CHAPTER - III
REVIEW OF LITERATURE

Central to the economic advancement of the present developed countries during and the aftermath of industrial revolution was ‘physical capital’. With the IT revolution all over the world during the late 20th and the early 21st century, physical capital has lost to ‘human capital’, as the central agent of economic development. There are various studies focusing on different aspects of healthcare utilization. The review of such literature is helpful to study research problems in a better way. Some of the important studies, pertaining to the subject have been reviewed in this section.

3.1. Importance of Human Capital:

The article by Davenport (2005) proposes to break up human capital into four essential elements namely knowledge, skill, talent and behaviour. It throws light on some of the more enlightening aspects of human capital such as human capital investment, risk associated with human capital investment and the investment contract. The concluding part of the article deals with various methodologies adopted by managers to increase the human capital ROI as well as methodologies adopted by employees to hedge risks associated with human capital investment.

Duraisamy and Duraisamy (2008) highlight the need for investing in human capital. It is both an end in itself and a means to achieve other ends. There are compelling arguments for accelerating investment in Health. Good health is considered
to be an integral part of development. It contributes to higher market productivity and hence earnings of the economically active population, improves the quality of life and also accounts for longevity and well being of the population. The benefits of good health are so pervasive that health investments are accorded high priority everywhere.

Gandhi (2004) analyses the evolution of the concept of human capital and the importance of Human Resource Development (HRD) and Human Development Index (HDI). The most important indicators of HRD fall in two categories - those which measure a country’s stock of human capital and those which measure the gross or net addition to the stock or more precisely the rate of human capital formation over a specified time period. While the stock of human capital indicates the level of HRD which has been achieved by a country, the rate of human capital formation indicates its rate of improvement. HDI consists of three indicators namely literacy, life expectancy and per capita income. On the basis of the development in these three indicators countries will be ranked. India ranked 115th out of 162 countries in terms of UNDP’s HDI in 2001, it is 124th in 2002 and it is 126th in 2006 (http://hdr.undp.org/hdr2006/statistics/).

The paper by Shariff (2007) attempts to highlight the human development parameter differentials. Even though it has taken a century of public efforts more so after the independence to enhance literacy rate to about 65%, what is important is 35% of Indians are still illiterate and educational disparity is startling between various states, regions and among gender and castes. Even though infant mortality rate has decreased over years, there widespread differentials between states i.e., U.P, Bihar, Maharashtra,
and M.P have around 75 per thousand infant mortality rates. Also there is vast difference between urban and rural areas as to the place of delivery. Nevertheless, India’s achievements must be assessed in such a way that it has indeed come out of the low human development tracks through achieving secular progress in social sphere.

Pillai (1994) relates Kerala Model of Development to development in health sector. To him, improvement in the quality of human resources, by way of education and health, contributes not only to economic growth but also to the overall general well being of the people. He also highlights the role of private sector in Kerala in the development of health sector. To him, in Kerala, development of health sector was mainly due to its good base in 1950’s and continued efforts undertaken by various state governments.

Durfee’s (2005) article is based on a research study to ascertain the increasing role of the CFO’s in the present human capital management scenario and its integration with corporate strategy. Human resource issues are now being considered even by the directors. Some of the key findings of the research are as follows: despite high spending, few know of the return on human capital investments, CFO’s see human capital as a key value driver, the top workforce priorities are building leadership capabilities and raising workforce productivity, CFO think that they should be more involved in human capital decision.

Haynes (1991) examines the relationship between socio-economic status and health service use. He found that morbidity was related to housing tenure and care...
availability, rather than to occupational status. He also found that age adjusted morbidity ratios were higher for females in multiple occupancy dwellings in inner city areas.

3.2. Health and Development:

According to Sen (1998) health transition has to be a central feature of significant social progress. Health transition refers to the transformation of a society with high morbidity and mortality rates into one in which people standardly live long, disease free lives. Though India achieved some progress in health front, it is far away from such a health transition. It is in this context that the issue of objectivity of health assessment assumes crucial importance. According to Amartya Sen, the reported morbidity rate is not a good reflection of the health situation in India. A more literate population, greater availability of health services and medical facilities may reduce death rate but may increase the perception and understanding of illness. That is why there is high morbidity and low mortality in Kerala and low morbidity and high mortality in Bihar.

Gupta and Bisht (2010) address the problem of missing mission in health. The National Urban Health Mission (NUHM) was supposed to address the unmet health needs of urban Indians. Yet it has failed to commence work even 18 months after the announcement of its formation. A rapidly urbanizing India has been marked by a series of epidemics of communicable diseases in the last two decades and increasing informalisation of the economy. Despite recognizing the urgency for revitalizing urban health services, the NUHM is yet to be rolled out. The efforts at approaching urban health have suffered from truncated visions. The range of
participatory processes that marked the formulation of the NRHM has been lacking
for NUHM. Therefore, urban health system needs serious and quick reforms.

Nair (2008) speaks about the rich-poor divide in health status in India. This study attempts to shed light on how the India’s poorest people are faring, demonstrating the persistence and pervasiveness of inequalities in health using NFHS-3 data. We find that the poorest people fare worse than the richest on a range of health outcomes including infant and childhood mortality and nutritional status and fertility indices. Widespread discrepancy exists in the use of health services like vaccination coverage, health care visits, maternity related services etc. In general, the poor in India are disadvantaged in all aspects of health. The poor are more likely to find that the health services are unavailable, inaccessible, too expensive or of relatively low quality.

Narayana (2008) highlights about the contradictory nature of high growth but no public health scene in India. Even though India has become one of the “growth engines” of the world; we are not able to translate the growth into long healthy life for the vast population. He compared the Canadian initiatives of recent years to evaluate the Indian performance. While Canada contained very well the SARS outbreak of 2003 and learning from it responded by restructuring the Public Health Agency(PHA) and by creating the position of Chief Public Health Officer(CPHO). Compared to Canada our problems are much bigger and more frequent, e.g., chikunguniya in Kerala. Also Polio eradication is crying for a public health approach, but we continue to spend millions on the PPI campaign. We refuse to learn from crisis. This attitude must be changed.
Ghosh (2008) in his keynote address in the international conference on health and development speaks about the market failure and health care systems in developing countries. He argues that in developing countries, Health Care Systems (HCS) have been facing the problem of market failure, implying that the fair rules of market principles do not apply and patients often become losers. Explaining the theoretical issues involved, the paper examines various causes of market failures in HCS including: rent seeking activities by doctors, asymmetric information between doctors and patients, between patients and insurance companies, and the oligopolistic behaviour of health care practitioners. The policy implications of the study suggest that in many cases, govt. intervention is essential to eliminate market failures in the HCS in developing countries.

Dominic (2001) in his paper examines the real concepts of health and development as well as their correlation with emphasis on the available health conditions in Nigeria, through some health indicators. Health and development are interdependent and mutually supportive. The road to health and the road to development are the same making it more beneficial to provide health services in close association with other developmental services. This implies that the pursuit of economic development, neglecting the health component can lead to deterioration in the environment affecting all aspects of the quality of life. As far as Nigeria is concerned, health care has not been good, rather very pathetic. Nigeria’s health sector is besieged with numerous problems like high cost of medication, poor state of existing health facilities, lack of access to
modern medical technologies etc which make it extremely difficult to deliver health services to the masses.

Kumar (2001) in his seminar paper reveals the direct relation between poverty and health. To him, the relation between poverty and health is complex and multidimensional. Poverty has direct relation with morbidity and longevity of people. Normally a state having low poverty will have higher health status.

Gupta (1998) makes an attempt to take stock of India’s achievements in health, which is an important component in raising the well being of her population. An examination of the health status indicates that India is doing well in some respects but not so well compared to many developing countries. Morbidity rate and under nutrition are high even now. Vast disparities are there between different regions of the country and also among various castes and gender in health status. Even though various policies and programmes were introduced, these were not effective in cent per cent.

