REVIEW OF LITERATURE

2.1. Introduction

The review of literature makes an attempt to understand the research work already made in the field of role of health service in economic development and its major issues and research gap in the area of health services from the point of the present research study.

The secondary sources of data available in different forms such as books, journal articles, theses and other reports were reviewed for the purpose of the present study. The intermediate and other health service, Indian and public health service and research gaps found in the literature are presented in this chapter.

Any serious and meaningful full work needs to start with comprehensive review of literature in the field. Such a survey of literature, not only helps to acquire an in-depth knowledge in the area of research but also to find out gaps in research. It is also selective a recourse has to select the coins of literature to be reviewed and determine the purpose for which we have to study them. The following review of literature has been reviewed.

To understand the problem precisely and to focus on the rationale of the study, it becomes urgent to have an idea about the studies conducted so far related directly or indirectly with the problem.

The present chapter reviews some available empirical studies regarding different aspects of health status in India and its respective states. The review of these studies provides a broad scenario of various dimensions of health status. For this purpose, the whole chapter has been divided into three sections.

Section A

2.2. Women and Child Health

It covered articles relating to Women and Child Health.

The reviews of studies covered in this section are as follows:

Jayaram Kannan and P Ilango (1990) studied health hazards of women working in beedi industries, the concept of health services for adolescent girls in beedi industries, is definitely accepted as different type of health service. Health hazards of these girls usually do not come to the light of medical records. Generally they are...
tracked by Para-medical personnel general practitioners or charity hospitals they also suffered from the uterus and other gynae problem some precaution method apply for these worker certainly get good health and standard of living. (Kannan & P, Health Hazards of Women Working in Beedi Industries)

Marianne Lebben etal (2002) studied reproductivity health and health sector reform in developing countries establishing a frame work for dialog. It was a international conference paper examine the reaching agreement on compatible aims relating to reproductivity health and health sector change and strengthening health policy- making structures, system, skills, and values. It was critically examined to health status and the integration of reproductivity health approve into health system. (Marianne, 2002)

Somnath Roy and etal (2002) examined the introduction guidelines it is increasing of unwanted pregnancy and also unsafe abortion and their hazardous of consequences are related to inadequate or poor implementation of reproductive health care programme and service most important aspect of this paper added the factors that influence acceptance and continued use of contraceptives, the problems that are encountered in the transfer of technology from the clinic to the community and systematic steps for programme introduction of contraceptive including emergency contraceptives.

The world seek about termination of unwanted pregnancy about 40-60 million in every year. Most of these occur in developing countries and more abortions are carried out under unsafe conditions. The developing countries unsafe abortion is one of the great neglected problems of reproductive health per year. At least 70000 of approximately 5800000 maternal deaths is a consequence of complications of unsafe abortion procedures.

The high incidence of unwanted pregnancy and unsafe abortion is a mainly due to the unmet need of family planning resulting from non-availability of un effective family planning methods or poor quality of reproductive health care services. In recent years, the most important of integrated and comprehensive reproductive health (RH) care is a being increasingly realized and emphasized.
Reproductive health care are three major components are directly related to this problem

- Women’s health and safe motherhood including safe and human management of unwanted pregnancy and consequent induced abortion;
- Effective family planning ensuring free reproductive choice, gender equality and fulfilling women’s reproductive rights and
- Adolescents’ reproductive health and proper development of their sexuality. (Somnath, 2002)

Marianne Lubben and etal (2002) analyzed the reproductive health and health sector reform in developing countries: establishing a framework for dialogue its not a clear how policy making in the field of reproductive health relates to changes associated with programmes for the reform of the health sector in developing countries. In this paper examines factors that limit dialogue between the two areas and proposes the following framework for encouraging it the identification of the programme.

The international conference on population and development (ICPD) held in Cairo in 1994, policies on reproductive health have been influenced increasingly by questions of human rights and decreasingly by demographic considerations. It is a significant change in organization, financing and resource management in this sector, often as part of broader restructuring and democratization of the public sector. In this policies have been developed by different actors, pursuing different objectives, through decision making processes that have been rarely coincided.

Reproductive health and health sector reform is a growing body of research indicating that components of health sector reform may be both beneficial and detrimental to reproductive health. (Lubben, 2002)

Lakshmi (2003) Awareness and health of rural woman studied have brought out the fact that the awareness is higher in this village in the case of immunization and family planning. Among channels of communication for diffusion the heath care measures overall analysis an even though the development in the information technology model the people realize the importance of various health care measures. (Lakshmi, 2003)
Poonam Sharma (2003) healthy women happy family studied the irony is that women the ones responsible for looking after the entire family their contribution is very high, that’s kitchen(making foods) and primary medicinal properties. (Sharma, 2003)

Sivaram Prasad and Dr. Tallure Srinivas (2003) Women and health studied the consequence of this inferior statues have found expression in several forms female feticide, female infanticide, a higher death rate among women, lower life expectancy, lower literacy level as well as shows maternal mortality of world level. Women are amazing they survive in spite of neglect, discrimination, the double burden of house work and wage earning, torture violence; poor nutrition injection women are truly amazing. (Prasad & Srinivas, 2003)

BBL Sharma etal (2004) studied Health and nutrition link aged in poverty prospectives. There is considerable evidence from around the world that women’s employment has the potential to benefit household nutrition and utilization health care through increasing household income. Nutritional adequacy in agricultural household in Kerala was found to be clovly related to women’s employment, poor policy for exempting from user charges is crucial as alternative ways for financing health care for those who cannot afford to pay the suffering from poverty and hunger driven conditions. (BBL, 2004)

Sidramshettar (2004) studied women’s in particular were the neglected areas in health care services. It has shows the women in Karnataka is inextricably inter – twined with the socio economic and cultural factors, illiteracy, low income, early age at marriage, rural residence and other cultural and economic factors constrain women in acquiring health services the overall suggested improving education for women, as well as income generating , and awareness of the family planning. (Sidramshetter, 2004)

Subhash Barman (2006) analyzed the knowledge, attitude and participation of elected gram panchayat members in health and family welfare programmes in Hooghly, west Bengal in 80 percent of the respondents had the knowledge of the educational institutions and public and private health care facilities. Health committee members were involved in promoting health awareness among the people about child immunization, safe drinking water, acceptance of family planning methods,
government run health care programmes and arrangements for the treatment of the all rural people. The government of west Bengal has been issued an order regarding the involvement of panchayat members for the promotion of the health and family welfare services. In these persons should have been adequate knowledge favorable attitude and commitment towards the health and family welfare programmes. (Subhash, 2006)

Sommath Roy and etal (2007) in their article comprehensive health care including sexual and reproductive health of adolescents and youths is of vital importance to the nations. The terms of adolescent (age 10-19), youth (age 15-24) and young people (age 10-24) have been defined. During adolescence for example transitions between childhoods to adulthood, rapid changes occur in physical, functional, sexual, emotional and psycho-social aspects which need to proper attention and care. Three is a development of human sexuality which comprises the knowledge, beliefs, attitudes, values and behavior of individuals regarding sex. Human sexuality is an integral part of human personality and it helps in achieving and maintaining physical and mental health.

Various dimensions of sexual and reproductive health care of adolescents and youths in the world India and south Asia have been reviewed. Young people should be provided with supportive environment within their families, schools and communities. Health care of adolescents and youths should cover general health, disorders of reproductive systems and sexual land behavioral problems. (Sommath, 2007)

Somnath Roy and Deoki Nandan (2007), examined the development towards achieving health reproductive health for all and millennium development goals: a critical appraisal for strengthening action programmes. They are explained a presentation is divided into two parts. In the first part health development and health maintenance in the India since independence to recent years have been systematically reviewed. Achievements made as well as achieving health for all (HFA) and reproductive health for all (RHFA) goals through general health care and RCH-1 and II and national rural health mission programmes are discussed.
In the second part the millennium development goals (MDGs) have been described and current situation in India has been reviewed. In a various barriers to progress towards achieving HFA, RHFA and MDGs have been identified and appropriate effective implementation of a various action programmes also described.

