CHAPTER - II

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2.1 Introduction

Many studies have been conducted on Public, Private and Public Private Partnership in healthcare. This chapter provides the details of studies happened earlier.

Health refers to soundness of body and mind, which should be free from diseases and disorders. In order to lead a healthy life, proper health care is essential. Good health is possible through good hospitals with life-saving equipments.

Health is an important aspect of human resource development. Good health care facilities and services are essential for creating healthy citizens and society that can effectively contribute to social and economic development. With increased urbanization, industrialization and the changing environment, health related issues and problems are being emphasized and have become great concern for the contemporary world.

Capital formation is very important variable in determining the rate of growth of the economy. The ability to add the physical wealth depends on their physical and mental capabilities. Such capabilities depend on their health, education and training. Health conditions of the people and economic development go hand in hand because better the health conditions leads to higher level of their capabilities to develop economy. Health of an individual is affected by general health conditions of the country and vice-versa. Therefore, health of a community needs higher attention while considering development of the country. In general, level of living of the people in a nation is affected by the health conditions of the population of that country and this depends on the health care facilities available in that country.

Health is fundamental need towards national progress in all the economies. In terms of resources for economic development, nothing is considered of higher importance than the health of the people which is a measure of their energy, capacity and potential man-hours for productive work in relation to the total number of people maintained by the country. For the efficiency of industry and agriculture, the health of the worker is an essential consideration.

Over the years, through the researchers, academicians and government have tried to find ways and means of healthcare, many issues and aspects of health, such as provision of quality services and an effective delivery system, managing health
expenditure with its financing and adequate expansion of service network throughout the country to achieve equity in access to health care are yet to be completely resolved. More attention has been paid to the micro aspects of health economics by the researchers, government, policy makers and the development planners. Hence the present research work attempts to focus “A comparative Economic study of Public and Private Health Care Service with reference to Bijapur District”. The review of literature has been carried out thematically and chronologically as under:

- Nature, Scope and Significance of Health
- Public Health Care Services
- Private Health Care Services
- Public Private Partnership in Health Care Services (PPP)
- Other Sectors involved in Health Care

2.2 Nature, Scope and Significance of Health

Health is viewed differently by different people all over the world. The world Health Organization defines health as “A state of complete physical, mental and social well-being and not merely an absence of disease or infirmity”.

“Health is a positive state of well-being in which harmonious development of mental and physical capacities of the individuals lead to enjoyment of a rich and full life. It implies adjustment of the individuals to his total environment-physical and social.”\(^{15}\)

S.C. Seal, in his Presidential address, defined health as “Flexible state of body and mind which may be described in terms of a range within which a person may stay away from the condition wherein he is at the peak of enjoyment of physical mental and emotional experiences, having regard to environment, age sex and other biological characteristics due to the operation of internal or external stimuli and can regain that position without outside aid”.\(^{16}\)

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\(^{15}\) Government of India, *First Five Year Plan*, 1951, p.488.

\(^{16}\) Online Available at <http://shodhganga.inflibnet.ac.in/bitstream/10603/11652/10/10%20chapter%202.pdf> accessed on 22/03/2013
As per Stanley H. King (1962)\textsuperscript{17} perception of disease is also an important factor affecting the health services utilization. Poor perception is a reflection of faulty health practices and results in health in the high-class families. In his study he gives the symptoms of three well-known diseases, cancer, diabetes and poliomyelitis. The analysis revealed that the number of respondents who were not able to identify even a single symptom steadily increased with decreasing with education and income. Many low income respondents perceived that cancer was a communicable disease.

The literature on utilization of health services has mainly looked in terms of access, in relation to geographical distance and time. Access to health care services is linked to the distance of the facility and also the time involved reaching there by the ill person (Shanon et al, 1973).\textsuperscript{18}

Banarjee (1973) is of opinion that, the structural constraints like poor image of primary health centre due to lack of medicines, overcrowding long queues, cultural and social gap between the health worker and the patient limits utilization of health services.\textsuperscript{19}

On the basis of urban and inner urban areas, Donaldson (1976)\textsuperscript{20} revealed that, it is the urban area in which slum households are huddled together which suffers a lot due to health inequalities. The health services and health status of inner urban area is worse compared to the urban center. The problem of unemployment, overcrowding, air pollution, infant and child mortality, birth rate and mortality rate etc are also high in urban areas compared to urban centers. He suggests for adopting a package measures for improving the health status and encouraging the health services utilization on the part of people in the inner urban areas.

\begin{itemize}
    \item \textsuperscript{17} King Stanley H., “Perception of Illness and Medical Practice”, Russell Sage Foundation, New York, 1962.
    \item \textsuperscript{18} Shanon G. W. Sinner J.C. and Buschar R.C., “Time and Distance, The Journey for Medical Care”, \textit{International Journal of Health Studies}, Vol. 3 No 2, 1973, pp. 237-244.
\end{itemize}
Social class and health inequalities project the inherent inequalities, which exist not only in health but also in health care utilization services (Blexter 1976). Accordingly, the complex factors such as occupational risks, education, income living environment etc, are responsible for creating health care inequalities, he suggest for providing more doctors specially women doctors, health visitors, district nurses, medical and psychiatric social workers with more responsibility.

As stated by WHO (1977), “In our anxiety to make an effective comprehensive health service available as soon as possible to the maximum number of people, the available material, financial and manpower resources that are rooted in traditional medical practices should not be overlooked. Against this background the traditional systems of medicine can play a vital role as an additional or alternative approach in a country’s Health Delivery Programme”.

E. Berthet (1979) defines Health as follows: “We no longer ought to define health only in terms of sickness but rather in relation to the harmonious development of every individual’s personality. After all, it represents a balanced measure of a person’s total potential – whether biological, psychological and social; and to the notion of individual health we should add the concepts of family and community health.”

Brink and Nader (1981) examined the pattern of primary care utilization in tri-ethnic-urban school children in Galveston, Texas USA. They found that social class and ethnic group have a strong relationship with the use of medical services. Brink and Nader also found that Anglican’s with low socio-economic status used the service less often than others.

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Yesudin (1981)\(^{25}\) studied the health behavior of four social classes – high, middle, low and very low in the utilization of health services in Bombay city. He observed that as the low and very low social class households are educationally backward, their knowledge, level of diseases, available health services and their perception desire to seek health services to found to be lower than that of middle and high class households. The low and very low classes use mostly the Government health services because of their poverty. They are also not aware of all the services available in General hospitals and as a result their use is restricted to outpatient department mostly.

According to Kamble (1984)\(^{26}\) Health is an important asset of a community and a healthy community is the foundation of strong nation. Health is an important determinant of economic and social development because disease creates vicious circle by depleting human energy, leading to a low productivity and earning capacity; deteriorating quality and quantity of consumption and standard of living. Therefore, a nation should to give adequate attention to the health care of its people.

The social status of family has a vital influence in the degree of utilization of health services. Children of less educated mothers with low socio-economic status and ethnic origin received less care than the others. The trend was statistically independent of the family’s economic situation or level of activity faced by them suggesting a greater influence of child receiving practices rather than as a consequence of pure economic circumstance (Fergusson et al 1984).\(^{27}\)

Yesudian (1984)\(^{28}\) focused the poor health status of the metropolitan cities inspite of spending major chunk of funds on health services. His study was based on morbidity and mortality analysis of the city of Bombay, and it reveals that primary

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health care is the vital need of the city, but which is neglected for providing special
health care through major hospitals including medical college hospitals and certain
municipal General hospitals. The poor living in the urban slums are facing the
problem of safe drinking water, the sewage problem of latrine facilities. All these
worsen the prevalence of communicable diseases in the city. He observed that the
health sector has failed to meet the primary health problems of the people in the urban
slum.

