CHAPTER-II
REVIEW OF LITERATURE

A meaningful analysis of any scientific discipline depends on how we build our theoretical formulations revolving round theory, method and data. The analysis of health care delivery system in Haryana and particularly in Rohtak district has to be within the mainstreams of researches done in the field of health care facilities. The review of literature pertaining to the field has direct bearing on the present enquiry.

To introduce the undertaken research and to understand the different aspects of the subject, a review of the literature is presented below; Studies under review can be grouped in (i) Public health care; (ii) Interaction between doctor-patients and other health personnel (iii) public-private health care and (iv) private health care.

PUBLIC HEALTH CARE:

Jeffery (1988) in his book “The Politics of Health in India” provides a detailed account of health services in India since 1947 to the 80s. Even the author highlights the status of health and health services in India before independence. He also considers the health status and services during British rule, the patterns of health expenditure in India, different health plans and policies, education of health personnel, working pattern of health institutions and the training for paramedical workers. He points out that since 1970, the reforms have continued but the health system in India needed more attention, specially at rural level. Also there is a need for improved water supply and sanitation. The author suggests that with more attention and great efforts the ‘Health of All’ in India by the year 2000 may be an attainable goal.

Mehta (1992) in his book “Society and Health” elaborates the context of India Health Scenario by taking certain issues like health and medical care
delivery system in India, healthcare as a profession, health education, role of physicians and nurses etc. The book indicates that health is the responsibility of both the individual and the society. But it suggests that as far as health maintenance is concerned, the individual has a far greater responsibility than society. The analysis of different aspects of health care system and population suggests that keeping in view the majority of rural population and inaccessibility of health care services, the indigenous medicines and practitioners including homeopaths should also be considered within the mainstream of our health care system. The book deals with the very important issue of health education and also gives a brief account of the growth and development of health sociology in India.

Bidani and Ravallion (1997) try to address two questions; Are the poor less healthy? And does public health and spending matter more to them? A random coefficients model was estimated, regressing aggregate life expectancy and infant/parental mortality rates across 35 counties against data on the distribution of consumption per person, allowing for differential impacts of public health spending and primary schooling. The results suggest that those living under $2 per day can expect to live nine years less on an average than the rest, and that their children are fifty percent more likely to die before their birthday. Thus the incidence of consumption poverty is an important determinant of consumption poverty in aggregate health outcomes. The better-off appear to be protected from those differences, presumably because they are in a better position to substitute private for public health spending. This finding reinforces efforts to protect public spending on basic health and education, not doing so could entail large costs to poor people.

Nagla (1997) in her study ‘Sociology of Medical Profession’ has tried to find out the prevalence of various medicine systems and people’s preference towards these systems. The study also provides a historical background of evolution of various medical systems in country. This also
presents an interpretation of various schemes of health and prevention and treatment of diseases in the context of National Health Policy and different Five Year Plans. The contribution and activities of voluntary agencies in terms of Homeopathy and naturopathy etc. have also been discussed. The study suggests that health policy and medical infrastructure in the country needs to be viewed and treated within the wider societal context. This attempts to see Allopathic medical system as a profession and also the health and illness in the state of Haryana.

Peter (2001) in his study entitled 'Health Equity and social Justice' outlined an approach to health enquiry that proceeds indirectly and embeds health equity within the general pursuit of social justice. The study argued that social inequalities in health are unjust basic structure of society i.e. a basic structure that imposes sacrifices to the worse-off groups. The study observes that to be able to form a judgment on social inequalities in health, one needs to understand the underlying causes. Understanding the effects the basic structure has, on people's prospects of health, may help us to decide whether or not these institutions ensure the social bases for self-respect for everybody.