The basis for organization of health services in India through the primary health care approach in modern time, was laid by the recommendation and also guidance provided by the health survey and development committee in 1946. The community development programme was launched in October 1952 as the first integrated all round rural development programmes. It was only proposed to establish one primary health center (PHC) for an each community development block (CDB). (Roy & Nandan, 2007)

Vinitha C.T and etal (2007), examined the level of reproductive health awareness and factors affecting in a rural community of south India. It is that awareness of health especially for women in India is a very challenging work. These study 624 women aged 13-49 years from 532 households belonging to two health sub-center areas the north Tamil Nadu was done in the awareness of one level and also different factors affecting awareness on reproductive health issues like are safe sex, reproductive tract infection, safe age to bear children and types of family planning methods. Apart from these women’s an education also important and awareness of educational status. Only 9.5 percent of the adolescents interviewed had knowledge on safe sex. Adolescents age is 15 years and above, belonging to an extended family with educational status of above 5th grade, working outside home and having a standard of living had significantly more awareness on safe sex a79.5 percent of women aged 13-49 years knew it was unsafe to bear children before 20 years. Age, marital status and place of residence were a significantly associated with awareness of women. Awareness of women is a most important and also challenging task to care of women because of the social standing of women. (Vinitha, 2007)

Lindsay B. Gezinski (2011) discussed the global gag rule: impacts of conservative ideology on women’s health in the implementation for human rights discourse and political activism. Multiple factors have led to an increase in the number of unwanted pregnancies in the global south including urbanization, inadequate contraceptive supplies land increases in women’s education and labour-
force participation. The negative associated with the policy’s of implementation will be discusses, as well as its human rights discourse and political activism.

International federation of social workers (IFSW) and the international association of schools of social work (IASSW) promote the right to participate as a human right. They state social workers should promote the full involvement and participation of people using their services in ways that enable them to be empowered in all aspects of decisions and actions affecting their lives. Family planning service such as abortion is necessary for women to retain total control of their own bodies. Empirical research pertaining to the GGR is an extremely limited as has been shown here. The production of new theory based, empirical research must occur. In a research- advocacy linkage will insure that empirical research grounds lobbying efforts resulting in policy maker’s confidence in a research that supports comprehensive reproductive health aid. (Lindsay & Gezinski, 2011)

Renu Khanna (2012) conducted the feminist gender and rights perspective for evaluation of women’s health programmes. It explained about the evaluation practical of a women’s health advocate who learnt lessons about evaluation of health programmes from the experience of being an evaluated. The author lays out of the principles that she tries to follow while undertaking evaluations, namely her concept of women’s health and the values and ethical principles that guide her practice. Women’s health an advocate in India. They are told my worldview on evaluations has developed from experiences of being evaluated.

Gender is a term of that is used to distinguish those features of males and females that are socially, psychologically and subjectively constructed as opposed to sex, which is used to indicate biologically determined features. Men and women are very differentiated by social or gender characteristics as well as by biological or sex characteristics. Gender issues are of concern to both sexes and not to women alone. Lowest statues for women leading to gender inequalities, women’s access to health care are compromised and women have poorer health status. (Renu, 2012)
Section B

2.3. India Health Service and Public Health Services

This section covered articles which were related Indian health Services and Public Health Services. The studies relating to this are:

According to Aggarwal (1977) persistent high fertility caused important health problems not only because economic improvements which were essential for good health get restricted, but also because it posed an immediate health problem for the mother and the child. In the most developing countries married women aged between 17-37 were characterized by continuous nutritional drain from repeated pregnancies and lactation resulting in material depletion and measured risk of maternal mortality which increased with every pregnancy beyond the third. Study concluded that in recent years there has been a growing concern about the widening gap between population growth and food supply in developing countries in view of rapid population growth. Available food supplies were inadequate in nutritive quantity for a healthy and active life. Retarded development and poor health were responsible for low stamina and low physical activity. Low physical activity resulted in low productivity, which in turn caused more poverty and more inadequate food supply. Unless this vicious circle is broken, future generations will have reduced stature, lower body weights, and lower level of physical capacity and consequently reduced working efficiency. (Aggarwal, 1977)

Walter, Breeze (1985) study focused on strategies for the monitoring of the performance of National Health Services. They recognized three major components for evaluation: economic efficiency, social acceptability and medical efficacy. They had used different indicators and data set to achieve each of its objectives. As a means of monitoring the quality of curative services which were based on routinely collected statistics they selected 14 disease groups for which mortality was taken as an outcome indicator for the study. Age Standardized Mortality Ratios (SMR’s) were calculated in 98 areas for age ranges in which medical care was most likely to be effective. The indicators appeared to be effective and stable overtime and also identified significant variation between areas. The major problem while attempting this study regarding the performance of the health services was regarding the accuracy of information. The study observed that UK and USA has achieved similar reductions in mortality. (Walter, 1985)
Durgadas mukhopadhyay (1988) A critical appraisal of most media and a plea for traditional media in health education and communication. Education and communication are important component of health care system. Its most developing countries 75 percent or more of the health budget is it still devoted hospital and doctored-based care for less than 25 percent population. And 90 percent of the total media budget is spent for the garish and valgure entertainment of less than 25 percent population. The message in the villages can involve themselves in the health care programmes. (Durgadas, 1988)

Ram and Mohanty (1989) in their paper attempted to access the variation in human progress and human deprivation among the major states of India like Punjab, Tamil Nadu, Bihar, Orissa, Kerala etc. The study has examined the nature and linkage between human resource development and demographic parameters at state level. Two indicators of human resource development namely Human Development Index (HDI) and Capability Poverty Measure (CPM) had been constructed at state level. It was found that there was wide variation in human progress and human deprivation across the country. Study found that greater investment in human resources with particular attention to poor states was essential for reducing poverty and population growth of our country. Human development brought together the production and distribution of commodities and expansion and use of human capabilities. (Ram & Mohanty, 1989)

Nandraj (1991) study aimed to find out the conditions of private nursing homes/hospitals in the city of Bombay and to find out the functioning of private nursing homes/hospitals. This study was undertaken for the committee set up by the Bombay High Court to go into the regulation and the laying down of minimum standards for nursing homes and hospitals. The nursing homes/hospitals were selected on a random sample basis from each of the wards in the Eastern zone of Bombay. The researcher visited twenty-four nursing homes/hospitals and physical verification was done along with a checklist and an interview guide. The study found out that fifty percent of the nursing homes were either in a poorly maintained building or they were in dilapidated condition. Most of the nursing homes were congested, lack adequate space. The passages were congested, and entrances were narrow and crowded. Seventy-seven percent do not have scrubbing rooms. Less than a third had qualified nurses. Seventy-seven percent of the nursing homes that had an Operation Theatre did
not have a sterilization room, while 66.7 percent did not have a generator. None of the nursing homes incinerate infectious waste material but instead dump it in municipal bins. None of them keep records of noticeable diseases. (Duggal & Nandraj, 1991)

Rao (1991) in his paper "Estimation of Community Health Status Index on the Basis of MIMIC Model" presented a multiple Indicators Multiple Causes (MIMIC) model, which treated the health status of the community as an unobservable variable. On the basis of this model, a community health status index (CHSI) has been estimated for 15 states of India using cross-section data on health indicators and health causes separately for the year 1971 and 1981. The index used by him was very useful in ranking the states in terms of their health status and in monitoring their progress. The estimated values of the structural coefficients in the model throw light on the differential marginal impact of improvement in health causes on the CHSI and also on the different indicators. (Rao, Estimation of Community Health Status Index on the Basis of MIMIC, 1991)

Soman Krishna (1992) studied the family dynamics of women’s health and illness and their interaction with the larger social processes. For this study the complete census of the socio-economic status of households was conducted. The sample was taken of 272 households. There were 971 individuals in the specified age group of 15 and above and 456 were women. The study found out that women continued to stay within the boundaries of households, performed labour without actively participating in decision making process. Estimates of annual reported illness of women showed direct differentials in socio-economic categories. For illness, women were dependent upon the private practitioners in the village who did not have any medical qualification. Women in the poorer section mostly used government services for immunization and iron supplementation. The reasons for women’s restraint in seeking medical treatment were their perceptions severity, sense of responsibility towards family, its economic conditions and priorities of men. (Soman, 1992)

