CHAPTER – II

REVIEW OF LITERATURE

This chapter examines and reviews the studies conducted by various researchers in the field of rural health-care and community participation in health-care activities and the reproductive and child health. This chapter discusses issues under various rural health-care, performance of health-care services in rural centres, providing facilities to the beneficiaries, improvement in health-care infrastructure, delivery services to the beneficiaries, community participation programmes and delivery of quality health-care services in the rural healthcare sector.

2.1 NATIONAL EXPERIENCES

Most of the reviews are related to infant mortality, death of maternal mothers and investment on health.

Haines; R. Horton and Z. Bhutta (2007) As author stated like PHC the selective programmes of health care attracts people to avail health service. Shortages in health workers, in developing country have been using community-
health workers. The study also reveals the research evidence about the cost-effectiveness of some components of PHC, such as the role of community participation improving neonatal and maternal mortality in India. It is stated that PHC can reduce the inaccessibility in health-care and by using communities in health systems.

Amlan Majumder V. Upadhyay (2004) pointed the primary health-care system existed on reproductive health-care services. The existing three-tier structure provides health-care services to its people. The objective of primary health-care is to provide health-care services to the vast majority of rural population. The three tiers are: (i) sub centre, (ii) primary health centres, and (iii) community health centre. The rural health-care also aiming to provide health services through a network of integrated health and family welfare programme system. India is one of the members to the Alma Ata declaration of 1978 and accepted the slogan “health for all by the year 2000 AD” through the universal provision of primary health-care services (Government of India, 1983). However, India could neither achieve reproductive health related goals (Srinivasan, 2000 and
Sood, 2000), nor could it develop a good health-care infrastructure for rural people (Majumder, 1999). Productivity, efficiency and quality of care of public rural health service sector have always been questioned from many different fields. The author has explained the relationship between efforts and accomplishments in primary health-care.

Nirupam Bajpai and Sangeeta Goyal (2004) the focus to identify the infant and child mortality and maternal death and morbidity which affect millions of children and women. In India, health-care is inadequate in terms of coverage of the population, especially in rural areas, and not adequately used because of the dismal quality of health-care practiced. In most public health centres miss management leads to drugs and equipments missing or in short supply, there is shortage of staff. Due to this even the poor, opt go to private hospitals. The poor people face burden of poverty and ill-health, the financial burden of ill health can get into further poverty. Public investment in health, and in particular in primary health-care, has to be much higher to achieve health targets, by providing required services at free of cost. Study also stresses the need for effective health.
Madhurim Nudni (2000) examines primary health. The scenario in India, in health, review of policy, plan and committee reports are discussed. It is pointed that health as an integral part of the socioeconomic development of a country. It must provide the most holistic approach achieving goals of development. It is emphasized that the need for strong first-level care with strong secondary- and tertiary-level care linked to it. It suggested an integration of preventive, promotive, curative and rehabilitative health services that had to be made accessible to the people, with objective of equity. The study recognized that health is influenced by a multitude of factors within health services. So need of multi-sectoral approach to health and clearly stated that primary health-care had to be linked with other sectors.

2.1.1 Rural Healthcare Issues and Challenges

Ghuman B.S. and Akshat Mehta (2009) discuss the problems and prospects of health-care services provided in India. It is stated that India growing economically at a rapid rate after the new economic policy adopted in 1990. However, this rapid economic development has not made impact on social
development - particularly in the health sector. Health sector has given accorded very low priority in terms of allocation of resources. Public expenditure on health is less than 1 per cent of GDP in India, which has been a decline during the post economic liberalisation period. The resource allocation to the health sector has adversely affected quality of health services. The unequal access to health services is common in both urban and rural areas. In order to improve the access and quality of health services, government need to enhance public spending on health sector at least 3 per cent of the total GDP. The objective of study is to examine the access of health services of various economic strata, gender and space; to examine the quality of health services in India; and to made suggestion to revamp the whole health policy and institutional mechanisms to improve access and quality of health services particularly for the vulnerable sections of society.

Medical and Public Health Report (2008) stated that the main objective of the state is to promote the welfare of the people by extending promotive, preventive, curative health-care services. To achieve these objectives, the state has to improve the health-care delivery system which can reach to the poorest section
of the society by providing necessary infrastructure like beds, provision of sophisticated equipments, providing specialised services, enhancing the strength of the medical, as well as paramedical, personnel and by improving the quality of services provided. The important objectives of the health and family welfare sector are to: provide effective tertiary care to all sections of the public by making available the modern medical techniques and technologies in government teaching hospitals. provides the research relevant to human development and quality of life. increasing the access and utilization of health services, particularly among the needy and underserved population. to formulate effective interventions in the area of maternal and child health to reduce IMR and MMR. implementing schemes for prevention and control of communicable diseases and non-communicable diseases with special focus on newly emerging water borne diseases and life style diseases. creating awareness and ensuring timely availability of accident and trauma care services to reduce mortality.

**Rygh EM, Hjortdahl P. (2007)** explore the possible means to improve health-care services in rural areas. The big challenge is the lack of a generally
accepted international definition of rurality, which makes it difficult to generalise from one region to another, and to develop an evidence-based understanding of rural health-care. In evaluating the study it was found that the development of new forms of interaction is particularly relevant in rural regions – such as interdisciplinary and team-based work with flexibility of roles and responsibilities, delegation of tasks and cultural adjustments. Apart from this, programmes like integrated and managed care, outreach programmes, shared care and telemedicine were relevant initiatives suggested. These may have to be associated with greater equity in access to care, and more coherent services with greater continuity, but they are not necessarily linked to reduced costs; they may, in some cases, entail additional expenses. The effectiveness of these programmes depend upon primary health-care system as a base.

Jamison, T. and Ramanan Laxminarayan (2007) stated that Indian government has launched the National Rural Health Mission (NRHM). The study explains the current status and future prospects of health financing in India in light of NRHM, its objective is to draw attention to the benefits of public health
spending, explore reasons why public spending has been much more effective at improving health outcomes in some regions but not in others, and to apply lessons learnt from the disease control priorities project-India. The approaches of NRHM has been explained. Health systems need to improve the level (and distribution) of health outcomes and to provide financial protection to the population, both from unanticipated large health expenditures and from income loss.

