Chapter - II

LITERATURE REVIEW: SOME THEORETICAL CONCEPTS AND ISSUES PERTAINING TO ACCESSIBILITY AND DISTRIBUTION OF HEALTH CARE FACILITIES

The present chapter discusses the literature on various aspects associated with distribution and utilization of health care facilities in the context of its overall organization and public policy. Overview of the literature have been presented in the first part while the second part advances some theoretical issues, concepts and perspective pertaining to accessibility and distribution and utilization of health care facilities in urban areas.

AN OVERVIEW OF LITERATURE

The studies on the relevant theme may be broadly grouped into three categories:

A. Distribution and Organisational setup of Health Care Facilities;
B. Socio-Economic characteristic affecting utilisation of health-care facilities; and
C. Planning and Public Policy on Health Care.

Distribution and Organisational setup of Health Care Facilities.

The distribution or Spatial location looks into the provision of the facilities located in an area with a particular population size. The next issue is what population size the facility is catering to and the concentration and dispersion of facilities due to various socio-economic and other factors.

The first key principle of health care facilities strategy is equity or equitable distribution of health services, i.e, health services must be shared equally by all people irrespective of their ability to pay, and all (rich or poor, urban or rural) must have access to health services. At present, health services are mainly concentrated in the Kanor towns and cities resulting in inequality of care to the people in rural areas. The worst hit are the
seedy and vulnerable groups of the population in rural areas and urban slums. This has been termed as social injustice. The failure to reach the majority of the people is usually due to inaccessibility.

The following paragraphs would make an attempt to discuss some of the studies related to distribution and organizational setup by Indian as well as Western scholars.

The government of India in 1943 appointed a committee known as Bhore committee who prepared a report. The report stressed on (a) medical relief should be made available to all irrespective of capacity to pay for it (b) health facilities should be nearer to people etc.

By the end of the second Five Year Plan (1956-61), a fresh look at the health needs to provide guideline for the national health planning in the context of the Five Year Plans. In 1959 the Mudolair committee observed that free medical coverage was neither feasible nor practical. They were of the view that first of all the existing primary centres should be strengthened. The committee strongly recommended the case for mobile vans for reaching area far away.

The National Health Policy 1983 suggests the decentralized system of health care delivery following the given norms.

While discussing distribution of services in terms of its location according to the population size, Akhtar and Izhar's study regarding India and Zambia observes 80% of the rural population have access to a very small portion of the health care provision. In terms of higher level hospital specialism, such as open hearth surgery, the Indian case show grows imbalances. Seven out of eighteen hospitals offering this specialism are in Maharastra state (5 in Bombay alone) the small state of Kerela, with under 5% of the population, has two such hospitals, while none exist in Bihar, where 10% of the population reside. U.P. with 16% of the population has one such hospital. 'Primary' here seems to operate here at state level; the 'higher order' states with major cities are best favoured in terms of distribution of modern medical personnel and facilities.

Mcglashan (1982), in a study of ten Caribean islands notes that epidemiological transaction had progressed to different extents by the late 1970's suggesting a type of regional differentiation in its occurrence. It seems reasonable, too, to assume that
epidemiological transaction may be progressing locally at one speed in rural areas and at another within urban areas. Furthermore, well-to-do urbanites may be rapidly developing a western pattern of mortality whilst poorest urban dwellers remain subject to a host of infections and directly diseases. Lack of environmental health, bad nutrition, low wages mean that many infections diseases are in still in danger to the urban poor.

Akhtar Rais and Abdul Qayoom Khan (1993) in their paper regarding spatial organization of health facilities in Jammu and Kashmir, examines inequalities in the provision of health facilities examines inequalities in the provision of health facilities in the state of Jammu and Kashmir. There are imbalances in the distribution of medical institutions, beds, and medical personnel in the different distinct of the three natural divisions. The study also indicates that degree of urbanization has no significant role in the availability of health facilities. Besides, transport network, particularly in the Kashmir and Ladakh divisions of the state, is highly underdeveloped. Health planning of the state should take into consideration the equity consideration rather than efficiency while making future plans for the development of health care services in the state. Since the settlements are dispersed in the region, a group of villages can be selected for the provision of health facilities, thereby increasing accessibility to health care facilities. Besides adequate funds should be allocated for the construction of doctors' allocated quarters in the rural areas. This will help increased availability of doctors in the study area.

Zaidi (1985) observed that in Pakistan, urban and class bias has resulted in inequality in access to health facilities to the urban poor and rural masses.2

Philips (1990) in his study about health care in third world countries discusses the geographical variation in the distribution of health care facilities. The various difficulties involved in extending access to health care and the reasons for differential accessibility and urban bias in the distribution of health care. In third world countries apart from


2 S.A. Zaidi (1985), "The urban bias in health facilities in Pakistan", Social Science and Medicine, 20(5) : pp.473-82
paucity of resources, the health care delivery system have often grown up in a fragmented manner, provided by public, private and charitable aid sources, they have frequently been non-complimentary or even competing in their functions and locations. An application of location allocation model may be used as a planning tool to assist decisions on the optimal location of a given number of facility in a region.  

The key areas identified in Hyma and Ramesh (1993) include distribution, size and type of health services; locational pattern governing the choice of traditional medical practitioners's accessibility factor relating to distance as it the free services do influence the utilization pattern of low income groups regardless long distance; referred system etc. The study presents some discussion on methodological issues and approaches in the sight of data and information obtained from field survey. The study concentrates on the spatial and functional organization and utilization of various health care services of indigenous medicine at intra-urban levels in selected towns in the state of Tamil Nadu in Southern India since 1978, as well as indigenous medicines current role in integration in government primary health centres (PHC)'s in the state. They talk about the survey based research strategy is the only, means by which one can comprehend the utilization behaviour and spatial patterns of use of multiple therapy systems. Successful planning and management of health services demands knowledge of the pattern of morbidity in a given populations as well as as utilization of services.

A techo-economic survey undertaken by the National Council of Applied Economic Research (1973), revealed some important shortcomings of health-care facilities in Delhi: (i) uneven utilizaton of health-care facilities in hospitals and

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dispensaries, while major hospitals remain crowded, colony hospitals with similar facilities remained under utilized, (ii) a wide disparity in the facilities available to different groups of people (iii) less emphasis on preventive measures, and lastly (iv) lack of co-ordination among different agencies with regard to planning and administration of medical facilities.

Banerjee\textsuperscript{6} (1976) comprehensively studied health administration of the metropolis. She observed that Municipal health services were unequally distributed among its localities and attributed this to uneven growth due to population explosion and migration. These factors also exerted enormous pressure on the prevailing health facilities. It was further pointed out that the local government had not been able to evolve policies and programme for providing health services consistent with the needs of the people. Defused administrative structure and fragmented policies have severely affected the bureaucratic performance. The efficiency of the technical staff was also affected by poor service conditions. The scholar further observed that stable political leadership and political will was required to run administration efficiently.