Uplekar (1996) study attempted to understand the nature of the social and operational constraints affecting TB control and identified ways to remedy them. The study was conducted in the rural and urban areas of Pune district, Maharashtra. Data collected was both qualitative and quantitative in nature. Interviews were held of 605
households in 12 villages (in 6 primary health centre areas) and 408 households in urban areas in 42 census blocks, a total of 1013 households. Informal interviews with 299 TB patients in 6 PHCs and 3 urban TB clinics were conducted. Data was collected from the healthcare providers such as the health functionaries at different levels of PHCs and urban clinics and private medical practitioners in selected rural and urban areas. Data was also collected from the supervisory and administrative staff at the district TB center and the state TB directorate. Other sources of data collection included observations, informal interactions and focused group discussions, case studies with both the users and providers of health services. The study found out that the people who developed symptoms of TB generally went to private medical practitioners for treatment. The patients were rarely subjected to sputum examination. The emphasis always was on diagnosis based on the x-ray of the chest. Patients of TB preferred the services of private doctors for 2 reasons- less waiting time and convenience of clinic timings. But patients did end up in the public health services either by themselves or referred by private doctors chiefly due to their inability to pay for prolonged care in the private sector. Non-adherence to treatment by patients is known to be a major impediment in controlling TB. The reasons for this were high cost of care, disappearance of most of the troublesome symptoms on partial treatment, and also non-availability of services, low image of public services in people's mind. According to the study, about a third of the patients had incurred debts in order to bear the expenses of their treatment. Rural patients had spent almost double the amount spent by their urban counterparts. In the private sector, drugs and doctors were the main item of expenditure. In rural and urban areas, all kinds of private medical practitioners entertained patients of TB. They were oblivious to the detrimental effects of their management practices like x-ray based diagnosis, use of multiple irrational drug regimens, lack of education of patients, lack of patient follow up and total absence of maintenance of any kinds of records. These practices were due to inadequate basic training and lack of continuing education. So, training must be done and it must be made simple, demonstrative, on-site, periodic and cover not only the technical and managerial aspect but also the social and behavioral dimensions to help them tackle effectively the problems of non-adherence to treatment at the field level. PHCs have to be strengthened by providing them with adequate resources, and this need proper monitoring and surveillance from the levels above. (Uplekar, 2002)
McKinsey (1998) conducted in association with Chartered of Indian Industries (CII) found out that the healthcare system in India is quite poor. The study noticed that demand for healthcare has grown up in last 10 years, thus it required hard work and collaborations between government and private sector. Further, India has low levels of pre-payment and lack of competition between healthcare providers. The industry was unorganized in India with low spending on in-patient care, low affordability in industry, lack of standards and malpractices. (McKinsey, 1998)

Vimala nandkarni et al (1998) Health advocacy, implication for the social work profession studied health services development in India has been influenced by two powerful forces pulling it in different directions. The colonial values and practices and mentioned some analyzes of health, processes, strategies and impact and strongly advocates that health and social change be integrated in the social work curriculum. (nandkarni, 1998)

Bhat, Ramesh (1999) study gave an account of the policy initiatives by State Governments of Punjab, Rajasthan, Tamil Nadu, West Bengal and Maharashtra to develop relationships between public and private sector. Secondary data was used for the study. The study had concluded that in our country the public-private initiatives were in premature state. While designing a PPP venture, the government should pay attention on following aspects: Information, Public goal and Private initiative, Coordination and monitoring, Market subsidy and incentives, Institution and Organization. The study had emphasized on the importance of PPP as a form of privatization. If these measures were implemented properly, the ventures could provide an efficient and equitable option of healthcare delivery. (Bhat, 1999)

Parmar (1999) aimed to study the extent to which patients’ rights were respected or violated by private Intensive Care Unit (ICU) / Intensive Critical Care Unit (ICCU) in Mumbai. To study about the infrastructure, equipment, staffing and overall functioning and finally to examine the existence and non existence of regulation by various bodies expected to be responsible and their role. For this study, 40 private hospitals were selected from the central and western suburbs of Mumbai which displayed an ICU / ICCU board. The questionnaires were prepared based on a review of standard critical care books and literature available. The study found out
that there was absence of new and sophisticated gadgets that were needed for critical care. Life saving drugs was not stored in sufficient quantity. All hospitals in the sample employed non-allopathic doctors on a round the clock duty for critical care, where experienced, qualified specialists were needed. Basic cleanliness was absent. The charges per day levied on patients were exorbitant. There was total lack of holistic approach and teamwork amongst the specialists. There was no attempts made to upgrade the unit or the application of basic knowledge and concepts in critical care. The study found that many of those deaths in private ICU / ICCU could have been prevented, if the admission had been made in higher level institution. Many of the deaths were hushed up and the belief of the public that 'death in ICU / ICCU is expected' was taken advantage of. The lack of awareness about what was expected in terms of 'critical care' has helped the mushrooming of these units. The study also found out that the phenomenal mushrooming of private ICU / ICCU hospitals paralleled the commercialization of the medical profession after 1985. Kickbacks and commission in medical practice has been responsible for admissions to such units. Thus, as a solution people and doctors should be made aware of their rights and doctors their duty vis-à-vis health care for people. There is a need to lay down standards for every hospital and nursing homes, and they must be made legally binding. There is also a need to formulate laws, rules and regulations for private hospitals. Lastly, current private ICU / ICCU hospitals in Mumbai must recognize and adapt to the realities of available resources rather than permitting inadequate care detrimental to the health and life of the public and against all human rights. (Parmar, 1999)

Shyam Ashtekar (1999) investigated the primary health care: a forgotten perspective in India has been the poorest health profile among even the Asian nations. It is the basic causes of ill health like poor nutrition, unsafe drinking water, poor sanitation, poor literacy, low status of women within a family and society continue to stay with us. The fundamental reforms are necessary to both in the health care system and factors listed above. In health care system given first contact care facility in rural as well as urban area is the most important task that awaits us. Government also approach new scheme properly education training support, legal recognition, financial responsibility shared between users and government linkages with referral care and local institutions are all need for health care program. Primary health care is not
impossible, the resources are not wanting but there is neither will nor direction. As a nation we are need to correct this in exact time.

India overall health status is one of the poorest among world nations. It is a due to both poor living conditions and scant health care. The former drinking water safety and sanitation, nutrition and women’s low status are problem areas. In India can boast of a unique and large-scale quack problem that is bursting at seems and has damaged the very foundation of national health care. (Ashtekar, 1999)

Kapilashrami M C and etal (2000) examined the involvement of private sector in health: suggested policy guidelines and mechanisms are recent years all over the world at all levels of development are engaged in a creative search to find out the better ways of organizing and financing health care. It is concerns have been equity, efficiency and effectiveness. Respectively more developing countries are facing the burden of old unresolved problems and also newly emerging challenges. In many countries adopted in privatization, globalization and liberalization have become a important part of the political agenda. In India has been a significant role in private health care services system. Private health care center in estimated that about 57 percent of the hospitals and 32 percent of total hospital beds are in this sector.

Health policy guidelines in our constitution for the development of health, population, nutrition, education, children etc. The national health policy document also emphasizes the need to encourage private investment in the field of health. (Kapilashrami, 2000)

Padmanabhan B.S (2000) examined the health care: challenges ahead in this health policy in the new millennium should be address itself to strengthening the state run health infrastructure by increased allocation of funds and community involvement to ensure an efficient and also effective referral system, instead of shedding its responsibilities and leaving the poor in the lunch.

The MUCH-TALKED about year 2000 (Y2K) has been dawned but the commitment made 25 years ago by the member nations of the world health organization at Alma Ata to ensure health for all by 2000 is yet to be fulfilled. In India is no exception, despite the fact that well- designed plan and structure to research health care to all the people was visualized even 50 year ago based on the report of
the Bhore committee. The nation cannot be achieving a goal in a span of five decades; it is indeed a sad commentary. But it is not that there has been a lack of commitment; nor has been the policy and programme back up been wanting. In a successive the government irrespective of the party in power have pronounced that health of the people is an important factor of national development and needs to according the highest priority. The fact, this led the government to re-state in the eight plan its goal as “health for the under-privileged by 2000”. But even this has been become elusive this does not mean that the national health policy of 1983 and the programmes initiated so far under it have had no impact whatsoever. (Padmanabhan, 2000)

Mahal, Ajay (2001) summarized the empirical findings on the use of health services by the poor, providing a national-level analysis as well as state level comparisons. It found that as in most developing countries, publicly financed and delivered curative health care services in India were more likely to service the richer segments of the population than the poor. The delivery of private services was more skewed in favor of the rich. Secondly, it found that those below the poverty line continued to rely on the public sector. Thirdly and importantly, the richest quintile used tertiary level hospital services both in and out patient more likely than the poorest quintile. Further, it was found out that public services in urban areas were found to be more equitably used than those in rural areas. Gender and caste and tribal affiliations on aggregate do not appear to affect utilization rates. Finally, large variations were found across states in public and private service delivery. (Mahal, 2001)

Padmaja K (2002), examined the user fees for public health care institutions the reasonable amount may be charged from those beneficiaries who could afford to pay them. Some amount can be set a apart for extending free medical facilities to the poor without imposing in any burden on the government. Health is a very essential to national progress and interims of resources for economic development nothing could be of greater significance than the health of the people. In people with sound health can be accelerate the pace of economic industrial and social development. Charaka the renowned Ayurvedic physician who are lived 2500 years ago had said “health is critical for the realization of the four fold aims of life ethical artistic materialistic and spiritual.
Public health care institutions are the last resort for the poor. Left with no choice they are availing these services inspire of so many an inconveniences. It is a proper and efficient running of these institutions is a most of the benefit of the poor. The government charging a reasonable amount from those institutions to improve the financial position of these institutions. (Padmaja, 2002)

Raj mani Tripathi (2002) conducted the health problems and health care of rural elderly according to WHO defines health as a physical, mental and social well being. It is reported that the first priority of the future should be full care of the aged. Children the aged necessity of health and personal care and hence the need to establish separate geriatric wards in the hospitals with trained separate medical staff.