134 members countries of World Health Organization assembled at Alma Ata,
USSR, during 6-12 September, 1978, adopted the resolution to the health goals of:
“Health for All By 2000 AD” is so vital to the health policy, especially the primary
health care. “Human resources of the country are undoubtedly the most precious
endowment. Health care intrinsic to the well-being of the people and has to be
promoted as an economic value, and as a mean to reduce absenteeism, disability, and
rise efficiency, productivity and finally the income earning capacity. These aspects of
the goal have certain implications to the Indian economy. The health status of the
millions of people in the world today causes considerable concern, and the story of
the developing countries is particularly pathetic. On the global level it calls for a new
approach to close the gap between ‘haves’ and ‘have nots’ through equitable
distribution of health resources, transfer of health technologies, upgradation of skills
and information systems, strengthening of infrastructure so as to ensure the level of
health for all the citizens of the world, and enable them to lead a socially and
economically productive life. In this context the concept of primary health care, close
to their houses, so as to enable all people lead a healthy life, is stressed.29

As pointed by Verma (1992)30, “Health is simply an everyday word that is used
to designate the intensity with which individual’s cope with their internal states and
their environmental conditions. In Homo sapiens ‘healthy’ is an adjective that
qualifies ethical and political actions. In part, at least, the health of a population
depends on the way in which political actions condition the milieu and create those

29 S. Chandrasekhar, Reddy Sanjeeva P.L,K.Rani Gopal.,“Towards 2000 AD: Indian Health
circumstances that favors self-reliance, autonomy and dignity for all, particularly the weaker.”

According to India Health Report (2003)\textsuperscript{31} “It is increasingly being recognized that good health is an important contributor for productivity and economic growth, but it is first and foremost an end in itself. In a poor country like India, where the only asset most people have is their bodies, health assumes even greater significance. Good health and its natural corollary i.e. defense against illness is fundamental to human beings. If the state exists to safeguard the right of its citizens for the fundamental prerequisites of survival, it must also own up its responsibility to protect them from illness and premature mortality.”

Gangadharan K. (2005)\textsuperscript{32} describes health improvement is influenced by three sets of factors: (a) health factors which include medical intervention (b) health promoting factors such as housing, water supply, sanitation and hygiene (c) non health factors which include social and economic factors. Historical analysis shows that the second and third sets of factors had considerable bearing on health improvement.

Rabindranath Ojha (2006)\textsuperscript{33} is of opinion that, in the social services: health is of paramount importance as a national asset and basis to sustain as well as stimulate optimum levels of efficiency. Health is a prerequisite for increasing productivity, while successful education relies on adequate health as well. The preponderance of the evidence is that health and nutrition do affect employment, productivity, wages and very substantially so among the poorest of the poor. The finding magnifies the policy priority of health in development, not only is health is major goal in itself; it has a significant impact on income levels as well. Thus health of the people is an index of prosperity and well-being of a nation.

According to WHO\textsuperscript{34} “A programme of services that should make available to the individual, and thereby to the community, all facilities of medical and allied

\textsuperscript{34} “WHO”, Technical Report Series, No.176.
sciences necessary to promote and maintain health of mind and body. The programme should take into account the physical, social and family environment, with a view of prevention of disease, the restoration of health and the alleviation of disability. The extent of the services should vary according to the local conditions.”

As per W Selvamurthy, (2010)35, Economy and healthcare are the two major thrust areas in every part of the world. If the country has a healthy population, it has a productive workforce that leads to a vibrant economy. India’s booming population, currently 1.1 billion increasing at the rate of 2% annually, will place an enormous burden on India’s healthcare infrastructure. By 2050, the population is projected to reach 1.6 billion. Lack of environmental sanitation, safe drinking water, undernourishment, and limited access to prevent the curative care are the major contributing factors for poor health in India.

“An Analysis of Health Sector in Karnataka” (2010)36by T. Rajendra Prasad and H. Sudhakar, states that there is a need to improve the water facilities, slum improvement and housing development so as to avoid the health hazards faced by the economy. Although tremendous work has been done by the state to improve the sector but still there is lot of scope to extend the work which ultimately results in human development which is pre-requisite for economic development of any nation.

2.3 Public Healthcare Services

Public health deals with the protection and improvement of community health by organized community effort with social and preventive medicine further it refers to caring for the people of a community by giving them basic health care, health information for improving living conditions with minimum cost. In the subsequent paragraphs an attempt is made to summaries few studies concerned to public healthcare.

35 Selvamurthy W., Convocational Address at the 12th Convocation of Sri Ramachandra University, Perur Chennai on 26th March 2010, University News 48 (20) May 17-23, 2010, p. 25.
Sivaraju S. (1938) marks, “Primary health care includes many components like, community participation, social structure, physical factors, availability of technological tools, indigenous health practices, and linkage between new and old technological system for curative and preventive health services in the community. As delivery of health care is to reach everyone throughout the country, there exists a necessity for optimum integration of various components of health care system depending on the socio-economic and cultural background of each community. In this regard, comprehensive evaluative studies on the existing patterns of health care services by taking into consideration of various components of primary health care like, government health programmes, role of private medical practitioners, etc”.

According to G. H. Beaton, (1974) “Public Health is the planning, carrying-out and evaluation of health measures and systems services that both maintain and improve the health of a population group and prevent and control diseases within that population group”.

In the caste wise utilization of health services in India, the awareness of medical facilities is lowest among scheduled caste and scheduled tribe groups. They prefer Government hospitals; choose a place where treatment is offered free of cost and rarely to go to private practitioner (Rao 1981).

Sivaraju S. (1987) in his study on the differential utilization of Government hospital services in Andhra Pradesh revealed that the respondents who are either partly or fully satisfied with the Government Hospitals are relatively more in coastal Andhra Pradesh as compared to those in Rayalaseema. On the other hand in Rayalaseema nearly one third of the respondents were not at all satisfied with the Government hospitals which reveal the poor image of Government Hospitals in the minds of the public. Better economic conditions prevailed among the people in

coastal Andhra Pradesh made the people to utilize medical services in a better manner compared to other region. Cleanliness and orderliness of the clinic, time spent by the patient to see the doctor, privacy provided at the clinic, facility to rest and facility offered to the accompanying etc. was relatively better in costal Andhra Pradesh, because of the accessibility of good infrastructural health facilities namely, optimum doctor population ratio, higher socio-economic conditions of the people as compared to their counterparts in Rayalaseema.

According to Giffith D.H., (1993)\textsuperscript{41} in spite of several efforts on the part of the Government, the health care programmes are not reaching fully to the ultimate consumers. It is observed that only 10 to 20 percent of the population is utilizing Government Health Programmes and rest of the population prefers either home remedies or private medical practitioners.

The study conducted by Purohit and Siddique (1994)\textsuperscript{42} analyzed the utilization of Government health services is very poor in India in general and particular in Kerala Based on NSS and NCAER data of 1992. He gives a picture of degree of health services utilization in India across three stage categories i.e. low, medium and high expenditure group. It is found that the level of government expenditure had direct influence on the availability as well as utilization of various health services in the country. The pattern of utilization shows that public institutions are utilized more for inpatient care and for outpatient care, majority of them prefer private doctors and private clinics. They revealed that the cost of hospital treatment in urban areas is higher compared to private sector hospitals. The study observed the growing popularity of indigenous non-allopathic systems and growth in private sectors involvement in expensive tertiary care.

Economic Planning in India has essentially meant allocation for Hospital and Dispensaries, Medical Education and Research, Control of Communicable Diseases, Rural Health Programmes, Training Programmes, Environmental Sanitation, Water Supply, Indigenous system of medicine and Homeopathy. Health planning in the


successive five Year Plans has meant varying increasing in allocation under these separate heads. In the absence of health planning, free market system permit vast linear expansion of curative science in urban areas based on specialties and super-specialties at the cost of minimum medical health care in rural areas.\textsuperscript{43}

Sundar (2000)\textsuperscript{44} in his field study conducted in Dakshinpur a low income re-settlement colony of Delhi reveals the under-utilization of Government health services by the slum dwellers. Poor environment and living conditions have given rise to high incidence of diseases like tuberculosis, respiratory tract infection, worm infestation and diarrheal diseases. The study revealed that poor health status of population is mainly due to ignorance and a greater reliance on traditional practice than due to lack of purchasing power or non-availability of health services. The study pinpoints that the health project undertaken for the area with the objective of improving awareness of family planning and importance of maternal and child health care. The services mainly rest with an array of functionaries involved in the health care system and their dedication is a must for the success of any health services utilization programme.

The public release of health care quality data into more formalized consumer health report cards is intended to educate consumers, improve quality of care, and increase competition in the marketplace as stated by Helen Halpin Schauffler and Jennifer K Mordavsky (2001)\textsuperscript{45}. The purpose of their review was to evaluate the evidence on the impact of consumer report cards on the behavior of consumers, providers, and purchasers. Studies were selected by conducting database searches in Medline and Health star to identify papers published since 1995 in peer review journals pertaining to consumer report cards on health care. The evidence indicates that consumer report cards do not make a difference in decision making, improvement of quality, or competition. The research to date suggests that perhaps we need to rethink the entire endeavor of consumer report cards. Consumers desire information

that is provider specific and may be more likely to use information on rates of errors and adverse outcomes. Purchasers may be in a better position to understand and use information about health plan quality to select high-quality plans to offer consumers and to design premium contributions to steer consumers, through price, to the highest-quality plans.