Sen, Iyer and George (2002) present preliminary result of an analysis of data sets on morbidity and health care utilization from two NSS surveys in the 1980s and 1990s together with empirical results of other studies, which point the worsening of class-based inequalities in access to health services for both men and women. They argue that despite attempts to develop a wide range of institutions and to provide a floor of basic services through the public system in order to meet the goals of affordable and accessible health care for all, the reality was rather different. Public health services were poor in terms of access and quality. They have shown that by the mid 1990s, the private sector had become dominant in terms of both out-patient and in-patient
Untreated illness among the poor have clearly increased. Rao (2004) recognizes that health status is related to and determined by numerous factors such as per capita income, way of life, housing, sanitation, water supply, infrastructure, untraditional education, health services provided by the government climate, religious beliefs etc. The study found that during 1986-99, the birth rate declined significantly by 10.10 percent while the death rate also climbed down from 9.9 percent. Expansion and extension of health facilities to improve their accessibility and availability yielded positive results. However, the finding of the study that the stagnant or marginally negative infant mortality rate during 1990-2000, particularly in rural areas is a matter of great concern that need to be addressed immediately. Higher rate of literacy, high level of per-capita income, larger expenditure on public health, improved medical facilities both in public and private sectors, contribute to an improvement in health status.

Das, Rai and Singh (2004) point out the poor quality of care of public health service in Uttar Pradesh in their paper ‘Medical Negligence and Rights Violation.’ They talk about it in the context of poor quality of care received by women in tubectomy camps in Uttar Pradesh. The paper reveals that about 85.3 per cent persons who have adopted this method availed this service from government facilities. But in Uttar Pradesh, there is a heavy burden of failure, morbidity and often mortality in these cases. As a study conducted in this context by ‘State Innovations in Family Planning Services Agency (SIFPSA, 1999) reveals that almost 50.5 per cent of the women suffered post-operative complications and the failure rate is 4.7 per cent. In fact, the paper clearly highlights the special and urgent need for a standardized quality care provided by public health services.

Ahuja (2004) in his paper ‘Health Insurance for the poor’ has made an attempt to underline the necessity and importance of health insurance for the
poor as a financial tool to meet their healthcare needs. The paper suggests that community based health insurance can be an effective way of reaching the poor. The paper suggests that private health insurance should also be included in health insurance schemes for the poor but with much managerial impact. The author points out that there is much economic imbalance in India. Therefore, poor people suffer because of their incapability to pay. That’s why they should be included under any insurance system whether public or private, but these insurance schemes must strike a balance between economic efficiency and equity.

Chowdhury (2004) in his paper ‘Recent Welfare Schemes : An Assessment’ presents an analysis of the welfare health schemes for the poor. He specially, points out two welfare schemes i.e. UHIS (Universal Health Insurance Scheme) and SSS (Social Security Scheme) for the unorganized sector workers. The Universal Health Insurance Scheme (UHIS) offers a package of insurance cover for a limited reimbursement of expenses for hospital services. This covers the expenditure during hospitalization in particular health services centres i.e. government hospitals, health centres operated by NGOs, trusts and private parties etc. The Social Security Scheme also is a scheme which covers workers in organized sector. The Sewa’s Integrated Social Security Scheme, ESIS (Employment State Insurance Scheme) and Central Government Health Scheme also work for a large section of population but the author suggests that private sector, with a better management, should also be included in insurance sector to cover more and more people under health insurance.

Rao (2004) in her paper on ‘Health Insurance : Concepts, Issues and Challenges’ underlines the importance of health insurance as the best instrument to reform and restructure the health system. The present insurance financing and payment systems are not suitable for all sections of population so the Budget of 2003 and 2004 talked about a generous health insurance
package aimed to protect the poor from financial risk. Infact, the main objective of the paper is to analyse the conceptual and critical aspects related to designing of health insurance suitable for India. As in India, there is the dominant private sector and people are paying much on healthcare, so there should be a suitable public policy on health insurance that has to be concerned with their misery.

Roy, Kulkarni and Vaidehi (2004) in their paper ‘Social inequalities in Health and Nutrition in Selected states’ have discussed that government has created a large number of primary health centres and subcentres under its ‘Health for All’ programme. But ‘National Family Health Surveys’ 1 and 2 show the other side of picture which reveals that these health services either do not reach disadvantaged sections or are not accessed by them. The paper also highlights the inequalities in nutritional status and health care in different states with a focus on caste and tribe. It tries to examine whether caste and tribe have any relation with these inequalities. The data presented in this paper prove that in caste- ridden society like India, social hierarchy is a serious handicap for utilization of health services and educational sector. It is also related with the different economic conditions and educational status of individuals belonging to different caste and tribe categories.