Ageing of society has been now become a worldwide phenomenon. The number of senior citizens and their ration to the total population has been increasing rapidly in the developing and developed countries. The advanced medical science, better nourishment, improved standards of public health has all contributed to increased longevity. This is a developed world has been taking effective measures to cope with the problems of looking after its growing number of senior citizens. But in developing countries have been so far a failed to take sufficient notice of this problem. Its plans to support the elderly are generally inadequate. In our society many old people living in long life is as adversity.

There are many causes for health problems of old people, such as living habits, diet, heredity, occupational and environmental hazards, lack of exercise and adequate health care and health systems for the aged. Health condition of the rural male aged is better than that of his female counterpart. 34.13 percent of male and 18.92 percent of female respondents rated their health as very good. Again there were 21.43 percent male and 36.49 percent female elderly. WHO thought that their health was fairly all right while 44.44 percent for male and 44.59 percent female elderly reported their condition an unhealthy. Improve the quality of life elderly today and tomorrow. (Raj mani, 2002)

Reddy (2002) in his study has considered health indicators and determinants of health status of people for 21 states of India for the year 1951 -1981. They studied the relationship between Percent of literacy and expectation of life in India. The correlation coefficient in case of males came out to be 0.97 and in case of females
0.93. Of the eight determinants, female literacy turned out to be the most important determinant of health status. Hence, it was pointed out that the spread of literacy must be paid due attention for the enhancement of health status. (Reddy, 2002)

Shresthova (2002) assessed the use of personal and professional transport use among women’s trade unions association in India and found out that in the majority of cases women and their families used public buses or walked to health outlets. Further, it reveals that women participating in his study were less likely to hire a rickshaw in cases of personal health emergencies (8 percent) than for the other family members (14 percent) which illustrated that even where intermediate forms of transport were available to access emergency health services, even better off professional women were less likely than other family members to use them. (Shresthova, 2002)

Susham Chandra (2002) conducted the new health policy focuses on primary sector in the biggest challenges for the successful implementation of the new health policy; the country should be paying more attention to in the coming years. The national health policy declared to the ailing health system and increasing the primary health sector outlay to ensure a more an equitable access to health services across the geographical and social expense of the country.

The government plans to increase its contribution to the health sector from 0.9 percent of the GDP at present to 2 percent over the next eight years. On the year 2010 the policy of envisages an increase in aggregate expenditure on the health sector from 5.2 percent of 6 percent. It has also been recommended to the states to increase expenditure from 5.5 percent to 7 percent of their budget by 2005 and further to 8 percent by 2010.

According to national health policy 55 percent of the outlay would be for the primary sector and 35 percent and 10 percent for the secondary and tertiary sectors respectively. (Susham, 2002)

Wagstaff (2002) in his study tried to quantify the trade-off between the health costs of rising incomes against the health benefits. Results showed that reducing income inequality and raising the share of health expenditure financed publicly might reduce health inequalities, but neither the effect is at all strong and nor is statistically
It is clear from the results that economic growth tended to increase health inequalities. Countries that were successful in raising their per capita incomes have paid their price in terms of higher health inequalities. Another finding of the study was that the countries with the lowest average rates of under-five mortality and malnutrition have the largest gaps between poor and non-poor children. Evidence from trends in health inequalities showed that health inequalities have tended to grow both in developing and developed countries at times of economic growth. The study suggested that this is probably due to technological change going hand-in-hand with economic growth, and a tendency for the better off to assimilate technology ahead of the poor. (Wagstaff, 2002)

Annigeri (2003) evaluated the district health accounts: an empirical investigation it is an economic reforms of combined with a research crunch have compelled planners and policy makers alike to constantly and frequently take stock of resources available to the vital health service sector. This is examining the health sector resources and financial flows accruing to this sector were for a long while limited mainly to public sector. This is a micro level concept of health in the hope of evolving in due course methodology applicable to broad areas such as the state and the country.

This is a policy makers and planners the health sector and seeking ways and means of finding a new source base for this vital sector. In the last two decade health expenditures of an economy both from public as well as private sectors. Efforts by able smith (1963, 67), Griffith and mills (1982) and mach and able smith (1983) are considered to be important milestones of the financial.

A carefully understanding of the financial flows to the health sector seems to have emerged as an important policy tool in the recent years. In any developing countries were conditions to measures of health expenditures from the only public sectors. (Annigeri)

Gita Sen (2003) conducted an inequalities and health in India its impact of economic style in women’s health and reproductive rights in India. This saturation continue to worsen unless the deep inequalities within the system. It has been established economic reforms of the year 1990s on human development in India. It
has a fair amount of public welfare its need to improve our general health and education level of the economic reforms is to be a successful impact. In India facing severe inequalities between rich and poor, upper and lower castes, women and men, to which health services are affordable and equitable is a crucial to the well being and indeed survival of the disadvantaged.

Before independence, the health survey and development committee (Bhore committee, Government of India, 1946) was health care should be universally accessed by all regardless of their ability to pay. Health status indicated appears to have slowed down and even stalled in some cases in the past decade. On 1990s decline in infant mortality was very slow down and also per-natal and neo-natal mortality have not fallen. In the 9th plan, planning commission has expressed concern at the drop in routing immunization of children. Maternal mortality is very high in the second round of the National Family Health Survey. (Gita, 2003)

Krishnavani (2003) Ecology and health the linkage, studied the deterioration of environment has a direct bearing upon the health of citizens. The prevention of ecological purity should be a high priority agenda for the state. Health is very important of peaceful life of every one these article shows general measurement of health, life expectancy, infant mortality rate, nutrition food, ill health human being because of water pollution, air pollution, noise pollution, green house effect and global warming etc. (Dr Krishnavani, 2003)

Nagda (2003) caste and health care utilization the trend, studied Rajasthan state, caste structure of population shows wide variations in utilization of health care facilities. A direct relationship between caste and differential health care utilization. Upper castes have better education, living standard and enjoy a better status of health than lower castes. It analyze the four caste means SC, STs, OBC, and Others. The infant mortality is higher among the SC and STs, who are invariably poor and illiterate. The upper castes were quite conscious of their health and though about prevention of diseases. (Nagda, 2003)

Natasha palmer etal (2003) studied a new face for private providers in developing countries, the use of private health care providers in low and middle income countries (LMICs). Studied a wide spread and is the subject of considerable
debate. They review have a new model of private primary care provision emerging in South Africa. It shows to private sector better than public sector in health care as well as low cost. (Palmer, 2003)

Paul J Vander maas (2003) studied population health are affecting health agendas, studied measures of population health (SMPH) combine information on mortality and non fatal health to represent the health. The important issues are the first one is selection of health domains and the measurements of health indicator the second one the calculation of health expectancies. (Paul, 2003)

Ramu v Baru (2003) examined the privatization of health services its identify the size and characteristics of private provisioning in health care in India, Pakistan, Bangladesh and Sri Lanka as well as the variations in the pattern of such private sector presence in these countries. The private medical practice and the dispensation of medical care for a price have been known for a long time. The commercialization, corporatization and marketisation of health care a phenomenon of the last quarter of the 20th century. The process of during the late 1970s and early 1980s thanks to a global recession, which enveloped both developed and developing countries, imposed a fiscal constraint on government budgets and encouraged imposed a fiscal constraint on government budgets and encouraged them to public expenditure in the social sectors.

After independence, the government of all four had committed themselves to investing and building a welfare state governed by principles of equity and social justice. But in expect Sri Lanka, which managed to build a universal and free welfare service did not invested in the welfare sector especially in health. Number of research questions which could be further explored include the structure and social characteristics of the private sector, what restructuring of the public sector has been meant for access and equity, experience of privatization for different sections of society and the volume and type of medical equipment being imported into these countries. (Ramu, 2003)

Ritu Priya (2003) examined the health services and HIV treatment by the five initiatives to provide anti-retroviral (ARV) treatment to three million persons worldwide by 2005 has been strong positive and negative implications when viewed from a
health system perspective, a political economy perspective and a positive persons perspective. In suffering due to the human immunodeficiency virus (HIV) warrants with prevention being long overdue (Priya 1994). Issues of ARVs in a public health programme are a vexed one. It is a pro-people perspective that opposes ARVs and reminds activities of the drawbacks of depending on ARVs for dealing with the same problem. In developing systems that institutionalize the moves towards holism in medical care by giving them concrete shape, can be long term achievements of the three by five initiatives. (Ritu P., 2003)

Ritu Sadana and Tikki Pang (2003) conducted to health research systems: a framework for the future an integral part of WHOs work is a research and its equitable use WHOs constitution says that “the extension to all people of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health”. Health research has been called a global public good. The United Nations millennium development goals require the health research for their achievement. This goals concern the reducing child mortality, improving maternal health, combating HIV/ AIDS, Malaria, Tuberculosis and other diseases; and eradicating extreme poverty and hunger. Importance of global health research mechanisms for bridging the health gap between rich and poor countries.

The better understanding and strengthening of national HRS will also make a valuable contribution to global health research by providing benchmarks and information on best practices and lessons learnt. (Ritu & Pang, 2003)

Savedoff (2003) has identified at least four different approaches for answering the question of "how much" a country should spend on health. These four approaches range from rough comparisons with other countries to a full budgeting framework. In general, the peer pressure approach was the easiest to quantify but probably the least informative. The political economy approach focused attention on the process of political decision-making, but is less likely to produce a quantitative estimate of requirements. Only the budget approach appeared to be both feasible and directly confronting the issues of current and desired health status, prices, effectiveness and tradeoffs. According to author, fundamentally there was no shortcut. This seemingly straightforward question cannot be adequately answered without doing the hard work of addressing these four basic questions together.
a) What health problems together.
b) What health status do we aspire to
c) How effective are our health services, activities and policies
d) What are the processes of inputs. (Savedoff, 2003)

Sunil Nandraj and Anagha Khot (2003) examined the accreditation system for health facilities: challenges and opportunities in regulatory systems increasing demand for good quality care from the middle class and the entry of private health insurance companies there is a need to examine mechanism such as a accreditation for improving the quality of health services. Health care delivery in the India is a mixed ownership patterns and differing systems of medicine. Health system is a achievement of demographic, infrastructural and epidemiological indicators. Health services are a respect to access, affordability, efficiency, and quality effectiveness services.

The quality of care available in the both public and the private sector has come under scrutiny. Private sector care is increasing evidence of poor quality as a measured by reported and actual diagnostic and treatment practices inadequate facilities and equipment: over prescribing and the subjecting of patients to a unnecessary investigations and interventions and failure to a provide information to patients. It is national and international policies promoting an increased in involvement of the private sector in the delivery of health services. (Sunil & Khot, 2003)

Xiang Biao and Theresa Wong (2003) analyzed the SARS: public health and social science perspectives it’s unprecedented in many ways. The first one, we may well be the first real epidemic of a globalised Asia. The second one it has been prompted a new measures put in place rapidly and with wide scope to counter the spread of the disease. Since its first reported detection in Southern China in November 2002, sever Acute Respiratory Syndrome (SARS) has spread to 28 countries. As of June 12, 2003, 8445 people around the world have been contracted the virus, 790 have died. The outbreak is a estimated to cost Asian countries between 10.6 and 30 billion US dollars.

SARS is unprecedented in many ways, in the first real epidemic of a globalised Asia, transmitted through an “international mobility that most of us take
for granted”. The tourism industry was one of the first casualties of the outbreak. The most impact of ASRS on the travel industry is also said to be ever bigger than the 9/11 attacks, which may lead to the loss of nearly six million jobs.

The second one they have been witnessed a slew of new measures put in place at an unprecedented speed and with in unprecedented scope to counter the spread of the disease. For example, Singapore changed its infectious diseases act to give health officials more than in punishing people who disregard quarantine orders and doctors instructions. (Xiang & Theresa, 2003)

Jayashree (2004) Aging men and health concerns studied healthy individuals are able to function well in order to ability to do so person’s definition is more practical. It is always associated with poor health illness and disability, these study found based on 58-65 year age group. The most common health problems reported were blood pressure and diabetes. Finally income plays an important role in managing health care of aging men their need for government and NGOs helps. (Jayashreee, 2004)

Kathleen Mc Garry (2004) Health and retirement studied retirement data is one of the most important decisions facing older workers. It suggests that poor health is strongly correlated with the decision to remain employed and that the observed correlated with changes in health and only weakly related to changes in financial variable. Because retirement plans ought to incorporate all expected changes in health that are affecting expected labor force attachment. (Kathleen, 2004)

Radhakrishna and Ravi (2004) in their paper have analyzed the trend in malnutrition over the past two decades and showed that improvement in health status have not kept pace with the reduction in poverty. About half of the population particularly children and women- the most vulnerable groups- suffer from various forms of malnutrition. This is seriously retarding improvement in human development and further reduction of mortality. The study showed that malnutrition is uneven across states. Some middle-income states such as Tamil Nadu and Kerala had comparatively better nutritional achievements than higher income states like Gujarat and Maharashtra. North-eastern states were comparatively better performing states and some of them have even out- performed Kerala. Concentrated efforts were needed to break the vicious circle of malnutrition among the poor. Improvement in incomes of the poor and the support of health services are the long term solutions to eradication of malnutrition. (Ravi, 2004)
Rao (2004) study objectives were to identify and assess the impact of critical factors that have a bearing on executive health, which included lifestyle and habits, stress level, common health problems, preventive measures adopted and facilities at the workplace. A survey on executive health was conducted on a representative sample of 275 participants during 2001-02. Over two-thirds of the respondents admitted that they have one or more health problems that have bothered them for more than three months. Among them, over half of them reported two or three health problems. Hypertension, gastric problems, headache and obesity were the major areas of concern. Junior and middle level executives suffered more from gastric and postural problems than their seniors. Obesity was dominant in the middle management level. Over two-thirds of the respondents took non-vegetarian food, go out for business lunches and undertake outstation travel; a little less than half sit for seven or more hours during a working day and consume alcohol in one form or the other and over one-fourth smoke. The stress profile of the sample was not alarming. But stress does contribute to health problems. Thus, this study pointed to the fact that employee health was a crucial determinant in organizational competitiveness and success. Further, greater insights were possible when executive health was correlated with other organizational factors. (Rao, Common Health Problems of Indian Employees, 2004)

Roy et al. (2004) studied the Social inequalities in health and nutrition in selected states. An India is committed to the goal health for all and in the last four decades. Because of so many primary health center and sub centers has been created. It examines the some state of nutrition inequality socio economic, and health among caste/tribe categories. Analyzed of differential between four major groups in Indian society. In this paper brought stratification of utilization of health care programmes and national statues. Compare the one state to another suffering from many problems because suggested firstly remove the social inequality particularly cast/tribe and income inequality. (Roy, 2004)

Sankar and Kathuria (2004) in their paper attempted to analyze the performance of rural public health system of sixteen major states in India. The study concluded that investment in the health sector alone would not result in better health indicators, efficient management of investments is required. The analysis of variation
across states in the health systems in the rural areas suggested that there were two critical ways to improve health outcomes. The first was to enhance the efficiency of health sector. The second was to create more infrastructures and thus provide better health access to rural people and make more physicians available in rural areas. So, in order to cure what ails the health system in many Indian states, efforts need to be made in the direction not only of providing more infrastructure but also using them in the most efficient way. This demonstrated that states should not only increase their investments in the health sector, but should also manage it more efficiently in order to achieve better health outcomes. (Kathuria, 2004)

Subramanian et al (2004) studied health behavior in context exploratory multi-level analysis of smoking, drinking and tobacco chewing in four steps. It was showed to describe the socio – demographic and economic patterning of smoking drinking & chewing behaviors in India there is strong relationship b/w the health behaviors and individual /house hold SEP they analyzed health behavior in this context of developed countries show not only impotent patterns which provide insights into the ecological understanding of what influences these behaviors but also are important bases for population-based interventions analysis presented here was a step in this direction and therefore necessarily exploratory. (Subramanian, 2004)

Suranjana Sharma (2004) studied health care financing in India; the government of India established the so many programmes for health. It is improved the public health and sanitation, hospitals. India’s expenditures of health is increasing compare with independence 1980s it had been family welfare programmes, and public health programme for urban areas has been found to be about ten times higher than rural areas. (Suranjana, 2004)

