2.1. Introduction:

An attempt is made in this chapter to review the relevant literature which could serve as a necessary empirical, theoretical and intellectual backdrop for the present study. It pertinent to note here that for an empirical study such as present one it is rather imperative to place it in the context of existing empirical and theoretical knowledge to contextualize the findings of the present study. A review of literature as the present one could also enable one to identify the gaps in the empirical literature in the context of which the findings of the present study could be taken as warranted in filling up of those gaps. Such a review would also enable the researchers to apprise themselves of the theoretical approaches and orientations that are in vogue in the study of the phenomenon under investigation as well as acquaint themselves with the methodological tools, techniques and approaches that have been employed in the study. It is also assumed that a review as such as the present one would provide the researcher the requisite intellectual and empirical insights and inputs in approaching the phenomenon being investigated into. Lastly, it is hoped that such a review would also provide necessary, textual and the recall backdrop against which the findings of the present study can be more relevantly and meaningfully analyzed and interpreted.

It is contemplated that a review of literature should focus on the issues that have been already addressed in the empirical as well as theoretical literature focusing on the phenomenon under investigation pretending to the causes, the extent, the nature as well as the determinants. At the same time it should also take stock of the perspectives approaches and orientations on the one hand and methods, tools and techniques on the other, employed in the in the study and the analysis of the factors and issues stated above. A good review of literature should aim at the thematic classification of the studies focusing on diverse issues pertaining to the phenomenon under investigation
and analyze the major findings that could be taken as extending the limits of knowledge about the phenomenon instead of ending up as a mere survey of literature published on the in subject. It is precisely owing to these reasons an attempt is made in this chapter to analytically a focus on relevant literature pertaining to health care facilities and status of public hospitals. However, it needs to be mentioned here that in a doctoral thesis as the present one completed under the constraints of time and resources it will not be possible to do enough justice to the richness of the literature and as such, few of the significant studies made in the relevant literature published are covered in the review of literature.

2.2. Review of Literature:

The collected secondary literature is reviewed as under.

Ashok Vikhe Patil, et al (2002) published an article entitled “Current Health Scenario in Rural India” in ‘Australian Journal of Rural Health’. In this study seven that. About 75% of health infrastructure, medical man power and other health resources are concentrated in urban areas where 27% of the population lives. Contagious, infectious and waterborne diseases such as diarrhoea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections dominate the morbidity pattern, especially in rural areas. However, non-communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/AIDS, accidents and injuries are also on the rise. The health status of Indians, is still a cause for grave concern, especially that of the rural population. This is reflected in the life expectancy (63 years), infant mortality rate (80/1000 live births), maternal mortality rate (438/100 000 live births); however, over a period of time some progress has been made. To improve the prevailing situation, the problem of rural health is to be addressed both at macro (national and state) and micro (district and regional) levels. This is to be done in an holistic way, with a genuine effort to bring the poorest of the population to the centre of the fiscal
policies. A paradigm shift from the current ‘biomedical model’ to a ‘socio-cultural model’, which should bridge the gaps and improve quality of rural life, is the current need. A revised National Health Policy addressing the prevailing inequalities, and working towards promoting a long-term perspective plan, mainly for rural health, is imperative.

Ranganayakulu Bodavala (2002) writes on “ICT applications in Public Health Care System in India: A Review” in ‘ASCI Journal of Management’. India’s public healthcare network is five decades old. It is plagued by many problems like absenteeism of doctors, lack of proper facilities and most significantly lack of proper referral services to urban hospitals and specialist centers. Due to these reasons the utilization and confidence in the public healthcare system is very low. Successive governments have tried to improve the various measures in the system with marginal success. Application of ICT tools will improve access and delivery of healthcare services to vast majority of poor people living in rural areas in India.

Rychetnik, et al (2002) published “Criteria for Evaluating Evidence on Public Health Interventions” in ‘Journal of Epidemiology and Community Health’. Public health interventions tend to be complex, programmatic, and context dependent. The evidence for their effectiveness must be sufficiently comprehensive to encompass that complexity. This paper asks whether and to what extent evaluative research on public health interventions can be adequately appraised by applying well established criteria for judging the quality of evidence in clinical practice. It is adduced that these criteria are useful in evaluating some aspects of evidence. However, there are other important aspects of evidence on public health interventions that are not covered by the established criteria. The evaluation of evidence must distinguish between the fidelity of the evaluation process in detecting the success or failure of an intervention, and the success or failure of the intervention itself. Moreover, if an intervention is unsuccessful, the evidence should help to determine whether the intervention was inherently faulty (that is, failure of intervention concept or theory), or just badly delivered (failure of
implementation). Furthermore, proper interpretation of the evidence depends upon the availability of descriptive information on the intervention and its context, so that the transferability of the evidence can be determined. Study design alone is an inadequate marker of evidence quality in public health intervention evaluation.

*Narayana (2003)* published an article entitled “Changing Health Care System” in ‘Economic & Political Weekly’. To improve the financial viability and quality of health care in public hospitals, the Andhra Pradesh Government initiated a series of reforms. However, because of lack of resources, there has been stagnation in the size and decline in the quality of public health care. The state’s patronage of the private sector in health care has been justified on the ground that it would ease the pressure on government hospitals. But in reality private hospitals are replacing rather than complementing public hospitals by weaning away resources from government hospitals.

*Vijayakumar Yadavendu (2003)* published a paper “Changing Perspectives in Public Health: From Population to an Individual” in ‘Economic & Political Weekly’. This paper focuses on the overriding influence of methodological individualism in the historical construction of public health. While evidence of a holistic approach to health is observed in the writings of people like Hippocrates, the developments subsequent to the establishment of the Cartesian paradigm, contained strong elements of individualism. In fact, systematic epidemiological studies in the 19th century rightly justified epidemiology’s claim as the basic ‘science’ of public health. But, the gradual progression away from the population perspective towards risk factor, clinical and finally molecular epidemiology, bears evidence of the increasing influence of individualism in public health.