Dr. KR Thankappan, Dr. P Sankara Sarma, Dr.V. Mohanan Nair and Dr. Rajappan Pillai (2002)\textsuperscript{46} examined the study on service delivery in health and family welfare in Kerala and came to the conclusion that, sub centres and primary health centres did not perform delivery and related services their role needs to be redefined. Non-communicable diseases like cardiovascular diseases, diabetes, chronic obstructive pulmonary diseases, cancer and mental illness are increasing in the state. In addition road traffic accident is also increasing. The role of grass root level organizations and manpower in the health sector needs to be redefined so that health services will become more efficient.

The integrative review of reports on the health care workforce shortage by Michael R. Bleich, Peggy O. Hewlett, R. Santos, Rebecca B. Rice, Karen S. Cox, Sheila Richmeier (2003)\textsuperscript{47}, examined 15 reports that focused primarily on nursing and were conducted by various stakeholders. They found problems at both the national and institutional levels and noted that the reports contained similar problem and solution. They also found gaps between these problems with no solutions and some solutions didn't address any of the suggested problems. Gaps occurred among problems and solutions listed in the following theme categories: demand, health care economics, workforce planning, research, data support, and technology. They presented the results of their analysis and recommendations to the federal government, national organizations, institutions, and to the nurses. These recommendations don't provide a comprehensive strategy for averting the nursing


shortage, but they offered a basis upon which one may be created. Their result synthesized information that can be used to direct action strategies. Out of their work, their gap analysis was developed, which provides new knowledge and a platform from which a comprehensive action plan can be derived. The imperatives, carved from the collective recommendations within the reports, frame the organizing structure around which sound strategies can be determined devised by groups and individuals. They challenged key stakeholders to use these findings as the starting point for transformational change.

Ateev Mehrotra, R. Adams Dudley and Harold S. Luft (2003)\textsuperscript{48}, reviewed the literature on a number of the potential explanations for the rise in health care expenditures in the United States such as - the aging population, the costs of dying, technology, physician incomes, administrative costs, prescription drugs, managed care, and the underfunding of public health. Their goal was not to pass definitive judgment on the forces driving health care costs, but they want to spread the information of health care. So special emphasis is on how health expenditures are measured? They found that frequently it is difficult to accurately estimate how individual forces influence total health care expenditures. They conclude that interpreting the causes of the rise in expenditures goes beyond simple observations of trends and depends on how we value various segments and aspects of health and health care.

Rabindra Nath Ojha (2005)\textsuperscript{49} points out that the Government initiative for health for all is a move in the right direction. The Government of India has launched a National Rural Health Mission (NRHM) on 12\textsuperscript{th} April 2005: with objectives to provide integrated comprehensive and effective primary healthcare to the unprivileged and vulnerable sections of the society especially women and children by improving access, availability and quality of health care services.

The key strategies of the mission includes to ensure intra and intersectoral convergence, strengthening public health infrastructure, increasing community participation, creating a village level cadre of health workers, fostering public-private partnerships.


partnerships, emphasizing quality services and enhanced programme management inputs. The plan of action of the Rural Health Mission aims at reducing regional health imbalance in health outcomes by relating health to determinants of good health. The mission also aims at increasing the outreach of the health system from the sub-center level to village level by providing a trained and Accredited Social Health Activist per thousand populations as in Anganwadi set up. The present system of health planning and management is uniform for state level.

Byra Reddy and S.J. Manjunath (2006)\(^50\) points out that, there are basically threefold reasons among others, which are felt instrumental in causing health inequalities in India. For a state that promises health for all, 0.9 percent of gross domestic product on health is woefully inadequate. As there is threshold to health, beyond which productivity and functioning are seriously impaired a greater emphasis on the country’s health is necessary. Therefore the state should view the causes for health inequalities seriously and take appropriate measures.

Sunil Amrith has gone through “Political Culture of Health in India: A Historical Perspective” (2007)\(^51\) and came to the conclusion that, the State commits to provide better health for the people, but argues that the nationalist movement’s initial commitment to the state provision of welfare arose from a complex combinations of motives with concern to democracy and equity as well as concerns about the ‘quality’ and ‘quantity’ of population. The depth of ambition for public health was unmatched by infrastructure and resources; as a result the state relies heavily on narrowly targeted, techno-centric programmes assisted by foreign aid.

Jeffrey, Yamini and Salimah, (2007)\(^52\) argued that the current crisis faced by the public health care system can be largely be attributed to the failure of accountability. No doubt government has recognized the importance of accountability as the key to resolving the current crisis. Efforts to address this are best articulated in NRHM that attempts to strengthen voice by empowering local governments to

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manage and control public health services, so the policy makers represents the wishes of people particularly in rural areas where the majority of poor people live and the policy makers are successfully transmit the wishes through the provision of proper incentives to providers that significant improvements will be made in the health care system in India.

Cost-effectiveness analysis refers to utilization of limited resources optimally. The cost-effectiveness analysis in health care is actually rather small, and high-quality studies are rather rare. Furthermore, the applications of economic analysis to health policy have been hampered by a number of problems, including those that are methodological and contextual. H. David Banta and G. Ardine deWit (2008)\textsuperscript{53} considered a number of areas of public health policy but paid special attention to a growing area of inquiry and application: the overall coverage of health services. They stressed that Cost-effectiveness analysis had played a relatively small role in general coverage decisions, but in recent years, it had been applied increasingly to decisions concerning pharmaceutical coverage. They speculate on concerning reasons for their particular focus in cost effectiveness analysis.

As per the study of Peter Berman and Rajeev Ahuja on “Government Health Spending in India” (2008)\textsuperscript{54} although the government of India has set a goal of increasing government health spending to 2-3 percent of gross domestic product over the coming five years, even with optimistic assumption, it can’t meet the stated goal, so after analyzing the recent trends in government health spending by the centre and states, the need is felt of sound fiscal targets for health spending and it should be based on goals for outcomes on the resources needed to achieve them, which are largely lacking. So it suggests that large and sustainable increases in government health spending which requires more focus on the state’s spending and also to the improvement of the capacities of the states and districts to use resources for health effectively.


\textsuperscript{54} Berman Peter, Ahuja Rajeev, “Government Health Spending in India”, \textit{Economic & Political Weekly}, 13/06/2008, p-209.
C. Sathyamala (2008)\textsuperscript{55} explains after examining the development of health care in India, it is evident that the primary health care strategy was a logical outcome and justification for health policies that were antithetical to the principle of social justice. Thirty years down the line, the village health worker has metamorphosed into the Accredited Social Health Activist, but the health situation cannot be significantly improved without challenging the exploitative social structure.

Mansi Shah (2008)\textsuperscript{56} shown that the efficacy of a public healthcare institute in Kolkata. One of the primary reasons for the excess demand on public hospitals is the difference in the cost of services when compared to private health care institutes. While services in government hospitals like her surveyed hospitals were largely subsidized, private healthcare is largely profit oriented and hence were expensive. The facilities in the public hospital are of poor quality, there have been reports on the irregularity of doctors and medical staff, inadequate equipment and non-maintenance are some of the factors which plagued desired efficiency of these hospitals. She further discussed that despite of the facts one must take into account the pressure of providing healthcare to lakhs of people on everyday basis as a mammoth task. She concluded the expenditure on health care by state government has not increased but on the other had fallen over the years. She recommended for state governments to increase their expenditure on health care & the existing network of healthcare facilities which suffer largely from inefficient management can be helped through public-private partnerships which have helped in the improvement of the delivery of services in other aspects of the Indian economy.

