CHAPTER II

REVIEW OF LITERATURE

Review of related studies is a pre-requisite for both explorative and innovative research in Economics. To get clarity and carry out a comprehensive study, it is necessary to review the earlier studies. This would help the researcher to have a better understanding of the perspectives of the research problem. In defining one’s research problem in precise terms and formulating objectives, the experience gained in reviewing quite a large number of related studies have a vital role to play. Without a review of previous studies, it will be somewhat difficult for the researcher to deal with the particular research work correctly. Review of related studies is also essential to know the research gap, the areas that have not been so far studied. Hence, an attempt is made in this chapter to review some of the available research articles related to health and National Rural Health Mission.

The review of literature is classified into ten sections. They are: health and economic development, health and nutritional status of the people, reproductive health, maternal mortality rate and infant mortality rate, factors determining the health status, government schemes to promote the health of people, health care expenditure, health care infrastructure, problems in health care delivery system and measures to improve the health status of people.
1. Health and Economic Development

Health is an important factor which determines the quality of human capital which helps in the economic development of the country. Hence, much importance is given to the development of the health status of human being. Many researchers have also highlighted this aspect in their studies which are being reviewed in this section.

Sedamkar (2011) finds out that health is an important asset of a society and a healthy society is the foundation of a strong nation. Health is an important determinant of economic and social development because diseases create a vicious circle by depleting human energy, leading to low productivity and earning capacity, deteriorating quality and quantity of consumption and standard of living. The majority of the respondents were not visiting the doctors. Most of the respondents said that as the costs of medical check-up were very high, it was not affordable for them to approach a doctor for consultation and treatment.

Patil and Patil (2010) have indicated that the health service is one of the most important factors of all human endeavours to improve the quality of life. Health development is recognised as an essential and important part of the nation's socio-economic development.

Ramachandran (2008) remarks that health is an essential input for the development of human resources and the quality of life and, in turn, the social and economic development of the nation. Improvement in the health status of the population has been regarded as an index of social development. Moreover, health is regarded as a priority for promoting the development of individuals and community. The rural health care services and their development constitute an integral part of total social and economic development of women in rural areas.
2. **Health and Nutritional Status of the People**

The health of a person mainly depends upon the intake of nutritional foods and the health care given. The studies related to health / nutritional status of the people and the factors determining it are presented in this section.

The Editorial of Economic and Political Weekly (2007) delineates the health problems and malnutrition of children in India. Malnutrition leads to one-third of all newborn babies weighing less than the minimum acceptable 2.5 kilograms and the United Nations Human Development Report shows that India has among the highest proportion of undernourished children in the world. The government schemes for children under six spent a meagre amount of Rs.288 per child in 2004-05. In the union budget for 2006-07, only 1.66 per cent of the total funds were allocated to programmes for this age group. Under ICDS, services were rendered to four crore children through seven lakh anganwadis. It is a poor coverage, in the sense that less than 50 per cent of the children in the 0-6 age group were covered. The children under six should have access to ICDS (preferably as a legal right) and the scheme’s services need a radical development. However, the status of the young child is inextricably linked with the mother and if she does not receive proper support (proper maternity benefits, well-run-crèches, implementation of minimum wages and other things) the child’s development is bound to suffer drastically.

Rao, et. al., (2006) carried out a study on the Saharia tribe in Krishnagaj and Shahbad blocks of Baran district in Rajasthan to assess the diet and nutritional status of the Saharia tribal population. The study reveals that the prevalence of under-nutrition among children of age group 1-5 years as significantly higher (72 per cent) than that reported for the state of Rajasthan (48 per cent). Illiteracy was a major
problem which was as high as 81 per cent of male and 96 per cent for female among the tribals. They follow breastfeeding practices only after the third day of delivery and most of the mothers (about 85 per cent) would discard the colostrums because of the false belief that it was not good for newborn, on the advice of elders or traditional practices.

Ediriweera (2004) points out that Sri Lanka has recorded impressive achievements in health, nutrition and family planning with comparatively low levels of public expenditure on health. Current life expectancy is 73 years, compared with a regional average of only 61 years and infant mortality rate (IMR) is around 16 per 1,000 births. Life expectancy has increased and the population is ageing, non communicable and degenerative diseases in adults such as heart diseases and diabetes are becoming more common and must be addressed.

3. Reproductive Health

The wellbeing of the newborn child depends upon the care given to the mothers during pregnancy both physically and mentally; normally known as reproductive health. The studies on the reproductive health status and the care to be given are reviewed in this section.

Dhar (2011) indicates that in India, menstruation and menstrual practices are clouded by taboos and socio-cultural restrictions for women as well as adolescent girls. The limited access to safe sanitary products and facilities is believed to be one of the reasons for constrained school attendance, high drop-out rates and ill-health due to infection. Lack of accesses to menstrual hygiene (which includes sanitary napkins, toilets in school, availability of water, privacy and safe disposal) could contribute to local infections including Reproductive Tract Infection (RTI). It is closely inter-
related with poor menstrual hygienic and pose grave threats to women’s lives, livelihood and education. To ensure the better menstrual health and hygienic for adolescent girls the government launched subsidised sanitary napkins to the age group of 10-19 years in rural India, as an a part of Adolescent Reproductive Sexual Health (ARSH) scheme in RCH-II. It aimed to ensure that, the adolescent girls in rural areas have adequate knowledge and information about menstrual hygienic and the use of napkins.

Dhar (2010) portrays that in India 52.3 per cent of births take place at home and of this only 5.7 per cent is attended by skilled persons. As a result, there is increasing chances of maternal mortality. The maternal mortality rate (MMR) in India is as high as 254 deaths per one lakh live births and India’s commitment to the Millennium Development Goal of MMR is less than 100 deaths by 2015. For this, the Government of India has revised its new guidelines for antenatal care that skilled person must attend the birth mainly by auxiliary nurse midwives (ANM), lady health visitors (LHV) and staff nurse. According to the new guidelines the heath workers, now called skilled birth attendants (SBA), will possess technical competence like administer routine care, identification and manage complications arising during pregnancy and childbirth. They will also assist delivery at home and during the post-partum period. As per this new initiative, the government will empower the ANMs, LHVs, staff nurse and multipurpose health workers to undertake certain life saving measures like allowing them to dispense uterotonic drugs to prevent post-partum haemorrhage (PPH) a major cause of death during childbirth and administering drugs during emergency to stable the patient prior to referral. So the presence of an SBA at
every delivery along with the availability of an effective referral system can help to reduce maternal morbidity and mortality to a considerable extent.

Mukuria, et. al., (2005) reported that children whose mothers had, at least, one or more antenatal visits faced fewer chances of being stunted or underweight than those children whose mother had no antenatal visit. Mothers’ having proper antenatal care has awareness towards healthy behaviour.