Sankar and Kathuria (2004) in their study ‘Health System Performance in Rural India’ attempt to analyse the performance of rural public health system in India. This study was conducted in 16 major states. The study reveals that not all states with better health indicators have efficient health systems. The study concludes that investment in the health sector alone in not enough, but an efficient management of the investment is required. Secondly, there is a need to create more health infrastructure and thus provide better access to health facilities. Both qualitative and quantitative measures need to be taken of health system performance to produce results.
The paper 'Budgeting for Health: Some Considerations' by Kumar (2005) is an attempt to understand the health needs of the Indian population and health related announcements in the budget of 2005-06. The paper points out three important elements – first is to ensure adequate finances, second is the requirement of well-motivated village health workers and third is to improve managerial efficiencies and accountability. To ensure all these elements, active involvement of local governments in health promotion and non-governmental organization in delivery of healthcare is required. The author tries to suggest that NRHM (National Rural Health Mission) programme must be implemented with great effect. The budget announcement for 2005-06 to increase allocations for financing the NRHM is an important step because rural population needs more attention in health care and great efforts are needed for this particular segment.

Bose (2007) in this paper ‘India’s Disturbing Health Card’ discusses the state-wise health chart. In it, he has discussed about the health problems faced by women and children. He points out that the National Family Health Survey – 3 data show disturbing trends for children and women in reproductive age, especially in the sick states of Bihar, Madhya Pradesh, Uttar Pradesh and Rajasthan. The data show that Himachal Pradesh is progressive on several indicators and comparable to Kerala, while West Bengal is showing signs of joining the ailing states. The author suggests that states with disturbing health cards should be in the list of ‘high focus’ states. These states should have special treatment under ‘National Rural Health Mission.’

Joe, Mishra and Navaneetham (2008) in their paper discuss and analyse the National Family Health Survey – 3 data. This paper presents an analysis of income-related health inequality in India. The analysis reveals that the degree of health inequalities escalates with the rising income inequalities. It suggests that increase in income inequality result in high levels of health inequality. It further stated that if medical care is subsidized through public
spending, it will help to lower the consequences of health inequality. The paper suggests that average income of the population is significant in determining the health status. The paper suggests that different income groups have different needs, therefore plannings should be made to understand and take into account the source of inequality and to identify vulnerable groups to arrive at efficient resource allocation and policy making.

The paper ‘Demand and willingness to pay for health care in rural West Bengal’ by Mazumdar and Guruswamy (2009) has focused on demand, utilization and quality of health care in rural northern Bengal. The paper is based of northern Bengal which investigates willingness to pay (WTP) for publicly provided health care service for malaria and diarrhea and household demand for health care. Monthly per capita consumption expenditure (MPCE) is used as primary measure of household economic status. The results show that most of the respondents are willing to pay upto an amount of Rs. 40 for better services in public hospitals. But others responded that they are not willing to pay because hospitals and facilities are meant to be delivered free of cost. The findings indicate that most of the people are willing to pay for better quality and availability of drugs and medicines even for public services.

The eleventh five year plan proposed to introduce a new health plan for urban areas called ‘NUHM’ i.e. National Urban Health Mission. The paper ‘The missing Mission in Health’ by Gupta and Bisht (2010) throws light on this issue. It highlights that National Urban Health Mission was introduced to address the health problems and needs of urban Indians. It says that despite a number of public and private healthcare providers and institutions in urban areas, a large proportion of homeless and people living in slum areas are left-out, due to migration from rural areas and urbanization, the urban population is increasing rapidly. The paper depicts that NUHM was launched about one and half years ago but it has failed to mitigate the health problems for the urban poor. Many problems like lack of budgetary support and less effective
health insurance schemes are there. There is a need to strengthen entire complement of support services including health insurance, blood banks and ambulance facility etc. In fact, there is a need to reform and renew the whole urban health system.