S K Satpathy and S Venkatesh (2008)\textsuperscript{57} pointed that, the task of ensuring the availability of MBBS doctors and specialists and to build capacity for rural health care in India is huge, but doable. Their challenges include shortages, imbalances and low productivity, compounded by insufficient investment, inadequate pre-service training, migration, work overload, freeze in salaries and work environment issues like infrastructure, technical safety and community support etc. The gaps within the

\textsuperscript{55} C. Sathyamala, “Reflections on Alma-Ata” Economic and Political Weekly, 22/11/2008, p. 32


existing infrastructure and the services both within and outside the public sector are the urgent needs. Minimum health people are not enough. The solutions for meeting the HRH challenge include (i) creation of a sustainable health system by improving the training curriculum and enhancing the training facilities for health workers; (ii) coverage strategy should not only address the numeric adequacy but also the appropriate skills-mix and outreach to vulnerable populations; (iii) motivational issues such as a positive work environment, adequate remuneration/compensation, career development and a supportive health system, adequate compensation and working conditions to ensure retention of skilled workers in the health system; (iv) advancing competencies through education to develop appropriate attitudes and skills, and creating conditions for continuous learning; (v) linking HRH to the NRHM in addressing health workforce issues, and (vi) recognizing that solutions for HRH issues go beyond the health sector and are linked to broader fiscal and financing policies and processes.

Emma Wanjiku (2009)\(^58\) shared her unique insight about healthcare, as it is one of the most important components in our life. Disease or illness can really mean a down turn in our life. The biggest asset we can have in life therefore is health. Health care is normally defined as the management or treatment of any health problem through the services that might be offered by medical, nursing, dental or any other related service. When we focus about the care of health, we are focusing of all goods and services that are produced to improve on our health. They may be curative, preventative or even palliative solutions. A system of health care is one that is organized to give health services to a population or a group of people. She stresses out that health care can be for an individual or for a large group of people depending on how the systems are organized. She explained that in developing countries, people usually take care of health as an individual thing and, if we do not have enough money, we might not get access to quality care. There are so many disparities and, some systems in certain countries are becoming worse; not able to deal with demand of health. Health is not a cheap affair; we have to have a good system if we want it to work for us. She suggested that the Governments have the responsibility to create or

formulate policies that will favor people in this regard. Good systems of health can be erected by the top most leadership of a state.

B. S Ghuman and Akshat Mehta (2009) examined the problems and prospects of health care services in India and concluded that, India as a nation has been growing economically at a rapid pace particularly after the advent of New Economic Policy of 1991. However 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 percent of GDP in India. It has further witnessed decline during the post economic liberalization period. The meager resource allocation to 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). They summarized 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 GDP.

Ravi Duggal, (2009) analyzed to increase spending on public health by hiking allocations to its National Rural Health Mission programme has failed because the states have responded by reducing their expenditure. Instead of decentralizing expenditure on health, the centre has taken control of a larger share of resources for the sector, which have been adequately utilised even for the priority programmes. The irony is that those who deliver care understand the situation and can plan the budget having no role in decision making while the decision makers have no idea of the ground realities.

Kaveri Gill (2009) seeks to evaluate quantity and quality of service delivery in rural public health facilities under NRHM. On appropriate and feasible measures,


on the static and dynamic condition of physical infrastructure; by the numbers of paramedical, technician and medical staff employed, as well as figures for attendance and gender breakdown; by the supply, quality and range of drugs; by availability and usage of decentralized untied and maintenance funding of centres; and by actual availability of laboratory, diagnostic and service facilities. Quality is defined in relation to the condition of the above tangibles, as also supplemented by subjective data on intangibles, such as patient satisfaction, gathered from the exit interviews. The micro-findings across four states, 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’, but to do so would be irresponsible, meaningless and defeat the very purpose of this evaluation, which was to highlight the micro-components of features that are important to this Mission’s capacity to deliver services, how states are faring on implementing these various strands, and what factors might be causing problems where implementation is less than desirable. The NRHM 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. True, there are problems in implementation, so that delivery is far from what it ought to be. On physical infrastructure, medicines and funding, procedural problems might be more easily scaled with time (in some instances, they already appear to have been overcome), whereas on human resources, and to the extent these impact actual availability of services, structural issues of some complexity need careful resolving with a definite long term investment in the training and education of paramedical and medical staff, especially women, and close monitoring of attendance. However, the parameters of the question this study seeks to answer are very much within the ambit of how to better performance under the NRHM, and not whether the Mission ought to have been undertaken in the first place, of which there can be no doubt.

Rajib Das Gupta and Ramila Bishat (2010)\(^2\), points that, The National Urban Health Mission was supposed to address the unmet health needs of urban Indians. But yet it has failed to commence work even 18 months after the announcement of its

formation. A rapid urbanizing India has marked by a series of epidemics of communicable diseases in the last two decades and increasing in formalization of the economy. Therefore an urban health system needs serious and quick reforms.

Monica Das Gupta, Desikachari B R, Rajendra Shukla, Somathnan, Padmanaban P and Datta (2010) examined the contribution of Central Government’s policies and they analyzed the Central Government’s policies and Tamil Nadu’s public health system, which offers basic principles for strengthening public health within the administrative and fiscal resources available to most states. They suggest establishing a public health focal point in the health ministry and revitalizing the state’s public health managerial and grassroots cadres. The needs should be phrased in four areas. (1) Enactment of public health acts to provide the basic legislative underpinning for public health action; (2) establishment of separate public health directorates with their own budgets and staff; (3) revitalization of public health cadres; (4) health department engagement in ensuring municipal public health.

According to Narinder Deep Singh (2010) commercialization and privatization of health services have excluded a sizeable proportion of the population, particularly those belonging to socially disadvantaged groups like landless labourers, marginal and small scale farmers and poor from the coverage of health services provided by organized sector in rural areas. The subsequent financial burden of private health care services is responsible for a large proportion of total borrowing by these underprivileged sections of society. So policy measures like increasing the share of state’s expenditure on health care, especially in rural areas, improving the existing health care facilities by filling up the vacant posts in such institutions, frequent surprise visits by higher officials to check absenteeism, compulsory rural postings of staff and fixing accountability of employees are necessary to improve the rural health scenario in the state.

According to R.H. Janganawari, M.B. Belavatagimath and M.M. Talawar (2010)\textsuperscript{65} the government of Karnataka has accorded priority to health sector over the years and has taken efforts to improve standard of living of people and their by creating a positive influence on the health and well-being of the citizens of the state. Karnataka is following three tier pattern of health infrastructure in rendering primary health care through primary health centre, sub centres and community health centres by the way of implementing various health programmes.

Brijesh Purohit, (2010)\textsuperscript{66} described healthcare by using stochastic frontier technique it has provided an idealized yardstick to evaluate the performance of the health sector carried out in two stages of estimation as per the data of district-level panel, it has been indicated that the efficiency of the public health delivery system in Karnataka remains low, there are considerable disparities across districts in per capita availability and also utilization of hospitals, beds, manpower inputs hamper in life expectancy in the state. Results from the second stage of the estimation suggest that in rural areas, improvements in infrastructure facilities like safe drinking water supply, toilets, electricity as well as better coordination between social sector and economic policies, especially at the district level, it also help the state to improve life expectancy speedily and more equitably in the deficient districts.

Meeta and Rajivlochan on (2010)\textsuperscript{67} focused on the absence of first level healthcare facilities and high cost of treating even routine illnesses are the immediate problems in the existing healthcare system as also the fact that high costs do not necessarily imply reliability of treatment. No insurance scheme or altruistic healthcare providers can address these problems. The solution lies in strengthening the public healthcare system.

\textsuperscript{65} Janganawari R H, Belavatagimath M B, and Talawar M M, “Health Infrastructure in Karnataka” Southern Economist, 01/05/2010, p. 87
\textsuperscript{66} Purohit Brijesh C, “Efficiency Variation at the Sub-State Level: The Healthcare System in Karnataka” Economic and Political Weekly, Vol. XLV NO 19, 08/05/2010, p.71
Dr. Paramjit Kaur Dhindsa and Seozy Bhatia (2010) are of opinion that, drawing data from 12 major states of India over a time span of 10 years i.e. 1993-94 to 2003-04 and also by its Data Analysis, the paper documents the efficiency of public health expenditure is used to reduce infant mortality rate. So India’s dream of becoming “World Class” in health care system can be achieved by increasing the budget allocation on health sector by government by efficiently utilizing its public and private resources. Hence, India faces the daunting challenge of meeting healthcare needs of its vast population and ensuring efficiency, accessibility, equity and quality of health care and therefore achieving the objective of growth with equality and social justice.

As per the study undertaken by S. Srinivasan, (2011) concludes that, when we consider expenditure on medicines in India it accounts for 50% to 80% of treatment costs, India’s pharmaceuticals success has clearly not translated into availability or affordability of medicines for all. As a part of Universal Access to Healthcare, good quality health care should be accessible, affordable and available to all in need. Providing quality medicines to all – free at the point of service – in all our public facilities is an achievable task. This article estimates the cost of providing free and quality medicines at all levels of public healthcare and offers suggestions such as – I. Restrict the list of medicines available in this country to essential medicines. II. Price regulation of all these medicines. III. A national vaccine policy to regulate the entry of new vaccines as an expanded programme on Immunization (EPI). IV. Proactive use of Trade Related Aspects of Intellectual Property Rights (TRIPS).