Pandey, et. al., (2004) in their study find that the newly formed states of Chhattisgarh and Jharkhand are more likely to use antenatal care services than their counterparts living in Uttaranchal. The hilly terrain in Uttaranchal may be responsible for the low utilization of antenatal care services. The women living in urban areas are more likely to go for antenatal care services compared with their rural counterparts. Similarly, women with the lower birth order are more likely to use antenatal care services than women with the higher birth order. The higher the educational level of the spouse, the more is the utilization of antenatal care services. Women from the better economic background are more likely to use antenatal care services than those from poor economic situations. The delivery care is utilized more by women from Uttaranchal than women living in Jharkhand. Women with higher birth order utilize less delivery care service than women with the lower birth order in all the three states. The younger women use more delivery care than women aged 25 years and above.

A study undertaken by IIPS (2000) indicates that poor dietary energy and lack of antenatal care and postpartum care during and after the pregnancy determine women’s health. Iron deficiency anaemia is found to be common among pregnant women in India, which is a result of poor dietary intake during pregnancy. The marital status of women, who are divorced, separated and widows reported higher prevalence
level of undernourishment compared to their married counterparts. Similarly, women with no education have a higher prevalence of low body mass index.

4. Maternal Mortality Rate and Infant Mortality Rate

The Maternal mortality rate (MMR) is the ratio of the number of maternal deaths during a given time period per 1,00,000 live births during the same time period. Infant mortality rate (IMR) is the number of deaths of children less than one year of age per 1,000 live births. Studies related to these aspects are reviewed below.

Radkar and Parasuram (2007) in their study revealed that in the world almost 6,00,000 women die each year from pregnancy related causes, 99 per cent of them belonged to the developing countries and it is about 50 times higher than the developed countries. Developing countries like India, Pakistan and Bangladesh account for 28 per cent of the world’s birth and 46 per cent of its maternal deaths. Maternal health is a problem of serious proportion in India where an estimated 1,36,000 women die each year from causes related to pregnancy, childbirth and abortion. As per the survey, the maternal mortality rate (MMR) of India has considerably decreased from 753 during 1980-1982 to 301 in 2001-2003. This 60 per cent decline in MMR was mainly due to the adoption of Reproductive and Child Health (RCH) Programme at the national level. But the maternal mortality is strongly associated with rural areas and in low standard of living. For these women access to quality health care services is difficult.

Padma (2005) has analysed the level of safe motherhood in a rural area of Andhra Pradesh and other southern states. The study also tries to understand the perception and limiting cause that comes in the way of safe motherhood. The age at marriage and age at first pregnancy in Andhra Pradesh are the lowest in the country.
The real care and protection in ensuring safe motherhood have not reached desired levels. The main problem in these rural areas is the lack of awareness about the need for maternal health care. Especially in the backward district, women perceive pregnancy and the problems are gone through the natural process. Their inability to convince family members succumb them to unsafe motherhood practices. The unfriendly behaviour of the government health staff and the uncontrolled levels of the fee charged by the private health centre and fears of unnecessary caesarean sections imposed by private hospitals are forcing the lower economic sections to opt for home deliveries. So in the backward district, women frequently go to untrained health care providers, viz, rural medical practitioners (RMPs), dais and traditional healers. The most commonly received antenatal care in both the districts is the supply of iron folic acid (IFA) tablets and TT injections. Among the women who receive the IFA tablets, all do not consume them in backward areas due to misconceptions. Maternal care includes not only care during pregnancy and delivery but also during the post-partum period. Care after delivery is highly neglected by both women as well as health care providers.

5. Factors Determining the Health Status

The health status of people is determined by several factors such as social, economic and demographic factors: There exists inequality in the health status of the people on the basis of socio-economic and demographic differentials, rural, urban divide and gender disparities. Socio-economic and cultural factors play an important role in determining the health status. Studies available on this aspect are reviewed in this section.
Patra (2008) in his study highlighted six vaccine preventable diseases (tuberculosis, diphtheria, whooping cough, tetanus, poliomyelitis and measles). These diseases covered under the universal immunization programme and vaccination is given free of cost to every child. There is a gap between the targets and achievements even after several years. So this study mainly focuses on the causes of poor immunization coverage in India. It applies a logistic regression model to analyse the NFHS-II data (10,070 children of 12-23 months of age during the survey). The number of demographic and socio-economic variables (i.e., sex of the child, birth order, residence, mother’s education, mother’s age, antenatal care, religion, caste/tribal, standard of living index, media exposure, mother’s awareness, mother’s empowerment index, zone of states and electricity) are used to analyse the immunization coverage. The study reveals that male children are more (51.2 per cent) likely to immunized than girl children. The livelihood of vaccination increases with mother’s education level, mother’s age up to 29 years and mother’s exposure to mass media, electricity and mother’s awareness about immunization. Antenatal care during pregnancy raises immunization. Muslim children are least likely to be immunized comparing to the children from Christian and other religions. Immunization increases with the standard of living index of children’s households and mother’s empowerment index. It shows very clearly that socio-economic variables are influencing more, which leads to the poor immunization coverage in India.

Rout (2008) does a micro level study to find out the impact of income and education on household health expenditure in Orissa. The study is based on primary data and the total sample size is 371 households, 121 from urban and 125 each from both rural and tribal areas. It is found that income and education have a positive and significant influence on health.
Jones, et. al., (2011) pointed out that the World Health Report 2000 proposed three fundamental goals for health systems encompassing population health, health care finance and health systems responsiveness. This paper examines inequality and polarization in responsiveness and contributing towards an integrated analysis of health system performance. It uses data from the world health survey to measure and compare inequalities in responsiveness across 25 European countries. In order to respect the inherently ordinal nature of the responsiveness data, median based measures of inequality and polarization are employed. The results suggest that in the face of wide differences in the health systems analysed, inequalities in responsiveness vary substantially across countries complementing the considerable evidence indicating wide international disparities in inequalities affecting the two other health system goals, health and fairness in health care finance. Moreover, the indices vary across countries, northern European countries exhibiting greatest inequality and southern European countries least inequality.

Dhandapani (2009) highlights that the Indian tribals are traditional, conservative and underprivileged people who are socially and economically weaker and also under poverty and live in a subsistence economy which is generally backwardness. In the remote villages, the availability of hospital facility is very poor. The tribal people use indigenous and other medicine because it is cheaper than the modern medicine. So the price of modern medicine has to be reduced and made affordable to the people.

