhausted their own life savings and 22.9 per cent had depended on loans from family and friends. The overall percentage of households having health insurance was found to be just 3.64 percent. With the growing incidence of diseases were due to largely changes in lifestyle, health insurance is recognized as one of the primary protection needs for all the members of the family. The financial preparedness to deal with health issues in India is low and health expenses continue to be a major source of stress for Indian households. A large section of households spend borrow money to take care of their major medical expenditure. This can change if health insurance becomes an essential aspect of financial planning for individuals across the country.

There exist the need for financial literacy in India which showed that Indians, whether urban or rural, poor or rich, primarily save money out of their household income for emergencies, to educate children, to cater for old age to buy a house, however, the instruments they choose to save is not appropriate.

While 36 per cent of the Indian households keep their savings at home and 51 per cent in bank deposits. Also health expenses were clubbed with emergencies and not addressed separately. A focused approach to improve awareness and financial literacy to improve protection for health problems is urgently needed today (The Economic Times, 13th September, 2008).[11]

1.4 REVIEW OF REPORT – "HUMAN DEVELOPMENT IN SOUTH ASIA, 2004 THE HEALTH CHALLENGE":

The founder of UNDP Human Development Report Dr. Mahbub Ul Haq had developed "Mahbub Ul Haq Development Centre (MHHDC)" in November 1995 in Islamabad, Pakistan. This review was divided in to four major groups, viz., conceptual framework for the challenge of health in South Asia; state of South Asia Health, health and health care in India; and its overview.

1.4.1 A Conceptual Framework for the Challenge of Health in South Asia:

Right to live is the most basic human right. In order to prepare a conceptual framework it was necessary to consider some rigid facts about South Asia region. As per the Report "Human Development in South Asia, 2004, The Health Challenge", the facts of South Asia included viz., (1) the life expectancy at birth of South Asian is 63 years, which was lowest in the world after that of Sub-Saharan Africa; (2) 92 out of 1,000 children under the age of five died in South Asia; (3) the Maternal Mortality Ratio in South Asia was 516 per 1,00,000 live births; (4) around 30 per cent of children in South Asia still were not fully secured from infection against preventable childhood diseases; (5) around one-third of South Asians lived in absolute poverty and were unable to afford quality healthcare; (6) 46 per cent of children under-five were under weight; (7) two- third of South Asians lacked access to sanitation facilities, and (8) more than Five Million people in South Asia were infected with HIV/AIDS due to low awareness (Human Development in South Asia, 2004).[5]

Table Number 1.19 provides an overview of the current status of some of the most important determinants of ill health.

Table Number 1.19: Fundamental Determinants of ill-Health in South Asia

Sr. No.	Fundamental Determinants of ill-Health (other than lack of health services)	Percentages of South Asia's Populations (In Percentages)
01	Adult Illiteracy Rate, 2002	43.0
02	Population Below Poverty Line ($ 1 a Day), 1990-2002.	32.3
03	Population Without Access to Safe Water, 2000	14.1
04	Population Without Access to Sanitation, 2000	65.4
05	Malnourished Children (Underweight), 1995-2002.	46.0

Source: Ibid.[5]

One can understand from the above table that under right to health people should be provided health care services but it is not enough to eliminate the root of the problems of ill health. As a determinant of health the poverty; illiteracy; lack of safe drinking water; sanitation, and the magnitude of malnourishment are undoubtedly connected with health. Another equally important aspect is implementation of health related human rights. The normal procedure for implementing human rights exists at two levels.

The first level included Government efforts to promote human rights by providing special assistance to marginalized communities and vulnerable groups, or by drafting policies that are guided by human rights.

In South Asia the Government had met failure because policymakers were often not concerned about extending human rights to marginalized sections of society. The second level included protection of human rights through a network of national and international mechanisms for monitoring and judging and documenting Governments on the status of human rights in the country.

The performance of healthcare system in various countries against two major indicators Immunization coverage and births attended by skilled staff are given as follows.

Table Number 1.20: Proxies for the Extent of Healthcare System in South Asia

Sr. No.	Selected Countries	Immunisation Coverage Rate for Measles (In Percentages of the Children Aged 12-23 Months, 2002)	Births Attended by Skilled Staff (In Percentages of Total, 1995-2000).
01	India	67	43
02	Pakistan	57	20
03	Bangladesh	77	12
04	Nepal	71	11
05	Sri Lanka	99	97

Source: Ibid.[5]

Sri Lanka was the only country in the South Asia region where the healthcare system seemed to be adequate. The expenditure on healthcare in South Asia was inadequate. Per capita spending by South Asian countries are as follows.

Table Number 21: Per Capita Spending on Health in South Asia, 2001

Sr. No.	Selected Countries	Per Capita Spending on Health (In $)
01	India	24
02	Pakistan	16
03	Bangladesh	12
04	Nepal	12
05	Sri Lanka	30

Source: Ibid.[5]

Lower – income countries needed $ 30 to $ 45 as the minimum per capita sum. A vast gap existed between required expenditure and the current expenditure on health.

The developing countries, on an average, spent $ 47 per capita on health compared to high income countries which spend $ 2,841 on healthcare per capita. Per capita spending on health in South Asia ranges from $ 12 in Nepal and Bangladesh to $ 30 in Sri Lanka. Public expenditure on health in South Asian countries was 1 per cent of GDP compared to the developing countries average of 2.7 per cent and developed countries average of 6.3 per cent.

The low level of public sector service utilization reflects that public was not satisfied with these services. In case of India and Pakistan, as a part of South Asian region, the share of public sector in outpatient services was only 20 per cent.

Despite the public sector services are cheaper than private sectors, the damage is caused to the performance of the public sector provisions due to certain problems, viz., inadequate health infrastructure; inadequate provisions of medicines; inadequate trained health personnel; inadequate attention in public sector to individual case; perceived low quality of public healthcare services, and preoccupation of Governments with vertical projects which utilizes the same health personnel that provide other basic services.

In South Asian countries, the private sector dominates the healthcare provisions as it is completely unregulated and private sector has moved to fill inadequate provisions by public sector. In case of India and Pakistan as a part of South Asia the share of private sector in out patient services was extremely high, about 80 per cent. The majority of public expends for private health services were through out-of-pocket payments as it was very expensive. The private services were not only expensive but such services were often very poor in quality; medicine practitioners were not properly qualified; exploitation of people due to majority was illiterate etc. Despite the low quality of health care provisions, there are excellent high quality corporate hospitals in urban centers in most countries, but, that are extremely expensive and out of reach for the vast majority of people.

In order to make the healthcare system of South Asia more suitable for poor people, revitalization of healthcare system is necessary by certain interventions, viz., and increase in public funding for health and its proper channellising; enhance public health infrastructure; lower burden of out-of-pocket expenditures for poor clients; regulation of private sector; increase donor funding; curtail user fees for public sector case; effective public-private partnerships, and empower local Governments to implement services.

1.4.2 State of South Asia in the Health:

In case of South Asia, health is biggest challenge and constraint for human development and facing a burden of communicable and non-communicable diseases, and the challenges of new and resurging diseases like HIV/AIDS, Tuberculosis etc. About 27 per cent of the estimated cases of TB in the World occur in South Asia and had highest percentage of underweight, dismayed and tired out children less than five years of age in the World. Malnutrition is one of the important causes of high rates of Mortality and Morbidity among children. Only 35 per cent of the population in South Asia had access to improved sanitation facilities, while 86 per cent have access to improved water resources. Uneven progress has taken place in South Asia. Overall, the health sector in South Asia suffers from lack of funds, inadequate infrastructure, inefficient management of health system and inadequate political commitments to provide healthcare for the masses (Ibid).[5]

The necessary detail about the expenditure in various regions of the world is given below.

Table Number 1.22: Health Expenditure by Various Regions of the World, 2002

Sr. No.	Selected Regions	Total Health Expenditure as Percentages of GDP	Public Expenditure on Health as Percentages of GDP	Public Expenditure on Health as Percentages of Total	Health Expenditure Per Capita (US $)
01	East Asia & Pacific	4.9	1.9	38.8	48
02	Europe & Central Asia	5.8	4.3	72.4	123
03	Latin America & Caribbean	7.0	3.4	48.0	255
04	Middle East & N. Africa	4.9	2.8	59.3	166
05	South Asia	4.8	1.0	21.6	22
06	Sub-Saharan Africa	6.0	2.5	41.3	29
07	High Income Countries	10.8	6.3	62.1	2,841
08	Europe EMU	9.3	6.8	73.5	1,856

Source: Ibid.[5]

South Asia's the total expenditure on health as a percentage of GDP averaged to 4.8 per cent, and public expenditure as a percentage of GDP averaged only 1 per cent, which were lowest compared to other regions in the world. Further the details about health expenditure within the countries of South Asia Region are given as follows.

Table Number 1.23: Health Expenditure in South Asia, 2001

Sr. No.	Selected Countries	Total Expenditure on Health as Percentages of GDP		General Government Expenditure on Health as Percentages of Total Expenditure on Health		Private Expenditure on Health as Percentages of Total Expenditure on Health		Health Index (Rank)
		1997	2001	1997	2001	1997	2001	
01	India	5.3	5.1	15.7	17.9	84.3	82.1	140
02	Pakistan	3.8	3.9	27.2	24.4	72.8	75.6	147
03	Bangladesh	2.9	3.5	33.7	44.2	66.3	55.8	146
04	Nepal	5.4	5.2	31.3	29.7	68.7	70.3	162
05	Sri Lanka	3.2	3.6	49.5	48.9	50.5	54.1	79
06	Bhutan	3.6	3.9	90.4	90.6	9.6	9.4	132
07	Maldives	6.5	6.7	81.9	83.5	18.1	16.5	78
08	South Asia	-	4.8	-	22.1	-	77.9	-

Note: General Government Expenditure on Health is defined as public expenditure on health.
Source: Ibid.[5]

To illustrate, Maldives is the only country, within the South Asia, that spent more than six per cent on health as a percentage of GDP. The major failure of the health systems in South Asia is due to lack of access of people to water, sanitation, health facilities, and the availability of health services and health provider. The required detail about access to water and sanitation by various regions in the world, in 2000 is given in table number 1.24.

Table Number 1.24: Access to Water and Sanitation by Region, 2000

Sr. No.	Selected Regions	Population with Access to improved Sanitation (In Percentages)	Population with Access to improved Water Source (In Percentages)
01	Arab States	83	86
02	East Asia & The Pacific	48	76
03	Latin America & Caribbean	77	86
04	South Asia *	35	86
05	Sub-Saharan Africa	53	57
06	Developing Countries	51	78

Note: * The aggregate average calculated by MHHDC used here differs from UNDP calculations as it refers to only seven South Asian countries excluding Tran and Afghanistan.
Source: Ibid.[6]

Only 35 per cent of the population of South Asia had access to improved sanitation which was very low compared to other regions, whereas 86 per cent of South Asian population had access to improved water source which was competitive with the other regions. In south Asia, in terms of water coverage, 61 per cent in 1993 increased to 86 per cent in 2000; an additional 145.9 million had access to safe drinking water source. Although, the percentage of South Asian total population having access to sanitation had increased from 30 per cent (361 million) in the year 1993 to 35 per cent (491 million) in the year 2000. The total number of people without access to sanitation had increased from 830 million in the year 1993 to 835 million in the year 2000. In seven years (1993-2000), 175 million were added to South Asia's population which had resulted in increase in the number of people without sanitation. The Table 29 provides details about access to water and sanitation in South Asian in general and also by urban and rural areas, for the year 1990 and the year 2000 as follows.

The estimates of medical costs in India and United States are given in Table Number 1.25

Table Number 1.25: Estimated Medical Costs in India and the US

Sr. No.	Nature of Costs	India	United states
01	Magnetic Resonance	$ 60	$ 700
02	Hip Resurfacing	$ 5,000	$ 21,000
03	Total Cost of Surgery	$ 10,000	$ 2,00,000
04	Malpractice Insurance for Heart Surgeons	$ 4,000	$ 1,00,000
05	Death Rate for Coronary Bypass	0.8 per cent	2.35 per cent

Source: Ibid.[5]

Further the surgeons in India's private hospitals are mostly trained in the developed countries and returned to India. Even in the United States, there is hardly a hospital without a doctor of Indian origin and nobody question the capability of these medical professionals. It is estimated that Indian's medical industry could yield as much as $ 2.2 billion annual revenue by the year 2012 but it would go a long way in addressing some of the challenges that the health sector faces in India.