*Abhijit Banerjee, et al (2004)* writes on “Health Care Delivery in Rural Rajasthan” in ‘Economic & Political Weekly’. This paper reports on a survey conducted in rural Udaipur to gauge the delivery of health care and the impact it has on the health status of the largely poor population of the region.
The study shows that the quality of public service is extremely low and that unqualified private providers account for the bulk of health care provision. The low quality of public facilities has also had an adverse influence on the people’s health. In an environment where people’s expectations of health care providers seem to be generally low, the state has to take up the task of being the provider or regulator.

Deepa Sankar and Vinish Kathuria (2004) write on “Health System Performance in Rural India Efficiency Estimates across States” in ‘Economic & Political Weekly’. The present study attempts 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. The results show that not all states with better health indicators have efficient health systems. The study concluded that investment in the health sector alone would not result in better health indicators. Efficient management of the investment is required.

Monica Das Gupta and Manju Rani (2004) published a research paper entitled “India’s Public Health System How Well Does It Function at the National Level?” India has relatively poor health outcomes, despite having a well-developed administrative system, good technical skills in many fields, and an extensive network of public health institutions for research, training, and diagnostics. This suggests that the health system may be mis-directing its efforts, or be poorly designed. To explore this, the authors used instruments developed to assess the performance of public health systems in the United States and Latin America based on the framework of the Essential Public Health Functions identified as the basic functions that an effective public health system must fulfill. This paper focuses on the federal level in India, using data obtained from senior health officials in the central government. The data indicate that the reported strengths of the system lie in having the capacity to carry out most of the public health functions. Its reported weaknesses lie in three broad areas. First, it has overlooked some fundamental public health functions such as public health regulations and their enforcement. Second, deep
management flaws hinder effective use of resources, including inadequate focus on evaluation; on assessing quality of services; on dissemination and use of information; and on openness to learning and innovation. Resources could also be much better utilized with small changes, such as the use of incentives and challenge funds, and greater flexibility to reassign resources as priorities and needs change. Third, the central government functions too much in isolation and needs to work much more closely with other key actors, especially with sub-national governments, as well as with the private sector and with communities. The paper concluded that with some re-assessment of priorities and better management practices, health outcomes could be substantially improved.

Shivakumar (2005) published a paper entitled “Budgeting for Health: Some Considerations” in ‘Economic & Political Weekly’. The announcement of the National Rural Health Mission and the commitment in the recent budget to increase allocations for health are necessary steps in the right direction to correct India’s shockingly poor health record. As national and state level strategies unfold over the coming months, a vigorous and informed public discussion is needed to create a national consensus for dramatically increasing investments in health with concurrent improvements in accountability and management of the healthcare system. 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 National Rural Health Mission in its endeavour to provide good quality healthcare for all.

As stated by Sathyamala (2006) in her paper “Public Health Foundation of India: Redefining Public Health?” published in ‘Economic & Political Weekly’, commented that the setting up of the Public Health Foundation of India marks the coming together of interests that are inimical to
public health. The Public Health Foundation of India and its institutes – albeit located in India and with the blessings of the Indian government – will in effect function as an extension of American interests. It is to be governed by technocrats/bureaucrats and nominated Non-Governmental Organisations and will be subjected to little or no accountability/scrutiny by the Indian polity.

Achudume and Olawale (2007) written on “Microbial Pathogens of Public Health Significance in Waste Dumps and Common Sites” in ‘Journal of Environmental Biology’. Microbial pathogens of public health significance found in waste and common sites were collected from four different dumping sites and assessed for pathogenic agents. The modified methods employed were based on the classical methods and basic principles of the reactions followed by biochemical enzymatic standards described for gram negative non fermenting bacteria. The results have shown presence of bacterial species including Pseudomonas, Mirococcus, Actinomyces, Neisseria, Bacillus and Klebsiella. These pathogens can infect wounds and cause sepsis and mortality and can even occur with such organisms to cause secondary infection. These groups of organisms are almost impossible to control since they are ubitiquous. Public health may be ensured from pathogenic agents at waste sites by prompt removal of waste and proper management (mechanical sorting and excavating) methods.

Baru and Nandi (2008) in their paper research entitled “Blurring of Boundaries: Public-Private Partnerships in Health Services in India” published in ‘Economic & Political Weekly’, trace the evolution, structure and characteristics of public-private partnerships in healthcare over the last six decades. It argues that these partnerships have broken down the traditional boundaries between the market and the state, leading to the emergence of multiple actors with multiple roles and newer institutional arrangements that have redefined their role, power and authority. The fragmentation of role and authority has serious consequences for comprehensiveness, governance and accountability of health services.
Devika and Rajasree (2008) published a paper on “Health, Democracy and Sickle-cell Anaemia in Kerala” in ‘Economic & Political Weekly’. It is based on a study conducted of the sickle-cell anemia patients among the Chettys in Wayanad district of Kerala, which exposes the failure of public action in healthcare. It emphasizes the need for sustainable care of these patients, which can be made available only if panchayats take an active interest. But the sick get less support from the panchayats and mainstream political parties. This is also a reflection of the present crisis in the public healthcare system of Kerala, which is characterized by poor quality and falling utilization rates.

Mehrotra (2008) published a research article on “Public Health System in UP: What Can Be Done?” in ‘Economic & Political Weekly’. The paper offers a menu of options for reform of Uttar Pradesh’s public health system. Though some actions have been taken after the introduction of the National Rural Health Mission in late 2005, a large number of very serious problems remain. Unless they are addressed, the monitorable targets of the Eleventh Five-Year Plan in regard to health and nutrition in India will not be met, since UP has such a large weight in the unmet needs of public health in the country.