Gupta and Das et al. (2010) in their paper ‘How Might India’s Public Health System be Strengthened? Lesson from system and central government’s policies should be analyzed and strengthened on the basic principles of Tamil Nadu’s public health system. The public health system in Tamil Nadu offers some basic points for strengthening public health system within the administrative resources available to most states. The central government can consider linking its fiscal support to states’ health budgets to phased progress in some fields like the enactment of state public Health Acts to provide legislative underpinning for public health work, to establish separate public health directorates in states, to provide their own budget and workface and to revitalize the workforce at managerial and grassroots levels. The authors suggest that those measures can do much help to use public funds more effectively for protecting people’s health.

INTERACTION BETWEEN DOCTOR-PATIENT AND OTHER HEALTH PERSONNEL:

Poynter (1969) in his edited book on Medicine and culture emphasized on the extent culture and medicine are inter-related and also on the role of medicine in the rapidly changing society. The discussion is made in the context of the two great civilization of Asia i.e. China and India, where traditional and popular medicine system and modern medicine system are prevalent together. The concern is to understand how these should be reconciled in the countries where transformations are taking place, and the role of changing medical profession. All the societies have their own needs and nations regarding health care and medicine. So the role of medicine and
doctors should be according to the social as well as scientific needs. For example, same kinds of doctors are not needed in Nigeria and Washington. Therefore, medicine and medical profession is influenced and directed by some inter-related forces which may be historical and cultural.

Ewles and Simnett (1985) in their book ‘Promoting Health : A Practical Guide’ discuss very important issues related to health and healthy promotions. They are of the opinion that first of all, the persons who practice health promotion should have clear ideas and direction about health promotion programmes. There should be clear aims and objectives. There should be proper communication with clients. All the professionals, organizations and health agencies whether public or private should have co-ordination and teamwork. All these things will help to motivate people towards healthier living. And with the help of people, health promotion programmes can be made more popular and successful.

‘Medical Care : Readings in Medical Sociology’ is an edited book by Lal and Chandani (1987) which contains sixteen significant papers on different issues. These papers discuss important issues like growth of medical sociology in India, health system and polity, doctor-patient relationship, medical profession in India, rural health care services, utilization of health services, patient satisfaction and health policy in India etc. R. Venkataratnam in his paper ‘Health System and Polity : A Note on India Scene’ points out that changes in health situations in India can be obtained with the effective changes in existing socio-political structure. Mohan Advani in his paper indicates that patient’s satisfaction largely depends on professional healer. D. Banerji emphasized the social-orientation of health technology. He was of the opinion that health workers should personally contact the people, identify their problems and find out the solution within social-epidemiology frame. He suggested that socio-cultural, economic and psychological factors should be significantly considered in the study of health.
The book on sociology of Health and health care edited by Taylor and Field (1993) contains many papers related to health care. The book provides deep understanding of sociology of health and its relation to nursing profession. It conveys that health promotion is a great necessity in all kinds of societies. Health and health promotion are shaped by social and cultural factors. It suggests that doctor-patients relationships and nurse-patients relationships should be viewed in the sociological context role in understanding people’s experience of illness, the ways to cure, disability and mental disorder. It suggests that organization and delivery of health care must be designed according to the particular social structure.

Nettleton (1995) in her book ‘The Sociology of Health Illness’ provides deep insight to the issues of health and illness in a sociological meaning. The book deals with health beliefs, social context of health and illness, social inequalities and health status, health policies and health promotion etc. social construction of medical knowledge and professional-patient relationship is very important. The medical profession and medical knowledge should be based on social aspects. It discusses that health policies should include health promotion, community health care and active participation of the people. In the era of globalization, people are not only the recipients of medical treatment but also the active participants in the maintenance of their own health.

Sundar (2000) conducted a field study in Dakshinpur, a low-income resettlement colony of Delhi. This study reveals that poor environment and living conditions have given rise to high incidence of diseases. The study reveals that the reason for underutilization of health services mainly rests with an array of functionaries involved in the health care system and their deep involvement is must for the success of any health services utilization programme.
Gandhi (2002) observed that most of the countries in the world including India and other countries in South East Asia Region have recorded impressive gains in development during the century. Despite overall movements to control some communicable diseases, many are still deep rooted in the country and are still the major causes of mortality. The study suggests that effective health information system should be established. Good quality of facilities and adequate drugs, vaccines and equipment should be manufactured and made available at affordable prices. So in order to meet the challenges of 21st century and to achieve the objectives of Nation Health Policy 2001, the health should be attached higher priority on political agenda.