1.4.2.1 A Measurement of South Asia's Health and Health Index of South Asia:

The data obtained by UNDP and World Bank are used and health index of 177 countries was prepared and out of these the Health Index for South Asia, 2002 was as follows.

Table Number 1.26: Health Index for South Asia

Sr. No.	Selected Countries	Health Index Value	Status Index	Infrastructure Index	Limitations Index	Human Development Index	Rank Among 177 Countries
01	Maldives	0.751	0.830	0.704	0.769	0.752	78
02	Sri Lanka	0.751	0.892	0.618	0.875	0.740	79
03	Bhutan	0.544	0.743	0.417	0.596	0.536	132
04	India	0.476	0.708	0.310	0.575	0.595	140
05	Bangladesh	0.458	0.733	0.332	0.435	0.509	146
06	Pakistan	0.458	0.701	0.283	0.565	0.497	147
07	Nepal	0.379	0.681	0.275	0.285	0.504	162

Note: Data Obtained from UNDP 2004 and World Bank 2004 used in calculating Indices.
Source: Ibid.[5]

In one compare the health Index of South Asian Countries, the result of South Asian Countries were poor. The performance of South Asian countries was poor and the most common factor among all South Asian countries for such poor performance included, poor health infrastructure, high maternal mortality, undernourishment, poverty, illiteracy, and lack of sanitation.

1.4.3 Health and Health Care Sector of India:

India is not only diversified in terms of language religion, food, cultural, geography but also diversity in terms of health performance. The key details about comparison of health, manpower and hospital beds as on 1990-1998 is given as below.

Table Number 1.27: International Comparisons of Health, Manpower, and Hospital Beds, 1990-1998

Sr. No.	Particulars	Physician per 1000 Population	Nurses per 1000 Population	Midwifes per 1000 Population	Hospital Beds per 1000 Population
01	Indian Public Sector	0.2	-	0.2	0.4
02	India Total	1.0	0.9	0.2	0.7
03	World	1.5	3.3	0.4	3.3
04	Low Income Countries	1.0	1.6	0.3	1.5
05	Middle Income Countries	1.8	1.9	0.6	4.3
06	High Income Countries	1.8	7.5	0.5	7.4

Note: Income category is defined by per capita Gross National Product (GNP) in 1999; low income countries < $ 755; middle-income countries $ 756-9265; high-income countries > $ 9265. Country income averages are unweighted. Table is reproduced from World Bank 2001c.
Source: Ibid.[5]

The comparison of India's healthcare with the performance of countries at international level was made and it became evident that India fell below the low income countries in terms of personnel and facilities for health care. India's performance was not only poor in terms of healthcare infrastructure but the utilization of these healthcare facilities was also poor shown as below.

Table Number 1.28: International Comparisons of Health Service Utilization and Disability Adjusted Life Years (DALYs) Lost Per 1000 Population

Particulars	Inpatient Admissions per capita per year (Percentages)	Average length of inpatient stay (days)	Outpatient visits per capita per year	DALYs (per 1000 population)
Indian Public Sector	0.7	14.0	0.7	-
India Total	1.7	12.0	3.9*	274
World	9.0	13.0	6.0	234
Low Income Countries	5.0	13.0	3.0	256 **
Middle Income Countries	10.0	11.0	5.0	-
High Income Countries	15.0	16.0	8.0	119

Note: Income category is defined by per capita Gross National Product (GNP) in 1999; low income countries < $ 755; middle-income countries $ 756-9265; high-income countries > $ 9265. Country income averages are unweighted. * Includes all visits to health providers, regardless of system of medicine. ** Estimated for low and middle income countries combined. Table is reproduced from World Bank 2001c.

Source: Ibid.[5]

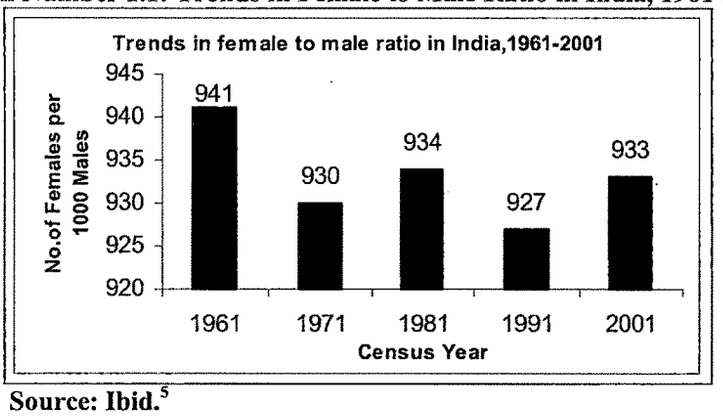
It became evident that utilization of healthcare facilities in India was lower than other low-income countries.

1.4.3.1 Health Scenario of India:

Health scenario of India can be viewed on the basis of certain indicators, viz., Infant and Child Survival; Sex Ratio; Maternal health; Reproductive health; Communicable diseases; Nutrition, and Financing of Healthcare expenses. So far as Infant and Child Survival is concerned the difference in Infant Mortality rate can be measured at viz., National level; State level; Rural and Urban level; differences among marginalized social groups, and Under Five Mortality Rate (U5MR) in India.

So far as sex ratio is concerned, the average female to male ratio was 990 per 1000 male. In Western Europe the ratio was 1064 female per 1000 male; in Africa it was 1015 female per 1000 male and in Asia the ratio wais 953 female per 1000 male. In India the sex ratio has declined over the years as shown in the graph number 1.1.

Graph Number 1.1: Trends in Female to Male Ratio in India, 1961-2001



Source: Ibid.[5]

The sex ratio showed little improvement to 933 but overall it was less than 1961 Census. India along with her close neighbours viz., Pakistan, Bangladesh, China, and South Korea appeared to form an art of anti – female countries that cuts across religious and nationalities.

The Maternal Mortality Ratio (MMR) is given in Table Number 1.29.

Table Number 1.29: MMR in Selected Developed Countries, 2000 (Per 1,00,000 Live Birth)

Sr. No.	Selected Countries	MMR *
01	Korea Rep.	20
02	Sri Lanka	92
03	Malaysia	41
04	China	56
05	Pakistan	500
06	Indonesia	230
07	India	540
08	Bangladesh	380
09	Nepal	740

* Values adjusted for under- reporting and misclassification for the year 2000.

Source: Ibid.[5]

So far as Maternal Health is concerned the Maternal Mortality Ratio (MMR) in India was high as compared to some selected countries. The performance of India in terms of burden of diseases compared to high, low and middle income countries are given as follows.

Table Number 1.30: Burden of Diseases in India, High, Low and Middle Income Countries, 1998 (In Percentages)

Sr. No.	Selected Countries	Injuries	Communicable Diseases	Non-Communication Diseases
01	India	17	50	33
02	Low and Middle income countries	16	44	40
03	High income countries	12	7	81

Source: Ibid.[5]

It appeared from the table number 1.30 that compared to high, middle and low income countries, the burden of communicable diseases in India accounted for 50 per cent of the total burden of diseases in India compared to only 7 per cent in high income countries. The data on burden of diseases revealed that India has to control the communicable diseases on the top priority basis.

So far as financing of health care expenses are concerned, the India's mobility and Mortality rates were higher not only due to widespread hunger and poverty but also due to low public investment in health. In terms of total five years plan expenditure, the health expenditure had declined as a proportion of total plan expenditure from 3.3 per cent in the first plan to 0.6 per cent in the ninth plan. With least ability to pay, the poor have the greatest need for health services and they bear the highest proportion of health care costs.

1.4.3.2 Profile of Diseases:

The death due to communicable diseases was as high as 42 per cent of the total deaths. These were also responsible for 2.5 million child deaths below the age of five years and an equal number of deaths among young adults. The preventive incidence of various Non – Communicable Diseases (NCDs) for 1998 has been estimated and given as follows.

Table Number 1.31: Estimated Number of Cases of Selected NCDs in India, 1998

Sr. No.	Diseases	Prevalence/ Incidence	Number of Cases (In Million)	Percentages of total Population
01	All cancers	Prevalence	02	0.2
02	Heart Diseases	Prevalence	65	6.6
03	Respiratory Diseases	Prevalence	65	6.6
04	Diabetes mellitus	Prevalence	13	1.3
05	Injuries	Incidence	07	0.7

Source: Ibid.[5]

It revealed that about a fifth of the population would have at least one of those selected NCDs. In addition to NCDs, it was estimated that the prevalence of major mental illness in India was one to two per 1000 while minor mental illness occurred in five to ten per cent of the population. The levels of suicides were estimated to occurred at a rate of 11 per 1,00,000.

1.4.3.3 Healthcare Provision:

With the major health programme, the public sector provides a range of health services and private sector continues to dominate and accounts for a significant proportion of National Health expenditures.

1.4.3.4 Provision of Health Care through Public Sector:

In 1980, the Government of India appointed a working group on population policy. The committee suggested differential interventions in different states in terms of health and family welfare programmes. India consisted of three-tire primary healthcare delivery system for rural areas, with Sub Health Centre (SHCs), Primary Health Centers (PHCs), and Community Health Centers (CHCs),and District Hospitals, Sub-centers, catering to a population up to 5000, are the most peripheral points of contact between the healthcare system and the community. The clinics of Ayurveda and Unani also provide proved medical care. There are various research and training centers. But, with all these the system facing any problems viz., poor-staffing, absence of staff, absence of simple consumables etc. Such absence of adequate care in the primary health care system often forces the people to get the treatment from exploitative private sector. The PHC system is unable to bring about reduction in infections and communicable diseases. The PHC provides a range of preventive and promotive services through its healthcare programmes. Few of such programes are outlined in brief as follows.

1.4.3.5 National Malaria Control Programme:

Due to high morbidity and mortality caused by malaria, the Government of India commenced a National Malaria Control programme in the year 1953. Due to initial success of the programme, it was converted into the Malaria Eradication Programme in the year 1958 aimed at eradicating Malaria in India by the year 1966. But, in 1966 the programme run into problems and from the year 1974 deaths due to malaria also began to show an increase and reached to 6.47 million in the year 1976. The modified plan of operation was launched in 1977 but despite this the year 1994 once again witnessed high rate of mortality.

1.4.3.6 National Tuberculosis Control Programme:

A National Sample Survey conducted during 1955-1958 revealed that 1.8 per cent of the population suffered from TB and it had affected rural and urban areas evenly. A review of National Tuberculosis Programme in the year 1992 revealed that only in 40 per cent of cases the treatment was completed due to inadequate budget and a chronic shortage of drugs. The Revised National TB Control Programme (RNTCP) was formulated with DOTs (Directly Observed Treatment Short-Courses) strategy. Although the DOTs programme had revealed impressive results, the sustainability of programme was questioned. The Tenth Plan acknowledged poor coverage due to gaps in primary healthcare infrastructure and manpower.

1.4.3.7 National Leprosy Elimination Programme:

The Government of India commenced a National leprosy Control programme in the year 1954, which was converted into the National Leprosy Elimination Programme in the year 1965. Diseases elimination stage has been reached in ten states and nearly 8.9 million persons were cured.

1.4.3.8 National AIDS Control Programme:

The single largest infectious diseases and the fourth leading cause of death in the world is HIV. New infections are largely among the under-25 age group including a large proportion of women. The first case of HIV infection was detected in India in the year 1986 in the state of Tamil Nadu. As on date there were more than 5 million HIV cases detected in India. The Government of India responded soon after the first case was reported in the year 1986, and initial AIDS prevention efforts were confined to Maharashtra, Tamil Nadu, Manipur and some big cities. Since 1992, the World Bank has been funding India wide National AIDS Control Project. The first phase of this project (1992-1999), with an International Development Assistance (IDA) credit of US $ 84 million, focused on strengthening blood banks, sexually transmitted diseases clinics, Surveillance Systems and increasing awareness. The second phase of the project was launched in the year 1999 with in IDA credit of US $ 191 million.