Mukherjee and Karmakar (2008) published a paper on “Untreated Morbidity and Demand for Healthcare in India: An Analysis of National Sample Survey Data” in ‘Economic & Political Weekly’. This paper studies the problem of poor health outcomes in India from the demand side, and using the unit level data from the 60th round of the National Sample Survey analyses the determinants of not accessing medical care. This analysis is confined to persons who have reported being ill within 15 days of the survey but have not sought either public or private professional medical services. There are systematic variations in accessing healthcare between urban and rural areas, as well as between males and females in each sector. While in the rural areas, the demand for healthcare increases significantly with the education level of the head of the household, in the urban areas the evidence is mixed. Richer economic sections constitute a larger proportion of sick persons who do not
access medical care, especially in urban areas. Paradoxically, among poor households, which cite financial reasons for not accessing healthcare, women are less likely to be discriminated in rural than in urban areas.

Chungkham Holendro Singh (2009) writes on “The Public-Private Differential in Health Care and Health-Care Costs in India: The Case of In-patients” in ‘Journal of Public Health’. The analysis revealed that more than 58 percent of the patients have utilized private health-care facilities in India. As expected, the mean cost of treatment in private hospitals is Rs. 5,019 after adjusting for confounders compared to Rs. 1,307 for public hospitals. The mean adjusted cost of treatment of heart diseases is Rs. 5,981, followed by Rs. 5,402, Rs. 4,616, Rs. 2,478 and Rs. 891 for urological diseases, gynecological disorders, tuberculosis and diarrheal diseases, respectively. Better off patients incurred the highest out-of-pocket costs, in the range of Rs. 4,967 to Rs. 8,457.

It is evident that for the diseases considered in the study, the private sector plays an important role in providing health facilities. The cost of hospitalization in private health facilities is considerably higher compared to that of public facilities as far as the five ailments are concerned. Among the ailments, chronic conditions were seen to consume higher costs of treatment. However, more people opted for the unregulated private facilities.

Raban, et al (2009) published a paper on “Essential Health Information available for India in the Public Domain on the Internet” in ‘BMC Public Health’. Health information and statistics are important for planning, monitoring and improvement of the health of populations. However, the availability of health information in developing countries is often inadequate. This paper reviews the essential health information available readily in the public domain on the internet for India in order to broadly assess its adequacy and inform further development. The essential sources of health-related information for India were reviewed. An extensive search of relevant websites and the Pub Med literature database was conducted to identify the sources. For each essential source the periodicity of the data collection, the information it generates, and the geographical level at which information is
reported, and its availability in the public domain on the internet were assessed. The available information related to non-communicable diseases and injuries was poor. This is a significant gap as India is undergoing an epidemiological transition with these diseases/conditions accounting for a major proportion of disease burden. Information on infrastructure and human resources was primarily available for the public health sector, with almost none for the private sector which provides a large proportion of the health services in India. Majority of the information was available at the state level with almost negligible at the district level, which is a limitation for the practical implementation of health programmes at the district level under the proposed decentralization of health services in India. This broad review of the essential health information readily available in the public domain on the internet for India highlights that the significant gaps related to non-communicable diseases and injuries, private health sector and district level information need to be addressed to further develop an effective health information system in India.

Sakthivel Selvaraj and Anup K Karan (2009) published an article “Deepening Health Insecurity in India: Evidence from National Sample Surveys since 1980s” in ‘Economic & Political Weekly’. Drawing on evidence from the past morbidity and health surveys (1986-87 to 2004) and consumer expenditure surveys (1993-94 to 2004-05) of the National Sample Survey Organization, this paper argues that public provisions of healthcare in India has dwindled to new lows. Outpatient and hospitalization care in India in the past 20 years has declined drastically, leading to the emergence of private care players in a predominant way. While healthcare costs have shot up manifold in private provisioning, government health facilities are increasingly compelling patients to look for private outlets for procuring drugs and diagnostics. Due to these developments, millions of households are incurring catastrophic payments and are being pushed below poverty lines every year.

Sunil S Amrith (2009) published a research paper entitled “Health in India since Independence”. This paper suggests that history is essential to an understanding of the challenges facing health policy in India today.
Institutional trajectories matter, and the paper tries to show that a history of under-investment and poor health infrastructure in the colonial period continued to shape the conditions of possibility for health policy in India after independence. The focus of the paper is on the insights intellectual history may bring to the understanding of deeply rooted features of public health in India, which continue to characterise the situation confronting policymakers in the field of health today. The ethical and intellectual origins of the Indian state’s founding commitment to improve public health continue to shape a sense of the possible in public health to this day. The paper shows that a top-down, statist approach to public health was not the only option available to India in the 1940s, and that there was a powerful legacy of civic involvement and voluntary activity in the field of public health.

According to Das Gupta, et al (2010), as described in their paper “How Might India’s Public Health Systems Be Strengthened? Lessons from Tamil Nadu” published in ‘Economic & Political Weekly’, the central government’s policies have inadvertently de-emphasised environmental health and other preventive public health services in India since the 1950s. Diseases resulting from insanitary conditions impose high costs even among the more affluent, and rapid urbanisation increases the potential for disease spread. The authors analyse 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 suggested establishing a public health focal point in the health ministry, and revitalising the states’ 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) revitalisation of public health cadre; and (4) health department engagement in ensuring municipal public health.
Mahal and Indira Rajaraman (2010) in their research paper entitled “Decentralisation, Preference Diversity and Public Spending: Health and Education in India” published in ‘Economic & Political Weekly’. Education and health are commonly devolved functions to sub-national governments, even in nations which have a unitary rather than a federal structure. The paper investigates, for the specific case of a federal country like India, whether differences between states in shares of public spending on health and education show convergence over time, and the impact of episodic horizontal partitioning of states on this process. The analysis rejects the hypothesis that preferences for health across state level jurisdictions are becoming more uniform over time, but for education, there is evidence of convergence, albeit at a low rate.

Nand Kishor (2010) published a paper on “Public Health Implications of Oral Health –Inequity in India” in ‘Journal of Advanced Dental Research’. Oral health inequity- inequitable access to oral health services contributes to the health inequity of the population and further exasperates the socio- economic inequity. This paper attempts to elaborate the nature of oral health inequity in India, by exploring the process and trajectories of oral health inequity. This paper also attempts to provide an over view of oral health care services to the general population and how some section of the population are systematically excluded from the oral health care services. Considering the oral health burden in India, this paper argues that, oral health care in India must be integral part of primary health care. The current national dental health policy needs urgent revision. Customize strategies to the unique needs and resources that exist in India. This is what is most likely to work and have a positive impact on the oral health of Indian population.