Nilsson (2009) examines the relationship between income, income inequality and child health in a developing country by testing three hypotheses, the absolute income hypothesis (AIH), that income determines individual health and that the
positive effect diminishes with higher income, the relative income hypothesis (RIH),
that individual income in relation to average reference group income influences
individual health status and the income inequality hypothesis (IIH) that the income
inequality affects individual health and independent from the effect of income. The
paper also examines the relationship between dimensions of globalization and life
expectancy. The most robust finding is the positive relationship between economic
globalization and life expectancy

Rao and Mita (2008) attempted to analyze the inter-state differences in health
expenditure over the period from 1995-96 to 2004-05 for 15 states in the Indian
union. The aggregate spending on health services as a ratio of Gross State Domestic
Product (GSDP) has been extremely low and has been declining over time. Even as
the cost of providing health services showed a misappropriate increase, the
expenditures exhibited a declining trend which implies that the decline in real
spending was of a greater magnitude. The inequality in per capita health expenditure
across states has exhibited an increasing trend and this is clearly a pointer to the
failure of the system to equalize public expenditure on health care services.

Wagstaff (2002) has undertaken a comparative study of nine OECD countries
and finds that inequality in self assessed health was not significantly associated with
total health care expenditure per capita, the percentage spent publicly or gross
domestic product per capita, but was positively and significantly associated with
income inequality. The following key findings in the empirical data are worth
highlighting. Firstly, inequalities in health are almost and always to the disadvantages
of the poor. The poor tend to die earlier and have higher levels of morbidity than the
better-off. Secondly, inequalities tend to be more pronounced for objective indicators
of ill health, such as anthropometric measures of malnutrition and mortality than for subjective indicators. In the developing as well as in the industrialized world, long term illness indicators, longstanding illness, limitations of a major activity and self assessed health tend to show inequalities to the disadvantages of the poor. Thirdly, there are large variations in the extent of health inequalities across countries, although these variations themselves vary with the indicators of health and social - economic status used. Fourthly, socio economic inequalities in health seem to be widening rather than narrowing. This is true of both the developing and industrialized world.

6. Government Schemes to Promote the Health of People

The government over the years has brought in several schemes in order to promote the health status of people. The studies dealing with those schemes are reviewed hereunder.

Annual Report on Health (2011a) describes under National Rural Health Mission, the number of districts with Mobile Medical Units increased from 363 in 2010 to 442 in 2011. As a result, diagnostic and outpatient care closer to hamlets and villages in remote areas are provided. Besides, the number of Village Health, Sanitation and Nutrition Committees (VHSNCs) constituted has been increased from 4.67 lakh in 2010 to 4.95 lakh in 2011. It is an important tool of community empowerment at the grassroots level. The VHSNC reflects the aspirations of the local community, especially the poor households and children. Untied grants of Rs. 10,000 are provided annually to VHSNC under NRHM. The ASHAs have contributed significantly to the promotion of Janani Suraksha Yojana (JSY) and institutional delivery and the promotion of attendance on immunization day. More than eight lakh women have been trained and deployed as ASHAs at the village level. More than 6.9
lakh ASHAs are provided with drug kits. Under the JSY scheme, the number of beneficiaries has increased from 7.39 lakh in 2005-06 to about 1.13 crore in 2010-11. In some States like Tamil Nadu and Kerala, Rogi Kalyan Samiti (RKS) has also been actively involved in raising funds from local sources for the betterment of health facilities. During 2011, 30,818 RKSs were functioning in the country, of which 1,198 RKSs were registered in the last one year.

Annual Report on Health (2011b) found that under the National Rural Health Mission, infrastructure development facilities, upgradation and renovation at all level of health care are given priority. Thus, in the last six years (up to June 2011), 55 new constructions and 238 projects of upgradation and renovation have been completed at the district level, 252 new constructions and 1,238 projects of renovation and upgradation have been completed at the Community Health Centre (CHC) level, 1,713 new constructions and 4,919 renovations and upgradation have been completed at the Primary Health Centre (PHC) level and 7,802 new constructions and 8,853 projects of renovations and upgradations have been completed at the Sub-centres. During 2011, 2,510 First Referral Units (FRU) were operating in the country. The large numbers of medical and paramedical staff had been taken on a contract to augment the human resources. During the year 2010-11 (July 2010-June 2011), 1,334 MBBS doctors, 2,003 specialists, 14,711 ANMs, 4,892 staff nurses, 3,079 AYUSH doctors and 1,113 AYUSH paramedics were appointed.

The Special Correspondent of The Hindu (2011) portrays that the Government of India had provided Rs.53,000 crore to the states under the National Rural Health Mission (NRHM) over the last six years. The success of NRHM is reflected in the eradication of polio. In spite of the achievements made so far, there were still areas of
concern. The pace of decline in various key health indicators like maternal mortality rate (MMR), infant mortality rate (IMR), total fertility rate (TFR), child death and morbidity due to communicable diseases did not improve as compared to the pre-NRHM period. So the Health Ministry can press for continuation of NRHM beyond the Twelfth Five Year Plan (2012-2017), which is currently up to Eleventh Five Year Plan only.

Jain (2010) in his study analyses the impact of the Janani Suraksha Yojana (JSY) on the maternal mortality rate (MMR). This study was based on two indicators, i.e., the proportion of pregnant women with complications among institutional deliveries and case-fatality ratio among them. This study found an increase in institutional deliveries which had very little effect on MMR, if the proportion of pregnant women with complications among institutional deliveries starts to decline or if the case-fatality ratio among institutional deliveries starts to increase. On the other hand, an increase in institutional deliveries will imply a reduction in the MMR if pregnant women with life-threatening complications are able to reach fatalities with adequate Emergency Obstetric Care (EmOC) in time and if the level of the MMR among those who reach these facilities does not increase with the increased workload. Hence, an increase in institutional deliveries resulting from JSY may not translate into a reduction in the MMR.

Jacob (2010) highlighted that National Rural Health Mission (NRHM) brings a dramatic improvement in the health system and health status of people in rural India. It has reiterated the focus on health and re-prioritised rural health and health care. NRHM has increased health finance and improved infrastructure for health delivery. It has established a standard, trained health care staff, coordinated technical
support from health resource institutions and non-governmental organizations. It has facilitated financial management, assisted in computerization of health data, suggested centralized procurement of drugs, hospital equipment and supplies and mandated the formation of village health and hospital committees and community monitoring of services. However, the NRHM need a constant monitoring of its impact on course correction and it should be built into the system for optimal results and for achieving the goal of “Health for all”.

Khan, et. al., (2010) analyse the impact of Janani Suraksha Yojana (JSY) on family health behaviours in rural Uttar Pradesh. It is a formative study using both qualitative and quantitative approaches. It reveals that the proportion of women who received, at least, three antenatal care (ANC) check-ups increased significantly from 19.2 per cent in 1992-93 to 34.4 per cent in 2009. However, it also indicates that the vast majority (66 per cent) of women are still not receiving the minimum recommended three ANC check-ups. To receive less than three ANC check-ups often were from Scheduled Caste / Scheduled Tribes (SC/ST), minority religion groups, non-literate, residing in remote villages or hamlets had not received three ANC check-ups due to lack of access to an accredited social health activist (ASHA). After the introduction of JSY, 44 per cent of women had delivered in the health institutions. But the share of institutional deliveries in private hospital declined from 63 per cent in 1998-99 to 37 per cent in 2009. Reciprocally, the share of institutional deliveries at public hospital increased from 37 per cent in 1998-99 to 67 per cent in 2009 due to the JSY incentives. It is very clear that the JSY monetary incentives, non-incentivized services and counselling by the ASHA have increased client - provider contact, the
percentage of women receiving three ANC check-ups and seeking institutional delivery. It brings to some reduction in the number of perinatal and neonatal deaths.