1.4.3.9 Reproductive and Child Health:

In 1950s, India commenced separate programmes for Family Planning and Maternal Child Health (MCH) services. Since the 1960s the focus had been largely on population control. The programme was renamed as Family Welfare Programme including MCH services. The expanded programme of Immunization was launched in the year 1979, and the universal immunization programme in the year 1985, integrated into the child survival and safe motherhood programme in the year 1990, but MCH services have frequently been crowded out by Family Planning (Ibid).[5]

1.4.3.10 Provision of Healthcare through Private Sector:

The private sector in India comprised of a large and heterogeneous group of actors and institutions. There exists a corporate hospital in urban localities that even the middle classes find difficult to access. On the other hand, there were vast numbers of ill qualified individual practitioners who provide the bulk of curative care in the country, and primary level care in particular. Between these two extremes there were range of non-profit NGOs, Trust, and Charitable and Religious Institutions that provide Medical and Healthcare. It was estimated that 93 per cent of hospitals and 64 per cent of hospital beds in India were in the private sectors as shown in the table number 1.32.

Table Number 1.32: Growth and Share of Private Sector Hospitals and Beds, 1974-1996

Year	Hospitals			Hospital Beds		
	Public	Private	Total	Public	Private	Total
1974	2,832	644	3,176	2,11,335	57,550	2,68,885
	(81.4)	(18.6)	(100)	(78.5)	(21.5)	(100)
1979	3,735	2,031	5,766	3,31,233	1,15,372	4,46,609
	(64.7)	(35.3)	(100)	(74.2)	(25.8)	(100)
1984	3,925	3,256	7,181	3,62,966	1,37,668	5,00,628
	(54.6)	(45.4)	(100)	(72.5)	(27.5)	(100)
1988	4,334	5,497	9,831	4,10,772	1,75,117	5,85,889
	(44.1)	(55.9)	(100)	(70.1)	(29.9)	(100)
1996	4,808	10,289	15,097	3,95,664	2,28,155	6,23,819
	(31.9)	(68.1)	(100)	(63.4)	(36.6)	(100)

Note: Figures in brackets denote percentage share
Source: ibid.[5]

The share of private hospitals had shown a dramatic increase from 18.6 per cent share in the year 1974 to 68.1 per cent share in the year 1996. On the other hand, the public hospital share had decreased from 81.4 per cent share in the year 1974 to 31.9 per cent share in the year 1996.

1.4.3.11 Management of Health Care:

As per constitution of India, the healthcare is the responsibility of Central & State Governments. The Central Government finances some public health programmes through centrally sponsored schemes, viz., Family Welfare Programme; The Universal programme for Immunization, and the AIDS control programme. The Central Government also bears the responsibility for running a large number of Research and Training Institutes. The State Government bears the major responsibility in implementation of programme and in financing of the rest of the health care budget, which comes to about 75 per cent of the total health expenditure. With the inefficiencies of health care system in both public and private sectors, the management of health care in India has not received the attention. First, reason is that public health is not a high priority for policy makers which are reflected in shortage of financial commitment. Second, India lacks a cadre of trained public health personnel to address health care needs. Third, lack of political commitment; and fourth reason is inappropriate development of human power, that is, India are producing more doctors they required while other staff, such as nurses and paramedical workers, are in short supply. The fifth reason is that there is not only shortage of manpower but there is also shortage of drugs and this has driven the patients, especially poor, in to the arms of the private sector.

1.4.3.12 Health Sector Reforms:

Variety of methods in India have been employed for health sector reforms, aimed at improving efficiency, effectiveness and quality of healthcare by public health care services, and such reforms includes contracting, public-private partnership, user fees, and privatization. For improving the efficiency of services in public health sector, the contracting has emerged as new mechanism.

In contracting system, all aspects of health facilities and functions can be contracted out to private parties, including clinical, Para-medical, and administrative functions. Contracting leads to a reduction in costs, introduces greater flexibility in the use of labour, and can be utilized to provide services in areas that were previously under serviced. The contracting in India has been integrated in to the blindness programme and the AIDS Control Programme, and franchising arrangements have been set up with private providers under the RNTCP. Many non-clinical support services in public hospitals have been contracted out. A future possibility suggests that NGOs can be contracted to provide primary health care services in rural areas. Considering the problems faced by the health sector of India, there is need to systematically review the experience before extending it to other areas.

Another way out is to create the provision of a range of incentives to the private health sector through the provision of land at throw away prices, grant of customs duty exemptions for import of sophisticated medical technology and loans from financial institutions. These incentives have been provided to profit and Non-profit institutions, but, study need indicated that it was utilized primarily by urban-based institutions that did not always provide free medical services to the poor. Another alternative source of health financing is levying of user charges. But, experience of countries in Latin America and Africa have indicated that user charges had not generated adequate resources and has failed to increase efficiency and effectiveness and had proved to exclude the poor and neediest. With varying degree of opposition the user charges have been implemented over the 1990s in the States such as Andhra Pradesh, Maharashtra, West Bengal, Madhya Pradesh, Orissa and Uttar Pradesh. But, with weak infrastructure in most public institutions and their poor outreach, user fees also tend to push more people to the private health sector.

By reviewing the cluster of projects that could be termed public-private partnership in health care, the Tenth Plan noted that many of these efforts were unsuccessful. Thus, contractual appointments of healthcare staff and hiring of private practitioners have not been able to fill the posts in urban-served areas. Earlier with a significant indigenous production of drugs the India characterized by low costs of drugs and pharmaceuticals. Over the 1990s the India had witnessed a sharp increase in medial care costs. India has also witnessed a greater connection of drugs production, a large role for multinational, a higher proportion of imported drugs and unbelievably steep rise in the costs of drugs. Costs of both outpatient and inpatient care had increased sharply in both rural and urban areas of India. In mid-1990s, compared to mid-1980s, Private outpatient costs have increased by 142 per cent as against 77 per cent in the public sector in the rural areas. In urban areas, private outpatient costs increased by 150 per cent compared to 124 per cent in the public sector. The increase in costs in inpatient care was even more striking, that is, average costs rose by 436 per cent in rural and 320 per cent in urban areas.

Any effort to improve public health in India must not only emphasis the important determinants of health but also the salient role of public spending. There is a common assumption that India is characterized by widespread State presence but, it is not the case with health sector.

Along with a weak State sector, an unregulated and powerful private healthcare sector raises several issues of universal care, comprehensive care and issues related with equity in health care. Larger macro-economic changes have increased regional, rural-urban and class inequalities that have compounded the problem (Ibid).[5]

1.5 HIGHLIGHTS OF GLOBAL PUBLIC HEALTH:

Countries in the world are pursuing the Millennium Development Goals and health of the people in the country is given more weightage so that healthy people contribute more in the output of the country and leads to economic growth of the country.

In this rest decade of the 21st century, immense advances in human well-being co-exist with extreme deprivation. In global health the benefits of new medicines and technologies are witnessed. But, there are unprecedented reversals such as, Life expectancies collapsed in some of the poorest countries, ravages of HIV/AIDS in parts of sub-Saharan Africa and to more than a dozen failed states. The world community had sufficient financial resources and technologies to tackle most of these health challenges; yet, today many national health systems are weak, unresponsive, inequitable - even unsafe. To implement national plans, developing capable, motivated and supported health workers is essential for overcoming bottlenecks to achieve national and global health goals (World Health Report, 2006).[12] The highlights of global public health by considering major health areas are given as follows.

1.5.1 Progress towards MDG 5: Maternal Mortality:

As per the Millennium Development Goal 5 (MDG 5) target for maternal mortality requires a decline in the maternal mortality ratio of around 5.5 per cent each year. The latest estimate, developed by World Health Organisation (WHO), United Nations Children's Fund (UNICEF), and the World Bank, was that 5,36,000 women died in the year 2005 as a result of complications of pregnancy and childbirth, and that 400 mothers died for every 1,00,000 live births. This is the "Maternal Mortality Ratio", the main indicator of the safety of pregnancy and childbirth. The MMR was 9 per cent in developed countries, 450 in developing countries and 900 in sub-Saharan Africa. This means that 99 per cent of the women who died in pregnancy and childbirth were from developing countries. No region in the world has achieved this result. Globally, the MMR showed a total fall of 5.4 per cent in the 15 years between the year 1990 and 2005, an average reduction of 0.4 per cent each year.

1.5.2 Gaps in Coverage Range From 20 Per Cent to Over 70 Per Cent:

Coverage, defined as the percentage of people receiving a specific intervention among those who need it. The Coverage Gap is an aggregate index of the difference between observed and "ideal" or universal coverage in four intervention areas viz., family planning, maternal and neonatal care, immunization, and treatment of sick children. Estimates from the most recent surveys showed that the mean overall gap across all 54 countries was 43 per cent, with values for individual countries ranging from more than 70 per cent in Chad and Ethiopia to less than 20 per cent in Peru and Turkmenistan. In 18 of the 54 countries, the gap was 50 per cent or more; it was between 30 per cent and 49 per cent in 29 countries and less than 30 per cent in the remaining 7 countries.

1.5.3 HIV/AIDS Estimates Are Revised Downwards:

Estimates of the size and course of the HIV epidemic are updated every year by UNAIDS and WHO. The number of people living with HIV worldwide in 2007 was estimated at 33.2 million. The new data and improved methods used in 2007 also led to a substantial revision of the estimates for the year 2006 and before. For instance, the new best estimate for the year 2006 was now 32 million and not 39.5 million as published in the year 2006. In fact, the number of people who become infected every day (over 6800) was greater than the number who dies of the disease (around 6000). Worldwide, 0.8 per cent of the adult population (aged 15–49 years) was estimated to be infected with HIV, with a range of 0.7–0.9 per cent.

1.5.4 Progress in the Fight against Malaria:

Malaria is endemic in many of the world's poorest countries. The MDG target aims to have halted and begun to reverse the incidence of the disease by the year 2015. In Africa, where 80 per cent of the global burden of malaria occurred, new data from household surveys and research analysis based on surveillance data allowed one to assess changes in intervention coverage in the fight against malaria in the region. Insecticide-Treated Nets (ITNs) are a cheap and highly effective way of reducing the burden of malaria. Though, the pattern is not consistent across Africa, In the majority of the 21 African countries with data from at least two national surveys, the proportion of children sleeping under ITNs increased five to ten times within five years.

1.5.5 Reducing Deaths from Tobacco:

The use of Tobacco is the single largest cause of preventable death in the world. Based on the WHO Report on the Global Tobacco Epidemic, 2008, total tobacco-attributable deaths from ischemic heart disease, cerebrovascular disease (stroke), chronic obstructive pulmonary disease, and other diseases projected to rise from 5.4 million in the year 2004 to 8.3 million in the year 2030, almost 10 per cent of all deaths worldwide.

More than 80 per cent of these deaths will occur in developing countries. However, nearly two thirds of the world's smokers live in just 10 countries: Bangladesh, Brazil, China, Germany, India, Indonesia, Japan, the Russian Federation, Turkey and the United States, which collectively comprise about 58 per cent of the global population.

1.5.6 Cancer, Mortality and Screening:

Globally, cancer is one of the top ten leading causes of death. It was estimated that 7.4 million people died of cancer in the year 2004 and, if current trends continue, 83.2 million more will die by the year 2015. Among women, breast cancer is the most common cause of cancer mortality, accounting for 16 per cent of cancer deaths in adult women.

Projections by UNAIDS, WHO and World Bank stated that globally, deaths from cancer was to increase from 7.4 million in the year 2004 to 11.8 million in the year 2030, and deaths from cardiovascular diseases was to rise from 17.1 million to 23.4 million in the same period. Deaths due to road traffic accidents were to increase from 1.3 million in the year 2004 to 2.4 million in the year 2030. By the year 2030, deaths due to cancer, cardiovascular diseases and traffic accidents will collectively account for 56 per cent of the projected 67 million deaths due to all causes. This increase in deaths from noncommunicable diseases will be accompanied by large declines in mortality for the main communicable, maternal, perinatal and nutritional causes, including HIV infection, tuberculosis and malaria (World Health Statistics, 2008).[13]

According to World Development Report, 2006 the inequalities in health gets translated into inequalities in other dimensions of welfare and Demographic and Health Survey (DHS) data from 60 countries, indicated that, Infant Mortality Rates vary markedly from a low of around 25 per 1,000 live births in Colombia and Jordan, to more than 125 in Mali, Niger, and Mozambique. But, the figures for children whose mothers had a secondary education or higher were dramatically lower. Further, infant mortality rates were also sharply differentiated across population groups defined by rural-urban residence and economic status. Extreme Stunting was another dimension of health which also varied across the countries. Overall rates were as high as 30 per cent in Pakistan and the Republic of Yemen, but, negligible in Trinidad and Tobago and very low in Jordan, Armenia and Kazakhstan. The difference between children born in rural and urban areas can be dramatic. In Guatemala stunting rates for children in urban areas were around 10 per cent, but in rural areas they were much as three times higher. So far as access to immunization was concerned, children born in families whose asset ownership places them in the top quintile of the distribution of economic status had a high probability of access to health services, having received at least one of three key childhood vaccinations (Bacille Calmette Guetrin, Diptheria, Pertussis and tetanus or measles).