Purohit (2010) writes on “Efficiency Variation at the Sub-State Level: The Healthcare System in Karnataka” in ‘Economic & Political Weekly’. This paper attempts an analysis of efficiency variation in health system performance in Karnataka. By using the stochastic frontier technique, it provides an idealised yardstick to evaluate the performance of the health sector. Carried out in two stages of estimation, the results of our model, using district-
level panel data, indicate that the efficiency of the public health delivery system in Karnataka remains low. Considerable disparities across districts in per capita availability as well as utilisation of hospitals, beds and manpower inputs hamper improvements in life expectancy in the state. Results from the second stage of estimation suggest that in rural areas particularly, improvements in infrastructure facilities like safe drinking water supply, toilets and electricity as well as better coordination between social sector and economic policies, especially at the district level, may also help the state improve life expectancy speedily and more equitably in the deficient districts.

**Sharma, et al (2010)** writes a working paper entitled “The Role of the District Public Health Nurses: A Study from Gujarat”. The role of District Public Health Nurses (DPHN) and District Public Health Nurse Officers (DPHNOs) as supervisors of the Public Health nursing and midwifery staff in a district was investigated. Thirteen DPHNs and DPHNOs from six districts selected from six geographic zones of Gujarat were observed for one week using the time motion method. Their activities and time spent were noted and the DPHNs/DPHNOs and their supervisors were interviewed. The role of the DPHNs has reduced over the years because they have not been assigned new roles with change in programmes and policies. Most of the DPHNs have training for clinical work in hospitals. Their 10 month training to qualify for PHN is inadequate to develop knowledge and skills in public health. There is a gap between their training and posting due to delays in government procedures of promotion. The DPHN/DPHNOs spend majority of their time in the office (49%) where they have a limited role. Their supervisory role for nurses and midwives has lost its importance. They spend about 1/3rd of their time in field supervision mostly visiting centres accessible by public transport as they do not have an allotted government vehicle. As they do not submit any field report, there is no follow-up action from their visit. Nevertheless they seem to have an important role in solving problems of field workers as they are mediators between the district and peripheral facilities. To conclude the DPHNs are
underutilized which affects the quality of maternal and child health services in
the district.

Abhay Shukla, et al (2011) writes on “Community Monitoring of Rural Health Services in Maharashtra” in ‘Economic & Political Weekly’. What happens when villagers are allowed to monitor their local public health facilities? India’s National Rural Health Mission is making such accountability a reality through its community-based monitoring initiative. This article presents the first three rounds of data collected by village health committee members in Maharashtra’s 225 pilot villages. The obstacles encountered by the process and its strengths and limitations are also discussed.

Agarwal (2011) published a paper on “The State of Urban Health in India: Comparing the Poorest Quartile to the Rest of the Urban Population in Selected States and Cities” in ‘Environment and Urbanization’. India has the world’s second largest urban population (after China). This paper shows the large disparities within this urban population in health-related indicators. It shows the disparities for child and maternal health, provision for health care and housing conditions between the poorest quartile and the rest of the urban population for India and for several of its most populous states. In the poorest quartile of India’s urban population, only 40 per cent of 12 to 23 month-old children were completely immunized in 2004–2005, 54 per cent of under-five year-olds were stunted, 82 per cent did not have access to piped water at home and 53 per cent were not using a sanitary flush or pit toilet. The paper also shows the large disparities in eight cities between the poorest population (the population in the city that is within the poorest quartile for India’s urban areas), the population living in settlements classified as “slums” and the non-slum population. It also highlights the poor performance in some health-related indicators for the population that is not part of the poorest quartile in several states – for instance in under-five mortality rates, in the proportion of stunted children and in the proportion of households with no piped water supply to their home.
Monika Jain and Priyadarshi Patni (2011) writes on “Public Health Management in India: An Overview of ICDS” in ‘Indian Journal of Management and Technology’. Health of people is not only a desirable goal but it is also an essential investment in human resources. Various intervention programmes have been launched by the government to improve the provision of basic services pertaining to public health and to devise a security system through which the most vulnerable section, viz., women and children could be protected. The Integrated Child Development Services (ICDS) programme is the reflection of the Government of India to effectively improve the nutrition and health status of underprivileged section of the population through direct intervention mechanism. ICDS is the world’s most unique health and welfare programme, which holistically addresses health, nutrition and development needs of young children, adolescent girls and women across the life cycle. In addition, the programme also addresses goals of universal elementary education and other primary health care goals. The convergence of services has resulted in better prenatal and immunization coverage in the ICDS blocks. In built monitoring system is the salient feature in this programme management, which draws attention to implementation flaws immediately and given an edge to this intervention based public health programme over others. This paper examines the strengths and weaknesses of management in ICDS and suggests what is required to enhance its impact.

Thresia and Mohindra (2011) in their paper “Public Health Challenges in Kerala and Sri Lanka” published in ‘Economic & Political Weekly’, remarked that despite their relatively modest economies, some of the basic population health indicators of Kerala and Sri Lanka are similar to that of the developed nations. Following a review of recent evidence on infectious diseases, non-communicable diseases, mental health and suicides, and maternal mortality, this paper argues that there are challenges arising from declining investments in the public health sector (and increasing privatization) and inadequate attention to the social determinants of health. It also lists suggestions for policy and a research agenda to further health equity.
As described by Zakir Hussain (2011) in their paper entitled “Health of the National Rural Health Mission” published in ‘Economic & Political Weekly’, the National Rural Health Mission was introduced as a flagship scheme of the United Progressive Alliance government in 2005-06 to address the needs of the rural population through an architectural correction of the health system. With the completion period drawing to a close in 2012, this paper critically evaluates the success of the intervention strategies under this scheme. Based on rapid appraisal surveys in selected districts, three common review missions by the Ministry of Health and Family Welfare, and data reported on the NRHM website, this paper attempts a desk review of the progress of the mission with respect to its core strategies – provisioning of health services to households through accredited social health activists, strengthening rural public health facilities, enhancing capacity of panchayats to control and manage provisioning of health services and positioning of an effective health management information system.