Uma maheshwri and Vijaya Khader (2004) Health based coping mechanisms in drought prone areas; studied water scarcity and crop failure are the main distressing features of drought. The event of illness households were faced with alternative choices between self-care and any array of providers including government clinics, private doctors, chemists, homeopathic doctor, anganwadi services traditional helpers, they postponed treatment or minor operations or undergoing sterilization for monitory considerations or not taking the treatment at all. (Uma & Vijaya, 2004)
Bloom (2005) in his study entitled “Public Health in Transition” explored the epidemiological transition of countries with rapidly expanding economies where chronic diseases were becoming the greatest challenge to health systems. In these countries people were living longer and developing diseases such as obesity, diabetes and heart diseases, which occurred more typically in developed nations like the United States. Bloom illustrated the economic benefits of using measures to prevent or reduce both infectious and chronic diseases. According to the study although health threats often cross national boundaries, there was no global organization in place to develop and coordinate an integrated response to such threats. A study listed eight recommendations that, if implemented, would have significant impact on health around the world. (Bloom, 2005)

Michael Bury (2005) Health and illness in a changing society, studied the British’s medical sociology communities. They analyzed medical sociology’s concerns and political context the policy relevant context of British medical sociology as well as the relive of sociologist on the government for research and finding this may also reflect medical sociology’s connection to the national health services and how sociology’s in the UK still have a place at the policy table. (Michael B. , 2005)

Deewan, Puneet, Chauhan (2006) study observed that a strong public sector TB control programme proved critical for provision of necessary advocacy, supervision in relation to building and sustaining partnerships with the private sector. Their study was held in a district of Kerala for detecting Tuberculosis (TB) patients and study found that there was a significant improvement in case detection. It was possible because of existence of a strong local government TB programme which was having adequate staffing, medication and capacity to monitor the partnership while continuing routine diagnostic and treatment services for the most of the TB patients. The Indian Revised National TB control programme has developed formal guidelines to help local programmes structure collaborations with private healthcare providers and non government organizations. These guidelines offered a diverse group of plans for the community of private providers, with options to participate in the referral, diagnosis and treatment of patients with TB. Further, the Indian TB program also made financial incentives available for local programmes to distribute to cooperating providers, although these incentives were not always used. (Deewan, Puneet, & Chauhan, 2006)
Gudipati (2006) assessed the India’s current health care system and its effect on India’s rural population and looked at the impact this may have on the country’s future. The Indian government has created an extensive network of public health centers throughout the country. While the network existed to serve rural and poor areas, these centers were grossly underfunded and understaffed. Evaluating the public health system requires looking at the current infrastructure of the system, the resource allocation within each public health center and at the qualification of the staff. Finally, it looked at public demand of the services provided by the public health systems. (Gudipati, 2006)

Anant Kumar (2007) reviewed the scope and limitations of self help groups in improving women’s health, focusing on their implementation in the state of Bihar in India. It critically assessed the extent to which SHG’s can be involved in attaining better health for women and children by exploring the crucial role of caste and class in access to health services. His study concluded that SHG’s failed to capture local structural contexts such as caste and class, and as a result, develop approaches that produced equitable health services provision to marginalized and poor people. (Kumar, 2007)

Amit (2007) study revealed that about 30 percent of cardiovascular patients who succumb to death in India fall in the age category of 35-64. About 15.2 million diabetic patients were there in India. The important observation was that the public health expenditure was far lower than that of Bangladesh, Pakistan and China with just 20.7 percent against 25 percent in Bangladesh, 34.9 percent of Pakistan and 45 percent of China. It revealed that the Percent of cardiovascular patients who succumb to death in India were estimated at 30 percent within the age group of 35-64 as compared to 12 percent in US,22 percent in China, 25 percent in Russia and 40 percent South Africa. He concluded that increased health budget should check the increased pressure of globalization, which could be the one reason for the same. (Srivastav, 2007)

Deoki Nandan and etal (2007) conducted the human resources for public health in India-issues and challenges in this is suitable skill mix and their appropriate development levels of health care set up are essential for the population. The
availability of human resources for health in rural areas and building their capacity in public health are daunting tasks. Further challenges include training policy.

Since independence, India has been developed a vast public health infrastructure which presently includes 144, 988 sub centers, 22669 primary health centers and 3910 community health centers, providing services to rural population. Besides over 7663 sub-divisional and district hospitals and others specialized hospitals are also functioning role in the delivery of health care. A huge training infrastructure is also available at national and state levels in both public and private sectors. Despite a well developed and extensive network of public health infrastructures: including institution for training and research the health outcomes is still behind the set goals. The influence of health care providers on health care provision and use of health care providers on health care provision and use of health care resources has been successfully recognized. Globally, human resources absorb a large part of public expenditure in the health. The low and middle income countries, cost of human resources for health usually amounts to 60 percent and 80 percent of the expenditure respectively. (Deoki, 2007)

Jayashree (2007) Health maintenance of retires studied health is a major concern in later life mean aged persons. Retires should develop a positive attitude towards life which would enhance their self-confidence. Physicians should change their negative attitude towards the elderly, all are retires planned for future before retirement. (Jayashree, 2007)

Peter Berman and Rajeev ahuja (2008) Government health spending in India studied the government of India become has set a goal increasing get health spending to 2-3 percent of G.D.P the simple understanding and tempting politically, spending levels is often not a good policy. They examined carefully recent trends in government spending on health in India. The government concerns suggest that increate in government health spending to be matched by increased skills government. Government –in both center and steps to plan and manage health spending wisely. In these boom items, increase the budget may be the casuist part of tasks ahead. (Peter & Rajeev, 2008)
Aishwarya and Sanjay K Mohanty (2011) assessed the mean of understanding the pattern of consumption expenditure and health spending in India. This paper examines the pattern of monthly per capita consumption expenditure (MPCE) by socio-economic and demographic characteristics of households using unit data from 64th round of national sample survey India 2007-08. Household consumption expenditure is analyzed with respect to food, non-food items, health and education. This is indicating that the share of health expenditure in India constitutes over five percent of total consumption expenditure and it is increases with age, economic status and educational level of the head of household.

The last decade, there has been a growing interest in understanding the total out of pocket (OOP) expenditure on health care of developing countries using unit level data at household and individual levels. These studies suggest the pattern of OOP expenditure on health care varies largely across the countries and is linked to the stages of demographic transition, development and public spending on health care. The growing OOP health expenditure to poverty and indebtedness and analyze the correlates land determinates of OOP expenditure. (Aishwary & Sanjay, 2011)

Yadawendra and etal (2011) conducted to the morbidity among elderly increase household health care expenditure, according to NSS 60th round data examines the effect of population ageing on health expenditure at the household and individual levels. It is a found that one quarter of the elderly reported their health as poor and the proportion increased with increase in age. It was more than 40 percent and it is increased with age so that per capital hospitalization cost for the elderly is four times higher than for others. Increasing age is characterized by progressive erosion of safety margins which leads to several physical and mental problems. The most aged people suffer from some ailment, are generally not aware of the consequences and need health care services. Often, health problems lead to major disabilities and restrict an individual’s movement, which makes his life miserable. Further, changing household’s structure implies an alternation in the living arrangements of the elderly, making them more insecure. (Yadawendra)
Zakir Husain (2011) Health of the national rural health mission studied it was a one of the program of an India. It’s related to family welfare, social health activities strengthening rural public health facilities. The actual delivery of the NRHM has fallen for short of its targets. The NRHM has succeeded in putting seek the issue of public health. At the top of government agenda, its constraints in creating the work force. Essential to provide the quality health services promised to a rural population of 75.4 crore. It is clear from the review carried out thus for that a good number of studies have been done in the field of health care. The most studied in inequalities caste as well as retire people suffering from income inequality and education. (Husain, 2011)

Anne Mills (2012) analyzed the health policy and systems research: defining the terrain: identifying the methods across low and middle-income countries on the one side and high income countries on the other side. There is confusion in the terminology relating to the study of health services and health system. This is discussed about the health services research literature and on recent work on HPSR. The labels of health systems research, health policy and systems research and health services research are the source of much confusion. They are own faculty of public health and policy of the London school of hygiene and tropical medicine, for example, those doing research on a topic such as hospital governance structures would be define themselves as doing health system research if the work concerns low and middle income countries, similar research in the UK world define themselves as health service researchers. The Alliance in 1998 for health systems has pioneered the broader term of health policy and systems research (HPSR), out of a concern to include the goal of influencing policy explicitly within the remit of health system research. They are explained how to production of new knowledge improve to societies organize themselves to achieve health goals. (Anne)

David C Mccoy and etal (2012) analyzed the systematic review of the literature for evidence on health facility committees in low and middle income countries. In community participation in health (CPH) was the first articulated within an international health policy circles as a very strategy for health improvement in a developing countries in the late 1970s. It is a running in parallel was growing appreciation for a more people centered land participatory from of development countries. (David)
Thomas J Bossert (2012) review the health systems is a avalanche of interest in health systems with countries, donors, international experts and academic institution all rushing to promote, fund or build capacity to address this wave of interest. This is literature on how to think about health systems, how to use of research on health systems to improve their performance and pleas for greater investment in knowledge about the health systems. It is a probably riding on the crest of this new wave and it will be important to make use of it to further our knowledge about how to achieve health system effectiveness. In goals economic uncertainty this wave may pass if we do not take advantage of it now.