So far as high-impact health services are concerned, the poor were considerably less likely than the non-poor to have access to high impact services, such as, skilled delivery care, antenatal care, and complementary feeding etc. DHS data further indicated that disabled people were much more likely to be poor. It has been argued that the social inequalities can be argued to be detrimental to individual health outcomes. The income inequality at the group level does not matter independently for individual health. Thus, the main inequalities that affect health may not be the income. The other dimensions of inequality are land ownership, women's agency (health and fertility in India), and democratic rights (in England in the 1870s and in the U.S. south in the 1960s). In general, an individual's rank in the relevant hierarchy has been found to be important to health (World Development Report, 2006).[14]

The large inequalities in health care use and health outcomes in many developing countries did not reflect different preferences or needs but they arose from constraints on the ability of individuals to achieve good health. Income is one important constraint and low-income people around the world had worse health and use fewer health services. Ethnicity, race, and location also influenced outcomes.

Infant Mortality Rates among blacks in South Africa were 5.5 times higher than those among whites; life expectancy among the rural Chinese was almost 6 years lower than among urban dwellers, while the life expectancy gap between China's richest and poorest provinces was 10 years. A lack of knowledge about hygiene, nutrition, available services, and treatment options, particularly among the uneducated, lowers demand for health services. Health clinics (hospitals), especially in poor and remote areas, were often inaccessible, have high rates of absenteeism and low quality and responsiveness to clients. There are various ways to attain good health viz., by (i) boosting people's knowledge about basic health practices and services, (ii) expanding their access to affordable care, and (iii) enhancing the accountability of providers (Ibid).[14]

The hospitals are significant in the sense that hospital takes a large part of health care budget. Hospitals policies and practices have an enormous impact on health care and put the hospitals at the position of apex body of the healthcare system. In the light of the expectation in new millennium, all healthcare enterprises will be required to seek best governance practices to act as guidelines and shall reflect priorities of healthcare providers. Such guidelines will enable, encourage and energizes them to manage the interface between national health policies, unique local needs, availability of local economic realities and performance challenges of local hospitals (Ibid).[14]

1.6 REVIEW OF LITERATURE OF THE HEALTHCARE SECTOR OF INDIA:

A brief outline has been offered as follows.

The public health is given priority by any community as it is of supreme importance. The introduction of Government programmes, policies, and legislations from time to time reflect the efforts of Government to make the safer and healthy environment for public.

The review of literature on healthcare sector has been grouped as follows.

(1) Healthcare and well being of society (2) Healthcare Indicators (3) Healthcare and Budget (4) Healthcare and Insurance (5) Healthcare and National health policy (6) Healthcare and User charges (7) Healthcare and Public Private Partnership (8) Healthcare Service Management and Medical Professional Behaviour (9) Healthcare Quality Improvement and Satisfaction from Healthcare Services.

An attempt has been made to discuss about it in brief as follows.

1.6.1 Healthcare and Well Being of Society:

Improving the health of individuals, particularly those belonging to socially and economically disadvantaged groups, is a key objective of the Government of India, and a major consequence of a Constitution that repeatedly directs the State to this end. The concern for health improvements, especially among the poor and the disadvantaged, whether supported or taken up in Government policies or elsewhere, stems from several considerations viz., the increasing recognition that improvements in health translate into substantial gains in economic performance and overall well-being of society; good health may be considered an end in itself, irrespective of any contribution it can potentially make to enhance economic growth; poor health has significant adverse implications for the economic well-being of affected households and individuals, particularly for poor households; and the adverse health can influence the economic well-being of affected households arises from incomes foregone on account of the morbidity or mortality of affected members, or taking time off from work to care for the sick. This can lead to tremendous financial burden on poor households and indebtedness, sometimes resulting in liquidation of their assets (Ramamani Sundar, Abhilasha Sharma, 2002).[15]

So there is no gainsaying that People's health status is intimately linked to the condition of their lives and the livelihoods that people pursue. The road towards health is a long-term one and it calls for good accessible, affordable medicare and disease Prevention and control. The solution lies in creating social Safety Network, by enhancing investment in creating resources and security measures for health, which can be reflected in the budgetary allocations of the Central Government of India giving a sense of direction to the States. Health is a State subject and as such most of the funding for medicare infrastructure and its upkeep comes from the State Budgets (EPW Editorial, March 2000).[16] Even as State Financing had either shrunk or had been diverted to specific areas, considered essential, private health care has grown quickly, widening its range of activities.

Not only have general and specialist hospitals, nursing homes and individual practices grown, but there has also been an explosion of sophisticated Diagnostic and Pathological Service Centers. This pattern of expansion has attracted sharp criticism on the grounds that had resulted in narrowing the access of health care to large sections. This growth has largely been unplanned. State plans have focused almost entirely on expanding the public systems allowing private growth to take place without adequate monitoring of quality or efficiency. The shrinking transfers to the States from the budget of the Central Government are considered responsible for smaller health care budgets by State (EPW Editorial, August 2002).[17]

1.6.2 Healthcare Indicators:

It is difficult to measure the health of India's population against single set of measures. An attempt has been made by the researcher to provide a brief sketch on the health of India's population against selected criteria. To illustrate, selected indicators of health had improved substantially when compared for the period during 1951 and 2001. Life Expectancy had rose to 64 years; the Infant Mortality Rate (IMR) has fallen to 63 per 1,000 populations; Crude Birth Rate had declined to 25, and Crude Death Rate had fallen to 8.1 (J.Kishore, 2006).[1]

As per Economic Survey 2006-2007 & 2007-2008, one could find some improvement in the quality of health care over the years. There exist continuous improvements found during 1951 to 2008 in various health indicators. Crude Birth Rate (Per 1000 Population) had reduced from 40.8 in the year 1951 to 23.5 in the year 2006. Crude Death Rate (Per 1000 Population) had reduced from 25.1 in the year 1951 to 7.5 in the year 2006. Similarly, Total Fertility Rate (Per Woman) had reduced from 6.0 in the year 1951 to 2.9 in the year 2005.

Infant Mortality Rate (Per 1000 Live Births) has reduced from 146 from 1951 to 57 in the year 2006. Child (0 – 4) Mortality Rate (Per 1000 Children) was 57.3 in 1972 it had reduced to 17.3 in the year 2005. The Life Expectancy at Birth for Male had increased from 37.2 in the year 1951 to 62.3 in the year 2001-2005. The Life Expectancy at Birth for Female had increased from 36.2 in the year 1951 to 63.9 in the year 2001-2005 (The Economic Survey, 2006-2007 & 2007-2008).[3]

The Report of the National Commission on Macro Economics and Health (2005-2006) founded that over 1,00,000 deaths have been averted due to the up scaling of Directly Observed Treatment Short-Course (DOTS). Indian doctors are comparable to the best in the world as they are technically proficient, and capable of performing sophisticated procedures, and that too at a fraction of the cost available in the west (Ministry of Health and Family Welfare, 2005).[2] The Rural Primary Public Health Infrastructure had recorded an impressive increase consisting of 1,45,000 Sub-Centers, 23,109 Primary Health Centers, and 3,222 Community Health Centers, catering to a population of 5,000, 30,000 and 1,00,000 respectively as well as 3,000, 20,000 and 80,000 population in tribes and desert areas respectively (Annual Report of Health & Family Welfare, 2005-2006).[4]

Eight of the world's distinguished economists addressed on issues that would be required to prioritize to advance the welfare of the developing countries at Copenhagen Consensus, 2004, and in which HIV/AIDS received first priority and policies to attack hunger and malnutrition followed close behind. Additional spending on infant and child nutrition was one of the important items of proposals offered in this conference. India's response to the issue took the form of the Integrated Child Development Services (ICDS) programme. Over the years, child malnutrition, which contributed to more than 60 per cent of the 2.4 million under-five child deaths annually, had been treated from the standpoint of treatment rather than prevention and it needs early solutions. According to the World Health Organisation (WHO), and the Tenth Five-Year Plan, child malnutrition is related to inappropriate infant feeding practices. Several studies have reported that infant feeding practices are very poor in India. Exclusive breastfeeding for the first six months is practiced in about 40 per cent of the infants and appropriate complementary feeding after six months is about 33 percent. Sadly, India's policy-makers, planners, and programme managers seek solutions where none exist. It is hunger which gets treated with supplementary nutrition. Ensuring optimal infant and young child feeding is the best way out as it provides food, health and care all at once. The ICDS reaches only a quarter of the child population through bundle of services that the ICDS provided which includes growth monitoring of children and education of families. But, in actual fact this hardly happens. The Pradhan Mantri Gramodyog Yojna is meant to focus on nutrition of the under-three, but food supplementation remains its mainstay. Programmes dealing with child health and development lack coordination have a fragmented approach and are grossly under-budgeted. The solution lies in improving infant and young child feeding practices through country wide breastfeeding support centers in all public and private sector facilities managed by a skilled counsellor. Interventions for the development of infants and young children – those who will vote, work, lead and sustain India are urgently needed and they come at a price (Arun Gupta, 2004).[18]

One may take example of child malnutrition rampant in Maharashtra and elsewhere. It came to the notice around April 2006 that tribal children in the districts of Amravati, Thane and Nasik have been dying of malnutrition. The administration was in denial mode, often refused to accept these as malnutrition deaths and blame it on tribal ignorance. All the claims of India of progress and development became a tragic travesty as children continue to die for lack of food in these villages. More than 10,000 children were believed to have died of malnutrition in the Maharashtra State. Children continued to die not because of scarcity of food, but because of rampant corruption and theft in the food distribution System. Not just tribes, but 47 per cent of Indian children below the age of three are malnourished and this is higher than in Sub-Saharan Africa (30 per cent) which has a lower per capita income. Six decades after national independence, India has yet to free children from hunger (The Economic Times, 19th April, 2006).[19]

According to United Nations Children's Fund (UNICEF), India has the highest number of malnourished children in the whole of the world one in three of the world's malnourished children is Indian. Of the world's malnourished children there were 47 per cent of under-lives in India.

The corresponding figure for China was only 8 per cent but in Ethiopia (47 per cent) and Bangladesh (48 per cent). Malnutrition occurs when there is insufficient nutrition intake. The reasons are inadequate diet on the one hand and inappropriate food intake on the other. Besides poverty, absence of balanced diet is due to a dysfunctional public distribution system and there are other factors that have deep social reasons. Gender inequality makes women feed better and more to the male child at the cost of the girl child. Also, since all children are immunized against childhood diseases, they are vulnerable to weight loss and weakness. Illiteracy and ignorance are other reasons for why mothers fail to take good care of infants. Merely, talking about achieving MDGs is not enough, efforts are needed to improve nutrition and its intake should be stepped up via education, public awareness, good sanitation and an efficient public distribution system (The Economic Times, 5th May 2006).[20]

The arrival of India among leading nations of the world brings with it immense responsibility both for the Government of India and the private sector. Though, India had proved in many areas, it still leg behind in providing basic services to its masses. The success of a India is judged by the Government's capability to provide basic services to its people and healthcare is one of it. In fact, the Government of India has realized that the role of private sector should be expanded in health care services. Moreover, an environment needs to be created where healthcare sector is given the same importance and incentives alike Infrastructure, IT, Hotel and Tourism. The Government of India has been pushing for a Rural Healthcare Plan arguing that the healthcare delivery capability is concentrated in urban areas. Indeed, India needs to look at a model which is suitable for it and its large population but at the same time it must be commercially viable for investors to put in their money. Certain State Governments and private entities are experimenting with a Micro Insurance Model. That can work, provided there are innovative solutions and an engagement between the public and private sector. Through, such micro insurance scheme for patients the Government could formulate a policy which would allow patients to choose from a list of approved hospitals as per specific needs. Further, public hospitals should be given autonomy to operate as financially self-sustaining institutions that will have a tremendous effect on the quality of care and would create a service-oriented mindset for its patients.

The Government of India need to create an independent regulatory body to ensure all approved public and private institutions are provided a certain minimum standard of health care, thereby changing the role of the Government of India from a supplier to a monitoring and developing agency.