Bangdiwala, et al (2012) published a paper entitled “Public Health Education in India and China: History, Opportunities, and Challenges” in ‘Public Health Reviews’. Public health education in China and India has a long history that has been both deeply responsive to the unique needs and medical traditions of each country and sensitive to global influences. The history of public health education in China reaches back several centuries, with substantial input from American and European organizations during the Republican Era, 1911-1949. In India, centuries-old health care traditions were influenced during the colonial period by the British Empire prior to independence in 1947. Political upheaval in both countries during the 1940s further impacted the public health systems as well as public health education. The primary goal of this review is to outline public health education in India and Mainland China, with a focus on describing the historical systems and structures that have promoted the development of formalized public health education. The authors examined current challenges, and analyze opportunities for improvement. Health reforms in China and India need to consider new and
modern models for public health education, perhaps in independent faculties of public health, to reinvigorate public health education and strengthen the position of public health in addressing the health challenges of the 21st century.

**Bhuputra Panda, et al (2012)** published a paper “Public Health Nutrition Programmes in Odisha: A Conceptual Approach to Assessment of Intervention Subject: Medicine” in ‘Global Research Analysis’. Under nutrition is a global issue. India ranks second in world of the number of children suffering from malnutrition. Odisha is located in the eastern zone of India, shares about 8% of the total under nutrition burden of the Country. Despite of several flag-ship programme interventions by the Government of India and the State Government of Odisha, under nutrition especially amongst 0-6 years children has not shown any significant decline over last five decades. This paper analyzes the existing public health nutrition interventions in the State using the conceptual framework of UNICEF and provides future directives for generating evidences towards setting programme and policy objectives.

**Choudhury (2012)** writes on “Health Seeking Behavior and Health Related Resources in Amolapaam Village of Sonitpur District, Assam: A Participatory Research Approach” in ‘PARIPEX: Indian Journal of Research’. Health seeking behaviour is an important issue in health management, but unfortunately, it is not given proper importance by the policy makers for which the health care schemes are incapable to touch those people for whom the schemes have been introduced. This paper based on Participatory Rural Appraisal tried to fulfill the twin objectivise viz to study health seeking behaviour of the people living in Amolapaam village of Sonitpur district, Assam and to study the availability of health related resources in the village. The paper has indicated that the Amolapaam village is out of reach of different health related schemes.
Padma Bhat-Deosthali, et al (2012) published on “Addressing Domestic Violence within Healthcare Settings: The Dilaasa Model” in ‘Economic & Political Weekly’. Women experiencing violence most often decide to seek legal action only after the violence has escalated and that too without having any documentary evidence. The Dilaasa crisis centres at two public hospitals in Mumbai since 2001 have been established out of the recognition that the public health system is an important site for the implementation of anti-domestic violence intervention programmes. The crisis centres therefore straddle both discourses of public health and gender. The paper offers critical insights into the model and its impact in terms of its ability to reach out to women who are undergoing abuse and offer them multiple services in one setting.

Ravi Duggal (2012) writes on “Challenges in Financing Healthcare” in ‘Economic & Political Weekly’. The Third People’s Health Assembly was held in July in Cape Town, South Africa with its theme of “Health for All Now”. Developing countries which transformed public health systems under the structural adjustment policies into insurance-based health models have failed in providing healthcare to the poor. Where does India stand in relation to the ruling United Progressive Alliance’s commitment to take public health spending to 3% of the GDP by 2012.

Sathyamala, et al (2012) published “Public Report on Health: Some Key Findings and Policy Recommendations” in ‘Economic & Political Weekly’. A bottom-up view of the health conditions and services in six states – three performing and three not-so-well performing ones – was arrived at through a study by a multidisciplinary team with varied experiences in health research. This paper presents the results of a Public Report on Health that was initiated in 2005 to understand public health issues for people from diverse backgrounds living in different region-specific contexts. The findings, which have policy implications, have been used to analyze the ongoing official attempts to deal with the various challenges thrown up by the National Rural Health Mission.
Shankar Prinja, et al (2012) writes on “Health Care Inequities in North India: Role of Public Sector in Universalizing Health Care” in ‘Indian Journal of Medical Research’. Income inequality is associated with poor health. Inequities exist in service utilization and financing for health care. Health care costs push high number of households into poverty in India. The authors undertook this study to ascertain inequities in health status, service utilization and Out-Of-Pocket (OOP) health expenditures in two States in north India namely, Haryana and Punjab, and Union Territory of Chandigarh. Data from National Sample Survey 60th Round on Morbidity and Health Care were analyzed by mean consumption expenditure quintiles. Indicators were devised to document inequities in the dimensions of horizontal and vertical inequity; and redistribution of public subsidy. Concentration Index (CI), and equity ratio in conjunction with concentration curve were computed to measure inequity. Reporting of morbidity and hospitalization rate had a pro-rich distribution in all three States indicating poor utilization of health services by low income households. Nearly 57 and 60 per cent households from poorest income quintile in Haryana and Punjab, respectively faced catastrophic OOP hospitalization expenditure at 10 per cent threshold. Lower prevalence of catastrophic expenditure was recorded in higher income groups. Public sector also incurred high costs for hospitalization in selected three States. Medicines constituted 19 to 47 per cent of hospitalization expenditure and 59 to 86 per cent OPD expenditure borne OOP by households in public sector. Public sector hospitalizations had a pro-poor distribution in Haryana, Punjab and Chandigarh. The analysis indicates that public sector health service utilization needs to be improved. OOP health care expenditures at public sector institutions should to be curtailed to improve utilization of poorer segments of population. Greater availability of medicines in public sector and regulation of their prices provide a unique opportunity to reduce public sector OOP expenditure.
Sinha (2012) writes on “Health Evidence from the States” in ‘Economic & Political Weekly’. The quality of implementation of the National Rural Health Mission in a number of states has transformed the public healthcare system considerably. Learning from these improvements which have focused on the grass roots, local recruitment is the best way to forge a credible public health system that has public accountability.