Papiya Mazumdar (2006) the author pointed the issue of rural health-care, which has a greater significance in the developing world, mainly with changing role of the state in providing health-care. This study reveals the levels, trends and patterns of public expenditure on health during 1995 to 2006 in India, both at the national and state levels. The study finds that public expenditure on health, as a proportion of GDP, has remained unchanged over the years, with revenue expenditure accounting for the larger share. Among the states, the relatively poor ones were found to be spending more on health, both per capita and as a proportion of GDP, compared to the richer states. It was found that expenditure on health by the state had not provided adequately on par with overall economic
prosperity, and private out-of-pocket expenditure has been increased. The study suggests alternative health financing strategies based on recent initiatives across the country, such as health insurance and supply at subsidized rate.

Kay A. Johnson (2006) as pointed the rural health-care policy and finance obstacles reduced access the preconception of care and, reportedly, limited professional practice changes which would improve the availability of needed services. The study also reviews the barriers and opportunities for rural health-care financing preconception care, based on a review and analysis of state and federal policies. This study explains the states’ experiences with and opportunities to improve rural health-care coverage, through public programmes such as medicaid, medicaid waivers, and the State Children’s Health Insurance Programme (SCHIP).

The community health centres which are providing primary and preventive care to women has been discussed. Three major policy aiming to: improve health-care coverage, increase the supply of publicly subsidized health clinics and direct delivery of preconception screening and interventions in the context of public health programmes is discussed.
Purendra Prasad (2000) the study shows the image of health-care related problems of the rural poor in Gujarat. It is found that most rural poor have problems in accessing health-care services, not because they lack trust on biomedicine as is commonly perceived, but due to the failure of the state to figure out the social spaces in health-care policies. The findings of a study of the shows epidemics in Gujarat the supply of drugs, opening of special wards in the hospitals, increased allocation of equipment, doctors, health workers, which are contributing for morbidity.

2.1.2 NRHM Policies and Approach

Srabanti Mukherjee (2010) the author stated the relevance of good health of its citizens, in the course of economic and social advancement and elevating the quality of life of our rural citizens, with the introduction of National Rural Health Mission (NRHM). The aim of the mission is to extend the availability of improved health-care facilities to the people residing in rural areas, especially the vulnerable section, viz., the poor, women and children. This study also attempts to explain the effectiveness of NRHM in terms of each of these goals and also overall
effectiveness of the mission. 100 rural doctors from the expanse of India, Odisa, Assam, Jharkhand and Chhattisgarh has been interviewed with 10 different small sets of questionnaire based on nine major goals of NRHM for the purpose. However, due to inadequate infrastructure, health manpower, implementation of Ayush, lack of penetration of health insurance, etc., it cannot be concluded to be 100% effective.

**NRHM A.P. Government Ministry Report (2008)** reveals Government of Andhra Pradesh, National Rural Health Mission (NRHM) in April 2005. While Andhra Pradesh needs to spend an additional required fund to the rural primary healthcare services, not provided. On the basis of capita expenditure basis, Kerala stands the top ranking and Punjab also has good health-care indices. The lowest ranking is found in Bihar. Hence funds are needed to improve healthcare and healthcare indices awareness, equitable distribution and utilization of services is equally impart for the improvement of healthcare service. The implications of providing health services in rural areas of these two states, as given by NRHM estimates, are: Andhra Pradesh needed to enhance its allocation by almost 44%
over 2006-07 in 2008-09, whereas Kerala was required to step these up by 52%.

This is a big challenge to the states.

Satpathy, S.K. and Venkatesh, S. (2006) discussed the National Rural Health Mission (NRHM) which is an ambitious strategy of the government, aims to restructure the delivery mechanism of rural health-care to the rural area providing by universal access to equitable, affordable and quality health-care that is accountable and responsive to the people’s needs, reducing child and maternal deaths as well as stabilising population, and ensuring gender and demographic balance. The mission is an agenda of the government’s commitment to raise public spending on health. Increased GDP aims to undertake architectural correction of the health system. The mission will enable the system to effectively implement programme by increased allocation and promote policies that strengthen public health management and service delivery in the country. Stakeholder consultations were held over a six-month. The Planning Commission, the National Advisory Council, other government ministries/departments, health professionals and
nongovernmental organisations (NGOs) have to draw the mission strategy for providing better health services.

Sucha Singh Gill and Ranjit Singh Ghuman (2005) have identified the importance of prioritising rural health-care particularly from the preventive aspect. This study explains the effectiveness of NRHM, initiatives in rural areas, for reducing the growing disparity in health-care facilities between rural and urban Punjab. The study also shows that rural health is neglected in Punjab. In the study it is mentioned that successive governments have made no concert effort revitalize the health sector in the rural areas, which leads to deterioration in health services and poor health of the people. This is perhaps because the rural society is unorganised/non-unionised. The study strongly advocates the need for treatment plants should be established in the proximity of the towns and cities, cost of which must be borne by the users of these services. The study summarises that, to improve the health services in the rural areas, the village community has to be involved in the maintaining and functioning of the whole system for the benefit of the users.
Ramesh Bhat and Somen Saha (2004) have found that the deviation in the Union Budget, 2004-05, compare to earlier budgets with its specific focus on the social sector. The National Health Policy (NHP) formed relates to the reforming the existing institutional health-care delivery system. The various studies also show the malfunctioning of the prevailing government health-care. This is due to bad mechanism of coordination and information sharing across departments and various offices involved in implementing the programmes, the structure bear a resemblance to broken hierarchy without any one assuming responsibility of performance or management of key resources. The study reveals the inefficiency in implementing programme due to many drawbacks.