Apart from uplifting the standard of healthcare in India, it is also important for Government of India to support and engage the community in which people live (Shivinder Mohan Singh, 2006).[21] The Government of India can support the community by making favourable allocations for healthcare in the Central budget from time to time.

1.6.3 Healthcare and Budget:

The allocations in the Central budget as made by the Government of India from time to time in favour of healthcare are discussed in brief as follows.

The budget for 2000-2001 allocated was Rs 5,852.83 Crores for the Ministry of Health & Family Welfare. Of this the largest chunk goes, of course, to the Department of Family Welfare, Rs. 3,541.47 Crores or 60.5 per cent of the total budget for the ministry. This is quite in keeping with the tradition set ever since India adopted a Family Planning Programme in the year 1960. The shrinking transfers to the States from the Centre have imposed austerity in the State budgets which has translated itself as smaller health care budgets (EPW Editorial, March 2000).[16]

In the year 2003-2004 Budget, a number of concessions in the form of reduction in excise, customs duty, and income tax exemptions were declared for the healthcare industry. Launching of an insurance scheme was a laudable beginning but overall rural healthcare gained little. A significant beneficiary of the Union Budget for the year 2003-2004 was the Healthcare Sector as a whole. The different sub-sectors that seemed to have been noticed in the budget were Pharmaceuticals, Biotechnology and Healthcare Institutions. The Finance Minister had pointed out that measures pertaining to the health sector were designed keeping in mind three objectives that is to contribution to enhanced national health, to promote India as a global health destination, and to enable easier access to health facilities to the disadvantaged sections of the Indian society (Deepa Sankar, Vinish Kathuria, 2003).[22]

An improvement in the health status of the population requires not the least a larger and better-differentiated investment plan. While there is undoubtedly an infusion of capital, mostly private, in the health sector, this is not likely to expand the 'disadvantaged' citizen's access to health care. Not surprisingly, health has comprised a slowly decreasing proportion of the total Central Budget allocations, from 0.7 per cent in the year 1999-2000 to 0.57 per cent in the year 2003-2004.

Even more surprising was the fact that public health as a proportion of the total budget of the department had declined from 39 per cent in the year 1999-2000 to 34.5 per cent in the year 2002-2003 and 34 per cent in the budget for the year 2003-2004 (EPW Editorial, 2003).[23] The most appropriate solution for the improvement in health care lies in the Private Health Insurance.

A Review of the Budget of the year 2006-2007 revealed a changed trajectory, with much larger allocations for rural sectors viz., Agriculture and Rural Development, and Social Sectors like Health, Education, Women and Child Development.

In fact, health and education together were to chassed nine per cent of the Gross Domestic Product (GDP) including State Government spending. Thus, by the year 2008-2009, assuming the current growth rate, the GDP at current prices is likely to be Rs. 52,000 Billion and three per cent of it would be a whopping Rs. 1,500 Billion, which should be nearly five times of what the State and Central Governments of India currently spend on the health sector (Ravi Duggal, 2006).[24]

The Government of India did laudable job in the budget of the year 2007 by supporting the healthcare by increasing allocation for health and family welfare to 21.9 per cent. The emphasis was also on Mother and Child Care, Integrated Child Development Services and Prevention and Treatment of Communicable Diseases. The Government of India's intention was clear when it announced its efforts to achieve zero level diseases through the National AIDS Control Programme. The reduction in import duty on medical equipment by 5 per cent, which is now 7.5 per cent. There were also measures for improvement in healthcare in rural areas in the form of increased budget allocation of National Rural Health Mission from Rs. 8,207 Crores to Rs. 9,947 Crores (R. Basil, 2007).[25]

In the budget of the year 2007-2008, the 150 per cent weighted deduction in pharma, R&D and exemptions for clinical trials in the budget were introduced. Similarly, reductions in customs duty of medical equipment were encouraging. But, this benefit was mainly meant for biotech and pharma, and not so much for hospitals. It just showed that the pharma sector was viewed as an industry whereas healthcare delivery is not. The allocation of Integrated Child Development Plan (ICDP) had gone up by Rs. 700 Crores. The funds for the National Rural Health Mission (NRHM) too had increased from Rs. 8,207 to Rs. 9,947 Crores. Ayurveda, Homeopathy and Unani combined were allocated Rs. 120 Crores. Unfortunately, no effort seems to have gone towards creation of a healthcare infrastructure.

The Healthcare Sector of India deserves to be categorized as part of an infrastructure sector and encouragement must be given to all the investors. In a nutshell, one cannot help but have the nagging feeling that policy decisions and the budget did not match the lip services of the Government of India towards improvement of the healthcare, which should make it more affordable and accessible for the people of India (Brig Joe Curian, 2007).[26]

The Union Budget of the year 2007-2008 took cognizance of the needs of the healthcare and medical devices sector. It has attempted to address crucial concern areas for the industry and has provided incentives to make this industry more competitive while ensuring that healthcare is more accessible and affordable for patients (Ram Sharma, 2007).[27]

1.6.4 Healthcare and Insurance:

According to Ajay Mahal (2002), the passage of the Insurance Regulatory and Development Authority (IRDA) Bill in December 1999 in the Indian Parliament marked a definitive point in the move towards the privatization of the Insurance Sector in India.

The entry of private health insurance companies in India is likely to have an impact on the costs of health care, equity in the financing of care, and the quality and cost-effectiveness of such care. However, an informed consumer and well-defined and implemented insurance regulation regime will ameliorate some of the bad outcomes and improve quality in health care. In an ideal world with well informed consumers who can evaluate alternative health care and insurance packages, with proper legal protection and affordable care, private insurance may not be harmful for cost and quality, although its impact could still be adverse from an equity point of view. The entry of private health insurance could have adverse implications for some of the goals of health policy, particularly for equity. There are areas where regulation with regard to health insurance would be clearly useful in instituting benefit packages, restrictions on risk selection procedures, and addressing aspects of consumer protection (Ajay Mahal, 2002).[28]

On December 29, 1999, the president of India gave his assent IRDA Bill, which also opened up the insurance sector for foreign and private investors.

India is also a signatory to the General Agreement on Trade in Services (GATS), and is one of the few developing countries that have offered a commitment to open up its hospital sector for foreign investors.

The dual events, of privatization of the insurance sector, and increased foreign investment in the hospital sector, are expected to have significant impact on the health sector in India, and in particular are likely to change the supply of, as well as the demand for health care services. Based on primary data collected in Delhi from about 500 households, it was found that a wide disparity across sections on willingness to participate. The challenges for the new system is to pool individuals across risk and economic status categories, set up a multi-tier system to meet objectives of equity and efficiency in health care delivery and for planners and regulators, to keep health insurance separate from other non-health insurance (Indrani Gupta, 2002).[29]

The introduction of several new health insurance products and their aggressive marketing is also creating a demand for quality rated services. Although, none of this expansion is likely to be generally accessible to those who currently use State hospitals, health insurance is generating a new layer of employed middle class who may find such services affordable (EPW Editorial, August 2002).[17]

One policy intervention has been suggested a move towards a cross-subsidized universal insurance scheme, that would ensure quality and affordable care as a base on which sophisticated and saleable services might sit well. No wonder the absence of a well- structured and grounded policy is being so truly felt (EPW Editorial, 2003).[23]

Health insurance in India has two main divisions that is, individual and group. Policies will continue to be determined by the individual risk profiles but the growing awareness of the field will give it a different emphasis. Periodic health checkups and suggestions for improvement will align with lower premiums for good risk. Group healthcare is a different story and by itself has been a loss making portfolio. The general perception that group insurance potential is overshadowed by the lack of profit has rendered insurers soft on this sector (Ajit Narain, 2007).[30]

The year 2007 ushered in detariffing for motor and fire insurance. The tariff regime did not allow insurance companies to offer any discounts on the rates prescribed by the Government of India. Therefore, they offered unprecedented discounts on tariff products like Group health insurance covers. As a result of collecting low premiums on group health insurance, this portfolio had always shown losses when analyzed on a standalone basis. With detariffing of motor and fire insurance, the competition is expected to whittle down the fat margins that insurers enjoy in fire and engineering insurance and eliminate cross-subsidies for health insurance. In detariffing, the rating will be based on the risk profile of the customer and it will be in the customers' interest to make his/her risk profile better.

Hospitals which will proactively help insurance companies would manage better claim ratios and likely to be preferred by the customers. Also, new products will come in to the market which will focus on keeping the insured healthy with emphasis on preventive health (Deepak Mendiratta, 2007).[31]

Retail health insurance is a loss-making portfolios and after detariffing companies had to cut down their losses. In view of this fact, private and public insurance companies are unveiling newer policies with more capping and restrictions based on the total of the sum insured. Companies have to focus on overall cost management with emphasis on prudent underwriting, operational and distribution efficiencies, leveraging economies of scale, excellent service, building brand image, underwriting innovative products/policies and cost-optimization, to survive in a cut-throat competition and lessen price sensitivity. There is a need for a collaborative partnership between insurers, healthcare providers, agents and brokers, the Government and community-based organizations and the IRDA for the growth of the health insurance sector (Dr. Biswendu Bardhan, 2007).[32]

Cashless services in the insurance sector are to play an important role in growth of insurance sector. It is becoming popular and has been recorded around 15 to 65 per cent of the hospital revenue that comes from credit facility provided by the hospitals (Dr. Biswendu Bardhan, 2006).[33]

Moreover, the Government of India has, at various points in time, embraced the objective of promoting the health of the poor and the disadvantaged in its policy statements and actions.

Jan J. Kerssens, Peter P. Groenewegen (2003) have attempted to examine the reasons people switch amongst insurance organizations with an objective to promote managed competition in Dutch health insurance.

Their results showed that those in the entry group were statistically significantly less satisfied with their former insurance organization than those in the other groups (exit and stayers) with the insurance organization under investigation. They were also less satisfied than the other groups in respect of the flat-rate premium. It was concluded that in the absence of clear differences between insurance organizations, the advantages of managed competition maybe too difficult to achieve (Jan J. Kerssens, Peter P. Groenewegen, 2003).[34]

1.6.5 Healthcare and National Health Policy:

The economic reforms of the 1990s had created a trajectory of public health spending. It showed a downward trend both in terms of share of the Central Government's budget as well as a proportion of the Gross Domestic Product (GDP). Prior to economic reforms, in the mid-1980s, public health expenditures was around 1.6 per cent of the GDP, and 3.95 per cent of the Central Government's budget These figures provided a dismal picture of 0.9 per cent and 2.7 per cent in the year 2001 respectively, which went further down to 0.8 and 2.4 per cent in the year 2005. The use of the Public Health System during the decade of 1987 and 1996, as per the National Sample Survey (NSS), Government of India, showed a shocking decline of over 30 per cent in proportion of patients seeking care in public health institutions (Ravi Duggal, 2006).[24]

According to Imrana Quadeer (2002) the Draft of the National Health Policy (NHP) 2001 spelt a significant departure from the 1983 policy objectives of providing primary health care for all, specially the underprivileged. Instead of creatively utilizing private sector to provide basic affordable health care, it all but hands over the task to the private sector, inevitably undermining existing National Health Programmes. (Imrana Qadear, 2002). Although, health is largely the States' responsibility, the Government of India has historically directed its growth and development, with the several centrally-sponsored disease control and other critical programmes. The NHP, 2001 had acknowledged the growing constraints on the States' resources that were meant for the health sector budgets were shrinking, and accepted that there had to be injection of substantial resources into the health sector from the Central Government Budget. It candidly accepted that even after 50 years the spread of health infrastructure was well below target shortage of 16 per cent overall and of over 50 per cent in the case of community hospitals, a secondary level of the infrastructure. The NHP, 2001 identified availability of medicines at the primary care level as the reason for the relatively better utilization of public health centers in the southern States. It envisaged the kick starting of the revival of the primary health care system by providing some essential drugs under central government funding through the decentralized system. It had stressed the need for establishing a reliable data system for disease surveillance, which would require some investment (EPW Editorial, March 2002).[35]

The Government of India programmes for vaccination also helped poor infants in improving health conditions. The Central Government of India had introduced (in 2003) the hepatitis-B Vaccine in its Expanded Programme of Immunization (EPI). Introducing the hepatitis B Vaccine in the National Immunisation Programme would not only cost the Government more than all the other six vaccines on the programme, but would yield little by way of public health protection. (Anant Phadke, 2003).[36]

Many such programs and various schemes introduced by State Governments in the Primary Health Center (PHC) needed to be implemented effectively and monitored continuously.