He is also of opinion that, if we do not have a free universal healthcare system, movement towards achieving it should begin. The best way to restore faith in the system is to stock quality medicines at all levels of public healthcare.

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Sujay R. Joshi and Mathew George (2012)\textsuperscript{70} explored that the community participation as one of the major principle of primary health care. The ASHA programme, under the NRHM based on the experiences of various CHW schemes in the country and is considered to have the potential to generate community participation through its implementation. It has been found that the role of incentives in the overall work activity of ASHAs is significance. Due to the excessive focus of ASHAs on curative care, the community considers ASHAs more as an extended arm of the health services system and not as a change agent as envisaged in the programme, it is because the priorities set by the ASHAs are more those of the health services system and not necessarily that of the community or there is failure of any specific mechanism through which ASHAs can understand as the felt need of the community, thereby addressing their health needs in the given context. This has resulted in the sparse response of the community to the activities of ASHAs as they could not transcend the power dynamics in the community even after working therein. Thus it is important to note that the ASHA programme in its current form has failed to generate community participation which raises a serious concern about the future of this CHW programme as the key for sustainability of any CHW schemes is its ability to communities. CHWs do have tremendous potential and capacities which could strengthen the primary health care system, not by positioning its base only in the health service system but also within the community.

C. Sathyamala and others (2012)\textsuperscript{71} have evaluated and noticed that, a bottom-up view of the health conditions and services in six states where three states have performed well and rest three states not performed so well. This conclusion was arrived through a multidisciplinary team with varied experiences in health research. Their study demonstrates that the conditions, in which people grow, live and work, are the social determinants of health. Access of food, water, sanitation and working conditions are the critical determinants of health status. Socio-economic status like

\textsuperscript{70} Joshi Sujay R. and Mathew George, “Healthcare through Community Participation: Role of ASHAs”, \textit{Economic and Political Weekly}, Vol. XLVII No 10, 10/03/2012, p.70.

income levels, gender and caste with social policies deeply affect the possibility of leading healthy life. The findings of their study affirms that the vast majority of people who live in rural India, improvements in health status lies in bringing about fundamental changes in their living conditions. The states which have access of food have positive impact of lives on people as compared to other states. Policy recommendations of the study are as follows: 1. a decentralized situational analysis and planning for health is essential. 2. The district level planning requires building epidemiological capacities at district level linked to the health care services. 3. It should be a part of integral part of plan of health ministries. 4. The policy, planning, administrative, supervisory and monitoring systems at all levels should be strengthened. 5. Village and cluster level variations should be addressed by the local health service units.

A study conducted by T Subba Lakshmi, Prashant Kumar Panda and Himanshu Sekhar Rout (2012)\(^{72}\) recommends that the government needs to take necessary steps to reduce poverty and should try to increase voter’s income, literacy rate and check population growth which will cause government expenditure on health to grow. The percentage spending on health in the state is around 1, which is low and can be increased by suitable mechanism of resource efficiency. This will help to increase capital investment on health sector in terms of opening of additional hospitals in the backlog areas.

### 2.4 Private Healthcare Services

Private healthcare or private medicine is healthcare and medicine provided by entities other than the government i.e. by private hospitals with the motive of for-profit or non-for-profit. Similar studies have been discussed below:

According to Ravi Duggal (1991)\(^{73}\) like hospital beds, the number of hospitals, dispensaries, health centres, nurses and other paramedics are far from adequate,
especially in the rural areas. He indicated that as for medical practitioners if we consider practitioners of all systems of medicine and add the non-qualified practitioners (quacks) then their number for the country becomes more than adequate and the same is true for pharmacists also. The reason for the large number if medical practitioners and pharmacists is very obvious - a thriving for-profit private health sector (private medical practice and the pharmaceutical industry). The scenario revealed that the for-profit private health sector exists in India in an adequate quantum but this is not available to the entire population easily because of its urban-metropolitan concentration and secondly the quality of a large proportion of this sector is questionable. In contrast, the private health sector has grown rapidly in the post-colonial period with State support. The State's health sector policies have encouraged the growth of the private health sector in medical care-specifically curative services-by investing resources in medical education, providing subsidies and soft loans to set up hospitals and private practice, by giving tax and duty waivers to the hospital sector and for import of medical equipment, and by allowing graduates of medical colleges (who have been trained at public expenses) to set up private practice freely or to migrate abroad in large numbers. He bring to a close that as per this scenario, private health expenditure assumes a great significance because to support such a huge private health sector the quantum of household resources being expended must be phenomenal.

Ismail Radwan (2005)\textsuperscript{74} is of opinion that Despite India’s great strides since Independence, fertility, mortality and morbidity remains unacceptably high. Although poverty and low levels of education are the root causes of poor health outcomes, poor stewardship over the health system bears some responsibility. Although India’s states exhibit a wide variation in health outcomes, all but the best-performing states need to focus on improving both sexual and reproductive health care and child health care and on reducing communicable diseases for the poor. His paper examined the public and private responses to this situation detailing the reasons behind the failure of the public sector and ways in which the private sector can be encouraged to play a role in providing health care for the poor in India. He concludes that there are three promising areas for the private sector including; (i) contracting out the primary health

\textsuperscript{74} Radwan Ismail, “India - Private Health Services for the Poor”, Policy Note, May 2005, available at <www.sasnet.lu.se/EAS4Spapers/11lismailRadwan.pdf> accessed on 21/05/2012.
centers, (ii) social franchising and (iii) demand-led financing. His study was focused on what to do to improve health care for the poor, while a series of separate background papers focus on how to do it and state specific issues in Andhra Pradesh, Bihar, Karnataka, and Punjab.

Uma Nath is of opinion that (2005) Speciality hospitals are need of the hour. Their market impact has already been experienced in the last decades. A word of caution needs to be exercised for investors or providers that seek such care where one should be careful of unnecessary hospitalization or stay that might occur in the over enthusiasm of treating disease profiles. It is also necessary for the entrepreneur to allow other cross subsidization in order that the poor and the needy may also benefit from such care.

Partha Goswami (2009) concludes that, the size of India's healthcare industry is worth US$ 20 billion. Of this, 82% of the total health expenditure comes from the self-paid category, while employers account for 9% and insurance covers 5% of the total healthcare expenses. When hospitals are expanding at a pace never seen before, the innovative strategies and business models that needs to be applied to remain competitive and viable in this market have to be sought out. His study was based on a patient satisfaction survey. Both quantitative and qualitative data collection technique were used. The samples were collected from the patients attending the OPD & IPD departments of the research hospital were approached then, patients soliciting medical care from the private clinics were interviewed. In addition to this, the Chief Administrative Officer (CEO) & Additional General Manager (AGM) of the research hospital were also included in his study. His study sample included 50 patients each from the OPD as well as the IPD of the hospital. 20 patients were included from the private clinics. The results for IPD and OPD patients of the study hospital show that, the majority was from the upper middle and rich classes. For both IPD and OPD patients the most dominating factor influencing the decision to seek care in the study hospital was the general physician. He observed that for IPD services there were a large number of patients from the vicinity as well as relatively far off places whereas

76 Goswami Partha Sarathi, “A Study on Patient Satisfaction as a Marketing Tool for a Tertiary Care Hospital”, Research Project, Tata Institute of Social Sciences, Mumbai, 04/05/2009.
for OPD services. The huge majority was of patients residing <50 kms of his research hospital. There was no significant difference between the satisfaction levels of patients seeking healthcare in his research hospital when measured across various age groups. Respondents earning higher than 4 lakhs per annum were more satisfied with the services provided by the hospital for both OPD as well as IPD. The qualitative analysis of the patients seeking treatment from GP clinics shown that the health care needs of tier-2 cities have always been dominated by private practitioners. The perception among general public in that city was that the hospital is a very expensive hospital where only the super-rich can ever afford to seek treatment. Patients were more likely to revisit doctors whom they had consulted earlier and received considerable benefit. The comparative lower cost in treatment from GPs seemed to endear them to all patients alike. There seems to have been no effort from the administration of the research hospital to market itself in the past.