Arvind Pandey, Nandini Roy, Sahu, D., Rajib Acharya (2004) study explains the utilisation of antenatal care services and assistance extended. The study related the three states, namely Chhattisgarh, Jharkhand and Uttarakhand. The study concludes with need for the reproductive and child health programme to visualize a dynamic strategy, giving due weightage to the geographical and socio-economic factors. The issues of availability, accessibility, acceptability,
affordability and appropriateness related to health-care still persist as mismanagement. The only way to come out from this problem is to form public health system in such a way that it becomes accountable, inexpensive and available by superior management of resources and community initiatives. With this objective, the Government of India has launched the National Rural Health Mission in 2005 across the country. The major objectives or national rural health mission are to ensure the following: (a) Development of infrastructure of state governments, (b) Availability of critical manpower, (c) Reach of mobile medical vans, (d) Mainstreaming ayush (the homeopathic and Ayurvedic doctors), (e) Coordination with the community by ASHA (trained female community health activist = ASHA or accredited social health activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system), (f) Implementation of public private partnership, (g) Inter-sectoral coordination, (h) Appropriateness of expenditure planning, (i) Penetration of health insurance.
David H. Peters, Sujatha K. Rao and Robert Fryatt (2003) pointed out the health system which was designed in a different era, when expectations of the public and private sectors were of different directions. India’s demographic changes needs suitable health care to reduce disparities in life expectancy, disease, access to health-care and protection from financial risks have increased. These factors are challenging for the health system existed. Study also argue that the content of national health policy needs to be more diverse and accommodating to specific states and districts. States will be able to develop policies to deal with the periodic outbreak of non-communicable diseases and more appropriate health financing systems. The central government has to focus on reducing the large inequalities in health outcomes across India and tackle the growing challenges of health such as epidemics, and provide the much needed leadership on systemic issues such as the development of systems for quality assurance and regulation of the private sector.

National Health Accounts Report (2001-02) discusses the variations in spending per capita across states, like Kerala, Haryana, Punjab and Himachal
Pradesh. Assam, Odisha and Rajasthan have different per capita expenditures on health. The study emphasise the focus on interventions that generate maximum levels of health gain and financial protection. Target interventions need to address disease conditions that are major sources of under-five mortality and burden from infectious diseases.

2.1.3 Rural Healthcare System in India

Ramani K.V. and Dileep Mavalankar (2005) explained the status of Indian health system. It identifies that the critical areas of management concerns in Indian health-care system are mainly due to several factors like non-availability of staff, weak referral system, poor service delivery, financial shortfalls and lack of accountability of quality of care.

Dileep Mavalankar, Ramani K.V., Jane Shaw (2004) described the threats to reproductive health programmes in India. It is stated in the study that the reasons behind the failures in the programme of reproductive health services are both complicated and multi-faceted as the result it was not possible to be successfully addressed through health system reform. It is suggest to identify the
failures in service are attributable to specific causes and which could be altered by reform in the normal reform procedure of the health system. It is also suggested to expedite the reforms in the health system to facilitate the improvement of reproductive health services in India.

Brijesh C. Purohit (2001) have explained the structural adjustment in the Indian rural healthcare sector has felt in the reduction in central grants to states for public health and disease control programmes. The decreased share of central grants has an impact on the poorer states, which have found it more difficult to raise local resources to mobilize the revenue. With the help of reforms, there is an increase in the state expenditure on the health-care sector in the future. Due to this, number of notable changes are appearing in the Indian health-care sector. The policy responses to these private initiatives are reflected in measures comprising strategies to attract private sector participation and management inputs into primary Health-Care Centres (PHCs), privatisation or semi-privatisation of public health facilities such as non-clinical services in public hospitals, innovating ways to finance public health facilities through non budgetary measures, and tax
incentives by the state governments to encourage private sector investment in the health sector. Knowing the vital importance of present market forces and policy responses in shaping the future health-care scenario in India. Study explains in detail both aspects and their implications for the Indian health-care sector. The study indicates that, despite the newly emerging market forces health care service suffers.

Poornima Vyasulu and Vijayalakshmi V. (2001) study discussed the reproductive health services and panchayat raj system in Karnataka, the reproductive health-care services available to women in rural areas in the state, and the various factors influencing them. On the basis of data of Primary Health Centres (PHCs), and the availability of maternal health services, in the state it is analysed that the status of reproductive health services, their access is limited. The role of Panchayati Raj institutions (institutions of rural local government) in providing these services has been explained. Institutional structure quality of services; and social factors are taken to examine maternal health-care. The findings indicate that the resources available for health-care are inadequate,
particularly for Reproductive and Child Health (RCH) in rural areas. Inadequate in panchayats leads to not taking any significant initiatives to improve maternal health-care.

**Government of India (1999)** report indicate the functioning of the CHCs, taking into account the availability and accessibility factors. The study stated that 71 per cent of variation in utilisation of services by these variables.

**Sodani (1997, 1999)** the study related to the functions of health-care for the state of Rajasthan. Author has taken into account 11 independent variables like age, education, time gap, duration of illness episode, number of visits, distance, income, number of rooms, family size, highest level of education among males and highest level of education among females. After the international conference on population and development in 1994 (ICPD) at Cairo, the quality of care is coming to be acknowledged as equal in importance with access to reproductive health services. Delivering successful care involves respect for the individual needs and rights of the clients, and useful service from the staff in hygienic conditions (UNFPA, 1994, 1995). This review not shown in terms on Indian
family planning. This study explains several variables from: availability, accessibility, family characteristics, social structure and quality of care, etc.

Peter A. Berman (1998) stated that the scenario of developing countries which have implemented formal health-care system strategies with the financing and delivering of health services. However the purpose of plans and investments in the actual health-care systems in many countries is not satisfactory. However, policies and plans continue to be implemented. It reveals that the need for long-term strategy to develop a national health service. Model of health-care provision practiced is misguided and wasteful. The role of non-governmental health-care providers for achieving the basic services is explained. Major problems like, quality of care and the financial burden of unregulated fee-for-service medicines, are also noted. In this direction India and many developing countries have to rethink their health-care system development strategies and develop good strategy by using already extensive non-government health-care sector, rather than to view non-government services simply as a constraint to successful public programmes.
Das and Hammer (2007) have brought out within the several special features related to health care. Health-care has the characteristics which are different from other goods and service. As authors stated the complexity of health-care, which makes information exchange and the establishment of reputations more difficult. Therefore, private and public in providing health-care are both likely to be beset with inefficiencies and quality problems. This problem is not in rural India but in urban India also.