The editorial of Economic and Political Weekly (2010) highlights the evidence of the Comptroller and Auditor General (CAG) report that the National Rural Health Mission has succeeded in raising expectations from the public health system and some fundamental inadequacies have persisted through the first three years of the mission. In some states pre NRHM data were not available to measure the efficiency of the mission. Half of the states and UTs had not even prepared their long-term perspective plans. The worse thing is that at the level of the Ministry of Health and Family Welfare, there was no road map to state-wise long term goals to achieve the national targets. Some of the specially focused states (Bihar and Assam) received less than their allocated shares of the funds. But these states are having a very high unspent balance in a previous year. This obviously shows a poor absorptive ability and capacity building. In family planning schemes, female sterilization accounts 96 per cent of the total and spacing methods have low usage. Under the Janani Suraksha Yojana (JSY) in several states, the majority of pregnant women were registered but did not use the health centres for delivery.

The editorial of Economic and Political Weekly (2010) indicates the latest performance audit of the NRHM shows that the shortage of service providers at different levels across the country continues to pose a challenge. While contract workers have been engaged to fill vacancies and 6.16 lakh ASHAs have been appointed, the shortfall of medical care providers needs effective attention. In 15 states, 11 per cent of the PHCs were functioning without an allopathic doctor while in 28 states and Union Territories an AYUSH doctor had never been appointed. The
problem of shortage of medical service providers in rural areas is one that most countries face. In India, 74 per cent of the graduate doctors lives in urban areas, serving only 28 per cent of the national population. It also examined the option of a short training course after which the practitioner would be licensed to provide medical services with a notified package of primary health care.

The Special Correspondent of The Hindu (2010) states that the Government of Tamil Nadu opens 50 Primary Health Centres (PHCs) to match the population at a cost of Rs.23.83 crore which would be started under National Rural Health Mission and Rs.40.87 crore were issued to improve 40 PHCs. The PHCs have been equipped to do caesarean and minor surgeries and a total of 2,694 caesareans were done in 2009-‘10. Soon the government will start a free scheme to detect and control diabetes and blood pressure prevailing among the rural population. They would be equipped with glucometer and blood pressure apparatus. Village nurse and health inspectors would be involved.

Acharya and Mcnamee (2009) in their study conclude that more than 5000 women die every year in Gujarat due to pregnancy complications in remote, coastal and tribal areas. The state faces an acute shortage of qualified gynaecologists in public health facilities. However, many of the deprived and low income areas have the presence of private gynaecologists with Emergency Obstetric Care (EmOC) facilities and, therefore, the Government of Gujarat decided to enlist the support of the private gynaecologists in reducing maternal mortality and launched the Chiranjeevi Yojana Scheme. The Chiranjeevi Yojana Scheme provided the facilities to women below the poverty line to go to empanelled private nursing homes at the government costs. Its aim was to remove financial barriers for the poor to access qualified private health
service providers. A survey in Surat district shows that empanelled private health service providers are situated in urban areas and most of them consider only safe cases, sending the complicated ones to public hospitals or being diverted elsewhere and not considered as a part of the scheme. This defeats the entire purpose of the scheme as complications requiring emergency obstetric care are the major cause of maternal mortality. Also, if only safe cases are treated, the reduction in maternal mortality shown under the scheme is questionable.

Dhar (2009) indicates that good primary health care system transforms the lives of millions of people. India had not done well enough in providing a quality health care and health schooling system to address the basic need of the people. ASHAs under National Rural Health Mission act as a link between the people and health facility in rural areas to strengthen the health system efficiently and equitably which has global significance and improved health care if it achieves the target.

Sinha (2009) has critically reviewed the article written by Shyam Ashtekar and points out that the National Rural Health Mission provides a large canvas and platform for health action but the writer misses many issues and does not make his suggestion from the right perspective. During the short period of its existence, there is ample evidence to show that the mission has been moving in the right direction crafting a credible public system of health delivery starting from the village and going up to the district level.

Bose (2007) in his study analyses the Janani Suraksha Yojana (JSY) scheme of the Government of India implemented to speed up the reduction of maternal mortality. It should focus more on the creation of health infrastructure and ensure road connectivity in the rural areas rather than merely doling out money to poor families.
But the cash assistance given after delivery takes no note of antenatal care, particularly nutrition of pregnant women. There is no doubt that health care has been abandoned and a scheme of distribution of money has been devised with the usual frills of complicated administrative procedures. The programme aims only to invest more money, it will be a waste of our resources and it is the quality of health delivery system in the rural areas remains what it is.

7. Health Care Expenditure

Health being an important aspect in developing in human resources, the government allows for the development of health care infrastructure facilities and services in its Annual Budgets and Five Year Plans. Literature related to health care expenditure and factors determining is reviewed in this section.

Singh (2010) in his study find that health expenditure has been significant in causing or increasing the indebtedness of cultivators, especially marginal and small cultivators in rural Punjab. Credit taken for health care facilities is nearly 20 per cent and 23.2 per cent of total credit acquired by marginal and small farmers was for health care purpose. Their main reasons for cheap medical facilities through government health services were inadequate and not available at times. There are a fewer number of public health institutions than their actual requirement. These institutions in rural areas are overburdened. Some of the basic facilities in these government health institutions are not available such as electricity (404 sub centre (SCs) and five primary health centre (PHCs)), water (389 SCs and 24 PHCs) and all-weather motorable roads (134 SCs and 10 PHCs) do not exist. The shortage of manpower, absenteeism of medical staff, poor/outdated/non working medical equipment and lack of basic infrastructure are the problems existing in these institutions. The state government
expenditure on health has been decreasing in the overall budgets (7.19 per cent in 1,985-86 to 3.45 per cent in 2007-08). Low public sector spending on health services result in an overdependence on the private sector for getting health services which are quite costly. The poor people pay from their own sources which are many times inadequate, forcing them to acquire credit sometimes at an exorbitant rate of interest, thereby increasing the debt burden on them, so that out-of-pocket expenditure comprises a major share of expenditure on health care in Punjab, especially in rural areas.

Duggal (2009) in his study portraits the public health budgets in the context of the National Rural Health Mission (NRHM) over a period of four years from 2004-05 to 2009-10. Under the NRHM strategy, it has made some efforts to raising its financial stake in the public health sector but they have so far failed due to the problem of fund availability with the states and larger control of health resources by the union government. It is evident that the investment by the public sector for health care has been inadequate to meet the demands of the people. The state has over the years committed not more than 3.5 per cent of its resources to the health sector, it can be seen that the health care expenditure has not kept pace with the increase in government expenditure. Further, the volume of spending on health services in the rural areas has a direct relationship with the availability of health care facilities.

Berman and Rajeev (2008) examine the recent trends in government health expenditure prior to and following the launch of the NRHM i.e., over a period from 1999 to 2005 and 2006-07. Secondly, the role of central government and states in government health spending has been examined. Finally, the paper projects the trend in government spending to explore whether the goal of two per cent is feasible and
what might be done to put in place more and more sustainable government health 
financing. Declining government health expenditure can be seen in the decline in the 
share of health expenditure of centre and states in the total government expenditure 
during 1999-05, the decline in the share of states health expenditure in their total 
expenditure has also been greater than in the share of centre’s health expenditure. But 
it is quite clear that the government’s health spending since April 2005 has increased 
significantly by about 41 per cent.

Guruswamy, et.al., (2008) examined the level, trends and patterns of public 
expenditure on health from 1995 to 2006 in India both at the national and the state 
level. The database of the Centre for Monitoring Indian Economy (CMIE) on public 
finance and national income statistics was largely used as the major data source. For 
the state level analysis, 15 major states have been taken into account. It is found that 
the overall growth of public expenditure on health as a proportion of gross domestic 
product (GDP) has remained stagnant at around one per cent over the years from 
1996-2006. Although the individual growth rates of GDP and total public expenditure 
on health follow a similar path, the stagnant nature of the public expenditure as a 
percentage of GDP depicts the macro perspective of public financing of health 
expenditure in India during the decade 1995-2006. Among the states, differences exist 
in health expenditure patterns and the less developed states were found to be spending 
more on health, both per capita and as a proportion of gross state domestic product 
(GSDP), compared to the developed states. However, proportionate to the total public 
spending on health expenditure is largely meagre and is generally around one per cent 
of the total public expenditure.
Mehta (2008) makes an attempt to analyse the public and private expenditure pattern by making use of the data of Reserve Bank of India (RBI) and national sample survey organization (NSSO) data of the 55th round of household’s consumption expenditure. The study concludes that even though India spends six per cent of its gross domestic product (GDP) on health care, more than 70 per cent, of this six per cent comes from private sources. Out of this 70 per cent, most of its ‘out of pocket’ expenditure is in rural areas. From the viewpoint of public expenditure, it has been found that even though both direct and indirect taxes are progressive in nature but in terms of government allocation of resources, rural areas have been neglected as most of the government expenditure have flowed to urban areas. Further the government expenditure on preventive and curative services again tends to favour the urban and the richer groups. Allocation of government expenditure and provision between the centre and the state tend to be biased in favour of better off states, which affects the poor in the poorer adversely.

Sinha (2008) focuses on the health expenditure budget of 2008-09 and suggests that 15 per cent increase in the current year’s budget is not adequate to reach the two to three per cent GDP public expenditure. It is also a little disappointing as a large scale effort to build absorptive capacities that have been made from the years 2005 to 2008 under the NRHM in the states. From the perspective of moving up two to three per cent of GDP public expenditure on health, the increase in the budget allocations for health is below the expectations. Nearly 80 per cent of the public expenditure on health comes from sources other than the Ministry of Health and Family Welfare, Government of India. There is a strong case for central government’s spending increasing on an even faster pace.
Salve in Sabanna (Ed) (2007) highlights the conditions of health care in India. In 1995, 140 million people were denied access to basic health care. In 2006-07, the budget allocation towards health and family welfare increased from 22 per cent to Rs. 12,546 crore. The increased allocation does not fulfil the health needs of the people of India. Lack of nutritious diet, inadequate medical care, poverty and unhygienic conditions are still prevailing. Moreover, India aims to reach the goal of ‘health for all’. To reach this goal, a wide network of the primary health centre and sub centre has to be formed. However, in India, the health status is poor when compared to other countries in South Asia.

Bhat and Nishant (2006) pointed out the relationship between income and public and private health care expenditure for the year 1990 to 2002. For the analysis real per capita gross state domestic product (GSDP) has been used to represent income and per capita state public health expenditure. For the purpose of the study 14 states that account for more than 90 per cent of the total population of the country has been included. The analysis of public expenditure suggests that state governments have the target of allocating only about 0.43 per cent of GSDP to health and medical care. Moreover, for every one per cent increase in state per capita income, public expenditure has increased by around 0.68 per cent. This study suggests that the private health expenditure has grown substantially faster than real incomes. For each one per cent increase in real per capita income, the real per capita private expenditure on health has gone up by 1.95 per cent.

Kaushik, et.al., (2006) have examined the relationship between health status and expenditure on health and education and per capita income by using the data for the period 1971-2001 for Himachal Pradesh. For the purpose of this study data on
four variables a measure of the population's health status, real per capita expenditure on medical and public health, real per capita expenditure on education and a real per capita income have been used. The study uses Johansen's methodology to test the existence and uniqueness of co-integrating vectors among the variables. The results suggest that the health expenditure - health status relationship is different from health expenditure - income relationship as there is a lack of causation in the relationship. One way causation flows from per capita expenditures on medical and public health to health status. The results further suggest that causality that flows from per capita expenditure on education to infant mortality rate (IMR) is stronger than the impact of real per capita income on health status.

Annigeri (2003) has attempted a micro level estimation of the district health accounts of Karnataka for the year 1997-98. The district health accounts in terms of percentages indicate that all private funds account for about 52 per cent of the resource flowing into the district. Out of this, 37 per cent are contributions by households, eight per cent by NGOs and about five per cent others, public resources account for about 47 per cent of which state governments spend about 33 per cent, union government spends about 10 per cent and the local bodies contribute about two per cent. The study clearly shows that the dependence of the community on private facilities is more in comparison to public facilities.

Sankar and Vinish (2003) look at the budget proposals more critically with the appraisal of the health care sector in 2003-04, to find out whether the increase in budgetary allocation to the health sector can really make a significant dent reach the proposed target of two per cent of GDP and 25 per cent of total government spending by 2010. It can be seen that in the 2003-04 budget, the share of total health allocations
in the total allocations increased from 1.64 per cent in 2001-02 to 1.74 per cent as proposed. The increase is mainly due to the increased allocations in the family welfare department than for public health, even under the department of family welfare services it declined from the budgeted Rs.1,718 crore and the revised Rs.1,662 crore in 2001-02 to Rs.1,563 crore in 2003-04. This is in contrast to the increase in allocation in the urban welfare programmes.

Gumber (2001) analyses the budget 2003-04 on health expenditure and finds out that traditionally both central and state governments have been spending only one third of its expenditure on preventive and curative care whereas in many countries like Sri Lanka, this is almost two-thirds. Further, out of the total curative care spending, nearly 75 per cent is spent on secondary sector hospitals which are primarily located in the urban areas. The rural areas are often ignored in the process.