Eyles \textsuperscript{7} (1985) examines the changing nature of resource allocation formula for health care provision in New South Wales which involves the redistribution of resources to other health care functions, including community health, aged care services and community-based services for the developmentally disabled. The general effect of the resource allocation remains to be redistribution.

Humphrey \textsuperscript{8} (1985) in his paper describes and accounts for the existing distribution of medical services in remote areas. In contrast to traditional geographical approaches which have sought to explain problems associated with service provision in remote areas in terms of high costs of overcoming vast distances and low population threshold, it is argued that such geographical and economic factors alone are insufficient

\textsuperscript{6} Usha Banerjee, \textit{Health Administration in a Metropolis}, Delhi, Abhinav, 1977


\textsuperscript{8} J.S. Humphreys, "A Political Econmy Approach to the allocation of Health Care Resources: The Case to of remote areas of Queensland", ibid 223-241.
basis for explanation. Rather, it is necessary to view. This issue in broader context of 
eexisting ideology that underpins the procedures relating to the allocation of society’s 
scarce resources, and the role of political and bureaucratic processes that are responsible 
for health care inequities. The adoption of political economy framework recognises the 
problem of resources allocation as essentially a political matter requiring an analysis of 
power relations. The case study of health care in non-metropolitan Queensland, serves to 
illustrate the significance of ideology and the role of the state as they impinge on health 
status of the population. Matters of distributive justice have an extremely low priority 
when the primary objective of a society relate to the requirements of capitalism.

Kundu\(^9\) (1992) provides an outline of the existing organisational structure 
responsible for the provision of the health care services and examines their sensitivity to 
the needs and affordability of the poor. He concludes that the system has been designed 
to meet the minimum needs and affordability of the poor and is vulnerable to 
manipulation by vested interests. He observes that programmes and schemes are 
inadequate and superficial to meet that needs of the poor.

It is evident in the study by Duggal,\(^10\) et al (1995) in the health expenditure 
across the States that the investment by the public sector for health care has been 
inadequate to meet the demands of the people, which in fact was perceptible in the 70’s 
and became marked in 90’s The most persistent declining trend has been on expenditure 
on hospitals and dispensaries, especially since the 80’s as this decline may be seen in the 
context of massive expansion of Private Hospitals since the late 70’s.

Prasad (1995)\(^11\) in her study probes the functioning of both the public and 
private health care system in an urban setting, namely Hyderabad, and examines the 
performance of each sector through the perception of the users. The basic objective of

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States-Part I", *Economic and Political Weekly*, vol.XXX, no.15, April 15, pp.834-
844.
11 Sheela Prasad (1995), *Urban Health Care A Study of Private And Corporate 
the study is to test the hypothesis that the growth of the corporate sector in urban health care has led to widening inequalities in the quality of health care. The study is a preliminary investigation into understanding the dynamics of urban health care.

Ghosh\textsuperscript{12} (1993) studies the organization design and function of an health center, as he explained that urban situation creates special conditions and problems in the organization of medical services. Most of the large hospitals with its specialized services are located in the heart of the city and primarily provide specialist care. For primary health care, few depends on private practitioners. This happens, because in health planning not much thought was given to the organization of comprehensive preventive and promotive health care services to the urban community. The primary health centers set up by the government over the years is now lying unused with practically no drugs, available because of the sharp cut in public expenditure on health and the focus on privatization on health services.

Sahni & Xirasagar\textsuperscript{13} (1993) in their paper discusses the present status of health infrastructure and issues arising out of the current approaches to health care in urban areas are discussed. Experiences and innovative approaches to health care in urban areas are discussed. They emphasize on the fact that at a first glance, the health infrastructure in urban areas appears to be more than adequate which are mainly for the organized sector but the only organization providing with services to the slums are the UHRWCS (Urban Health and Family Welfare Centers). It is only alternative approach which Experiments with the Primary Health Care in Urban slums.


Gupta\textsuperscript{14} (1993) discusses the referral services in urban health care delivery system where he talks about the major health issues in urban areas like poor coverage, fragmentation of responsibilities between different institutions and duplication of services in many areas. He described about referral system in other countries and mentions the gap which exist in our country and suggests some models for regionalization of health services.

Visaria and Gumber\textsuperscript{15} (1993) in their paper tried to measure and explain existing differences in the utilization pattern of primary health care across different income groups. Available evidence show that while an urban bias remains in terms of the availability and accessibility of health services, the public sector provisions were largely used by the lower income groups. They observed that through the rural urban differences continue to exist during the 15 years between 1976-90, infant morality rates in rural areas have dropped marginally compared to urban areas.

Khandewale\textsuperscript{16} (1996) study on Delhi focuses on the organisation and functioning of its municipal health administration. An attempt has been made to study evolution, formulation of health policy in order to understand operational aspects of health institutes. The study observes the drastic changes in the budget proposal due to resource crunch. The author realises that the referral system should be strengthened with a thrust on smaller hospitals rather than large, unmanageable ones and health programs should be moulded as per needs of the locality.

\textsuperscript{14} J.P. Gupta, (1993) "Referral Services in Urban Health Care Delivery System". ibid. pp. 147-165.

\textsuperscript{15} Pravin Visaria and Anil Gumber, (1993), "Differences in the Utilization of Health Services in Western India, 1980-81, 1986-87," in Madras Institute of Development Studies, 23rd Inter - Disciplinary Workshop.

Gill (1996) in his article describes the consequences of the Punjab Health Systems Corporation. The main objective of this move has been qualitative improvement in the hospital services at the Secondary level where the World Bank loan of Rs. 400 crore has been made available for this purpose. The hospitals attached to teaching institutions and rural dispensaries have been left out of the purview of the corporation. A large section of the people who are quality conscious and have the capacity to pay are fast moving towards the private clinics/nursing homes as there is a visible decline of service in government hospitals.

It is evident from the overview of the literature that though some work has been done in the field of organisation and administration of health care facilities distribution is still a less researched area in the context of the availability of the health care facilities. For this there has been a detailed comprehensive and in-depth study of the distribution aspect disclosing the finer details involved in the concentration and dispersion of all the health care facilities. The focus of the present study is to highlight the above mentioned facts in an analytical perspective.

Social Economic Aspect

Suchman (1966), in his model placed great reliance on social group influences and less emphasis on the psychological, state of readiness. He hypothesized that very different levels of knowledge and attitudes to disease and illness would exist among ethnic and social groups. It was suggested that a comopolitan social structure is more likely to have a scientific health orientation.


Nolan\textsuperscript{19} (1967) and his associates conducted a study to find whether the removal of economic barrier through prepayment for health services. It was found that majority of the upper classes paid visits for health supervision, but a majority of the lower classes visited clinics for acute condition.