A study by M. Gopinathreddy, K Jayalakshmi, Anne-Marie Goetz, 2006, conducted that measuring PHC in Tribal areas of Vishakhapatnam. The study considered how the local political dynamics, which is shaped by competition between political parties and between authorities representing tribes, the State development administration and health officials, affected the Primary Health Centers capacity to treat poor tribal patients. The Community Health Workers (CHW) scheme in Andhra Pradesh State was integrated with the management of the PHCs and ultimately the department of health and family planning as well as the local tribal development agency. This case study from a tribal area in north-eastern Andhra Pradesh showed that the CHW schemes, and the Primary Healthcare System, failed to offer a number of reasons attributable to power relations within the health system (M Gopinathreddy, K Jayalakshmi, Anne-Marie Goetz, 2006).[37]

A study undertaken by Charu C. Garg, 1998, to develop a National Health Accounts Framework for India proposed to describe the various sources from where the funds came from, how they flew through the various financial intermediaries, and finally how different providers and socio-economic groups used it. (Charu C. Garg, 1998).[38]

Health has been accepted as a fundamental right of all people by the Constitution of the World Health Organisation (WHO) and in the International Declaration of Human Rights, India has made significant investments in health and health research, but so far a Health Research Policy has not been formulated.

The Indian Council of Medical Research (ICMR), an Autonomous Council established under the Ministry of Health and Family Welfare, is the agency responsible for medical research in the nodal ministry. The first National Health policy of 1983 was a response to the commitment to the Alma Ata declaration to achieve "Health for All by 2000". It accepted that health was central to development and had a focus on access to health services, especially for rural populations. A common criticism of scientific activities in India in general, and of medical research in particular, has been that no significant achievements have occurred, particularly in the post -independence period. The contributions made by these essentially Indian discoveries to national welfare are unquestionable, but in some instances they had to be rediscovered by international agencies before they were nationally implemented (Indian Council of Medical Research (ICMR) Bulletin, 2004).[39]

Health recognised as a fundamental issue in National Development and a factor that promotes equity. A clearly defined Health Research Policy, therefore, considered as the basis for maximising the Return On Investment (ROI) in this important field to facilitate this process by following the below given guide lines.

- Generating the evidence base for Health Systems and Services, so that they will be significant promoters of equity and contribute to national development.
- Establishing linkages between health research and national health programmes to facilitate the operationalisation of evidence based programmes and to obtain feedback for the optimisation of health research.
- Encourage the development of fundamental research in areas relevant to health, such as physiology, biochemistry, pharmacology, microbiology, pathology, molecular sciences and cell sciences, to ensure that a national critical mass of scientists who can contribute the benefits of modern technology to health research is developed.
- Ensure that the optimum benefits of modern technology are harnessed to promote national health.
- Build and integrate capacity for research in national health programmes, research institutions and in the private sector (profit and non-profit organisations) utilising as far as possible areas of excellence already available in the country.
- The optimal use of Information, Communication and Networking (IC&N) technology to ensure that the global knowledge base is available for national programmes, and that research is channeled in relevant directions without unnecessary duplication.
- Health research should be truly intersectoral- and harness the resources in areas such as social sciences, economics and traditional systems of medicine.
- Optimum harmonisation of national policies in a variety of areas (education, social sciences, population, agriculture, nutrition, trade, commerce, etc.) considered as essential to facilitate intersectoral collaboration and partnership, so that maximum developmental returns can occur from health research.
- A National Health Research Management Forum should be established as the body responsible for evolving, harmonising and evaluating the implementation of the Health Research Policy (Indian Council of Medical Research (ICMR) Bulletin, 2004).[39]

1.6.6 Healthcare and User Charges

World Bank and the International Monetary Fund (IMF) recommended user charges as a financing mechanism to achieve the goals of increasing efficiency, equity, quality, sustainability and effectiveness in the health sector (Sonia Andrews, Sailesh Mohan, 2002).[40]

Manu N Kulkarni (2005) in his analysis of the health sector budgeting touched on two issues, that is, How to strengthen the National Rural Health Mission (NRHM) and, and how to sustain the Health Intervention activities by not charging user fees for health services provided by the Government of India. If the State primary Health Care is made efficient and effective, poor patients are prepared to pay the user charges without question. The concern of NRHM should be to provide the best primary health care for mothers and infants and the patients would be happy to pay user charges without a murmur (Manu N Kulkarni, 2005).[41]

Ramamani Sundar, Abhilasha Sharma, (2002) conducted a Survey of urban poor in Delhi and Chennai in order to examine the patterns of morbidity and healthcare utilization by the urban poor living in slums and resettlement colonies and also compared the health status of the two segments. It was found that poor people and residents of slums were likely to be especially vulnerable to illness because of the generally unhygienic conditions in which they live, and their low levels of awareness of preventive care. Lack of awareness about preventive care and health facilities was particularly acute for slum residents who were new migrants to the cities from distant States and rural areas. Low-income households living in slums and resettlement colonies were susceptible to the economic shocks associated with serious disease, given their high dependence on labour income, and their having low levels of savings so that there is a real risk of indebtedness in times of ill health. The most important reason for not seeking treatment turns out to be illness not considered serious. There were interesting sex differentials in the reasons for not seeking medical treatment. In both Delhi and Chennai, the percentage of illness occurred, for which no treatment was sought due to financial constraints, was higher for females than for males. Lack of time and long waiting seemed a more important reason for males than for females. Also, in the case of the old people (60+) financial constraints appeared to be an important reason for not seeking treatment in Delhi as well as Chennai.

The findings also indicated that people living in resettlement colonies had a better health status and lower prevalence rate of illness than the slum dwellers because of people of resettlement colonies living in a better environment, living in pucca houses, better placed in terms of support from municipality; better waste disposal facilities; proper drainage facilities etc. As far as utilisation of health facilities is concerned, in spite of the presence of health facilities nearby a significant proportion of the sample populations living in the slums/colonies did not seek treatment for all their illnesses, particularly the old people. It indicated the need for providing free healthcare services for the elderly especially those belonging to the lower strata. This has a significant implication for financing of healthcare in the context of ageing population. The study also found that a number of NGOs were working in the area of health in the slums and resettlement colonies of Delhi and Chennai.

The healthcare activities of these NGOs needs to integrated with those of the Government health services (Ramamani Sundar, Abhilasha Sharma, 2002). [15]

Deepa Sankar, Vinish Kathuria, (2004) measured performance of the health system of in Rural India, that attempted to analyze the performance of rural public health systems of 16 major States in India using the techniques from stochastic production frontier and panel data literature. Their results showed that not all States with better health indicators had efficient health systems and concluded that investment in the health sector alone would not result in better health indicators. (Deepa Sankar, Vinish Kathuria, 2004). [42]

Abhijit Banerjee, Angus Deaton, Esther Duflo, (2004) attempted to measure health care delivery in rural areas of the State of the Rajasthan that showed the extremely low quality of public service and also that Unqualified private providers accounted for the bulk of health care provision. The low quality of public facilities had an adverse influence on the people's health (Abhijit Banerjee, Angus Deaton, Esther Duflo, 2004). [43]

Arvind Pandey, et.al. (2004) too measured the maternal health care services in the Chhattisgarh, Jharkhand and Uttaranchal. It revealed specific results to the particular features of the three States which indicated that it was necessary for the Reproductive and Child Health (RCH) programme to evolve a strategy giving due consideration to the geographical and socio-economic factors. The study showed that women living in Jharkhand and Chhattisgarh were more likely to use Antenatal Care Services (ANC) than their counterparts living in Uttaranchal. The RCH programme was expected to address the needs of women from lower economic strata to provide services especially to its SC/ST pockets (Arvind Pandey, Nandini Roy, D. Sahu, Rajib Acharya, 2004).[44]

Alex George, (2002) conducted a study to measure the quality of reproductive care in private Hospitals in Andhra Pradesh. An exit survey conducted in private hospitals in Andhra Pradesh on the quality of reproductive care yielded valuable insights on women's perceptions of quality of care. The information so generated was a useful input in any attempt to institute standardization of practices in Medicare institutions. The major aspects it considered for all reproductive care producers included, diagnostic, medical and surgical equipment, ambulance facility, cleanliness in general, particularly changing of bed sheets, water supply, electricity, room space, room for attendants to wait, need for lady doctors to attend to women's reproductive care problems and behaviour of doctors and nurses including the doctors' ability to treat. It called for developing adequate standards for the Medical Termination of Pregnancy (MTP) procedures (Alex George, 2002).[45]

T K Roy, Sumati Kulkarni, Y Vaidehi, (2004) undertook study to assess the social inequalities in health and nutrition in selected States. Analysis of differentials between four major groups in Indian society, presented in this paper has brought out the effect of social stratification on utilisation of health care programmes and nutritional status.

There were not much differentials in the utilisation of ANC and the delivery services by caste/tribe in Rajasthan. Once the socio-economic variables were taken into account that is, for women with similar socio-economic background there were not much differentials in the utilisation of ANC and the delivery services by caste/tribe in the State of the Rajasthan. Scheduled tribes in Rajasthan were, however, different than the three caste groups in their behaviour to utilise ANC. Surprisingly and unlike in other states, the tribal women here were more likely to utilise ANC services than SC, OBC or 'other' caste women. Gujarat was found to be characterized by a high inequality, particularly in socio-economic variables. The inequality was much less in Maharashtra and Karnataka. Three States in the eastern region, namely, Assam, West Bengal and Orissa were in different stages of socioeconomic development and demographic transition. The situation was relatively better in West Bengal. Orissa has done better in fertility reduction than many other States, but it was one of the poorest states in India and mortality, particularly infant and child mortality was substantially high there (T K Roy, Sumati Kulkarni, Y Vaidehi, 2004).[46]

1.6.7 Healthcare and Public Private Partnership:

Heavy burden of patients, lack of medicines and equipment, high absenteeism and shrinking funds of the Government of India are some of the roadblocks to implementing successful health programmes at Primary Healthcare Centers (PHCs). Public Private Partnership (PPP) shall act as a tool to improve quality and or increase quantity of services to consumers. The increase in public benefits may be either an increase in capacity to deliver or an increase in the quality of the delivery. State Governments can handover management of sub-health centers, PHCs, community health centers to private partners under lease agreements or can also partner with private players to set up and operate a network of diagnostic centers in the States covering its hospitals with appropriate range of diagnostic services on a fee-for services and profit-sharing agreements which would be for 10 to30 years with suitable exit clauses (Dr. Alok Roy, 2007).[47]

Only one sector cannot be held responsible for Healthcare in the nation. Although, there have been some spectacular achievements in the health sector, the overall picture is rather grim. While India had sophisticated world class tertiary care facilities, its primary healthcare is riddled with problems due to a resource crunch, poor management of manpower and equipment communicable diseases, life style diseases, accidents and injuries and newer emerging infections seem to have overwhelmed the healthcare industry. There has to be an alliance for the new vision of health sector. The alliance is between the local and Central Government, the business class and NGOs and also the consumers and the corporate hospitals. The corporate sector should to join hands with the State and Central Government to run resource-starved State Medical Colleges and District Hospitals in an efficient manner.