Planning Commission Report (2006) elaborating institutional, explains the structure of development planning, which includes public health services, has not been able to render effective services to rural populations of India. The report noted that the lack of accountability, leading to pervasive absenteeism and low effort, and offering decentralisation as a solution. Five years later (Planning Commission, 2006), the same problems were highlighted once more: where rural health-care in many experience states observe doctors/health providers, paramedical force, shortage of medicines, inadequate supervision/monitoring and lack of attitudes. The authority fails to recognize the service either as good or bad.
The government’s own analysis found the failure of decentralising as the reason for lack of improved health outcomes, the 10th Plan aimed at providing essential primary health-care, particularly to the underprivileged and underserved segments of our population. It also expected to entrust the responsibilities and funds for health-care to local government. The report concludes that implementation of objectives has been slow down. However, progress towards these objectives has been slow and the 10th Plan targets have been missed.

2.1.4 Healthcare Infrastructure Development in India

Boston Analytics Reports (2009) reveals the fact that though India’s healthcare system has gradually improved not reached the expected level compared to other neighboring countries. Though there has been in the number of medical establishments in the country, still a severe shortage of sub-centres, primary health centres, and community health centres found. Lack of adequate health-care is also reflected in the low density of health-care personnel. Report reveals that variety of institutions like dispensaries, primary health-care institutions, small hospitals
providing specialist services, large hospitals providing tertiary care, medical colleges, paramedic training schools, laboratories, etc. are not adequate.

**Infrastructure Reports (2007)** the report examines the rural health-care services infrastructure, like physical facilities, personnel, administrative systems, and financial investments needed to deliver essential health services. Primary health-care service is very important in health-care system. The shortage of primary care staffing Ratio the ratio of population to full-time equivalent primary care physicians in direct service provides an index of the availability of primary care are noted. State’s health-care services infrastructure delivers acute, primary, specialty, and long-term care. Though the infrastructure provided has not guarantee, access to services. At pressures from growing demand, the gap between rising costs and flat or declining revenue, and increasing numbers of uninsured patients posed a threat.

**Umesh Kapil Panna Choudhury (2005)** experienced the health-care infrastructure existed in India. Vast public health infrastructure like sub-centres, Public Health Centres (PHCs) and Community Health Centres (CHCs). Are
established and large cadre of health-care providers are appointed. But this vast infrastructure is able to provide to only 20% of the population, whereas 80% of healthcare needs are still being provided by the private hospitals. The study reveals the inadequacy of trained health-care provider, including a doctor with any degree, is available per every 16 villages. Although, more than 70% of its population lives in rural areas, but only 20% of the total hospital beds are located in rural areas. As a result, rural India is suffering acute health care problem. The role of NRHM noted which cover all the villages in these states through approximately 2.5 lakh village-based accredited social health activists (ASHA) who would act as a link between the health centres and the villagers. One will be ASHA raised from every village or cluster of villages.

**Murugesan, P. (2004)** analysed the trends and levels of the health system in India. He stated the importance of the primary health-care level, health and socio-economic development which so closely intertwined for achieving the objective. While the economic development of progressing over the last decade, our health system is not given the importance. Though government initiatives in
public health have proved recorded improvement fails to reach. Health is the main
goal for economic development and poverty reduction. Health sector is complex
with multiple goals, multiple products, and different beneficiaries. India can afford
to meet the increasing expectations of its users and staff. But the challenges are
many to ensure availability, access, affordability, and equity in delivering health
services to meet the community needs. Thus the describe the status of Indian
health system and suggest a few health measures of maternal health indicators
provided by three rounds of National Family Health Surveys. It is concluded by
identifying the roles and responsibilities of various stakeholders for building
health systems that are responsive to the community needs, particularly for the
vulnerable section.

Deepak Bhandari (2002) the author examined the available services of
necessary funds to invest in infrastructure development of secondary or tertiary
level rural health-care hospitals. The fund from the World Bank received by the
states like Andhra Pradesh, Karnataka, Maharashtra, Odisha, Punjab, U.P,
Uttarakhand and West Bengal) to improve secondary level facilities. However
fund is not improved facilities due to the absence of an adequately maintenance
system and poor management systems. It is also pointed the public awareness of
and expectations from health services provided by the government are rising
rapidly. The National Health Policy, 2002 states: since 1983, the mortality through
life-style diseases like diabetes, cancer and cardiovascular disease increased. The
burden of trauma and emergency increasing. However, government has adequate
fund to create such facilities to prevent them. It is estimated that, with the present
economic situation, national budgets can afford to invest for preventing health
hazards.

2.1.5 Importance of Rural Healthcare Financing

Julian Schweitzer (2008) views of the author is that public healthcare
finance and decentralization as central to resolving India’s systemic public health
crisis. There is an appreciation for some status for success in achieving the target
of health. The need for political commitment, community participation, human
resource management, women’s empowerment, and governance importance is
discussed. The importance of state and local government on the success of
national health mission has been noted. The study also stated the importance of political commitment for effective implementation of health care. The failure due to weak and divided community participation; poor hiring, management, deployment, and incentive systems for mid-level health workers and doctors. Therefore the success of the national rural healthcare mission will depend crucially on developing state and local institutional capacity, including strong partnerships with civil society organisations and private-sector actors. Adequate money is necessary condition for success, but it will not be a sufficient condition if political commitment, governance, and administration not effective.

Ravi Duggal (2007) examine the importance of finance for equity in access to health-care. The less proportion of public health-care resources committed to health-care in India is very low in the world. Tough Indians are in poverty, spend out-of-pocket for health. This is a cause of the huge inequities in access to health-care. The paper suggested for strengthening public investment and expenditure in the health sector. It also expected the reform of the existing health-care system by restructuring existing mechanism which also factors in the private health sector. In
the conclusion it is over-emphasized the fact that health is a public or social good has to be under state control.

