CHAPTER - II

REVIEW OF LITERATURE

The present chapter examines and reviews the studies conducted by various researchers in the field of rural health-care management and community participation in health-care activities. This chapter discusses issues under various sub-headings to understand the health-care approaches in terms of the rural health-care management flows, performance of health-care services in rural centres, providing facilities to the beneficiaries, improvement in health-care infrastructure, delivery services to the beneficiaries, community participation programmes and delivery of quality health-care services in the rural healthcare sector. These areas are covered under two sections, viz., (i) national experiences of rural health-care management, and (ii) international experiences in rural health-care management

2. 1. National Experiences

2. 1.1. Management role in primary healthcare centres. Some of the recent studies in this area are discussed in the succeeding paragraphs.

Dileep v. Mavalankar (2008). This study explores the primary health-care system in India. This study is very large and covers almost all the parts of the country. It has more than 20,000 PHCs and 140,000 sub-centres spread in more than 400 districts. This system consumes a large amount of resources and provides the services for primary care including the preventive programme. The system is mainly managed by doctors, some of whom have brief public health training. This study argues that, given the lack of training of doctors in management. It is imperative that the doctors who are put in charge of the PHC system receive reasonable skills and training in management so that the resources spent on the PHC system can be utilised well - in an efficient and effective manner. Unfortunately, the experience so far has been that there is hardly any systematic effort on an adequate scale to meet the training needs of the PHCS system for management training. The efforts done so far, even under the international supported projects, are too less and of poor quality. It is also observed that most of the management training is very divorced from the day-to-day realities of the working of the PHC system
and the kind of challenges they face. Finally, the study argues that substantial efforts will be needed to be put in preparing doctors for the management posts in the PHC system. This will require large investments in training and linking training to practice in the field. **Haines; R. Horton and Z. Bhutta (2007). This** brings out the vision of primary health-care (PHC) in the Alma Ata declaration and highlights some of the management concepts between this and the selective approach to PHC, which promotes a few cost-effective interventions. The study explains that, despite movements towards selective packages of health-care and health-care reforms, the idea of PHC, as described in the Alma Ata declaration, is attracting renewed interest. There are several reasons for this. Shortages in health workers, especially in developing country or states, have showed renewed interest in the role of community-health workers. The study also highlights the growing research evidence about the cost-effectiveness of some components of PHC, such as the role of community participation improving neonatal and maternal mortality in India. PHC is also better able to address pervasive health inequalities, poor coverage of basic health-care, and lack of engagement by communities in health systems.

**H.M Swami and Vikas Bhatia (2005).** This study examines the primary health-care system over the decade, the achievements made in the country through implementation of primary health-care delivery system has resulted in longevity of life. Today, India has 70 million elderly populations over 60 years of age. However, the current health policies and programmes do not address significantly to raise their health status to the desired level, if the existing primary healthcare infrastructure in form of manpower and health centres are utilized. With some training to health-care providers, the health-care status of the elderly can be improved.

Initiation of the primary healthcare programme in India. The major thrust has been on improving the health status of children and women. Almost all the national programmes have been implemented either to control tropical diseases or are concerning maternal and child health besides family welfare. Over the years, the country has made substantial gains in not only improving health indicators, but also developed an extensive network of health-care delivery system throughout the country.

**Amlan Majumder v. Upadhyay (2004):** This study focuses on the analysis of the primary health-care system in India with focus on reproductive health-care services.
The health-care system in India, at present, has a three-tier structure to provide health-care services to its people. The primary health-care has been developed to provide health-care services to the vast majority of rural people. The primary tier comprises three types of health-care institutions: (i) sub centre (SC), (ii) primary health centre (PHCS), and (iii) community health centre (CHC). The rural health-care infrastructure has been developed to provide primary health-care services through a network of integrated health and family welfare delivery system. India is a signatory to the Alma Ata declaration of 1978 and expressed its commitment to attaining the goal of “health for all by the year 2000 A.D” through the universal provision of primary health-care services (Government of India, 1983). However, India could neither achieve reproductive health related goals (Srinivasan, 2000 and Sood, 2000), nor could it develop a good health-care infrastructure for rural people (Majumder, 1999). Productivity, efficiency and quality of care of public rural health service sector have always been questioned from many different fields. The present study attempts to reveal the true condition of the system by examining the relationship between efforts and accomplishments in primary health-care

Nirupam Bajpai and Sangeeta Goyal (2004). This study brings out that. India’s achievements in the field of health-care have been less than satisfactory and the burden of disease among the Indian population remains high. Infant and child mortality and morbidity and maternal mortality and morbidity affect millions of children and women. Yet, health-care is inadequate in terms of coverage of the population, especially in rural areas, and grossly underutilised because of the dismal quality of health-care provided. In most public health centres which provide primary health-care services, drugs and equipments are missing or in short supply, there is shortage of staff and the system is characterised by endemic absenteeism on the part of medical personnel due to lack of oversight and control. As a result, most people in India, even the poor, choose expensive health-care services provided by the largely unregulated private sector. Not only do the poor face the double burden of poverty and ill-health, the financial burden of ill health can push even those on the brink of poverty into poverty. Public investment in health, and in particular in primary health-care, needs to be much higher to achieve health targets, to reduce poverty and to raise the rate of economic growth. Moreover, the health system
needs to be reformed to ensure efficient and effective delivery of good quality health services.

**Helen Keleher**, (2001). This study discusses why primary health-care offers a more comprehensive approach for tackling health inequities than primary care. The study attempts to focus more intently on how to deal with alarming measures of health disadvantage and inequities. Simultaneously, in the study about this area, whether intended or not, primary health-care and primary care are terms that are increasingly interchanged. This study argues that this slippage in language is counter-productive. First, because it disguises the transformative potential of strategies and approaches that can make the fundamental changes necessary to improve health status and secondly because the structures and practices of primary care sector are not necessarily compatible with notions of comprehensive primary health-care. There is much to be lost if primary health-care and health promotion are disguised as primary care, and not understood for their capacity to make a difference to health inequities although of course, comprehensive primary health-care is interdependent with services provided by primary care.

**Madhurim Nudni** (2000). This study examines the primary health-care scenario in India: review of policy, plan and committee reports the Alma Ata declaration of 1978 gave an insight into the understanding of primary health-care. It viewed health as an integral part of the socioeconomic development of a country. It provided the most holistic understanding to health and the framework that states needed to pursue to achieve the goals of development. The declaration recommended that primary health-care should include at least: education concerning prevailing health problems and methods of identifying, preventing and controlling them; promotion of food supply and proper nutrition, and adequate supply of safe water and basic sanitation; maternal and child health-care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health and provision of essential drugs. It emphasized the need for strong first-level care with strong secondary- and tertiary-level care linked to it. It called for an integration of preventive, promotive, curative and rehabilitative health services that had to be made accessible and available to the people, and this was to be guided by the principles of universality, comprehensiveness and
equity. In one sense, primary health-care reasserted the role and responsibilities of the state, and recognized that health is influenced by a multitude of factors and not just the health services. It also recognized the need for a multi-sectoral approach to health and clearly stated that primary health-care had to be linked to other sectors.

**Imrana Qadeer (1999).** Though India signed the Alma Ata declaration in 1978 and pledged its implementation, the Sixth Five Year Plan made no mention of it. The programme of immunisation and later the child survival strategies were promoted, and selective PHCS silently became a part of health sector planning” balance, reach out to the majority, build basic infrastructure, and contextualize health within social and economic development (government of India 1980). The other, more pragmatic, pushing selective PHCS and population control strategies in the name of primary health-care. The question that is posed is: does the World Bank’s strategy tend to promote the latter?

**2. 1.2. Rural Healthcare Issues and Challenges**

**B. S. Ghuman & Akshat Mehta (2009).** This study examines the problems and prospects of health-care services in India. India as a nation has been growing economically at a rapid pace particularly after the advent of new economic policy of 1991. However, this rapid economic development has not been accompanied by social development - particularly in the health sector. Health sector has been accorded very low priority in terms of allocation of resources. Public expenditure on health is less than 1 per cent of GDP in India. It has further witnessed a decline during the post economic liberalisation period. The resource allocation to the health sector has adversely affected both access and quality of health services. The unequal access to health services is reported across strata, gender and location (i.e., urban and rural areas). With a view to improve access and quality of health services, government should enhance public spending on health sector in the vicinity of 3 per cent of the GDP. A principal objective of this study is to examine the access of health services across economic strata, gender and space; to examine the quality of health services in India; and to suggest appropriate recommendations to revamp health policy and institutional mechanisms to improve access and quality of health services particularly for the excluded segments of society.

**Healthcare System 2020 Report (2008).** The study identifies healthcare issues and challenges and reviews some experience with interventions to improve health
delivery. Interventions aimed to: improve the policy process in the health sector by promoting more effective stakeholder engagement, enhancing participation at a variety of levels to promote more effective delivery of health programmes, and improving accountability and transparency in the health sector. The study concludes that good health-care delivery emerges from the actions and linkages among the state, providers of health-care services and citizens. Health-care delivery improvements through their impacts on rules, roles, responsibilities and institutions – affect the availability, quality, distribution and utilisation of health services. Efforts to increase the quality of health-care governance constitute worthwhile and effective undertakings for improving health systems functioning and for increasing the provision and utilisation of health services

Medical and Public Health Report (2008). According to the study, the main objective of the state is to actively promote the welfare of the people by extending promotive, preventive, curative and rehabilitative health-care services. To achieve the objective, the state has taken steps to improve the health-care delivery system so that it can reach the poorest section of the society by construction of buildings to provide more beds, provision of sophisticated equipments, providing specialised services, enhancing the strength of the medical, as well as paramedical, personnel and by improving the quality of services rendered. The important objectives of the health and family welfare sector are as follows:

1) To provide effective tertiary care to all sections of the public by making available the modern medical techniques and technologies in government teaching hospitals
2) To provide research relevant to human development and quality of life
3) To increase the access and utilization of health services, particularly among the unreached and underserved population
4) To design and implement the effective interventions in the area of maternal and child health to reduce IMR and MMR to the expected levels
5) To implement schemes for prevention and control of communicable diseases and non-communicable diseases with special focus on newly emerging vector borne diseases and life style diseases
6) To create awareness and to ensure timely availability of accident and trauma care services to reduce morbidity and mortality.

Rygh EM, Hjortdahl P (2007). The study explains the possible ways to improve health-care services in rural areas. While there is abundant literature on making health-care programmes integrated, interdisciplinary and managed in order to reduce fragmentation and improve continuity and coordination of care, only some part of this relates to rural issues. An added challenge is the lack of a generally accepted international definition of rurality, which makes it difficult to generalise from one region to another, and to develop an evidence-based understanding of rural health-care. In evaluating the study it was found that the development of new forms of interaction is particularly relevant in rural regions - such as interdisciplinary and team-based work with flexibility of roles and responsibilities, delegation of tasks and cultural adjustments. In addition, programmes such as integrated and managed care pathways, outreach programmes, shared care and telemedicine were relevant initiatives. These may be associated with greater equity in access to care, and more coherent services with greater continuity, but they are not necessarily linked to reduced costs; they may, in some cases, entail additional expenses. Such endeavours are to a large extent, dependent on a well functioning primary health-care system as a base.