Private Sector can provide facilities for training of para-medical personnel and can help also in improving the environment, sanitation, clean water supply, preventing air pollution etc. Patient education should become an integral part of healthcare in planning of all hospital operations (Dr. P.K. Dave, 2007).[48]

The concept of Public-Private Partnership (PPP) in health services has been increasingly adopted as an alternative option by State Governments. In the realm of health services, for quite long, people have suffered on account of various factors. Notable among these are: absence or near-absence of medico and para-medico personnel in remote areas, negligence on the part of health bureaucracy and medico personnel alike, lack of infrastructure including unavailability of primary health centres (PHCs) and sub-health centres (SHCs) in required numbers in the rural areas, etc. What aggravated the matter further was the progressive reduction in budgetary allocation in health sector. Most State Government has resorted to alternative options largely based on the concept of Public-Private Partnership (PPP). The well known models of PPP as practiced in some of the states are viz., offering subsidized land in Delhi, Punjab and Rajasthan and certain exemption on excise duty on import of machinery as well as other fiscal incentives to private sector to set up super-specialized hospitals; Handing over management of primary health centers to NGO such as Gujarat but, PHCs would continue to be wholly financed by the State Government, and Involving industries in managing health centers as in Tamil Nadu (Girish Kumar, 2002).[49]

India has the distinct advantage of being a democratic nation and is now the rising phoenix with a growth rate in excess of 08 per cent of the GDP. Healthcare is the area that touches one billion people and, therefore, calls for path-breaking approaches to deal with this sensitive sector. India's healthcare spending is nearly 5.2 per cent of the GDP. The annual spend for healthcare delivery is approximately $ 25 billion, out of which the Government of India spends a hefty $ 5 bilion or approximately Rs. 22,000 Crores. The Government of India should primarily focus on good governance, security and law and order, infrastructure, education and healthcare, but the model of delivery need to be radically changed to bring out professionally-managed expert organizations that would be fully accountable for every rupee spent. It is high time that 100 per cent of healthcare allocations reach to the common man (Anil Kamath, 2007).[50]

1.6.8 Healthcare Service Management and Medical Professional Behaviour

Joby John (1996) demonstrated how the drama metaphor is applicable and useful in understanding perceived quality in health care services. Three critical elements that were examined in establishing the relevance of the drama metaphor to health care services, which included, viz.,

actors/audience the roles of the patients and the medical personnel as participants; setting the physical evidence of the facility where the service was delivered and consumed as determined by the patient's medical condition; and performance the process and outcome of health care delivery and consumption.

In health care service, these differences are found as function of patients' past experience with medical care and their individual personalities, which are determined to a great extent by their cultural values. Physicians can improve the performance and, thus, perceived quality by approaching each patient encounter using a better understanding of the cultural background of patients and how this might be relevant in the patient's medical condition (Joby John, 1996).[51]

Nicholas J. Ashill et. al. (2005) proposed a model for investigation of service recovery performance in a public health-care setting. The results showed significant relationships between perceived managerial attitudes, work environment perceptions, service recovery performance and outcome variables. The findings indicated that health-care managers are required to take actions on a number of fronts to assist progress toward the achievement of frontline service recovery excellence (Nicholas J. Ashill et. al., 2005).[52]

Pinar Guven-Uslu, (2005) investigated implementation of Benchmarking (BM) in three acute NHS trusts hospitals. It was concluded that there are limits to the rapid or broad implementation of BM principles in health services. It was argued that the patients and their expectations are not referred in BM. It also suggested that local implementation programmes should be used for BM health services. The basic implication of the study was that both academics and professionals working in the field of health services management might find the study useful especially in managing different professional groups' attitude in managing change in large organizations (Pinar Guven-Uslu, 2005).[53]

R. Srinivisan (2007) assessed that the possible prospects of health care sector of India in the year 2020 and put forward an optimistic scenario promised on an average 8 per cent rate of economic growth during the decade of 1990s and 10 per cent Per Annum. More importantly, healthy life expectancy at birth in China was estimated in the World Health Report, 2001 at 61 (M) and 63.3 (F) whereas in Indian figures were 53 (M) and 51.7 (F) respectively. An integrated approach is necessary to deal with avoidable mortality and morbidity and preventive steps in public health are needed to bridge the gaps, especially in regard to the Indian women. Taking all the factors into consideration, longevity estimates around 20-25 could be around 70 years, perhaps, without any distinction between men and women (R. Srinivisan, 2007).[54]

One of the important components of the private health care sector has been health care facilities set up by corporate sector. The financial sustainability of these facilities is closely linked to the financial performance of the main business. Sunil Kumar Maheshwari, Ramesh Bhat (2004) examined a case of one such hospital which is part of a corporate facing difficult time and its revival strategy. Tinplate Hospital, one of the oldest hospitals in Jamshedpur, was started to extend medical care facilities for its employees in the early 1940's. It graduated into a 210-bedded hospital with 35 doctors and 187 supporting staff in 1990s.

The parent company was facing serious financial losses in late 1990s. Due to recurring losses, inadequate operating performances and increasing expenditure the management of the parent company was in a dilemma whether to close down the hospital or at least downsize the staff to save an annual expenditure of nearly Rs. 30 million. The hospital redefined its offer of services, undertook leadership changes and improved operations to achieve financial independence. It continues to provide free medical facilities to nearly 28,000 members of 5,500 families of the employees of the parent company. The turnaround of the Tinplate hospital could be ascribed to three broad areas i.e., strategic, leadership and operational (Sunil Kumar Maheshwari, Ramesh Bhat, 2004).[55]

One of the strategic directions the hospital took was developing partnerships and networking with various healthcare providers in that region. In the health sector, the clients approach hospitals through the referral system. One of the important strategic shifts this hospital made was allowing the private doctors to use the facilities at the hospital. This not only helped the hospital to solve problem of man-power resources, but also improved the capacity utilisation. These interactions and partnerships between various providers in health sector can assume several forms and institutional arrangements. The experience of hospital has been good in implementing these partnerships. It is important that while developing such initiatives, one takes care of several factors such as, sharing of information; involving all stakeholders; good monitoring mechanisms, and institutional capacity to address complexities (Sunil Kumar Maheshwari, Ramesh Bhat, 2004).[55]

Michael Calnan (1995) examined the experience of a range of different European countries with different types of health-care systems. Some of it had experienced major reforms of their health care in order to describe how far countries have been concerned to take into account citizens' views. It suggested that while managers and doctors may want the public to be involved in rationing decisions, the public are on the whole ambivalent and more reluctant to play an active part in such process (Michael Calnan, 1995).[56]

Igal M. Shohet, Sarel Lavy (2004) reviewed the state of the art in the main domains related to Healthcare Facilities Management (FM) and defined the central themes in the development of a healthcare FM model. FM, Maintenance Management (MM) and Performance Management (PM) were reviewed in a wider context, such as maintenance management, performance management, Risk Management (RM), Supply Services Management (SSM), and development and found that domains were interrelated, and can be integrated using information and communications technology, which provided the desired environment required for the challenging decision making and development prevalent in healthcare FM (Igal M. Shohet, Sarel Lavy, 2004).[57]

Puay Cheng Lim (1999) explored the applicability of Quality Function Deployment QFD in health care. Service quality considered as a measure of how well the total service package meets customers' expectations. In health care, customers' satisfaction was considered as more intangible and less concerned with measurable units of goodness. Therefore, the procedures required for establishing customers' expectations need to be more rigorous and should include a number of different approaches. Service quality requirements should address hospital's processes as well as measurable elements of quality, because the service offering and service delivery is intertwined (Puay Cheng Lim, 1999).[58]

Kerry D. Swinehart (2004) presented the results provided by an instrument that was locally designed to provide the most utile aggregation and presentation of patient satisfaction information for healthcare providers. It provided substantial evidence to support the notion that local, rather than global, measurement instruments were needed to provide the most relevant and useful results when assessing patient satisfaction as a part of continuous quality improvement (Kerry D. Swinehart, 2004).[59]

Waleed M. Al-Shakhaa, Mohammed Zairi, (1998) achieved better outcomes in health care services with fewer resources by studying the implementation of patient focused care in the health care provision context and particularly in the area of Pharmaceutical Care Management as an integrated process in the delivery of health care in a hospital setting. The changes in health care provision have in many instances meant that the provision of pharmaceutical services needed re-assessing (Waleed M. Al-Shakhaa, Mohammed Zairi, 1998).[60]

Larry A. Mallak (2003) used Critical Incident Technique (CIT) in a US acute care hospital that was having an emphasis on patient centered care and healing environment. CIT results provided specific information on what people do that support the culture and what they do that works against culture. The use of CIT had specific benefits and costs, benefits included, CIT yields a rich, bottom up description of the culture; CIT provided both positive and negative examples of how the culture practiced; when compared with conventional culture measures; and; CIT provided an internal point of comparison. These benefits require some costs that is, to collect, enter, and analyse CIT data requires a few more resources compared to machine score instruments (Larry A. Mallak, et. al. 2003).[61]

Jane W. Licata, et. al. (1995) conducted a study in the hospital having a 991-Bed Metropolitan private hospital with 670 affiliated physicians and respondents were also asked to rate the quality of the hospital on 15 attributes based on Marketing Lens Model (MLM). The findings showed that while primary care physicians and specialists tend to assess hospital quality in terms of medical competence, consumers also considered hospital characteristics. It represented the first empirical effort to test the efficacy of the MLM as a means of diagnosing quality perceptions in a complex exchange channel. The MLM can be a useful tool for measuring quality assessments and perceptions of medical care by physicians and patients (Jane W. Licata, et. al., 1995).[62]

Allen E. Smith et. al. (2001) presented a flexible application operationalizing the strategies of total quality management and continual and rapid improvement in the area of assessing patient satisfaction. Mountain States Health Alliance (MSHA) established seven strategic criteria for the Outcomes Assessment Strategy and Information System (OASIS) Design based on its own strategic initiatives and quality improvement principals. As pressures from stakeholders continued to mount, it became increasingly important that patient satisfaction information must be used to improve processes. The system presented provides one piece of an overall approach that was considered to be the result in a rise to world-class status for the health care industry (Allen E. Smith et. al., 2001). [63]

J.D. van der Bij, J.M.H. Vissers (1999) used the framework that was initiated by three case studies with process-related assignments in different hospital settings. In these three case studies the framework appeared to be useful as a starting-point for a more specific elaboration tailored to the case (J.D. van der Bij, J.M.H. Vissers, 1999). [64]

Annabelle Mark (2005) was to discussed emotion in the in health-care organizations and indicated a shared international desire to understand meaning in emotion that was spreading across organizational process and into all professional roles within health care (Annabelle Mark, 2005). [65]

Dennis A. Pitta, and Michael V. Laric (2004) explored several approaches to value that are important in the functioning of the value chain, and investigated value as the foundation of the value chain and had explored several perspectives on value. Three main elements of value that emerged as important were viz., delivering superior value, the customer's perceived value, and the lifetime value of the customer to the firm. It also delineated differences between the supply chain and the value chain. The value chain is based on the supply chain concept but takes the perspective that at each stage, value is to be created for the ultimate consumer (Dennis A. Pitta, Michael V. Laric, 2004). [66]

Kristina L. Guo et. al. (2005) evaluated the need for the Service Line Management Approach in Health Care and the findings revealed four essential competencies that is, conceptual, participation, interpersonal, and leadership, that must be gained by leaders to bring about organizational growth. (Kristina L. Guo et. al., 2005). [67]

Ralf Klischewski, Ingrid Wetze (2003) assessed Service Flow Management (SFM) and presented an approach that claimed to be suitable for supporting flexible interrelated services as required in healthcare. The SFM was oriented around services understood as relations between provider and customer and defined interrelated services in terms of chains of service points (Ralf Klischewski, Ingrid Wetze, 2003). [68]

1.6.9 Healthcare Quality Improvement and Satisfaction from Healthcare Services:

Douglas Amyx, et.al. (2001) conducted experimental design to examine how three elements of healthcare experience, such as, Patient's freedom to choose a physician, Patient's receiving their preferred physician, and Health outcomes, impacted on patient satisfaction with healthcare services. Results of the experiment indicated that given an undesirable health outcome, allowing patients a choice of favourable physician favourably raised patient satisfaction level. Further, patients who were treated by physician whom they preferred rated the health care experience more positively than did patients who received non-preferred physicians (Douglas Amyx, 2000). [69]

Jaap van den Heuvel et.al. (2005) described the outcomes of implementation of International Organisation for Standarddisation (ISO) 9000 quality management system in the Red Cross Hospital (General Hospital with 384 beds) located in the Netherlands. The Findings suggested number of advantages from using ISO. The focus on patients was re-established. All processes were identified and subject to continuous improvement. Performance measurements were introduced and given an integrated picture of results. Measurements subsequently lead to improvement of quality of care and to quality system improvements. The documentation system serves the organization's needs without leading to bureaucracy. Positive effects on patient safety were demonstrated compared with ten other hospitals. Given the need for adequate quality management tools in health care and the need for demonstrating quality, the positive effects reported by this study showed how ISO is expected to become more prevalent in health-care organizations (Jaap van den Heuvel et.al., 2005). [70]

Joel Harmon et. al. (2003) discussed High-Involvement Work Systems (HIWS) in the Healthcare set up, and argued that two strong imperatives for healthcare managers were reducing costs of service and attracting and retaining highly dedicated and competent patient care and support employees. It suggests that managers implementing HIWS incur real expenses that were likely to be more than offset by more satisfied employees, less organizational turmoil, and lower service delivery costs (Joel Harmon et. al., 2003). [71]