Anil B. Deolalikar and Jamison, T. (2007) examines the present status and future possibility of rural health financing in India with the objective of the rural health-care. Authors’ contribution has been to synthesize what is known in the context of rural health-care. It is also pointed out the success and failures in providing health care in different states. The possibility of financial resources made available to the rural health-care is discussed. In states like Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh, and Odisha, are quoted as examples where 45% of India’s population, found where more infant and child mortality and child malnutrition found. On the other hand, Kerala, Tamil Nadu and Gujarat, non-communicable diseases are fast replacing infectious diseases and malnutrition as the leading causes of morbidity and mortality. These studies emphasize the need for improved public sector for effective implementation of health care. The study also insisted the center-state financial responsibilities to improve the health services.
Stijn Claessens (2006) has explored evidence on the importance of rural health-care finance for economic well-being. The data on the use of basic health-care financial services by households, sample of countries, assesses the desirability of universal access, and provides an overview of the macro-level, legal, and regulatory obstacles to access are available. It shows that in spite of health-care finance, use of rural health-care financial services is far from universal in many countries, particularly developing countries. Accessibility of health-care financial services has not been a public policy objective in many countries which is responsible not to achieve. Study emphasized the access to financial services by strengthening institutional infrastructure, liberalising markets and facilitating greater competition, and encouraging innovative use of know-how and technology. Government interventions to directly broaden access to rural health-care finance, however, are costly and fraught with risks; among others, the risk of missing the targeted groups. The study recommends for global intervention like WHO aimed at improving rural health-care data on access and use and suggestions on areas of further analysis to identify constraints to broadening access.
Melitta Jakab, Alexander Johannes Paul Jutting, and Anil Gumber (2002) authors have attempted to give empirical evidence regarding the performance of rural health care and extending financial support to the marginalised people. To prove that household sample survey was applied and regression analysis used. Two model were used for analysis. One is financial protection given by the government, and another was spending from packet. The conclusion shows the variation in these two to derive the services.

Kananatu, K. (2000) study proves that the development of the health-care delivery system in India is commendable. The strength and weaknesses of the public health-care system and the financing problems fund are also analysed. The funding of both the public and private sectors cost has been pointed out. The advantages of operating a health financing scheme which is affordable and controllable proved the cost-containment and quality assurance. Finally emphasize the need for the establishment of a national healthcare financing, a mechanism to sustain the health-care delivery network and operate it as a viable option. A
comprehensive model of the national health financing has been proposed in the study.

Saltman and Ferroussier-Davis (2000) have discussed the determinants of financial protection, health, and social inclusions supply in health system and related sectors. The factors like GDP, prices, inflation, availability of insurance markets, effective tax systems, credit, and savings are discussed. The role of organisational and institutional factors which contribute to the incentive environment of health-financing and service delivery systems examined. The management, the health-care policy actions by governments, civil society, and the private sector role is discussed. The role of government as an instrument that can be used to strengthen the health system, the financing of services, and the regulatory environment within which the system functions is sought. These include: regulation, contracting, subsidies, direct public production, and ensuring that information is available. In countries of poor governance, civil society and donors role expected.
Charu C. Garg (1998) has described the financing and delivery of health-care in India for achieving equity. For that the role of public and private sources are examined. Inequity in delivery of health-care is existed due to different geographical locations on the basis of self-reported ill health. The study state that, even though the government sources of financing is limited, the large proportions being spent by the people on health-care. Both government and private expenditures are higher for higher income group who are living in urban areas and working in the organised sector. The lower income people in rural areas bear higher burden of health expenditure from their income. It is fond that delivery of health-care is also found to be biased in favour of urban areas. The study based on secondary data which are available from the Ministry of Finance, Government of India.

2.1.6 Public Healthcare System Role in India

Nirvikar Singh (2008) has examined the delivery of public health-care services in India, which has decentralization nature of governance. Study discus the relationship between states and central with reference to providing quality
health delivery. The recent policies formulated for health programmes are discussed. In the conclusion the study has discussed the pattern of public sector investment on health in India. Thereafter, the basic features of inter-governmental fiscal relations, recent developments, and accountability mechanisms practiced at sub-national public goods are reviewed. The study has discussed the recent public policy proposals on the provision of health-care, in a federal system of governance. It also offered the suggestions for reform priorities to improve public health-care delivery system in India.

**Umesh Kapil and Panna Choudhury (2005)** stated that India has made a vast public health infrastructure of sub-centres; public health centres and Community Health Centres. Along with this paramedical staff like auxiliary nurse midwives, male health workers, lady health visitors and male health assistants are functioning. Despite this vast infrastructure only 25% of the population covered by government remaining 75% provided by the author other rural part of India deprived of adequate health services. The national rural health mission which has been launched by government of India is able to solve such problem. The ASHAs
would be able to create awareness among people about sanitation, hygiene, contraception, and immunization; to provide primary medical care for diarrhea, minor injuries, and fevers; and to guide them for referral services.

2.1.7 Community Participation in Rural Healthcare

Author has explained term community has a multitude of interpretations. Study various approaches to defining a community. The explanation of community including demographic approach, characteristics of the population, like gender and age, are central to the definition. The spatial approach has been analysed for location of health institutions. Examples like offices, schools and hospitals which are essential services are determined by physical barriers. Study has concluded with the definition of country having capacity to work towards solutions to its own community problems.

Gilchrist (2004) approach is similar to many studies which identifies the community stated that networks that exist between individuals, groups and organisations are the integral to people’s lives are central to the meaning of community. The community development model, suggested by the author plays a
central role in assisting people to connect with one another to empower individuals and groups to solve problems which prevent them from communicating and working together. Communities are formed by members. While the definition of community in terms of location has been the most common term in the past. Study also identify the significant characters of plurality of contemporary society.

Rifkin, Muller, and Bichmann (1988) the definition of depends on specific populations who are at risk. This definition is stemmed from the epidemiological view of community. In Primary Healthcare Centres, the equity, effectiveness and efficiency, groups of people have needs to be identified for resources allocation. Therefore, it is important to take into account this aspect of health concerns in seeking a realistic definition of community.