Felder et al., (2000) make an attempt to derive the demand for health care expenditure for the last two years of life from a model that accounts for age, mortality risk and wealth. The study is based on individual data of 415 deceased persons from a sample of more than 6,000 members of a major Swiss health insurance company who died in the period 1987-1992. The data include health care expenditure, gender and age as well as specifies the insurance policy of the individuals. The empirical evidence confirms that most of the hypothesis derived from the model i.e., health care increases with closeness to death and for retired individual, health care expenditure decreases with age. Furthermore, income and extent of insurance coverage have a significant impact on health care expenditure for the last two years of life. Patients with supplementary insurance for hospital treatment incur a higher cost of dying than patients with average insurance coverage. Finally, low income individuals as
compared to high income individuals incur lower health care expenditure in the last months of life.

Sodani and Gupta (1998) provide insights into the health care expenditure and utilization to elicit information on patterns of household expenditure on government and private sources of treatment in both rural and urban segments of the tribal areas of Rajasthan, the study revealed a high dependence (50 per cent) of the traditional practitioners in the rural areas. There was a substantial rural-urban differential in the average expenditure per illness episode. Rural people spent on an average of Rs. 931.7 per illness episode for treatment which was one and half times more than urban people considering both acute and chronic illness together. The study also revealed that rural people have the significantly higher burden of almost all components of indirect expenses for treatment.

Devarajan et. al., (1996) try to shed light on the relationship between the composition of public expenditure and economic growth. Using data from 43 developing countries over 20 years from 1970 to 1990, they found that an increase in the share of current expenditure has positive and statistically significant growth effects. By contrast, the relationship between the capital components of public expenditure and per capita growth is negative and these results confirm that developing country governments have been misallocating public expenditures in favour of capital expenditures at the expense of current expenditures.

8. Health Care Infrastructure

Health being an important social overhead for the development of human resources, it is essential to improve the health care infrastructure both physical and capital. The literature on this aspect is reviewed and is presented.
The Special Correspondent of The Hindu (2011) reported that in many remote areas like hilly states, tribal areas and northeastern states, access to health facilities continued to be a problem mainly in view of the difficult terrain, geographical spread and lack of human resources. The Ministry of Health and Family Welfare has proposed a Bachelor degree in ‘Rural Health Care’ course as one of the solutions to improve the availability of health personnel for these areas. So if these health services are provided under National Rural Health Mission number of health workers (human resources) are needed for their efficient performance.

Husain (2011) in his study revealed that after the implementation of National Rural Health Mission, there is a positive impact on several indicators like immunization, institutional deliveries and antenatal care. The service delivery capacity of the public health system had increased at each level. Outdoor patients visits had increased at all three levels (sub centre (SC), primary health centre (PHC), and community health centre (CHC)). The maximum improvement was found at the PHC level (129 per cent) followed by an almost similar increase at the district and CHC level (86 per cent). The main beneficiaries of indoor services at each level were invariably women followed by children and men respectively. 7.49 lakh ASHAs have been selected from 2005-06 to 2009-10. While this is a large number implying that about 90 per cent of all villages have been covered. Though 94 per cent of ASHAs has received the first module training. The NRHM did not pay sufficient attention to the socio cultural context in which the health system is situated and which ultimately determines the success of policies and measures including decentralization. This is perhaps the most important factor limiting the success of the NRHM.
Purohit (2010) analyses the efficiency variation at a sub-state level in the health care system of Karnataka. It indicates that the efficiency of public health delivery system remains low. Considerable disparities across districts in term of per capita availability of hospitals, beds and manpower inputs has an adverse impact on improving the life expectancy in the state. To overcome the problem the author suggested that in rural areas particularly, improvements in infrastructure facilities like safe drinking water supply, toilets and electricity as well as better coordination between social sector and economic policies, especially at the district level, may also help the state to improve the life expectancy speedily and more equitably in the deficient districts.

Kumar and Singh (2010) in their study have highlighted that the increased allocation of central plan funds to state health sector and pro-rural policy of state governments helped to grow public health infrastructure during 1970’s and 1980’s in rural Punjab. It would have more access to low cost and quality treatment of rural people in their door steps. But since 1991, no effort was made to improve public health infrastructure both in rural and urban areas. Consequently, a wide gap existed between rural and urban health infrastructure and indicators. In rural Punjab population served per bed was 1,555 persons compared to 624 persons per bed in urban Punjab during the year 2004-05. Further, it shows morbidity prevalence rate was also noticed to be very high in case of communicable disease (172.16 per thousand population) than that of chronic (155.67 per thousand population) and other diseases (41.24 per thousand population). Overall, the morbidity prevalence rate was found to be very high, that is 396.07 per thousand population.
Joe, et. al., (2008) have advocated for a policy matrix which not only accommodates immediate or direct health investments such as medical facilities but also consists of basic interventions indirectly related to the health of individuals. Such investment is largely sought in the form of investment in basic education, better housing, water and sanitary conditions as well as the introduction of programmes to provide income security. Perhaps the state should acknowledge the fact that social sector expenditures, particularly on health and education, are complementary in nature and if put together do produce large individuals as well as social benefits.

Lalitha (2008) examines the approach of the Government of Tamil Nadu towards drug procurement and supply, which is undertaken by the Tamil Nadu Medical Services Corporation (TNMSC) an autonomous agency. It has helped the government to streamline the entire drug procurement and supply in a rational manner. Procuring the drugs from the list of essential drugs paves the way of rational spending of the limited resources earmarked for drugs. The intervention by TNMSC has resulted in the procurement of drugs continuously at a lower price, which can help the government reach out to more people and in strengthening the technology in government health care.

Mehrotra (2008) in his study has indicated that the population served in Uttar Pradesh per government hospital, per government hospital beds, per doctor, per sub-centre, per primary health centre and community health centre are all systematically lower than the national average but at the same time in all cases better than Bihar. In addition to the primary health care infrastructure Uttar Pradesh state is one of the country’s most expensive public funded ayurveda, unani, siddha, naturopathy and homeopathy hospital and dispensary systems in the country. However, the promotive
public health measures by government and the population wide health measures that underpin a medical, clinical care delivery system, so far do not seem to be forthcoming except in the case of a slight increase in institutional deliveries.

Mooij and Mahendra (2004) analyze the social sector spending priorities of the Indian government over the period 1990 to 2001, the social sector comprises of health, education, water and sanitation, housing, anti poverty programmes and employment in the Indian budgets. Overall the figures revealed that the social sector expenditure is low as compared with the proportion of GDP. India used to spend on the social sector in the late 1980’s and also when compared with some other developing countries and certainly as compared with East Asian countries.

9. Problems in Health Care Delivery System

The Government has adopted several programmes for the betterment of the health status of the people. Though many efforts are being made, there are still many leakages and malfunctioning of the system. The studies pointing out this aspect is being reviewed as follows.