This is added emphasis on the millennium development goals (MDGs) and the slow progress of toward their achievement in many countries, in international community and national governments have been turned increasingly towards attempting to reduce the health system constraints. During 2008, the G8 called for greater attention to health system strengthening as compatible with the prior focus on vertical programmes. In 2009, the World Bank convened a seminar on health system strengthening attended by representatives from the world health organization, GAVI and global fund. It is a healthy woman and healthy children calling for a health system funding platform was on initiated at the UN general assembly. In 2010, the WHO and others sponsored the first global symposium on health system research in Monteux, Switzerland. (Thomas, 2012)

**Section C**

**2.4. General Health Disease and Health Insurance**

This section covers articles which were related with studying General Health Diseases and Health Insurance.

Srinivasan R (2001) analyzed the health insurance in India a big business set up and tends to remain a loss leader in the some stages and can become a viable only in urban context with the large-scale risk pooling and effective demand. Health insurance is a properly developed and regulated can be act as a bridge between patients and provides balancing quality of care at reasonable costs with an effective and accountable health care. Health insurance has been growing phenomenon in more developing countries. In developing countries is a private health insurance starts to
among large white multi-national companies and percolates downwards especially to those group coverage. Health care systems evolve over time as a result of historical factors under the influence of economic and social factors. (Srinivasan, 2001)

Allyn L Taylor (2002) investigated the global governance, international health law and WHO: looking towards the future examined the evolving domain of international health law encompasses increasingly diverse and complex concerns. In the 21st century health development likely to expand the use of conventional international law to is create framework for coordination and cooperation among states in an increasingly interdependent world. Farther in health aspect of future international health lawmaking under the auspices of a single international organization is unworkable and undesirable, the WHO should endeavor to serve as a coordinator, catalyst and where appropriate, platform for future health law codification. In the leadership of by WHO could be enhance coordination, coherence and implementation of international health law policy.

Now a day international health law encompasses increasingly diverse and complex concerns, including aspects of biomedical science, human reproduction and clothing, disability, infections and non communicable disease and safety control for health services, foods and pharmaceuticals. Who its help enhance the development of national and effective international health law WHO will be able to provide intergovernmental organizations to promote effective global cooperation to address global health problem. (Allyn, 2002)

Hung and others (2002) conducted a study control of malaria: a successful experience from Vietnam involved the malaria remains a threat to almost 50 percent of the world’s population. The new cases simply estimated 200 million and 1-2 million deaths per year, the disease remains a major causes of morbidity and mortality. The new method of controlling malaria has appeared since the introduction of insecticide treated bednets (ITBNs) in the 1980s, and also they are not expected in the near future. The control of strategy comprising proper a application of existing means is advocated early in diagnosis and treatment (EDT) of symptomatic malaria to prevent progression to a sever and potentially fatal stages; preventive measures including use of ITBNs and selective residual spraying and predication, containment
and it is possible prevention of epidemics and strengthening of local capacities. It is use of ITBNs has been to reduce a malaria morbidity and mortality, this measure needs to be supported by an adequate on health care system providing EDT, it possibly at approach of ITBNs and EDT in is roll back malaria initiative, but there is a little study of the combined efficacy of these two approaches.

In the Vietnam, malaria became a very serious problem during the late 1980s and also early 1990s. In 1991, a total of 1642000 cases of uncomplicated malaria, 32000 cases of severe malaria and 4650 deaths from the disease were reported and resistance to a chloroquine and sulfadoxine pyrimethamine was widespread. The mountainous, forested regions of the country, which have limited basic health care facilities and are populated by ethnic minorities, were especially affected.

The results of this study provide the basis for further research into the advantages and disadvantages of these combined interventions, including operational and economic studies in areas of seasonal transmission or continued low-intensive transmission with seasonal increases. (Mark, 2002)

Ruth bell and others (2002) carried out a study on the improving equity in the provision of primary health care: lessons from decentralized planning and management in Namibia. This paper draws lessons from a review of primary health care services in Windhoek the capital of Namibia, undertaken by a regional health management team. In this review was carried out because of perceived increases in workload and inadequate staffing levels, arising from the rapid expansion of the city associated with inward migration.

Health sector reform in developing countries adding the decentralization of management and the provision of primary health care is expected to produce changes in the pattern of health service delivery and improvements in the equity of provision. This is requires that local heath management teams develop the skills to assess the adequacy of provision and to identify and implement ways of improving services. This paper analysis the Khomas regional health management team undertook a review of primary health care services in urban Windhoek, Namibia, in order to obtain evidence that would underpin local planning decisions. (Ruth, 2002)
Sukhan and etal (2002) assessed the cost of malaria control in China: henan’s consolidation programme from community and government perspective has it was introduced market reforms in the 1990s, government finance for public health fell and disease-control programmes depend on regulated user fees. Henan province with its population of 90 million provides a clear illustration of this trend. For example in 1970, Henan has the highest annual incidence of malaria in China (17 percent; 10.22 million cases). But in 1992, only 318 cases were reported (0.37 cases per 100000 population), and by 1993, Henan achieved the consolidation phase (“basic elimination”), only one step away from eradicating the disease. In this actions were taken, even though the economic costs of malaria control were unknown.

The problems in Henan are typical of many of the 19 malaria endemic areas in China, especially those above latitude 25degree N. Estimated the costs of controlling malaria in Henan, where disease control is at the consolidation stage, we examined input costs for each of Henan’s three malaria control outputs: vector surveillance; population blood surveys; and case- management. In the world health report 2000 ranks China a low 139th for health expenditure per capita and even though the population health is good it will deteriorate unless the health system improves. The report provides policy makers with timely information for planning malaria control and shows how much information can be collected. (Sukhan, 2002)

Cynthia B.E Chee and Lyn James (2003) examined the Singapore tuberculosis elimination programme the first five years that the Singapore tuberculosis elimination programme was launched in 1997 because the incidence of the disease had been remained between 49 and 56 per 100000 resident population for the preceding 10 years. In other activities are the revamping of the national tuberculosis notification registry, the discontinuation of BCG revaccination for schoolchildren the tightening up of defaulter tracing and the education of the medical community and the public. Singapore is an island city state with a total population of about 4 million, of whom 3.26 million are resident and 0.74 million non-residents on long term employment, student or social visit passes. Ethnically the resident population is 77 percent Chinese, 14 percent Malay and 8 percent Indian, with 1 percent being of other ethnicities. The proportion of people aged over 60 years is 11 percent it is projected that 27 percent will be in this age group by 2030.
Since 1965 Singapore has been made striking social and economic progress. The incidence of tuberculosis declined from 300 per 100000 in the 1960s to 55 percent 100000 in 1987 as a result of substantial improvements in environmental hygiene, housing and sanitation, the provision of medical services, the advent of short course tuberculosis chemotherapy, and the national tuberculosis programme mortality from tuberculosis decreased from 12 percent of all deaths in 1950 to less than 1 percent in the 1990s. However, the tuberculosis notification rate remained between 49 and 56 per 100000 populations from 1987 to 1997 respectively. (Cynthia & James, 2003)

Fu Dongbo and etal (2003) evaluated the implementation and quantitative evaluation of chronic disease self management programme in shanghai; China: randomized controlled trial that the chronic disease mainly focus on heart disease, stroke, cancer and lung disease are becoming a leading causes of disability and also premature death in China. The year 1996 total deaths in 81 percent of non communicable diseases. Chronic disease is also a major health care cost for China. In China, shanghai has been the heaviest burden of non communicable diseases, because it has the largest population and also the largest ageing population. Major primary health problem to be a chronic disease in shanghai. Self management for people with chronic disease is now widely recognized as a necessary part of treatment. Chronic disease self-management has been shown in the some county like united states, Canada and the united kingdom is to be useful in the maintain and improving patients’ health behavior and health status, while lowering health care utilization through the improved self managements skills, “self-efficacy” and better communication between patients and health providers. (Dongbo, 2003)

Law C.K and Yip P.S.F (2003), analyzed the healthy life expectancy in Hong Kong special administrative region of China the examined this paper identifies some problems of the two methods and discusses the accuracy of estimates of HALE that rely on data from the WHO assessment. The population of health is vital for health care planning at a country and also world levels. According to WHO defines health as “a state of complete physical, mental and social well being and not merely the absence of diseases or infirmity”.