Sorenson, et al (2012) writes on “Health Literacy and Public Health: A Systematic Review and Integration of Definitions and Models” in ‘BMC Public Health’. Health literacy concerns the knowledge and competences of persons to meet the complex demands of health in modern society. Although its importance is increasingly recognized, there is no consensus about the definition of health literacy or about its conceptual dimensions, which limits the possibilities for measurement and comparison. The aim of the study is to review definitions and models on health literacy to develop an integrated definition and conceptual model capturing the most comprehensive evidence-based dimensions of health literacy. A systematic literature review was performed to identify definitions and conceptual frameworks of health literacy. A content analysis of the definitions and conceptual frameworks was carried out to identify the central dimensions of health literacy and develop an integrated model. The review resulted in 17 definitions of health literacy and 12 conceptual models. Based on the content analysis, an integrative conceptual model was developed containing 12 dimensions referring to the knowledge, motivation and competencies of accessing, understanding, appraising and applying health-related information within the healthcare, disease prevention and health promotion setting, respectively. Based upon this review, a model is proposed integrating medical and public health views of health literacy. The model can serve as a basis for developing health literacy enhancing interventions and provide a conceptual basis for the development and validation of measurement tools, capturing the different dimensions of health literacy within the healthcare, disease prevention and health promotion settings.
Susan Thomas (2012) writes on “Affordable Mobile technology towards Preventive Health care: Rural India” in ‘IOSR Journal of Dental and Medical Sciences’. Most of the chronic non-communicable diseases are consequences of unhealthy lifestyle practices, resulting in premature morbidity or mortality. The cost of treating chronic diseases has increased the economic and social burden nationally as well as globally. In developing countries such as India, approximately ¾ of the population reside in rural areas experiencing inequalities in health care access. Mobile phone usage has increased globally. These devices are commonly used by the community and are affordable to all segments, especially the rural population. Innovative mobile health technology with public-private partnership can sensitize customers on various health products and services by mobile apps or text messages. Empowered by many preventive health care programs, the m-health text message technology becomes a potential powerful tool for behaviour change as it is widely available and inexpensive. By improving the health-care seeking behaviour and treatment compliance, the efficiency of treatment could increase thus reducing the costs to health plans. This paper discusses the implication of mobile phone messaging to improve the process of health care delivery and health service. Through increase preventive care use, today’s patients and community health workers can make better choices to successfully modify their behaviour and become healthy and productive citizens.

Alma Pentescu, et al (2013) published a paper on “The Positioning of the Private Healthcare Providers in Romania: An Important Strategic Approach” in ‘Indian Journal of Applied Research’. According to data provided by MEDNET Marketing Research Center, the number of people who used private healthcare services has increased, in Romania, from 40.1% in 2008 to 80% in 2012. Given the fact that the Romanian healthcare market was 5.3 billion Euros worth, in 2011, of which 500 million Euros accrue to the private healthcare sector, it may safely be said that the private healthcare services in Romania are a successful business. To improve their efficiency on this market, the private healthcare providers in Romania are becoming
increasingly concerned about knowing their customer’s expectations, measuring customer’s satisfaction and differentiating against competitors. The elaboration of appropriate strategies involves the need for market positioning of these providers, positioning being a powerful tool that creates and maintains real differences between brands on the market. This paper aims to argue the importance of positioning to the private healthcare providers, to display the positioning of a leading private healthcare provider on the healthcare market in Sibiu (Romania) and to highlight the impact of positioning on the marketing mix variables.

Anitha and Navitha Thimmaih (2013) published a paper “Satisfaction From Primary Health Care Services: A Comparative Study of Two Taluks in Mysore District” in ‘PARIPEX: Indian Journal of Research’. The utilization of any social services including health services have never been equitably distributed throughout society is proved by many studies. Along with utilization, it is also important to check the satisfaction associated with access to social services especially health services and its association with other variables. It would be interesting to examine the relationship between utilization and satisfaction. Because the utilization rates itself does not disclose whether the users are satisfied with public health services delivered through Primary Health Centres (PHCs) or not. In this context the present paper made an attempt to study the utilization of public health services along with satisfaction through a comparative study. The results indicated that higher utilization is not a sign of higher satisfaction in the context of Primary Health Centres. Further the study identified some variables like Doctor’s availability, Quality of Service, Cleanliness etc., influencing satisfaction in study area so that right decisions are taken in order to increase the satisfaction rates associated with PHCs.

Beena Joice (2013) published on “A Study on Workforce Challenge in Healthcare Industry: An Imperative Factor” in ‘Indian Journal of Applied Research’. With the increased competition and competitors in this corporate world, every organization must focus on being more adaptable,
resilient, nimble, employee and customer oriented to accede. The Predominance of the word challenge, irrespective of the sectors has left no space without the buzz of notes like satisfaction, talent hunt, versatility, compensation, workforce management, recruitment, retention and so on for the organization to survive. Healthcare sector is preferred, by looking at the rate of the growth in India which is moving ahead and is neck to neck with the pharmaceutical, software, construction industry of the country. Amidst this, healthcare sector faces innumerable challenging factors of talent management, training, workforce planning, recruitment and retention. The study is been planned to find out the challenging tasks of attracting, recruiting, training and retaining in this sector and the possible ways to move ahead for better accomplishment.