A model by Anderson\textsuperscript{20} (1968), refined by Aday et al (1980) has emphasized family life - cycle and behavioural determinants of utilization. Factors what may predispose towards utilization are a family’s size, composition and health beliefs, but certain enabling factors such as family’s or community’s health resources may enhance utilization.

A more sophisticated and complex model by Gross (1972)\textsuperscript{21} incorporates behavioural components as major determinants of utilization. The model incorporates accessibility. This model incorporates a wide range of variables.

Khandekar\textsuperscript{22} (1974) restricted her study to maternity and child health services of Bombay. Though she found that middle income group had better knowledge of health services. She did not come to the conclusion that income was the sole factor in determining such a pattern. She analyzed the role of age, family, size, education and occupation.


\textsuperscript{20} R.A. Anderson (1968), \textit{A Behavioural Model of Families use of health services}, Center for Health Administration Studies, 25, University of Chicago, Chicago.


Kannan et.al (1991)\textsuperscript{23} in his study on Kerala Sastra Sahitya Parishad conducted household survey in 1987. The study probes into morbidity disability pattern, maternal and child health. According to the social-economic status and environment status.

Tragler\textsuperscript{24} (1985) studied the relationship of socio-economic status with mortality patterns, data health attitudes, and utilization of health services. Poverty, unfavourable living environment poor sanitation and absence of curative and preventive health services were the factors contributing towards the unhealthy conditions of the slums.

Mahta (1992)\textsuperscript{25} stresses on the fact that an individual as a component of society influences as well as gets influenced by the societal norms, values and interfunctional patterns. The varying situations and the human complexities give rise to various patterns of health care, a need to strengthen the sociological aspects through appropriate leadership structure.

Yesudian\textsuperscript{26} (1988) in his study highlights the role of social inequality in the utilization of health services. Further their different educational achievements produce differential knowledge of health services needs. The author suggests an integrated development programme for the poor to narrow down social inequality. The author fails to throw some light on the organizational structure of health care to absence the programmes and schemes undertaken for the health care for the public and look into the drawbacks and failure of the scheme.


Baru\textsuperscript{27} (1993) in her empirical study on inter-regional variation in health services in Andhra Pradesh recognized that health status of a population is shaped by a variety of factors like food, water, sanitation, housing, income, availability and accessibility to health care facilities. Health services is one just input required to improve health status of the population which are shaped by socio-economic and political factors in society.

George and Nandraj’s\textsuperscript{28} (1993) study on Maharashtra focuses on the socio-economic indicators to examine the relationship between health sector development and capitalist growth. The study reveals that Maharashtra presents a picture of moderate achievement in the field of health care against the context of remarkable economic development.

Mutatkar\textsuperscript{29} (1995) in his paper explains that through industrialization have developed modern mega cities, but rural poverty has pushed villages to the cities, which were never planned to accommodate immigrants. Public health and social problems have arisen lowering the quality of life. Communicable diseases among the urban poor co-exist with non-communicable diseases among the comparatively affluent. Problems of pollution, crime and chronic morbidity increase.

Sekhar, P. Satya (1995)\textsuperscript{30} in discussion has disagreed on some of a few aspect in an article by Brijesh Prohit and Tasleem A. Siddiqui an utilization of health services in India. First of all Sekhar points out the methodological anomaly of comparing the NSSO survey and NCAER study which are non comparable. The NSSO provides data

\begin{itemize}
  \item \textsuperscript{27} Rama V. Baru (1993), "Inter-regional variations in Health Services in Andhra Pradesh", \textit{Economic and Political Weekly} 28(20), 15 May 93; pp. 963-967.
  \item \textsuperscript{28} Alex George and Sunil Nandraj. (1993) "State of Health Care in Maharashtra: A comparative Analysis". \textit{Economic and Political Weekly} 28 (32-33): 7-14 August, 1671-77.
\end{itemize}
only on the incidence of morbidity and it is well documented in significantly higher than
the incidence rates. Further the NCAER study was a one - time study and unlike the
NSSO study it did not consider the possibility of any seasonal variations in the reporting
of any morbidity levels. Sekhar also had some reservation of the classification of states
into low, medium, high expenditure states, based on All India per capita expenditure on
health.

Reddy, C.P. Nagi and Satya Sekhar, P(1996)\(^{31}\) in their paper presents the basic
results on the utilization of medical services where the data base is state sample. The
study mainly by focuses on the aspects like source of treatment, system of medicine type
of ward payment category, amount paid to hospital per illness episode and total
expenditure incurred per illness episode.

Ravindran, T.K. Sundari (1996)\(^{32}\) study attempts to Draw attention to the
consequences of material and social deprivation on the health of a scheduled caste
population through the examination of health status of the most vulnerable population sub-
group, namely children under the age of five years. The study show that SC population
in Chengalpattu, both infant morality rates and probability of dying before the age of five
are higher than for the general rural population, as indicated b comparable rates for rural
Tamil Nadu. The study reveals that curative health services are actively sought, within the
constraints imposed by the socio-economic situation. Neither 'ignorance' nor 'cultural'
beliefs prevent people from seeking health care. The study observes that the poorest
section of the population use private health facilities in preference to primary health
centers is an indicator of the failure of public vicious circle is set in motion, which further
widens health inequalities. The important issues like landlessness, exclusive dependence
in wage labour, illiteracy, poor housing condition, safe water, and lack of sanitary facility

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\(^{31}\) Reddy, C.P. Nagi and Satya Sekhar, 1995 P. "Utilization of Medical Sciences
Andhra Pradesh Evidence from 42 Round NSS Data" (ed) Health Care Services
Management Editor A. Ranga Reddy Delta Publishing House Delhi, pp.89-106.

\(^{32}\) Ravindran, T.K. Sundari, "Social Inequality and Child Health Status A Study of
a Scheduled Caste Population", op. cit pp.85-121.
causes avoidable morbidity such as respiratory problem, worm infection and skin diseases. Unless these issues are tackled inequalities in health experienced by SC population cannot be narrowed down by "reservation" and "quotes".

Asthana's (1995) paper describes environmental and other health hazards in five slum settlement in Vishakhapatnam. Despite considerable differences in infrastructural and socio-economic developments, morbidity rates were not found to vary between the study settlements.

Visaria and Gumbur (1996) analyzed the utilization of health care facilities in Gujarat and Maharashtra both urban and rural areas. The household survey was mainly done keeping in mind the effectiveness of the universal immunization programme, which was launched in the country as a whole in 1985 in the midst of some controversy. Visaira and Gumber have attempted in differentiating the utilization of health services in terms of immunization against major vaccine preventable diseases and post natal maternity care. These services play a vital role in influencing the level of infant, child and maternal morbidity and mortality.