Anne, Darran and Christina (2002) observed that the positive association between health and income in adulthood has antecedent in childhood. The study found that a family’s long run average income is a powerful determinant of children’s health status. It is likely that families with high income are better able to manage the chronic health problems. But poor families are deprived of high level health facilities. Poor children also arrive at the doorstep of adulthood with lower health status and with less education.

World Development Report (2006) observed that inequalities in incomes, in health and in educational outcomes have long been a stark fact of life in many developing countries. The report present evidence on the inequality of opportunities with and across countries and illustrates the mechanisms through which it impairs development. Domestically, it makes the case for investing in people, expanding access to justice, land and infrastructure and promoting fairness in markets. The world Development Report, 2006 is essential reading for understanding how greater equity can reduce poverty, improve health, advance development and deliver increased opportunities to the poorest groups in our societies.
PUBLIC-PRIVATE HEALTH CARE:

Yesudian (1981) conducted a study in Bombay city to understand the health behaviour of different social classes, i.e. high, middle, low and very low. He observed that low and very low social classes use mostly the government health services because of their financial problems. Also they have least knowledge about most of the diseases and their treatment. Mostly, they prefer the place where treatment is offered free of cost. While the people who have paying capacity prefer better treatment of diseases whether in public or private.

Bhat (2000) in his paper ‘Issues in Health: Public-Private Partnership’ discuss and analyse the policy initiatives and health financing scenario in India. He summarizes the key issues and prospects of developing public-private partnerships in India. The paper reveals that different states have offered subsidies to the private sector. The Punjab government offered subsidized land to private sector while other states like Delhi and Rajasthan offered subsidies not only on land but on tax, equipments and infrastructure. But he argues that these steps are not sufficient. The public-private partnership in health in India is at a very early stage. So this will need significant institutional development work. The paper tries to suggest that a policy should be evolved which takes a sector-wide view in clarifying the role of public-private institutions appropriately. The public policy towards private sector needs to spell out the mechanisms of providing incentives to private sector. He says that these partnerships are in demand in the present conditions, but these should be regularized to have fruitful results.

Mondal (2003) conducted a study in Bardhman district of West Bengal. This study explains the social aspects and behavioural pattern during pregnancy in terms of nutrition, health and treatment seeking. The study reveals that due to lack of education, low income, lack of medical facilities, more preference for the traditional ways and inaccessibility were the
important reasons for not taking institutional help during pregnancy. Among these women, 56.4 per cent responded that they had not consulted anywhere while only 11.1 per cent went to private clinics due to serious problems.

Drache and Sullivan (1999) in their edited book ‘Health Reform: Public Success and Private Failure’ have highlighted different aspects related to private health care services. Many authors have expressed their ideas in their papers on various issues related to private health care such as decentralization of health services, health reforms, consumerism, public-private partnership and also the need of an international health policy. The book discusses that privatization is the need and demand of the present world. Increasing requirements for better health facilities has paved the way for the privatization of health services. So these services should be dealt within the particular and international scenario as well.

Randall and Gupta (2000) found that health expenditure in India as a percentage of its GDP is higher than the level in many under developed countries in Asia and a greater part of this comes form the private sector. In other words, public sector expenditure on health care is rather under funded and also suffers from quality and access problems resulting in higher dependence of consumers on the expensive private treatments. The main contention of the paper is that the higher financial burdens of consumers on account of health arise because of lack of or inadequate insurance to meet their health care expenditure. According to the study, even those covered by health care plans experience growing inefficiencies and low quality of services. The authors believe that there is an enormous potential for health care insurance that needs to be tapped through public and private initiatives.

Baru and Nandy (2008) in their paper ‘Blurring of Boundaries : Public Private Partnerships in Health Services in India’ discuss the evolution, structure and characteristics of public-private partnerships in health care over the last six decades. This paper argues that these partnerships have broken
down the traditional boundaries between market and state, with multiple roles of actors and newer institutional arrangements. There should be free and fair competition in the selection of partners. This states that there is an intrinsic asymmetry and ambiguity in terms of choice of partners, terms and conditions of partnerships and lack of clearly stated norms and rules, which has serious consequences for governance and accountability. Therefore, to have better results in the field of health delivery, there is need to critically analyse these partnerships and assess their role for the future.

Kumar (2008) discusses some important issues and challenges of healthcare in India. Lack of quality in public health, improving rural healthcare, women’s healthcare and empowerment, investment in healthcare and complementary and alternative medicine are the major issues. He is of the opinion that reforms on a large scale are needed in health sector and there is a long way to go. He says that high-value private players are entering health sectors and the health care is growing costly. On one hand we are facing the problem of brain-drain and on other hand India is becoming favoured destination for medical tourism. That’s why we need to evolve a multi-dimensional approach in health sector.

Datta (2009) in her article on ‘Public-Private Partnership In India: A Case for Reform’ highlights the emergence of public-private partnership model in different sectors i.e. infrastructure, education and health. Public-private partnership is a new trend of development where state and private organizations work together to achieve the common goals. Privatization of the public services has led to the exclusion of the poor. Therefore, private resources should be brought in to public projects, not public resources in to private projects. As far as, health sector is concerned, there is a dismal record at providing health care to the population living in different states especially the poor. So the policy of public-private partnership in health sector should be strengthened by bringing together the primary health centers, social
franchising and demand-led financing and NGO’s etc. The most important thing is that the role of different agencies should be explained and decided clearly.

Chatterjee (2009) in his research publication examines the implication of globalization of services under the GATS (General Agreement on Trade in Services) Treaty for the health sector of the Indian economy during the post – reform period. The book covers an analysis of globalization, GATS and health sector and provides a critical review of the literature on health and economic development. The book points to the link between poverty, malnutrition and morbidity in India. It suggests that a turn-around in the country’s health conditions can not be expected but integration of trade policy and health policy reforms are necessary to face the challenges thorn open by the new open regime. It emphases that poor public health infrastructure and rise in private health expenditure has worsened the scenario. So collective efforts are needed.

Neelima and Reddy (2009) in their study on ‘People’s perspective on Health Care Services in rural Andhra Pradesh: An Epidemiologic Study’ have tried to understand peoples views regarding present health care system i.e. public as well as private health care system. Regarding public health care system, respondents focused on problems such as lack of government hospitals in the village, distance and transport problems, absence of the staff from the hospital during duty hours, lack of free medicines and supporting staff etc. Regarding private health care system, it is revealed that most of the respondents were dissatisfied because of over-charging by the private doctors. They felt it to be burdensome on them. Regarding the choice of medicine system, a considerable number of people preferred allopathy for the reason of immediate relief and also because of the easy availability of allopathic medicines.
A paper ‘Effective Public-Private Partnership in Health Care: Apollo as a Cautionary tale’ by Thomas and Krishnan (2010) underlines the importance of regulating the health care institutions falling the public-private partnerships. The study has pointed out through an example of Apollo Hospital groups which failed to provide free services to the poor patients under the agreement with government under public-private partnerships. India has tremendous disparities in the health sector. On one hand, rich people have access to high level treatment and on the other hand, poor people do not get even the primary health care. Therefore, there is a need to regulate the private health sector. Enforcement of laws pertaining to registration and licensing of practitioners and medical care institutions are much needed. An urgent need for reducing cost and effectiveness of service provision is also highlighted.

PRIVATE HEALTH CARE:

National Council of Applied Economic Research (NCAER) conducted a national survey in 1990 which brought out that in 54.75 per cent cases private doctors were utilized in urban areas and in rural areas the percentage of the utilization of private health facilities was 55.46 per cent. The average household expenditure on health was 142.60 Rs. per illness episode in urban areas and 151.81 Rs. in rural areas.

Kerala Shastra Sahitya Parishad (KSSP) undertook a study under the supervision of Kannan, Kutty, Thankappan and Aravindan (1991) in the rural areas of Kerala which revealed that 66 per cent respondents utilized private health care facilities. The household spent 7 per cent of their total reported income in health care.

Baru (1998) examines and discusses an important and critical issue of privatization of health care and its social basis which is transforming the future of public health services in India. Despite the growth of the public sector until the 70s the private sector was also expanding and had actually
consolidated itself. It traces the growth of the private sector in India and examines the role of professionals. It argues that in India, where a significant percentage of population lives in poverty, paying for private health care is an additional burden, which will result in further impoverishment so there is a need to regulate private sector at both national and state levels.

The paper ‘Beyond the law and the Lord : Quality of private Health care’ written by Nandraj (1999) indicates that private health sector constitutes a very large part in the health sector in India and still it is growing rapidly. The paper discusses through various data that private sector shares 4 to 5 per cent of gross domestic product. The people not only in urban areas but in rural areas also approach private health facilities in most of the cases. But the author suggests that sometimes private health institutions do not prove to be up to the mark in providing health facilities. So there should be any regulatory body to have check on private health institutions.

Duggal and Amin (1999) conducted a study in Jalgaon district of Maharashtra to know the expenditure over health care by households and also the utilization pattern of health services. The study brought out that in 83.45 per cent cases of active illness private practitioners and hospitals were approached and only in 9.07 per cent cases public health facilities were utilized. The per capita expenditure on health was found to be Rs. 182.49 per year. The household reported that 9.78 per cent of income and 7.64 per cent of total consumption expenditure were spent on health care.

Shah and Nandraj (1999) conducted a study in two backward districts of ‘Madhya Pradesh i.e. Morena and Sagar under foundation of Research in Community Health (FRCH) in 1999. The study showed that in this year in this particular area 1932 illness cases were reported. Out of these 69.05 per cent approached private health facilities and the per capita expenditure incurred by the household was 299.16 Rs. per year.
The paper ‘Rural Health : Practice Role for the State’ written by Gill and Ghuman (2000) throws light on the growing disparity in health care facilities between rural and urban areas with special reference to Punjab. The paper indicates that there is much difference between rural and urban health care facilities with regard to health institutions as there are more private health institutions in urban areas as compared to rural areas and also the medical and para-medical staff. It is the duty of the state to provide better health care facilities to the people in both urban and rural areas but rural areas must be given special attention.

Baru, Qadeer and Priya (2000) in their article ‘Medical Industry : Illusion of quality at what cost’? pointed out that since 1980s, the government has taken many steps for the development of private health sector. The government formally recognized private health care as an industry during mid 1980s. Many concessions and subsidies have been given to the private health sector. But there are some conditionalities for them also. One of them is that 20 per cent of in-patients and 40 per cent of out-patients should be among poor and must be treated free of cost. But the paper reveals that these conditionalities are not fulfilled by larger private hospitals. Another thing is that it is assumed that the private sector provides a better quality of services than the public sector. But a report on Delhi’s private hospitals reveals that many large hospitals have not adhered to the conditionalities. So there should be check on private institutions.

Baru (2003) in her article ‘Privatization of Health Services : A South-Asian perspective’ identifies key processes that influence the size and characteristics of private provisioning in health care in India, Pakistan, Bangladesh and Sri Lanka. The article reveals that the growth of middle class and their influence on both the supply and demand of health care services influence privatization. Especially in India, the growth of middle class has proved a turning point for the privatization of health care. Further, it argues
that the process of privatization in South Asia present common trends but also variations in terms of structure and characteristics across the four countries.

Sen’s (2003) edited book contains many thoughtful papers on WTO’s General Agreement on Trade in Services (GATS), ethics and medical care, critical analysis of health system’s performance, privatization of health in the context of different European countries. The book helps to understand what is happening to health services world wide. As for as India is concerned, the book points that private sector is growing rapidly. The growth of private medical care has had an adverse impacts on public hospitals and created social segregation and dichotomy in access to medical care. Public hospitals are used by the private sector hospital for dumping unwanted cases. The serious cases are transferred to government hospitals to avoid medico-legal problems to save their reputation. So the book underlines the great importance of having regulation on quality, pricing and working of private healthcare institutions.

‘Strained Mercy : Quality of Medical Care in Delhi’ is a thoughtful paper written by Das and Hammer (2004) based on the survey conducted in Delhi. The survey tries to reveal how health care providers quality affects the provision of health care. The paper tries to point out that in some cases doctors know what to do but they lack in practice. To examine these points they interviewed more than two hundred doctors of different clinics. It was revealed that providers in both, public and private sectors but specially in private sector, the providers feel constrained in their behaviour by the nature of the market. Sometime they know the right treatment but they have to suggest the treatment differently to cater to the patient’s expectations. The study is also important for understanding the regulation on the health market.