T. Jamison, & Ramanan Laxminarayan (2007). This study explains the national rural healthcare mission in response to the challenge of sustaining the rural health-care gains in the better-performing states and ensuring that lagging states catch up with the rest of the country, the Indian government has launched the National Rural Health Mission (NRHM). The study explains the current status and future prospects of health financing in India in the light of the NRHM, whose objective is to draw attention to the benefits of public health spending, explore reasons why public spending has been much more effective at improving health outcomes in some regions but not in others, and to apply lessons learnt from the disease control priorities project-India or DCPP-India to the question of how best to deploy the new financial resources made available by the NRHM. The approaches of NRHM take in this study. One can consider health systems to have two broad objectives – to improve the level (and distribution) of health outcomes and to provide financial protection to the population, both from unanticipated large health
expenditures and from income loss. Similarly, as a first approximation, one can consider health systems to have two types of resources at their disposal – financial and system capacity.

**Papiya Mazumdar (2006).** This study, summarising the issue of rural health-care, has placed greater significance in the developing world, mainly due to changing role of the state in providing health-care. This study examines the levels, trends and patterns of public expenditure on health during 1995 to 2006 in India, both at the national and state levels. The study finds that public expenditure on health, as a proportion of GDP, has remained stagnant over the years, with revenue expenditure accounting for the larger share. Among the states, the relatively poor ones were found to be spending more on health, both per capita and as a proportion of GDP, compared to the richer states. It was seen that expenditure on health by the state had not grown adequately along the path of overall economic prosperity, and private out-of-pocket expenditure seemed to be on the rise. The study cites a few alternative health financing strategies based on recent initiatives across the country, which needs to be reviewed with true intent, aiming at equitable, unbiased and universal access to health-care in the years to come.

**George R. McDowell (2005).** The findings of the study on the rural health-care underserved by” national association of community health centres” provides some insights into the character and problem of health-care and access to health-care in rural India. To determine the number of underserved India, an index was created that included poor performance in health status, limited access to primary care physicians, or socioeconomic characteristics. The citizens in the communities in the lowest quartile were then considered to be underserved. The majority of the countries designated as underserved (73 percent), were so designated because of depressed health status rather than access to physicians. In predominantly rural countries, access to physicians was much more significant in determining under service than in urban countries, although more than two-thirds of all rural counties were determined to be underserved by reason of depressed health status alone. There was, indeed, considerable variation in regions of the country in the determinants of medical under service. This suggests that the approaches to ameliorate problems in rural health-care will vary from community to community or state to state.
Kay A. Johnson (2006). This study looks at rural health-care policy and finance barriers, reduced access to preconception care and, reportedly, limited professional practice changes that would improve the availability of needed services. This study reviews barriers and opportunities for rural health-care financing preconception care, based on a review and analysis of state and federal policies. This study describes the states’ experiences with and opportunities to improve rural health-care coverage, through public programmes such as medicaid, medicaid waivers, and the State Children’s Health Insurance Programme (SCHIP). The role of community health centres in providing primary and preventive care to women is also discussed. In these and other public health and health coverage programmes, opportunities exist for rural health-care finance and preconception care for women belonging to the low-income groups. Three major policy directions are discussed. To increase access to preconception care among women of childbearing age, the federal and state governments have opportunities to: (i) improve health-care coverage, (ii) increase the supply of publicly subsidized health clinics, and (iii) direct delivery of preconception screening and interventions in the context of public health programmes.

Purendra Prasad (2000). This study depicts the image of health-care related problems of the rural poor in Gujarat. The study shows that most rural poor have problems in accessing health-care services, not because they lack trust on biomedicine as is commonly perceived, but because of the failure of the state to figure out the social spaces in health-care policies. The corresponding findings of a study of the leptospirosis epidemic in Gujarat show that the speedy supply of drugs, opening of special wards in the hospitals, increased allocation of equipment, doctors, health workers, during the 1997-99 epidemics was less significant to save lives.

2.1.3. NRHM Policies and Approach

Srabanti Mukherjee (2010). According to the study, identifying the relevance of good health of its citizens, in the course of economic and social advancement and elevating the quality of life of our rural citizens, the Government of India has initiated the National Rural Health Mission (NRHM) to carry out crucial correction in our basic health-care delivery network in the rural expanses. The aim of the mission is to perk up the availability of and access to improved health-care facilities by people residing in rural
areas, especially the vulnerable section, viz., the poor, women and children. This study attempts to analyses the effectiveness of NRHM in terms of each of these goals and also overall effectiveness of the mission. 100 rural doctors from the expanse of India, Odisa, Assam, Jharkhand and Chhattisgarh has been interviewed with 10 different small sets of questionnaire based on nine major goals of NRHM for the purpose. Finally these 10 sets were integrated and regressed to find out the effectiveness of the scheme. The study concludes that NRHM has created a very moderate momentum in improving the rural health-care framework. However, due to the inefficiencies in terms of infrastructure, health manpower, implementation of Ayush, lack of penetration of health insurance; it cannot be concluded to be 100% effective.

**NRHM A.P Govt Ministry Report (2008).** The Government of Andhra Pradesh launched the National Rural Healthcare Mission (NRHM) in April 2005. While Andhra Pradesh needs to spend an additional Rs. 17 billion to scale up the rural primary healthcare services, but is not providing quality health-care due to lack of allocation of funding as well as certain management problems. On a per capita expenditure basis, Kerala holds the top ranking and Punjab also has good health-care indices. The lowest ranking is for Bihar. The ranking for Andhra Pradesh is 12, despite the relatively higher expenditure. While funds are, no doubt, needed to improve healthcare and health care indices awareness, equitable distribution and utilization of services is equally critical for the improvement of healthcare indices. Kerala is high in two important dimension equitable spending between income group and efficiency of the use of resource. The implications of scaling up health services in rural areas of these two states, as given by NRHM estimates, are: Andhra Pradesh needed to step up its allocation by almost 44% over 2006-07 in 2008-09, whereas Kerala was required to step these up by 52%. Since these increases are not over one year, but two years, they are impossible to achieve though it is a challenging task.

**S K Satpathy and S Venkatesh (2006).** This study discusses the National Rural Health Mission (NRHM), an ambitious strategy of the government. It aims to restructure the delivery mechanism for rural health-care towards providing universal access to equitable, affordable and quality health-care that is accountable and responsive to the people’s needs, reducing child and maternal deaths as well as stabilising population, and
ensuring gender and demographic balance. The mission is an articulation of the government’s commitment to raise public spending on health from 0.9% of India’s gross domestic product (GDP) to 2.3% of GDP and aims to undertake architectural correction of the health system. The mission will enable the system to effectively handle increased allocation and promote policies that strengthen public health management and service delivery in the country. Wide ranging stakeholder consultations were held over a six-month period with state governments, the Planning Commission, the National Advisory Council, other government ministries/departments, health professionals and nongovernmental organisations (NGOs) to draw up the mission strategy.

Sucha Singh Gill & Ranjit Singh Ghuman (2005). The authors identified the need for prioritising rural health-care particularly from the preventive aspect. This study examines the effectiveness of NRHM, in terms of reach and social marketing initiatives in rural areas, for redressing the growing disparity in health-care facilities between rural and urban Punjab. The study shows that rural health is low down in the priority list of Punjab. It has been mentioned in the study that successive governments have made no concerted effort to rejuvenate the health sector in the rural areas, resulting in deterioration in health services and poor health of the people. This is perhaps because the rural society is unorganised /non-unionised. Hence, the study advocates that necessary treatment plants should be established in the proximity of the towns and cities, cost of which must be borne by the users of these services. The study concludes that, to improve the health services in the rural areas, the village community (through panchayat raj institutions) needs to be involved in the supervision and functioning of the whole system to make it accountable to the users. However, the study does not provide any analytical insight regarding how to implement such system.

Ramesh Bhat & Somen Saha (2004). The authors have found a remarkable deviation in the Union Budget, 2004-05, from the preceding budgets in regard to its specific focus on the social sector. The major thrust area in implementing the recommendation in the National Health Policy (NHP) relates to the reforming the existing institutional health-care delivery system. It is evident from various studies in this regard that the reasons behind the malfunctioning of the prevailing government health-care set up are perhaps its enormous unplanned expansion without giving due
consideration to developing appropriate management structures to handle a large number of employees. Mis correlated fragmentation of the health-care delivery system without any mechanism of coordination and information sharing across departments and various offices involved in implementing the programmes, the structure bear a resemblance to broken hierarchy without any one assuming responsibility of performance or management of key resources. As the study brings out, the system really has remained immature in terms of efficiency in management systems, namely, the financial, personnel, logistics, etc., to implement programmes effectively and with greater degree of transparency.

Arvind Pandey, Nandini Roy, D Sahu, Rajib Acharya (2004). The authors have correlated the utilisation of antenatal care services and assistance received during delivery in the states of Chhattisgarh, Jharkhand and Uttarakhand. Which are characterised by distinct geographical and topographical features. The study focuses on the particular features of the three states. The study concludes that it is necessary for the reproductive and child health programme to visualize a dynamic strategy, giving due consideration to the geographical and socio-economic factors. Hence, it may be said that the issues of availability, accessibility, acceptability, affordability and appropriateness with regard to health-care still persist as disquieting factors. The one and only way out from this problem is to craft the public health system in such a way that it becomes accountable, inexpensive and available by superior management of resources and community initiatives. In this context, the Government of India launched the National Rural Health Mission on 12th April, 2005 across the length and breadth of the country. The major objectives or national rural health mission was to ensure the following:

a. Development of infrastructure of state governments
b. Availability of critical manpower
c. Reach of mobile medical vans
d. Mainstreaming ayush (the homeopathic and ayurvedic doctors)
e. Coordination with the community by ASHA (trained female community health activist ‘ASHA’ or accredited social health activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system).
f. Implementation of public private partnership

g. Inter-sectoral coordination

h. Appropriateness of expenditure planning

i. Penetration of health insurance

**David H Peters, K Sujatha Rao and Robert Fryatt (2003):** The authors bring out that India’s health system was designed in a different era, when expectations of the public and private sectors were quite different. India’s population is also undergoing transitions in the demographic, epidemiologic and social aspects of health. Disparities in life expectancy, disease, access to health-care and protection from financial risks have increased. These factors are challenging the health system to respond in new ways. They argue that the content of national health policy needs to be more diverse and accommodating to specific states and districts. More ‘splitting’ of India’s health policy at the state level would better address their health problems, and would open the way to innovation and local accountability. States would be able to develop policies to deal with the periodic outbreak of non-communicable diseases and more appropriate health financing systems. The central government needs to focus on overcoming the large inequalities in health outcomes across India, tackle growing challenges to health such as epidemics, and provide the much needed leadership on systemic issues such as the development of systems for quality assurance and regulation of the private sector.

**National Health Accounts Report (2001-02):** This report brings out the variations in health spending per capita across states. Kerala has the highest annual per capita spending on health, followed by Haryana, Punjab, and Himachal Pradesh. At the other end, Assam, Odisha, and Rajasthan have the lowest levels of health expenditure per capita of the share of private spending in total health spending across states. With the exception of Sikkim, private spending accounts for the major portion of health spending in every state. This suggests that there is no systematic pattern in the ratio of public expenditure on health to gross state domestic product. Public expenditure on health is low in relation to state income in relatively affluent states like Haryana and Gujarat as well as in a poor state like Uttar Pradesh. It is important to focus on a smaller subset of interventions that can be financed by the government and scaled up effectively for several reasons. It has been seen that much of the impact of public spending on health can be
attributed to a handful of high-impact interventions, such as childhood Immunisations. A similar set of health conditions can significantly impact the health status of the citizens. Formulating a simple package can be more effective than paying for a large range of health interventions without regard to joint costs or shared use of inputs. These minimum packages have other advantages, like simplifying the planning of new investments in buildings and manpower. Rural healthcare should focus on interventions that generate maximum levels of health gain and financial protection. Target interventions should address disease conditions that are major sources of under-five mortality and burden from infectious diseases,

2.1.4. Rural Healthcare System in India

Kapil Yadav, Prashant Jarhyan, Vivek Gupta and Chandrakant S Pandav (2009). In this study, the authors state that the rural healthcare system of India is plagued by issues like severe resource crunch and underdevelopment of infrastructure - leading to deficient health-care for a large number of its citizens. The differences in urban-rural health indicators are a harsh reality even today; infant mortality rate is 62 per thousand live births for rural areas as compared to 39 per thousand live births for urban areas (2007). Only 31.9% of all government hospital beds are available in rural areas as compared to 68.1% for urban population. When the rural-urban distribution of population in India is considered, this difference becomes huge. Based on the current statistics provided by the government of India, the study have calculated that at the national level, the current bed-population ratio for government hospital beds for urban areas (1.1 beds/1000 population) is almost five times the ratio in rural areas (0.2 beds/1000 population). Apart from this shortfall in infrastructure, shortfall in trained medical practitioners willing to work in rural areas is also one of the factors responsible for poor health-care delivery systems in rural areas. There is a shortfall of 8% doctors in Primary Health Centres (PHCs), 65% for specialists at Community Health Centres (CHCs), 55.3% for health workers (male), 12.6% for health workers (female). This shortfall in human resources in rural areas is only going to increase in future, more so with corporatization and privatization of health systems. The rural population of India still does not get the basic quality of primary health-care as stated in Alma-Ata conference attended by governments of 134 countries and many voluntary organisations in 1978. “Primary
health-care is essential health-care made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and country can afford”.

**Ramani KV & Dileep Mavalankar (2005).** The authors have described the status of Indian health system. The study identifies that the critical areas of management concerns in Indian health-care system are mainly due to factors like non-availability of staff, weak referral system, poor service delivery, financial shortfalls and lack of accountability of quality of care.

**Maheshwari & Bhat (2004).** The authors have examined the revival strategy of a hospital, which is a division of commercial house and challenged with tough times. The case study is endowed with some interesting insights of reviving corporate hospitals in challenging times. The study can be useful in the context of the government hospitals too as the assertion of the study is that the government hospitals have resemblance with the corporate hospitals dedicated to its employees. It is claimed in the study that, similar to the dedicated corporate hospitals, the government facilities are required to provide free care or highly subsidised care to its users and are largely dependent on the financial allocations from government. Both dedicated corporate hospitals and government facilities depend on budget allocations, which subsequently depend on good financial health of the commercial houses and good fiscal position of government respectively.

**Dileep Mavalankar, KV Ramani, Jane Shaw (2004).** The authors have described some threats to the management of reproductive health programmes in India. It is stated in the study that the reasons behind the failures in the management of reproductive health services are both complicated and multi-faceted and therefore, not possible to be successfully addressed through health system reform. Hence, it is imperative to identify which failures in service are attributable to specific causes and which could be altered by reform in the normal reform procedure of the health system. In this paper, it has been suggested to ascertain concrete steps to expedite the reforms in the health system to facilitate the improvement of reproductive health services in India.

**Brijesh C Purohit (2001).** This study has summarised the impact of structural adjustment in the Indian rural healthcare sector has been felt in the reduction in central grants to states for public health and disease control programmes. This falling share of
central grants has had a more pronounced impact on the poorer states, which have found it more difficult to raise local resources to compensate for this loss of revenue. With the continued pace of reforms, the likelihood of increasing state expenditure on the health-care sector is limited in the future. As a result, a number of notable trends are appearing in the Indian health-care sector. The policy responses to these private initiatives are reflected in measures comprising strategies to attract private sector participation and management inputs into primary Health-Care Centres (PHCs), privatisation or semi-privatisation of public health facilities such as non-clinical services in public hospitals, innovating ways to finance public health facilities through non-budgetary measures, and tax incentives by the state governments to encourage private sector investment in the health sector. Bearing in mind the vital importance of such market forces and policy responses in shaping the future health-care scenario in India, this study examines in detail both these aspects and their implications for the Indian health-care sector. The analysis indicates that, despite the promising newly emerging atmosphere, there are limits to market forces. Hence, appropriate refinement in the role of government should be attempted to avoid undesirable consequences of rising costs, increasing inequity and consumer exploitation.

Poornima Vyasulu and V.Vijayalakkshmi (2001). The authors have discussed the reproductive health services and role of panchayats in Karnataka the reproductive health-care services available to women in rural areas in the state, and the various factors influencing them. Based on survey data on the status of Primary Health Centres (PHCs), and the availability of maternal health services, they have analysed the status of reproductive health services, their access and reach. This study also examines the role of panchayati raj institutions (institutions of rural local government) in providing these services. Three sets of explanatory variables are used to examine maternal health-care seeking viz. institutional structure quality of services; and social factors. The findings indicate that the resources available for health-care are meager, particularly for Reproductive and Child Health (RCH) in rural areas. The primary source of funding for RCH is largely central government grants. Inadequate devolution of funds, functions, and functionaries contributed to panchayats not taking any significant initiatives to improve maternal health-care.
**Government of India, (1999).** The study reveals that utilisation of services depends on a number of factors. Planning Commission (Government of India, 1999) evaluated the functioning of the CHCs, taking into account the availability and accessibility factors (area coverage of a CHCs, total number of doctors in a CHC, per cent of specialists present in CHCs, mean distance of PHCs from the CHCs). It has explained 71 per cent of variation in utilisation of services by these variables. The study did not consider factors related to family characteristics and social structure.

**Sodani 1997, 1999.** The author has estimated demand functions for health-care for the state of Rajasthan. Though he has taken into account 11 independent variables (age, education, time gap, duration of illness episode, number of visits, distance, income, number of rooms, family size, highest level of education among males and highest level of education among females), the author has not included availability factors. After the international conference on population and development in 1994 (ICPD) at Cairo, the quality of care is coming to be acknowledged as equal in importance with access to reproductive health services. Delivering successful care involves respect for the individual needs and rights of the clients, and useful service from the staff in hygienic conditions (UNFPA, 1994, 1995). This review has not revealed any study on Indian family planning incorporating primary health-care system to address the issue of quality of care. This study attempts to include variables from all the categories: availability, accessibility, family characteristics, social structure and quality of care.

**Peter A. Berman (1998).** The study brings out that most developing countries have pursued formal health-care system strategies which give primacy to government roles in financing and delivering health services. Despite decades of plans and investments based on this norm, the actual health-care systems in many countries are quite different than what was intended or desired. Yet, policies and plans continue to emphasise a statistic approach. This study argues that, given the current situation in many countries, this long-term strategy to develop a “national health service” type model of health-care provision is misguided and wasteful. The current and potential role of non-governmental health-care providers in achieving high levels of access to basic services is highlighted, using data from an extensive analysis of health-care financing and delivery in India. Major problems, related to quality of care and the financial burden of
unregulated fee-for-service medicines, are also documented. India and many other
countries need to rethink their health-care system development strategies and build upon
the opportunities offered by the already extensive non-government health-care sector,
rather than to view non-government services simply as a constraint to successful public
programmes.

**Das & Hammer, (2007).** The authors have stated that within the broader context
of public service delivery, health-care has several special features. More so than any
other public good, health-care has the characteristics of a “credence” good, where neither
pre-consumption search nor actual experience is sufficient to reveal the quality of the
service provided to the recipient. This property implies that market provision is subject to
severe potential problems associated with asymmetries of information. A related issue is
the complexity of health-care, which makes information exchange and the establishment
of reputations more difficult. Hence, private and public provision of health-care are both
likely to be beset with inefficiencies and quality problems. Indeed, there is evidence of
these problems even for well-off urban consumers in India

**Planning Commission Report (2006).** The elaborate institutional structure of
development planning, including public health services, has not been able to deliver good
outcomes for the rural populations of India that need it most. In the introduction, a 2001
document from the Planning Commission was quoted, noting the lack of accountability,
leading to pervasive absenteeism and low effort, and offering decentralisation as a
solution. Five years later (Planning Commission, 2006), however, the same problems
were highlighted once more: “rural health-care in most states is marked by absenteeism
of doctors/health providers, low levels of skills, shortage of medicines, inadequate
supervision/monitoring, and callous attitudes. There are neither rewards for service
providers nor punishments to defaulters.” The government’s own analysis identified a
failure to decentralise enough as the reason for lack of improved health outcomes, “the
10th Plan aimed at providing essential primary health-care, particularly to the
underprivileged and underserved segments of our population. It also sought to devolve
responsibilities and funds for health-care to PRI. However, progress towards these
objectives has been slow and the 10th Plan targets have been missed”
2.1.5. Healthcare infrastructure development in India

Boston Analytics Reports (2009). This study brings out that even though healthcare system in India reports explore although India’s healthcare system has gradually improved in the last few decades, it continues to lag behind those of its neighboring countries. Despite a steady increase in the number of medical establishments in the country, there still remains a severe shortage of sub-centres, primary health centres, and community health centres. Lack of adequate health-care is also reflected in the low density of health-care personnel. The public health-care delivery system consists of a large number and a variety of institutions dispensaries, primary health-care institutions, small hospitals providing specialist services, large hospitals providing tertiary care, medical colleges, paramedic training schools, laboratories, etc. Despite the size and reach of the public health-care system, however, India scores poorly on most health care indices.

Infrastructure Reports (2007). This study examines the rural health-care services infrastructure, which includes the physical facilities, personnel, administrative systems, and financial investments needed to deliver essential health services. Primary health-care services represent a crucial entry point into the health-care system. The adjusted primary care staffing Ratio the ratio of population to full-time equivalent (FTE) primary care physicians in direct service provides an index of the availability of primary care. State’s health-care services infrastructure delivers acute, primary, specialty, and long-term care. Infrastructure allows, but does not guarantee, access to services. It currently faces pressures from growing demand, the gap between rising costs and flat or declining revenue, and increasing numbers of uninsured patients. The data has been collected from National Rural Health-Care Mission

Umesh Kapil Panna Choudhury (2005) the study explores the health-care infrastructure in India. The country has created a vast public health infrastructure of sub-centres, Public Health Centres (PHCs) and Community Health Centres (CHCs). There is also a large cadre of health-care providers (auxiliary nurse midwives, male health workers, lady health visitors and male health assistants). Yet, this vast infrastructure is able to cater to only 20% of the population, while 80% of healthcare needs are still being provided by the private sector. Rural India is suffering from a long-standing health-care
problem. The study explains that only one trained health-care provider, including a doctor with any degree, is available per every 16 villages. Although, more than 70% of its population lives in rural areas, but only 20% of the total hospital beds are located in rural areas. In this review of the above issues, it seeks to provide effective health-care to the rural population throughout the country. The NRHM will cover all the villages in these states through approximately 2.5 lakh village-based “accredited social health activists” (ASHA) who would act as a link between the health centres and the villagers. One will be ASHA raised from every village or cluster of villages.

Dr. P. Murugesan, (2004). The main objective of this study is to examine the trends and levels of the health system in India over a period of time. At the primary health-care level, health and socio-economic development are so closely intertwined that is impossible to achieve one without the other. While the economic development in India has been gaining momentum over the last decade, our health system is at the crossroads today. Even though government initiatives in public health have recorded some noteworthy successes over time, building health systems that are responsive to community needs, particularly for the poor, requires politically difficult and administratively demanding choices. Health is a priority goal in its own right, as well as a central input into economic development and poverty reduction. Health sector is complex with multiple goals, multiple products, and different beneficiaries. India is well placed now to develop a uniquely Indian set of health sector reforms to enable the health system to meet the increasing expectations of its users and staff. Managerial challenges are many to ensure availability, access, affordability, and equity in delivering health services to meet the community needs efficiently and effectively. In this study, we describe the status of our health system, suggest a few health measures of maternal health indicators provided by three rounds of National Family Health Surveys (NFHSs), and conclude by identifying the roles and responsibilities of various stakeholders for building health systems that are responsive to the community needs, particularly for the poor.

Deepak Bhandari (2002). According to the author, the state governments in the country have the necessary funds to invest in infrastructure development of secondary or tertiary level rural health-care hospitals. Some states have received loans/grants from the World Bank (state health system development projects in A.P, Karnataka, Maharashtra,
Odisha, Punjab, U.P, Uttarakhand and West Bengal) to improve secondary level facilities. These improved facilities also tend to break down rapidly in the absence of an adequately funded maintenance system and poor management systems. Public awareness of and expectations from health services provided by the government are rising rapidly. This is to an extent fuelled by the rapidly escalating cost of medical care provided by the private sector providers who constantly raise-the bar on the range and quality of health-care services available in the country. The National Health Policy, 2002 states: “since 1983, the country has been seeing increase in mortality through ‘life-style’ diseases-diabetes, cancer and cardiovascular disease. The increase in the life expectancy has increased the requirement for care. Similarly, the increasing burden of trauma cases is also a significant public health problem”. There are little or no resources with the government to invest in facilities to take care of the increasing burden of these emerging diseases. It is estimated that, given the present state of economic health of state governments and the increasing deficit in national budgets, in the next ten years, the cost of caring for diabetic patients alone would cripple our economy.

2.1.6. Importance of Rural Healthcare Financing

Julian Schweitzer (2008). This study views the public healthcare finance and decentralization as central to resolving India’s systemic public health crisis. However, some states and districts have achieved success despite serious financial and administrative constraints. This suggests that factors such as political commitment, community participation, human resource management, women's empowerment, and governance may be as are more important. The success of the national rural health mission will depend on state and local institutional capacity, including strong partnerships with civil society organisations and private-sector actors. Increased resources and decentralization will not be sufficient by themselves. An examination of the failing districts will most likely reveal some systemic failures in developing the institutions and systems needed to ensure delivery of an integrated package of health services. These might include weak and inconsistent political commitment to improved services and better health outcomes for the poor; weak and divided community participation; poor hiring, management, deployment, and incentive systems for mid-level health workers and doctors. This would suggest that the success of the national rural
healthcare mission will depend crucially on developing state and local institutional capacity, including strong partnerships with civil society organisations and private-sector actors. Additional money may be a necessary condition for success, but it will not be a sufficient condition if political commitment, governance, and administration are weak.

**Ravi Duggal (2007).** The author posits that the way in which healthcare is financed is critical for equity in access to health-care. At present, the proportion of public health-care resources committed to health-care in India is one of the lowest in the world, with less than one-fifth of health expenditure being publicly financed. India has large-scale poverty. Yet, the main source of financing health-care is out-of-pocket expenditure. This is a cause of the huge inequities we see in access to health-care. The paper argues for strengthening public investment and expenditure in the health sector and suggests possible options for doing this. It also calls for a reform of the existing health-care system by restructuring it to create a universal access mechanism which also factors in the private health sector. The paper concludes that it is important to over-emphasize the fact that health is a public or social good and so cannot be left to the vagaries of the market.

**Anil B. Deolalikar and T. Jamison, (2007).** This study examines the current status and future prospects of rural health financing in India in the light of the rural health-care. Much has been written on this issue and the authors’ contribution has been to synthesise what is known in the context of rural health-care. Our objective is to draw attention to the benefits of public health spending, explore reasons why public spending has been much more effective at improving health outcomes in some regions but not in others, and to apply the lessons learnt from the disease control priorities project-India to the question of how best to deploy the new financial resources made available to the rural health-care, given the large health and institutional disparities between group and non-group states, the financing challenges are quite different in the two groups. In states such as Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh, and Odisha, which together account for 45 percent of India’s population, the health challenge lies primarily in the high levels of infant and child mortality and child malnutrition. In contrast, in non-group states such as Kerala, Tamil Nadu and Gujarat, non communicable diseases are fast replacing infectious diseases and malnutrition as the leading causes of morbidity and mortality. These studies raise issues of service delivery in low-capacity settings. Issues of
improving public-sector performance and leveraging the enormous capacity of the private health sector to successfully deliver health-care are central to any health system. The study discusses the mechanics of financing these health interventions and the implications for center-state financial responsibilities.

**Stijn Claessens (2006).** In this study, the author has reviewed the evidence on the importance of rural health-care finance for economic well-being. It provides data on the use of basic health-care financial services by households and firms across a sample of countries, assesses the desirability of universal access, and provides an overview of the macro-level, legal, and regulatory obstacles to access. Despite the benefits of health-care finance, the data show that use of rural health-care financial services is far from universal in many countries, especially developing countries. Universal access to health-care financial services has not been a public policy objective in most countries and would probably be difficult to achieve. Countries can, however, facilitate access to financial services by strengthening institutional infrastructure, liberalising markets and facilitating greater competition, and encouraging innovative use of know-how and technology. Government interventions to directly broaden access to rural health-care finance, however, are costly and fraught with risks; among others, the risk of missing the targeted groups. The study concludes with recommendations for global actions aimed at improving rural health-care data on access and use and suggestions on areas of further analysis to identify constraints to broadening access.

**Melitta Jakab, Alexander Johannes Paul Jutting, and Anil Gumber (2002).** The authors have sought to provide empirical evidence regarding the performance of rural health-care financing in terms of social inclusion and financial protection. Methods employed include: five non-standardized household surveys analysed from India (two samples); common methodology was applied to the five data sets. Logistic regression was used to estimate the determinants of enrolling in a community-financing scheme. A two-part model was used to assess the determinants of financial protection: part one used logistic regression to estimate the determinants of the likelihood of visiting a health-care provider. Part two used ordinary least-squares regression to estimate the determinants of out-of-pocket payments. Findings: It emerges that community financing health-care can be inclusive of the poorest even in the most economically deprived context. Nevertheless,
this targeting outcome is not automatically attributable to the involvement of the community. Rather, it depends on key design and implementation characteristics of the schemes. Health-care financial protection community financing reduces financial barriers to health-care as demonstrated by higher utilisation and simultaneously lower out-of-pocket expenditure of scheme members controlling for a range of socioeconomic variables.

**K. Kananatu (2000).** This review presents an overview of the India health-care system and its method of financing. The development of the health-care delivery system in India is commendable. However, the strength and weaknesses of the public health-care system and the financing problems encountered are also discussed. Cost of health-care and funding of both the public and private sectors were also revealed. One must optimise the advantages of operating a health financing scheme which is affordable and controllable which contribute towards cost-containment and quality assurance. Thus, there is a need for the establishment of a national healthcare financing, a mechanism to sustain the health-care delivery network and operate it as a viable option. A model of the national health financing has been proposed.

**Saltman and Ferroussier-Davis (2000).** This study examines the determinants of financial protection, health, and social inclusions supply in health system and related sectors. There is a hierarchy of interest from non-health sector factors in improving financial protection. These factors include: GDP, prices, inflation, availability of insurance markets, effective tax systems, credit, and savings programmes to more traditional parts of the health system (a) preventive and curative health services, (b) health financing, (c) input markets, and (d) access to effective and quality health services (preventive, ambulatory, and in-patient). In respect to the latter, organisational and institutional factors contribute to the incentive environment of health-financing and service delivery systems in addition to the more commonly examined determinants such as management, the health-care policy actions by governments, civil society, and the private sector. Finally, through their stewardship function, governments have a variety of policy instruments that can be used to strengthen the health system, the financing of services, and the regulatory environment within which the system functions. These include: regulation, contracting, subsidies, direct public production, and ensuring that
information is available. In countries with weak government capacity, civil society and donors can be encouraged to play a similar role.

Charu C. Garg (1998). This study describes the financing and delivery of health-care in India from the viewpoint of equity. In this context, typical financing mixes of public and private sources are examined. Inequity in delivery of health-care is analysed on the basis of utilisation of health services by people in different income quintiles, and in different geographical locations on the basis of self-reported ill health. The study explain that, even though the government sources of financing are mildly progressive, the large proportions spent by the households on health-care makes it overall regressive. Both government and private expenditures are higher for higher income quintiles and for people living in urban areas and working in the organised sector. On the other hand, people in lower income quintile and in rural areas bear higher burden of health expenditure as a proportion of their income. Delivery of health-care is also found to be biased in favour of urban areas. The study mainly uses secondary data sources. Data on tax and non-tax revenues of the government are available from the Ministry of Finance, Government of India documents.

2.1.7. Public Healthcare System Role in India

Nirvikar Singh (2008). This study examines delivery of public health-care services in India, in the broader context of decentralisation. It provides an overview of the basic features and recent developments in inter-governmental fiscal relations and accountability mechanisms, and examines the implications of these institutions for the quality of public health service delivery. It then addresses recent policy proposals on the public provision of health-care in the context of decentralisation. Finally, it makes suggestions for reform priorities to improve public health-care delivery, discusses the nature of health-care services and summarises the pattern of public-sector health spending in India. Thereafter, the basic features of inter-governmental fiscal relations, recent developments, and accountability mechanisms for the provision of sub national public goods are reviewed. Subsequently, the impact of the intergovernmental system and accountability mechanisms on the quality of public service delivery, including health-care are examined. The study specifically addresses recent public policy proposals on the provision of health-care, in the context of decentralisation. Finanally, it offers a
concluding assessment with suggestions for reform priorities to improve public health-care delivery.

Umesh Kapil & Panna Choudhury (2005). According to the authors, the country has created a vast public health infrastructure of sub-centres; public health centres (PHCs) and Community Health Centres (CHCs). There is also a large cadre of health-care providers (auxiliary nurse midwives, male health workers, lady health visitors and male health assistants). Yet, this vast infrastructure is able to cater to only 20% of the population, while 80% of healthcare needs are still being provided by the private sector. Rural India is suffering from a long-standing healthcare problem. Studies have shown that only one trained healthcare provider including a doctor with any degree is available per every 16 villages. Although, more than 70% of its population lives in rural areas, but only 20% of the total hospital beds are located in rural area. Most of the health problems that people suffer in the rural community and in urban slums suffer are preventable and easily treatable. In view of the above issues, the national rural health mission (NRHM) has been launched by government of India (GOI). The ASH would be trained to advise village populations about sanitation, hygiene, contraception, and immunization; to provide primary medical care for diarrhea, minor injuries, and fevers; and to escort patients to medical centers.

2.1.8. Community Participation in Rural Healthcare

The term community has a multitude of interpretations. Its usage over time has become so persuasive that its meaning is overlaid with a vast range of associations (Hawtin, Hughes & Percy-Smith, 1994). Hawe (1994) provides a summary of approaches to defining a community. She firstly describes community using a demographic approach where characteristics of the population, such as gender and age, are central to the definition. Her second approach is geographically determined where actual locations or specific settings are identified. Illustrations used by Hawe include workplaces, schools and hospitals – but could also include the actual physical boundaries of a particular community (rivers, mountains, local government boundaries). The third approach she presents is the commonly used community development or issues approach which describes a community as a social system, having a “…. Capacity to work towards solutions to its own community identified problems.”
Gilchrist (2004) takes a similar approach and uses relationships and networks as the basis for identifying a community. She argues that the informal networks that exist between individuals, groups and organisations which are integral to people’s lives are central to the meaning of community. The community development model, she proposes, plays a central role in assisting people to connect with one another so as to empower individuals and groups to overcome or renegotiate obstacles which prevent them from communicating and working together. Communities are “actively constructed by their members”.

While the definition of community in terms of location has been the most common usage of the term in the past, Barnes (1997), like Gilchrist (2004), presents a definition based on identity of people who share significant characteristics and experiences, adding that this better reflects the plurality of contemporary society.

Rifkin, Muller, and Bichmann (1988) would concur with this definition. They use the community development definition of community to focus on specific populations and “at risk” groups, such as the poor. This definition is rooted in the epidemiological view of community. In PHCs [primary health-care centres], in terms of equity, effectiveness and efficiency, groups of people need to be identified so that resources can be allocated to the greatest effect. It is, therefore, important to take into account this aspect of health concerns in seeking a realistic definition.

Wood and Judikis (2002) identify essential process elements of a community to include a sense of common purpose or interest, an acknowledgement of interconnectedness, respect for individual differences and a commitment to the well-being of members of the community. “Communities are stronger when individual members with diverse strengths and talents share in the community vision, purpose, interests and intended outcomes.” Wood and Judikis identify five different categories of community; nuclear (for example, family), tribal (racial, gender or social class), geopolitical (defined by geographic boundaries), life (contacts across a lifetime) and collaborative communities. A collaborative community exists to serve a specific purpose or address an identified need. This all-encompassing approach to describing communities fits well with the parameters of “community” identified in this research. There are a number of quite diverse communities all working towards achievement of the same goal -
that is - PHCs establishment. Process considerations, therefore, need to include shared goals, vested interests, and preferred ways of doing, power relationships and capturing the benefits of diversity.

**Laverack (2004)** acknowledges that there is considerable overlap between community participation, community development, community empowerment and community capacity building. Participation, like community, has a wide range of meanings. Labonte (1997) describes participation as the attempt to bring together different stakeholders for the purposes of problem-solving and decision-making. Rifkin (1988) provide an expanded definition, incorporating a notion of community and the social processes which contribute to determining and addressing need. Campbell & Jochelovitch (2000) agree that it is the process of participation that allows social representation to be expressed, reaffirmed and renegotiated, and provides a platform for dialogue between different representations. Morgan (2001) presents a number of approaches to participation. The utilitarian approach sees external agencies inviting communities to participate in a pre-determined project. This approach would be aligned with people’s understanding of the notion of consultation. However, Morgan argues that this approach is often used to offset costs,

**Irvin and Stansbury (2004)** hold the view that this participatory approach can be more expensive than decisions made by a single agency, even if the participants’ time costs are ignored. The second approach identified by Morgan (2001) is that of empowerment. Empowering local communities and creating social change to improve health outcomes and reduce inequalities are central to this approach. Labonte (1997) places emphasis on the importance of relationships in underpinning participation. Participation is a process “that continuously changes and unfolds as individual actors (and their varying group or organisational constituencies) negotiate the terms of their relationships.” An added dimension is one of commitment and responsibility across the spectrum from needs identification through to evaluation of established health services. **Rifkin (1988)** take a similar approach by identifying the factors which contribute to effective participation as: needs assessment, leadership, organisation, resource mobilisation and management. Rifkin suggests that these factors (with the exception of the last) present themselves at different places on a continuum: extending from wide to
narrow participation depending on the nature of the project. This approach, they propose, provides an opportunity to examine process rather than just the impact of community participation.

David Sanders (2007), in his introductory key note address, traced the international history of CHWS and the emphasis on people's participation in ensuring basic health of communities in the current context of globalisation. Over the past decades, the developing countries have seen many improvements in population health indicators such as infant mortality rate, crude birth and death rates and life expectancies. However, certain other indicators, such as neo-natal mortality, maternal morbidities and mortalities, and under-nutrition, have seen significant deterioration. Although aggregate data hides intra-national, interregional and inter group inequalities, a closer examination shows that urban-rural and gender related health inequalities have increased significantly even in developed economies, indicating differential access to health services. One of the primary factors contributing to these inequalities is the decreasing state budgetary allocations towards health, and resulting increase in private or out-of pocket expenditures. Predictably, the quality of public health services is low and deteriorating, predisposing the poor to increased health vulnerabilities. Given these realities, the need for primary health-care through strengthened community based and systemic interventions has assumed utmost importance. It is in this context that CHW programmes have been conceptualised as agents for realising the right to health for the poor, and have been positioned within global economic, social and political processes, which, in turn, determine the characteristics and efficiency of these programmes.

Laverack (2004) acknowledges that there is a considerable overlap between community participation, community development, community empowerment and community capacity building. Participation, like community, has a wide range of meanings. Labonte (1997) describes participation as the attempt to bring together different stakeholders for the purposes of problem-solving and decision-making. Rifkin, (1988) provide an expanded definition - incorporating a notion of community and the social processes which contribute to determining and addressing need.

Arguments in support of involving communities in the implementation of new policy are universally supported as one means for improving health and health-care
delivery (Guareschi & Jovchelovitch, 2004). Proponents support the belief that communities involved in the implementation of policy initiatives are more likely to embrace change, there will be improved acceptance of strategy expectations placed on communities by external agencies, participation will more likely produce better decisions and communities will have a better appreciation of issues and rationale for change (Arnstein, 1969; Beierle, 1999; Box, 1998; Irvin & Stansbury, 2004; King, Feltey & O’neill Susel, 1998; Oldfield, 1990; Stivers, 1990). Irvin and Stansbury (2004) highlight an important long term benefit. This is the opportunity accorded to community participants and agency personnel alike to learn from and inform one another. They propose that policies are more likely to be grounded in citizens’ preferences and the public are more likely to become sympathetic to tough agency decisions if participation is seen to be genuine. In addition, if citizens have regular contact with agency decision makers, they may act as advocates for government policy positions in their communities and government agencies can obtain important support for change which may otherwise be challenged if imposed unilaterally. In support of this, King and Stivers (1998) propose that improved participation can strengthen trust between bureaucrats and communities. The overall benefit could see participation as a transformative tool for social change (Nelson & Wright, 1995).

2.1.9. Healthcare Community Assessment and Performance

Melitta Jakab & Chitra Krishnan (2001). The study examined healthcare community financing to assess the performance of community involvement in health financing in terms of the level of mobilised resources, social inclusion, and financial protection; and establish the determinants of reported performance results, including technical design characteristics, management, organisational, and institutional characteristics. Community financing is an umbrella term used for several different resource mobilisation instruments. The instruments vary in the extent of their pre-payment and risk sharing, in their resource allocation mechanisms, organisational and institutional characteristics. Nevertheless, the common features they share include the predominant role of the community in mobilising, pooling and allocating resources, solidarity mechanisms, poor beneficiary population, and voluntary participation. Performance of community-based financing can be based on:
(i) How these mechanisms mobilise significant resources for health-care.

(ii) How effective it is in reaching a large number of low-income populations who would otherwise have no financial protection against the cost of illness.

(iii) How systematically community-based health financing schemes are reported to reduce the out-of-pocket spending of their members while increasing their utilization of health-care services. All studies with focus on community-based resource mobilisation were included. The reviewed literature is very rich in describing the phenomenon referred to as community financing in terms of scheme design and implementation.

**Johannes Paul Jutting (2000):** the rural healthcare in India” the main objectives of the. The potential social benefit of the schemes, i.e., their impact on health-care access, labour productivity, and households’ risk-management capacity, has been largely ignored. Community based health-care schemes are being increasingly recognised as instruments to finance health-care in developing countries. Taking the example of less mutual health organisation in rural areas, this review analyses whether members in a mutual health-care finance scheme have better access to health-care than non-members. A binary probit model is estimated for the determinants of participation in a mutual and a logit/log linear model is used to measure the impact on health-care utilisation and financial protection. It is seen that, while the health health-care schemes reach otherwise excluded people, the very poorest in the communities are not covered. Regarding the impact on the access to health-care, members have a higher probability of using hospitalisation services than non-members and pay substantially less when they need care. Given the results of this study, community-financing schemes have the potential to improve the risk-management capacity of rural households. The modeling of mutual healthcare schemes’ impact on health-care use and expenditure faces the important challenge of dealing with the problem of “self-selection.” This problem is currently receiving a great deal of attention in different areas of development economics, including measuring the impact of microfinance institutions, estimating the returns of education, and analysing the impact of health-care on various outcomes.

**Taylor J, Wilkinson D & Cheers B (2001).** This study explores the relationships between rural places and community participation in health service development.
Community participation in planning for health programmes and services is fundamental to effective and accessible primary health-care. It was found that community participants understood community participation as social interactions embedded in a community of place related to the betterment of the community. From this understanding, three concepts about community participation in health activities emerge. These are:

a. Community participation as development of place

b. The value of the community participation processes to the community

c. Community participation consistent with community values and attitudes.

An understanding of the relationships between community functioning and community participation is essential for health professionals working with communities and for the communities themselves. It may important in developing community-based initiatives in other fields such as social care and environmental management.

Somnath Roy and B.B.L. Sharma (2002). According to the authors, active community participation is one of the most important supportive activities for successful implementation of primary health-care for achieving the goals of health for all by the year 2000 AD. In this study, the nature, the various aspects and dimensions of community participation, and its role and scope in successful implementation of different components of primary health-care have been described. The concepts and general principles, as evolved from a wide range of experiences available from within and outside the country, have been systematically analysed and organised. The steps needed for operationalising community participatory processes have been indicated. Some of the successful experiences in bringing about community participation in the country have also been briefly presented to bring out the lessons learnt from them. at least eight essential components of primary health-care are to be implemented. These are: (i) education of the people about prevailing health problems and the methods of preventing and controlling them; (ii) promotion of food supply and proper nutrition; (iii) adequate supply of safe water and basic sanitation; (iv) maternal and child health-care and family planning; (v) immunization against major infectious diseases; (vi) prevention and control of locally endemic diseases; (vii) appropriate treatment of common diseases and injuries; and (viii) provision of essential drugs. For successful implementation of these components, organisation of the following eight types of supportive activities will be very important:
A. Community involvement and participation
B. Intra- and inter-sectoral coordination
C. Development of effective referral support
D. Development and mobilisation of resources
E. Involvement of managerial processes
F. Health manpower development
G. Medical and health services research, including innovative approaches
H. Development and application of appropriate technology.

2.1.10. Quality of Healthcare Services

Kaveri Gill (2009). The study seeks to evaluate quantity and quality of service delivery in rural public health facilities under NRHM. On appropriate and feasible measures, the former is assessed on the static and dynamic condition of physical infrastructure; by the numbers of paramedical, technician and medical staff employed, the micro-findings across four states (A.P, UP, Bihar, Rajasthan), which have resulted in rankings in individual sections of the study, suggest disparate situations at various levels of centres and on different components, reflecting context-specific underlying driving factors, some complex by nature. Based on these findings, one could easily rank the states on ‘overall performance of service delivery under NRHM,’ which has put rural public health-care firmly on the agenda, and is on the right track with the institutional changes it, has wrought within the health system.

B. S. Ghuman and Akshat Mehta (2009). According to the authors, the main objective of this study is to examine the quality of health services in India which include the problems and prospects in this area. India as a nation has been growing economically at a rapid pace particularly after the advent of new economic policy of 1991. However, this rapid economic development has not been accompanied by social development particularly health sector development. Health sector has been accorded very low priority in terms of allocation of resources. Public expenditure on health is less than 1 per cent of GDP in India. It has further witnessed a decline during the post-economic liberalisation period. The meager resource allocation to the health sector has adversely affected both access and quality of health services. With a view to improve access and quality of health services, government should enhance public spending on the
health sector in the vicinity of 3 per cent of the GDP. Data about health services has been collected from 352 households comprising 300 from the rural areas and 52 from the urban areas. For data analysis, the suitable statistical techniques have been used.

Jagdish Krishnappa, H V Sridevi and Dr U V Somayajulu (2006). The authors believe that health-care in India has improved in an impressive manner in the recent decades. However, the rural health-care in India faces the problem of varying morbidity patterns. This is reflected in the life expectancy (63 years), infant mortality rate (80/1000 live births), and maternal mortality rate (438/100000 live births). Given the limited health facilities available, quality health-care is still beyond the reach of millions of rural masses. This can be considered as a violation of basic human rights of the people to have the benefit of quality health services. This also highlights the rural health-care equity issues. The issue of rural health needs to be addressed both at macro and micro levels, involving a coordinated, holistic approach so as to improve the health status in rural India. The national health policy addresses the prevailing inequalities, and promotes a long-term perspective plan, mainly for rural health. Launching of National Rural Health Mission (NRHM) in India in 2005 aiming at integrating different vertical programmes, decentralising health-care service delivery at the village, and improving inter-sectoral action, was a major step in this direction. NRHM activities are also expected to help in substantial reduction in maternal and infant mortality from communicable diseases in the years to come. This study makes an attempt to understand the programmatic issues in rural health sector with specific reference to rural India and progress and review of NRHM in non-high focus large southern states of India, viz., Andhra Pradesh, Karnataka and Tamil Nadu. This study is based on the review of available literature and analysis of available secondary data.
2.2. International Experience

2.2.1. Implementation of Primary Healthcare Model

Armenia PHCs Model: Cardno Healthcare Group Report (2009). This study explains the Armenia primary healthcare model, the implementing of primary health-care reform (PHCR), increased access to and demand for quality health-care services; build sound health systems and structures; and improve utilisation of financial resources in the health sector in Armenia. Health-care personnel work with local and international partners to ensure efficient and effective delivery of health services to those most in need. The objectives of Armenia primary health-care are:

   a. Reform health-care system policies and procedures nationwide
   b. Build clinical service capabilities through a family medicine approach
   c. Improve the quality of health-care
   d. Foster improved health-care seeking behaviour through public health-care education health-care promotion activities

The emergence of health-care strengthens public and private sector institutions and systems, improves financial management, reforms budgetary procedures, implements innovative payment systems and performance-based rewards, and ensures transparency and accountability. Health-care Emerging Ltd is implementing the basic set of interventions nationwide using a regional rollout method

Amir Ashkan nasiripour, behrooz rezael and Mohammad hosein yarmohammadian (2009). The study makes a comparative evaluation of primary health-care management systems in selected countries and designing a model in this research primary health-care systems were reviewed and the nurses' roles were determined and then a model was designed for health networks in Iran. This was a triangulation research done in comparative method. In the first step, PHC systems were reviewed in different countries such as UK, Australia, Canada, Sweden and Turkey selected in purposive sampling. In the second step, the process of management of PHC services in selected countries were determined from accessibility, providers and referral system, and then compared to PHC system in Iran. Thereafter, a primary model was designed. In all of the studied countries, PHC services were delivered by health team including family physicians, nurses,
midwives, and health technicians in systematic networks including local health centres, family physicians’ offices and nursing clinics. Family physicians and nurses had a basic role in delivery of services. Also, other health practitioners such as psychiatrists were attached with the health teams. PHC services in most cases on the basis of people’s need and health information were transmitted between the providers by health files. It was found that an effective referral system exists between health services. The model of PHC delivery was on the basis of health team with systematic network of the local health centers and provides accessibility, quality and comprehensively of services. The authors suggest employment of educated nurses in health centres to provide more health services.

S Wong and S Regan (2009). This study discusses how to deliver primary health-care (PHC) services and increase their accessibility from the patient’s perspective. The authors conducted seven focus groups with people living in rural communities, in British Columbia, Canada, as they reflected on priorities for the use of PHC. Equitable access to health-care for all Canadians is a fundamental principle of the Canadian health-care system. Health-care systems that fail to provide equitable access for diverse populations can increase the gap in health disparities. Indeed, access to and utilisation of primary healthcare (PHC) services is one pathway by which inequalities can influence population health and equitable access to health services continues to be a common concern across geographic locations. The purpose of this study was to examine the perspectives of PHCS of people who live in rural communities. Primary health-care can be defined as an approach to health policy and service provision that includes both services delivered to individuals (primary care services) and population-level, public health-type functions. The geographic location of rural communities compounds the extent to which these people are able to access timely and continuous PHCs. In addition to discussing their priorities for PHCs services, participants completed a brief questionnaire designed to collect information regarding socio-demographics, health status and utilisation of primary health-care providers. Descriptive statistics were obtained from questionnaire data. Focus group data were coded using an evaluation framework specifically developed for PHCS.

Catherine Hurely (2009). This study sought to identify the extent to which the Alma Ata defined comprehensive primary health-care (PHCs) approach is practised and evaluated in Australia and to describe the role that GPS and other medical practitioners
play in it along with implications of this for future policy in light of the Health and Hospital Reform Commission (HHRC) and primary health-care taskforce reports, 2009 recommendations. In Australia, the PHCs approach occurs chiefly in aboriginal controlled community health services, state funded community health and in rural/remote and inner city areas. Participation by GPS in PHCs is limited by funding structures, workforce shortages and heavy workloads. Factors that facilitated the CPHCS approach include flexibility in funding and service provision, cultural appropriateness of services, participation and ownership by local consumers and communities and willingness to address the social determinants of health. The recent HHRC and primary health-care taskforce reports recommend an expansion of PHC services as a means of tackling health inequities. The findings of this a renewed research and policy focus on CPHCS was also evident. One such effort was the “revitalising health for all” (RHFA) research and capacity building project funded by the Canadian global health research initiative the a study was conducted and a narrative review of the literature (published and grey) from 1987 to mid 2007 as part of a global review carried out by teams of researchers in six regions in 2007 was brought out.

**WHO Report (2008).** This review examines the implementation of primary health-care (PHC) in Africa and identifies strategic interventions those are required to cope with the new challenges facing the health systems in the 21st century. The review addresses PHC policy formation and implementation, the resources that are available for PHC implementation, monitoring and review. The review finds that PHC policy formation had been well articulated in the national health policies by most countries. However, the extent to which PHC policies encompassed equity, community participation, inter-sectoral collaboration and affordability is still questionable. Factors delaying PHC implementation include weak structures, inadequate attention to PHC principles, inadequate resource allocation and inadequate political will.

The recommendations of the review include:

a. Health sector reforms with PHCS to ensure that initiatives promote equity and quality in health services

b. Improve the fairness of financing policies and strategies and service coverage for the poor
c. Support countries to address their particular human resource needs through clear articulation of human resources policies, plans, development and strengthening of national management systems and employment policies

d. Support countries to identify and put in place mechanisms for attracting and retaining health personnel

Michael J. Garner & Michael Birmingham (2008). This study focuses on primary health-care, in Canada. The use of complementary and alternative medicine has been increasing in Canada despite the lack of coverage under the universal public health insurance system. Physicians and other health-care practitioners are now being placed in multidisciplinary teams, yet little research on integration exists. The authors have sought to investigate the effect of integrating chiropractic on the attitudes of providers on two health-care teams. A mixed methods design, with both quantitative and qualitative components, was used to assess the health-care teams. Assessment occurred prior to integration, at mid study, and at the end of the study (18 months). Multidisciplinary health-care teams at two community health centres in Ottawa, Ontario, participated in the study. All physicians, nurse practitioners, and degree-trained nurses employed at two study sites were approached to take part in the study. A quantitative questionnaire assessed providers’ opinions, experiences with collaboration, and perceptions of chiropractic care. Focus groups were used to encourage providers to communicate their experiences and perceptions of the integration and of chiropractic. This project has demonstrated the successful integration of chiropractors into primary health-care teams.