There are many studies in which models have been used to describe, determine and predict utilization of health services the various social and psychological variables are used in models to investigate and to attempt to explain the utilization of health services. Some studies have attempted to incorporate aspects of the "demand side" according to age, sex and social class while other studies have emphasized on the supply side. Aday and Anderson (1968) have proposed a useful model which incorporates both the aspects of demand and supply.


Gross (1972) in a more sophisticated and complex model incorporates the aspect of accessibility which fits into the household level survey. The model incorporates a wide range of variables, but their numerical expression and measurement may be problematic.

The other studies highlights one common phenomenon that health care system in India does not meet the needs of the large section of the population. The present model is based on the ‘western technological institutional model’ which is costly. It relies too heavily on expensively trained doctors, nurses etc. The system is closely linked to a rapidly growing medical industry of drugs, equipment, technology which in turn has given rise to an almost organize industry though the benefits of all these do not go to the people in an even way. Yesudians study pertaining to utilisation patern also is a detailed study showing the social indicators. Kannan’s study concentrates upon the morbidity with the soci-economic status and environment status separately and the picture emerges very clearly when compared with these two indicators.

Reddy, Ranga, A. \(^{35}\) in his paper highlights certain pertinent issues of health care services in rural and urban India. He says that medical care is considered as price elastic. Un-organized urbanization is source for generating diseases. Right to health care can eliminate in equal distribution of health care and accessibility.

Sapir Debarati Guha’s \(^{36}\) (1996) study pertains to maternal and nutritional aspects of urban poor women and health specificities of the urban environment. The principal finding of the survey were the following: the significance of the traditional sector in health Care; the high cost of medical care and the high proportion of medical expenditure on medicines, the severe caloric and fat deficits among younger women and lactating mothers; the tendency to spend on less on medical care for women; and the penury of space and consequent exposure to pollutants. In the analysis of these findings, several areas have been identified as practical priority issues that need to be addressed by

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policy-makers. In Calcutta, primary health care is severely underdeveloped. Almost all care to the slum populations is provided through hospitals and so, thus, entirely curative in nature. The primary health care standards, the structure and orientation of the system is clearly difficult to apply in urban settings without appropriate modifications. The effective use of health care by women in the Calcutta slums, as in India is closely related to her status and value in society. Urbanization has done little to change traditional attitudes and roles towards women among the urban poor.

Baru's (1993) paper gives a historical account of the role played by the government and the private sector in India in the provision of health care. It indicates how the two have always co-existed and how government policies have either encouraged the private sector through investments in medical education, infrastructure and research, through loans, tax and import duty concessions on medical equipment or have left the sector alone.

Kethineni's (1991) study seeks to put the debate on relative efficiency of the state and market in production and distribution of health care services in a large theoretical perspective by bringing in Keynesian and Marxian views on the nature of the state intervention in a capitalist economy, particularly in health care, and to see their relevance in understanding the role of the state in provision of health care in India. The first part deals with market versus state in health care, the second section deals with Keynesian and Marxian views on the role of the state in a capitalist economy. The nature of the state intervention in the health care provision in India is analyzed in the final section.

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According to Sen Amartya\(^\text{39}\) (1996) health being the most crucial aspects of human well being where he stresses on "health transition" which has been achieved by rich as well as poor countries unfortunately India, despite making considerable achievements, lags far behind in this situation. His focus was on the two distinct aspects of the need for objectivity in assessing health status and policy. As far as health conditions are concerned, self-perception proves to be rather unreliable at the same time, provides important clues to the persistence of these deprivations. When the question of supporting market force or government roles comes then the challenge is far more complex. Health Transition have to be understood in less fragmented, more integrated terms.

**PLANNING AND PUBLIC POLICY ON HEALTH CARE**

Rama Chandradu and Kamalamma (1991)\(^\text{40}\) critically evaluates the trends in the health sector and highlighted the need for the preparation and implementation of health plan in India. Their empirical study though provided data on various health plan outlays, totally over looked the other programmes and only concentrated their discussion over Family Planning Programme.

Kundu (1992) in his study on urban poor observes that the very system of health care has been designed to meet the minimum needs and affordability of the poor is vulnerable to manipulation by vested interests. He observes that programme and schemes are inadequate and superficial to meet the needs of the poor.


Muraleedharan\textsuperscript{41} (1993) in his study raised certain fundamental questions regarding how health care services should be ethically perceived, what theoretical definitions would be appropriate and their use and implementation. He thinks that the purpose of public policy, both in market and non-market economics has always been to reduce barriers in access to health care. The exercise is stimulating and useful but it fails to deal with a major question which is nature of the society where the demand for quality in health care arises, and the class implication of the demand.

Tulasidhar\textsuperscript{42} (1993) in his empirical analysis tries to reflect upon the changes in the outlay in the health sector. The compression of public expenditure, will result in cuts in the centres allocation to be states. Recent changes in the allocation of resources of the health care in the centre and the states are reviewed and attempt is made to identify the threats of sustainability of present levels on expenditure on health care.

A critical analysis presented by Banerjee (1993)\textsuperscript{43} about the World Bank Report on the health sector in India observes that the report has astonishingly overlooked aspects like socio-economic forces and other critical inputs for health service development. The report missed the vertical programmes like target oriented time bound family planning programme of immunization which cause damage to the health services. Banerjee says that the team calls for greater central action of health services at a time when the country has opted for a major programme of decentralized administration and he does not consider it as a policy alternative the country can look forward to.

\textsuperscript{41} VR. Muraleedharan (1993) "When is access to health care equal? Some public policy issues" \textit{Economic and Political Weekly}, 28 (25); 19 June, pp 1291-96/

\textsuperscript{42} Tulasidhar, V.V. (1993) "Expenditure Compression and Health Sector Outlays" \textit{Economic and Political Weekly}, vol.XXXVIII, no.45, Nov. 6, pp.2473-2477.

Prabhu\textsuperscript{44} (1994) in his paper on the basis of World Development Report 1993 and India: Health sector financing Report 1993, seeks to highlight some of these issues as the characteristics of health financing in India. An analysis of the structural adjustment on the Union Government’s health expenditure and it examines the health sector financing at the state level.

Shiva Kumar, A.K.\textsuperscript{45} (1994) examines the World Development Report 1993 in the light of the health status of Indian, their health seeking behavior, the provisioning of health services both public and private sectors, and the effectiveness of government policy intervention.

Qadeer Imrana\textsuperscript{46} (1994) tries to analyze world Bank’s approach towards primary health care particularly with references to India. The first section looks at the evolution of PHC and its links with international interests. The second section examines what could be described as the dualism in India’s plans to build he health sector. The third section examines the World Bank’s interventions in health and attempts to link it with India’s receding commitment towards Health for All through Primary Health Care.

Gupta (1994)\textsuperscript{47} says that the World Development Report 1993 being the most comprehensive document of the World Bank regarding the health sector as a whole, and, in that sense, embodies the basic understanding of the Bank towards this sector. He tried to critically analyze the essential formulations being made in this document, as well as


attempt to project the implications of these formulations on the future development of health infrastructure in developing countries.

Antia (1994) in an article says that World Development Report 1993 is an example of cleverly crafted display of concern for deteriorating health of the world's poor by the same institution which serves the vested interests of western governments and multinational corporations, who, in their frantic search for the material resources of the entire planet, have reduced the majority of its human populace to a state of object poverty. This has undermined the very bassi of their health.

Donahue, John M and Mcquire, Meredith B. (1995) in their article addresses the question to what extent do health care strategies in a given political economy increase peoples perceptions of responsibility to take charge of their health, but do not structurally empower them to satisfy their health needs. In shaping health care policies, societies typically adopt one of three strategies, linking their larger political economy and modes of exercising power, a market place strategy, a state-managerial strategy or a national participatory structural power, there strategies result in three very different approaches to responsibility for health and illness. Changes in the political economy of health illustrates the changing field of choice within which care seekers must make their health care decisions.

Sarah Natasha and Amn (1995) in their paper describes the changes being introduced into the Russian health care system, particularly the introduction of a compulsory social health insurance system which is paralleled by encouragement of independent health insurance. An example of the implementation of these changes is

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provided by the early development in St. Petersburg. The effects of the likely changes on health care providers and users are discussed.

Grogan\(^5\) (1995) in his paper describes the evolving urban economy and examines the implications of these changes for access to health care courage. Provided first is a brief description of the Chinese Urban Health Care System. Three major area of urban economic reform since 1984 are outlined and the possible effects of these reforms on health care courage are discussed. The analysis reveals, first, the emergence of insurance courage inequalities under employment-based health insurance as China moves towards an open market economy.

Haddad and Fournier\(^5\) (1995) while talking about the quality, cost and utilization of health services in developing countries where a longitudinal study in Zaire has been conducted. The authors feel that the quality of public services has often been neglected in developing countries. While some attention is given to technical qualities, the interpersonal components of the quality of services are generally ignored or underestimated by planners and they are the very components which are most resistant to change. It will be a major challenge for health systems to address this issue of quality of care in order to minimize the negative impact of the introduction of user payment schemes. Therefore, now is the time to place quality next to coverage in planners agenda's.

Purohit and Mohan\(^5\) (1996) has come up with an article based on the report of a workshop on "Public Health Financing" held at Indian Institute of Health Management Research (IIHMR), Jaipur, on 3-4 March 1995. The World Bank publication

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suggested a need to streamline the expenditure on public health care. Against its backdrop, it was though necessary, given the diverse mechanisms of catering health services across the country, to bring forth experiences of various states and evolve a broad consensus regarding the future means of public health financing. The four main themes are the extent of privatization of health services, the under prioritizing of primary health services vis-a-vis tertiary health institution, re-evaluation of financial allocation in public expenditure on health and seeking new means to mobilize resources for health services. It was opined that in fixing priorities in the primary health sector that preventive and primitive aspects need to be stressed more and per-capita expenditure on drugs in rural areas has to be increased. The preventive aspect where water and sanitation should be taken care which could prevent 50-70% of diseases. The expensive medical equipment should be avoided.

Sanyal\(^{54}\) (1996) in his study on household financing of Health Care uses the result of the survey conducted by (NIPEP) 1993-94, (NSSO) 1992 and (NCAER) 1992, for the purpose of ascertaining the use of the government and private sources of treatment by the households and the expenditure increased, changes in the utilization pattern, expenditure and the differentials across the rich and the poor. The possibilities of rationalizing the user charges on the basis of NSSO and NIPEP results. Revenue earnings of the hospitals are computed with the help of estimated payments made by the households to arrive at some plausible macro level estimates of the additional resources that could be generated by large from large and small hospitals.

Banerjee\(^{55}\) (1996) interprets that the interplay of two types of socio-cultural and political forces have influenced the trends in public health practice in India. In the colonial period, while the interests of the colonial rulers were the dominant motivating

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factor, agitation for increasing the outreach of the health services to the masses of the people was a platform of the anti-colonial political struggle which led to the setting up of the Ofsohey and Bhore committees after independence the anti-colonial struggle took the form of struggle for democratization. There has been very rapid expansion of the health services since Independence but as pointed out in the National Health Policy document, there has been a strong privileged class, urban and curative bias in health service development, which reflects the class character of India society. Another series of setbacks came from a series of initiatives with powerful backing from affluent western countries. These initiatives by UNICEF and WHO, with powerful backing from affluent western counties. These initiatives have been very faulty from a scientific angle. The defects were even more damaging in social and economic philosophy of primary health care as enshrined in India’s National Health Policy. Kundu(1994)\(^56\) probed into the delivery of health care services beginning from the intervention at center and state level to the contribution of local bodies. He also described the role of public as well as private undertakings and voluntary agencies. He examines reimbursement scheme critically and finally he does an assessment of health delivery system. In this part he critically examines interplay of various factors responsible for the deterioration of public hospitals and then in difference of the health sector towards the poor.

Jeffery(1996)\(^57\) while commenting on political economy of health care thinks that health planning in India has shifted resources towards preventive medicine, rural areas and paramedical workers. The notable features of Indian health policy are the extent to which it has shift towards more appropriate models; and the role of factors internal of the government and political party structure which have limited the implementation of even these relatively modest growth in a widely spread structure of public health care facilities.


- but with no certainty that these facilities will be effective or well managed. They function not to raise labour productivity but to head off social discontent and to expand a public sector to provide the jobs and contracts which are the State Health Minister's stock-in-trade. The basis of the crisis in India is that health policy discussions still proceed on the assumption that the future is 'welfare statistic' in one form or another. The theme of the paper focuses on the fact that in policy was in the first 20 years after Independence, India’s health policy was in tune both with international ideas of how to deliver health services in poor countries and with the developing structures of the Indian State. The State is moving is one direction, international advice and funding is are unable seriously to address the health policy issues which confront them.

Baru 58 (1994) in her paper examines the available data to look into the structures of health care provision by public private and voluntary sectors across the states. The 42nd Round NSS data has been used to examine utilization patterns for both outpatients and in-patients care across the states. Its concluded with a discussion of the trends observed and the implications of the Bank’s recommendations for provision and utilization of health services.

Berman’s 59 (1996) paper reviews the size and composition of health expenditures in India and offers some comments and questions about what this information has to offer for the future development of health system. A recent estimate of national health expenditures and is compared with earlier figures which is followed by a comparison of India’s expenditure land with other countries. The link between health spending and health impact is explored.