Gautam, Tiwari and Sethi (2007) in their paper ‘Transition and challenges of Health in Global Context: An Indian perspective’ explains the health and health sector in global context. The paper explains demographic
and epidemiological transition taking place all over the world particularly in Indian sub continent. Due to increase in population, the world is facing many challenges in the health sector. The disease profile of the population differs with the difference in status. The underprivileged sectors of the society due to poverty, poor health, malnutrition and hygiene are vulnerable to infectious and communicable diseases. On the other hand, the people living in urban areas are facing some other kinds of problems such as obesity and other health problems caused due to their life-style and changing environment. To achieve the goal of ‘Health for All’ is not easy. It needs micro-level approach and efforts targeted in different sectors. Along with a focus on poverty, population stabilization and pollution, there is a need to use the health sector with a multi-sectoral approach in which proper utilization of private health sector and approach based on the problems of specified region is most important.

Berman, Ahuja and Bhandari (2010) in their paper on ‘The Impoverishing Effect of Healthcare Payments in India: New Methodology and findings’ find that the share of private healthcare spending in India is much higher and is a considerable financial burden on households. In this paper, an analysis of NSSO survey data is presented which provides a picture of spending in India. The NSSO 60th round data suggests that much of the impoverished i.e. 76.5 percent of households or 77.4 percent of individuals are in rural areas. In urban areas, it was 23.5 percent. The paper also highlight the WHO data (2008) which shows that in India, the private expenditure of total expenditure on health is 81 percent which is much higher as compared to many countries like China Chilli, Brazil, Malaysia and that health policies to an extent have not been successful and that’s why health related impoverishment remains high. So better analysis and more effective policies are needed.
An article ‘Rural Healthcare and Indebtedness in Punjab’ by Singh (2010) is based on a study conducted in selected villages of Amritsar and Gurdaspur districts of Punjab. In this study, 300 marginal and small farmers were selected and interviewed to understand the problem of increasing indebtedness due to the credit taken for healthcare purposes. It was found that due to privatization and commercialization of health services, a sizable proportion of the population i.e. small and marginal farmers is deprived of getting good health services. They acquired credit for two purposes mainly. One of them was for the purpose of agricultural inputs like seeds and fertilizers etc. The second important purpose was for health reasons i.e. nearly 20 percent to 23.2 percent of the total credit. It was found that they had to acquire credit because government health facilities were inadequate and not available at times. That’s why they had to avail private health facilities and these small number of government health institutions were also over-burdened. It is suggested that there should be increase in the share of state expenditure on health care and some other steps like improving existing health facilities, to check absenteeism and filling up vacant posts in these institutions should be taken.

The review of literature shows the recent trends prevalent in the delivery of health care services at different levels. The public health care studies which have been either conducted at hospitals or in primary health care situations come out with the findings of inadequacy, inefficiency at the level of infrastructure and at the level of providers of health care. The interaction studies between doctor-patients/ or consumers and other health professionals spell out the interaction at limited level. The consumers of health care find limitations of interaction at the level of overpopulation of patients, constraints of time and non-empathy of doctors. However, the providers of health care maintain that the interaction is limited because of shortage of doctors and also because of illiteracy and non-awareness of
patients. The current expanding scenario of private health practitioners has emerged as a challenge to serve the vast majority of the population. This in fact led to the concern of the consumers who are paying for the health care and in turn want to have appropriate health care. Lastly, the exclusive studies on private health care have outlined the danger of pushing people into debt as vast majority of the people are not able to have even the basic necessities of life. The flood gates of globalization has also entered into health care and resulting into further pushing them into poverty.

Since very few studies have been done on nature and pattern of private health care in totality, majority of the studies have not included the basic units of health care i.e. doctor, users of health care and also the organizational aspects in one framework. Exploration of our study becomes more important as we have also included the regulatory mechanisms perceived by the doctor as well as users/consumers. We have also tried to ascertain the views of consumers on health policy which in turn becomes the concern of country as a whole for the delivery of health to the people.