Government of Belgium and government of Tanzania (2008). The main aim of this study is to examine the progress of the project to support Karagwe district in improving its primary health-care (PHC) services. The study focuses on three areas: improved financing of services through cost sharing/cost recovery instruments and insurances, improved quality of care through provision of drugs and medical supplies, improvement of skills of the PHCS staff, . During the first half of 2008, a number of poor families were identified and exempted from payment for the community health-care financing services. The health services in Karagwe district are provided by the government, voluntary agencies and non-governmental organisations. There are three hospitals, three health centres and more than forty dispensaries in the district. Most of
these health facilities have critical shortages of qualified staff. Health equipments are insufficient and often the infrastructure is poor.

J. Macinko, H. Montenegro and C. Nebot (2007). This document describes the position of the Pan-American Health Organization on the proposed renewal of primary health-care (PHC) in the America. It highlights reasons for adopting this renewed approach. These include: the rise of new epidemiologic challenges that PHCs must evolve to address and the growing recognition that PHCs can strengthen society’s ability to reduce inequities in health. The document examines the concepts and components of PHCs and the evidence of its impact. It finds that PHCs represent a source of inspiration and hope for most health personnel and also the community at large. There is a need to reinvigorate PHCs in the region so that it can realise its potential to meet current and future health challenges. The proposed mechanism for PHCs’ renewal is the transformation of health systems so that they incorporate PHCs as their basis. This system entails an overarching approach to the organisation and operation of health systems that makes the right to the highest attainable level of health its main goal. The health system should be composed of a core set of functional and structural elements that guarantee universal coverage and are equity enhancing. This requires a sound legal, institutional, and organisational foundation, as well as adequate and sustainable human, financial and technological resources.

C. John Clements, Pieter H and Clement Malau (2007). This study explores issues regarding primary healthcare. There is nothing new about supervision in primary health-care service delivery. Supervision was even conducted by the Egyptian pyramid builders. Those supervising have often favoured ridicule and discipline to push individuals and communities to perform their duties. A traditional form of supervision, based on a top-down colonial model, was originally attempted as a tool to improve the performance of health service staff. This has recently been replaced by a more liberal “supportive supervision”. While it is undoubtedly an improvement on the traditional model, the authors believe that even this version will not succeed to any great extent, until there is a better understanding of the human interactions involved in supervision. Tremendous cultural differences exist over the globe regarding the acceptability of this form of management. While it is clear that health services in many countries have
benefited from supervision of one sort or another, it is equally clear that, in some countries, supervision is not carried out, or, when carried out, is done inadequately. In some countries, it may be culturally inappropriate, and may even be impossible to carry out supervision at all. The authors have examined this issue with particular reference to immunisation and other primary health-care services in developing countries. Supported by field observations in Papua New Guinea, the authors conclude that supervision and its failure should be understood in a social and cultural context, being a far more complex activity than has so far been acknowledged. Social science based research is needed to enable a third generation of culture-sensitive ideas to be developed that will improve staff performance in the field.

Wendy Rogers and Bronwyn Veale (2003). This study discusses the primary health-care and general practice. Primary health-care (PHC) is a term which has come to have many different meanings to different people. Recognising the complexities behind the term, and the relationships between PHCS, population health and general practice are important steps in addressing any possible shift in emphasis from general practice to PHCS. The philosophy behind PHCs is based on:

1. Holistic understanding and recognition of the multiple determinants of health
2. Equity in health-care
3. Community participation and control over health services
4. Focus on health promotion and disease prevention
5. Accessible, affordable, acceptable technology
6. Health services based upon research methods.

D. McCoy, E. Buch and N. Palmer (2000). According to the authors, the devolution of primary health-care delivery to local government means that inter-governmental relations are emerging as a critical issue in the transformation of South Africa’s health system. The role of contracts or service agreements in helping to define the nature of these inter-governmental relationships is important. This document, produced by the health systems trust, considers the nature of inter-governmental relationships. This study introduces the advantages and disadvantages of contractual relationships within the public health sector, examines different types of contracts, describes the nature of inter-governmental relationships in South Africa and features of the PHC approach and district health system
model integral to the South African health system, and discusses how these factors will influence and potentially be influenced by the use of contracts. It also emphasises the importance of integrated district and provincial health planning as the basis for contracts. In addition, this study discusses the issues raised and draws conclusions of interest to those involved in the process of establishing contracts. This study makes the following recommendations for a successful inter-governmental contractual relationship for the provision of PHCs:

a. Work from a national/provincial strategic and policy framework, and from a comprehensive and integrated area-based PHC plan.

b. Adopt a relational approach to contracting that encourages partnership, and emphasises trust, mutual support and a shared vision.

c. Adopt contract specifications that are broad and flexible, and which stress constructive monitoring and evaluation procedures.

Roger Feldman, David M. Deitz, BA, and Edward F. Brooks, (1978). The authors bring out that primary health-care centres have been proposed to meet the health-care needs of rural America. Some centres become financially "self-sufficient", receiving their entire budgets from direct patient or third-party payments; others shut down when external funding was withdrawn. An explanation for this difference is important, because funding agencies may not wish to subsidise centres whose financial future appears bleak. This study identifies the correlates of financial self-sufficiency. A survey conducted in late 1976 of 164 rural clinics provided 101 usable responses. Multiple regression analysis of the data shows that the longer a centre has been in operation, the more self-sufficient it will become. Hospital control of the centre and provision of laboratory tests increase self-sufficiency; outreach services and nonprofit status reduce it. Two variables related to financial self-sufficiency are separately examined. Clinics with a faster growth rate of patient visits are more self-sufficient, and smaller clinics tend to grow faster. More self-sufficient clinics experience less difficulty in retaining professional staff. The presence of a state Area Health Education Centre (AHEC) programme also eases the problem of staff retention.

Winnie Yip and Ajay Mabal (2008). In this study, the authors have explored the health-care systems of China and India. Both these countries have recently committed to
injecting new public funds into health-care. Both countries are now deciding how best to channel the additional funds to produce benefits for their populations. In the study, the author analyses how well the health-care systems of China and India have performed and what determines their performance. Based on the analysis, this paper suggests that money alone, channeled through insurance and infrastructure strengthening is inadequate to address the current problems of unaffordable health-care and heavy financial risk, and the future challenges posed by aging populations that are increasingly affected by non-communicable diseases. To facilitate comparisons between China and India, the study adopt an analytical approach that is commonly used in evaluating health systems and designing health-care reform. This approach conceives of a health system as a set of relationships in which the structural elements of the system are causally connected to the goals of the system. These elements include: health status, financial risk protection, and public satisfaction, and the equitable distribution of each of these. The health system provides financial risk protection, which can be assessed by two metrics. The first measures the percentage of households in a population that are pushed below the poverty level as a result of out-of-pocket payments for health-care. Existing evidence suggests that households in both China and India are vulnerable to financial shocks associated with ill health. A recent study shows that out-of-pocket health spending increases the percentage of people below the poverty level (US $1.08 per day) by nearly 20 percent in China, from 13.7 percent to 16.2 percent. In India, out-of-pocket spending increases the already high poverty rate of 31.1 percent to 34.8 percent, despite a smaller proportional increase compared to China.

Sonia Bhalotra (2007). This study explains the severe inequalities in health-care in the world. Poor countries spend a much smaller share of their national income on health expenditure than do richer countries. What potential lies in political or growth processes that can raise this share? This depends on how effective government health spending in developing countries is. Existing research presents little evidence of an impact on infant mortality. Using specifications similar to those in the existing literature, this study finds a similar result for India, which is that state health-care spending saves no lives. However, upon allowing lagged effects, controlling in a flexible way for trended unobservable and restricting the sample to rural households, a significant effect of health-
care expenditure on infant mortality emerges, the long run elasticity being about -0.24. There are striking differences in the impact by social groups. Slicing the data by gender, birth-order, religion, maternal and paternal education and maternal age at birth, the author finds the weakest effects in the most vulnerable groups. The study micro-data are derived from the second round of the National Family Health Survey of India. These micro-data are merged by state and year of birth with a panel of data on health expenditure and other relevant statistics for the 15 Indian states.

**Ministry of Health, China (2005).** The study explains the costs and efficiency in China’s rural health-care system. A variety of indicators suggest low levels of efficiency in China’s health sector. Bed occupancy rates are low: the average for all hospitals in China is just over 60%; the figure is below 40%. In the established market economies of the Organisation for Economic Cooperation and Development (OECD), the average is nearly 80%. The productivity of health staff is also low, with relatively few patients seen per day (about 5 outpatients per doctor and 1.5 inpatient bed days per doctor for general acute hospitals in 2004) (Ministry of Health, 2005). Low-capacity utilisation raises costs above the feasible minimum, although how far is not known and so does the provision of unnecessary care. One study found that 20% of all expenditure associated with appendicitis and pneumonia treatment was clinically unnecessary (Liu & Mills, 1999). In part, this was because of excessive drug spending (one third of drug expenditures were considered to be unnecessary by a panel of reviewing physicians), but it was also due to overly long hospital stays (the panel concluded that, for both conditions, length of stay could be reduced by 10–15%, without any adverse effects on health outcomes). Levels of productivity also appear to be stagnating or falling. Since the 1980s, the number of providers has increased, while caseload has been falling (Ministry of Health, 2004). Bed-occupancy rates were, as a result, falling, with slight improvements since then (Ministry of Health, 2005). The number of patients treated per provider per day has also fallen in rural areas.

**World Bank report (2005).** In this report, the focus is on improving health service delivery that have been discussed in the literature. Peabody (2006) summarises these in the context of low- and middle-income countries:
a. Generate and encourage the use of specific clinical algorithms based on evidence of best practice.

b. Have service providers acquire skill and speed by doing a few things frequently rather than many things occasionally. Learning by doing is key to improving performance. This lesson is very relevant for India given the hard reality that, at least initially, the rural healthcare mission will have resources only for a limited set of high-priority items.

**WHO Report (2008):** The National Rural Health Mission (NRHM) is one of the largest global programmes for revitalising primary health-care systems in India. The thrust of the programme is on securing quality health services that are accessible, affordable and accountable in remote rural areas. The NRHM works on the assumption that only by securing people’s health in people’s hand will we be able to address the wider determinants of health-care in India. The effort has been to craft a credible public system of health-care by establishing decentralised institutions of local communities from the village to the district levels. Such committees are under the umbrella of the local governments of India and allow for involvement of all those with the motivation to improve the lives of people. NRHM’s approval signified a paradigm shift that was aimed at crafting a credible public system of health delivery. From funding vertical schemes, NRHM advocated crafting of credible public platforms of health-care at all levels, from village level health and sanitation committees to panchayat owned sub health centres, PHCs, CHCs, sub-district and district hospitals; instead of forcing centrally designed schemes across all states.