Imrana Qadeer (2013) written a paper “Universal Health Care in India: Panacea for Whom” in ‘Indian Journal of Public Health’. This paper examines the current notion of universal health care (UHC) in key legal and policy documents and argues that the recommendations for UHC in these entail further abdication of the State’s responsibility in health care with the emphasis shifting from public provisioning of services to merely ensuring universal access to services. Acts of commission (recommendations for public private partnership [PPPs], definition and provision of an essential health package to vulnerable populations to ensure universal access to care) and omission (silence maintained on tertiary care) will eventually strengthen the private and corporate sector at the cost of the public health care services and access to care for the marginalized. Thus, the current UHC strategy uses equity as a tool for promoting the private sector in medical care rather than health for all.

Mir Parvez (2013) writes on “Satisfaction of Healthcare Professionals towards Performance Appraisal System (PAS)” in ‘Indian Journal of Applied Research’. In the current era of globalization, organizations need to focus on human resource performance appraisals to get maximum out of minimum. Research has revealed that the reliability of PAS increases if it is
properly linked with other HRD instruments and moreover helps in strategic decision making. The research paper tries to explore the satisfaction level of healthcare professional towards performance appraisal system. It has been found that the existing PAS needs to be re-engineered with other HRD instruments to bring the satisfaction among employees.


Nayar (2013) published a paper entitled “Universalizing Health Services in India: The Techno-managerial Fix” in ‘Indian Journal of Public Health’. The non-universal nature of health services in India can also be the result of many reforms and milestones the health services had passed through since independence. The reform era during the post-nineties is replete with many new trends in organizational strategies which could have led to crises in health services. The salient crises need to be dissected from a larger societal crisis and the specific crises in the health services system. It is evident that non-accessibility and non-availability and the sub-optimal functioning of the primary health centers are perennial issues which could not be addressed by indigenous, imposed or cocktail reforms (such as National Rural Health Mission) and by targeting as these only tinker with the health services. Needless to reiterate that there is a need to address the social dimensions which fall outside the technical sphere of health services. This paper based on an analytical review of relevant literature concludes that any efforts to universalize health and health-care can not only focus on technical components but need to address the larger social determinants and especially the societal crisis, which engender ill-health.
Poonam Mahajan (2013) published a paper “Regulations and their Scope in Public Health” in ‘PARIPEX: Indian Journal of Research’. From the inception of public health as a discipline, separate to mainstream healthcare, a body of law has developed in many countries which is intended to aid in preventing and containing disease. Public health law has come a long way from its beginnings in the original health acts of the 19th century, focusing on condition of sanitation and noxious environments. Now, most high-income countries (and a substantial proportion of low and middle income countries) have enacted more or less comprehensive legislation around control and reporting of infectious disease; quarantine; food hygiene, and so forth. These laws operate quietly in the background to greater or lesser extents throughout the world, and are an integral part of any country’s strategy around preventive health. This paper has incorporated some important regulation in the field of public health in India and a small discussion about the feasibility of these regulations.

Ritu Priya and Anjali Chikersal (2013) published a paper on “Developing a Public Health Cadre in 21st Century India: Addressing Gaps in Technical, Administrative and Social Dimensions of Public Health Services” in ‘Indian Journal of Public Health’. This paper presents a possible framework for designing a public health cadre in the present context, with lessons from health services development of the last six decades. Three major gaps that the public health cadre is meant to bridge have been identified. These are capacities within the system to address the technical requirements (epidemiological and health systems analysis); administrative/managerial dimensions; and the social determinants of health. Therefore, it argues that the cadre must not only have a techno-managerial structure, but also create a specific sub-cadre for the social determinants of health.

Shankar Prinja, et al (2013) published an article entitled “Equity in Hospital Services Utilisation in India” in ‘Economic & Political Weekly’. Studies from a number of low-income countries have found that the wealthy often use publicly financed health services at a higher rate than the poor. To
examine the situation in India, the use of public and private sector hospital services by economic class was analyzed and the relationship between utilization and public spending on health services and the reported Out-Of-Pocket (OOP) payments were assessed. Not surprisingly, hospital services in the private sector were found to be significantly pro-rich. In contrast to previous studies, it was found that India’s poor report using hospital services in the public sector at a higher rate than the wealthy, particularly in urban areas. However, this varied across states. High OOP expenditure correlated with higher degrees of inequity, and was a likely barrier to accessing care for the poor. Further work is required to explore the significant variation seen between states and to understand the history of its development. A number of policy options are discussed to reduce inequities in access to public health services in India.

Sharma (2013) published an article entitled “Sustainability and Quality in Health Care System: Organizational Structure-Process Approach” in ‘Indian Journal of Applied Research’. Concerns about sustainability in Health services are driven by the common observation that over time satisfactory outcomes are not achieved and adverse effects are observed. As the government healthcare sector increasingly feels the impacts of a professional’s shortage, retention of skilled clinical staff becomes paramount in context to output and uninhibited delivery of any service. Present study was planned to find out the role of organizational factors in retention of health care professionals, and Quality of Patient Care (QPC) in government hospitals. For this purpose, a detailed field study was conducted on 150 healthcare professionals. Findings indicate that continued functioning of healthcare system as well as meaningful and goal oriented performance depends not only physical resources but organizational and human resource issues are also crucial. Present study advocates that at the level of planning and implementation the organizational structure and process factors must be considered as important system variables.
Adeel Maqbool and Siraj Ahmad (2014) write a paper “Total Quality Management through Five ‘S’ in Health Care Organizations” in ‘International Journal of Scientific Research’. With increasing competition, advances in medical sciences, and rising patient expectations, the health care systems have become complex organizations. They need to obtain an optimum balance between the resources and patient satisfaction. Total quality management (TQM) has a great potential to address quality problems in a wide range of industries and improve the organizational performance. Juran (1995) has defined TQM as the system of activities directed at achieving delighted customers, empowered employees, higher revenues, and reduced costs. It is a philosophy aimed at continuously improving the quality and process to achieve customer satisfaction. Simply stated, it is the building of quality into products and process making quality a concern and responsibility for everyone in the organization. Total quality management (TQM) has a great potential to address quality problems in a wide range of industries and improve the organizational performance. The growing need to take initiatives by hospitals in other countries to improve the service quality and reduce wastage of resources has inspired the researcher to develop a survey instrument to measure health care quality and performance in the hospitals. Five-S, a simple tool was utilized as the initial step towards total quality management activities at a public hospital in Sri Lanka. This paper introduces the system improvement activities at the hospital which won several awards for quality of service at national level. Though there are multiple reasons for the significant improvement of performance at the hospital, the study team observes that Five-S has contributed heavily towards the success.