B. G. Saisha and S. J. Manjunath (2010)\textsuperscript{77} points that, the major characteristic of India is high growth of population and it is the responsibility of the government to provide an efficient and effective health care services. But in India it is highly impossible to provide health care services at free of cost because of heavy costs involved in obtaining sophisticated infrastructure and the need to maintain quality of services has compelled the government to invite private section participation.

Anand Zachariah (2012)\textsuperscript{78} is of opinion that Tertiary care plays an important role in determining the structure of the health care system and universal access to it. Breaking away from western-oriented tertiary care medical knowledge, a number of issues have to be rethought to define tertiary care in the Indian sitting that can be provided by the existing system. Providing tertiary care with district health services will mutually reinforce both and provide health care that is affordable and appropriate to local conditions.

\textsuperscript{77} B. G. Saisha and S. J. Manjunath, “Corporatisation of Health Care Sector in India” \textit{Southern Economist}, 15/05/2010, p. 49.

2.5 Comparison of Public and Private Healthcare Services

The following are the some of the studies based on public and private comparison in providing healthcare services:

According to the statement of Maurice Marchand and Fred Schroyen (2001)\textsuperscript{79} illness reduces a person’s health status when not receiving immediate treatment. Treatment can be obtained in a competitive private sector or in the National Health Service (NHS) where it is provided free of charge but after some (endogenous) waiting time. The equilibrium in the health care sector consists of a fee for private consultations and a contract offered to NHS physicians and in addition a waiting time in the NHS. Their findings are threefold, they are a mixed system with a small public health care sector gives a lower social welfare level than a pure private system. Second, a mixed system with a sufficiently large NHS may improve upon a pure private system if the distribution of earnings capacities in society is sufficiently wide. And finally, whatever the size of the NHS, the doctors working there should be given a contract that specifies a heavier work load than the one their private colleagues choose. This is the way the government can exert its monopsony power on the market for physicians to improve social welfare.

Daniele Fabbri and Chiara Monfardini (2003)\textsuperscript{80} utilized the data of the new Italian Survey on Health Ageing and Wealth (SHAW) to analyze physician services utilization in Italy explicitly acknowledging the existence of two different classes of providers: public and private. They considered visits by a specialist physician as the measure of individual services utilization. In their perspective they assessed the relative importance of variables like income, education, private insurance and supply characteristics as determinants of the utilization of such services, while controlling for individual health and need. According to their results age did not played any strong role in determining the utilization of medical consultations. They also found that holding a private health insurance is not important in determining the contact of either

\textsuperscript{79} Marchand Maurice and Schroyen Fred, "Markets for public and private health care: redistribution arguments for a mixed system". Belgian Programme on Interuniversity Poles of Attraction initiated by the Belgian State, Prime Minister’s Office, Science Policy Programming, 17/05/2001, p.1.

\textsuperscript{80} Daniele Fabbri and Chiara, “Public vs. Private Health Care Services Demand in Italy” Giornaledegli Economisti e Annali di Economia, Volume 62 - No 1, April 2003, pp. 93-123.
kind of specialists, but positively affects the frequency of private specialist visits. According to their analysis they received a strong indication of the importance of modeling the two counts, corresponding to private and public specialist visits, as driven by different processes. In this direction consists in considering the two processes as jointly dependent, describing their interrelation in an analogous way as the seemingly unrelated regression model. Their analysis extended the results of the demand for specialist visits, they found that being richer increases the propensity to contact a private specialist and consistently decreases the propensity to contact a public specialist. Commonly private specialist are of higher quality, so they concluded that in the Italian national health service access to better specialist consultation was pro-rich, with public provision mainly guaranteeing access to specialists consultation for the poorer. Moreover they found some indirect evidence of government failures to guarantee equal access opportunity to medical consultation across the country.

Nazlee Siddiqui and Shahjahan Ali Khandaker (2007) are of the opinion that, despite of recent developments in the Bangladesh healthcare sector there was still requirement of the quality of healthcare services. Their study compared the quality of healthcare services by different types of institutions, i.e. public and private hospitals, from the perspective of Bangladeshi patients to identify the relevant areas for development. They conducted a survey among Bangladeshi citizens who were in-patients in public or private hospitals in Dhaka city and also in hospitals abroad for the year 2002. About 400 exit-interviews were conducted using a structured questionnaire that addressed the probable factors of the quality of healthcare services in 5-point interval scales. Their results gave an overview of the perspectives of Bangladeshi patients on the quality of service in three types of hospitals. Their study revealed the quality of service in private hospitals scored higher than that in public hospitals for nursing care, tangible hospital matters, i.e. cleanliness, supply of utilities, and availability of drugs. The overall quality of service was better in the foreign hospitals compared to that in the private hospitals in Bangladesh in all factors, even the ‘perceived cost’ factor. Their paper has provided insights into the specific factors

of the quality of hospital services that need to be addressed to meet the needs of Bangladeshi patients.

The study of Rama V. Baru (2008)\(^{82}\) signifies that the privatization in highly iniquitous societies like South Asia was bound to marginalized access to the lower middle and poorer sections, which constitutes around 30-60 percent of the population. The studies on the utilization of services in India and Sri Lanka showed that the middle class had largely moved away from public provisioning in favour of for-profit care and the poor who used public services. The indirect costs for even publicly provided services are increasing and there is evidence that there may be section of the population who may not be able to afford even these services. Equity concerns are very important at this juncture for health policy. Since the middle classes have moved out of public provisioning the principles of universality have also been gradually undermined. She recommended that the concern for public health derives not only from the excessive growth of for profit market-based health care, but also from the differential state of public services across the region.

The study of Chungkham Holendro Singh (2009)\(^{83}\) revealed that more than 58 percent of the patients have utilized private health-care facilities in India. As his expectation, the mean cost of treatment in private hospitals is Rs. 5,019 after adjusting for confounders compared to Rs. 1,307 for public hospitals. The mean adjusted cost of treatment of heart diseases is Rs. 5,981, followed by Rs. 5,402, Rs. 4,616, Rs. 2,478 and Rs. 891 for urological diseases, gynecological disorders, tuberculosis and diarrheal diseases, respectively. He further discussed that better off patients incurred the highest out-of-pocket costs, in the range of Rs. 4,967 to Rs. 8,457. It is evident that for the diseases considered in the study, the private sector plays an important role in providing health facilities. His study concluded that the cost of hospitalization in private health facilities is considerably higher compared to that of public facilities as far as the five ailments are concerned. Among the ailments, chronic conditions were

\(^{82}\) Baru Rama V, “Health Sector Reform in South Asia”, A Comparative Analysis, Jawaharlal Nehru University, New Delhi, 2008 Online available at <www.psiru.org/reports/2008-10-H-southasia.doc> accessed on 17/08/2012.

seen to consume higher costs of treatment. However, more people opted for the unregulated private facilities.

S. L. Rao (2010) explored that life expectancy has almost doubled in India over fifty years. But health care delivery has skewed heavily in favour of urban over rural India. He felt that it is true on any parameter of availability, of doctors, nurses, hospital beds, chemists or medicines. He further explained that despite an elaborate health care delivery structure built by government over the years, and a rich variety of medical systems, the poor spend a disproportionate proportion of their incomes on health care. They spend primarily on allopathic systems, mostly delivered by private practitioners who are most often unqualified and untrained quacks. The prevalence of fake drugs is also high. The poor buy them because they find them to be affordable and cheap. There is considerable cross prescribing, despite its being prohibited, for example, ayurvedic prescribing antibiotics, and over-prescription as when powerful drugs are given for minor ailments. He was in opinion that the health care delivery can be made more efficient and effective by co-opting the private manufacturer, using basic training, developing a core list of generic drugs, strengthening the regulatory framework, and preventing misuse and abuse. He discussed that private practitioners predominantly deliver Indian health care even the public system is private in terms of the fees illegally charged to patients. The public health care system is largely allopathic, slow, inefficient and expensive. The legitimate private medical care is largely urban. In both urban and rural India, the poor in particular, depend on untrained and unlicensed medical practitioners, whose education is mainly that of school-leavers. These private practitioners provide ambulatory (out-patient) care. For illnesses requiring hospitalization, public hospitals are used, though there are a growing number of private nursing homes, especially in urban India offering such care. The private systems supported by a more reliable public hospitals structure have to be made trustworthy.

