CHAPTER II
A REVIEW OF CONCEPTS AND LITERATURE

For reasons of convenience and better understandings this chapter has been divided into two parts. Part – I deals with review of concepts which are popularly used in this work. While Part – II is a summary of the review of available literature on health and family welfare.

II A Review of Concepts

The purpose behind review of concepts is to know the important concepts which are used in this study. With the help of the same this study attempts to explain the problem chosen clearly. The following shall be the main concepts used in regard to the health point of view.

II: 1

Health WHO Definition (1948)

“Health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity”

Concept of Well Being

The WHO definition of health introduces the concept of “Well being”. Psychologists have pointed out that the “well being” of an individual or group of individual have objective and subjective components. The objective Components relate to such concerns as are generally known by the term “Standard of Living” or “Level of Living”. The subjective component of well-being (as expressed by each individual) is referred to as “Quality of Life”
Standard of Living

Income and occupation, standards of housing, sanitation and nutrition, the level of provision of health, educational, recreational and other services may all be used individually as measures of socio-economic status and collectively as an index of the “Standard of Living” (WHO definition).

Level of Living

It consists of nine components, health, food consumption, education, occupation and working conditions, housing, social security, clothing, recreation and leisure and human rights. These objective characteristics are believed to influence human well-being.

Quality of life

Quality of life was defined by WHO as “The condition of life resulting from the combination of effects of the complete range of factors such as those determining health, happiness (including comfort in the Physical environment and a satisfying occupation, education, social and intellectual attachment, freedom of action, justice and freedom of expression.

Governments all over the world are increasingly concerned about improving the quality of life of their people by reducing morbidity and mortality, providing primary health care and enhancing physical, mental and social well-being.

Health Care

Health Care is an expression of concern for fellow beings. It is defined as a “multitude services rendered to individuals, families or communities by the agents of the health service or professions for the purpose of promoting, maintaining, monitoring or restoring health. Health care service might be staffed, organized, administered and financed in every imaginable way but they all have one thing in
common people are being “served”, that is diagnosed, helped, cared, educated and rehabilitated by health personal.

**Health System**

The health system constitutes the management sector and involves organizational matters, e.g. Planning, determining, primitives, moralizing and allocating resources, translating policies into services, evaluation and health education. The aim of a health system is health development. A process of continuous and progressive improvement of the health status of population.

**Level of Health Care**

Health services are usually organized at three levels each level supported by a higher level to which the patient is referred. These levels are

i) **Primary Health Care**

This is the first level of contact between the individual and the health system where “essential health care (Primary Health Care) is provided. A majority of prevailing health complaints and problems can be satisfactorily dealt with at this level. This level of care is closest to the people. In the Indian context, this care is provided by the primary Health Centres and their sub centres with community participation.

ii) **Secondary Health Care**

At this level, more complex problems are dealt with this care comprises essential services and is provided by the 4 district hospitals and community Health Centre. This level serves as the first referral level in the health systems

iii) **Tertiary Health Care**

This level offers super-specialist care. This care is provided y the regional / central level institutions
National Health Policy

The policy sets out specific goals and targets to be achieved by 1985, 1990 and 2000 A.D. The emphasis is on achieving Health for all by 2000 AD through primary Health care approach and attaining the long-term demographic goal of a net reproduction rate of 1 by the year 2000 at the lowest feasible levels of mortality. In particular it has been emphasized that the infant mortality rate should be below 60 per 100 live births and the terms of the century.

Birth Rate

Birth rate is calculated as the number of births in a year per thousand population.

Death Rate

Death rate is calculated as the number of deaths in a year per thousand population.

Infact Mortality rate

IMR is calculated as the number of live births per thousand population in a year.

Crude Death Rate

It is defined as, “the number of deaths (from all causes) per the 1000 estimated mid year population in one year, in a given place”.

Immunization

Immunity is defined as the resistance against an infecting organism. Immunization is something like insurance as it removes the element of risks. But immunization is better than insurance. Insurance compensates for loss or tragedy, while immunization prevents the tragedy in the first place.
**Maternal mortality rate**

Maternal death is defined as “the death of a women while pregnant or within 41 days of termination of pregnancy irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

**Vaccines**

Vaccine is an immuno-biological substance designed to produce specific protection against a given disease. It stimulates the production of protective antibody and other immune mechanisms.

**Contraceptive methods**

Contraceptive methods are, by definition, preventive methods to help women avoid unwanted pregnancies. Contraceptive that is safe, effective, acceptable, inexpensive, reversible, simple to administer independent of coitus, long-lasting enough to obviate regent administrative requiring little or o medical supervision.
II.2 A REVIEW OF LITERATURE

The purpose of this study is to review all the relevant material which has a bearing on the topic. This chapter is being helpful in surveying the relevant materials related to the research work.

Sunil Nandaraj in his study pointed out in The World Bank Paper on “Health Financing in India’ advocated privatization and liberalization of the health sector. The share of the private health in India is between 4 and 5 percent of the Gross Domestic Product. India probably has the largest private health sector in the world. This sector has enlarged greatly in the post independence period. Compared to state expenditure on health the private household expenditure is nearly four to five times more than that of the state. The study revealed that the size of Private Hospitals is much larger than brought out by the Govt. Secondly, that indoor care provided by private hospitals is much larger than public hospitals and this growth has taken place mainly in urban areas. The increase has occurred not so much because private hospitals are better equipped, efficient and manned by better qualified and more humans staff as because public hospital have simply faster to keep pace with the demand and have been starved of finds, are neglected and run down.1

Abhijit Banerjee E.t.al. in their study on “Health Care Delivery in Rural Rajasthan” attempted to examine a survey conducted in rural Udaipur to gauge the delivery of health care and the impact it has on the health status of the largely poor

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The quality of public service is poor despite the fact that they heavily use health care facilities and spend a lot on health care. The quality of the public service is abysmal and unregulated and private providers who are often unqualified provide the bulk of health care in the area. Low quality public facilities also seem to be correlated with worse health: controlling for age, gender, distance from a road, and per capita monthly expenditures, lung capacity and body mass index are lower where the facilities are worse. Yet villagers seem pretty content with what they are getting; 81 per cent report that their last visit to a private facility made them feel better, and 75 per cent report that their last visit to a public facility made them feel better. Self reported health and well-being measures, as well as the number of symptoms reported in the last month appear to be uncorrelated with the quality of public facilities. The quality of health services may affect health but does not seem to influence people’s perception of their own health or the health care they are getting, perhaps because they have come to expect very little. Improving the quality of health care in an environment where the clients themselves are not particularly interested in complaining about what they are getting, will not be easy. The onus will have to be completely with the state, either in its capacity as a direct provider or as a regulator, and it is not clear that it is particularly well-prepared for this additional burden.²

Dahiya in his study attempted to examine the participation of women in economic activities is now emerging a universal phenomenon. Women are increasingly joining the world labour market and also assuming the role of entrepreneurs all over the world. Women’s share in self-employment is not only very low but is predominates, overwhelmingly, in the unorganised sector. Women are in the process of revising and redefining their roles and values in all spheres of activities.³

Satya Sundaram in his review article viewed that the performance of the Indian Economy in respect of segments such as education and health leaves much to be desired. The quantitative expansion in these segment is not accompanied by any qualitative improvement no wonder, India ranks low on human development index. In the spheres of health and education, better management of resources should receive top priority.⁴

Gururswamy studied the Health Problems of Street Children. He found out that: 1) Hazardous working atmosphere giving room for occurrence of contagious diseases. 2) Continuous and monotonous work affects health standards, 3) Non-availability of balanced diet leading to virtual panic causing fatigue and partial blindness, 4) Prone to dangerous disease and physical handicaps owing to non-application of vaccines and timely injection to prevent common illness and 5) Prone to skin diseases due to unclean bodies and colthes.⁵

³ Dahiya, Emerging profile of women entrepreneurs and workers in India, *Southern Economist* Vol 39, No 7, Aug1, 2000, Page No. 7

⁴ Sathyasundaram, Infrastructure and economic development, *Southern economist* vol. 36, No.1, May 1st 1990

R.K. Jain and Bharti Jain viewed that capability poverty has a sharper focus on human health by Human development aims at enhancing the physical and mental ability of people, its measure deals with three essential elements of human life – longevity, knowledge and better living standards. The concept of welfare state is now extended to human development by recognizing minimum standards of health, nutrition, education, well-being and security which are basic to civilized life. Human development is an end in itself. A well nourished, healthy, educated, skilled and about labour force is the requirement of the day. As human development aims at enhancing the physical and mental ability of people life expectancy is the best indicator or health nutrition status.\(^6\)

Hamumappa studied the efforts of the Govt. both at Central and State Level will not be able to adequately meet the social infrastructure requirements of the population. This is mainly due to paucity of funds and also lower prioritization in the fund allocation for developing social infrastructure like education, health, drinking water, etc.\(^7\)

Janet Currie et.al. viewed that the link between AFDC participation birth weight by. AFDC – Aid to families with dependent children was introduced in 1935 as a way to protect children against poverty for the most part, the program involves cash transfers to single mothers. This paper examines the relationship between a mother’s participation in AFDC during pregnancy and the birth weight of her child. Birth weight is the single most important indicator of infant health.

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6. Ibid, pp 27-33
It is a significant predictor of infant mortality and morbidity and of health and learning disabilities in later life. From the study, it is known that mothers on AFDC are more likely to have children at younger ages, to smoke, to drink and to delay obtaining prenatal care. It is hardly surprising then that women who participate in AFDC during pregnancy bear children of lower weight than do other mother.\textsuperscript{8}

David Cutles viewed that “Health” is a multi-attribute concept, encompassing both physical and mental components. The increase in health capital from 1970 to 1990 was about the same for both income groups. However, the gap in health for persons over 65 narrowed over this period, with elderly individuals below the poverty level realizing larger gains in health capital than elderly individuals above the poverty level. Measure of health capital will allow us to examine the value of the medical-care system more systematically.\textsuperscript{9}

The world bank study conducted for the states of Karnataka, Bihar, Andhra Pradesh and Punjab could find that although India has made great strides since Independence, fertility, mortality and morbidity remain unacceptably high both compared to countries in the region and those at similar income levels. Almost a third of the Indian population live in poverty. The impact of poverty on health care and vice-versa is significant. Achieving National Health Targets and the related Millennium Development Goals will entail addressing challenges to


the existing health system. While the root causes of poor health outcomes are poverty and low levels of education, government stewardship of the health sector bears some responsibility. Since independence, public financing and provision of health care services has been the main foundation of health care policy. Public sector health programs in India have faced well-recognized problems such as inadequate access by the most vulnerable groups, poor quality and coverage of primary and secondary facilities and until recently an excessive focus on sterilization and inadequate focus on maternal and child health. The private sector has moved in to fill this gap. At Independence, the private sector accounted for just 8 percent of health care facilities. This figure had risen to 60 percent by the early 1990s. There is also mounting evidence that the private sector is providing an increasing share of primary health care and that large segments of the poor are using the private sector. Until recently, governments have not explicitly recognized their responsibility for health policies outside the public sector. To date, private health care institutions in India have therefore grown in the absence of an explicit policy to define their role. This has raised questions regarding the quality and legality of care as well as the exploitation of the poor. Recently the Indian government has requested World Bank support in addressing these challenges.

Ravi Duggal in his study on poverty and health viewed that countries with universal or near universal access to healthcare have health financing mechanisms which are single-payer systems in which either a single autonomous public agency or a few coordinated agencies pool resources to finance healthcare. This
contributes to both equity in healthcare as well as to low levels of poverty in these
countries. It is only in countries like India and a number of developing countries,
which still rely mostly on out-of-pocket payments, where universal access to
healthcare is elusive. In such countries those who have the capacity to buy
healthcare from the market most often get healthcare without having to pay for it
directly because they are either covered by social insurance or buy private
insurance. In contrast, a large majority of the population, who suffers a hand-to-
mouth existence, is forced to make direct payments, often with a heavy burden of
debt, to access healthcare from the market because public provision is grossly
inadequate or non existent. Thus, the absence of adequate public health
investment not only results in poor health outcomes but it also leads to escalation
of poverty. This article critically reviews the linkages of poverty with healthcare
financing using evidence from national surveys and concludes that public
financing is critical to good access to healthcare for the poor and its inadequacy is
closely associated with poverty levels in the country. The study could find that the
achievements of the public health sector in improving health outcomes during the
eighties received a set back with the economic crises of 1991 and the subsequent
economic reforms which followed under the Structural Adjustment Programme
(SAP) strategy commandeered by World Bank. During the 5th to 7th Plan periods
public health services and public health investment were relatively robust and this
got reflected in faster improvements in health outcomes, to begin with in
developed States and to be followed by the underdeveloped. This approach
received a set back at the turn of the nineties when resource commitments in the
public health sector declined, and especially so in the developed States13. This is
reflected at one level in slowing down of improvements in health outcomes and the widening rural-urban gap of these outcomes. At another level, the public health care facilities are getting incapacitated because the necessary inputs that are needed to run these facilities are not being adequately provided for. The 2002 National Health Policy unashamedly acknowledges that the public health care system is grossly short of defined requirements, functioning is far from satisfactory, that morbidity and mortality due to easily curable diseases continues to be unacceptably high, and resource allocations generally insufficient. The study could conclude that this would detract from the quality of the exercise if, while framing a new policy, it is not acknowledged that the existing public health infrastructure is far from satisfactory. For the out-door medical facilities in existence, funding is generally insufficient; the presence of medical and paramedical personnel is often much less than required by the prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and the buildings are in a dilapidated state. In the in-door treatment facilities, again, the equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services.

Strauss and Thomas (1998) in their study attempted to examine the reverse causality and inter-dependence between health, income and economic growth. They identified that there is a close association among them.

Pritchett and Summers estimated the effect of income on health, measured by infant and child mortality as well as life expectancy. Some authors have also inquired into the distributional aspects of the income-health relationship.\textsuperscript{12}

Preston used cross-country evidence and suggested that the effect of income improvements on health was greater for the poorest countries than for the richest countries.\textsuperscript{13}

Bourgoignon noted earlier that health improvements contribute to income improvements or growth. With much evidence also pointing to the growth-poverty reduction nexus, better health can be seen as a factor that contributes to poverty reduction via some form of trickle-down mechanism.\textsuperscript{14}

Rough computations by the World Bank, using National Sample Survey (NSS) data, suggest that ill-health and associated economic losses cause as much as 22 lakh Indians, most living marginally above a poverty line standard of living, to temporarily fall below the poverty line each year, owing to a combination of income losses on account of being unable to work and declines in non-medical care consumption. The NSS for India for 1995-96 also reveal that when the poor fall sick, they are often unable to afford treatment, and even when they do decide to get treated, tend to sell off productive assets and rely on borrowing, all of which have the potential of decreasing their long-run earning capacity and the capacity to take advantage of any trickle-down labour market advantages offered by a growing economy.

Anbumani the Union Minister for Health said that the center is formulation a scheme to accredit every hospital and clinic in the counting. A quality rating system would be drawn up in consultation with the Medical Council of India and the Indian Medical Association.\textsuperscript{15}

\textsuperscript{12} Pritchett and Summers, “Ends and Means in Public Health Policy in Developing Countries.” 1995, In P. Berman ed. Health Sector Reform in Developing Countries:

\textsuperscript{13} Preston, Making Health Development Sustainable. Cambridge, 1975, MA: Harvard University Press.

\textsuperscript{14} Bourgoignon Kabra S. “Health Legislations in India: A Probe” 2004, Health for the Millions 23(4) : 24-5.

\textsuperscript{15} Anbu mani, The Hindu. Page no. 4. Jan.17.2005
P. Chidambaram, The Union Finance Minister said that there was a need for “equitable distribution of available resources”, and proper Utilization of health services. In order to spread health care to rural areas, the advent in 2004-05 extended tax concession for new hospitals with 100 beds or more. In 2003-04, the Govt. spent Rs.7, 470 Corers on health, and in 2004-05, it has been increased to Rs.8, 438 Corers.\textsuperscript{16}

Duraisamy found evidence of a strong negative effect of income or total consumption expenditure on morbidity and household assets emerged as an important determinant of child survival and preventive health care (Duraisamy and Duraisamy 1995).\textsuperscript{17}

Deolalikar demonstrated that health was a significant determinant of labour productivity using farm level data.\textsuperscript{18}

A study on health, wages and labour supply by Duraisamy and Sathiyavan (1998) revealed that a 10\% increase in the body mass index of males and females increased their wage rate by 7\% and 2\% respectively and labour supply by 20\% and 11\% respectively.\textsuperscript{19}


\textsuperscript{16} P. sChidambaram, \textit{The Hindu}. Page no. 6. Jan.19,2005
\textsuperscript{19} S., A. Mills and B. McPake, eds. \textit{Private Health Providers in Developing Countries: Serving the Public Interest}? London: Zed Books.
The NCMH study on the Delivery of Health Care Services in India empirically examined the linkages between health, poverty and economic growth at the sub-national (State) level in India was constructed a panel dataset of 14 States, including observations every ten years-1970/71, 1980/81, 1990/91 and 2000/01. This study was confined to the major Indian States for which consistent time series data were available. The States excluded from the study are: Jammu and Kashmir, Goa and Himachal Pradesh, eight north-eastern States, and seven Union Territories. In the year 2000, three of the States included in our sample, Bihar, Madhya Pradesh and Uttar Pradesh, were bifurcated. We have merged the data on the new States (Chattisgarh, Jharkhand and Uttaranchal) with their respective parent States and constructed a comparable series of all the variables for the study period. The States included for the study account for 90% of India’s population and 83% of the country’s total land area at present. State-level income and per capita income are represented by the respective State’s NSDP and the per capita NSDP (PCNSDP). Data on the NSDP and PCNSDP are produced on a regular basis by the Central Statistical Organisation (CSO) of the Government of India. These data were obtained from publications of the EPW Research Foundation (2002a, 2003) and CSO (2004). The value of NSDP and PCNSDP in these was reported in current prices and this had been converted into constant price series using a GDP deflator. The poverty variable was the head count measure, i.e. the proportion of the population living below the poverty line. The study analyzed the resource requirements for meeting certain targets of the health sector and analyses the gap between the required and the actual expenditure in 15
major States in India. It highlights the extent of resources that can be mobilized at the State level to meet the resource gap and estimates the residual gap that has to be met by Central transfers. Estimates indicate that the additional expenditure required for meeting the specific norms/targets in health and related sectors (which include safe drinking water, sanitation, nutrition, primary schooling and roads) is about Rs 300,168 crore. It was also argued that the expenditure on primary schooling and roads has various other positive externalities and are not exclusively incurred towards health. Although, not exclusively towards health, these expenditures have a significant bearing towards health outcomes and cannot be ignored if one has to reach the health targets. Even if one focuses only on medical, public health, safe drinking water and sanitation, which are directly incurred towards health outcomes, the total requirement is about Rs 100,415 crore.

In general, there is a deficit of about Rs 247,503 crore at the State level. The requirements are particularly high in States with low per capita income and high poverty levels. These are also the States where the productivity of expenditure and delivery of services are particularly poor. If one is constrained on the resource front, these aspects have to be specifically focused upon. Improving the productivity of expenditure and delivery systems in these low income States can actually reduce the resource requirement. However, it would be too optimistic to expect any appreciable improvement in the productivity of healthcare expenditure in the near future. In particular, it may be noted that the level of productivity and delivery systems are often affected by a number of social, cultural and historical factors which change slowly over time. These improvements therefore cannot act
as a substitute for increased allocation of funds in the short run. One therefore has to find resources to make increased allocation to healthcare expenditure in the next five to ten years. Increased allocation to healthcare expenditure can be done by (i) raising more resources; (ii) reprioritizing the expenditure allocation in favour of medical and public health, water supply and sanitation; and (iii) targeting the expenditures to States and regions where the health indicators are poor and have considerable catching up to do. The possibility of raising additional resources has been discussed at length. We have compared our estimates of taxable capacity with the estimates made by the TFC. The ability of the States to contribute additional resources to the health sector critically depends on their effort in raising revenues close to their capacity. The study suggested that achieving the MDGs and the Tenth Plan targets would require significant additional resources and improved productivity in spending to focus on outcomes rather than outlays. Much of the intervention in this area will have to come by way of consolidation of a plethora of Central schemes prevailing at present, and augmentation of specific purpose transfers for broadly defined purposes. The paper also argued that the appropriate design for targeting, preserving the incentives and to ensure participatory provision is to have a specific purpose transfer with matching contributions from the States, the latter varying with the level of their development.  

Ramesh Bhat et.al. in their study focused analysing the hospital efficiency of district level government hospitals and grant-in aid hospitals in Gujarat. The

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study makes an attempt to provide an overview of the general status of the health care services provided by hospitals in the state of Gujarat in terms of their technical and allocative efficiency. One of the two thrusts behind addressing the issue of efficiency was to take stock of the state of healthcare services (in terms of efficiency) provided by grant-in-aid hospitals and district hospitals in Gujarat. The motivation behind addressing the efficiency issue is to provide empirical analysis of government’s policy to provide grants to not-for-profit making institutions which in turn provide hospital care in the state. The study addresses the issue whether grant-in-aid hospitals are relatively more efficient than public hospitals. This comparison between grant-in-aid hospitals and district hospitals in terms of their efficiency has been of interest to many researchers in countries other than India, and no consensus has been reached so far as to which category is more efficient. The relative efficiency of government and not-for-profit sector has been reviewed in this paper. It is expected that the findings of the study would be useful to evaluate this policy and help policy makers to develop benchmarks in providing the grants to such institutions.

According to Ramesh Bhat, Increasingly the governments are facing pressures to increase budgetary allocations to social sectors. Recently there has been suggestion to increase the government budget allocations to health sector and increase it to 3 per cent of GDP. Is this feasible goal and in what time-frame? Health being State subject in India and much depends on the ability of the State governments to allocate higher budgetary support to health sector. This inter alia depends on what are current levels of spending, what target spending as per cent
of income the States assume to spend on health and given fundamental relationship between income levels and public expenditures, how fast expenditures can respond to rising income levels. We present analysis of public expenditures on health using state level public health expenditure data to provide preliminary analysis on these issues. The findings suggest that at state level governments have target of allocating only about 0.43 per cent of SGDP to health and medical care. This does not include the allocations received under central sponsored programmes such as family welfare. Given this level of spending at current levels and fiscal position of state governments the goal of spending 2 to 3 per cent of GDP on health looks very ambitious task. The analysis also suggests that elasticity of health expenditure when SGDP changes in only 0.68 which suggest that for every one percent increase in state per capita income the per capita public healthcare expenditure has increased by around 0.68 per cent. 21

J.C. Pant. Studied the role of rural women in generating income or less economic participation is difficult to be analyzed is isolations as they are not a class in members. They work because that is the way of life. The contribution of women to the economy continues to remain grossly under reported. The role of women needs special attention to get a more clear picture of the economic role played by women hood in India.22

According to Satia et.al. considerable progress has been made in improving the health status of the population over the last half-century. Despite this impressive progress, many challenges remain. The life expectancy is still 4 years below world average. So is under five mortality (12 per 1000 per year)

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higher that global average. Lot needs to be achieved in managing the communicable diseases. New disease patterns and non-communicable diseases are also emerging as major challenges. In this paper we make an attempt to explain the tardy progress in the health sector. The programme management by public sector, allocation of public resources to health sector, centre-state roles and financing of programmes, private sector role, contribution and role of NGOs, public-private partnerships in health have been discussed to paint a broad picture. The paper suggests that key challenge in the next century is the leadership challenge and reforms in the health sector require several measures. First, it requires a policy and programme emphasis that ensures access to quality primary health care for all. Second, there is need for inclusive political dialogue and decision making which will involve community groups representing voices of the poor, local private sector and the government in operationalizing the new vision of health sector. Third, the social capital in the sector needs to be built up which will promote trust, cooperation and other norms that enable health markets to function effectively.

To Ramesh Bhat hospitals are an important component of the healthcare delivery system. Over the years, India has experienced a significant increase in the number of hospital beds to meet the growing health demands of its population. Most of this growth has been experienced in the small sized private hospital sector (popularly known as nursing homes in India). The corporate hospital sector, however, has not exhibited similar growth though private expenditures on medical
and health care in real terms have grown at 10 per cent per annum and
government of India initiating number of policy reforms after 1991 aimed at attracting more capital to hospital sector. This experience has something to do with the financial health and risks, as these are critical determinants in attracting private capital. Using the financial balance sheets and profit and loss account data of 128 hospitals in India, this paper examines the financial health of hospitals in the private sector. Based on 26 key financial ratios, the paper empirically identifies relevant dimensions of financial health of hospitals. These dimensions are: profitability, financial structure, overall efficiency, cost structure, profit appropriation, technology advancement, credit management, fixed asset intensity, liquidity and current assets efficiency. It then discusses the implications of the findings. Because of lower profitability, lower financial efficiencies and less understood economies of scale, the risks in the health sector are likely to remain high. Other risk factors are the geographic pull factor, long gestation periods, a highly fragmented sector and inadequacy of standards. In this scenario, new investment in the health sector will remain resource dependent on subsidized channels of funding and will be sensitive to the out-of-pocket payment of fees, which still remains the channels of revenue of these hospitals.

Ramesh Bhat in his study attempted to examine the financial, performance of private sector hospitals in India. The study was based on the financial state data private hospitals fro the year 1999 to 2004. Using 25 key financial ratios, the study finds six key financial dimensions, these are fixed assets age, current assets
efficiency, operating efficiency, financial structure, surplus/profit appropriation, and financial profitability/operating cost ratio. The findings suggest that over the years hospitals have shown marginal improvement in financial performance. Though the total amount of debt is not high, it is the cost of debt and ability to service the debt which is making debt burden high for hospitals. The financial risks in this sector are high because of lower profitability and lower operating efficiency.23

Kapilashrami et.al. viewed that During the recent years, countries all over the world, at all levels of development, are engaged in a creative search to find out better ways of organising and financing health care. The country has well formulated policy guidelines in our Constitution for the development of health, population, nutrition, education, children, etc. The constitutional amendments from time to time provide an overall framework for health and development and reflect the political commitments. The Constitution of India also directs the States to increase the level of nutrition and standard of living of people. Since health is a State subject, the implementation aspect lies with the States. Inadequate resources in the States usually affect the policy implementation. It has been observed in various Five-Year Plans that private sector has contributed to health and family welfare activities in the country. The national health policy document also emphasizes the need to encourage private investment in the field of health. The responsibility of health lies jointly with the public and private sector and an optimal public-private mix would be the best solution for the country. Besides

seeking private investments in health, certain essential structural and functional changes are mandatory for the public health system to meet the future challenges of health in the country. The article analysed the role of private sector in health and suggests some policy guidelines and mechanism for optimal utilisation of private sector in health. Review of the Existing Health Care System in India. The study found that over the years, the country has expanded the health care delivery system. The country has 1,36,815 sub-centres, 22,962 primary health centres, 2,708 community health centres, 38,605 hospitals and over eight lakhs hospital beds. The public expenditure on health care in India comprises spending by the Central Government, the State Governments and the local bodies. The health expenditure of the government has been ranging from 2.63 to 3.29 per cent of the GDP in the last two decades. It has been estimated that nearly 60 to 70 per cent of the government expenditure on health goes towards the payment of salary of the staff. This leaves a limited scope for improvement of logistics and supplies systems, equipment, etc., which are becoming costlier day-by-day. As a result, the quality dimension of health services in the government sector remains neglected.

The share of the total health expenditure has been estimated to be 75 per cent by private out-of pocket expenses, 16 percent by the State Governments, 6 percent by the Central Government and rest 3 percent by the corporate sectors. Conceptual Framework and Approaches for Privatisation in Health Sector Presently, countries all over the world are engaged in innovative ways of organizing and financing health care. As the key concerns have been equity, efficiency and effectiveness, many developing countries are simultaneously facing the burden of old unresolved
problems and newly emerging challenges like privatization, globalization and liberalization. Privatization in health care services may be achieved by way of change in ownership i.e. decentralization or dis-investment. The other mechanism is liberalization or deregulation which means the activities organized by the State would be provided by the private sector e.g. allowing government doctors to do private practice after office hours, allowing private doctors to use public facilities, etc. Privatisation in health service can also be done by the government by contracting out services to private agencies or by allowing the private sector to manage public health facilities. Privatisation of health care financing may also be done by way of user charges. Providing free health care facilities may tend to stimulate demand by each and everyone, including the rich who can afford user charges. But charging the poor is not a rational decision in a democratic set-up and may go against their social welfare. So, a system of differential fees, may be charged, based on certain criteria such as type of facility used, geographical location and socio-economic status of the patients. The other way could be that the communities may contribute towards a collective fund which could be utilized by them whenever they fall sick. The study viewed that one of the most important policy concerns of the private sector with regard to health is to have suitable regulations to monitor and control its allocation of resources. Hence, proper registration of private hospitals, nursing homes and clinics by the appropriate authority may be done. Proper guidelines for private hospitals, nursing homes and clinics may be issued to ensure resources on manpower and equipment are properly spend to take care of the priority health problems with a view to provide
maximum service to the maximum number of people. Another concern is to have regulations for equal distribution of services in different geographical regions. The measure for this could be in the form of subsidies for land, water, electricity, etc. for opening health institutions in the backward, underprivileged, isolated, and difficult geographical regions. Licensing of private institutions would also ensure equal geographical distribution of health facilities. Moreover, tax rebates on income/profits for private health institutions can be extended to cover the poor and underprivileged population. Quality of health care by the private sector is another crucial area. To ensure quality care, the government can think of measures such as accreditation of institutions, legislative measures to protect the rights of consumers such as Consumer Protection Act 1986; periodic monitoring of the facilities and services by appropriate technical authority, periodic training and continuing education programmes by professional bodies.

J.N. Kitchlu in his article reviewed that the constitution of India is its directive principles of state Policy pledges that the state shall, in particulars, direct its policy towards security……that the health and strength of workers, men and women and the lender age of children are not abused and that citizens are not forced by economic necessity to enter avocation unsuited to their age or strength, the children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and mat childhood and youth are protected against exploitation and against and material abandonment. 24

Janet Currie and Nancy Cole in their article “welfare and child health the studied. The link between AFDC participation birth weight FDC – Aid to families

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with dependent children was introduced in 1935 as a way to protect children against poverty for the most part, the program involves cash transfers to single mothers. The paper examines the relationship between a mother’s participation in AFDC during pregnancy and the birth weight of her child. Birth weight is the single most important indicator of infant and learning disabilities in later life. From the study, it is known that mothers on AFDC are more likely to have children at younger ages, to smoke, to drink and to delay obtaining prenatal care. It is hardly surprising them that women who participate in AFDC during pregnancy bear children of lower weight than do other mothers.  

Manonmani studied the determinants of health status to Tamil Nadu state in terms of three indicators, namely, crude Birth Rate (CBR), Crude Death Rate (CDR) and Infant Mortality Rate (IMR). She used per capita income and public healthy expenditure at constant price, number of hospitals, dispensaries, Primary Health centres and bed strength per million population. She has used time series of data for Tamil Nadu for ten years between 1981-82 and 1990-91. The study concluded that i) services of primary health center has been important in reducing the Infant Mortality rate and ii) Per capita income of people is the state and overall social development schemes improve the health status.

Gupta and Anil Gumber (1999) study review’s the various inimitatives towards decentralization in the formulation of the several world Bank assisted projects in population, health and nutrition with a focus on the problems that may arise in the effective implementation of the policy.

They found that the district level, the revenue department and zilla parishads play crucial roles in the provision of medical and health services to the citizens in several days. Panchayat Raj institutions can play important role.\textsuperscript{27}

Rudolf Adlung Antonia Carzaniga’s study provides an overview of the basic structure of GATTs and the patterns of current commitments in health services and of limitations. The study found that as the impact of liberalizing forces varies significantly among countries and sectors, so do the across commitments currently listed under GATTs while over 90 percent of WTO members undertook some form of communication of tourism services and about 70 percent included financial or telecommunication services in their Uruguay Round Schedules, less than 40 percent made commitments on education and health.\textsuperscript{28}

Grace Haria Antony, K. Viswaswara Rao and N. Balakrishana attempts to study the validity of the Human Development Index which is used widely to measure health inequality and standard of living. Health of the population is directly related to economic efficiency. Educational status, accessibility to basic health services and also on political stability, social and cultural development. HDI is extensively used to measure the standard of living of a country (UNDP 1998), India HDI is lower than 0.5 and was classified along with less developed countries.\textsuperscript{29}

Sathiush B. Agnihotri (2002) study examines the relationship between the male and female infant and child mortality rates. The analysis considers a

\textsuperscript{27} Devendra V. Gupta, Anil Gumber Decentralisation some Initiatives in Health sector, Economic and Political weekly, Vol XXXIV (6) Feb 6-12, 1999, pp 356-362.
hypothetical reference population where the male and female children are identical in all aspects. Analysis of the time series data on the infant and child mortality data for India and 16 of its major states reveals two broad patterns. In one, the male mortality rates decline faster and faster and are accompanied by high levels of residual female mortality. The second pattern shows a faster decline in mortality of the girl children with low or negative residual mortality rates for them. Surprisingly this pattern is seen in a group of states known for the general bias, relative’s prosperity and practice of infanticide or foeticide through pre-natal care.\textsuperscript{30}

Lavy and Germain (1994) measured the quality of health care in Gahan in terms of infrastructure (electricity and running water); personnel (number of doctors and nurses); basic adult and child health services, including the availability of a laboratory and the ability to vaccinate children and to provide prenatal post natal and child monitoring clinical services and the availability of essential drugs (ampicillin, chlroquine, Paracetomol) and an operating room.\textsuperscript{31}

C.Sathyamala studied the impact of the toxic gas leak at Bhopal on the Reproductive health of the women exposed to the gases on the seriously exposed area and the moderately exposed area, the study Gas demonstrate the adverse effect of the gases on the menstrual function but is an useful marker for epidemiologic research. This study has demonstrated that the toxic gas leak disaster has had an adverse impact on the reproductive health of the women and has underlined the need to carry out long term follow-up of the exposed population.\textsuperscript{32}


\textsuperscript{32} C. Sathyamala, “the impact of toxic gases on Bhopal”, \textit{Economic and Political weekly} Vol 26, No.27 July 2 1994 p.No 16
Bhowmick expressed that for a better quality of service of the MPW scheme, the population and the area which one MPW is supposed to cover intensively appears rather high, that is 5,000 population as envisaged, but in reality this figure exceeds upto 8,000-10,000. The government should draw its attention on check this trend, otherwise the level of achievement would not be up to expectation.  

It would be better if female MPWs alone are mad to work for family planning and women health education. On the other hand, male workers may be given more responsibilities to carry out other multipurpose activities rigorously and to cover more beneficiaries.

Multi-purpose health workers are lacking in professional skills for conducting their duties efficiently. There should be more doctors including lady doctors at the PHC level. More visits should be made by the PHC doctors to the sub level which is the major source of the delivery of health services. Government doctors should not be allowed to carry out private practice.

Finally, to motivate doctors for staying in the rural area, there should be orientation courses on sociological inputs for medical practitioners, so that they can perceive society in a better way and get attuned to the though realities in relation to health care activities.

Shantha Ramamurthi et al., opined that in developed status, villagers use private doctors on payment due to convenient timings of their, less cost

involved compared to PHC use by way of travel, loss of wages etc., Moreover the staff of PHC are burdened by twelve vertical preventive programmes imposed by the centre like malaria, filarial, T.B, leprosy, STD, AIDS, blindness and immunization programmes, in addition to family planning programmes. Thus these three factors – lack of resources, shortage of personnel, equipment and drugs, unequal distribution between urban and rural areas; and the burden of vertical programmes fail to serve the poor.  

Sanyal declared that the result extremely low utilization of PHCs leads to increased load of patients on the first level of referral hospitals (district) and there from on the secondary and even the tertiary level hospitals. The emphasis on PHCs ironically was somewhat effective in the urban areas complementing the urban bias in the expansion to higher level medical care. The surveys thus bring out this foremost inefficiency in the public system, the root cause of which is well known- the paucity of adequate number of physicians and nurses in the PHCs.

Abhimanyu Singh and Usha Singh are of the opinion that the health staff showed lack of commitment and the programme was being conducted in a routine manner.36 instances of corruption were also reported. The health staff charged Rs. 100 for attending to each delivery and Rs. 10 for giving each dose of

immunization. The poor are not able to afford this and are deprived of these services. Such levies were not possible in camps or during visits to village. So the health staff expected the villager to come to the centre. The irregular attendance of health staff at the PHCs discouraged the women from going there. Instead, the preferred to go to the sub divisional or district hospitals. More than 50% of the children also complained of acute respiratory infection, 80% of blocked nose and sleeping difficulty, 30% had fever and 15% had breathing difficulties. These cases did not receive the same urgent attention as diarrhoea. Children in Ranchi and Sahasra districts suffered the most.

Krishnan reveals that household economic status is one of the major determinants of health status. Though the public health system is able to provide basic health facilities especially in rural areas through the primary health care, due to inefficiency as well as insufficiency in the system it may not be able to fulfill the complete health needs of the people. In poverty stricken households, fulfilling day-to-day food requirements itself is a tough task and considerable allocation for health is a distant dream. It has been proved and well established that health and poverty are closely related. Indian health system is very regressive where the distribution of the burden of treatment is unfavourable to the poor and it contributes to the aggravation of poverty of especially in rural India.

Ray has made use of the ideas based on the experience of the ICDs project.

in East U.P. The data were collected in November – December 1984. An attempt has been made here to understand the functioning of the 23 Anganwadi Centres (AWC) the performance of immunization, health check-up and medical care is very poor. For the last five years almost in 50 per cent of the AWCs no immunization or health check – up activities were conducted by the health staff. In the case of polio vaccine and other kinds of immunization the course remained incomplete due to various reasons. A list of ANM sub – centers was supplied by the MO but during our visit we found that in several villages the sub – centers are working either in the office records or in the house of ANM. A discussion with the MO, Dy. CMP and CMO of the district revealed that this fact is known to the higher officials. The LHV, who are in charge of supervising the activities of the ANMs, rarely visited the sub – centres and villages within their circles. In fact, the existing health service itself has proved to be very poor and the extra responsibility added in one of the important weaknesses of this scheme.\(^\text{38}\)

**Nayar** opined the most important finding of the study is that utilization of health centres was influenced by the ability to deliver the complete package of services. Variation in the availability of specialists, Para-medical staff, facilities for medical investigations, physical infrastructure and the complimentary nature of these inputs were found to be responsible for the differential utilization rates. The study points out the non-availability of one or more elements in this package could affect the utilization rates. It is significant that despite all the

constraints in the existing delivery system, a large majority of the households in the sample expressed their strong preference for public health care system as against the private facilities. Only about 11 per cent of beneficiaries were dissatisfied with all the services of the centres in the eight states, while around 43 per cent were satisfied with the services, another 45 per cent were partly satisfied. The dissatisfaction was largely because of non-availability of medicines or lack of proper attention. The logic of completeness in the packages of services that was responsible for the differential utilization of PHCs could also be applied to the PHC as well.\textsuperscript{39}

Prema Ramachandran viewed that improvement in the health status of the population has been one of the major thrust areas for the social development programmes of the country. This was to be achieved through improving the access to and utilization of health services with special focus on under-served and under-privileged segments of the population. The extend of access to and utilization of health care varied substantially between states, districts and different segments of society; this to a large extent, is responsible for substantial differences between states in health indices of the population. Unlike the earlier era, the technologies for diagnosis and therapy are becoming increasingly complex and are expensive. It is likely that larger investments in health will be needed even to maintain the current health status, because the technology required for tackling resistant infections and non-communicable disease are expensive and this will inevitably lead to escalating health care costs.\textsuperscript{40}


\textsuperscript{40} Prema Ramachandran, “Health care during the Tenth Plan”, \textit{Yojana}, January 2003, pp. 60-67.
Fred Arnold et al., echoed the view that the percentage of children under three years of age who are underweight is very high in India, although the percentage has declined somewhat over time, from 52 per cent in 1992-1993 (NFHS-1) to 47 per cent in 1988-1999 (NFHS-2). This reduction of about 0.8 per cent per year is similar to the percentage reduction observed in other developing countries where the improvement is largely attributed to overall development rather than to the effect of nutrition intervention programme National Nutrition programme with successful the of 2-3 per cent year.41

Ratha Krishna and Ravi are of the view that the overall reduction in malnutrition has been very slow. About half of the population, particularly children and women and women- the most vulnerable groups suffer from various forms of malnutrition and a greater of them suffer from sever malnutrition. Malnutrition is seriously relating improvements in human development and further reduction of child mortality. The risk of malnutrition is higher among children whose mother suffer from chronic energy deficiency. Mother present nutritional status in turn depends on her childhood nutritional status. Concerted efforts are needed to break the vicious circle (mother – child – mother) of malnutrition among poor. It needs to be emphasized that reduction of child malnutrition would greatly depend on delivery of effective and sustainable intervention to children and their mother. Improvement of incomes of the poor and supply of environmental and health services are the long term solution to the eradication of malnutrition. 42

Deepa Sankar Vinish Kathuria in their study attempt to analyze the performance of rural public health system of 15 major states in India using the techniques from stochastic production frontier and panel data literature. One of the most important findings here is that health outcomes in the rural areas of Indian states is positively related to the level of health infrastructure in terms of access of the facilities and availability of skilled professionals such as doctors. At the outset, it is indeed a positive aspect that India’s health outcomes have improved over time, as revealed in the decline of infant mortality rates from 146 per thousand live births in the Mid – 1950’s to 72 in late 1990’s. This has been made possible of extending promotive, preventive and curative services to all segments of society, including those residing in rural areas.

Rameshan and Shailendra Singh expressed that the results reveals that the services renders by PHCs are deficient in many respects in the perception of customers and community members of the villages and that the doctors and the staff are unable to redress adequately the grievances raised by villages. It is essential to improve the utilization of available facilities. For this, the doctor and the staff must be made more committed the changing their attitude and mindset. Therefore, proper training and incentives for the doctors and staff are the need of the hour. Further adequate community support and local participation are necessary in making PHCs services effective and people-oriented.

44. P. Ramesh, and Sahillendra Singh, “Quality of service of primary Health centres; insights from a field study” Vikalpa Volume 29, No. 3, July - September 2004
Kalpana Sharma in her recent study on the status of health care in three Maharashtra districts by the centre for enquiry into health and allied Themes (CEHAT) found that almost half of the PHCs had no doctor, 75 per cent did not have medicines and only 18 per cent had ambulances. Even if the PHCs had ambulances, 40 per cent had no driver. In rural esthetics. Only two out of the 19 rural hospitals surveyed could perform operation. There are 24 villages under the PHC with a population of 1000 and only 930 of the 2,915 children below the age of five are normal. Out 32 are severely malnourished, while the remaining, 1,271 are in grade and 684 are in grade two of malnutrition. All the women walk five to six to the PHC every day with their malnourished children.\(^45\)

Diggual and Antia point out that the curative services are not a priority in the PHCs and sub-centres network, family planning and immunization work talking most of the time of the staff. If the PHCs could be energized for curative services, the cost of treatment could be brought\(^46\).

To Government of India that state responsibility in India health delivery has always had a pronounced focus on curative rather than convective care, and has always had a strong urban bias, even as primary health care in the country has still a long way to go in terms of quality and average, and the majority of Indians still live in rural areas. The primary health care network in the country, consisting of community health workers, village health workers, anganwadi workers, primary health centres workers, sub-centres, auxiliary nurse midwives,


male multipurpose workers and PHC doctors, has failed to cater to the health needs of the rural populace. Presence of accountability, inefficient planning and inadequate resource have PHCs and sub centre built across country in many ways non-functional; they often back doctors and medicines. Poor infrastructure across rural India compounds the people’s hardships. In the context, the work of non-governmental agencies, many of which have a long record of dedicated, innovative community health service, with an emphasis on preventive care and community participation, assumes much significance.

Durgaprasad is of the view that the problems of health care are enormous. Access to primary health care is inadequate to the majority of the population because of non-availability of basic preventive and promotive health care packages, clinics, doctors, drugs, and paramedical personnel in rural areas. Consequently, 60-80 per cent of expenditure on medical and health care are borne by people themselves in our country, which is too high a proportion for our levels of poverty, and Health for all by 2000 AD appears to be distant dream as a result. Supplementation of allopathic medical facilities by indigenous and traditional systems as in Kerala and Tamil Name can be attempted. Greater stress on preventive health care, medicine and health education should be laid improvement in drinking water and sanitation need to be doubled. Nutritional interventions should be followed up with promotive health care programmes. Health literacy efforts should be made integral to preventive, promotive

curative and rehabilitative health care, meaningful involvement of the private sector in all these endeavors would go a long way in evolving a people oriented and a sustainable health care system.  