Doke, et al (2014) published an article “Community Based Monitoring Under National Rural Health Mission in Maharashtra: Status at Primary Health Centers” in ‘Indian Journal of Public Health’. This study compares the implementation of Community-Based Monitoring (CBM) in 45 Primary Health Centers (PHCs) in the pilot phase in Maharashtra with the equal number of randomly selected PHCs not implementing CBM (non-CBM)
from the same districts. Information was collected by teams from Community Medicine Departments by visiting selected PHCs. Establishment of monitoring committees and training of medical officers (MOs) had been completed as required but only 36.36% MOs were trained. Only 43.18% MOs received the facility report card. Most of the MOs (90.90%) attended Jansunwai and opined that it had increased community awareness and the barriers between the people and PHC staff were broken. There was no difference in fund utilization and meetings of Rugna Kalyan Samittees. Percentage of Institutional deliveries and women receiving Janani Suraksha Yojana benefits among home deliveries was more in the non-CBM group of PHCs.

Neamtiu and Cristian Pop (2014) write on “Public Health Assessment of Heavy Metals and Cyanides Exposure in Baia Mare Area” in ‘International Journal of Scientific Research’. Exposure to heavy metals was associated with health outcomes such as impaired development, cancers, kidney damage, cardio-vascular diseases. An evaluation was performed in order to assess the levels of exposure to heavy metals and cyanides in a population group living in the mining area of Baia Mare. Biological samples (blood, urine) were collected from the study participants living in the area and lab analyses were performed to measure the levels of the biomarkers of exposure to heavy metals and cyanides, in the biological fluids. An environmental health questionnaire was applied to the study participants. Higher than normal levels of biomarkers of exposure were measured in the investigated population sample, indicating that exposure to heavy metals continues and may increase in the absence of coherent and efficient policy actions.

Penchalaiah and Sobha (2014) published a paper on “Socio-Economic Inequality and its Effect on Healthcare Delivery in India: Inequality and Healthcare” in ‘PARIPEX: Indian Journal of Research’. Healthcare resources in India though not adequate, are ample. There has been a definite growth in the overall healthcare resources and health related manpower in the last decade. The number of hospitals grew from 11,174 hospitals in 1991 (57%
private) to 18,218 (75% private) in 2007. In 2000, the country had 1.25 million doctors and 0.8 million nurses. It shows that effects of social and economic inequality on health of a society are profound. In a large, overpopulated country like India with its complex social architecture and economic extremes, the effect on health system is multifold. Unequal distribution of resources is a reflection of this inequality and adversely affects the health of under-privileged population. The socially under-privileged are unable to access the healthcare due to geographical, social, economic or gender related distances. Burgeoning but unregulated private healthcare sector makes the gap between rich and poor more apparent.

Santoshkumar (2014) published an article entitled “Spatial Pattern of Primary Healthcare Services in Sonipat District 2012” in ‘PARIPEX: Indian Journal of Research’. The Present study covered Sonipat district (Haryana) located at 28°.98’N 77°.02’E. The study has been found out Spatial Pattern of Primary Healthcare Services in Sonipat District in 2012. Sonipat and Gohana have high primary healthcare services, Kharkhoda have moderate services and Ganaur have low primary healthcare services. There are many regions found by which the failure of referral mechanism in the public health care system.

Sowmya Paul and Amulya (2014) write on “Foreign Direct Investment in Indian Health Care Sector” in ‘Indian Journal of Applied Research’. The role of Foreign Direct Investment (FDI) in developing countries like India becomes considerably a key driver of economic growth. FDI contributes for the Development of the country in the form of development of Multinational companies (MNCs) in India, which provides education and training for their employees and brings new skills, information and technology to host country. The Foreign Institutional Investors (FII) are being a major support for the development of corporate hospitals in the country. Hence an attempt has been made to analyze the impact of FDI in Hospitals through several literature reviews, using secondary data and with the help of personal interviews of administrative staff of Mysore corporate hospitals.
Zahrani (2014) published an article “The Impact of Pharmaceutical Promotions on Primary Health Care Physicians’ Prescribing Behaviour in KAMC in Central Region” in ‘International Journal of Medical Science and Public Health’. Doctors are the main prescribers of medication for the patients. There are many factors that affect prescribing behaviour such as pharmaceutical promotions. To assess drug representatives’ influence on physicians’ prescription, to assess physician’s attitudes towards drug representatives and to study other factors that may affect the prescribing behaviour of physicians, the present study was made. A Cross-sectional study was conducted among 275 GPs and family physicians working in all primary care centres in KAMC in Central Region in 2011-12. A self-administered structured questionnaire was used. The questionnaire included questions regarding socio-demographics, clinic work load for physicians, factors influencing prescribing of a new drug including gifts offered by drug representatives, reference sources used for prescribing, CME hour characteristic and sponsorships by drug representatives and physician beliefs about impact of pharmaceutical promotions on prescribing. The findings revealed that of the physicians, 204 filled the questionnaire (response rate 74.2%), nearly 72% were non-Saudi, 71.6% were staff physicians and 59.8% had more than 10 years of practice. Guidelines updating and drug characteristics were the most important factors influencing physician’s prescription of a new drug, while the least factor influencing their prescribing was drug representatives. The most frequent resources used by physicians in case of any problems in prescribing process were textbooks. A minority of physicians was partially influenced by drug representative promotions affecting their prescribing patterns. Most of the doctors were not affected by gifts or drug related information given by the representatives. Majority of physicians relied on latest guidelines from medical literature and other standard references in writing prescriptions.
2.3. References:


