Chapter 1

Introduction, Scope and Methodology

Public administration, as an academic field, means the study of the art and science of management applied to the public sector, concerned much traditionally beyond the aspect of management and incorporated as its subject matter all the social services, which affected the running of public institutions. It is inherently cross-disciplinary, encompassing so much of other fields - from political science to sociology to business administration to law so to say leaving none concerned with society.

Woodrow Wilson published an essay in 1887, which marked the symbolic beginning of a fairly autonomous field of academic enquiry called Public Administration. According to John J. Corson and Joseph P. Harris: "Public Administration is decision-making, planning the work to be done, formulating objectives and goals, working with legislature and citizen organizations to gain public support and funds for government programmes, establishing and revising organizations, directing and supervising employees, providing leadership, communicating and receiving communication determining work-methods of procedures, appraising performance, exercising controls and other functions performed by the government executives and supervisors. It is the action part of government, the means by which the purposes and goals of government are realized."

W. Wilson further said, “There should be a science of administration which shall seek to strengthen the paths of government, to make its business less unbusiness like, to strengthen and purify its organization, and to crown its duties with dutifulness.”

In the words of Woodrow Wilson, “Public administration is detailed and systematic execution of law. Every particular application of law is an act of administration.”

F. A. Nigro opined that, “Public administration (i) is a cooperative group effort in a public setting: (ii) covers all the three branches - executive, legislative and judicial, and their inter-relationship (iii) has an important role in the formulation of public policy and is thus part of the political process: (iv) is different in significant ways from private administration; and (v) is clearly associated with numerous private groups and individuals in providing services to the community.”

No single definition is enough to explain the concept of public administration as public administration can also be defined from political, legal, managerial, and occupation perspective. However, its vast scope encompasses whatever the governments do. Public administration cannot exist outside its political context as it is in this context that makes it public, that makes it different from private or business administration. Public
administration is what a state does. It is created by and bound by the law and is an instrument of the law. It is inherently the execution of public law and every application of general law is necessarily an act of administration. Its legal basis allows public administration to exist, but without its management aspect, not much of public’s business would get done.6

Today, public administration as a field of systematic study and as an aspect of governmental activity has grown to a commanding stature. In course of time, many new fields like comparative public administration, development administration, international administration, area administration, new public administration, administrative ethics, new public management, and infrastructure administration have come up, which has widened the horizons of public administration. It was the New Public Administration movement, which marked a turning point in the growth of the discipline in the late 60s in USA. Young American scholars pioneered a new movement in American public administration, which came to be known as the 'New Public Administration'. The scholars gathered at Minnowbrook to hold Minnow Brook Conference in 1968 under the patronage of Dwight Waldo and challenged the 'givens' of orthodox public administration and pluralist political science. The features of New Public Administration included relevance, values, equity and change, which were debated in the Minnowbrook Conference.7

However, a latest paradigm shift in the evolution of public administration came into being in the 1990s, popularly known as 'New Public Management Perspective'. The New Public Management represented the second re-invention in public administration, the first being the New Public Administration of the 1960s. The basic theme was based on three Es - efficiency, economy and effectiveness. It emphasized on performance-appraisal, managerial autonomy, cost-cutting, financial incentives, output targets, innovation, responsiveness, competence, accountability, and market orientation.8

Thus, New Public Management has given new direction to the executers of the policies by putting onus on them to perform. It is a known fact that Administration has wide range of functions to be performed and some of these functions are of utmost importance to the individuals and society as a whole. These services are provided through various organizations, agencies which are better known as different fields of administration known by their specific purpose such as education administration, health administration, social welfare administration, police administration and other areas.

There are some basic services so dear to any society for its survival such as health, education and agriculture etc. The most pronounced of these services has been health as without the proper provision of health and health care services no Nation can
survive. Health care is a public right and it is the responsibility of the government to provide care to all people in equal measures. To provide better health status to its citizens, there are constitutional provisions meant for each level of the government.

According to the constitution, “Health is a state subject but yet the role of the union government cannot be underplayed as promotion of the health is basic to the national progress. Nothing is of importance than the health of the people for socio-economic development. The first five-year plan emphasized that nothing can be considered of higher importance than the health of the people, which is a measure of their energy and capacity as well as their potential. Therefore, for social development and to lead more productive life, health plays an important role.

Health Care Administration

Health care administration mainly deals with the matters related to the health, various policies and plans formulation and their implementation in order to achieve the objectives of health care i.e. promotion of health, prevention of diseases, cure and rehabilitation. Thus, health care administration is the branch of public administration, which deals with matters related to the promotion of health, prevention of diseases, medical care, and rehabilitative health care services, delivery of health services, development of plans and policies for manpower, medical education and training. The overall objective of health administration is to provide health services to the people with economy and efficiency.9

Efficiency in health care administration can be achieved through proper policy formulation and its implementation. Health administration is the force, which can help the health system in the formulation of sound health policy and its implementation.

According to C.E.A Winslow, “Health care administration is science and art of preventing disease; prolonging of life, promotion of health efficiency through organized community efforts for the sanitation of environment, control of communicable diseases, education of the individuals in personal hygiene, organization of medical and nursing diagnosis and preventive treatment of diseases, the development of social machinery to ensure to every citizen a standard of living adequate for the maintenance of health. So organizing these benefits, as to enable every citizen to realize his birth right of health and longevity.”10 Thus, public administration is the application of administration process and methods, which are used in carrying out the objectives of health care in an organized community.

According to K.S.Dozie. “The promotion and protection of health of the people is essential to sustained economic and social development and contribution to a better quality of
life and to world peace.” Health care administration is the force, which can help the health system in the formulation of sound health policy and its implementation. Health care administration deals with all the aspects of health care services and health studies the role of health care agencies, viz-public private and voluntary agencies to meet the health challenges.

Health

WHO (1948) defines health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. It further states that, the enjoyment of the highest attainment standard of health is one of the fundamental right of every human being without the distinction of race, religion, caste, political belief, economic and social condition. World Health Organization has also proclaimed that health as fundamental right of every individual and society. Health, being a wider concept, embraces the impact of diverse type of health services ranging from preventive to curative in nature. In fact, health is the foremost priority in the life.

Article 25 of the constitution refers to the citizens rights of the health. According to which everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary services and right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood and in circumstances beyond his control, motherhood and childhood are entitled to special care and assistance. All children whether born in or out of wedlock shall enjoy the same social protection.

Health is not merely the issue of doctor, social services, and hospitals. It is the issues of social justice and all communities have their concept of health as part of their culture. In some cultures, health and harmony are considered equal. Harmony being defined, “As being at peace with self, community, God and Cosmos. Health has different concepts, like biomedical and ecological concepts.” In addition to these is, a disease, which is maladjustment of human organisms to environment.

Humans’ ecological and cultural adaptation not only determine about the presence and occurrence of disease, but also the availability of food and population explosion. Improvement in human adaptation to natural environment can lead to longer life expectation and better quality of life even in the absence of modern health services. Psychological concept of health explains that health is not only a biomedical phenomenon but also one, which is influenced by social psychological cultural economic and political factors of people’s concern. Holistic concept of health advocates the synthesis of all the concepts.
Philosophical concept of health

Health is fundamental human right. Health is essence of productive life and not the result of ever-increasing expenditure of medical care.

Health is intersectoral.

Health is an integral part of development.

Health is central to the concept of quality of life.

Health involves the individual, state and international responsibility.

Health and its maintenance is major social investment.

Health is worldwide social goal.

Health has been declared as basic fundamental human right.

Health is vital for ethical, artistic, material and spiritual development of man.

Therefore, Health is not only an important factor in the development of individuals, but also for the society and the nation. Thus, health of the people is of considerable importance not only in terms of its cause and effects but also for achieving health for all.14

Determinants of Health: The factors, which determine the health, lie both within the individual and externally in the society. The two sets of factors are there which influence the health i.e. genetic factors and environmental factors to which an individual is exposed. The factors are following.15

Biological Determinants

Behavior and Sociocultural Conditions

Environment and Socioeconomic Conditions

Health Services & Aging of the Population

Gender

Figure 1.1 Determinant of health

Source: textbook of social and preventive medicine
Legal Aspects of Health

Health is the right of every individual and has been recognized by almost all countries of the world. In 1948 Universal Declaration of Human Rights, which consisted of 30 articles recognized that “all human beings are born free and are equal in dignity and rights.” Constitution of WHO has set the principle, “The highest attainable standard of health as one of the fundamental requirement of human beings.”

The Indian constitution in part IV, relating to the Directive Principle of State Policy under act per Article 47 states: that the state shall regard the raising of the level of nutrition and standards of living of its people and the improvement of public health its primary duty. This has resulted in greater degree of state involvement in the management of health services and the establishment of nationwide system of health care services.

Concept of Health Care

It is the expression of concern for fellow human beings, which includes multitude of services rendered to individual, family, or communities by the agent of health services or professionals, for the purpose of promoting, maintaining, monitoring and restoring health. All these services need planning organizing and financing in a way that these services needs to reach to the right beneficiary.

The term medical care is the subset of the health care system. Health care has been characterized into appropriateness, comprehensiveness, adequacy, availability, accessibility, affordability, and feasibility.

Health Care Policies

Health care services include availability of health care facilities, drugs, equipments, and workforce and health services at various levels and these should be easily available and accessible, especially to under privileged section of the society. According to Bose (1982), the aim of the health policy is to secure fundamental change in the health of the people, to break the circle of poverty, encircling the masses in the developing world and liberate the population to secure the changes that they have chosen, in which they participate as well.

Public health policy aims at the improvement of conditions in which people live including livelihood, lifestyle, environment, and necessary health services.

National health policy stresses upon the preventive, promotive, and curative aspect of health care and establishing primary health care services to reach needy people in the unreached areas.

National Health Policy

National Health Policy was formulated in 1983 for the first time after thirty-six years of independence on the recommendation of WHO, and since then there have been marked
changes in the determinant factors relating to the health sector. Some of the policy initiatives of the NHP-1983 have yielded results, while, in other areas, the outcome has not been as expected. The NHP-1983 gave required recommendation in the circumstances then prevailing in the health sector. The initiatives under that policy were:

- A phased, time-bound programme for setting up a well-dispersed network of comprehensive primary health care services, linked with extension and health education, designed in the context of the ground reality that elementary health problems can be resolved by the people themselves.
- Environmental Protection.
- Water Supply and Sanitation.
- Maintenance of Quality of Drugs.
- Immunization Programme.
- School Health Services.
- Maternal and Child Health Services.
- Occupational Health Services
- Intermediation through ‘Health Volunteers’ having appropriate knowledge, simple skills and requisite technologies.
- Establishment of quick referral system to ensure that patient load at the higher levels of the hierarchy is not needlessly burdened by those who can be treated at the decentralized level.
- An integrated network of evenly spread specialty and super-specialty services. Encouragement of such facilities through private investments for patients who can pay, so that the draw on the government’s facilities is limited to those entitled to free use.

Achievement of NHP 1983 over the time were:

- Eradication of smallpox and guinea worm diseases from the country.
- Polio is on the verge of being eradicated.
- Leprosy, kala azar, and filariasis can be expected to be eliminated in the near future.
- A substantial drop in the Total Fertility Rate and Infant Mortality Rate.

The public health initiatives over the years contributed significantly to the improvement of these health indicators, it is to be taken in to the consideration that public health indicators / disease-burden statistics are the outcome of several complementary initiatives under the
wider umbrella of the developmental sector, covering rural development, agriculture, food production, sanitation, drinking water supply, education and other areas.

Despite the public health gains as revealed, there is no gain in the fact that the morbidity and mortality levels in the country are still unacceptably high. These are indications of the limited success of the public health system in meeting the preventive and curative requirements of the general population.

Among communicable diseases, malaria staged resurgence in the 1980s before stabilizing at a high prevalence level during the 1990s. The reason is an increasing level of insecticide-resistance in the malarial vectors. TB has not shown any significant decline in the rate of infection and there has been a distressing trend in the increase of drug resistance type of infection prevailing in the country. HIV/AIDS - has emerged on the health scene since the declaration of the NHP-1983. The disease constitutes a serious threat, not merely to public health but to economic development in the country. The common water-borne infections – gastroenteritis, cholera, and some forms of hepatitis – continue to contribute to a high level of morbidity in the population, even though the mortality rate may have been somewhat moderated. There has been resurgence in mortality through ‘life-style’ diseases- diabetes, cancer and cardiovascular diseases. The increase in life expectancy has also increased the requirement for geriatric care. Similarly, the increasing burden of trauma cases is also a significant public health problem.

Another area of concern in the public health domain is the persistent incidence of macro and micro nutrient deficiencies, especially among the vulnerable sub-category of women and the girl child, has the multiplier effect through the birth of low birth weight babies and serious ramifications of the consequential mental and physical retarded growth.

NHP-1983, in a spirit of optimistic empathy for the health needs of the people, particularly the poor and under-privileged, had hoped to provide ‘Health for All by the year 2000 AD.’ In retrospect, it was observed that the financial resources and public health administrative capacity was far short of that necessary to achieve such an ambitious and holistic goal. 19

National Health Policy-2002

NHP-2002 envisaged an attempt to maximize the broad-based availability of health services to the citizen of the country based on realistic considerations of capacity. The changed circumstances relating to the health sector of the country generated a situation in which it was necessary to review and formulate a new policy framework. NHP-2002 was formulated for
the accelerated achievement of Public health goals in the prevailing socio-economic circumstances in the country.

**Recommendation of NHP2002**

**Delivery of National Health Programmes:** In India, National Health Programmes needs to be crafted with enough flexibility to permit the State public health administrations to have their own modifications according to their needs. A large gap in facilities persists even after the implementations of NHP1983. Applying current norms to the population projected for the year 2000, the estimated shortfall in the number of SCs/PHCs/CHCs is of 16 percent. However, this shortage is as high as 58 percent when disaggregated for CHCs only.

Apart from this, in order to meet the objectives of reducing various types of inequities and imbalances – inter-regional, across the rural – urban divide and between economic classes – the most cost-effective method is to increase the sectoral outlay in the primary health sector. In recognition of this public health principle, NHP-2002 was to sets out an increased allocation of 55 percent of the total public health investment for the primary health sector; the secondary and tertiary health sectors being targeted for 35 percent and 10 percent respectively.

**The State of Public Health Infra-Structure:** The country has been experiencing inadequate public health infrastructure. It has been estimated that less than 20 percent of the population seeks OPD services, and less than 45 percent of that seek indoor treatment. This is despite the fact that most of these patients do not have the means to make out-of-pocket payments for private health services. There is a general shortage of health care institutions medical personnel in the country. This shortfall is disproportionately impacted on the less-developed and rural areas. However, India has a vast reservoir of practitioners in the Indian Systems of Medicine and Homoeopathy, who have undergone formal training in their own disciplines. The possibility of using such practitioners in the implementation of State/Central Government public health programmes, in order to increase the reach of basic health care in the country is addressed in the NHP-2002. NHP-2002 lays greater emphasis upon the implementation of public health programmes through local self-government institutions.

Apart from this the outdoor medical facilities in existence and their funding is generally insufficient. Medical and para-medical personnel are often much less than that required by prescribed norms. The availability of consumables is frequently negligible. The equipment in many public hospitals is often obsolescent and unusable. The buildings are in a dilapidated state. The capacity of the facilities is grossly inadequate for inpatient department, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services.
Urban Health: NHP-2002 envisages the setting up of an organized urban primary health care structure. The structure conceived is the primary centre seen as the first-tier, covering a population of one lakh, with a dispensary providing an OPD facility and essential drugs, to enable access to all the national health programmes and a second-tier of the urban health existed at the level of the general hospitals run by the state, where primary centre refer the cases. The Policy envisages on the establishment of fully-equipped ‘hub-spoke’ trauma care networks to reduce accident mortality.

Information, Education and Communication: NHP-2002 recommend priority to school health programmes which aim at preventive-health education, providing regular health check-ups, and promotion of health-seeking behaviour among children.

Health Research: Emphasis would also be laid on time-bound applied research for developing operational applications.

Health Statistics: The Policy envisages the completion of baseline estimates for the incidence of the common diseases – TB, Malaria, and Blindness – by 2005. The Policy proposed that statistical methods be put in place to enable the periodic updating of these baseline estimates through representative sampling.

Five-Year Plans and Health

There is full realization of the fact that the health needs of the country are enormous and the financial resources and managerial capacity available to meet them, even the brightest projections, fall short of these needs. The National Planning Committee (NPC) set up by the Indian National Congress in 1938 under the chairmanship of Colonel S. Sokhey stated that the maintenance of the health of the people was the responsibility of the State, and the integration of preventive and curative functions in a single state agency was emphasized. Then the recommendations of the Bhore Committee came in 1946, which dealt with the issue of making health services available to all citizens irrespective of their capacity to pay for these services.

After Independence, Planning Commission in 1950, which was assigned a significant task to prepare the national plan. The Planning Commission came out with the Five Year Plans as the formula for sustained development and the objectives of the first (1951-56) and Second Five Year (1956-61) Plans were to develop the basic infrastructure and manpower as visualized by the Bhore Committee. Though health was seen as fundamental to national progress yet, less than 5 per cent of the total revenue was invested in the health sector. Right
from the First Five Year Plan, vertical programmes of health care, which were initiated, remained the centre of focus in all the subsequent Five Year Plans.

**First Five Year Plan:** Incorporated provision of water supply and sanitation, control of malaria, preventive health care of the rural population through health units and mobile units, health services for mothers and children, education, training and health education; self-sufficiency in drugs and equipment, family planning and population control. The Malaria Control Programme (MCP), which was made one of the principal programmes. Apart from this, the other programmes for the control of TB, filariasis, leprosy and venereal diseases, were launched. Health personnel at the grass root level were to take part in vertical programmes.

**Second Five-Year Plan:** The concern of the Health Survey and Planning Committee (Mudaliar Committee 1962) was limited to the development of the health services infrastructure and the health care at the primary level. It was felt that the growth of infrastructure needed radical transformation and further investment. The main thrust in this plan was on development of health infrastructure.

**Third Five-Year Plan** A major shift came in the Third Plan (1961-66) when family planning received priority for the first time. The population explosion in the country was seen as a big hurdle in the development process. The broader objective was to bring about progressive improvement in the health of the people by ensuring a certain minimum level of physical well-being and to create conditions favourable for greater efficiency. There was a shift in focus from preventive health services to family planning.

**Fourth Five Year Plan** During the Fourth Plan (1969-74), efforts were made to provide an effective base for health services in rural areas by strengthening the PHCs. The vertical campaigns against communicable diseases were further intensified.

**Fifth Five Year Plan** During the Fifth Plan (1974-79), policy-makers realized that health had to be addressed alongside other development programmes. The Minimum needs Programme (MNP) promised to address all this but became an instrument through which only health infrastructure in the rural areas was to be expanded and further strengthened. It called for integration of peripheral staff of vertical programmes but the population control programme got further impetus. Meanwhile the Chaddha Committee Report (1963), the Kartar Singh Committee Report on Multipurpose Workers (1974) and the Srivastava Committee Report on Medical Education and Support Manpower (1975) remained focused on giving recommendations on how the health cadres at the primary level should be distributed. With the widespread disillusionment with vertical programmes worldwide and the need to provide
universal health services there came the Primary Health Care Declaration at Alma Ata in 1978 to which India was a signatory as well.

**Sixth Five-Year Plan:** The Sixth Five Year Plan (1980-84) was influenced by two policy documents: the Alma Ata Declaration and the ICMR, ICSSR report on ‘Health for All’ by 2000’. The ICMR ICSSR Report (1980) was in fact a move towards articulating a national health policy that was thought of as an important step to realize the Alma Ata Declaration. It was realized that one had to redefine and rearticulate and get back into track an integrated and comprehensive health system that policy-makers had wavered. It reiterated the need to integrate the development of the health system with the overall plans of socio-economic and political change and financing and delivery of health care services in India. It recommended that the government should formulate a comprehensive national health policy dealing with all dimensions-like environmental, nutritional, educational, socio-economic, preventive and curative aspects. The Five Year Plan documents henceforth emphasized on restructuring and developing the health infrastructure especially at the primary level.

**Seventh Five Year Plan** stressed upon (1985-90) the rural health programme and the strengthening of three-tier health services system that the government had to make up for the deficiencies in personnel, equipment and facilities.

**Eighth Five Year Plan** This Plan (1992-97) distinctly encouraged private initiatives, private hospitals, clinics and suitable returns from tax incentives. With the beginning of structural adjustment programmes and cuts in social sectors, excessive importance was given to vertical programmes such as those for the control of AIDS, tuberculosis, polio and malaria funded by multilateral agencies with specified objectives and conditions attached.

**Ninth and Tenth Five Year Plan:** Both Ninth (1997- 2002) and the Tenth Five-Year Plans (2002-2007) emphasized on building good primary-level health care and referral services. Both these plans highlighted the importance of the role of decentralization but do not state how this will be achieved. The National Health Policy (2002) includes all that is wanted from a progressive document and yet it glosses over the objective of NHP 1983 to protect and provide primary health care to all. The Policy document talks of integration of vertical programmes, strengthening of the infrastructure and providing universal health care access.

**Health care System Reforms during Ninth Five-Year Plan:** Faced with the problems of sub-optimal functioning and difficulties in providing adequate investments for improving health care facilities in the public sector, almost all state governments initiated health system reforms with public sector institutions playing lead role. The structural reforms relate to reorganization and restructuring of all the elements of health care so that they function as
integral components of the health system. The functional reforms are aimed at improving efficiency by creating a health system with well-defined hierarchy and functional referral linkages in which the health personnel would work as a multi-professional team and perform duties according to their position, skills and level of care. The community-based link worker who acts as a liaison between people and health care functionaries and ensures optimal utilization of available facilities is to provide the last link. The PRIs is to participate in planning programmes and assist in implementation.\textsuperscript{22}

**Recommendations for Health Care System in Tenth Five-Year Plan**

- Building up a fully functional, accurate Health Management Information System (HMIS) utilizing currently available IT tools to utilize in communication link to send data on births, deaths, diseases, request for drugs, diagnostics and equipment and status of ongoing programmes through service channels within existing infrastructure and manpower and funding. This will also facilitate decentralized district based planning, implementation and monitoring.
- Building up an effective system of disease surveillance and response at the district, state and national level as a part of existing health services.
- Improving the efficiency of the existing health care system in the government, private and voluntary sectors and building up appropriate linkages between them.
- Mainstreaming ISM&H practitioners, in order to practice their system of care, and improving the coverage of the National Disease Control Programmes (NDCP) and Family Welfare Programmes.
- Involvement of voluntary and private organizations, self-help groups and social marketing organization in improving access to health care.
- Devolution of responsibilities and funds to Panchayati Raj Institutions (PRIs)
- Area-specific planning and monitoring, PRIs can help in improving the accountability of the public health care providers, sort out problems such as absenteeism, improve inter-sectoral coordination and convergence of services
- Evolving appropriate management systems for emergency, disaster accident and trauma care at all levels of health care. Developing all levels for emergency and disaster prevention and management.
- Effective implementation of the provisions for food and drug safety; strengthening the food and drug administration both at the centre and in the states.
Screening for common nutritional deficiencies especially in vulnerable groups and initiating appropriate remedial measures.

Recommendations on Health Care System in Eleventh Five Year Plan (2007-12)

One objective of the Eleventh Five Year Plan is to achieve good health for people, especially the poor and the underprivileged. A comprehensive approach is needed that encompasses individual health care, public health, sanitation, clean drinking water, access to food, and knowledge of hygiene, and feeding practices. India has built up a vast health infrastructure and health personnel at primary, secondary and tertiary care in public, voluntary and private sectors. For producing skilled human resources, a number of medical and paramedical institutions including Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) have been set up.

Considerable achievements have been made to improve health standards, such as life expectancy, child mortality, infant mortality, and maternal mortality. There is hope that poliomyelitis will be eradicated in the near future. Malnutrition affects a large proportion of children. An unacceptably high proportion of the population continues to suffer and die from new diseases that are emerging, apart from continuing and new threats posed by the existing ones. Pregnancy and childbirth related complications also contribute to the suffering and mortality. The importance of public provisioning of quality health care to enable access to affordable and reliable health services cannot be underestimated.

The country has to deal with rising costs of health care and growing expectations of the people. The challenge of quality health services in remote rural regions has to be urgently met. Given the magnitude of the problem, there is need to transform public health care into an accountable, accessible, and affordable system of quality services during the Eleventh Five Year Plan.

To facilitate convergence and development of public health systems and services those are responsive to health needs and aspirations of people. Special attention to the health of marginalized groups like adolescent girls, women of all ages, children below the age of three, older persons, disabled, and primitive tribal groups is incorporated in agenda. Good governance, transparency, and accountability in the delivery of health services to be ensured through involvement of PRIs, community, and civil society groups.23

Time-Bound Goals for the Eleventh Five-Year Plan were

- Reducing Infant Mortality Rate (IMR) to 28 per 1000 live births.
- Reducing Total Fertility Rate (TFR) to 2.1.
- Providing clean drinking water for all by 2009 and ensuring no slip-backs.
- Reducing malnutrition among children of age group 0–3 to half its present level.
- Reducing anemia among women and girls by 50%.
- Raising the sex ratio for age group 0–6 to 935 by 2011–12 and 950 by 2016–17.

**Scenario, Concerns, and Challenges**

**Maternal Mortality Ratio (MMR):** The MMR during 2001–03 has been 301 per 100000 live births. Levels of maternal mortality vary significantly across the regions. There has been a substantial decline during the seven-year period between 1997–2003. However, the pace of decline was slow.

**Infant Mortality Rate (IMR):** IMR is 58 per 1000 live births (SRS, 2005). It is higher in rural areas (64) and lower in the urban areas (40) of the country. (National Commission on Macroeconomics and Health, NCMH, 2005)

**Urban Growth:** It has led to increase in number of urban poor. Population projections postulate that slum growth is expected to surpass the capacity of civic authorities to respond to their health and infrastructure needs. As per 2001 census, 4.26 crores lived in urban slums spread over 640 towns and cities.

**Disease Burden**

India is in the midst of an epidemiological and demographic transition with increasing burden of chronic diseases, decline in mortality and fertility rates and ageing of the population, non-communicable diseases (NCDs) such as cardiovascular diseases (CVDs), cancer, blindness, mental illness, etc., have imposed the chronic disease burden on the already over-stretched health care system of the country.

**Communicable Diseases:** AIDS is acquiring a female face i.e. gradually the gap between females and males is narrowing as far as number of cases and infections are concerned with approximately 2-3.1 million people with infection. The risk of tuberculosis infection in HIV positive persons increased manifold.

**Tuberculosis:** In India is accounting for one-fifth of the world incidence. Every year 1.8 million people in India develop tuberculosis, of which 0.8 million are infectious smear positive cases. RNTCP has achieved nationwide coverage in March 2006.

**National Vector Borne Disease Control Programme:** Initiated with the convergence of ongoing programmes on malaria, kala-azar, filariasis, Japanese encephalitis, and dengue. Malaria cases in India declined from 3.04 in 1996 to 1.82 million cases in the year 2005. An estimated population of 130 million is exposed to the risk of kala-azar in the endemic areas.

Leprosy elimination at national level (<1 case/10000 population) as set by National Health Policy (2002) was achieved in the month of December 2005. Still it is prevalent with
moderate endemicity in about 20% of the districts. During 2005-06, 1.61 lakhs new leprosy cases were detected.

Non-Communicable Diseases (NCDs): Rapid epidemiological transition, burden of chronic diseases responsible for 53% of all deaths and 44% of Disability Adjusted Life Years. NCDs, especially diabetes mellitus, CVDs, cancer, stroke, and chronic lung diseases have emerged as major public health problems due to an ageing population and environmentally driven changes in behavior. Cancer has become an important public health problem with an estimated 7 to 9 lakhs cases occurring every year. It is estimated that there are nearly 25 lakhs cases in the country. The strategy under the National Cancer Control Programme (NCCP) was revised in 1984–85 and further in 2004 with stress on primary prevention and early detection of cancer cases. Tobacco related cancers account for about half the total cancers among men and 20% among women. About one million tobacco related deaths occur each year; making tobacco related health issues a major public health concern.

The Gaps in Health Care Infrastructure and Human Resources: Across rural areas, there is considerable shortfalls plus a large number of vacant positions of doctors, nurses, and paramedical personnel. There is also wide variation in number of persons served by a specialist in rural areas. During the last few years, there has been a great change in the availability of secondary and tertiary health care facilities in the country.24

Health Care Utilization: Increase in public health care infrastructure, utilization of public health facilities by population for outpatient and inpatient care has not improved. The NSSO(national sample survey organization) (1986–2004) Data clearly indicate that decline in utilization of the public health facilities for inpatient care and a corresponding increase in utilization of the same from private health care providers in both rural and urban areas. Critical shortage of health personnel, inadequate incentives, poor working conditions, lack of transparency in posting of doctors in rural areas, absenteeism, long wait, inconvenient clinic hours, poor outreach, time of service, insensitivity to local needs, inadequate planning, management, and monitoring of service/facilities appear to be the main reasons for low utilization.

Cost of Treatment by Households: According to NSSO (60th Round), the average expenditure for hospitalized treatment from a public hospital was less than half that of private hospital in rural areas and about one-third in urban areas. There are also inter-State variations. The cost per hospitalization in government hospital was lowest in Tamil Nadu (Rs 637 in rural areas and Rs 1666 in the urban areas) and highest in rural Haryana (Rs 11665) and urban Bihar (Rs 30822). The cost of hospitalization in private hospitals was
highest in Himachal Pradesh (Rs 14652 in rural areas and Rs 23447 in urban areas) and lowest in rural Kerala (Rs 4565) and urban Chhattisgarh (Rs 4359), respectively. As per NSSO 60th Round, during 2004, 24% of the episodes of ailments among the poor remained untreated in rural areas and 22% in urban areas.

National Rural Health Mission (NRHM)

NRHM was launched to address infirmities and problems across primary health care and bring about improvement in the health system and the health status of those who live in the rural areas. The Mission aims to provide universal access to equitable, affordable, and quality health care that is accountable and at the same time responsive to the needs of the people. The Mission was expected to achieve the goals set under the National Health Policy and the Millennium Development Goals (MDGs).

To achieve these goals, NRHM facilitates increased access and utilization of quality health services by all, forges a partnership between the Central, State, and the local governments, sets up a platform for involving the PRIs and the community in the management of primary health programmes and infrastructure, and provides an opportunity for promoting equity and social justice.

In the Eleventh Five Year Plan, the emphasis under NRHM was to not be on numerical achievements only but also on IPHS and enforcement of guidelines for improving the functioning of infrastructure being strengthened and created.

Primary Health Care Focus: Efforts were made for restructuring and reorganizing all health facilities below district level into the three tier rural primary health care system and have referral linkages with each other. Population-centric norms are modified and replaced with flexible norms comprising habitation-based needs, community-based needs, and disease pattern-based needs, accessibility, ensuring availability of essential drugs and supplies, vaccines, medical equipment, along with the basic infrastructure like electricity, water supply, toilets, telecommunications, and computers for maintaining records.

Decentralized Governance

Role of PRIs: PRIs have the mandate to manage the primary health system. The various tiers of PRIs has to decide the local priorities and supervise functioning of health facilities, functionaries, and functions through their participation in various committees. ASHAs are envisaged to be selected by and be accountable to the village Panchayats. Involvement of PRIs is also necessary to improve the coverage and quality of registration of births, deaths, marriages and pregnancies in all States.
Role of Civil Society: Community Based Health Partnership is the key to sustaining health action even with limited resources. This can take many forms, through the PRIs, community-based NGOs and of people, participating at all levels of health interventions. It needs active participation of the people for local action. Partnership with community groups (through youth, mahila mandals, SHGs, and Gram Sabhas) is necessary for local solutions to local problems.

Community Based Health Insurance (CBHI): The following activities are accorded priority during the Eleventh Five Year Plan:

- Legislation for registration of clinical establishments in the country.
- Development of uniform standards for infrastructure and service delivery.
- Recognition of RMPs as sahabhaagis in NRHM.

Emerging Technologies and e-health: Appropriate use of IT for an enhanced role in health care and governance is aimed at during the Eleventh Five Year Plan.

Human Resources for Health: NCMH 2005 (National Commission on Macroeconomics and Health) has recommended for additional funding for establishment of new medical, nursing, and other institutions, training of village level functionaries, and in-service training of health personnel.

The following strategies are accorded as priority during the Plan:

- Ensure availability of medical professionals in rural areas on a permanent basis, posting of doctors with adequate monetary as well as non-monetary incentives.
- States to expand the pool of medical practitioners including a cadre of Licentiate Medical Practitioners and practitioners of Indian Systems of Medicine and Homeopathy (AYUSH).
- A series of one-year duration Certificate Courses for MBBS graduates is launched in deficit disciplines like public health, anesthesia, psychiatry, geriatric care, and oncology. The private sector is also to be encouraged to participate in this venture.
- New medical, nursing, and dental colleges is established in the underserved areas.
- RMPs, after training, can contribute towards activities under NRHM.

National Programme for Prevention and Control of Diabetes, CVDs, and Stroke: During the Plan, the objectives are primary prevention of major NCDs through health promotion, surveillance, capacity enhancement of professional for diagnosis and management of NCD, reduction of risk factors, development of strategies and guidelines for prevention by intersectoral coordination were promoted.
National Mental Health Programme (NMHP) emphasized on community and more specifically family-based approach to the problem, strengthen District Mental Health Programme, finding problems at grass root level, importance of mental health care and counseling with user friendly psychotropie drug policy.

Injuries and Trauma: Data from Survey of Causes of Death and Medical Certification of Causes of Deaths reveals that 10–11% of total deaths in India were due to injuries. A scheme to up-grade and strengthen emergency care in state hospitals located on national highways has been under implementation with a view to provide treatment to road accident victims in hospitals as near the site of accident as possible. The emphasis is given for trauma care system covering the entire nation with state wide emergency medical service and trauma care. The components to include are provision of equipment, communication system, training and provision of human resources, registry and surveillance. The plan was to start a National Programme for Medical Emergencies Response (NPMER) including care facilities along highways and their upgradation to specific levels of trauma care, life support ambulance system, resource training and availability, appropriate trauma referral system.

Eleventh Five Year Plan Agenda
Thrust areas, which were to be pursued during the Eleventh Five Year Plan, are summarized below:

- Improving Health Equity
- NRHM
- NUHM
- Adopting a system-centric approach rather than a disease-centric approach
- Strengthening Health System through upgradation of infrastructure and PPP
- Converging all programmes and not allowing vertical structures below district level under different programmes
- Increasing Survival, Reducing Maternal mortality and improving Child Sex ratio through Gender Responsive Health care
- Reducing Infant and Child mortality through HBNC Home Based Neonatal Care and IMNCI
- Integrating AYUSH in Health System
- Increasing the role of RMPs
- Training the TBAs to make them SBAs
- Propagating low cost and indigenous technology
• Preventing indebtedness due to expenditure on health/protecting the poor from health expenditures & Creating mechanisms for Health Insurance
• Health Insurance for the unorganized sector
• Decentralizing Governance
• Increasing the role of PRIs, NGOs, and civil society
• Creating and empowering health committees at various levels
• Establishing e-Health & adapting IT for governance, e-enabled HMIS and Increasing role of telemedicine
• Improving access to and utilization of essential and quality health care
• Implementing flexible norms for health care facilities (based on population, distance, and terrain)
• Reducing travel time to two hours for EmOC (emergency obstetric care).
• Implementing IPHS for health care institutions at all levels.
• Accrediting private health care facilities and providers.
• Redeveloping hospitals/institutions.
• Mirroring of centers of excellence like AIIMS.
• Increasing focus on Health Human Resources by Improving Medical, Paramedical, Nursing, and Dental education and availability.
• Reorienting AYUSH education and utilization, Reintroducing licentiate course in medicine.
• Making India a hub for health care and related tourism.
• Focusing on excluded/neglected areas.
• Taking care of the older persons.
• Reducing Disability and integrating disabled.
• Providing humane Mental Health services.
• Providing oral health services.
• Enhancing efforts at disease reduction.
• Launching new initiatives (Rabies, Fluorosis, and Leptospirosis).
• Providing focus to Health System and Bio-Medical research.
• Making research accountable.
• Translating research into application for improving health.
• Understanding social determinants of health behaviour, risk-taking behaviour, and health care seeking behaviour.

**Review of Eleventh Plan Performance (Achievements)**

A review of the health outcome of the Eleventh Plan and of NRHM is constrained by lack of end-line data on most indicators. Analysis of available data reveals that though there has been progress, yet the targets have not been achieved.

**Table 1.1: Eleventh Five-Year Plan Monitorable Goals and Achievements**

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Monitorable Target</th>
<th>Baseline Level</th>
<th>Recent Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reducing Maternal Mortality Ratio (MMR) to 100 per 100000 live births.</td>
<td>254 (SRS, 2004-06)</td>
<td>212 (SRS, 2007-09)</td>
</tr>
<tr>
<td>2</td>
<td>Reducing Infant Mortality Rate (IMR) to 28 per 1000 live births.</td>
<td>57 (SRS, 2006)</td>
<td>44 (SRS, 2011)</td>
</tr>
<tr>
<td>3</td>
<td>Reducing Total Fertility Rate (TFR) to 2.1.</td>
<td>2.8 (SRS, 2006)</td>
<td>2.5 (SRS, 2010)</td>
</tr>
<tr>
<td>4</td>
<td>Reducing malnutrition among children of age group 0-3 to half its level.</td>
<td>40.4 (NFHS, 2005-06)</td>
<td>No recent data available</td>
</tr>
<tr>
<td>5</td>
<td>Reducing anaemia among women and girls by 50%.</td>
<td>55.3 (NFHS, 2005-06)</td>
<td>No recent data available</td>
</tr>
<tr>
<td>6</td>
<td>Raising the sex ratio for age group 0-6 to 935</td>
<td>927 (Census, 2001)</td>
<td>914 (census, 2011)</td>
</tr>
</tbody>
</table>

The monitorable goals and achievements of 11th five-year plan have been assessed with the help of data presented in the table 1.2. The MMR has declined from 254 to 212 per 100000 live births but still far short of the target of 100 per lakh, which was fixed to be achieved during the 11th plan. Similarly IMR came down from 57/100000 live births in 2006 to 44 in 2010 which could not achieve the target of 28 as was fixed for the 11th five year plan. Even TFR has shown the decline from 2.8 (2006) to 2.5 (2010). Yet the fixed target of 2.1 could not be achieved. Similarly, the progress on the front of reducing the malnutrition and anemia could not be assessed for nonavailability of data yet. The localized survey indicated that status of malnutrition anemia has not improved. The raising of the sex ratio for the age group of 0-6 years has also not shown result as it has declined further from 927(2001) to 914 (2011) as against the target of 935.

The 11th Five Year Plan has also not achieved commitment to provide emergency obstetric care in all the CHCs in the country. Similarly, the access to safe abortion was also not available in all the CHCs, a gap that is contributing to MMR. However, 449 mobile medical units have been deployed in the country till 2011 but their outreach medical services are not adequate to meet the needs of the people.
Health personnel evaluation has still shown shortage of medical and paramedical staff at all the level resulting into the inadequate delivery of health care services to the people.

**Recommendations for Health in Twelfth Five-Year Plan (2012-2017)**

At present, India’s health care system consists of a mix Networks of health care facilities at the primary, secondary and tertiary level. The system suffers from the weaknesses of availability, accessibility, quality & affordability of health care. Health care costs are expected to rise because, with rising life expectancy, a larger proportion of our population will become vulnerable to chronic non-communicable diseases (NCDs), which typically require expensive treatment. The public awareness of treatment possibilities is also increasing. India will have to cope with health problems reflecting the dual burden of disease i.e. dealing with the rising cost of managing NCDs and injuries while still battling communicable diseases that remain a major public health challenge, both in terms of mortality and in terms of disability. The total expenditure on health care in India, taking both public, private and household out-of-pocket (OOP) expenditure was about 4.1 per cent of GDP in 2008–09 (National Health Accounts [NHA] 2009), which is broadly comparable to other developing countries.

**Agenda for Health:** In order to ensure that all the services in the Twelfth Plan are provided with special attention to the needs of marginalized sections of the population by keeping in to the mind the,

- Access to services, Special services for the vulnerable and disadvantaged groups, effective Monitoring, and evaluation systems.
- Representation in community fora such as Rogi Kalyan Samitis, VHSNC, representation of the marginalized
- Training of health and rehabilitation professionals to incorporate knowledge of disability towards Universal Health Coverage etc.

**HLEG’S Recommendations under Twelfth Five Year Plan**

According to High Level Expert Group, UHC (Universal Health Coverage) ensures, equitable access for all Indian citizens in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) as well as services addressing wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider of health and related services. The coverage of assured services, especially in terms of
entitlement for in-patient treatment defines the specific mechanism through which the service will be delivered.

The HLEG has recommended the prioritization of primary health care, while ensuring that the Essential Health Package (EHP), which includes essential services at all, levels of care.

**Other Recommendations of High Level Expert Group on Universal Health Coverage**

- Health Financing and Financial Protection
- Access to Medicines
- Vaccines and Technology
- Human Resources for Health
- Health Service Norms: There should be equitable access to health facilities in urban areas by rationalizing services and focusing particularly on the health needs of the urban poor.
- Management and Institutional Reforms by National Health Regulatory and Development Authority (NHRDA), National Drug Regulatory and Development Authority (NDRDA), National Health Promotion and Protection Trust (NHPPT) are also recommended.
- Community Participation and Citizen Engagement: Existing Village Health Committees should be transformed into participatory Health Councils.
- Gender and Health: access to health services for women, girls and other vulnerable genders (going beyond maternal and child health).
- Accountability.

**Outcome Indicators:** state wise goals are the following:

- **Reduction of Infant Mortality Rate (IMR) to 25:** India is projected to have an IMR of 36 by 2015 and 32 by 2017. An achievement of the MDG of reducing IMR to 27 by 2015 would require further acceleration of this historical rate of decline. If this accelerated rate is sustained, the country can achieve an IMR of 25 by 2017.
- **Reduction of Maternal Mortality Ratio (MMR) to 100:** India is projected to have an MMR of 139 by 2015 and 123 by 2017. An achievement of the Millennium Development Goal (MDG) of reducing MMR to 109 by 2015 would require an acceleration of this historical rate of decline. At this accelerated rate of decline, the country can achieve an MMR of 100 by 2017.
- **Reduction of Total Fertility Rate (TFR) to 2.1:** India is on track for the achievement of a TFR target of 2.1 by 2017, which is necessary to achieve net replacement level of unity,
and realize the long cherished goal of the National Health Policy, 1983 and National Population Policy of 2000.

- Prevention and reduction of under-nutrition in children under 3 years to half of NFHS-3 (2005–06) levels: Underweight children are at an increased risk of mortality and morbidity. The prevalence of under-weight children is expected to be 29 per cent by 2015, and 27 per cent by 2017. The country needs to achieve a reduction in below 3-year child under-nutrition to half of 2005–06 (NFHS) levels by 2017.
- Prevention and reduction of anemia among women aged 15–49 years to 28 per cent.
- Raising child sex ratio in the 0–6 year age group from 914 to 950
- Prevention and reduction of burden of Communicable and Non-Communicable diseases (including mental illnesses) and injuries
- Out-of-pocket expenditure on health care is a burden on poor families, leads to impoverishment and is a regressive system of financing. Increase in public health spending to 1.87 per cent of GDP by the end of the Twelfth Plan, cost-free access to essential medicines in public facilities, regulatory measures proposed in the Twelfth Plan
- Funding as an instrument of incentive and reforms: Central plan expenditure has to expand by about 34 per cent per year. A key objective is to ensure that the states increase their expenditure on health. Accordingly, in the health sector, within the broad national parameters, States would have the flexibility to plan and implement their own Health Action Plans. A fixed portion of National Health Mission funds could be earmarked to States and UTs, using an objective formula based on the total population and health lag of the State.

<table>
<thead>
<tr>
<th>Department of Health and Family Welfare</th>
<th>Eleventh Plan Expenditure</th>
<th>Twelfth Plan Outlay</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH)</td>
<td>1,870</td>
<td>10,029</td>
<td>536%</td>
</tr>
<tr>
<td>Aids Control</td>
<td>1,305</td>
<td>11,394</td>
<td>873%</td>
</tr>
<tr>
<td>Total MoHFW</td>
<td>89,576</td>
<td>3,00,018</td>
<td>335%</td>
</tr>
</tbody>
</table>

**Table 1.2: Budget Support for Departments of MoHFW in twelfth Plan (2012–17)**

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**Other model for financing are**

- Public–Private Partnerships
• Recommendation for National Level Tertiary Care Institutions: More AIIMS like Institutions (ALIs) Centers of Excellence and a new category of mid-level health-workers named Community Health Officers could be developed for primary health care.

• Information technology in health to improve health care and systems, Support public health decision making for better management of health programmes and health systems at all levels Support to service providers for better quality of care and follow up Provision of quality services in remote locations through Tele-medicine

• Supporting education, and continued learning in medicine and health

National Health Mission (NHM) After the success of the National Rural Health Mission, we now want to expand the scope of health services in our towns also. The National Rural Health Mission will be converted into a National Health Mission (NHM), which would cover all villages and towns in the country. ‘The gains of the flagship programme of NRHM will be strengthened under the umbrella of NHM, which will have universal coverage. The focus on covering rural areas and rural population will continue.

A major component of NHM is proposed to be a Scheme for providing primary health care to the urban poor, particularly those residing in slums. The Ministry of Health and Family Welfare are working out modalities and institutional mechanisms for rollout of this scheme in consultation with Planning Commission. NHM would give the states greater flexibility to make multi-year plans for systems strengthening, and addressing threats to health in both rural and urban areas through interventions at Primary, Secondary and Tertiary levels of care.

Area will be

• Universal Coverage: Universal access to a continuum of cashless, health services from primary to tertiary care. Separate strategies shall be followed for the urban areas, using opportunities such as easier access to secondary and tertiary facilities, and better transport and telecommunication services.

• Achieving Quality Standards The revised IPH Standards would include the complete range of conditions, covering emergency, RCH, prevention and management of
Communicable and Non-Communicable diseases incorporating essential medicines, and Essential and Emergency Surgical Care (EESC) by enabling access to quality diagnostic facilities, pooling of resources available with different agencies, their up-gradation, achieving a minimum norm of 500 beds per 10 lakh population in an average and systems for Emergency Medical Referral to bridge the gaps in access to health facilities and need for transport in the event of an emergency.

- **Ensuring access to health care**: Among under-served population, the existing Mobile Medical Units (MMU) would be expanded to have a presence in each CHC. Mobile Medical Units may also be dedicated to certain areas, which have moving populations.

- **Decentralized Planning**: Aim is to be services accessible to populations in remote locations and within a defined time period. The districts and States using a ‘time to care’ approach would thus assess the need for new facilities of each category. This will be done based on contributing factors, including geographic spread of population, nature of terrain, availability of health care facility in the vicinity and availability of transport network. For example, a travel time of 30 minutes to reach a primary healthcare facility, and a total of two hours to reach a FRU could be a reasonable goal. As for staffing, the healthcare facilities should have a basic core staff, with provisions for additional hands in response to an increase in case load or the range of services provided. Indian Public Health Standards (IPHS) would be revised accordingly. Individual states can choose from a range of staffing options, including those suggested by the working groups on NRHM and by the HLEG. Both options will be included in the central funding. Such flexibility to states in location, size and staffing of the health care facilities would ensure optimum utilization of existing resources, and infrastructure. Every Panchayat and urban municipal ward should have at least one subcentre. The subcentres package of assured services, and consequent staffing will vary according to the epidemiological and health systems contexts.

**Priority Services areas will be**

- Access to essential medicines in all public health facilities
- Maternal and child health care will continue to be a major focus, especially given the inadequate progress in reducing IMR and MMR. Strategies to prevent pre-term births and manage pre-terms
- AYUSH doctors would to be given SBA, RCH and IMNCI training and their services will be used in meeting unmet needs. This will increase the availability of trained human resource for better outreach of child and maternal health services.
• Universal coverage of routine immunisation through campaigns in districts throughout the country is now within reach.

• Family Welfare services
• Communicable Disease Control
• Prevention and Control of Non-Communicable Diseases
• Focus on Public Health
• Behaviour Change Communication
• Care for elderly
• Mental health promotion
• Effective Governance Structures
• Health Delivery Systems

**Human Resources:** Trained and competent human capital is the foundation of an effective health system. Without adequate human resources, additional expenditure on health will not lead to additional services. Effectively functioning health systems depend on human resource, which range from medical, AYUSH and dental graduates and specialists, graduate and auxiliary nurses, and pharmacists to other allied health professionals. The production of human resource in health is a time consuming process, taking as long as nine years for a specialist, to eighteen months for an ANM. The current availability of health personnel in the country is below the minimum requirement of 250 health care personnel per lakh of population.

(From *Human Resources for Health: Overcoming the Crisis*, 2004, Joint Learning Initiative, page 23)

Generally accepted, doctor to nurse ratio should be at least 1:3 for the team to perform optimally. This ratio is currently 1:1.6 and is expected to improve to 1:2.4 by end of Twelfth Plan. These numbers regarding total availability mask the fact that there is substantial regional variation in the distribution of doctors and nurses, because of which we should plan for a total availability, which is significantly higher than the recommended minimum. If a goal of 500 health workers per lakh population by the end of Thirteenth Plan, we would need an additional 240 medical colleges, 500 general nursing and midwifery (GNM)/nursing colleges, and 970 ANMs training institutes. If work on these new teaching institutions begins from the 2013–14 annual plans, and is completed by the end of the Twelfth Plan, the flow of nurses and ANMs would begin within this plan, while doctors from these institutions would be available only from the beginning of the Thirteenth Plan. The ratio of doctors to nurses will then rise from 1:1.6 in 2012 to 1:2.8 in 2017 and reach 1:3 in 2022.

A density of 398 workers per lakhs would be well achieved by 2017, and 509 by 2021 by
• Expansion of teaching facilities
• Community participation and PRI involvement & research promotion

The National Health Policy of 2002 set an objective, which involved a re-orientation and prioritization of research to validate AYUSH therapies and drugs that address chronic and lifestyle-related emerging diseases. Cross-disciplinary research and practice requires standardization of terminologies of classical therapies, and development of Standard and Integrated Treatment Protocols (SITP). To take this ambitious research agenda forward, all five Research Councils of AYUSH will pool resources, particularly human resource, clinical facilities and information, to avoid duplication.25

National Rural Health Mission (2005-2012)

The existing evidence suggests that there is an extensive system of health care delivery which is however quite dysfunctional in many ways, making reforms in the system is something of a challenge. It is quite common that there are many beliefs due to cultural factors in rural and tribal areas, which act as hindrance in utilization of services affecting the health of the population. On the other hand, due to geographical variation in these tribal areas the location of this sub centre is far off to get access of health care facilities. The National Rural Health Mission (NRHM) has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country.26
The Mission seeks to provide universal access to equitable, affordable and quality health care, which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance. To achieve these goals NRHM will

- Facilitate increased access and utilization of quality health services by all.
- Forge a partnership between the central, state and the local governments.
- Set up a platform for involving the Panchayati Raj Institutions and community in the management of primary health programmes and infrastructure.
- Establish a mechanism to provide flexibility to the states and the community to promote local initiatives.
- Development of a framework for promoting inter-sectoral convergence for promotive and preventive health care.

**The Objectives of the Mission are**

- Reduction in child and maternal mortality
- Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women’s and children’s health and universal immunization
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary health care.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions & mainstream AYUSH.
- Promotion of healthy life styles.
The expected outcomes from the Mission as reflected in statistical data are:

• IMR reduced to be 30/1000 live births by 2012.
• Maternal Mortality reduced to be 100/100,000 live births by 2012.
• TFR reduced to 2.1 by 2012.
• Malaria Mortality Reduction Rate - 50% up to 2010, additional 10% by 2012.
• Kala Azar Mortality Reduction Rate - 100% by 2010 and sustaining elimination until 2012.
• Filariasis/Microfilaria Reduction Rate - 70% by 2010, 80% by 2012 and elimination by 2015.
• Dengue Mortality Reduction Rate - 50% by 2010 and sustaining at that level until 2012.
• Cataract operations increasing to 46 lakhs until 2012.
• Leprosy Prevalence Rate - reduce from 1.8 per 10,000 in 2005 to less than 1 per 10,000
• Tuberculosis DOTS series - maintain 85% cure rate through entire mission period and also to sustain planned case detection rate.
• Upgrading all Community Health Centers to Indian Public Health Standards.
• Increase utilization of First Referral units from bed occupancy by referred cases of less than 20% to over 75%.
• Engaging 4, 00,000 female Accredited Social Health Activists (ASHAs).

Health Care System

Health care system is intended to deliver health care services. It constitutes the management sector and involves the organizational matter. It operates in context to socioeconomic and political framework of the country. In India, following are the major sectors.

- Primary, secondary, and tertiary care institutions, manned by medical and paramedical personnel.
- Medical colleges and paraprofessional training institutions to train the needed manpower and give the required academic input.
- Programme managers managing ongoing programmes at central, state and district levels
- Health management information system consisting of a two-way system of data
- Collection, collation, analysis, and response.

So far, the interaction between these components of the system had been sub-optimal. In spite of the plethora of primary, secondary and tertiary care institutions and medical college hospitals, there are no well-organized referral linkages between the primary, secondary and tertiary care institutions in the same locality. Essential linkages between
structure and function are not in place. Logistics of supply and HMIS are not operational in most of the states.

1. Public Health Sector
A. Primary Health Care Includes
   • Primary health centers
   • Sub centers
B. Hospitals/Health Centers
   • Community health centers
   • Rural hospital
   • District hospital
   • Specialty hospital
   • Teaching hospital
C. Health Insurance Scheme
   • Employee state insurance
   • Central government health scheme
D. Other Agencies
   • Defense services
   • Railways

2. Private Sector
   A. Poly clinics, nursing homes
   B. general practitioners and clinics

3. Indigenous System of Medicine
   A. Ayurveda
   B. Yoga
   C. Unani, Siddha and Tibbi
   D. Homeopathy & Herbal medicines
   E. Acupressure and Acupuncture
   F. Unregistered practitioners

4. Voluntary Health Agencies
   National Health Programmes
   
   To improve the health of the people of Indian government has taken several measures. One of them is National health programmes. These programmes mainly focus on special issues like communicable diseases, women and child issue or condition like nutrition and health education etc. The programmes, which are currently functional, are need based or based on Community Need Assessment programmes. Few are the following programmes.
   • Vector born diseases control programme.
   • National malaria eradication programme
   • National Filaria control programme
   • Kala azar control programme
• Dengue fever control programme
• National leprosy eradication programme
• National tuberculosis control programme
• National AIDS control programme
• National programme for blindness control
• National goiter control programme
• Universal immunization programme
• Pulse polio immunization programme
• RCH programme
• National guinea worm eradication programme
• Japanese encephalitis control programme
• National surveillance programme for communicable diseases
• National mental health programme
• National diabetic control programme
• National health and family welfare programme
• National water supply and sanitation programme
• Minimum need programme

Levels of Health Care

Health care services are organized at three levels viz. primary, secondary and tertiary level of care each level is supported by higher level of care.

Primary Level of Care: This is the first level of care where interaction takes place between individual and health care system. This level of the care is closest level of the care to the people. In India, care is provided through community participation in this level. It is considered as one of the most effective level of care.

Secondary Level of Care: Problems that are more complex are dealt at this level. This level of care comprises of curative services and provided at districts Hospital and community health centre.

Tertiary Level of Care: This level offers super specialist care. This care is provided by the regional level of institutions. These institutions provide not only highly specialized care but also planning and managerial skills and teaching for specialized staff. In addition, this level support and complement the action carried out at the primary levels.30

Primary Health Care in India: At the beginning of 21st century, health care has become international topic of major concern. One of the reasons for that is pragmatism: national
health risk such as AIDS and bioterrorism. On contrary to that is ethical health care services should be provided to all the communities irrespective of their status and financial resources. Primary health care has been defined as a dynamic approach which integrates at community level by providing delivery of health care services as per the needs of the client at all levels. The world health assembly in May 1977 decided that main goal of governments and WHO in the year to come should be the attainment of health for all the people of the world by the year 2000 A.D. Further the WHO 21st target included the statement, “By the year 2010 people in a given region of a community should have much better access to family and community oriented primary health care, supported by flexible and responsive hospital system. However, at the same time, different pattern of population settlement calls for different pattern of health care.”

India is predominantly rural country and health care is rendered through primary level of health care to majority of people. A level of health that is to permit them to lead a socially and economically productive life.” The essential principle of HFA is the concept of “equality of health.” i.e. the people should have an opportunity to enjoy good health.

Chart 1.1: Primary Health Care System in India

<table>
<thead>
<tr>
<th>CHC</th>
<th>A 30 bedded hospital/referral unit for 4 PHCs with specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC</td>
<td>A Referral Unit for 6 Sub Centers 4-6 bedded, manned with a Medical Officer Incharge &amp; 1 subordinate paramedical staff</td>
</tr>
<tr>
<td>Sub Centre</td>
<td>Most peripheral contact point between Primary Health Care System &amp; Community manned with one H W (F)/AN M &amp; one H W (M)</td>
</tr>
</tbody>
</table>

Source: Rural Health Care in India

Concept of primary health care came in lime light in 1978 following an international conference in Alma Ata, USSR. This approach has been described as “health by the people.” And placing people’s health in people’s hands”. Primary health care was accepted by the member countries as the key to achieve the goal of “health for all” by the year 2000 A.D. Primary health care was defined as essential care and universally accessible to all citizens and acceptable to them through community and country can afford to maintain at every stage of their development in the spirit of self determination.” It addresses the main health problem of the community through promotive, preventive, curative, and rehabilitative health care. In India primary health care approach, provide universal comprehensive health care at a cost, which is affordable.
Primary Health Care Services

Realizing its importance in the delivery of health services, the centre, states and several government related agencies simultaneously started creating primary health care infrastructure and manpower. The government funded primary health care institutions include the rural, modern medicine primary health care infrastructure created by the states consisting of

- Subcentres 148366 on average coverage of 1/5615 (3000 to 5000 as per norms)
- Primary Health centers 24049 on average coverage of 1/34641 (20000 to 30000 as per norms)
- Community Health centers 4833 on average coverage of 1/172375 (80000 to 120000 as per norms) as on March 2012.

Tribals

India is a home to almost more than half of the world's tribal population. Approximately, more than 533 tribes are spread throughout different parts of India (Swain 2003). These tribes constitute around 8 percent of the total population, whereas the largest concentrations of tribes (15.4 million) are found in Madhya Pradesh (Chopra and Makol 2004). In Himachal Pradesh, tribal population is present in Kinnaur, Lahaul & Spiti and few areas of district Chamba. These tribes have peculiar characteristics that not only they are geographically distinct but also it has been found that each tribe having its own unique customs, traditions, beliefs and practices. Even within a particular tribal entity, differences in dialect, health practices, unique customs, values, and traditions are apparent (Naik et al. 2005).

Scheduled tribes are the lowest and traditionally poorest castes of the Hindu caste system. The term-scheduled tribes refer to various aboriginal ethnic minorities who are concentrated in their traditional lands in different parts of India. As a member of the scheduled tribes, they have distinctive social identities and face different forms of social and economic discrimination.

Tribal communities are different from other communities because of their traditional cultural background. The health care problems of tribal are more because of illiteracy, widely spread communities, poor sanitation in some areas and their customs and traditions. A number of welfare measures are undertaken by Government of India to improve general welfare, including health, in tribal communities. Despite this, there is a general belief that tribes are still following traditional methods of dealing with their health problems. So far,
very few studies have been reported on tribal health care and health practices followed by tribals.33

Since pre-historic time people have built up their settlements in different ecological zones of India. People here have got accustomed to live in varied ecological conditions. The people of India include a very large number of tribes, which are intrinsic part of our national life with their rich cultural heritage. The tribes settled down in India in pre-historic times, inhabiting mostly in the sparsely populated parts of hills and forests of Sub-Himalayan and North-Eastern regions, in the mountain belt of Central India between Narmada and Godavari rivers and in the Southern parts of the Western Ghats extending from Wynad to Kanyakumari.

The term tribe refers to a cultural and historical concept. According to Oxford Dictionary” tribe is a group of people in primitive or barbarous stage of development acknowledging the authority of a chief and usually regarding them as having a common ancestor”. For Verrier Elwin, “the word ‘tribe’ has been derived from the Latin root” The middle English term “Tribuz” meaning the three divisions into which the early Romans were grouped, came to evolve into the modern English tribe. Similarly, various authors have described the tribes by different nomenclature. As Ghurya named them ‘Backward Hindus’. Das and Das renamed them as ‘Submerged humanity’. Few named them Aboriginals, Primitive Tribe, Adivasi, Vanyajati, Vanabasi, Adimjati, Pahari etc.33

In the Constitution of India, the term tribe has not been defined clearly. Only the term ‘Scheduled Tribe’ is explained as, “the tribe or the tribal communities or parts of or groups within tribes or tribal communities.” which the President may specify by public notification. (Article 342) According to ILO Convention 107 (1957), the tribal or aboriginals have been defined as the tribal or semi-tribal groups of the independent countries deprived socially or economically and having their own customary laws/conventions. Hence in this way the term ‘tribe’ have been defined by various writers, Anthropologists, sociologists, economists and administrators in their own specific way.

Bardhan defined the tribes as a “course of socio-cultural entity at a definite historical stage of development. It is a single, endogamous community, with a cultural and psychological makeup going back into a distinct historical past.

Mujumdar defines the tribe as “a collection of families or common groups bearing a common name, the members of which occupy the same territory, speak the same language and observe certain taboos regarding marriage, Profession/occupation and have developed a well assured system of reciprocity and mutuality of obligations. Hence, it is clear from this

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definition that tribe is a separate group of persons having their own identity and cultural traits. They have customary laws, which are unwritten, but they obey them strictly. From the different definitions, the following common features of tribes emerge.

- Socially, culturally and politically an ethnic and coherent group;
- A social group speaking its own dialect and possessing a culture;
- A social group, which is small, homogenous, and distinctive.
- A group having a self-contained and self-sufficient economy;
- A social group, which is geographically isolated.

According to Singh et al., the tribal are predominantly rural. The literacy rate of the tribal was 23.63 percent lower than that of the general population. The health status of the tribal’s is lower and inferior compared to that of the general population. It is so because of the attitude of the tribal’s towards health, that disease is caused by supernatural powers and wrath of their deities and ancestral spirits and therefore, they can be cured by the pacification of these enraged supernatural powers by sacrifices of animals, religious rituals, sorcery and the witchcraft. Despite their supernatural beliefs the tribal’s have an indigenous medical system based on herbs.

State of Tribal Health in Indian Perspective

In order to ensure adequate access to health care services for the tribal population in the country there exists, 27912 SCs, 4001 PHCs, 1082 CHCs, 142 Hospitals, 78 mobile clinics and 2305 dispensaries have been established in tribal areas till March 2012. Experiments for improving access to primary health care among tribal are carried out in the states like,

**Andhra Pradesh:** Committed government functionaries are running health facilities in tribal areas

**Orissa:** Additional central assistance is provided for mobile health units with a fixed tour schedule.

**Karnataka, Maharashtra:** GO have adopted’ and are running PHCs in tribal areas.

The success of all these experiments is mainly due to the commitment of individuals and credibility of NGOs. 34

**Recommendations for Tribes in National Health Policy:** The National Health Policy 1983(being revised in 2002), categorically emphasized the urgent need for improving the tribal health especially through detection and treatment of endemic and other diseases specific to tribes. In pursuance of the policy commitments, the Ministry of Health and Family
Welfare continued to give focused attention to improve the health conditions of Schedule Tribes by implementing various health care programmes besides relaxing norms with a major objective to attend to the health needs of Schedule Tribes. A separate Tribal Development Planning Cell has been functioning under the Ministry since 1981 to co-ordinate the policy, planning, monitoring and evaluation of the health care schemes for the welfare and development of schedule tribes. Keeping in view that most of the tribal habitations are concentrated in far-flung areas, forest land, hills and remote villages, the population coverage norms have been relaxed as:

- For a Sub-Centre, the average norm for Hilly/Tribal areas has been fixed at 3,000 as against 5,000 for plains.
- For Primary Health Centre (PHCs) 20,000-coverage norm has been fixed for Hill/Tribal areas as against 30,000 for plains.
- The norm of Community Health Centers (CHCs) has been fixed at 80,000 for Hilly/tribal areas as against 1, 20,000 for plains.

Similarly, the Multipurpose Health Workers have been appointed for 30000 population in tribal areas against the norms of 5000 population for the plains.

Under the Minimum Needs Programme, 27912 Sub-Centers, 4001 PHCs and 1082 Community Health Centers (CHCs), 78 mobile clinics and 2305 dispensaries have been established in tribal areas by March 2012. In addition, the State governments have been advised to introduce schemes for compulsory annual medical examination of schedule tribes population in rural areas. Under these schemes, mobile health checkup teams are deputed to villages according to a schedule drawn up annually. In case of a need, tribal patients are entitled to avail free facilities in government/ referral hospitals.

Health care is a major problem in far-flung isolated tribal areas. Lack of food security, sanitation, safe drinking water, poor nutrition and high poverty levels aggravate the poor health status of tribes. The problem of malnutrition is multi dimensional and inter-generational in nature. Health institutions are few and far off.

Until recent times, abundance of fruits, tubers, roots, leaves in forests on one hand and indigenous health-care systems on the other hand, contributed positively to tribal health. Tribal people have developed their own medicinal system based on herbs and other items collected from nature and processed locally. However, the traditional systems cannot treat or prevent many of the diseases that modern medicine can. There are wide variations among members of different tribes in health status and in their willingness to access and utilize

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health services, depending on their culture, level of contact with other cultures and degree of adaptability.

The coverage and efficacy of health services would need to be planned with a focus on the prevalence of specific diseases amongst schedule Tribes, persistent shortages of medical and paramedical staff and lack of basic infrastructure such as roads, electricity, etc. The other problem is to find doctors and other paramedical personnel to serve in these institutions.

Therefore, creating more institutions by relaxing the norms further may not be a feasible solution, since it is even more difficult to find personnel for this increased number of institutions. Therefore, different patterns may need to be adopted in the tribal areas. To ensure access to the multi-doctor institutions, the road network as well as transportation to the surrounding villages would need to be vastly improved. The following actions can be taken. They are

- Efforts are made to devise new systems or patterns of institutions by which the access of tribes to modern health care would be enhanced.
- A synthesis of Indian systems of medicine like Ayurveda and Siddha with the tribal system and modern medicine is being promoted.

In accordance with the provisions of the PESA Act 1996, (provision of panchayat act, extension of the scheduled areas) the Gram Sabha is to have control over the para-medical staff of the health sub-centers, the intermediate Panchayats over the medical and paramedical staff of the PHCs and the Zila Panchayats over the medical and Para-medical staff of the CHCs and hospitals in their respective jurisdictions. Poor quality of drinking water and lack of awareness about hygiene and improved sanitation are major sources of water borne diseases. The government is to endeavor to improve health, drinking water supply, hygiene and sanitation amongst STs by:

- Focusing on eradication of diseases endemic to tribal areas, genetic disorders, sickle cell anemia, etc.
- Evolving a new strategy of combining indigenous tribal medicine with ISM&H so as to make healthcare accessible to interior tribal areas and also allowing the tribes to contribute their traditional knowledge;
- Taking up research, collection, collation and compilation of relevant statistics, health indicators such as nutritional status, life expectancy, IMR, MMR, disease-specific mortality rates, alcoholism, drug-addiction, disability rates, suicide rates,
• Giving special attention to the health requirements of children below 6 years, promoting immunization, preventing severe malnutrition as well as the care of pregnant and lactating mothers.

• Improving overall awareness about health, hygiene and improved sanitation among tribal community and empowering them to plan, implement, operate and maintain their own water supply and sanitation system.

• Covering earning members of tribal families with health insurance by the end of the Eleventh Plan with special provisions for every tribal girl joining the school at primary level. Reorganization and restructuring the existing government health care system including the ISM&H infrastructure at the primary, secondary and tertiary care levels with appropriate referral linkages. These institutions is to have the responsibility of taking care of all the health problems (communicable, non-communicable diseases) and deliver reproductive and child health (RCH) services for people residing in a well-defined geographic urban and rural area.

• Research and development to solve major health problems development of appropriate two-way referral systems utilizing information technology (IT) tools to improve communication, consultation and referral right from primary care to tertiary care level.

• Building up an efficient and effective logistics system for the supply of drugs, vaccines and consumables based on need and utilization.

• Horizontal integration of all aspects of the current vertical programmes including supplies, monitoring, information education communication and motivation (IECM).

• Training, administrative arrangements and implementation so that they are integral components of health care; there is progressive convergence of funding, implementation and monitoring of all health and family welfare programmes under a single field of administration beginning at and below district level.

• Improvement in the quality of care at all levels and settings by evolving and implementing a whole range of comprehensive norms for service delivery, prescribing minimum requirements of qualified staff, conditions for carrying out specialized interventions and a set of established procedures for quality assurance.

• Evolving treatment protocols for the management of common illnesses and diseases; promotion of the rational use of diagnostics and drugs.
• Evolving, implementing and monitoring transparent norms for quality and cost of care in different health care settings.

• Exploring alternative systems of health care financing including health insurance so that essential, need based and affordable health care is available to all.

• Improving content and quality of education of health professionals and Para professionals so that all health personnel have the necessary knowledge, attitude, skills, Programme and people orientation to effectively take care of the health problems, and improve the health status of the people;

• Skill up gradation of all health care providers through CME and reorientation and if necessary redeployment of the existing health manpower, so that they can take care of the existing and emerging health problems at primary secondary and tertiary care levels.  

Recommendation for Tribal Areas in Tenth Five-Year Plan 2002-07

Most of the centrally sponsored disease control programmes have a focus on the tribal areas. Under the National Anti Malaria Programme (NAMP) 100 identified predominantly tribal districts in Andhra Pradesh, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Orissa and Rajasthan are covered. In spite of all these, the access to and utilization of health care remain suboptimal and health and nutrition indices in the tribal population continue to be poor.

Besides, a focused attention was also paid to the deployment of medical and paramedical personnel in line with the recommended staffing pattern and regular field visits by them, and stocking of essential medicines/drugs, provision of Mobile Health Units, where feasible, spraying of DDT and chlorination of wells etc.

In tribal areas, various health programmes were also implemented as per the need of the specific community in the 100 hard-core identified tribal districts in the states of Andhra Pradesh, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Orissa and Rajasthan. They were covered under the enhanced Malaria Control Project with World Bank support.

The problem of Leprosy is highest amongst tribal. The National Leprosy Eradication Programme was implemented with 100 per cent central assistance covering the entire tribal population. Similarly, the National Tuberculosis Control Programme was also implemented with 100 per cent central assistance for the supply of anti-TB drugs, equipment etc. in tribal areas. Amongst the tribal, highly susceptible tribes are Primitive Tribal Groups and the nomadic groups, which are passing through the most fragile health conditions, when compared to the other tribes. Therefore, a new Scheme called ‘Medical Care for Remote and
Marginalized and Nomadic Communities’ (MCRMNC) were launched during the Ninth Five Year Plan with an approved outlay of Rs.5 crores. Under this Scheme, the following projects were taken up towards

- Prevention and control of ‘Hepatitis B’ infection amongst the PTGs of Andaman & Nicobar Islands.
- Intervention for hereditary common hemolytic disorders amongst tribal of Sundergarh district in Orissa.
- Intervention Programme for Cholera and Parasitism, Vitamin ‘A’ deficiency disorders among some PTGs of Orissa.
- Intervention Programme for Nutritional Anemia and Haemoglobinopathies amongst primitive tribal population.

For the exclusive benefit of the backward tribal dominant districts of Orissa, viz. Kalahandi, Bolangir and Koraput, a long term Action Plan was taken up rigorously with the aim of pooling the available resources and integrating them scientifically for speedy development. Apart from that, 53 mobile Health units have been functioning. The Programme of Reproductive and Child Health (RCH) also made some special provisions for those living in remote areas, where the existing services at PHC level are under-utilized. A scheme for holding special camps was initiated during the year 2000-01. The scheme is being implemented in 102 districts in eight states that are weak in implementation of RCH and seven North Eastern states.

Although the National Health Policy, 1983 accords high priority to extending organized services to those residing in the tribal, hilly and backward areas as well as to the detection and treatment of endemic diseases affecting tribal’s. Yet, the tribes continue to be one of the fragile populations, mainly due to their poor health and nutritional status. Tribal health is one of the important areas for action in the health sector. The major contributors to the increased disease risk amongst tribal communities include

- Poverty and consequent under-nutrition.
- Poor environmental sanitation, poor hygiene and lack of safe drinking water leading to increased morbidity from water and vector-borne infections.
- Lack of access to health care facilities resulting in the increased severity and duration of illnesses.
- Social barriers and taboos preventing utilization of available health care services.

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• Vulnerability to specific diseases, like G-6 PD deficiency, Yaws, and other endemic diseases like malaria etc.

In tribal population, there are wide variations in their health status, access to health care facilities and utilization of health services. There is continued commitment to provide essential primary health care; emergency life saving services, services under the National Disease Control Programmes and the National Family Welfare Programme is totally free of cost to all individuals and essential health care service to people below poverty line based on their need and not on their ability to pay for the services.°

Recommendation for Tribals in Eleventh Five-Year Plan 2007-12

• Mobile Dispensaries: The scheme provides grant-in-aid annually to meet recurring expenses for Doctor and other staff, medicines, besides meeting the costs involved in the purchase of a van/jeep and equipments. During 2010-11 up to 31.12.2010, 34 mobile dispensaries were funded in 11 States benefiting 2.12 lakhs ST beneficiaries.

• Ten or more Bedded Hospital: Assistance is extended for procurement of furniture & fixtures, hospital equipment, ambulances, a generator set and also for meeting the recurring expenses for honorarium to doctors, nurses, and other staff, procurement of medicines, building hiring charges etc. During 2010-11 up to 31.12.2010, nine hospitals have been funded in four States benefiting 3.15 lakhs numbers of ST beneficiaries.

Health Care services in Himachal Pradesh and Tribes of Himachal Pradesh

In Himachal Pradesh, 103 SCs, 43PHCs, 9 CHCs and 3 hospitals are there in the tribal areas against the requirement of 88 SCs, 13PHCs, 3 CHCs and no hospitals. However, Himachal Pradesh has far better health indicators than the country averages; still state is committed to health improvement, and makes the services available to far-flung and remote areas of the state made the basis for health care services. The main emphasis of the health care services is to:

• Increased utilization of public health services and strengthening of primary health sector
• Improving the quality of secondary health care.
• Public health administrative capacity building and extending public health services.
• Increased community participation and decentralization.
• Create dynamic, responsive, and public-centric health administration.
Table 1.3: Quantifiable targets achieved by year 2008-12 by the state of H.P.

<table>
<thead>
<tr>
<th>S.NO</th>
<th>INDICATORS</th>
<th>TARGET</th>
<th>EXISTING(2012) Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IMR</td>
<td>50</td>
<td>38</td>
</tr>
<tr>
<td>2</td>
<td>Crude death rate</td>
<td>7.0</td>
<td>6.7</td>
</tr>
<tr>
<td>3</td>
<td>Child mortality rate</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>4</td>
<td>MMR</td>
<td>300</td>
<td>NA</td>
</tr>
<tr>
<td>5</td>
<td>Life expectancy at birth</td>
<td>67 yrs</td>
<td>66.8 yrs</td>
</tr>
<tr>
<td>6</td>
<td>Low birth wt babies</td>
<td>20%</td>
<td>NA</td>
</tr>
<tr>
<td>7</td>
<td>Crude Birth Rate</td>
<td>17</td>
<td>16.5</td>
</tr>
<tr>
<td>8</td>
<td>Effective Couple Protection Rate</td>
<td>65%</td>
<td>NA</td>
</tr>
<tr>
<td>9</td>
<td>Total Fertility Rate</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>10</td>
<td>Essential Ante-natal Care</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>11</td>
<td>Deliveries by trained attendants</td>
<td>100%</td>
<td>NA</td>
</tr>
<tr>
<td>12</td>
<td>Institutional deliveries</td>
<td>45%</td>
<td>70%</td>
</tr>
<tr>
<td>13</td>
<td>Growth rate</td>
<td>1.4</td>
<td>NA</td>
</tr>
</tbody>
</table>

Data in the table indicate that the targets to be achieved by 2012 has been achieved in the sphere of IMR (Infant Mortality Rate), CDR (crude death rate), birth rate, (TFR) total fertility rate, essential ante-natal care, deliveries by trained attendants and institutional deliveries. However, the areas of child mortality rate (CMR) and life expectancy at birth needs to have attention in order to improve the outcome indicators. Despite the dramatic achievements in the sphere of health in the state, the state now needs to focus on the second generation of achievements, where the quality of services and efficiency are of vital importance. The state is all set to launch the Integrated Disease Surveillance program to combat the communicable diseases. RCH-II program has been already to take off with focus on health of mother and child, and to support all the efforts, state has been continuously engaged in increasing the public health administrative capacity and extending the services to the masses, aiming at availability of health facilities close to the residences of people, availability of trained manpower in all health institutions, improved quality of health care services, use of modern technology in health administration and management, and active participation of the community, voluntary and private sector, better coordination between different sectors and decentralization of powers.

Planning to achieve the objectives for health care services

It envisages the equality & access and aims to do a situational analysis, to correct the imbalances, efforts to reduce shortcomings, increase the efficiency and effectiveness and create a foundation to build a society which is healthy in all the aspects; body, mind and soul. Two intrinsic goals namely: Responsiveness of health system to legitimate expectations of the people of Himachal Pradesh & Fairness in financing and protection of poor from financial
risk are the underlying goals for the state. The aim is to provide the services to the people of Himachal Pradesh.38

- Equal and increased distribution of primary health care services.
- Rationalize the distribution of manpower to increase the utilization and access of services.
- Increase the number of specialists in the state to take care of complicated cases and provide specialized services.
- Continuous training of health personnel to meet the new emerging challenges and increased patient satisfaction.
- To synergize efforts with indigenous system of medicine to increase the outreach and extension of services.
- To increase involvement of community and NGO participation.

Aim
- Respect for the dignity of the person
- Prompt attention to health needs
- Basic amenities
- Respect for confidentiality
- Liquid waste disposal
- Hospital bio-medical waste management
- Solid waste management
- Excreta disposal
- Good governance practices shall initiate and strengthen existing health system to address environmental health issues in the state.

State is to focus on strengthening of infrastructure and service delivery to provide the basic care at village level, improve facilities and services in CHCs and regional hospitals and providing the best available specialized care through medical colleges.

Strengthening of Primary Healthcare in relevance to Tribal Health

As earlier said state has already surplus of health care institutions in the tribal areas. The state government recognized the need to extend the health services to the areas, which has been underserved, and providing the care to each member of the state.39

- All health Institutions to be maintained in proper conditions, and administration shall place special emphasis on proper construction of buildings, maintenance, and upkeep.
- As per the national health policy 2002, state government to utilize practitioners of Indian system of medicine and Homeopathy to expand the pool of service providers to provide the basic primary health services.
• Adolescent Health with emphasis on awareness, percolation, and sensitization of adolescents to the health in a manner that is sensitive to their needs with the help of adolescent health program.
• In addition, the focus on anemia and problem of malnutrition with special focus on women and children along with adolescent.
• State has been in the epidemiological transitional phase, and shall focus on emerging lifestyle diseases and identification of high-risk groups for the same.
• Improve the reproductive and child health services, Operation theatres and Labor Rooms shall be constructed in all Community Health Centers. First Referral Units has to be made functional in all the districts.
• Priority to senior citizens shall be accorded in OPDs.
• Special Programmes were initiated to tackle high-risk behavioral tendency. Special emphasis will be placed on adolescent health.

Strategies’ for strengthening of secondary health care in tribal areas: For provision and access of curative aspect of health care and to further strengthen the secondary health care and increase the supply, following initiatives are undertaken:
• Gaps between sanctioned and existing bed strength in all Civil Hospitals is made up by providing more bed space.
• New Civil Hospitals are opened in the sub-divisions, where no civil hospital exists.
• Blood Banks shall be started in Regional Hospital Keylong & Rekong Peo
• Quality Circles shall be set up in all civil hospitals to improve the service delivery and patient satisfaction.
• More powers shall be given to Aspatal Kalyan Samitis to generate more resources. Peoples’ representatives shall be included in Aspatal Kalyan Samitis as members.
• HIV Testing and counseling facilities shall be set up in Regional Hospital Chamba and Keylong.
• Tele counseling services shall be set up in Civil Hospitals of tribal and remote areas and shall be linked with Medical Colleges in the state.
• All Civil Hospitals at sub-divisional level shall be provided with Semi automatic Blood Analyzers to improve the laboratory services.
• All the laboratories up to block level are upgraded under ISDP program for the surveillance of communicable diseases.
• 100-bedded Civil Hospitals shall provide specialized services in medicine, surgery, Obstetrics and Gynecology and Pediatrics (Child diseases).
• Preventive care and screening efforts is strengthened in the state. All Regional and 100-bedded hospitals shall have special clinics the objective to provide primary prevention i.e. screening for early Detection and IEC facilities to provide people with relevant information.
• All Hospital shall be computerized up to block level.
• All hospitals shall have Hospital Manual and Citizens Charter and shall place emphasis on provision of quality services
• Management of hospital waste and its safe disposal is the priority. All hospitals shall be provided with equipment like incinerators, autoclaves and chemicals to dispose of biomedical hospital waste as per the provisions of the Hospital Biomedical Waste Rules 1995.

Table 1.4: State of health in Himachal Pradesh in comparison to India in 2012

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Indicator</th>
<th>HP</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Birth Rate 2012 (Per 1000)</td>
<td>16.5</td>
<td>21.6</td>
</tr>
<tr>
<td>2</td>
<td>Death Rate 2012 (Per 1000)</td>
<td>6.7</td>
<td>7.0</td>
</tr>
<tr>
<td>3</td>
<td>Maternal Mortality Rate 2012</td>
<td>212</td>
<td>N/A</td>
</tr>
<tr>
<td>4</td>
<td>Infant Mortality Rate 2012</td>
<td>36</td>
<td>42</td>
</tr>
<tr>
<td>5</td>
<td>Infant Mortality Rate 2012 (0-4 years)</td>
<td>9</td>
<td>12.2</td>
</tr>
<tr>
<td>6</td>
<td>Total Fertility Rate 2012</td>
<td>1.8</td>
<td>2.4</td>
</tr>
<tr>
<td>7</td>
<td>Life expectancy in years (male)</td>
<td>66.5 years</td>
<td>(51,2406) 64.6 years</td>
</tr>
<tr>
<td>8</td>
<td>Life expectancy in years (female)</td>
<td>67.3 years</td>
<td>67.7 years</td>
</tr>
</tbody>
</table>

The above-mentioned figures in the table have been indicated that birth rate of Himachal Pradesh is 16.5 as compared to 21.6 of India. Whereas the death rate is 6.7 as compared to 7.0 of India. Similarly, IMR, TFR, life expectancy for males and CMR are also less than the Indian scenario. However, the data for MMR was not available. Whereas the life expectancy for females was less than the Indian figures.

As it is clear from the discussion that state is improving its health care system and the health status of the people. In addition, when it comes to equity and accessibility, it really needs to be addressed specially in far-flung and remote areas of the state. As per the data, available, health care facilities are adequate in terms of infrastructure. The delivery of health care services provided under National Rural health Mission as per IPHS standards recommendation in eleventh and twelfth five-year plan to achieve the goals for health i.e. universal health care needs to assessed.

The above discussion indicates that tribal health care in the state of Himachal Pradesh is a major concern for the state and people of the tribal areas. Thus, administration tribal health care in the state of Himachal Pradesh in itself constitute a research problem which has been investigated in the present study and for the purpose of making the study in-depth and extensive, the exhaustive review of literature has been carried out in the ensuing pages.
Review of Literature

Books

In India concept of health is as old as Vedas (6000BC). Since times immemorial, health system has been developed extensively.

**Milton I. Romer (1948)** discussed the Rural Health and Medical Care and pointed out that rural areas have more incidences of communicable diseases and to improve the rural health and medical care. Central council for health and planning development programme was introduced in the first five-year plan.

**W. William Stoles (1953)** emphasized the importance of health education. According to him through health education, the individual is to learn some important aspect of promotion of health and prevention of outbreak of disease. Author has also suggested measure to deal with disease and community health

**V. Hiscock (1954),** discussed the rural community with primary health care and community organization and broad appraisal of the whole health situation and national resources and detailed standards for the control of specific diseases. Publication mainly deals with the aspects of public health, planning of community health work, organization and administration. He has explained about the financial aspects of community health work.

**Wilson G. Smillie (1955)** discussed the Public Health its Promise for the Future gave historical perspective to the public health and to human welfare. It explains that public health is an integral part of social development. Each step is interrelated to the social changes in the community. His work also explains that social development is a slow continuous, on flowing process very gradual but irreversible.

**M. Barbara Osborn (1964)** defined comprehensively the term community health and its historical perspective. He described some of the health problems of USA and world health. Other part of the book deals with various organization agencies, which interact and meet the needs of the community health.

**Usha Banergee (1976)** discussed “health administration in metropolis” has dealt with the organizational framework of health services within Delhi Municipal Corporation limit. In this publication, she has dealt with organizational framework of health services. The author discussed the problems of health administration that rises from particular mode of job distribution and from the practices of entrusting decision making which are constrained by political considerations. She has explained the difficulties in implementing health legislation relates to communicable diseases and food adulteration in Delhi Municipal Corporation.
J.L. Burn (1977) discussed Recent Advances in Public Health and explained the aspect of primary health care administration. This explains about the public health problems.

D.N. Sexena (1978) discussed Health Care and Education for Rural People and emphasized the importance of community participation in health care and education for rural people. The health system has a major role in expanding public health education, including information about available health services. The ultimate goal of both health education and community organization is to enable communities to plan and design services to meet their basic needs, and implement these plans using their own workers and such resources can be mobilized locally. The immediate need is to get people to perceive and articulate their health problems and priorities, and to demand both primary care and referral health services.