Wood and Judikis (2002) have identified the essential elements of a community which include a sense of common purpose, an acknowledgement of interdependence, respect for individual differences and a responsibility to the well-being of members of the community. Study stated that communities are stronger when individual members with different strengths and talents exchange in the
community vision, purpose, interests and intended outcomes. They have 5 different categories of community such as nuclear family, tribal, geopolitical, life and collaborative communities. A collaborative community formed to serve a specific purpose which is necessary. This all-encompassing approach to describing communities fits well with the parameters of community identified in this research. Inspite of diverse communities all work towards achievement of the same goal to have primary health centre. Therefore, it is necessary to include shared goals, vested interests, and preferred ways of doing, power relationships and capturing the benefits of diversified character.

*Laverack (2004)* has found that there is considerable conflicts between community participation, community development, community empowerment and community capacity building. Participation, like community, has a wide range of meanings. Community participation is an attempt to bring together different stakeholders in order to solve problem and decision-making. Another author Rifkin (1988) provides an expanded definition, community and the social processes which contribute to determining and addressing the needs. Many authors
agrees that it is the process of participation which allows social representation to be shown, reaffirmed and renegotiated, and provides a platform for discussion between different representations. The approach of utilization sees external agencies inviting communities to participate in a pre-determined project which may be aligned with people’s for understanding the notion of consultation.

Irvin and Stansbury (2004) the view of authors is that the participatory approach can be more expensive than decisions made by a single agency. The same approach identified by Morgan is the empowerment. Empowering of local communities and creating awareness for social change may reduce the inequalities is central point to this approach. Labonte (1997) places emphasis on the importance of relationships in underpinning participation. Participation of community is a process necessary for changes and unfolds their ability to negotiate their relationships. The theme of the study is to strengthen the community participation for better health services. The factors which contribute to effective participation like needs assessment, leadership, organisation, resource mobilisation and management are considered. The involvement of community depends on the
nature of the project, which provides an opportunity to examine process rather than just the impact of community participation.

David Sanders (2004) has traced the international history of community health workers service provided at global level. Though the developing countries have seen many improvements health indicators such as infant mortality rate, crude birth and death rates and life expectancies, still certain other indicators, like neonatal mortality, maternal morbidities and mortalities, and under-nutrition, have not significant reduced. Study examined the urban rural barrier and gender related health inequalities which are increased significantly even in developed countries, indicating differential access to health services. As state reason is the decreasing state budgetary allocations towards health, which increase in private or out-of-pocket expenditures. The quality of public health services is low for the poor and vulnerable section. Given these realities, the need for primary health-care through strengthened community based and systemic interventions has assumed utmost importance. From this point of view CHW programmes have been conceptualised as agents for realising the right to health for the poor, and have been positioned
within global economic, social and political processes, which, in turn, determine the characteristics and efficiency of these programmes.

Health and Basic Service published by UNICEF. The theme of the book is on health and approaches to basic health needs in developing countries. The first part of the book elaborately explains the medicine, health and human development in developing countries. The health scenario of western pattern has been compared with developing countries. The poverty and its consequences on health standard in developing countries have also been analysed. The complex problem of political, social cultural and environmental roots, extremely limited resources, poor communications, vast distances, individual and community and lack of education act and react upon one another in such a way as to maintain the developing countries in a perpetual state of poverty. It has been inferred that the existing vicious circle is not permitting people to come out of it in the developing countries.

“The most obvious economic signs of under development are low productivity, low national product and low average income per person. The standard of living in developing countries is low for the great mass of the people and life is beset by the
problems caused by the insufficient or faulty food intake, poor housing conditions, poor health, inadequate public and private provision for hygiene and medical care, insufficient communications, transport and educational facilities and systems of education and training that are ill-adopted to the peoples needs” are responsible for low standard of health in developing countries. The conditions of under privileged rural population in developing countries has been narrated, which is very much similar to that found in India. Therefore, the scarce resources are to be carefully planned for equitable distribution of services between haves and have nots as well as urban and rural. Another chapter on assessment, stresses the importance of countries’ involvement, more equitable distribution of funds, the development of man power for national health needs, decentralization of planning and administration. Integration and coordination of health services in terms of nutrition, education, sanitation, communication and transport, which are necessary to meet the health for all should be given special importance in the study area.

The book also contains various recommendation to WHO and UNICEF. It has urged to pay immediate attention for providing health services to under
privileged population of developing countries. The recommendation made by experts are well suited to Indian conditions and particularly to the study area.

The 3rd part of the book is devoted for basic services for children in developing countries which is a report by the executive Director of UNICEF submitted in 1976. The report gives a clear picture of basic services required for reducing the infant mortality rates in the developing countries. It deals about the need for accelerating the delivery of basic services to underserved communities and gives possible approaches on the following aspects.

The principles for delivering of basic services to disadvantaged communities; mobilisation of national and local resources, nutrition services, water supply and other activities. Identification of a target population who really need health services; cost estimates, provision of basic services to urban slums and shanty towns.

The above cited aspects are deeply concerned in rendering the qualitative and quantitative health services. The same approaches are much needed to a
country like India. Though the book is in the form of a report, it has relevant information to the present study. This book mainly deals with general health and health policy related to developing countries.

Public Health is a recent edition added to Literature of Health Services, which exclusively deals with public health in India. The first and second chapter of the book related to health problems and health services in India, the relationship between health and development and Indian perspective. The theme of these two chapters is to explain the existing system of health services in India and its role in National development as a development partner. While discussing the relationship between health and development some of the characteristics features of Indian Society and Indian economy are also dealt. Information on existing health problems and health services rendered in urban as well as rural India are more relevant to the topic.

As noted in the first five year plan document, “India is committed to a process of development which will raise standards and open out to the people new opportunities for a richer and more varied life.”
The Five Year Plans and the schemes adopted for development of India in respect of health, reveals how India failed to provide basic health needs to Indian people. The concept of community health and Government involvement in community development has been described comparing them to other developing countries in respect of per capita expenditure on health by the Government.