Narayana (1997), by analyzing the inter state variations in the health status in India, argues that the improvement in health status is an outcome of development measured not in terms of per capita income, but in terms of overall socio-economic conditions. It is assumed that development is not simply a process of linear progression in various sectors, independent of one another, but an interdependent and integrated process. Therefore, the study lays emphasis on the identification of inter-relationships between various socio-economic components in
the process of development. The study highlights the multidimensional nature of development and also the centrality of distributive justice in the socio-economic development. Health problems are rooted in socio-economic reality and a solution to them must necessarily confront the basic developmental issues.

Srivastava and Mohanty (2010) explain about economic proxies, household consumption and health estimates. While the official estimates of poverty in India are derived from the consumption expenditure data, economic proxies are increasingly used to explain the differentials in health and health care utilization in population based surveys. Using data from the World Health Survey, India 2003, covering a nationally representative sample of 10,750 households and 9,994 adults, this paper examines the extent of agreement of monthly per capita consumption expenditure(MPCE) and economic proxies(combined with the wealth index) with the differentials in health estimates according to two alternative measures. It finds that economic differentials in health and health care utilization based on economic proxies are not similar to those of direct measures. There is an urgent need to integrate an abridged version of the consumption expenditure schedule in population-based health surveys. The results also indicate that the extent of agreement of the MPCE with the wealth index is weak. Only 31% of households are classified in the same quintile of MPCE and wealth index and the health estimates are sensitive to those two measures.

Muraleedharan and Peters (2008) reviews the state of alternative approaches to regulation of health services in India, using consumer and market based
approaches, as well as multi-actor and collaborative approaches. They argue that poor regulation is a symptom of poor governance and that simply creating and enforcing the rules will continue to have limited effects. They argue that India’s future health system is more likely to achieve its goals through greater attention to consumer and other market oriented approaches, and through collaborative mechanisms that enhance accountability.

On the eve of 2005 budget, Kumar (2005) speaks about the urgent need of a vigorous and informed public discussion to create a national consensus for dramatically increasing investments in health with concurrent improvements in accountability and management of the health care system. The announcement of the National Rural Health Mission and the commitment in the recent budget to increase allocation for health are necessary steps in the right direction to correct India’s shockingly poor health record. Equally important is induction of a cadre of village-based health activists, all women, who will link communities to an upgraded public health system. These women should emerge as the missionaries dedicated to advancing health in India. Money, medicines and medical facilities will be meaningless without these missionaries. Finally, flexibility, innovation, focus, inclusion and openness must become essential features of the functioning of the NRHM in its Endeavour to provide good quality health care for all.

Yesudian (2008) critically analyses the impact of national health programme on the development of health systems in states. To his, the effect of national
health programme on the health system varied from one state to another. The states that have already stronger health systems and performing better found that national health programmes least useful because the existing health system is already dealing with the health issue as part of the health care of the state. Those states that have the weakest health systems benefited from the national health programmes because their health systems were not dealing or inadequately dealing with major health issues in the state and national health programmes have really filled-in the void. This differential impact of national health programmes on the state health systems brings out the lesson of dealing with different states differently in implementing the national health programmes.

According to Kannan (2000), poverty alleviation is not just a matter of adequate consumption of food or other necessaries of daily life, but should also include other dimensions i.e. education and health especially health. The former is ‘entitlement’ aspect of poverty and the latter is ‘capability’ aspect. It is only when these two aspects are combined that one can move towards a more holistic definition of poverty.

The paper by Ahuja (2007) looks at the viability and necessity of introducing Health Impact Assessment (HIA) in policy making. Health impact assessment is globally gaining widespread credibility and adoption in the policymaking process as it leads to a holistic view of healthcare and informs policy dialogue in a more coherent manner. But in India, this process has not yet begun. The article suggests an integration of HIA with environmental impact assessment in order to draw upon the strength of the latter and bring in an integrated approach to the issue of impact
assessments and their monitoring. It is also suggested that, given the expertise of the environment sector and the special, individual based need of the health sector, an agency that combines both Environmental Impact Assessment (EIA) and Health Impact Assessment (HIA) will be most appropriate. Not only that, it could also include social assessment as part of its agenda. Such an agency will tide over interdepartmental hegemonies, resolve conflicting concerns and bring about efficiencies in cost, effort and operation.

Bir (2006) explains about health sector reforms: strategies and experiences in India. In India, we have the national health policy and even the national rural health mission documents, but do not have well-defined blue prints of strategic action plan for health sector reform are the state levels, because health is the state subject. Some of the states have taken initiatives and moved forward to reform activities despite their unfavorable environment. The reform initiatives have been stated without developing its proper systems and methods for monitoring policy implementation. In India, the development of policy and institutional analysis in the health sector has been deficient in inputs of epidemiological, demographic and socio-economic researches. There is a need for the development of techniques, which will enable the planners to analyze the effects of different approaches to policy and institutional change in health sector. Because, the govt. health care delivery system unfortunately is still elitist, the access of health care services is elitist and the poor people really do not get much out of it, despite the fact that it is a system which is
supposed to reach out for them.

Mathur (2004) analyses the impact of information technology on cost, efficiency and equity as drivers of cross border trade and investments in health care. It has promoted efficiency in healthcare by enabling information to be available and cheaply distributed. It enables distance consultation and cross referral among professionals where density of medical professionals is highly variable across urban and rural areas and the expertise of specialism difficult to replicate at every location. Again digitalized connectivity has improved transparency, expanded choice and created new value chains for all concerned but its impact on cost of health care is unclear.

Varshney (2006) pieces together a story of health mismanagement in Assam. Assam faces a spate of malaria deaths. As the disease assumes near epidemic proportions, it is becoming increasingly clear that the govt. does not have the will or infrastructure to cope either in Assam or other affected regions. But what is most damaging is that health authorities seem to be in denial. The govt. does not have the systems to break malaria. Information is necessary to have right drug regimes. Despite WHO guidelines, the govt. has not changed to the combination regime.

In the present high morbidity and low mortality scenario, larger investment in health would be required for maintaining the current health status, since technology required for tackling drug resistant infections and non-communicable diseases are expensive. This would lead to escalating health care cost. N.S.S.O data indicates rising health care cost as one of the reasons for indebtedness among the poor.
Rajan (2008) in her paper analyses the current status of health care in India and public health spending on medical health and family welfare in India. Despite the best efforts by the government to improve the health status of the Indian population, health care services are far from satisfactory in our country. This is most recognizable when we compare the present health indicators with those of other countries. Public spending in health care has shown a declining trend (0.9% of GDP) in India. The escalating health cost is paid by patients out of pocket. Even minor illness can bring big financial burden and thus impoverishment. Hence affording health care is a big question to the lay man in India.

Gupta (2010) in their paper put forward measures to strengthen public health system. The central government’s policies have inadvertently de-emphasised environmental health and other preventive public health services in India since the 1950’s. Diseases resulting from unsanitary conditions impose high costs even among the more affluent, and rapid urbanization increases the potential for disease spread. The authors analyses the central government’s policies and then describe Tamil Nadu’s public health system, which offers basic principles for strengthening public health within the administrative and fiscal resources available to most states. The paper suggests establishing a public health focal point in the health ministry, and revitalizing the state’s public health managerial and grassroots cadres. There needs to be phased progress in four areas: 1) enactment of public health acts to provide the
basic legislative underpinning for public health action 2) establishment of separate
public health directorates with their own budgets and staff 3) revitalization of public
health cadre and 4) health department engagement in ensuring municipal public
health.

Chazhoor (2007) speaks about consumers’ right to healthcare. Health care
is one of the basic needs of humanity at large. The right to health care can be defined as
that right which not only makes available to people proper health care facilities but also
enhances their ability and access to make proper use of those facilities. The neglect of
healthcare reduces a person’s capacity to take part in the various activities within society.
Besides this, such neglect reduces the capacity of the whole society in the future.
Therefore, health care is not only an object of development by itself, but a pre-requisite
for the development of future generations.

He presents an optimistic scenario in the health sector. He expects the life expectancy to
be increased to 70 years by 2020. As regards TB, it is possible to arrest further growth in
absolute numbers by 2010 and thereafter to bring it less than a million within
internationally accepted limits by 2020. As regarding malaria, it will be reduced by half
and AIDS infection will be leveled of by 2007. As regarding infant mortality rate, it will
be 30 per thousand by 2010. In the case of cancer, it is feasible to set up an integrated
system for proper screening, early detection, self care and timely investigation and
referral. The level of public expenditure will be increased to 30% of the total health expenditure.

Patel (2008) in his article an attempt is made to highlight in brief the present status of health service infrastructure, its impact with sharp focus on UN Millennium Development Goals and need to integrate health service infrastructure with the self help groups. He concludes that implementation of NRHM focusing Millennium Development Goals can effectively be improved by integrating it with self help groups, which are promoted, nurtured and linked with banks to socially, economically and politically empower rural poor, particularly women and lifting them above poverty line through continuous generation of assured income.

According to Kumar and Vani (2008), the health status of Indians is still a cause for grave concern especially that of rural India where nearly 73% of Indian population lives. To improve the prevailing situation, the problems of rural health are to be addressed both at macro (national and state) level and micro (district & village) levels. A paradigm shift in the approach from ‘health for people’ to ‘health by people’ has to be adopted for the effective implementation of the various programs taken up by the government.

Nayar (2004) in his article shares his worries about rural health. To him, it is time to recognize that utter neglect of primary care and primary healthcare institutions has influenced the utilization of health services and contributed to the worsening epidemiological profile in the country in recent years. In the present form,
the proposed mission adds to the confusion about the approach to healthcare in the country. Cost-effective interventions such as the rational distribution of financial and medical resources, including drugs, effective manpower distribution and primary healthcare approaches, should be part of the vision. These are often brushed aside for ushering in the privatization logic. What is also needed at present is a vision that gives primary or rather credibility to the vast network of health institutions that the country has built over years. States should be allowed to define their own priorities and plan programmes. Apart from this, there is also a need to equip and enable elected representatives at the village and block level for handling health issues. The rural health mission would greatly benefit if it follows the vision of those that scripted India’s health service system based on an integrated and unified approach as against the selective interventions being proposed in recent years.

3.3. Health Care - Public and Private:

Health care payments, being unpredictable, have the potential to jeopardize the living standards of any household. In the absence of adequate healthcare financing options it can have serious consequences on socio-economic welfare in terms of increasing poverty and widening inequality across regions. On this premise, the paper by Mishra (2008) analyses the implications of health care payments towards poverty and inequality across the different states of the Indian union. The findings suggests that about ten per cent of the households in rural as well as urban India spend to the tune of 15% of the total consumption expenditure on health care. This again varies across provinces
ranging between 1 to 20% with varying level of concentration across expenditure classes indicating a desirable pattern of the richer experiencing such expenditure more as against the poor. Further, the same phenomenon is investigated in terms of its intensity moderating the difference between the states as regard the average gap of catastrophic expenditure against a normative proportion of total expenditure made on account of health.

Govindarajalu (2008) in his paper analyses the govt. health expenditure in India between 1995 and 2007. The overall picture of govt. spending on health reveals that the trend in the expenditure has been increasing in nominal terms but slow in real and per capita terms. However, the combined expenditure of both centre and state has shown the declining trend over the period. At the same time there has been increasing trend in govt. health expenditure as per cent of GDP and also in the share of govt. health expenditure in total govt. expenditure during 2005 and 2007. It has been observed that this increasing trend is due to the introduction of NRHM launched in 2005. It has been observed that the overall trends in govt. expenditure on health in India was declining prior to 2004 and registered increasing trend since 2005 due to the inception of NRHM.

Gangadharan (2008) in one of his seminar papers analyses the impact of new economic reforms on the health sector of Kerala. To him, the Indian health care system, particularly the Kerala health care system witnessed a shift in healthcare to medical care, increasing and often unnecessary use of technology, mass reduction in healthcare expenditure by the states and hike in out of pocket expenditure on the part of
public and instead of growing health awareness there began to occur growing health care-
high morbidity. The policies pursued in this regard in Kerala resulted in making the 
hospitals mere scarecrow and culminated a wider demand supply gap of health care 
services especially among the deprived and marginalised sections in Kerala. Health care 
began to treat as private good and converting health care into a market driven, profit 
driven enterprise. The reform measures also resulted in the negligence of preventive 
medicine and emphasis on curative care on the one side and the domination of private 
sector and rapid hike in private health care expenditure in Kerala.

The paper by Bhat and Jain (2006) examines the relationship between 
income and public and private healthcare expenditures. The basic objective of 
healthcare systems is to meet a country’s health needs in the most equitable and 
efficient manner, while remaining financially sustainable. Each country, given the 
historical evolution of its healthcare systems, adopts different strategies to achieve 
these goals. The financing of healthcare through public and/or private channels is one 
important component of this strategy, as it has a significant bearing on the way 
healthcare is delivered and also has implications for the health policy goals of equity, 
efficiency and sustainability. Understanding what determines expenditures is 
important from the viewpoint of health policy. The main findings of the study are the 
following. In the absence of reimbursement mechanisms, people borrow substantially 
to finance healthcare. Cost concerns arise because with the growth of the private 
sector, one is not informed about the scale on which private healthcare services are
being produced. The greater populations in the age group of 15-60 years have further burdened the ailing health system of India. In India, more than 60% of the health budget is spent in the recurring costs of salary and little remains for capital investment and maintenance of essential infrastructure.

The utilization of govt. health services is very poor in India in general, particularly in Kerala. A study made by Purohit and Siddiqui (1992) based on NSS and NCAER data of 1992 gives a picture of the degree of health utilization in India across three state categories i.e., low, medium and high expenditure groups. It is found that the level of govt. expenditure had direct influence on the availability as well as utilization of various health services in the country. The pattern of utilization shows that public institutions are utilized more for in patient care and for out patient care, majority of them prefer private doctors and private clinics. They revealed that the cost of hospital treatment in urban areas are higher compared to rural areas because of higher duration and cost of treatment in govt. sector compared to private sector hospitals.

Lokhandwala analyses the situation of public health infrastructure in our country. (http://www.issuesinmedicalethics.org/083ed073.html.) Our infrastructure is far short of what is required. We need 7,415 community health centres per 100,000 populations. Actually we have less than half the number. Only 38% of our Primary Health Centres have all the required medical personnel. In the case of other rural health care personnel too there are similar and dramatic differences between what we need and
what is allocated and what is actually in place. Again, the private hospitals are outstanding the public hospitals.

Varatharajan argues that Panchayaths in Kerala allocated a lower proportion of resources to health than that allocated by the state government prior to decentralization. (http://intl-heapol.oxfordjournals.org/cgi/content/abstract/19/1/41) While Panchayath resources grew at annual rate of 30.7%, health resources grew at 7.9%. The study concludes that decentralization brought no significant change to the health sector. Active Panchayath support to Public Health Centres existed in only a few places, but wherever it was present, the result was positive. Kerala should find an alternative strategy to channel panchayaths towards health before leath loses its battle for resources.

Sankar and Kathuria (2004) in their joint article attempts to analyses the performance of rural public health systems of 16major states in India. The results show that not all states with better health indicators have efficient health systems. The study concludes that investment in the health sector alone could not result in better health indicators. Efficient management of the investment is also required.

In his article, Pater (2006) shares his worries about health privatization in Andhra Pradesh. In the past few years, the state govt. had established 85 PHC’s with four sub-centres each, but infrastructure was inadequate, both physically and in human terms. Given the magnitude of the problem, Biman Natung, Head of Voluntary health Association of A.P, stepped in with a proposal to privatize healthcare. Although the proposal raised quite a few eyebrows in the political and
voluntary establishments, Anshu Prakash, the then state commissioner of health and family welfare, deputed D. Padung, deputy director, material and child health, to work out the modalities. A public-private partnership project thus evolved. In 2005 November, the govt. selected four NGOs to run 16 of its 85 PHCs and in this there was only one local NGO. People are of the opinion that most of the selected NGOs hardly have first-hand experience of the state. Natung casts serious doubts over the selection procedure also. The author is of the opinion that it is not clear whether privatization in the health care sector will work. But what is clear is without transparency even the best of intentions will not meet with success.

There is a saying that "prevention is better than cure". But this cardinal principle was neglected by the planners and policy makers in developing countries including India. In an analytical study of 19 selected municipal corporations in India, Mathur (1992) revealed that municipal health programmes is more oriented towards curative health care services rather than preventive or primary health services. On an average, the municipal bodies spend Rs.6.51 per capita per annum on operationalisation of various schemes with regard to preventive health care sector which is almost five times lower than what they spend on curative health sector. Such a low level of spending on preventive health care is creating a major health problem in urban areas because infectious diseases are far more effectively controlled by preventing their incidents than by healing their symptoms. The negligence of preventive health, mainly due to financial stress of the municipal
bodies, is causing serious havoc in the urban health delivery system.

The article by Dilip and Duggal (2006) studies Mumbai's healthcare services which have a declining quality trend in public healthcare services due to decline in public health investment and overcrowding. Healthcare services in Mumbai, India, reflect the disparity of allocation of funds for the healthcare services in rural and urban areas. The study brings out how a largely poor urban community in the biggest metropolitan city in India is lacking access to public healthcare services. The non-availability of a public hospital within or in close proximity to their locality and an inadequate number of public dispensaries makes life difficult, especially for the poor who too are forced to seek care from the private sector. The findings of the study clearly indicate that the potential demand for public health services is very high provided they are conveniently located and affordable. Therefore, the state must assume a more proactive role in strengthening access and quality of care of its health services for its citizens.

The article by Ahmad (2006) focuses on Bangladesh, where the government, has an ambition of decentralizing healthcare infrastructures. Public healthcare services are found inadequate which compels people towards alternatives that are highly unsatisfactory. It has been the policy of the government to promote pluralism in service provision together with the improvement of its own facilities. It implies that capacity building must be developed in the govt. sector regarding regulation, co-ordination and commission of services.
Zachariah (2006) in his article reveals the power of people’s movements in making access to health care for all. Community activism in Brazil and Thailand compelled national governments to provide treatment to the HIV positive population, a decision facilitated by Pharma companies, including many from India, cutting prices 40 fold. The study concludes that if quality and expensive care can be provided for one disease, then the same should be achievable for common diseases which require less expensive treatment.

Kundu and Kanitkar (2002) addresses the under development of the primary health care in urban slums of Maharashtra, the state which has the highest number of slum dwellers in the country. The paper describes the health status of slum dwellers in Maharashtra and discusses the constraints in the existing urban health delivery system. It examines the quality of primary services provided by the health posts in urban areas, outlines key areas for policy advocacy and recommends specific steps to improve primary health care services.

Bhat and Jain (2006) analyses the role of private and public healthcare expenditure in total health expenditure. To them, in India, public expenditure contributes a significantly small percentage in healthcare expenditure i.e., 17.9% of the total. Government priority for healthcare expenditure is decreasing over the years. On the other hand, private expenditure on health as a per cent of per capita income has almost doubled since 1961. That is, in 1961-70 it was 2.71% and in 2001-03 it is 5.53%. Even though India has created a huge system of public health service delivery, more than 60% of the
health budget is spent in the recurring costs of staff salary. Little remains for capital investment and maintenance of essential infrastructure.

Sarma (2004) explains about the trend and effectiveness of government spending on the health sector especially on primary health care for the rural population in Assam. In Assam, the government sector plays a dominant role in health care delivery. The non-government agencies including private commercial sectors and the voluntary non-government organizations have a much smaller presence in the health sector in Assam than at the all India level. The share of health sector in the allocation of expenditure of the government of Assam has been showing a declining trend because of fiscal hardship. There is also rural-urban inequality in health care utilization. Therefore, there is an emergency to boost up public expenditure on health.

Ramachandrudu (2004) analyses the health scenario and health sector reforms in Andhra Pradesh. The state spends only Rs.69 per capita on health which is very low compared to Kerala where it is Rs.122 per capita. There is an urgent need to step up public health expenditure in Andhra Pradesh. Compared to all India level, the health status in Andhra Pradesh is better. Regarding people’s choices in type of hospitals for medical care, about 75% prefer private hospitals and there is a boom in the private hospitals. After 1970’s, a number of health sector reforms were introduced in Andhra Pradesh.

Ager and Pepper in their study examines the patterns of health service across the rural population of four districts of Orissa, with special reference o perceptions
of the availability and quality of state services at the primary care level. 

Households reported utilizing a wide range of health care providers, although hospitals constituted the most frequently and primary health centres the least frequently accessed services. Private Practioneers (qualified and unqualified) represented major sector of provision. Key factors guiding patterns of utilization were reputation of the provider, cost and physical accessibility.

A study by Sundar and Sharma (2002) examines the pattern of morbidity and healthcare utilization by the urban poor living in slums and resettlement colonies in Delhi and Chennai and compares the health status of the two segments. The study reveals that the overall morbidity rate of any illness has worked out to be marginally higher for Delhi than Chennai in the case of both slums and resettlement colonies. As far as utilization of health facilities are concerned, in spite of the presence of health facilities, nearly a significant proportion of the sample population living in the slums/colonies do not seek treatment for all their illness, particularly the aged due to financial constraint.

Baru (1998) attempts to look at the characteristics of the private sector and its relationship to the public sector since independence. Given the central role played by the state in providing medical care, the policy towards private sector has been reviewed to show that a mixed provision of services existed even at the time of independence and the state not only accommodated but also protected private interests. Over the years, the private sector has grown and diversified its operations. The magnitude, structure and characteristics of private enterprises have been examined both at the national and state
levels through different data sources. The study concludes that the growth of private sector is not independent of the evolution of the public sector. The private sector has used the public sector for its growth.

Gangadharan (2005) in his another study explains about the utilization of health services in urban Kerala. The study reveals that rapid urbanization is the root cause of all urban health problems. The poverty related health hazards are increasing in the urban set up and morbidity rate is also in the rise. The data related to seeking of treatment for different illness reveals that as socio-economic status declines the percentage of households seeking treatment for all illness declines. The study also reveals that the low class and the very low class –both in the slums and urban areas - did not consume health services to the fullest extent they required.

Dilip uses the data from NFHS to show how the same cohort of women utilizes facilities in the private sector for delivery care services, sterilization care and treatment of their children. (http://www.popline.org/docs/1579/171962.html.) The preference of public/private sector depends on nature of service in demand. The role of private providers in health care was found to be limited in the case of family planning services, but almost 50% awaited delivery care services were from the private sector. A majority of women were found to prefer treatment from the private medical providers if their children were suffering from fever or cough. People with a high potential to pay preferred the private sector irrespective of the nature of service they required.
Mahmud (2004) reviews Bangladesh’s achievements in health and population and examines the role of government policy making in bringing about this significant social change. Emerging challenges in the sector are highlighted and the strategies for state provision of health and family planning services in view of these challenges and the pro-poor development agenda are discussed. The study concludes that reducing socio-economic inequalities in health outcomes and improving aggregate health indicators further will be extremely difficult in the future without significant transformation in quality of care and management of service provision.

Saisha and Manjunath (2010) explains about corporatisation of health care sector in India. One of the characteristics of India is high growth of population and it is the responsibility of govt. to provide an efficient and effective health care services. But in India, it is highly impossible to provide health care services at free of cost. The heavy costs involved in obtaining sophisticated infrastructure and the need to maintain quality of services compelled the Govt. to invite private sector participation.

3.4. Maternal Health and correlation between female education and health care:

Rao (2001) is of the opinion that though traditionally all the cultures have appreciated the vulnerability of mothers, little emphasis was made by way of planned efforts in the developing countries for converting the realization into action until very recent times. Women traditionally continued to be silent sufferers, their health seeking behaviour being dependent on several factors. Lack of access to care,
ignorance, superstitions, socio-cultural factors, male dominance, joint family system are some of the reasons for women not seeking care. To him, for the women’s empowerment for health, some measures should be taken like better strategy, local adaptations, availability of supportive health services, public opinion, training at both medical and paramedical levels, communication, intra sectoral and inter-sectoral co-ordination, information management system and research.

Jose and Navaneetham (2008) in their paper analyses levels of women’s malnutrition in India over the seven years between 1998-99 and 2005-06 based on the National Family Health Survey. The study concludes that not only do the levels of malnutrition among women in India continue to be quite high, but the levels among women from disadvantaged social and economic groups are much higher. The period of high growth and onset of a reasonable reduction in poverty did not seem to improve women’s nutrition significantly rather malnutrition especially iron-deficiency anaemia has increased among women form disadvantaged social and economic groups. The adverse influence of maternal malnutrition extends beyond maternal mortality to causing intrauterine growth retardation, child malnutrition and an increasing prevalence of chronic disease.

Jose and Navaneetham (2010) in another article examine the relation between social infrastructure and women’s under nutrition. The paper examines whether access to aspects of social infrastructure, such as toilet facilities, drinking water on the premises and clean cooking fuels, leads to a decline in the incidence of
under nutrition among women, which remains quite high in India. The analysis based on the National Family Health Survey-3 (NFHS-3) 2005-06 unit level data, suggests that access to these three aspects of social infrastructure is likely to enhance women’s nutrition in India. Of these three aspects, the influence of access to clean cooking fuels remains quite significant. The findings, which assume importance from multiple angles, underline the importance of policies and programmes that ensure access to social infrastructure to the poor, in general, and poor women in particular.

Shukla (2008) explains about rural women and their nutritional health. Women are over-represented among the poor. Poverty is associated with higher female employment but lower income with greater drudgery in domestic work but lower access to support services, and with high fertility. All these contribute to poorer nutrition and health status of families. The paper concludes that a holistic approach to women’s health which includes both nutrition and health services should be adopted and special attention should be given to the needs of women and the girl at all stages of the life cycle.

The study by Navaneetham and Kharmalingam examines the patterns and determinants of maternal health care use across different social settings in South India i.e.; in the states of Andhra Pradesh, Karnataka and Tamil Nadu by using the data from National Family Health Survey carried out during 1992-1993. (http://ides.repec.org/p/ind/cdswwp-/307.html) The study indicates that determinants of maternal health care services are not same across states. Although illiterate women were less likely to use maternal health care services; there was no difference among the
educated. The level of utilization of maternal health care services was found to be highest in Tamil Nadu followed by Andhra Pradesh and Karnataka. Results from this study indicate that health workers might play a pivotal role in providing antenatal care in the rural area.

Bose (2007) speaks about our country’s disturbing health card. The NFHS-3 data shows disturbing trends for children and women in the reproductive age, especially in the BIMARU states. In spite of the Child Marriage Restraint Act, 1929, 53.4% of rural women in India were married before they turned 18. The figure is 69% in Bihar and 67% in Rajasthan. A sizeable proportion of India’s teenagers are involved in reproductive activity, with sharp rural-urban difference. Also there is high level of prevalence of anemia among women and children, high levels of infant mortality rate (varies between 73% in U.P and 15 % in Kerala) etc.

The need to integrate women into development has been universally recognized, but indices to reflect gender disparity are not free from complications. Utilizing a disaggregated indicator analysis, this article by Rustagi (2000) identifies gender backward districts among 15 major Indian states based upon 13 gender sensitive indicators. The main findings of this study are based on the 50 worst districts in terms of any single indicator. In the states of Rajasthan, Haryana and Punjab all districts record poor status of women, while in U.P, M.P and Bihar most districts exhibit backwardness by one or more gender selected indicators. A.P, West Bengal and Orissa with seven districts each are the states in the middle range. The
states of Karnataka, Kerala, Tamil Nadu, Himachal Pradesh, Maharashtra and Gujarat are relatively better off in terms of the chosen variables.

An article in Hindu (2006) based on the survey conducted in 43 districts between March and May 2005 in Delhi stresses the need for focusing on maternal health in the country, where nearly 1,300,000 women die annually from pregnancy and child-related complications. All most all these deaths are preventable. In every 5 minutes a woman dies of pregnancy-related causes. For every 1,00,000 live births in India, 407 mothers die – a number four times higher than the National Population Policy (NPP) 2010 goal of restricting the incidence to 100. While there are a number of reasons for the high maternal mortality rate including early marriage and childbirth, lack of adequate health care facilities, inadequate nutrition and absence of skilled personnel, yet the lack of empowerment of women, gender inequalities and discrimination limit their choices and contribute directly to their ill health and death. Even the best infrastructure and facilities will be of no use unless women are aware of and have access to them.

Sivamurthy (2001) analyses the relationship between women’s education and people’s quality of life in India. Education in general and female education in particular, enhances the awareness of the people regarding the way of living. Although impressive increases have taken place in female literacy and education in India, widespread disparities are there between states. The study concludes that development of women’s education shall yield substantial benefits for the people’s quality of life. Hence,
policies which promote women’s education must be given high priority in order to use it as a catalytic agent for improving the people’s quality of life in the country.

Using data from the NFHS in India, Govindaswamy and Ramesh examines the relationship between education and utilization of maternity and child health services. (http://www2.eastwestcenter.org/pop/misc/subj-5.pdf.) This work verifies the positive relationship between mother’s education and utilization of maternal and child health services in a much more detailed way-by examining the utilization of antenatal care services – and takes the research in this area one step further. From the programmatic point of view, the conclusions reached in this paper reinforce the call for continued investments in female education, which are indispensable for achieving reduced infant and child mortality and morbidity and possibly have an impact on factors that reduce maternal mortality.

Many studies have explored that female literacy reduces fertility. However, it was not clear how strong this link is. Parikh and Gupta (2001) analyses how effective is female literacy in reducing fertility based on a study in two states-Andhra Pradesh and Uttar Pradesh in a multiple regression framework. The study concludes that without overall development, literacy although a critical preconditioner, affects fertility reduction in a small percentage terms. Other measures, such as economic development of women and their work participation rate, provision of health and family planning services are also needed for a heavy impact on the reduction of fertility.
Gopal (2004) explains about the health implications of the census of India 2001. She considers life expectancy and infant mortality as the crucial indicators of health status. Literacy is the crucial non-health care determinant of health status. There is a clear positive relation between literacy and life expectancy and negative relation between literacy and infant mortality rate. She is highly afraid of the increasing morbidity level and increase in communicable diseases in India.

Mishra and Mishra (2004) uses NFHS-2 data to explore certain linkages between literacy status of a couple with outcomes like household standard of living index and others having implications on women and child health. An attempt has also been made to link the proximate criterion in literacy in the couple domain with outcome variables such as standard of living index, instances of sickness among women from specific diseases like asthma, TB, Malaria and Jaundice; linkages with indicators like under nutrition in women have also been analyzed. The exercise affirms the advantage of proximate literacy over the secluded illiterate in terms of outcome measures of women and child health as well as household standard of living index. On the other hand, while patterns are not distinct in terms of a comparison between proximate female illiterate and proximate male literate, indications point to the latter doing comparatively better.

The significance of education for leading a healthy life was highlighted by Norman (1985) who stated that education was a parallel to health care and both were strategically important contributors to fair equality of opportunity in a society.
According to him both education and health address needs which are not equally distributed among individuals.

Fester and Tilden (1983) are of the opinion that investments in education have spill-over effects not only on healthy man power development of a country, but also on the country’s health status itself. According to them sound investments in the infrastructure of education and health could be seen as a good form of income redistribution in kind, especially if these services are provided free or at subsidized prices to low income families who previously did not have sufficient access to them.

Saxsena (1989) opined that education and health are the two components of human capital formation and interacting with each other results in intellectual, social and physical development of individuals which lead to higher productivity and subsequently to higher income, paving the way for higher investments in all sectors including education and health, which results in human capital on other.

Susan (1980) has stated that literacy rate and income distribution are important variables in determining the mortality rate and life expectancy of all societies and the former is more important than the numbers of doctors per capita. Education emerges as the most important variable when the mortality rate alone is considered.

Carrin (1984) also has admitted that education is an important variable
in policies aiming at better health. He pointed out that there was a positive relationship between the parental education and the nutritional level among children. Carrin's analysis of various countries proved that malnourished children generally have illiterate parents and that parents with an average three to five years of schooling had normally well nourished children.

Complication of pregnancy and children in developing countries often result in illness or permanent disability for the mother or child. While the tragedy of maternal mortality affects mainly the poorer sections, it is only very recently that serious attention has focused on the issue of ‘safe motherhood’. The paper by Padma (2005) analyses the levels of safe motherhood in rural areas of Andhra Pradesh vis-à-vis other southern states. It also seeks to understand the perceptions and limiting causes that come in the way of safe motherhood. While data suggests that women in rural A.P experience safe motherhood, social and group perspectives reveal that many women are exposed to unsafe motherhood, very often non-biomedical causes influence the medical determinants of safe motherhood.

Ghosh and James (2010) in their paper bring our attention to levels and trends in Caesarean births. To them it is becoming a cause for concern. A consistent increase has been observed in the rate of caesarean section deliveries in most of the developed countries and in many developing countries, including India, over the last few decades. An analysis of the National Family Health Survey data shows that the rate of this form of delivery in states like Kerala, Goa, A.P, West Bengal and Tamil
Nadu is alarmingly high. States with marked demographic transition as well as high institutionalized births have an inflated rate of C-section deliveries. While an important reason for medical intervention is the attempt to save the lives of mother and child, there are also other societal forces playing a vital role. Very high incidence of C-section delivery among the affluent groups and in private hospitals points to factors beyond the purely economic motive.

3.5. Child Health and Nutrition:

Children are the citizens of tomorrow who would substantially and significantly contribute towards socio-economic development of a nation and hence the physical and mental health of a child becomes important issues. Pattanaik (1994) in her book concentrated upon the nutritional status of the children particularly living in poor state like Orissa and to found out the extend to which their physical development and educational achievement have affected. It is revealed that nutritional status of urban children is better than that of rural children. To her, educational level of parents and household income are positively related with nutritional level and negatively to size of family.

Gupta (2008) speaks about the nutritional and Anaemia status of urban children in India. Health and nutritional problems in urban areas seldom get attention, inspite of the fact that currently nearly one third of India’s population is living in urban areas. NFHS-3 shows that prevalence of malnutrition and anaemia is relatively lower among children in urban areas compared to children living in rural areas.
However, nearly one third children in urban areas of India are underweight and more than 60% urban children suffer from some degree of anaemia.

Infant and child mortality rates reflect a country’s level of socio-economic development and quality of life. In India, 8.5% of children die before their 5th birthday. This critical situation has led to the developing countries to formulate strategies for improving health conditions of the people which begin with child health and survival. Prasad (2001) examines health communication campaigns for child survival in India. In India, policy makers have begun to pay attention to the UNICEF “child survival revolution” based on the GOBI-FF strategy, an acronym for growth monitoring, oral dehydration therapy for diarrhea, breastfeeding, immunization, food supplements and family planning. This multi-pronged child health strategy is expected to increase the survival and overall well being of infants and children under five years. Health communication campaigns in the mass media help to create widespread awareness about proper nutrition, hygiene, immunization and contraception. Public information campaigns can enhance skills and change the attitudes and preferences of parents, especially mothers, thereby promoting child survival.

Mehrotra (2006) analyses child malnutrition and gender discrimination in South Asia. India, Pakistan and Bangladesh account for child malnutrition rates that are higher than in sub-Saharan Africa. This is directly related to discrimination against women in South Asia. The focus of all interventions has to be on improving
the health status of women generally and as far as the infant is concerned, targeting most interventions in the first three years of life. Additionally, school feeding programmes will ensure that a poor family is saved the cost of at least one square meal for its children. Finally rapid action is needed so that access to safe water and sanitation is extended to the entire population.

Swain (2008) speaks about nutritional deprivation of children in Orissa. This paper seeks to measure deprivation in terms of physical development and calorie-intake of children in two villages of Orissa. While the first aspect focuses on retardation in the physical growth of children as reflected in their weights vis-à-vis age, the second aspect highlights the inadequacy of children’s calorie-intake. Swain concludes that the children of these two villages of India are quite typical of a deprived community, being stunted and wasted to some degree from early childhood. Malnourishment has been felt most frequently and severely among the children. Poor nourishment reflects on morbidity and illness. Government intervention is utmost necessary to correct these mistakes.

The article by Gragnolati (2006) examines the effectiveness of the Integrated Child Development Services Programme in addressing the challenge of child under nutrition in India. It finds that although the ICDS Programme appears to be well-designed and well-placed to address the multidimensional causes of malnutrition in India, there are several mismatches between the programme’s design and its actual implementation that prevent it from reaching its potential. These
include an increasing emphasis on the provision of supplementary feeding and preschool education to children aged to four to six years, at the expense of other programme components that are crucial for combating persistent under nutrition; a failure to effectively reach children under three; and, ineffective targeting of the poorest states and those with the highest levels of under nutrition which tend to have the lowest levels of programme funding and coverage. In addition, ICDS faces substantial operational challenges.

Viswanathan (2006) in her article analyses access to nutritious meal programmes by using 1999-2000 NSS data. The 1999-2000 National Sample Survey data indicates that a large majority of children in India from poorer households did not have access to the meal schemes operational in the country. The only exception to this was Tamil Nadu where the schemes seemed to work the best in rural area in the age group of seven to nine-year olds, without any discernible gender gap and was well targeted among the needy households. Further, among the poorer children, literacy rate and educational attainment were clearly higher when they had access to school meals perhaps implying that school enrolment and attendance improve in the presence of such schemes. This data however showed rather low coverage of Integrated Child Development Scheme among pre-school children across all states indicating problems of under-reporting or under recording.

Kulkarni (2006) examines the need for revisiting child survival programmes. The very evident flaws in India’s polio eradication programme
launched in the 1980’s are indicative of the fact that bodies at the international(UNICEF) and the national level(i.e. the Indian govt.) have failed in their primary task of controlling child mortality rates. Similar experiences have been reported from other countries. The UNICEF needs to rededicate itself a new vision to the health-related goals that form a vital part of the millennium development goals, by reaching out to groups and organizations operating at the grass root level.

Though the press has reported on the fallout of the implementation of the two - child norm in the six Indian states of Haryana, Himachal Pradesh, Rajasthan, A.P, M.P and Orissa, there is a dearth of studies on the subject. The paper by Visvaria (2006) undertook an empirical study of the perceptions and views of the policy makers, programme implementers and disqualified elected representatives in four of these states. Some have argued that adoption of the two child norm by elected panchayat members could have a “demonstration” effect on the community. However, evidence suggests that even at the village level, caste, class and gender politics dominate and those who belong to the backward communities offer no role model to members of higher castes or their own kith and kin. The two child norm impinges on basic human rights, is anti-women and anti-weaker segments.

Dr. kurian (2007) in her article stresses the role of breast feeding in reducing infant mortality. Breastfeeding should be recognized as a basic need for survival of infants. The mothers who suckle their offspring within one hour after birth have a greater chance of successfully establishing and giving exclusive
breastfeeding for the first six months. Exclusive breastfeeding for the first six months keeps the baby healthy and ensures development to the full potential. Initiation of breastfeeding within one hour of birth is the first and most vital step towards reducing infant mortality, by reducing the overwhelmingly high neonatal mortality rate. August 1 to 7 is being observed as world breastfeeding week every year.

Levels of child malnutrition in India are exceptionally high. According to the recently released NFHS-3, carried out in 2005-06, 46% of India’s children under the age of 3 are underweight. The corresponding levels of child malnutrition are much lower in most other countries - 28% in sub-Saharan Africa and 8% in China. Kumar (2007) by using the NFHS-3 data locates the main reasons for high levels of child malnutrition in India. The first and most important reason is low birth weight babies. In India 20-30% of babies weigh less than 2500 gms at birth. This suggests the onset of malnutrition in the womb itself. Adversely affecting the birth of well-nourished babies is also the poor health and malnutrition status of women. The second factor is related to the limited reach of public health services and messages. In 2005-06, only 44% of children aged 12-23 months were fully immunized. Also affecting the health and nutritional well being of children is the limited reach of and access to maternal care services. NFHS-3 reveals that only half of the mothers across the country received at least 3 antenatal care visits during pregnancy and only 48% of births were attended by a trained birth attendant. The third reason lies in the care of the child. Despite the importance of breastfeeding,
appropriate feeding for preventing malnutrition, only 46% of babies’ up to 5 months old were exclusively breastfed. And the fourth clue is found in the limited opportunities available to women.

According to Chandrasekhar and Ghosh (2007), despite rapid economic growth, the nutritional status of our population appears to be worsening according to some important indicators from NFHS-3. In our country more than half of our children (56.5%) still do not receive full immunization and are therefore prey to completely eradicable diseases. The NFHS-3 provides some depressing reminders of the low and, in some cases, worsening nutrition status of most of our citizens, especially the young. The per cent of underweight children less than 3 years of age was 47% in 1996-97, 51.5% in 1998-99 and 45.9% in 2005-06. In the latest survey, 79.2% of children in the age group of 6-35 months had anemia and it was 74.2% in 1996-97 and 57% in 2005-06. The results of the latest NFHS should certainly cause alarm bells on the state of public nutrition to ring very loudly in the corridors of power.

Dhar (2006) in his article explores the acute malnutrition standards of children in India by quoting U.N report. India accounts for 57 million of the world’s 146 million malnourished children. According to the U.N Report, at the current rate of progress, the millennium development goal to halve child hunger by 2015 will not be reached till 2025. One in four children under five in developing countries are underweight and nearly half of them live in India, Pakistan and Bangladesh.
According to U.N Report, severe malnutrition is more frequent among girls, half of all children in India under three are under weight, a quarter of all children are born with low weight, and three quarters of under three children and half of adult women are anemic.

Gupta and Khaira (2008) argue that the problem of malnutrition among children is not merely a health issue but a question of India’s economic resurgence. The authors say that more energy and resources need to be spent on the window of opportunity of the first 24 months of life. In India about 40 million children under three years of age are undernourished. Promotion of good breastfeeding and adequate and appropriate complementary feeding after six months to children has long lasting health benefits. However mere acceptance of reality and starting special programmes towards this end will remain an exercise in futility unless we remove the fundamental flaws in running these programmes.

Ghosh and James (2010) in their paper bring our attention to levels and trends in Caesarean births. To them it is becoming a cause for concern. A consistent increase has been observed in the rate of caesarean section deliveries in most of the developed countries and in many developing countries, including India, over the last few decades. An analysis of the National Family Health Survey data shows that the rate of this form of delivery in states like Kerala, Goa, A.P, West Bengal and Tamil Nadu is alarmingly high. States with marked demographic transition as well as high institutionalized births have an inflated rate of C-section deliveries. While an
important reason for medical intervention is the attempt to save the lives of mother and child, there are also other societal forces playing a vital role. Very high incidence of C-section delivery among the affluent groups and in private hospitals points to factors beyond the purely economic motive.

3.6. Inequality in Health Care Utilisation:

Inequalities pervade in all sectors in India, health has been no exception to this statement. According to Reddy and Manjunath (2006), the richest 20% enjoy three times the share of public subsidy for health compared with the poorest countries. The poorest 20% of Indians have more than double the mortality rates, fertility rates and under nutritional levels of the richest 20%. On an average, the poor spend 12% of their incomes on the health care, as opposed to only 2% by the rich. This implies that even the comparison of health status indicators between the poorest and richest sections of population brings out unacceptable levels of inequalities prevailing in India. They attribute three important reasons for the existing health inequalities namely insufficient public health expenditure, unbridled growth of private sector in health care and poor rural health infrastructure. To them, it is the most important duty of the state to take appropriate measures.

Joe and Navneetham (2008) utilize the National Family Health Survey-3 data to present empirically income-related health inequality in India. It undertakes a state-level analysis of inequities in child health by applying the widely accepted measures of concentration curves and concentration indices. It finds that the poorer
sections of the population are beleaguered with ill health whether in the quest for
child survival or due to anxieties pertaining to child nutrition. Further, an attempt is
made to comprehend the relationship between income inequality and health status in
the Indian context. The analysis reveals that the degree of health inequalities
escalates when the rising average income levels of the population are accompanied by
rising income inequalities. The income-poor sections have different needs and
therefore, planning and intervention necessitates an understanding of the sources of
inequality and recognition of the vulnerable groups to arrive at efficient resource
allocation and policy decisions.

Chakravarty (2008) explores the various health problems of the tribes. The tribal population constitutes more than 10% of the Indian population as per 2001
census. The tribes’ due to ignorance, illiteracy and social traditions normally do not
accept any new positive interventions in their lifestyles in general and medical care in
particular. Therefore they don’t avail themselves of the health care facilities available
in sub-centres and PHCs. The tribes are not taking care in delivery related issues and
90% of deliveries are at home. Vaccination and immunization of infants and children
are not adequate. Extreme magico-religious beliefs are there among tribes. Moreover,
educational level is very low among them. What is needed is creation of awareness
about preventive and curative medical care among them.

Salvekar (1975) analyses the economic class differentials in the health
care utilization. Inequalities in medical care access are a severe problem in the
utilization of health services in both urban and rural areas. The study revealed that access differentials among children were surprisingly consistent and unrelated to health care system and structures. It appeared that higher family income was associated with greater access to health care among children at all levels of need.

While a large number of primary health centres and sub centres have been created as part of the governments “health for all” programme, surveys such as NFHS-1 &2 reveal that health services either do not reach disadvantaged sections or are not accessed by them. Roy (2004) assesses the extent of inequalities in health care and nutritional status across states with a focus on caste and tribe in selected states. It highlights the effect of social stratification on utilization of health care programmes and nutritional status. The states like Madhya Pradesh, Gujarat and Orissa shows much high inequality and the states like Uttar Pradesh, Rajasthan, Maharashtra, Karnataka, Assam, and West Bengal shows less inequality.

3.7 Health Insurance-need and scope:

There are two important limitations to the present health care system and its functioning in India. The first limitation is exceptionally high health care expenditure, over three fourth of which is private out of pocket expenditure. The other one relates to unsatisfactory outcomes of these expenses. This highlights the need for alternative finances, including provision for medical insurance at a much wider level. Ellis (2006) attempts to review a variety of health insurance systems in India, their limitations and the role of the General Insurance Corporations as an
important insurer agency. It also attempts to develop a prospectus of strategy for
greater regulation and increased health insurance coverage by making sustainable
changes – particularly in claim settlements and the exclusion clause.

Mathiyashagan (1998) in his articles speaks about willingness to pay for rural health insurance through community participation in India. The main objective of this article is to examine the willingness to pay for a viable rural health insurance scheme through community participation in India, and the policy concerns it engenders. The willingness to pay for a rural health insurance scheme through community participation is estimated through a contingent valuation approach by using the rural household survey on health from Karnataka state in India. The results show that insurance schemes are popular in rural areas. In fact, people have relatively good knowledge of insurance schemes rather than saving schemes. Most of the people stated they are willing to join and pay for the proposed rural health insurance scheme. However, the probability of willingness to join was found to be greater than the probability of willingness to pay. Indeed, socio-economic factors and physical accessibility to quality health services appeared to be significant determinants of willingness to join and pay for such a scheme. The main justifications for the willingness to pay for a proposed rural health insurance scheme are attributed from household survey results: a) the existing govt. health care provider’s services is not quality oriented, b) is not easily accessible and c) is not cost effective. The paper suggests that policy makers in India should take serious note of the growing influence
of the private sector and people’s willingness to pay for organizing a rural health insurance scheme to provide quality and efficient health care in India. It is also argued that regulatory and supportive policy interventions are inevitable to promote this sector’s viable and appropriate development in organizing a health insurance scheme.