Menon (2012) has expressed that the Maharashtra state had faced a serious problem of growing malnutrition. The monthly progress report of the ICDS reveals that 26 per cent of children are underweight. The infant mortality rate was almost double (66.47 per cent) in the slum areas of Mumbai whereas the state infant mortality rate was 34.57 per cent. The poor communities have little access to public health care and depend on quacks. There are only 105 beds in maternity wards for a population of 12 lakh. Inadequate service leads to home delivery or women going to private clinics which are expensive and the crisis of primary health services and lack of an adequate number of anganwadi in slum areas are some the reasons for
malnutrition and deaths. However, the home deliveries, low birth weight and lack of basic amenities were putting more and more women and children at risk.

Kuruvilla (2011) remarks that the health services in India are in bad shape. The withdrawal of the government from service sector has created havoc. It resulted in untold misery to millions. It left the health care sector high and dry. Private enterprises and corporate bodies have grabbed this sector. Obviously in India, there were not enough primary and secondary health centres. They are not distributed evenly through the length and breadth of the country. Further, the health centres are not equipped well, nor are they manned by adequately trained staff.

Berman, et. al., (2010) have pointed out that in recent years protecting the population from large financial risks associated with health care expenditure has been accepted as one of the core goals of the health system. Financial risk protection for health in India through health insurance still has very low coverage and the evidence suggests that it is not very successful in providing protection. There is an increasing interest in developing government programmes to address health related financial risk in India. The main policy strategy for addressing this problem had been financed by the government as free or highly subsidized public delivery services.

Jacob (2010) explains that the National Rural Health Mission has had a major impact on the health and hospital infrastructure of rural India. It has brought budgetary flexibility in the system with specific funding for local needs. It also funds human resources in a situation of shortages and yet, in many places, nothing has changed. While the renovated and clean primary health centres and district hospitals have made a big difference, the prevalent work ethic leaves much to be desired. While many doctors and nurses serve diligently, many are apathetic to the needs of patients.
The infusion of money alone will not change the morale or the circumstances of service.

Meeta and Rajeevlochan (2010) have pointed out that the public health system in India, especially in the rural areas, barely exists today. The absence of first level health care facilities and the high cost of treating even routine illnesses are the immediate problems in the existing health care systems. The majority of expenditure incurred by households is in the private sector. Service providers in the public sector are simply not there and heavy costs of health care incurred by all and most especially, by those in the rural areas. Public spending on health in India is among the lowest in the world, being about one per cent of the country’s gross domestic product (GDP) and 73 per cent of all health expenditure in India is financed by out-of-pocket payment by the people as compared to 56 per cent in China and 13 per cent in the United States.

Selvaraj and Anup (2009) in their paper pointed out that the public provision of health care in India has dwindled to new low. Outpatient and hospitalization care in India from 1986-87 to 2003-04 have declined drastically, leading to the emergence of private care players in a predominant way. While health care costs have shot up manifold in private provisioning, Government health facilities are increasingly compelling patients to look for private outlets for procuring drugs and diagnostics. Due to these developments, millions of households are incurring catastrophic payments and are being pushed times every year. Evidence from large household sample surveys (NSSO) suggests that reporting of short duration ailments (based on 15 day recall) has increased almost by four times during the last decades from approximately 2.4 per cent in 1986-87 to more than nine per cent in 2003-04.
Menon (2008) narrates the poor health care, lack of services and medicines and unsafe practices existing in a Primary Health Centre in Sayvan of Maharashtra. Anaemia, chronic malnutrition and a high perinatal mortality are persistent issues in the state. 46 per cent of the children under the age of five are stunted. More than 33 per cent of infant deaths were reported from three adivasi blocks of Dahanu, Jawhaw and Murbad in Thane district. Shortages of doctors were acute in adivasi blocks and in rural areas. Only adhoc appointments were made to fill vacancies. There is also a shortage of health assistants, multipurpose worker (MPWs) and ANMs in the states. It leads to more death in adivasi blocks and in rural areas in the state of Maharashtra.

Menon (2008) notices that in Thane district of Maharashtra ANMs, and doctors in Primary Health Centre, are not performing their duties. In the Primary Health Centre, the doctor refused to give treatment for a badly cut hand because the adivasi women came early in the morning at 7 am on a Sunday. In another case, when women came for delivery at the Sayvan Primary Health Centre, there was no doctor present and she was asked to go to another hospital which was 15 kilometers away from the Primary Health Centre. Moreover, four infant’s deaths were reported in one hamlet of Thane district last year. Above all the National Rural Health Mission allocated Rs.32 crore to Thane district but the amount spent is only Rs.19 crore.

Panda (2006) has examined the reasons for low health care facilities in India and finds that there is a continuous decline in the share of expenditure on medical and health for all Indian states. This was considered as one of the most important reasons for the backwardness in health care facilities.

Banerjee, et. al., (2004) have highlighted a survey conducted in rural Udaipur to gauge the delivery of health care and its impact on the health status of the largely
poor and in weaker sections of the population in the regions. It shows that the quality of public service is extremely low, that unqualified private providers account for the bulk of health care provision. The low quality of public facilities has also had an adverse influence on the people's health. It is also seemed to be correlated with worse health: controlling for age, gender, distance from a road and per capita monthly expenditure, lung capacity and body mass index are lower where the facilities are worse. In an environment where people's expectations of health care providers seem to be generally low, the state has to take up the task of being the provider or regulator.

Venkatasubramanian (2004) has highlighted that the development of health care sector is the toughest challenge for the Government of India. The major challenges of health care system were vast population, the paucity of resources and non availability of affordable health care to the poor. It is expected that the effective implementation of the health sector reforms and the policies and strategies indicated in the Tenth Five Year Plan and National Health Policy 2002, in the country will achieve the goals set and complete the demographic and health transition within the time frame.

Chandra (2002) remarks that the National Health Policy (NHP) announced in 2002, aims to revive the ailing health system and increase the primary health sector outlay to ensure a more equitable access to health services across the social and geographical expanse of the country. However, it does not articulate any mechanism to regulate the exorbitant drug prices and the spiralling cost of health services to provide succour to a vast section of the population in the low income group when they may need these facilities. Already prices of various essential drugs and formulation have gone up. This becomes the biggest challenge for the successful implementation
of the new health policy which the health authorities in the country should be paying more attention in the coming years.

Sadanandam (2001) points out that the intervention by the princely rulers of Kerala state had generated a demand for modern medical services. Large networks of institutions were set up to provide family welfare and immunization services with a positive impact on the reduction of birth rate and infant mortality rate. But in hospital services, the intentions to ameliorate rural-urban disparities and to redress regional inequity were not met completely. A large share of resources was utilized to pay salaries without a corresponding increase in productivity. The subsidised medical education brought only a very little benefit for the welfare of the community.