The third chapter of the book is devoted for concept of doctors and doctrines in the Indian Health Sector. This particular topic explains the profession of medicine and the moral responsibility of medical professionals. Health is a vital concern of every human being irrespective of class, creed and sex, hence it is a moral responsibility of doctors to be devoted to the doctrine.

The development of various professions, is one of the prominent characteristics of modern society. While discussing the professions, the author has emphasised certain characteristics of profession of medicine as “Profession is commonly used to mean work done skilfully to pay but when considering a more specific definition of the word as it applies to health profession it should have the
following elements.

1. A profession is based upon a discrete and definable body of knowledge.

2. In practice of profession its members demonstrate skill based upon knowledge and upon specific training in their profession.

3. A profession generally admits members and regulates internal mobility through a system of examination certification or registration and establishes standards for the professional conduct of its members through the enforcement of a code of ethics.

4. A profession involves services for the well being of the society at large.

5. A profession frequently involves a critical appraisal and evaluation of one’s work by peers and co-professionals.

6. Relationship between the two interacting parties, that is, the professional and the client is formal, but based on mutual trust and confidence marking it as a special kind of relationship.”

While explaining the concept of profession it has been stressed on the
relationship between community and professionals. The concept of profession now-a-days is confined to the consultancy based on the knowledge and skill he possesses.

A new development in the field of medicine is the introduction of private, interests in grooming medical industries, whereas the Government represented all or certain section of people, the private interests including the pharmaceutical, medical, medical technology and health insurance industries developed in the western countries aimed at profit maximisation. The same tendency is being followed in India too. “With changing bureaucracy and management styles, the organisation of medical practice also has changed from Solo practice to corporate practice or service in hospitals and bureaucratic institutions. The individual power of doctor got diffused and transferred to medical associations and councils. The hospital has become the primary medical workshop, a centre for technological medicine.”

The service of doctor and concept of doctrine in India has been compared with developed western countries. Some of the characteristic features of early
periods of medical systems like tantric healer of India, folk healer of China are also being explained. The existing system of medical practice has created a wide gap between practicing values and needs of the society in India. This is supported by the statement. “This gap between the practicing values of consulting medical professions on the one hand and the needs of the society on the other, unless bridged meaningfully, will never have anything approaching equal to that of health for all by 2000 AD as accepted by the professions structure itself.” The book also deals on the ethics of profession. It has been pointed out in the book that the ethics of public servant or people’s representative and the ethics of the doctor are not merely different but antithetical.

The second chapter of the book dealing about doctor and doctrine has narrated the qualities of good doctor and doctrines. The significance of doctor and doctors’ role in the modern period particularly in a country like India has been highlighted. “The need for ethical values is specifically needed today if we are to save ourselves from utter destruction and catalysm. It is here that the medical scientists are required to playa vital role. The physician in the course of his
services delivery has his responsibility towards the patient, the people among
whom he lives and also towards the members of the health profession itself. It is
here that the doctor needs a great degree of patience perseverance, empathy,
firmness and act. As the community places a complete confidence in his role the
ethical obligation is to respect that trust and faith. Thus the function of doctors and
concept of doctrine has been explained in relation to India and other developing
countries.

The fourth chapter of the book is related to Public Health Policy in India.

Policies are mainly based on the form of Government that exists in any country.
The objectives and purpose of the Government, determines the policies of any
country. Health being an important basic need, has gained importance in the
Democratic and Welfare nations. Because health continues to depend more than
ever on our social economic and ideological values, questions of health and illness
are determined less in medical colleges and research institutions than in industrial
and political office.” In India the public health policy is mainly based on
philosophy of political parties that came to power.
Apart from the specified aspect, some of the important issues like Management in Indian Public Health Service System, Health communication in rural India and India’s commitment towards health for all by 2000 AD have also been explained.

2.2 International Experiences

2.2.1 Implementation of Primary Healthcare Model

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

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

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

McCoy, D., Buch, E. and Palmer, N. (2000) reported that the devolution of primary health-care delivery to local government means that inter-governmental relations are emerging as a critical issue in the transformation of South Africa’s health system. The role of contracts or service agreements in helping to define the nature of these inter-governmental relationships is important. This document, produced by the health systems trust, considers the nature of inter-governmental relationships. This study introduces the advantages and disadvantages of contractual relationships within the public health sector, examines different types of contracts, describes the nature of inter-governmental relationships in South Africa and features of the PHC approach and district health system model integral
to the South African health system, and discusses how these factors will influence and potentially be influenced by the use of contracts. It also emphasises the importance of integrated district and provincial health planning as the basis for contracts. In addition, this study discusses the issues raised and draws conclusions of interest to those involved in the process of establishing contracts. This study makes the following recommendations for a successful inter-governmental contractual relationship for the provision of PHCs: a. Work from a national/provincial strategic and policy framework, and from a comprehensive and integrated area-based PHC plan. b. Adopt a relational approach to contracting that encourages partnership, and emphasises trust, mutual support and a shared vision. c. Adopt contract specifications that are broad and flexible, and which stress constructive monitoring and evaluation procedures.

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

Winnie Yip and Ajay Mabal (2008) explored the health-care systems of China and India. Both these countries have recently committed to injecting new public funds into health-care. Both countries are now deciding how best to channel the additional funds to produce benefits for their populations. In the study, the author analyses how well the health-care systems of China and India have performed and what determines their performance. Based on the analysis, this paper suggests that money alone, channeled through insurance and infrastructure strengthening is inadequate to address the current problems of unaffordable health-care and heavy financial risk, and the future challenges posed by aging populations that are increasingly affected by non-communicable diseases. To facilitate comparisons between China and India, the study adopt an analytical
approach that is commonly used in evaluating health systems and designing health-care reform. This approach conceives of a health system as a set of relationships in which the structural elements of the system are causally connected to the goals of the system. These elements include: health status, financial risk protection, and public satisfaction, and the equitable distribution of each of these.

The health system provides financial risk protection, which can be assessed by two metrics. The first measures the percentage of households in a population that are pushed below the poverty level as a result of out-of-pocket payments for health-care. Existing evidence suggests that households in both China and India are vulnerable to financial shocks associated with ill health. A recent study shows that out-of-pocket health spending increases the percentage of people below the poverty level (US $1.08 per day) by nearly 20 percent in China, from 13.7 percent to 16.2 percent. In India, out-of-pocket spending increases the already high poverty rate of 31.1 percent to 34.8 percent, despite a smaller proportional increase compared to China.

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

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

**World Bank Report (2005)** concluded that the focus is on improving health service delivery that have been discussed in the literature. Peabody (2006) summarises these in the context of low- and middle-income countries: a. Generate and encourage the use of specific clinical algorithms based on evidence of best practice. b. Have service providers acquire skill and speed by doing a few things frequently rather than many things occasionally. Learning by doing is key to
improving performance. This lesson is very relevant for India given the hard reality that, at least initially, the rural healthcare mission will have resources only for a limited set of high-priority items.

2.2.2 Rural Health-Care System in International Experience

Thomas C. Ricketts (2000) says the rural healthcare system has changed dramatically over the past decade because of a general transformation of healthcare financing, the introduction of new technologies, and the clustering of health services into systems and networks. Despite these changes, resources for rural health systems remain relatively insufficient. Many rural communities continue to experience shortages of physicians, and the proportion of rural hospitals under financial stress is much greater than that of urban hospitals. The health-care conditions of selected rural areas compare unfavorably with the rest of the nation. The market and governmental policies have attempted to address some of these disparities by encouraging network development and telemedicine and by changing the rules for medicare payment to providers. The public health infrastructure in rural America is not well understood but is potentially the most fragile aspect of the rural healthcare continuum. The character of rural health-care delivery in the 1990s has undergone significant changes caused by the rapid transformation of the U.S. Health-care system.
**WHO Report (2000)** proposes that primary health-care review can be at seven levels – national, district, health centre, community health workers, community leaders and household levels. The main objectives of a review is to identify the strengths and weaknesses of a national programme in order to establish or adjusted priority and to make specific recommendations for future action” (WHO, 2000). Aspects to be covered in a review of primary health-care as outlined by WHO are: 1. Health aspects The health aspects involved an evaluation of the process, output and impact of the PHCs programme from the health sector perspective, using various indicators that reflect the results in terms of health sector performance, health activities output with respective individual programme and the health impact. 2. Social aspects. The social aspects involve an evaluation of community involvement in health, including the influence of people at all levels in bringing about better health, the outcome in terms of community satisfaction and human resources development at the community level. 3. Inter-sectoral aspects This includes an assessment of how the contributions of other sectors, are affecting the health of the people (WHO, 2000).

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

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

*World Bank Healthcare Report (2000)* reviews the impact of scheme membership on health-care financial protection in India; a two-part model was used. The first part of the model analyses the determinants of using health-care services. The second part of the model analyses the determinants of health-care expenditures for those who reported any health-care use. There are several reasons for taking this approach. First, using health expenditure alone as a predictor of financial protection does not allow capture of the lack of financial protection for people who choose not to seek health-care because they cannot afford it. As the first part of the model assesses the determinants of utilisation. This approach allows us to see whether membership in community financing reduces barriers to accessing health-care services. Second, the distribution of health expenditures is typically not a normal distribution. Many non-spenders do not use health-care in the recall period. The distribution also has a long tail due to the small number of very high spenders.
**World Bank Development Report (1993)** explains health-care financing policy formulation in India, many of the international agencies had failed to encourage appropriate insurance-based alternatives to fee payment at the point of use. In particular, the 1993 world development report did not make recommendations for low-income countries that would change the situation in the short to medium term. Many national and international departments and agencies now accept that the principles of health insurance are applicable to low-income populations and are willing to study examples of insurance initiatives for poor and informal households. The outcome suggests that the design of community health insurance schemes may be improved by (a) design specifications that utilize data on willingness to pay (WTP) of the target population and projected health-care costs; and (b) incorporating modalities of operations that facilitate cost-effective exchange between a formal organization and individuals acting in an informal environment.

**World Bank Report (2005)** focus on improving health service delivery that have been discussed in the literature. Peabody (2006) summarizes these in the
context of low- and middle-income countries: a. Generate and encourage the use of specific clinical algorithms based on evidence of best practice. b. Have service providers acquire skill and speed by doing a few things frequently rather than many things occasionally. Learning by doing is key to improving performance. This lesson is very relevant for India given the hard reality that, at least initially, the rural healthcare mission will have resources only for a limited set of high-priority items. c. Improve provider incentives by creating a legal and ethical environment where-care providers do not profit personally from the sale of drugs, diagnostic procedures, or provision or referral of care. Overuse and misuse of resources typically flourish in such unethical environments.

John D. Potterfield (2000) has described the community health services in America. As he stated the community hospitals in the United States are voluntary hospitals systems which are private, non-profit, community oriented institutions. The management of such hospitals governed by board of trustees selected from responsible citizens in the community. The special features of the voluntary hospital system in the United States are widely discussed. The physician is
described as a pivotal link between hospital and community. It also deals with methods of providing community health services.

**Milton T. Rower (1977)** explores the existing distribution of doctors and specialization. The service of doctor and para medical forces or auxiliary services are explained. The field of specialization like ophthalmology, surgery and pediatric are also distinguished. These services are to the needs of patients. The existence of traditional healers in the developing countries is also highlighted. The concept of team work including doctors secondary practitioners auxiliary health worker is very much advocated rather than a solomedical practitioners. It is also pointed out that, inspite of substantial increase in world’s supply of doctors their availability to serve people within any individual country has remained extremely uneven.

**Park K. (1975)** has given the history of health and health services. The various policies implemented to prevent different diseases. The vital issue like infant mortality rate and health of maternal mother has been discussed. The nutrition and its impact of health status is emphasised. The disease related to environmental hazards and occupational health which is a burning issue in the
field of health has been highlighted. The author has given the health information
and basic medical vital statistics.