The need to better understand patient priorities in order to provide higher levels of patient care was a challenge for managers across the UK, National Health Services (NHS). The paper written by Rhian Silvestro (2005) sought to report on the development and evaluation of a tool for measuring the gap between patients' priorities and their perceptions of an NHS service, and the match between the patient and management perspective. The study suggested that the tool can be used to quantify the gap between patient priorities and their perceptions of health service performance. The tool may also be used to measure staff's perceptions of patient priorities and perceptions, with a view to identifying those functional staff who best understand the patient perspective (Rhian Silvestro, 2005). [72]

Richard S. Lytle, Michael P. Mokwa (1992) tested a model of health care quality with an objective to study health care quality as a function of providers' conformance to patients' requirements or expectations at three separate product benefit levels of the health care product: tangible, intangible, and core. It was found that the significance, strength, and direction of the relationships between physician interaction variables (intangible benefits), staff interaction variables (intangible benefits), physical environment variables (tangible benefits), and patients' perceptions of health care quality were different across pregnant versus nonpregnant (core benefit) subgroups (Richard S. Lytle, Michael P. Mokwa, 1992).[73]

Dominic Montagu (2002) surveyed four franchises in three countries viz., Kenya, Pakistan, and India were surveyed as part of a study of social franchising operations to examine, access to services as well as commodities appears to be a significant factor, in rural areas and urban areas, affecting clients' ability to receive care of any kind, and to choose a franchised provider if a choice of service providers exists. Many of the conclusions from this study concludes that in rural areas, access to services as well as commodities appears to be a significant factor affecting clients ability to receive care of any kind, and to choose a franchised provider if a choice of service providers exists (Dominic Montagu, 2002). [74]

Sue Proctor; Gill Wright (1998) assessed women's responses to their experience of maternity care, and sought to gain insight into the service features they associated with negative and positive reactions. There was variation in the factors identified through the different phases of the service antenatal, labour and postnatal care. However, staff attitudes were a main source of positive comments throughout the service, and lack of information and poor explanations were a consistent source of negative responses (Sue Proctor, Gill Wright, 1998). [75]

Nigel Sewell (1997) reviewed the range of quality activity in a National Health Service (NHS) hospital trust UK, using a staff questionnaire survey, self-assessment against the 'Baldrige Quality Award criteria', and the application of the SERVQUAL approach to service quality assessment. It was found Study finds that there were needs for greater integration of quality effort, to engage with patients in a more meaningful manner, and to achieve greater commitment and involvement from clinicians and managers (Nigel Sewell, 1997). [76]

Sandra Hogarth-Scott, Gillian Wright (1996) examined the debate on quality in health care in light of General Practice (GP) fundholding and the Patients' Charter in the UK. It concluded that, in the changing political and public environment, GPs are facing the challenges of managing service quality (Sandra Hogarth-Scott, Gillian Wright, 1996). [77]

Loay Sehwail, Camille DeYong (2003) explored implementation of Six-Sigma in Healthcare sector based on a case study that was conducted at Mount Carmel Health, a three hospital; system in Columbus Ohio, USA. It showed that six-sigma had proven its benefits in healthcare through providers.

It concluded that healthcare organization commitment and extensive training to their employees to six-sigma will continue to offer results in short term and long term benefits (Loay Sehwail, Camille DeYong, 2003).[78]

Sean McCartney, Reva Berman Brown (1999) reviewed the literature concerning outcome measures used in health services. It suggested that outcome measures which answer all requirements will remain elusive, and their effectiveness will vary according to the circumstances of the generation and use. Moreover, the very use of outcome measures as management tools can lead to subversion of the meaning which led to their selection in the first place (Sean McCartney, Reva Berman Brown, 1999).[79]

Douglas Amyx et. al. (2000) conducted an exoeriment to examine the impact of patients' freedom to choose a physician and health locus of control on patient satisfaction. The results of the experiment indicated different patterns of satisfaction among subjects based on measures of Health Locus of Control (HLC) (Douglas Amyx et. al., 2000).[80]

Jill Guthrie et. al. (2003), based on data from the 1996 New South Wales (Australia) Inmate Health Survey, examined female inmates utilization and satisfaction with provision of health services, with focus on Particular variables, such as indigenous status, mean age, age range, and education as associated with provision of health services. The important findings of the study was that correctional centre location was associated with inmates' satisfaction with healthcare services and it has implications for Governments regarding physical access to health services, and for ensuring services meet inmates' needs at each correctional centre location (Jill Guthrie et. al. 2003).[81]

Elizabeth A. Anderson (1995) under took the research to assess the quality of service provided by a public university health clinic. The mean expectations and perceptions aggregated according to the five SERVQUAL dimensions: tangibles, reliability, responsiveness, assurance, and empathy. Results revealed that perceptions fell short of expectations for every category, indicating negative service gaps that is, perceptions minus expectations. In analyzing the distance (gap) between expectations and perceptions, empathy and tangibles exhibit the smallest gaps while assurance has the largest gap. The gaps for reliability and responsiveness were very close in size, following assurance. It was concluded that the measurement of service quality to be important in evaluating the effectiveness of the health center's strategic planning process with regard to quality improvement initiatives (Elizabeth A. Anderson, 1995).[82]

Mike Hart (1997) offered the results of a monitoring exercise introduced in one local hospital of British Health Service undertaken to address the amount of time that patients spent waiting when attending outpatient departments in hospitals, and discussed whether a purely quantitative approach to quality can deliver the desired improvements. It revealed that over-concern with purely quantitative indicators of quality could lead to the emergence of practices which actually destroy quality (Mike Hart, 1997).[83]

Huseyin Arasli, Lillia Ahmadeva (2004) assessed public perceptions regarding approaches to quality and their implementation in hospitals in Northern Cyprus, to assess the levels of satisfaction of patients using these services, and to determine whether there were any ways to increase the total quality of services in the light of Total Quality Management (TQM). The results showed that hospitals, especially public hospitals, do not pay sufficient attention to customer satisfaction, and traditional reactive policies have followed this trend for many years. There were a great number of complaints from patients, doctors, and other service providers and users in public hospitals. A comparison of the total quality efforts and practices of public and private hospitals in the Famagusta region of Northern Cyprus leads us to the conclusion that the public sector is in a much worse position than the private sector (Huseyin Arasli, Lillia Ahmadeva, 2004).[84]

Manjit K. Bansal (2004) evaluated the rationale of applying relationship marketing and service quality concepts within the primary health care sector. It revealed that the relationship marketing paradigm presents itself as a potentially exciting way of addressing issues associated with ensuring that the highest level of quality was delivered in this area of the UK National Health Service (Manjit K. Bansal, 2004).[85]

Jochanan Benbassat, Mark Taragin (1998) reviewed quality improvement methods that have been reported to be feasible, effective and acceptable by practicing physicians. It concluded that these three features were essential for a continuous quality improvement process in health care (Jochanan Benbassat, Mark Taragin, 1998).[86]

Vasco Eiriz et. al. (2005), attempted to develop a framework for evaluating the quality of Portuguese health care organisations based on the relationship between customers and providers, to define key variables related to the quality of health care services based on a review of the available literature, and to establish a conceptual framework in order to test the framework and variables empirically. It suggested that health care services quality should not be evaluated exclusively by customers (Vasco Eiriz et. al., 2005).[87]

Johan Hansson (2000) explored the notion that the introduction of Total Quality Management (TQM) in the public health care sector indicated a conceptual break with a tradition in which the authority to define and interpret the meaning of medical practice has been located solely within the medical profession. It argued that the realization of management ideals in everyday practice was dependent more on the availability of pre-existing technologies and standard procedures than on the ingenuity of particular organizational and institutional actors (Johan Hansson, 2000).[88]

Joby John (1994) examined the influence that referent opinion that is one's own opinion and the recommendations of relevant others has on patient perceptions of the quality of care patients receive at hospitals. A study of discharged hospital patients revealed that the demographic profile of a patient also has a mediating influence on this effect.

Hospital administrators were urged to pay close attention to the relationship between types of referents patients use and how they form their evaluations. Patients were apt to be more satisfied with a hospital if they placed a relatively greater emphasis on their own opinion when making the choice. Females were more likely than males to be satisfied with their hospital stay when their own opinion was important in hospital selection. Health care providers should survey patients prior to admission to identify patients who depended on the opinions of others for their selection of provider so that extra measures can be taken (Joby John, 1994).[89]

Mosad Zineldin (2006) examined the major factors affecting patients' perception of cumulative satisfaction and attempted to address the question whether patients in Egypt and Jordan evaluate quality of health care similarly or differently. Its Results revealed that Hospital C has above-average total and dimensional qualities and patients are the most satisfied in accordance with all dimensions of services. Hospitals A and B had under-average total qualities as the majority of patients were not satisfied with services. Comparing hospitals A and B, in the majority of dimensions (with the exception of Q5), the quality in hospital B was higher than in hospital A. Patients' satisfaction with different service quality dimensions was correlated with their willingness to recommend the hospital to others. A cure to improve the quality for health-care services can be an application of total relationship management and the 5Qs model together with customer orientation strategy. The study argued that a patient's satisfaction was a cumulative construct, summing satisfaction with five different qualities (5Qs) of the hospital, which includes, quality of object, processes, infrastructure, interaction, and atmosphere (Mosad Zineldin, 2006).[90]

Tony Conway, Stephen Willcocks (1997) presented a conceptual model of quality to understand the relationships between perceived service quality and patient expectations, experience and satisfaction. It was felt that such an explanatory model may be of managerial value in that it has the potential to identify key areas of concern and areas for action (Tony Conway, Stephen Willcocks, 1997).[91]

William E. Kilbourne et. al. (2004) studied the process of assessing the cross-national reliability of the instrument within health care contexts. The results suggested that it has the potential to serve as a means for comparing perceptions of service quality across countries. It proposed and tested a second-order factor model with tangibles, responsiveness, reliability and empathy as first-order latent constructs and service quality as the second-order latent construct. The results confirmed a stable, four-factor (tangibles, responsiveness, reliability and empathy) structure that was similar to previously defined service quality dimensions and is invariant across the countries studied (William E. Kilbourne et. al., 2004).[92]

Puay Cheng Lim, Nelson K.H. Tang (2000) set up management model using Quality Function Deployment (QFD) where strategies are developed through a partnership between managers and clinicians for the provision of total quality healthcare in the light of dramatic changes in the health-care environment that allows hospitals to become customer- and quality oriented. Results revealed that the two most significant service elements were staffing, and service delivery. The application of QFD revealed three main benefits, viz., QFD translates customers' expectations into appropriate service quality specifications; QFD clarifies customer priorities for competitive advantage; and QFD gives directions for the improvement of service quality and helps organisations to think in terms of the entire system and not just isolated service elements or isolated customer expectations (Puay Cheng Lim, et.al. 2000).[93]

Julie Martin-Hirsch, Gillian Wright (1998) addressed the definition and measurement of quality in maternity care. It developed a pro forma for monitoring and hence managing midwifery quality and service quality model has been designed, and the Model named "Measuring Effective Midwifery Services" (MEMS). It was clear from the literature and from the information from the women, that the inconstant dependent variables viz., continuity, control, choice, information and equitable services, were the themes to measure when assessing effective ways of delivering maternity care. The MEMS model provides an information base for effective marketing and consumer satisfaction in maternity services (Julie Martin-Hirsch, Gillian Wright, 1998).[94]

Daniel Butler et. al. (1996) conducted threefold and it was found hospital quality to be composed of two major dimensions, human performance, and facilities. Finding showed that there were differences in perceptions of quality between users and observers of hospital services (Daniel Butler et. al. , 1996).[95]

Patrick Asubonteng et.al. (1996) explored the evolution of the quality issue within the health care industry and also the significance of quality in the health industry along with the historical origins of quality management. It was concluded that a fundamental understanding of the process of total quality management was an absolute requirement (Patrick Asubonteng et.al., 1996).[96]

J. James Cotter et. al. (2002) outlined the domains and a research agenda leading to improvements in the quality of transitions of care between health-care settings and focused on the fact that changes in the healthcare financing had restructured the organization and delivery of health care. Health-care financing and the resulting organizational structuring had reinforced the compartmentalization of healthcare delivery. Therefore, healthcare providers need to focus on transitions of care that is movement of patients across health-care settings (J. James Cotter et. al. 2002).[97]

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