### 2.2.2. Rural Health-Care System in International Experience

**Gina M. Berg-Copas (2009).** The purpose of this study was to develop a greater understanding of health-care issues in rural area communities. These issues, identified as global in nature, also have been identified in rural area, a predominantly rural state. Public health departments provide services to 2.9 million residents in 105 counties. In rural areas, there is wide variation in public health capacity across rural area, and rural areas have difficulty maintaining health-care resources. Concerns identified by rural area community focus groups have legitimate and supported bases. The purpose of this focus group study was to identify community perceptions of health-care needs of rural area and
to understand better the perceived strengths and weaknesses of those communities. Community strengths include: quality of life, community involvement, health-care facilities, agency collaboration, and commitment to health-care worker recruitment. Weaknesses are: language barriers, aging population, health-care workforce availability, physician and spouse recruitment, access to medical, dental and mental healthcare, poor oral hygiene, and community members identified several opportunities for rural areas, including the high quality of life, agency collaborations, public health,

Paul (2008). This study discusses the health policy and development, compares the attrition rates of health professionals in three private not-for-profit and three government general hospitals in West Nile Region, Uganda, between 1999 and 2004. It also examines the destinations to which the rural health-care professionals were lost, the reasons for their leaving and the source of new staff. The paper finds that the annual attrition rate of health professionals are high especially in private hospitals. The most frequent reasons for attrition are: poor conditions of service, low pay and poor relationships between the staff and the managers. Most replacements come from training institutions, which impacts on the quality of services in terms of the skills needed for service delivery the authors offers recommendations to the Ministry of Rural Health-care. These include:

a. Offer well managed additional monetary incentives to health workers service in the rural areas
b. Put more funds into the health sector in order to fill in staffing gaps
c. Invest funds in training of health service managers for better management of health service.

Robert J. Parsons, Bruce P. Murray, and Richard B. Dwore (2003). This study describes the results of a literature search of pertinent professional literature written on issues important to rural health-care delivery in the United States. Rural health-care delivery has become, in many respects, a major national concern during the past decade. Problems include: the continuing and marked exodus of health-care providers and organisations from “rural” and “pioneer” regions of the country, the numerous federal and state initiatives intended to insure the availability of health-care services and providers in rural communities and show government commitment to rural health issues, and the increased emphasis on memberships to rural health and health-care delivery by
the respective healthcare provider professional and affiliate associations. Overall, significant and salient issues facing health-care providers and administrators in the rural sector during the 1990s have made rural health-care delivery increasingly more complex and difficult to handle, while proving that it will be one of the toughest challenges that the entire American system of healthcare delivery will face in the new millennium. Solutions to rural healthcare problems are likewise illusory. The rural hospital, the bastion and central focus of rural healthcare delivery for half a century, is under siege in many areas, the most threatening being an inability to survive financially. Without the proper funding, it is impossible for these rural hospitals to deliver the quality and variety of care that concern rural patients. Furthermore, lack of funds creates different concerns for each of the stakeholders, i.e., the rural practitioners, patients, and healthcare administrators. However, the federal government has through the critical access hospital program provided funding to improve the status of rural hospitals.

D.Martin and H.Wrigley (2002) this study considers the problem of deriving realistic access measures between population demand and health service locations, in the context of a rural healthcare region of England. The study reviews approaches used in earlier work by the authors and others, and considers new public healthcare information systems that are now becoming available. An application is presented which incorporates the modeling of both private and public healthcare times for access to district general hospitals in Cornwall. This information has been assembled from published timetables in order to evaluate the use of more sophisticated access measures that might be used when such data becomes more generally available. The work is set within the context of an ongoing substantive research programme concerned with health outcomes in the rural south west of England.

Thomas c. Ricketts (2000): in this study the author says the rural healthcare system has changed dramatically over the past decade because of a general transformation of healthcare financing, the introduction of new technologies, and the clustering of health services into systems and networks. Despite these changes, resources for rural health systems remain relatively insufficient. Many rural communities continue to experience shortages of physicians, and the proportion of rural hospitals under financial stress is much greater than that of urban hospitals. The health-care conditions of
selected rural areas compare unfavorably with the rest of the nation. The market and governmental policies have attempted to address some of these disparities by encouraging network development and telemedicine and by changing the rules for medicare payment to providers. The public health infrastructure in rural America is not well understood but is potentially the most fragile aspect of the rural healthcare continuum. The character of rural health-care delivery in the 1990s has undergone significant changes caused by the rapid transformation of the U.S. Health-care system.

**WHO Report (2000)** proposes that primary health-care review can be at seven levels - national, district, health centre, community health workers, community leaders and household levels. “the main objectives of a review is to identify the strengths and weaknesses of a national programme in order to establish or adjusted priority and to make specific recommendations for future action” (WHO, 2000). Aspects to be covered in a review of primary health-care as outlined by WHO are:

1. **Health aspects**
   The health aspects involved an evaluation of the process, output and impact of the PHCs programme from the health sector perspective, using various indicators that reflect the results in terms of health sector performance, health activities output with respective individual programme and the health impact.

2. **Social aspects**
   The social aspects involve an evaluation of community involvement in health, including the influence of people at all levels in bringing about better health, the outcome in terms of community satisfaction and human resources development at the community level.

3. **Inter-sectoral aspects**
   This includes an assessment of how the contributions of other sectors, are affecting the health of the people ..... (WHO, 2000)

**WHO (1992)** opines that “ in PHCs evaluations and other studies, household surveys are often the only reliable way to get crucial data for the population as a whole, such as indicators of health status, coverage of health services and essential PHCs elements (e.g., immunisation, sanitation, water supply), use of health facilities”. Informations from households shall be collected through structured questionnaire, posing questions to a well informed adult in the household during the house visit. Data will also
be obtained from visual observation. Main types of issues considered at this level would be (1) social and economic determinants including inter-sectoral action and community involvement. This can help to identify the vulnerable or under served population in the areas of economic, educational or social development using indicators such as employment, literacy, agricultural productivity, wages or income level. (2) Provision of health-care - aspects to be considered as accessibility, acceptability, affordability, quality and utilisation of services as perceived at the household level. (3) Health programme indicators - indicators related to essential components of primary health-care will be considered - health education, immunisation, nutrition, maternal and child health and other programmes.

Kooreman, (1994). In this study the author explains the efficiency of health-care units. A number of studies have been conducted worldwide, and a few in India, to calculate the efficiency of healthcare units. In these studies a number of input and output factors have been considered while calculating the efficiency of the unit. Many health-care studies in India and abroad have defined different input factors, such as number of doctors, number of nurses/paramedical staff, cost of supplies, and cost of high-cost technical machinery. Some of the outputs selected are number of regular ad-missions, number of surgeries, case mix categories, and number of discharges. Apart from these quantifiable factors, Kooreman states that efficiency is also a measure of some hard to quantify factors, such as improved health status or improved quality of life.

World Bank Healthcare Report (2000). In this study, the author reviews the impact of scheme membership on health-care financial protection in India; a two-part model was used. The first part of the model analyses the determinants of using health-care services. The second part of the model analyses the determinants of health-care expenditures for those who reported any health-care use. There are several reasons for taking this approach. First, using health expenditure alone as a predictor of financial protection does not allow capture of the lack of financial protection for people who choose not to seek health-care because they cannot afford it. As the first part of the model assesses the determinants of utilisation. This approach allows us to see whether membership in community financing reduces barriers to accessing health-care services. Second, the distribution of health expenditures is typically not a normal distribution. Many non
spenders do not use health-care in the recall period. The distribution also has a long tail
due to the small number of very high spenders.

**World Bank Development Report (1993).** This study explains health-care
financing policy formulation in India, many of the international agencies had failed to
encourage appropriate insurance-based alternatives to fee payment at the point of use. In
particular, the 1993 world development report did not make recommendations for low-
icome countries that would change the situation in the short to medium term. Many
national and international departments and agencies now accept that the principles of
health insurance are applicable to low-income populations and are willing to study
examples of insurance initiatives for poor and informal households. The outcome
suggests that the design of community health insurance schemes may be improved by (a)
design specifications that utilize data on willingness to pay (WTP) of the target
population and projected health-care costs; and (b) incorporating modalities of operations
that facilitate cost-effective exchange between a formal organization and individuals
acting in an informal environment.

**World Bank Report (2005):** in this report focus on improving health service
delivery that have been discussed in the literature. Peabody (2006) summarizes these in
the context of low- and middle-income countries:

a. Generate and encourage the use of specific clinical algorithms based on evidence
of best practice.

b. Have service providers acquire skill and speed by doing a few things frequently
rather than many things occasionally. Learning by doing is key to improving
performance. This lesson is very relevant for India given the hard reality that, at
least initially, the rural healthcare mission will have resources only for a limited
set of high-priority items.

c. Improve provider incentives by creating a legal and ethical environment where-
care providers do not profit personally from the sale of drugs, diagnostic
procedures, or provision or referral of care. Overuse and misuse of resources
typically flourish in such unethical environments.
2.2.3. Conclusion

This chapter discussed the literature contribution of scholars in the fields of rural health-care management, primary health-care concepts, health-care centre infrastructure development and community participation. The variables that have been used in the works are studied in-depth to carry on with the objectives framed for this study. The existing study is built on the theories of performance measurement in health-care centre primary care delivery system, availability of facility in primary health-care and therefore enough emphasis is given.

The literature, while reflecting a range of approaches to defining primary health-care quality services and community participation, has an implied agreement that it is a complex construct influenced by many factors including context, relationships and power issues. Over time, definitions of community have moved from an emphasis on tangible aspects such as geographical location and ethnicity to consideration of the more dynamic and complex interrelationships, networks, process elements and diversity. One common theme emerging from the literature on participation is the importance of power sharing for sustainability. Debate is continuing about the degree of success being experienced internationally in operationalising the emancipatory discourse of the WHO declarations.

A number of frameworks to facilitate health-care and community engagement have been presented in this chapter representing different approaches to managing structural issues, imbalances of power, skill acquisition and interdependencies. The reality of implementing policy which requires communities to be meaningfully engaged also has risks. Careful consideration of these risks, the literature suggests, will ensure the likelihood of disempowerment, project failure, conflict and disillusionment be minimised.

The next chapter looks into theoretical framework of rural healthcare management, primary healthcare concepts and community participation. The chapter discusses the various practices, activities and methods involved in rural health-care system. The performance measurement primary health-care system concepts, its uses and how it is deployed in the health-care are discussed in a detailed manner to augment the argument in favour of the present study.