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Ghose\textsuperscript{60} (1996) in his paper on Health Care and globalization says that a look at some indicators of health in the period 1990-93, after the enforcement of structural adjustment, contrasted those for the period 1987-90 fields a picture which should cause serious concern. He is not surprised since the public health centers set up by the government over the years is now lying unused with practically no drugs available because of the sharp cut in public expenditure on health and the focus on privatization of health services.

Reddy, Janardhan, D. (1995)\textsuperscript{61} in his paper studies the health care services in G15 G7 countries. He analyses the basic indicators of health status which are population per physician, population per hospital bed, infant mortality rate, maternal mortality rate, percentage of population with access to safe water and sanitation services, percentage of national budget spent on public health and per capita health expenditure.

Sekhar, P. Satya (1995)\textsuperscript{62} in his paper studies the interrelationships between mortality and the cause of death patterns in Andhra Pradesh. The important data source for mortality are Sample Registration System and Vital Registration System. An attempt has been made to study the age-specific and cause-specific mortality levels.

Most of the studies were mainly on the public policy where important aspects were analysed. Banerjee and other authors succeeded in understanding the World Bank Report and criticized it for over looking some of the important aspects in health sector planning and the "essential clinical package" which is cloaked in a garment for the concern of the poor remains to be a crucial hoax for them.


Muraleedharan's exercise was stimulating and useful but it fails to deal with the nature of the society where the demand for equality in health care arises.

Kundu's study provides a very useful exercise on the utilisation pattern on 42nd round of NSS data which successfully bring out the finer details of the prevailing health care system in urban areas and how 92% of the slum dwellers are forced to use private centres due to the lack of accessibility in government health centres.

In the light of the above discussed literature review the present study has tried to focus on organisational setup and distribution factor of the available facilities in the urban Delhi.

Secondly the study tries to examine the area wise distribution of facilities and its utilization pattern. Thirdly the variation in the utilization pattern among different segment of the population according to different socio-economic background. The study tries to fulfill the research gap in the field of distribution as it has been a less researched area. The study also tries to al the three aspects of distribution, accessibility and utilization in relation to various factors in a wholistic way.

ACCESSIBILITY AND DISTRIBUTION OF HEALTH CARE FACILITIES: SOME THEORETICAL ISSUES AND CONCEPTS

This section would make an attempt to discuss the theoretical perspectives about the aspects of availability, accessibility and utilization of health care facilities within the context of organisational structure in the urban areas.

The provision of health care services is only one example of a wide range of services, the availability of which is not only a major determinant in the level of wellbeing of quality of life enjoyed by households, but also on occasions, essential for their survival. Health care services are available both privately as well as publicly.

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When it is the question of publicly provided goods and services, competition and conflicts largely take place in the political arena. The parliamentarians, politicians, ministers and bureaucrats compete with each other in furthering their political interest in total disregard to the needs of the larger section of the economically weaker section of the society.

As far as the question of resource allocation of private services are concerned, it follows the basic market principle of supply and demand and services are rendered according to one's ability to pay.

On the other hand the government procedures for the allocation of public resources are more complicated as their distribution invariably result from the interplay of many factors such as economies of scale, and the threshold requirement of the population, demand factor, and political pressure in terms of accessibility. Given the limited supply of resources, the problem is, how best to allocate the limited resources.

Resource allocation is closely linked to the issue of provision and issues related to inequalities and inequities, while discussing provision one cannot avoid the concept of equitable provision of services where actual location which is the principle of territorial social justice is as important as the amount of expenditure involved, while providing such services. Good medical care implies that it is accessible to people at the right time and place where and when they need it.

Remote areas characterized by low density of population, minimum threshold requirements and lack of purchasing power does not attract private entrepreneurs to operate services and thus the essential services is left to public sector.

Accessibility plays a major role in determining the spatial inequity. A set of argument stresses that some degree of spatial inequity is inevitable, and even acceptable but social inequity is not acceptable. Equity implies that people may receive differential treatment if such a course of action is deemed fair and just. Hence an inequitable distribution may well be equitable. In other words, differentiation may be acceptable where as discrimination is unfair.

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64 J.S. Humphray, op. cit, pg. 222-242.
Dejong and Rutten\textsuperscript{65} (1983) have outlined four basic principles of distribution, utilitarian, (and efficiency goal minimising the surplus of benefits over cost equalitarianism (where health status is equalized by giving priority to those in most need); equal access (where everyone has equal access regardless of what or how much is provided); and libertarian (where distribution results from freely negotiated transfer in the market place) and libertarian (where distribution results from freely negotiated transfers in the market place).

**HEALTH CARE PROVISION - A FRAMEWORK**

The existing system of health care should be according to the varying needs of the recipients representing different socio-economic categories of the population.

The availability of services is, theoretically related to a population’s need for them. Services vary over space according to the social and spatial variation. Some areas remain unserved by basic primary health care while some show over servicing in the public services. There is a general tendency of under servicing of primary level care in the private sector.

It is an implied fact that certain distributional principles are followed to determine the equitable distribution of resources. This distributive principle takes into consideration the persons needs and capacity to pay and accordingly sharing out costs and benefits proportionately.

Based on one assumption that all citizens require medical treatment equally, it follows that the services should be distributed with respect to population size. In evaluating the fact of distribution of medical services distance is one of the several factors of relevance, which is overlooked as greater priority is attached to other demographic, economic and social factors.

It becomes important to examine the ideology of those in power structure and their activity. It is also necessary to examine its role within a society’s socio-economic and political system which is known as political economy perspectives. Within the framework

\textsuperscript{65} G.A. Dejong and F.F. Rutter (1983), "Justice and Health For All", *Social Science and Medicine* 17, pp.1085-1095.
of political economy, health care represents one of the collective consumption goods and which they constitute to be public provision of socially necessary facilities and services, commodities that are not priced in market place.

Health care, depending on how the state conceives, can be regarded as a specific commodity, or part of broader societal good which is to be catered for wider ranging programmes relating to national development. Again there arises a set of conflicts on whether emphasis should be placed on curative or preventive programmes institutional or domiciliary services, centralised or community-based services. The implication of each policy is shown to differ significantly with respect to income distribution, public health and safety measures, health education provision of health services and right to health. Friedman (1975)\(^{66}\) argues that process of national development and spatial integration is an eminently political one. This means government power, links with private economic power to influence the location of resources. This basic fact gets unrecognized by planners while allocating resource.

**NATIONAL HEALTH POLICY**

The ministry of health and Family Welfare evolved a National Health Policy in 1983 keeping in view the national commitment to attain the goal of Health for All by the year 2000. The policy lays stress on the preventive, promotive, public health and rehabilitation aspects of health care and points to the needs of establishing comprehensive primary health care services to reach the population in the remotest areas of the country, the need to view health and human development as a vital component of overall, integrated socio-economic development, decentralised system of health care delivery with maximum community and individual self-reliance and participation.

To translate the above objectives to reality, the health policy lays down specific goals to be achieved by the year 2000. Through the framework of the sixth and seventh

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five year plans and the 20 point programme steps are already under way to implement the policy. Some of the are:

a) to establish one health sub-centre for every 5000 rural population (3000 in tribal areas and hilly areas) with one male and female health worker

b) to establish one primary health centre for every 30000 rural population (20000 in hilly and tribal and)

c) to establish community Health Centres, each serving a population of one lakh.

d) to train traditional birth attendants or Dais in each village.

Suggested Norms For Health Personnel

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Category of Personnel</th>
<th>Population</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td>Doctors</td>
<td>1 per</td>
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<tr>
<td></td>
<td></td>
<td>3500</td>
</tr>
<tr>
<td>2.</td>
<td>Nurses</td>
<td>1 per</td>
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<tr>
<td></td>
<td></td>
<td>5000</td>
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</tbody>
</table>

Hospitals

Sub-divisional hospital cover 5 lakh population.

Background of Health Care System in India

Health Care Services in India is to be provided with minimum cost with consistent and effectiveness on account of scarce resources and low level of economic development, keeping in mind the urgency and importance of resource a 'package' approach has been adopted. The social and political considerations had a major impact on health service development since the Five Year Plan were incorporating socio-economic aspects in it.

The political leaders in India were the members of the privileged upper class where the new positions of responsibility and power rapidly invested them with still greater privileges. The leadership failed to understand the day to day real life situation of the masses. their inclination was to adopt the Western conceptual approach which is the western-high tech model as they tried to impose it upon India without examining the ground realities of the masses. The need of the hour is to frame out a health care
approach accordingly. The monetary and technical assistance as provided by foreign as well as government agencies should be used keeping in-view of the needs of the people with a thrust on equity, and social justice.

Along with the allocation of resources, choice of technology was lying in the hands of the politicians and privileged class where they stressed, the import of high technology relevant to their needs. This explains why, inspite of acute limitation of resources, many expensively medical institutions have cropped up.

The existing approach is considered 'hospital based', 'cure-oriented', serving 'upper crust of the society' in urban areas.

In this era high - technology being wide spread for the survival of medical industry has also led to an over use of technology, which is an additional burden for the poorer people and forces patients to spend more then necessary.

SOCIAL BACKGROUND OF URBAN HEALTH IN CARE IN INDIA

According to R.K. Sachar, and P.J.S. Gill\(^67\) during the last forty five years health care system in India mainly focused on increasing coverage in the rural areas. they stressed on the fact the 3600 towns and cities in India with some 40 million people living in slums have to depend largely on private practitioners (mostly quacks) for their health scare needs.

Urban areas mostly have large hospitals, medical college hospital, research centres as well as private nursing homes and clinics. The urban scenario is totally different from rural and it creates different kind of problem in the organisation of health services. It is true the urban areas possess all the best facilities hospitals and doctors but all hospitals with its specialised services are located at the heart of the city and they primarily provide specialised care. In that case one may say that most of the urban areas lack in terms of well organised primary health care system. For primary care people largely depend upon

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private practitioners. This is prevalent mainly because not much attention was given to
the organisation of preventive and promotive health care service, and increased the gap.

In spite of such concentration\(^{68}\) of health services in the cities compared to rural
areas and relative proximity of hospitals and other facilities, standard of health care seem
to have fallen below minimum levels for those who live in slums and jhuggis jhopris. A
vast discrepancy exists in the quality of health care delivered by the private sector among
the various segments of the population.

In practice many people in the city go to pharmacists for basic advice and visit
hospitals during emergency. This invariably leads to a highly irrational approach to health
care. Emphasis on cure has been at the cost of preventive and public health measures.

Health services in urban areas continue to draw models from developed countries
for technical excellence and government support these trends for establishing national
identity and prestige. The trend lacks relevance, priorities and cost-effectiveness of the
developmental measures.

**URBAN SLUMS AND HEALTH CARE PROBLEMS**

Slum dweller\(^{69}\) and urban poor who constitute a large Section of the urban
population. have a poor level of health because they are under-nourished, suffer from
infectious and parasitic infections, live in unhygienic conditions in unhealthy environment
and are ignorant about health care and health related matter. They are not aware of
various health hazards they are exposed to, and fail to utilized health services fully.

Houses crowded together, open sewerage system, open garbage, poor sanitation,
and water logging are common phenomenon of a slum environment. Such an environment
would encourage diseases like diarrhoea, gastro-enteritis and respiratory illness. Medical
facilities are not available within the vicinity of slums. Apart from some municipalities

\(^{68}\) J.P. Gupta (1993), "Referral Services in Urban Health Care" in op. cit., pp.147-
168.

\(^{69}\) N.S. Deodhar and P.K. Mutatkar (1993), "Urban Health Care In India", op.cit.,
pp.29-44.
providing dispensaries. It has been observed\textsuperscript{70} that in urban areas the poor section of the population goes for private doctors. Interestingly, the exorbitant charges of these doctors were not mentioned as a hindrance in availing these services. This may be because immediate and personalised attention of the private doctors compensates for the higher charges. What the slum dwellers want is quick, and easy access to a doctor, proper attention and quick relief through medication so that the loss of the wages earned on a daily basis is minimal. Due to ignorance they also land up towards unqualified and untrained doctors for treatment who use antibiotics and other drugs indiscriminately. Urban poor like their rural counter parts, accept medical technology for cure of ailment but do not understand disease causative theories which are likely to motivate them to accept preventive measures such as nutrition, personal hygiene and sanitation and immunisation.

Even the indigenous health system have institutionalised on modern lives with medical colleges, pharmaceutical industries and consulting chambers of medical practitioners. These traditional practitioners have become commercial healers, and health education and preventive aspects are neglected.

Most\textsuperscript{71} of the urban poor in India are still rooted in a rural way of life following occupation like animal husbandry, poultry, rope-making, basket weaving and numbers other cottage industries and handicrafts. A large chunk of scheduled class population performs scavenging and other basic sanitary services and sizeable number of people performs traditional jajmani services like that of washerman, barber and domestic servant. All the people may be territorially urban but their socio-cultural values are similar to that of their rural counterparts. Though they are a part of the urban community but regarding health care they still have a very careless attitude.

\textsuperscript{70} Amitabh Kundu(1993), \textit{In the Name of the Urban Poor: Access to basic Amenities}, Sage Publications.