Sandeep Moolchandani (2011) elucidated that the hospitals form an important arm of the healthcare delivery system. Though the focus of various National programmes may be on primary health but secondary and tertiary public hospitals form one of the largest expenditure category in the national health budget. Over the past decade in spite of the complexity of hospitals having increased many fold, not many changes made in the management structure of public hospitals. Further he explained that it was very well known that hospitals should be hundred percent clean and hygienic, but in practice government hospitals are generally the filthiest places. Even central level tertiary government hospitals are run on primitive principles, problems of poor governance and administration is not a hidden fact. Waiting times in government hospitals can reach up to two hours just for accessing outpatient services. In addition he described that lack of governments’ commitment towards quality assurance in government setups, low management capacities at health facilities, lack of policies and guidelines from the State, as well as structural problems of the centralized health system are key problems in Public Health Sector leading to inefficient use of scarce resources and deficiencies in the quality of services provided. He enumerated the reasons the public hospitals should start focusing upon delivering optimum quality of services, those are Public Hospitals impose significant opportunity costs to the society, In 2000-01, 48 percent of public health expenditure in Maharashtra, which amounts to Rs.5396.11 million, was incurred on medical care alone, decreasing utilization of Public Hospitals for Inpatient and outpatient Care. He concluded that 80 percent of households prefer to use private sector treatment in India for minor illnesses, and 75 percent of households prefer to go to the private sector for major illnesses. Numerous other studies have confirmed the dominance of the private sector and the reasons for this dominance: government health services entailed longer waiting periods, arrogant behaviour of doctors and non-availability of medicines. Even though the treatment in public hospitals is free, the patients have to pay for tests, and bear the incidental costs of boarding and lodging. A significant amount of taxpayer’s money is spent on

Government hospitals which puts these hospitals in a critical position to be accountable for the quality of services and deliver quality services within the constraints of available resources. It should be tried by the public hospitals to prevent diversion of its customer to private setups due bad quality of services. This warrants an existence of a quality management and control mechanism for government hospitals. Quality of service should not be denied just because the direct consumer is not asking for it; but concrete measures towards quality assurance are necessary because lots of money is being spent in providing the infrastructure and bearing the administrative costs in the public hospitals. A few state governments (Gujarat, Kerala) are coming up with answers to these questions by taking concrete actions towards quality assurance and commitment for continuous quality improvement.

2.6 Public Private Partnership in Healthcare Services (PPP)

There were certain deficiencies in public sector and also in private sector in provision of healthcare services, these deficiencies gave birth to public private partnership in providing quality healthcare, such related studies are discussed below:

To study the utilization pattern and factors determining the utilization of private and public health care services, a cross sectional study undertaken by Shenoy (1997)\textsuperscript{86}, in both urban and rural community of Thiruvananthapuram district in Kerala state. The study was clinical and epidemiological. The study revealed that out of 4800 subjects from 1001 households consented to participate, 2237 participants had morbidity problem and out of this 1552 utilized health care services. Of the total patients utilized health care services, 67 percent utilized private and 33 percent utilized public health centers. The study showed that for the age group 45-59 was significantly less likely to use private service as compared to adults with 14-44 years. Low SES was significantly less likely to use private service as compared to those with acute illness. He pointed out the need for devising strategies to improve the accessibility and utilization of public health care services in a better manner.

M. C. Kapilashrami, A. K. Sood and B. B. L. Sharma (2000)\textsuperscript{87} recommended the following essential changes such as: i) Regionalization of health services with effective referral system. ii) Integrated holistic approach while addressing health problems in communities. iii) Development of linkages with other sectors (inter-sectoral co-ordination) to ensure decentralized developmental planning including health. iv) Health infrastructure and effectiveness. v) Strengthening of the community based schemes such as village health guide scheme, training of traditional birth attendants, etc. vi) Development of work culture, moral values and a sense of commitment amongst the employees in the public health system. Although there is a huge manpower in the public health system, its full potential remains to be utilised for the reasons.

Abhijit Das (2007)\textsuperscript{88} has discussed the public-private partnership as an initiative to improve efficiency, effectiveness and equity in the provision of healthcare services. The private sector is the most important source of healthcare services in India, providing close to 80 per cent of all services, according to the government’s own reckoning. A related fact is that nearly 75 per cent of health-related expenses are out of pocket and occur at the point of service delivery. Over the last few years there have been many initiatives to improve the efficiency, effectiveness and equity in provision of healthcare services in the country. Public-private partnership is one such initiative. He concluded that the bulk of poor Indians seeking care visit the private sector, efforts to include the private sector within a formal planning and monitoring system for healthcare service delivery through the public-private partnership approach should be welcome. However current efforts are inadequate on many counts and the problems must be addressed if a robust, accountable and quality public-private partnership mechanism has to be developed.

\textsuperscript{87} Kapilashrami M.C., Sood A.K. and Sharma B.B.L., “Involvement of Private Sector in Health: Suggested Policy Guidelines and Mechanisms”, \textit{Health and Population - Perspectives and issues} 23(2): 2000, pp 53-60

\textsuperscript{88} Das Abhijit, “Public-private partnerships for providing healthcare services” \textit{Indian Journal of Medical Ethics}, Vol. IV No 4, October-December 2007, pp. 174-175
A. V. Srinivasan (2008)\textsuperscript{89} has classified hospitals into three categories based on the number of beds. Category C hospitals are located in many places for easy reach. They have 30 or fewer beds and provide primary care. These are clinics and nursing homes. Category B hospitals have 31–100 beds, provide some specialty-care, have few designated departments including some investigation facilities. They have arrangements to provide basic needs to patients and attendants. Category A hospitals have more than 100 beds, are multi-specialty, use better technology and attract superior qualified professionals. In all categories, both public and private sector hospitals function. He stressed that public sector hospitals are city administered, community supported and managed by government, they provide service free of charge, operate on a budget and are controlled by external agencies like department officials and are ‘not for profit’ earning. Furthermore he classified Private sector hospitals which are run by trust, charity and religious organizations. They may charge for the services with the objective of ‘not for profit’ earning. In the private sector another class of hospitals that are large-sized, multi or single specialty and provide services such of higher technology, they are ‘for profit’ earning and run on the lines of corporate organizations. The Category A private hospitals are for profit and Category B private hospitals are management–oriented which have reached the critical-mass level in the resources to look for optimization which are not controlled by external agencies. Though more and more institutions are offering programmes to equip hospital administrators, the supply is falling short very much and the market has not matured enough to reach this level of demand. According to him, various institutions in the country, which wholly or partially specialize in hospital administration, are hardly training 1,000 graduates in a year and most of them are employed in private sector.

A. Venkat Raman and James Warner Bjorkman (2008)\textsuperscript{90} explored the deficiencies in the public sector health system in providing health services to the population which was well documented. The inability of the public health sector had forced poor and deprived sections of the population to seek health services from the


\textsuperscript{90} A Venkat Raman and Warner Björkman James, “\textit{Public Private Partnership in Health Care Services in India}”, 2008.
private sector. They proved that, in many parts of India, the private sector provides a large volume of health services but with little or no regulation. They explained that to address the inefficiency and inequity in the health system, many state governments have undertaken health sector reforms and one of these reforms has been to collaborate with the private sector through Public/Private Partnership (PPP). State governments in India are experimenting with partnerships with the private sector to reach the poor and underserved sections of the population. Collaboration with the private sector to provide health services to the poor has generated many challenges. These include the motives of the private sector, scope and objectives of partnership, policy and legal frameworks, benefits of such partnerships, technical and managerial capacity of governments and private agencies to manage and monitor such partnerships, incentives for the private sector, stakeholder’s perspectives towards partnership, and explicit benefits to the poor through such partnerships. Their research evidence on these issues in India which are scanty and the research study, conducted by the authors under the Indo-Dutch Programme on Alternatives in Development, compiled 16 in-depth case studies of public/private partnership projects from nine different states in India. The case studies examined issues such as type of partnership, scope and objectives for the partnership, services covered and special provisions for the poor, obligations of the public and private partners, mechanisms used for the selection of private partner, performance monitoring, payment mechanisms, incentives to the private provider, stakeholder/beneficiary perspectives, and the sustainability of the partnership. Based on an analysis of the case studies and the functioning of the partnerships, this paper discusses whether PPP has been particularly designed to provide health services to the poor. Their study provides insights into how the partnerships originated, how they work, how the poor have been targeted, constraints and bottlenecks in the design, implementation and management of partnerships, and performance of these partnerships in reaching the targeted population. Their paper argues that, if well designed and implemented in stages, PPP is an innovative mechanism that benefits the poor. It would be unfair to categorize PPP as privatization or marketization because most of the partnerships that are designed to deliver health services were either civil society organizations or from the non-profit private sector. However, some arrangements involve the private for-profit sector in PPP. Their paper highlights significant policy perspectives on public/private
partnership in health sector. Operational issues in the context of equity, accessibility to the poor and the deprived groups are discussed.