10. Measures to Improve the Health Status of People

Many researchers in their studies have identified certain measures which have to be adopted to improve the health status of the people. Such studies are reviewed in this section.

Singh (2009) points out that the health care infrastructure provided by the government, operates in three tier system, viz., sub centre (SC), primary health centre (PHC) and community health centres (CHC). Health care requires not only physical infrastructure and equipment but also skilled and specialized human capital in the form of medical training and qualifications. Making policies and putting programmes in place is indeed a welcome step but in order to ensure that desired results are achieved, each one of us has to play our role, either as doctors, auxiliary nurse midwife (ANM), medical personal, political leaders or a general human being.

Gupta et. al., (2007) in their article explain that India neglects the early care and development of children, especially those under the age of six. The third National
Family Health Survey (NFHS) shows that 46 per cent of all children under three are underweight and almost 80 per cent children in the age group of 6-35 months are anaemic. Only 44 per cent of all children in the 12-23 months age group has received all recommended vaccines and only half of the pregnant women had, at least, three antenatal check-ups. The government spent very few (about only one per cent) of the total union budget on children under six years of age. Therefore, a better policy priority must be given towards children under six, not only to protect their rights but also to ensure the future generation with better health and wellness. Because of this situation they recommended some suggestions to overcome these problems by extending all ICDS services to all children under six and all eligible women, improving the quality of services, raising the number of anganwadis with priority to disadvantaged groups, to provide adequate incentives to ASHA’s for the relevant services (including home based, neonatal care, breastfeeding and nutrition support).

Effective pre-school education for children aged three to six years cannot be achieved without the involvement of anganwadi workers (along with anganwadi helper). To provide anganwadi-cum-crèches, to introduce a national scheme for maternity entitlements in the informal sector for care during pregnancy and after delivery was introduced by the government.

Srinivasan, et. al., (2007) indicate that the state level effects of various Reproductive Child Health (RCH) services are significantly higher than those at the district level. The pace of annual progress after 1998, many RCH indicators were slower than before and a few indicators (child immunization) have worsened, despite the expenditure on the programme being doubled (i.e., Rs.3,445 crore compared to Rs.1,607 crore during 1995-96). The decentralization and integration of basic health
care services may not be effective unless monitored centrally and backed by full time health professionals, medical and para-medical personnel at the delivery level. So they suggested that it cannot be improved only through anganwadi workers, ANM and ASHA’s. Integration of various services at the field level has to be done with a lot of cautious. Since peripheral health workers tend to develop specialized skills and interests and they cannot be expected to carry over frame one programme to the other with the same effectiveness and efficiency. Further policy measures must be done on the basis of this basic knowledge.

Ojha (2006) pointed that the importance of community participation forms the cornerstone of the concept of primary health care to achieve the goal of ‘Health for all’. For the success of the programme, it is essential to encourage and ensure full community participation through the effective propagation of relevant information through which individuals, families and community can assume responsibility for their health and well being. A regular interactive session with mother, parents groups and old age persons added by audiovisual demonstration along with household contact and monitoring the development of local resource group should be incorporated.

Sankar and Kathuria (2004) have analysed the performance of rural public health system of 16 major states in India using the techniques of stochastic production frontier and panel data literature. It shows that not all states with better health indicators have an efficient health system. States vary enormously in their levels of health outcomes such as mortality levels and in particular, in the level of infant mortality. Bihar was not a badly performing state in the efficiency. On the other hand, states like Tamil Nadu and Karnataka which are believed to have improved their
health indicators showed poor efficiency in performance. The performance of Kerala is better only in comparison with the other 15 states and though health attainment levels are high and comparable with other developed or developing countries. Some states have large private sector health care in their rural areas catering to public health demand and offering preventive and promotive services, as in the case of Kerala. However, most other states do not have qualified private health care significantly operating in rural areas. The health outcomes in rural areas of Indian states are positively related to the level of health infrastructure in terms of access to facilities and availability of skilled professionals such as doctors. However, the efficiency of the health systems depends on the extent of education in the state. Investment in the health sector alone would not result in better health indicators. Efficient management of the investment is required.

Pattanaik (2004) evaluated the announcement made in the Alma Ata Declaration in 1978 and states that, gender equity in the representation and balanced representation of all caste groups in the health and family welfare committees formulated at the village level would promote effective community participation that is necessary for attaining the goal of ‘Health for all.’ The other health improvement methods were persistent sensitizations of community members through orientation training, focus on group discussion, monthly or quarterly meeting and promoting their involvement in workshop or seminars would also effectively stimulate community participation.

Chakraborothy and Mukherjee (2003) remark that the rural hospital in West Bengal share only 9.4 per cent of the total hospital beds, whereas the percentage of rural population in the total population is 72. It is widely known that the health status
of the population does not depend entirely on the availability of medical care facilities. It seems that if the market for private inpatient care in West Bengal were somewhat developed, the government hospitals would have been less crowded and could perhaps satisfy expectations of those who would still choose to go to them. The crucial tasks of the government are regulation of the private sector and collection and dissemination of information to create better informed consumers and providers.

Subi (2003) in her study has pointed out that the government should take adequate steps to improve the facilities of the existing rural health care services both quantitatively and qualitatively by the opening of more rural based health care centres with sufficient health staff which will enable the people to get enough health care services. Nutrition is also essential for health and work efficiency. Food and nutrition security could be ensured to all the poor in rural areas by way of providing food items through public distribution system (PDS) and is to be sharply targeted exclusively to the households living below the poverty line and cost should be made affordable. The government, as well as the private hospitals, should provide free medical camp in the needed areas particularly the rural based remote areas.

Padmaja (2002) argues that the public health care institutions are the last resort for the poor. Left with no choice they are availing these services in spite of so many inconveniences and efficient running of these institutions are a must for the benefit of the poor. For that, charging a reasonable amount from those who can afford to pay is a welcome option that should be taken by the government, to improve the financial position of these institutions.
Research Gap

Most of the studies reviewed here are related to areas located in another state of India rather than Tamil Nadu. They have clearly portrayed the health and nutritional status of people, factors determining it, health care infrastructure, problems in the health care delivery system and the measures to improve it. In this account, many programmes have been implemented for the betterment of the health status of the people. The impact of the health programmes in improving the health status of the people is hardly studied. Hence, this study aims at knowing the impact of National Rural Health Mission in improving the health status of rural people. The public health sector in India is not fully developed. In Tamil Nadu, it is functioning well and it is the duty of the researcher to find lapses existing in the public health system to achieve fine results. In this respect, the present study focuses on the limitations of the public health care services provided in Kanyakumari district of Tamil Nadu in order to suggest policy measures to authorities concerned and for addressing problems encountered by health care seeking people particularly the poor rural people. Further, studies are lacking in areas such as factors influencing the preference for a health system and health care institution. Further, the reproductive health care is not dealt in detail in the earlier studies. Hence, an attempt is made to cover systematically the areas which were not covered by previous researchers.