Mahal (2002) analyses the potential impacts and regulatory issues of private health insurance in India. He is of the opinion that the entry of private health insurance could have adverse implications for some of the goals of health policy, particularly for equity. However, an informed consumer and a well defined and implemented insurance regulation regime could potentially address many of the bad outcomes.

Gupta and Trivedi (2006) appeals that instead of different ministries taking initiatives to provide health insurance coverage for the areas or populations that are under their jurisdiction, it is important for planners to understand that parallel schemes run on public money can only introduce inefficiencies and wastage into the system. It is necessary to plan the spread of health insurance on a national scale and to set up an apex body that would be in charge of implementing health insurance in the country.

Gupta (2002) in another study at Delhi by taking 500 households as sample tries to analyze the attitude of people towards private health insurance. It reveals that health care cost on households especially among low income group is
very high. He finds a fairly high willingness among low income households to participate in insurance programme.

Ahuja (2004) analyses the health insurance scenario of the poor. Health insurance is emerging as an important financing tool in meeting the health care needs of the poor. Neither market mediated nor government provided insurance is an appropriate way of reaching the poor. Community based health insurance is a more suitable arrangement for providing insurance to the poor. It could take different forms and each of these forms may be suitable depending on the characteristics of the target population, their health profile and health risks to which the community is exposed. Indeed, for a country as diverse as India, there can be no pan India model and all different forms need to be explored. However, increased public health spending and reforming of public health facilities is a must for the success of these community based health initiatives.

Despite many policy measures taken by the central and state governments, the indebtedness of farmers, especially marginal and small cultivators, keeps increasing. Some recent studies on agrarian distress show that significant role of healthcare expenditure in increasing indebtedness. The article by Singh (2010) presents the result of a study conducted in selected villages of Amritsar and Gurdaspur districts of Punjab in 2008-09 to estimate the level of credit taken for healthcare purposes by marginal and small farmers. In Punjab, households have undertaken nearly 76.1% of the total healthcare spending from their own sources,
whereas public spending is only 18%, and all other sources like non-governmental organizations etc contribute only 5.9% of total health expenditure. This forces them to acquire credit sometimes at an exorbitant rate of interest, thereby increasing the debt burden on them. The study concludes that commercialization and privatisation of health services have excluded a sizeable proportion of the population, particularly those belonging to socially disadvantaged groups from the coverage of health services provided by organized sector in rural areas. The subsequent financial burden of private healthcare services is responsible for a large proportion of total borrowing by these underprivileged sections of society. Therefore, policy measures are necessary to improve the rural health scenario in the state.

Gumber and Kulkarni (2000) in their paper explores the availability of health insurance coverage for the poor and especially women, their needs and expectations of a health insurance system, and the likely constraints in extending current health insurance benefits to workers in the informal sector of Gujarat. The study reveals that health insurance for informal sector has a substantial scope for improvement of its services, particularly better utilization of its facilities. The study also shows that the poor prefer public sector management of health care facilities.

Rao (2004) in her paper tries to explore whether the health insurance system can be made to generate better health outcomes, enable participation of civil society, widen choice of provider, provider accountability, optimize utilization of existing capacities and promote more need-based deployment of resources. The study
concludes that in the existing economic environment where fiscal deficit is not under
control and inflation has crossed 6%, the growing demand for health services due to
huge disease burden, narrowing tax base and ineffective tax collection system making
it impossible to relay only on public budgets to finance the overwhelming needs of the
health sector, the rapidly growing private sector inducing demand on a scale and in a
manner that is impoverishing a large number, make a compelling case for extending
health insurance to the poor and near poor.

Desai (2010) in her article speaks about the role of national health
insurance programme. Illness is a leading cause of household financial crisis in India.
In principle, Indians can access subsidized health services provided by a public sector
with extensive coverage. However, by almost any account, public sector health
facilities offer care of poor quality, particularly in rural areas. This state of affairs has
forced a large majority to depend on the private sector, mostly in the form of out of
pocket spending that accounts for more than 70% of all health spending in India. Two
recent govt. initiatives seek to shift this burden away from households-NRHM and
Rashtriya Swasthya Bima Yojana (RSBY). Both these have the potential to transform
the health and financial security of poor households. The experience of VimoSEWA
indicates that health insurance must be firmly linked to an effective public health
system. A high % of claims for preventable illness, unnecessary expenditure on
medicines, increasing hysterectomies and inequitable claims patterns are four trends
that are likely to be seen in the implementation of RSBY. To ensure that health
insurance plays its intended role, appropriate investment in prevention, particularly in water and sanitation, as also, community involvement and a strengthened public sector are essential.

Berman (2010) explains about the impoverishing effect of health care payments in India: new methodology and findings. High private health care spending as well as high out of pocket spending in India is placing a considerable financial burden on households. The 60th National morbidity and health care survey of the National Sample Survey Organisation provides an opportunity to examine the impoverishing effect of health care spending in India. This paper presents an analysis of the NSSO survey data with some new approaches for correcting some of the biases in previous assessments of the “impoverishing” effect of health spending. Despite these corrections, the result suggests that the extent of impoverishment due to health care payments is higher than previously reported. Furthermore, outpatient care is more impoverishing than inpatient care in urban and rural areas alike.

Vyasulu (2008) reveals his idea against health insurance. Medical insurance is now being actively promoted by the government as a means of providing and covering the costs of healthcare. But such insurance is riddled with problems and faces some very India-specific constraints. It may contribute to the growth of the insurance industry but it is a second-best solution that represents the abdication of responsibility by the state to provide health care for all its citizens.
Jajoo and Shan (2004) in their joint article describes the trajectory of moral and social upliftment of villagers in the Sevagram region of Maharashtra that had its roots from the initiation and success of a micro health insurance scheme first introduced to ensure uniform health care to the poor and needy in Nagpur village. With its increasing acceptance across more villages, the scheme was extended to cover income generation programmes as well as women’s self help groups addressing the village as one social unit for development. At the next stage, the health insurance scheme moved towards action-oriented individuals who could play leadership roles in the country. This empowerment and leadership conferred on selected individuals helped to initiate the anti-liquor movement in the villages around Sevagram.

Acharya (2007) analyses the burden of health care expenditure. Health status of populations is considered as an important indicator of development. Theoretical work as well as empirical evidence has clearly established the positive link between good health and economic development. The burden of health care expenditure in general and hospitalization expenditure in particular, can be catastrophic for household finances. The evidence available from the NSS surveys indicates that health care expenditure is one of the fastest growing components of household consumption even among the poor. Thus high health care cost can be controlled through health insurance. But public and private health insurance companies have traditionally targeted only the urban middle and upper class. It is in this context that NGOs in India have taken initiative in providing protection to poor by the provision of health insurance since the focus is one the poor, it is known as
Micro Health Insurance (MHI), Community Based Health Insurance (CBHI), Community Health Insurance (CHI) and Community Based Insurance (CBI). There are about 13 NGOs in India that are running MHI scheme for poor out of these, Gujarat is home to four such innovative health insurance experiments namely Self Employed Women’s Association (SEWA), Tribhuvandas Foundation (TF) Agha Khan Health Services, India (AKHS, I) and Navsarjan. All these are playing a very positive role in the field of health insurance for poor.

Though Kerala’s health sector is a topic of continuous research among researchers, many of these studies are on the general framework. There are not many studies which analyze the health care scenario of a particular region or district. That is grass root level studies are very rare in the health sector of Kerala. The northern district of Kerala, Kannur, is also not an exception to this situation. It is in this context that the present study is designed which tries to analyze the above mentioned problems in the health scenario of Kannur district. It is hoped that the study will reveal the strengths and weaknesses of the healthcare scenario of the district.