The article of Birla and Taneja (2010)\textsuperscript{91} SAP (situation-actor-process) – LAP (learning-action-performance) analysis showed that the healthcare infrastructure was incapable of meeting health goals and was largely dominated by disjointed and unconnected strategies, and lack of resources. There was an urgent need to develop an alternate system for healthcare delivery in the form of PPPs, which the GOI is also encouraging. PPPs should be considered as innovative joint alliances, functioning on joint parameters of risks and rewards. Balance should be maintained between the healthcare needs of the public and the interests of the private players. The healthcare needs are different for different situations and different target populations. He explained that it is difficult to propose one single model as one model may not fit in every situation. However, in the absence of a clear guideline or policy in formulating PPPs, these models tend to be quite varied in nature, scope and delivery. He concluded that a PPP framework can provide a sustainable and mutually advantageous collaborative arrangements and improving the quality of healthcare delivered.

Rumki Basu (2011)\textsuperscript{92} discussed Rashtriya Swasthya Bima Yojana (RSBY) which was introduced from April 2008 India has pioneered a public private partnership model to provide health insurance to the poor. RSBY has several stakeholders – the central government, the state governments, the insurance companies, the public/private health care providers and the below poverty line (BPL) families – who will all benefit from the new scheme which is the first government social sector scheme to embrace a business model of profit. In less than 3 years the RSBY has enrolled more than a third of India’s BPL families – the target is to enroll 300 million poor by 2012-13 through this innovative scheme. This is an IT enabled scheme and will provide for healthy competition among public and private health care


providers leading to real improvements in health infrastructure especially in rural areas. He concluded that despite severe initial challenges RSBY considered as a successful public/private partnership model in terms of outreach and sustainability and well become a precursor to other schemes in the social sector.

The study of Arun Jithendra M. (2011)\(^93\) had brought out many important factors that significant in specific to PPP and to other PPPs that the government might undertake in the future like PPP Policy which frame worked the state government of just branding in return of PPP and a narrow approach in the aim to achieve quality of care, since it is a well-known fact that private sector is for profit sector and works towards maximizing profits year on year. He also of opinion that this policy will only invite companies which are in position to donate and also which wants branding to increase its image in public domain. The beneficiaries were completely in favour of technological developments in the PHC and feel this increase the confidence of accessing the government health centres even during the time of emergencies. Moreover they are satisfied by the fact that these services are provided for free whereas they would have had to pay a very high price to access these in a private set up. He recommended that the state government should try to alter the PPP policy and also look to accommodate other models of PPP which could be progressive in its objective to improve care in the government health centres. The PPP models should not just be considered as freebies being offered by donors but also ways and means to sustain these should be worked out and models that could increase the ability to endeavour into such initiative should be looked into. In line to this the public should be made aware of the entire process of PPP and efforts should be taken to actively involve them as stakeholders in decision making process to make them feel responsible. The bureaucratic systems should be made more efficient by making it flexible and informal by adoption of new management techniques to avoid unnecessary hassles in the administrative procedures by avoiding red tapes. Hence the need of the hour is to prevent the public health system from flagging which has led to experimentation in newer avenues like PPPs. But these innovations are to be taken as a short term approach to bridge the existing gaps currently but it should not be considered as a panacea for all the issues of the health system.

According to Sudha S.R. Public Private Partnership would improve equity, efficiency, accountability, quality and accessibility of the entire health system. The public and private sectors can potentially gain from one another in the form of resources, technology, knowledge and skills, management practices, cost efficiency and even a makeover of their respective images by its strength and innovativeness, efficiency and learning from competition. The private sector plays important role in transferring management skills and best practices to the public sector. Health Sector is important and timely in light of the challenges the public sector is facing in health care finance, management and provision\textsuperscript{94}.

2.7 Other Sectors involved in Healthcare

In James Tobin’s (1994)\textsuperscript{95} paper he discussed universal coverage, it is argued, implies universally required insurance, to avoid inverse selection into last resort care implicitly guaranteed. It also entails community rating, such that insurers cannot choose among risks. Individual mandate makes more sense that employer mandate. A system is purposed in which individuals can choose among a government Medicare-like plan and private insurance offering equivalent services. Means-tested assistance would help individuals pay premiums.

Hima Gupta (2007)\textsuperscript{96} found that almost 79 per cent of health expenditure is borne by private bodies and the rest by the public. She argued that to stimulate private health insurance growth, the Indian government should recognize health insurance as a separate line of business and distinguish it from other non-life insurance. Particular emphasis is placed on the present health care scenario in India and international field generally. A global comparison of selected Asian countries, regarding their national incomes and health expenditure in public and private sectors, generates insights. Third

party administrators (TPAs) facilitate a cashless health services for their customers and offer back-up services to the insurance companies.

Vinod Vyasula (2008)\textsuperscript{97} points that, medical insurance is now being actively promoted by the government as a means of providing and covering the costs of healthcare. But such insurance is riddled with problems and faces many constraints. It may contribute to the growth of the insurance industry but it is the second best solution that represents the abdication of responsibility by the state to provide health care to all its citizens.

“Keeping the ‘Health’ in Health Insurance” (2009)\textsuperscript{98} A study conducted by Sapna Desai, The Rashtriya Swasthya Bima Yojana and National Rural Health Mission have the potential to transform the health and financial security of poor households. The experience of Vimo SEWA indicates that health insurance must be firmly linked to an effective public health system. A high percentage of claims for preventable illness, unnecessary expenditure on medicines, increasing hysterectomies and inequitable claims patterns are four trends that are likely to be seen in the implementation of RSBY. To ensure that health insurance plays an intended role, appropriate investment in prevention, particularly in water and sanitation with community involvement is essential.

Vinay Kant and Shelly Saxena (2011)\textsuperscript{99} is of opinion that over the last 50 years, India has achieved a lot in terms of health improvement. This article has focused current health coverage set up in India and points out the inherent limitations of scaling up in the present scenario. This article throws light on the private/voluntary insurance in India, including its growth, major health insurance products available in Indian market i.e. Mediclaim.

During humanitarian emergencies, NGOs operate through various programs that attempt to develop health consciousness, public health levels, local medical training, and primary and secondary healthcare capacity with support from UNFPA.


UNICEF, UNHCR, WHO, and other larger agencies, NGOs are more than ever finding adequate sources to provide major assistance to ailing public health systems and to support education initiatives aimed at reducing the spread of disease, decreasing mortality attributable to failed public health infrastructure and unhealthy living conditions.¹⁰⁰

The desirability of empowering communities to take care of their health problems themselves has been raised since long. Often it is argued that self-help is an ingredient of the Primary Health Care strategy with its focus on "peoples' health in peoples' hands". The strong point is orientation towards action and progress; people would learn to be in the role of health care providers in the process.¹⁰¹

### 2.8 Research Gap

A comprehensive study of review of related literature indicates certain research gaps, which are listed below:

From the above review it is noticed that many researchers have studied ‘Health’, ‘Health Care’, ‘Public Health Care’, ‘Private Health Care’, ‘Public Private Partnership in Health Care’ as independent issue; specific importance is not given for comparison between them.

Many of the researchers have focused education, water supply, sanitation etc but more stress is not given to healthcare services under social sector.

Very few studies are based on national comparison of health sector. But no studies are found of public and private comparison in healthcare.

None of the studies found conducted at the Bijapur District Level. Hence, present study intends to fill the research gap.

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2.9 Conclusion

It is globally accepted that the health of people plays a major role in the overall economic and social development of the nation. The efficacy of a health system of a nation depends on its propagation of good health, appropriate prevention and curative remedies for various diseases; it can be witnessed not only in developing or least developed countries but also in so called developed countries.

A brief look of the above ‘review of literature’ brings to notice that comparison between public and private health care service has snatched the attention of many health professionals, economists, sociologists, social workers, psychologists, policy makers and many other human service professionals. This complex concept has been widely studied by many scholars and academicians all over the world and still it is one of the most vital topics for the researchers. Although comparison of public and private health care services has been studied but as listed in the research gap, there are some gaps that need to be filled. Hence, the present study tries to fill research gap.