Emmel stated that the strategy of PHC has been rejected primary health services are considered to be a list of technical measures add upto second that expensive curative service will become increasingly visible to the poor and available only to the privileged few. The Alma declaration was a document which emerged out of a strong desire for justice and equity. The community was emphasized as the agent of which, appropriately mobilized, could insist upon better health care better development, It was a call for mass struggle. The WHO has add PHC. Its approach is efficiency rather than equity; the market rather social justice; the expert with a magic bullet rather then interacted and health care provision; the disease rather than social, economic political development. Health for all for the 21\textsuperscript{st} century is a document reflects neo-liberal, right wing prescriptions at the expense of the dedre It is a return to economic trickle down and disease control.  

Ramamani Sunder said that some of the results of National council of Applied Economic research NCAER’s Household survey of care have important policy implications. The reported lower balance rate of illness for which medical treatment was sought for been and the female children indicate that the

“perceived need” for medical and is much smaller for the weaker sex. The health status of the can be improved only by changing their health perception. This can achieved by enhancing the status of women. 50

Another important finding of the survey is the greater reliance on private – sector medical care in both rural urban areas of the country. One of the reasons for this was the availability of private medical care at the shorter distance. The study also brought out the disparity between the rich and the poor in their dependence on private vs public health care facilities. In order to achieve the goal of health for all, the government has to ensure the availability of primary health care at a reasonable distance and cost for all sections of the population.

Imranna Qadeer in his public health perspective explains that the two things are clearly needed. First, within reproductive, priorities should be clearly articulated and reflected in the budgetary allocations, secondly, maternal and child health, nutrition, contraceptive services, and communicable disease control must be integrated. Within the sphere of the health service this will provide a solid foundation for women’s health including their reproductive health. Handling reproductive health in isolation in not only an inefficient way of dealing with the problem of women’s reproductive health but it also robs them of their dignity. An integrated approach alone can give optimal results by handling women’s health as an entirety. To achieve the best results the health service system needs supportive social, economic and legislative action favouring women. 51

Swapna Mukhopadhyya is of the view that women’s health has never held the center stage in official thinking and policy design in India, except in the limited context of women’s child-bearing functions. The alarmingly high levels of maternal mortality and morbidity cited in the reported of the Bhore committee and a number of other committees government to subject maternal and child health to separate action under the five – year plans. In terms of the percentage budget allocation for health, however, MCH has been a very insignificant 52.

Aliva Mohanty and Tripathy are of the view that health is mental of human progress. Women’s health status affects their activity and thereby affects their social roles in society and development. Activity affects health, the effects of women’s work, income or economic status. Nutrition is closely interlinked with health. Low personal status of woman makes her more prone to several diseases – a various health status. It assumes special significance in the cases of because they bear and rear children. According to them child health affected by the ill health of the mother 53.

Rashmi Mishra viewed that the question of women’s health is woven into the process of development of any nation. Greater for women impacts positively on the health of other family members. In the status of livehood both in quality and quantity are visible recently in Orrissa viz., (a) birth rate which was 15.3 in 1968 has come 11.1in 1998, (b) life expectancy at birth for female which

was 49.5 the period 1980 has gone up to 61 during 2001. (c) child marriage is in vogue, (d) infant mortality rate which stood at 149 in 1979 has to 98 in 1998, (e) Universal immunization programme is being children has reduced from 3.78 per cent in January 1998 to 2.65 per in September 1999. In spite of all these measures gender differential in matter of nutrition and healthcare especially in case of pregnant women nursing mothers are still prominent. Antenatal care, safe deliveries with social paramedical personnel and post-partum monitoring are main factors behind safe mother hood. The proportion of pregnant women living antenatal care (at least twice) and those who have had deliveries over medical attention are highly correlated. Accordingly, safe mother and index (SMI) is constructed for each state by taking simple average of more two proportions, separately for rural and urban areas.\(^{54}\)

**Thiruvenkitaswamy** examines the health status of children in rural and urban areas of Maharashtra. The results show that the state for ahead of all Indian States except Kerala and Tamil Nadu. But the variation between the rural and urban areas in terms of child health is very low. Poor economic status of the households is the major cause for poor status of child health along with poor literacy, lack of infrastructure, efficient public health services, etc., Hence radical policy changes on allocation of resources and power is an immediate concern for the government of child health and to reduce the rural and urban disparities.\(^{55}\)

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Abusalch Shariff conducted a survey which provides information regarding the percentage of immunized children in the 1 to 2 year age group and 0 to 2 year age group against DPT, Polio, BCG, and Measles and also regarding those who were immunized against all possible disease. About 50 per cent of the children (1 to 2 years of age) were fully immunized in rural India although the proportion of partly immunized children at 64 per cent. The proportion of both fully immunized and partly immunized children was higher among the economically developed states of Haryana, Gujarat, Maharashtra and Punjab and among the southern states of Kerala, Tamil Nadu and Andhra Pradesh. Immunization (Full and part) was low in Rajasthan (only 21 per cent of the total children) followed by the states in the North – eastern region and Bihar. This may be attributed to the better availability of health care infrastructure that plays a dominant role in higher levels of immunization among children. 56.

Franciszavier expressed that in the country as a whole, 65 per cent of the women reported that they had received Antenatal care (ANC) during the last pregnancy, but the regional estimates suggest a range of variation from 2 in the extremely arid region of Rajasthan to 100 per cent in the central coast of Kerala. The level of Antenatal care was over 80 per cents is most areas of peninsular India. In coastal areas and in the extreme south, the levels crossed the 90 per cent mark. 57.

Children among those who were aged 12-23 months at the time. Children who had a BCG vaccination, three polio drops, three had one measles vaccination at any time before the interview have been to be fully immunized.

In the 76 regions the percentage of fully immunized children from 12 in Nagaland to 79 in Bisht Doad of Punjab. All regions of Maharashtra and Tamil Nadu showed high levels of immunization, but none regions had reached universal immunization.

Padmananthan Sundar that the Much-Talked about year 2000 has dawned but the commitment made 25 years ago by the member of the world health organization at Alma Ata to ensure health for all is yet to be fulfilled. India is no exception, despite the fact that designed plan and structure to reach health care to all the people was proved even 50 years ago based on the report of Bhore Committee. If cannot achieve a goal in a span of five decades it is indeed a sad dfnty. It is not that there has been a lack of commitment; nor has the programme back-up been wanting. Successive governments, positive of the party in power have pronounced that health of the people important factor of national development and needs to be accorded the priority. However, translation of these into action at the ground level edd out to be far below expectations. Particularly in respect of health delivery or rural population and urban slum-dwellers. In fact, this led the management to re-state in the Eighth plan its goal as “Health for under by 2000”. But even this has become elusive.

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Shivani Dharmarajan opined that health of a nation can best be judged by the health status of its people. So far, experts have considered general mortality, infant mortality and expectation of life a birth to be the primary determinants of improved health status. However, studies on fertility, morbidity, the impact of health programmes and the use of health services, have recently been introduced to assess the status of a population. Mortality data, nevertheless, still remain an integral part of health situation analysis. Historically speaking, at the time when India won its independence, the health situation in the country was extremely dismal. However, considerable progress has been made over the last five decades; this is reflected in the improvement in some health indicators (like the crude death rate, infant mortality rate and life expectancy). Overall, mortality (in particular, infant mortality) has declined dramatically and life expectancy at birth has increased to 62 years.59

Anant Kumar says that as malnutrition amongst the child population in the country is widely prevalent, it follows that a moderate to severe degree of malnutrition would persist among girl child too. As a consequence, the malnutrition persists throughout adolescence and in pregnancy. As a result, the growth and development of urban child is affected, giving rise to low birth weight. About 30% of the total births in the country constitute low birth weights and this in turn leads to high infant and child mortality and morbidity. According

59. Shivani Dharmarajan, “NGOs as Prime Movers Sectoral action for social Development”, NOGs and Health Care in Third World, First Published 2001, Kanishka Publishers, Distributors, New Delhi, Pp. 222-227
to the NNMB data (National nutrition Monitoring Bureau) a very high proportion of girls are at obstetric risk as they enter the 14\textsuperscript{th} - 15\textsuperscript{th} year of life with a height less than 145 cm and weight less than 38 kg. Adolescent girls need to be considered as a package services/facilities, when will enhance their capacity for advancement and enable them to become capable citizens.\textsuperscript{60}

**Ministry of health and family** welfare expressed the view the number of antenatal check-cups and tinning of first check-up are important for the health of the mother and the outcome of the pregnancies. These conventional recommendation is to schedule the first check-up within weeks of the women’s last menstrual period. The reproductive and child health programme includes the provisions of at least three antenatal care units for pregnant women and requires that each pregnancy should be registered in the first 12-16 weeks. Thus the first antenatal check-up should be place at the latest during the second trimester of pregnancy.\textsuperscript{61}

**Pattanaik** has rightly remarked that although government programmes India gone a long way in reducing the number of women dying from maternity related causes, the number of pregnancy related deaths in rural areas in the country are still among the world’s highest. Moreover, many studies have shown that rural women engaged in hard physical labour during pregnancy delivered low weight babies.\textsuperscript{62}

**Arvind Pandey et al.,** are of the view that women living in urban areas are more likely to go for ANC services compared with their rural counterparts.

\textsuperscript{60} Anant Kumar, “Poverty and Adolescent girls Health’, *Yojana*, Sep. 2001, Vol 45, pp. 30-32.
Similarly, women with lower birth order are more likely to use ANC services than women with higher birth order. The same study shows that women with higher birth order utilize less delivery care services than women with lower birth order. These findings suggest that there is need to appraise rural women and those with higher birth order about the importance of ANC services in all the three states studied. Moreover, promotion of better health care practices among women could be enhanced by better participation of private, public, and non–governmental organizations working in the area of health and development.  

Bharattacharjee reveals that the family planning acceptance was by and large selective. Overtime, there had been a large-scale expansion in the health delivery system including infrastructure facilities in order to provide services particularly the MCH and family planning. This infrastructure facilities along with large number of medical and paramedical staff and substantial funds were put in to action to achieve higher rate of family planning acceptance. This specific push in the programme has succeeded in breaking the socio-cultural barriers to achieve its size. It has been observed that there are some specific advantages of higher age at marriage such as lower of pregnancies by reducing the span of fertile union, better health of mother and child etc., Many population experts have demonstrated from the analysis of various survey data and with hypothetical situation that increase in the age at marriage would reduce the birth rate both in the long term and in the immediate short term. The range of variation is estimated to be at 10 per cent to 30 per cent in reducing birth rate.

Mishra et al., endorsed the fact that in India, empirical evidence illustrates that the integration of family planning and health services, especially maternal and child health services, has a positive bearing on the family planning programme, which eventually improves the health of the mother and her child.\textsuperscript{65}

\textbf{Special correspondent} viewed that according to the reproductive and child Health survey 1998, the unmet needs for contraception are high in Bihar (42 per cent), Uttar Pradesh (38 per cent), Rajasthan (28 per cent) and Madhya Pradesh (27 per cent). About 60 per cent of the growth can be attributed to the large size of population in the reproductive age group, which is often referred to as the ‘momentum’ factor. Another 20 per cent of the growth in population is due to the high unmet needs for contraception and the remaining 20 per cent due to socio-economic factors such as high infant mortality, low status of women, preference for son, illiteracy and poverty.\textsuperscript{66}

\textbf{Special correspondent} maintained that however, the main problem relating to population stabilization is the high levels of unmet needs for contraception, maternal and child care services prevailing in high-fertility states such as Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chattisgarh, Jharkand, Uttarakhand and Orissa. The National population Policy (NNP) 2000, aims to fully meet the unmet needs for basic reproductive and child health services at the earliest.\textsuperscript{67}


\textsuperscript{66}. Special correspondent “Population panel plans pilot projects in privates hospitals”, \textit{The Hindu} August 17, 2003, P-10.

\textsuperscript{67}. Special correspondent, idbi
Dinesh Paul stated that inspite of our national commitment the present status of the child in India is unsatisfactory. There are millions of children suffering from malnutrition and infection, when results in their stunted physical and mental growth. These children require care, support and services to provide them with a healthy normal life.

The birth rate in the country declined from 36.9 per 1000 population in 1971 to 27.2 in 1997. The goals to be reached are to reduce the birth rate to 21.0 by the year 2000, the infant mortality rate is also to be reduced from the current 71 per thousand live births to less than 60 by 2000. In 1998-1999, 22.36 million children received three doses of DPT, while 12.18 million were immunized in 1984 – 1985. The coverage of BCG vaccination, DPT and polio immunization in around 23 million children for 1998 - 1999. This means that the services have to be strengthened to meet the objectives of the universal coverage by 2000.

The existing data on the proportion of mothers receiving antenatal care clearly indicates that it may not be feasible to attain 100% coverage with the minimum package of antenatal care as specified below. Moreover, the manner in which this data has been obtained seems to be incorrect. It is therefore, recommend that the data required to define a beneficiary for antenatal care needs to be defined.

At present half of the deliveries are conducted by untrained birth attendants in India. Therefore, with full confidence it can be sad that the target of 100% coverage by trained birth attendant is also not feasible.

The ministry of Health should try to promote institutional deliveries under RCH programme and one lady Doctor may be posted in each Primary Health Centre for conducting deliveries in areas where MMR is more than two. The safe disposable delivery kit should be given to the mother during antenatal examination at the time of third trimester to achieve 100% coverage by birth attendants, using safe delivery kit.

Jejeebhoj found that unsafe motherhood is still a reality in much of India and particularly in its rural areas. Few women have access to antenatal care, high risk cases go undetected, anemia is acute during pregnancy, deliveries are conducted largely by untrained attendants in unhygienic conditions and knowledge of health and nutrition needs during pregnancy and the postnatal period are poorly understood. Deliveries are largely conducted by untrained personnel and in unhygienic conditions, both of which contribute significantly to poor maternal health. Maternity benefits are woefully absent which compounds maternal ill-health; the recent talk of restricting maternity benefits in the organized sector to two children has serious implications for both maternal and child health. The health delivery system and the constraints they face in expressing these—let alone the constraints they face in obtaining services. Doorstep services are essential for scheduled women and these are rarely undertaken and where undertaken, focus largely on contraception rather than on reproductive health in general. Despite the fact that the large majority of births continues to take place attended by untrained personnel, the incorporation of trained traditional dais (TBAs) in the provision of antenatal and natal services has
not been a priority in the health system. Since younger generations are unwilling to become dais, there is the likelihood of a serious shortage of delivery attendants. 69

Srinivasan is of the view that a vast network of rural health institutions has been developed. Rapid expansion has, however, resulted in a considerable drop in the quality of functioning of health institutions. For several reasons, the quality of services and work done by various health institutions and by different categories of health personnel are poor, resulting in low credibility among the rural community. Moreover, for want of quality, the efficiency and effectiveness of the programmes and services have been limited and the causes of non-utilization and or underutilization of health services and facilities by the people, especially the rural communities, for making rural health care services more meaningful to the rural community, it is needed to bring about fundamental changes in the focus and approach to the entire health care delivery system in general and rural health care, in particular. 70