45
Disability adjusted life expectancy (DALE) is one of the most summary measures of population health developed by the global burden of disease study to enable comprehensive assessment of the global burden of disease and injury, inform global priority setting for health research and report on trends in population health across the world.

In the Hong Kong SAR between 1996 and 2000 despite the fact that life is expectancy for men increased from 76.7 to 78.0 years and for women from 82.7 to 83.9 years respectively. Life expectancy should be used as an indicator in the planning of health care resources for policy makers needs careful thought. (Law & Yip, 2003)

Michael Hubel and Anna Hedin (2003) examined the developing health impact assessment in the European union in this article examines that it is not surprising the use of impact assessments has been pioneered at local and regional levels. Where the potential impact of the proposal cover a limited geographical area and the projects tend to be a specific and tangible, such as infrastructure plans for roads and airports (EU) is the potential impact of a piece of legislation or even a whole policy area, is much complex in adds further layers of complexity.

The EU interest in health matters and powers a regarding them has been increased so has its interest in interjectorily approaches to health. This a attributable to three factors. Firstly, the European community’s involvement in health is largely through work outside its narrow public health competence; secondly, there is already a strong tradition of impact assessments within the community, in particular environmental impact assessment (EIA). Finally, the community institutions are insisting on coherent approaches to health across polices.

In addition to the assessment of potential inputs has been to a take into account the social, cultural, economic and climatic diversity of the community and its member states, especially after enlargement. It is different political traditions and citizens and behaviors. (Michael & Anna, 2003)

Niyi Awofeso (2003) analyzed the healthy cities approach reflections on a framework for improving global health its reflections on a framework for improving global health. In this review examined the roots of the healthy cities concept of may
be traced back to 1844, when the health of towns association was formed in the United Kingdom to deliberate on Edwin Chadwick’s reports about poor people living conditions in towns and cities. In new concept of health in these concerns in the “new public health” era dates from the healthy Toronto 2000 convention in 1984 and subsequently, the enthusiasm of the world health organization in regional office for Europe to the translate its principles into a tangible global programme of action to promote health. According to world health organization health city as “one that is continually developing those public policies and creating those physical and social environments which enable its people to mutually support each other in carrying out all function of life and achieving their full potential”.

In health cities principles draw on a lot of work on the social determinants of health, notably studies initiated by Thomas Mckeown. He is proposed “invisible hand” of improved nutrition in various ways of most on important social interventions, such as improvements in living and working conditions, public health practices and human rights. In worlds the majorities of city dwellers are more important than public health shibboleths. (Awofeso, 2003)

Rashidah and Abdullah (2003) reviewed the NGO advocacy on women’s health and rights in southeast Asia in the Asia-pacific resource and research center for women (ARROW) it is a regional women’s in NGO committed to promoting and the protecting women’s health rights and needs, it is a particularly sexual and reproductive health and rights. In the focus of ARROW is to advocate for the countries to adopt some policy and pommes. They are gender and rights approach through accessible, affordable, comprehensive health, reproductive health and population policies etc. they are goal to this by strengthening women’s movements and encouraging civil society organizations to become stronger and more effective in holding the government accountable to international commitments, influencing policy agendas and gaining concern is how to a improvement of lives in poor and marginalized women and girls through advocacy particularly in the area of sexual and reproductive health and rights including violence against the women. This is impact of globalization and privatization as a part of health sector reform need to be understood and closely monitored as these are currently in the largest factors in reducing women’s access to health services. (Rashidah & Abdullah, 2003)
Riti Shimkhada and John W Peabody (2003) examined the tobacco control in India. The study analyzed that the control of tobacco use in developing countries has been lagged behind the dramatic rise in tobacco consumption. The India, third largest grower of tobacco in the world, amassed 1.7 million disability adjusted life years (DALYs) in 1990 due to disease and injury attributable to tobacco use in a population where 65 percent of the men and 38 percent of the women consume tobacco. Despite these measures, the new legislation will not be enough to control the demand for tobacco products in India. The Indian government must also introduce policies to raise taxes, control smuggling, close advertising loopholes and create adequate provisions for the enforcement of tobacco control laws.

Today of the 1.1 billion people who smoke worldwide, 182 million (16.6 Percent) live in India. Consumption of tobacco in India continues to grow at 23 percent per annum and by 2020 it is predicted that it will account for 13 percent of all deaths in India. Tobacco control measures can negatively impact of the economy by creating massive employment loss future national comprehensive tobacco control legislation in India will be require better understanding of the political economy. The Indian government begun to act on the seriousness of the situation and initiate a legislative process to combat this social ill. Its strong political but from the government and intense education of the population will be required if the tobacco epidemic in India is to brought under control. (Riti & John, 2003)

Wiput phoolcharonen and etal (2003) analyzed the development of health impact assessment in Thailand: recent experiences and challenges it is a difficult circumstances but with high hopes. So many years, the government has been taken a clear direction to change Thailand economy and society into a newly industrialized country. Some policies designed to fulfill this strategy, however added an investment in infrastructure and industrial development have been caused negative health effects on local people. On 2000 launched National health system reform has been initiated the new concept of civil involvement in public policy processes. In development of public health policy to pursue the principle of all for health in order to achieve the ultimate goal of health for all. (Wiput, 2003)
Indrani Gupta and Mayur Trivedi (2006) studied health insurance redefined health for all through coverage for all. In developing countries like India, health coverage countries to be an exception. Rather than a rule only low percent Indian’s. Currently have some form of health coverage district a government policy on health; the health sector is currently changing shape mostly due to market forces. Health for all India coverage it’s difficult to attain but next several years its positive change. (Gupta & Trivedi, 2006)

Parvanthy Sunaina (2011), examined the comprehensive health insurance scheme (CHIS) in Kerala: some issues of comprehensiveness and equity. This is implemented in Kerala from October 2, 2008 on the lines of the Rashtriya Swasthya Bima Yojana (RSBY). It is a caters to those below the poverty line, CHIS is envisages bringing within the insurance fold a larger population. This is attempts to discuss how to successful the scheme has been in providing comprehensive insurance coverage and also some issues of equity that it is a brings in its wake.

CHIS helps to provides financial access to services to the beneficiaries it does so only to a limited extent. This scheme with respect to enrolment of beneficiaries, empanelment of service delivery etc, quality of health is a demand side financing alternatives are initiated along with a supply side interventions is focus on improving the quality of services. (Parvanthy, 2011)

Barbara Wolfe and etal (2012) evaluated the income and health effects of tribal casino gaming on American Indians in the legalization of American Indian casino gaming in the late 1980s allows of examination of the relationship between income and health in a quasi experimental way. Income from gaming accrues to individual tribes members revenue and to the finance tribal infrastructure. In the year of from 1988-2003 on tribal gaming health care access and the individual health and socio economic characteristics data. They are use in this information within a structural, difference-in-differences framework to study the effort of casino gaming on tribal member’s income, health status, access to health care and the health related behavior. In this results given the identified estimates of the positive effect of gaming on American Indian income and on a several indicators of American Indian income and on a several indicators of American Indian health, health related behaviors and to health care.
In different socio economic status are associated with a large gaps in health status mortality, health risk behaviors, stress and psychological well being access to a care and health information. (Barbara, 2012)

Hongyun FU mark J VanLandingham (2012) evaluated the mental health consequences of international migration for Vietnamese Americans and the mediating effects of physical health and social networks: Results from a natural experiment approach”. In this literature on immigrant mental health is a extensive, major substantive and methodological gaps remain. There is a little population based research that focuses on the mental health consequences of migration for Vietnamese Americans. Generally wide range of mental health problems among immigrants has been identified; the potential causal or mediating mechanisms underlying these problems remain elusive. In this article addresses these challenges by employing a “natural experiment” design involving comparisons among three population based samples of Vietnamese immigrants, never, leavers and returners. This study investigates the long-term impact of international migration on Vietnam’s mental social networks and physical health on these migration related outcomes. In this results reveal both the mental health advantages and disadvantages among Vietnamese immigrants relative to the two groups of Vietnamese nationals. (Hongyun & VanLandingham, 2012)

Thus, in this chapter an attempt has been made to review different aspects relating to women and child health status, public health services, general health diseases and health insurance.