\textsuperscript{71} D.B. Ray, "Basic Issues And Real Challenge: Health In Urban Poor", op.cit., pp. 61-71.
The health hazards of urban poor are therefore directly related to firstly poverty, secondly polluted and stressful urban environment and thirdly feeling of instability and insecurity. They are more vulnerable to communicable diseases and malnutrition and at the same time, they are exposed to great risks of accidents at work on the roads and in the dwelling places. Simultaneously health hazards associated with child labour, alcohol and drug abuse etc. increase their morbidity. Even in the most undeveloped rural areas, they do not experience such extremes of health hazards.

HEALTH CARE ACCESSIBILITY IN THE CONTEXT OF URBAN SCENARIO

The previous discussion mainly revolved around the question of availability and distribution of health care facilities and the influence of various political and economic factors affecting location and organisational structure.

The very basic question after this would be whether available services have a proper access for all the users. Accessibility playing a major role regarding the aspect of health care services. It depends upon the policy-makers how best they can make it accessible to the various segments population.

Limited resources makes investment process much difficult as each and every rupee committed to health care would lead reduction in other things. The advance in medical technologies and the cost-effective issues of individual and societal level have given rise to complications.

In the designing of the health care system a few factors need to be taken into consideration viz - (a) nature of health care service (b) the recipients - to which socio-economic category they belong (c) criterion for availability of existing services (d) delivery system (e) management of finance i.e., who control it and how it has been implemented (f) delegation of power and authority vis-a-vis health care system.

These are the major factors determining the welfare of the users. Intimately linked with the concept of social justice. The allocation should be just according to various

segments of the population with varied socio-economic background where each person is entitled to a fair share of such services. These leads to a few fundamentals aspects—
(a) percentage share from total resources allotted to various categories of health care (b) percentage share according to need (c) the basis or any particular norm followed for the fair share the third issue deals with the question of affordability we talk in terms of equal access to health care.

Allocation done on the basis of per capita sounds to be a very just approach though it is not free from weakness as different individuals may have varying health care needs. Thus one can say that equality of public expenditure may in reality be inequality.

While availing the health care services the cost should remain same for every body. This again has been done on the presumption that all the members of the society being to the same economic class and have the same purchasing power. This again remains to be a debatable issue as a person with higher income receives the same treatment the person with lower income. This does not reduce the inequality as the rich man is obtaining the free services, there by making the poor more poorer. The rare resources thus being enjoyed by the higher income group segment of the population would justifiably be diverted towards the health care of the economically poorer section of the people and a prepared amount of equity in question be derived.

Space play an important role when we talk about accessibility. Distance travelled by individuals is directly related to the rate of utilization of the services public sector does not provide health care at the doorsteps. It is important to note that distance decreases accessibility much more for the poor than for the richer section of the population.

While explaining economic accessibility Kundu \(^73\) thinks that public sector facilities are provided free of cost (excepting for a registration fee or Rs. 50 or Rs 1.00 in some cases) to the poor while non-poor (with income above a certain level) are required to make payments. It must however, be added that no strict procedure is followed in identifying the poor and the hospitals have been quit generous in extending

\(^{73}\) Amitabh Kundu, op. cit., p.12.
free medical services to many among the non-poor. Besides, the charges are very low, covering only a small proportion of the cost of providing the services. It is thus evident that pricing of services has not been used in restricting their availability to the poor.

The organised sector with large autonomous bodies belonging to public and private undertakings, that do not have their health care facilities or limited medical facilities follow the reimbursement scheme of medical expenditure. A system of full or partial reimbursement is followed by central and state government employees. The people attached to the organised sector again can avail these special facility but the unorganised and poor segment of population are uncontinuously left out.

AN ASSESSMENT OF HEALTH CARE DELIVERY SYSTEM

Kundu\textsuperscript{74} is an analysis of the organisational structure, functioning of the institutions and the health sector reveal that a bias in favour of the poor expected in a subsidy is almost non-existing. The urban poor who constitute a large sections of the population are excluded from the special comprehensive health service developed for the employees of the organised sector comparison of central government and some public and private sector companies and corporations. They have a better access to qualified medical personnel and technical facilities of a high order with the help of a good refererl system.

Employees working with state government and central government adopted some health care schemes for reimbursement of medical expenditure where benefits of such schemes are available by a small section of the employees in the highest income bracket.

The general population in which urban poor constitute a large number in entitled to a very small portion of health care facilities. There are only a few hospitals in Delhi and a couple of them in other cities to the general public. That too, only a small fraction of the poor manages to reach these hospitals because of physical distance and various administrative difficulties. The poor who are only entitled to general hospitals have to compete with people having higher income level engaged with organised sector are also entitled to avail the health care facility from a general hospital. They very question of

\textsuperscript{74} Amitabh Kundu, op. cit., p.12.
equality is contradicted. The public health care has a very complicated and long process of registration which due to their ignorance, lack of knowledge and lack of self confidence while running from one department to the other, bewildered and entangled in the formalities of registration because all the more difficult for the poor. Thus they waste more time looking for the right place and by the time they land up to a proper place there is a long que awaiting in front of him/her. The waiting hours become prolonged for them as people with better contacts and higher education level get to persuade the doctor to avoid the huge queue and get a early check up. The poor people want quick relief as prolonged illness would lead them to go without income as they are daily wage earners. It is difficult for them to stay away from work for half a day. On the other hand the indifferent attitude of the medical personnel, low quality of service, non-availability of medicine and basic testing facilities and not functioning of a referral system discourage the poor to use the public health care facilities.

The rich or organised working class are aware of all facilities provided to them. They can pursue their situation by struggling with the complicated bureaucratic formalities. Their education, knowledge and the way they talk and present themselves help them to impress and highlight their problem and gather attention. Apart from that they would seek help of the contacts they have and use their power of influence.

Thus we can say that public health delivery system, by its very design is biased in favour of the rich organised working class and excludes the poor unorganised workers.

It has been a general trend in the intermediate and apex levels of services, the demand is several time more than at the primary level. According to this demand the investment has been negligible for the strengthening of the middle and higher level facilities excelling the research wing. The only task they perform is to provide consultation, a few routine tests, and then patients are often referred to non-governmental clinics. When such a situation of extreme scarcity, private accessibility is determined by personal relationship, bureaucratic linkages and corruption. In such a situation it is out of question, for the poor to avail required facilities as they neither have connections nor can afford this privately.
The sub-standard quality of services in general hospitals forced the
government employees of public and private corporations to setyp medical service system
of their own. They reimburse their medical expenses to private clinics and government
health agencies a heavily on this account, their-by limiting resources for the unorganised
sector. Thus we can see that the limited resources are not harnessed in an even manner.

Introduction of checks and regulatory restrictions are required to protect the
interest of the patients as well as the providers to establish a equitable and sustainable
health care system, irrespective of the fact that health care system is market oriented or
centrally controlled. One cannot ignore the importance of Consumer Protection Act in
delivering a better quality of health care.