B.C. Ghosal and B. Bhandari (1978) discussed the Community Health Worker Scheme in their publication regarding the strategy to bring about community participation in health. The scheme is intended to bring the wider participation in health activities. Community health worker is the member of the community, selected by the community to provide basic health services at the doorsteps and accountable to them. The worker is also responsible for motivating the community to identify its specific health problems, organizing to deal with them, and generating the participation of people in health activities.

S.L. Goel (1984) had published a book on health care administration. He discussed about health care administration, its nature and scope along with its relationship to socioeconomic development. These publications highlight the primary health care in general. These mainly deal with the nature, scope and role of health care administration and relationship with socioeconomic development. It also deals with administrative aspect of health care administration and challenges in health care administration in context to developing countries with special reference to South East Asia. Population explosion is the main issue, which needs the attention of policy makers, administrators. However, has been without much success. This book mainly deals with population policy and family planning programmes to bring out the change in the program with time bound stipulation of objectives. It discusses the role and stages in the formulation of health policy and plan. Apart from this, the book deals with analysis of issues associated with education.

N.D. Kamble (1984) analyzed rural health and the health problem in rural areas. The publication illustrates that health problems are rampant in rural areas not due to lack of...
medical facilities but general poverty and lack of balance diet to larger proportion of rural population. Apart from these financial resources are normally absorbed in the urban areas, due to lack of availability of health care units, which lack in rural areas and do not attract additional funds.

D.P. Sharma (1999) 54 has discussed the idea and concept developed and considered by expert in the field of health in relation to bearing on the process of delivery of primary health care goal i.e. health for all.

S.L. Goel (2001) 55 in his publication health care management and management of hospital has brought out several problems faced by health administration and suggested that community participation in health care delivery system is the key factor. In all his publication, he addresses the issue of developing skills and capabilities among the professional along with professional competency among the person responsible for health care administration. According to him it is important to incorporate in the syllabus of medical institution at graduate and post graduate level the teaching with research of health care personnel in administration through executive development programme he emphasized on the need of training of health care personnel. In one of his volume he explains about the administration supported by the international agencies. Apart from this, he has dealt about the organization and working of the hospital and other rural health care, he has also dealt with agencies. He also dealt with the interrelation ship between the different health care agencies i.e. hospital, CHCs, PHCs, and SCs as well as issue faced by them administratively and technically. In one of his volume, he has discussed about the health education and sanitation as an essential feature of health development, which leads to socioeconomic development. It also deals with the issue, modification and future strategy of national health programmes both in the area of communicable and noncommunicable diseases. In this publication, it is also examined about the problem encountered in implementation of the health policy and comes out with various valuable suggestions. In his third volume the author deals with the general management like policy making, planning, decision making, and supervision etc. He has also discussed about the interpersonal relationship and transcultural analysis, motivation, morale and modernizing health care administration. Last volume laid stress upon development and management of primary care and issue likely to be encountered in the 21st century.

Rais Akhtar (2004) 56 has discussed the special organization with health care facility, inequalities and accessibilities issues. It has also addressed about the knowledge of health care in different cultures. This publication also mention about the spatial organization of the health care facilities, inequalities, accessibilities location allocation model and knowledge about the
health care system in different culture in India. Explanation about the health and illness belief is also mentioned in the book.

S.L. Goel (2005) ⁵⁷ has discussed about the organizational and administrative aspects of health care administration. The role of UN, WHO, UNICEF etc has also been assessed. The role of health administration at union level has been assessed in order to improve the administrative set up as per the needs of the society. Author has discussed the problem of coverage of the health services and its machinery at CHC, PHC and SC level. The problem concerned with multilateral technical assistance provided through these agencies by qualitative and quantitative analysis in order to assess their impact on health status of the people inhabiting this world. Further, the role of health administration at union level is assessed in order to improve its administrative set up to serve the need of the society. Author has looked in to the serious problem of the society i.e. coverage of health services and its machinery at CHCs, PHCs and SCs level.

Journals

S.C. Seal (1975)⁵⁸ has carried the comprehensive study on health administration in India. He explained the aspect of health and its administration. He has described the existing socioeconomic, demographic environment and mortality. He explained the pattern of health services in India and principle of health administration. This book also covers the aspects like available treaties on economic of medical care, budget allocation, local health services administration, community development projects, municipal health, hospital administration and health education etc.

ICSSR-ICMR (1976) ⁵⁹ analysed the studies in the field of health care and stressed the need of the use of modern management techniques to ensure cost effectiveness

Milton I. Roemer (1977)⁶⁰ has dealt with Comparative National Policy on Health Care, with national health policy in different country. This publication deals with perspective policy for health care, which could be developed by developing country.

C.L. Anderson (1973) ⁶¹ has discussed the problems which are amenable to community action and the benefit of which are channeled to individual citizens in his publication Community Health. The publication also dealt with mental health

Naik (1977) ⁶² criticized adoption of western model of health care by India

Mary Alice Clindo (1981) ⁶³ explained the role of nutrition in preventive health care. It deals with the integration of nutrition components into health care delivery system. Emphasis is given on one of its section of the nutritional problems of groups vulnerable to nutritional deficiencies.

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M.D. Saigal (1982) has analyzed the various approaches for the primary health care. He claims that people is encouraged individually and collectively to participate in health development. Govt. and medical professional is to help the people in realizing their responsibility to take care of the basic needs of the community.

Bose A. (1982) discussed on Health policy in India dealt with different aspect of health care administration. This mainly deals with the aim of health policy to secure the fundamental change in health status of the people. This study also explain about the decision on medical education, health facility health coverage medical research etc. It also includes the decision as regard the relative role of the govt., private and voluntary agencies in the promotion of health care.

Bose and Desai (1983) studied evolution of the concept of primary health care through various stages and the basic issues related to his innovative way for attaining the goal of health for all by 2000.

G. Lachenmann (1985) has analyzed the problem faced by the primary health care in the field of human resources development. According to the writer, human resources for primary health care must not only be developed for peripheral services, but that all categories of health personnel must be trained to support these approaches. Human resources should also not be reduce to formal categories and training for the institutional health system, but the productive resource which constitutes the patient and the population in general should be tapped for health.

D. Reproves (1985) has highlighted how health education is introduced in secondary schools of social republic of Slovenia, part of federal Republic of Yugoslavia. The main emphasis of introducing of health education is to create healthy conscious and to be responsible towards the community health. Basing on certain principles like prevention, early detention and active cooperation of the population in treatment and rehabilitation. In secondary schools, health education is considered as a compulsory programme. Keeping in mind that health education can influence their parents and community, learn more about first aid and preventive education and hygienic life-style. Various health education approaches, themes and concrete programmes were imparted.

Patrick Vaughan, Gill Walt and Anne Mills (1985) have studied the approaches and activities of primary health care. They also consider four major management issues that all MOH staff must tackle if they are to implement PHC successfully, namely how to plan for better health, to integrate vertical and horizontal programme activities, to budget by programmes and to implement decentralized management. In conclusion they have
enunciated that, the district could provide the most effective level for coordinating 'Top Down' and 'Bottom Up' planning of health services, better inter-Sectoral planning, community involvement and improved coordination between government and private health care.

Somnath Roy (1985) explains that the concern and concept of health development and primary health care in India date back to ancient time. In modern time the basis for health care delivery through primary health care is the recommendation of Bhore committee which gave its recommendation in 1946. It mainly deals with the principle of health for all. The concept and essential component for the development of PHC are support activities. The possible remedial measures for the existing problems have been suggested. Proper orientation and motivation is the need of the hour in order to have the achievement of set goals.

Azhar Kazmi (1988) analyzed that in large country like India the responsibility of the government is onerous because the large section of the population is BPL. So main dependency is on the government owned and managed health care institutions. The task of providing health care to this type of population in the next fifteen years can be possible if all concerned realize the relevance of management principle and technique for productive and efficient use of available resources.

Ravi Duggal (1992) is of the opinion that most of the time discussion is on primary health care and WHO definition of health. This definition is for the ideal state but not practicable under present circumstances. It has been happened with Primary Health Care, as planners are emphasizing on the various elements of WHO definition in their plan and programme.

K.Sasi Kala And Amal Ray (1992) assessed the integrated approach to health and family welfare comprise the blending of medical, public health and family welfare services at grass root level with PHC as main implementation agency. The linkage of organizational processes and social factor with the field staff work behavior has also been assessed. Author is of the claim that the main hindrance in the way of achieving objectives is the failure of the planners to relate the population control exercise to wider societal process. There is a need to reform the educational system to have scientific truthfulness.

Community action for health (1993) emphasizes on the need of peoples participation in health

Adele M.E. Jones (1993) has analyzed how the community health programmes are felt in the South Pacific countries. The author strongly supported the community health programme can be one of the most important and most available forms of education for the total community. He also outlines health programmes, health education initiatives, and an approach to participatory training in the South Pacific countries.
NIHFW completed more than 24 projects (1996-97)\textsuperscript{75} and some of them are on Health research system, study on health care providers in rural areas, assessment of training needs of health care functionaries. Development of health care delivery model for tribal areas, a study on willingness and economic capacity to pay for health care services etc are carried out.

R.K.Sapru (1997)\textsuperscript{76} in his publication on health care policy and administration in India says that though India has also adopted the national health policy in the context of the world wide objective of health for all by 2000 AD; now reoriented towards health for underprivileged, yet the country is nowhere near attainment of the same. So sustained efforts are needed to improve the health status of the people in order to raise it to the acceptable standards. He has also high lights the deficiencies, distortions and other problems related to the planning and implementations. In the end, he has given the parameters of corrective measures through evolving a proper perspective, keeping in view the change in the circumstances to the present day need.

Sanghmitra S. Acharya (1997)\textsuperscript{77} examined the inter-linkage between the changing perception of the development and concern for the women health. It highlight the development shift in the thinking in the population perception in context from targeting women during 1970 to making men more responsible. He addressed the need of health for women beyond the reproductive age. Special reference has been given to the STD, HIV/AIDS in discussing women vulnerability. Paper recommend about the creation of the awareness among the young and adolescent girl regarding the sexuality, health and family life education regarding STD, advice on nutrition etc. It also emphasizes about the involvement of NGO for policymaking and programme implementation.

BBL Sharma (1999)\textsuperscript{78} attempted a comprehensive study focusing on financing health care reforms and discussed the important situational points in context of liberalization and emphasis in the seventh and eighth plan. He also discussed the issues in the health sector reforms having bearing on the constitutional provisions like equity accessibility efficiency in utilization of resources, gender bias quality of health care and impact of liberalization on health care facilities.

Michel Moran (1999)\textsuperscript{79} explained his opinion that health care reforms has been something of an international epidemic for last twenty years. He explained the in the wake of post war expansion in the health care spending and the end of long boom.

Christopher J.L. Murray and Julio Frank (2000)\textsuperscript{80} discussed that health system vary widely in the performance and the countries with similar level of income, education and health expenditure differ in the ability to attain key health goal. The author proposes a
framework to advance the understanding of health system performance. The first step is to define the boundaries of health system based on the concept of health action. Health action is defined as any set of activities whose primary intention is to improve health enhancing responsiveness to the expectation of the population and assuring the fairness of financial contribution. Improving health means increasing the average health status and reducing the inequalities. The responsiveness includes two major components that is respect of the person and client orientation. Fairness of financial contribution means that every household pay a fair share for total health bill for a country. Everyone is protected from the financial risk due to health care. The measurement of the performance relates to the goal attainment to the resource available. Variation in the performance of these functions is the way in which the health organizes the four key functions: stewardship, financing, and resource generation by investigating these. It is not only possible to understand the proximate determinant of the health system performance but also to contemplate major policy challenge. There is a widespread agreement that both the configuration and application of state authority in the health sector should be realigned in the interest of achieving the agreed policy objectives. The desired outcome is frequently characterized as a search for good governance serving the public interest. The author examine the WHO report 2000 that the concept of stewardship offer the appropriate basis for configuration. Various dilemma that could impede or preclude or preclude such a shift in state behavior have been examined. The author concludes that the concept of stewardship holds substantial Promise if adequately developed and effectively implemented.

Norman J. Bryant, R. A. Castano et al. (2000) analyzed and adopted a tool originally developed for health insurance reforms in US. They are of the opinion that fairness is a wide term that includes the exposure to risk factors, access to all form of care and financing. It includes the efficiency of management and resource allocation, accountability and fairness and patient’s provider autonomy. The objective in the opinion of the author is to promote discussion about fairness across the disciplinary division that keeps the policy analysis and the public understanding.

Peter Berman (2000) is of the view that success in the provision of ambulatory personal health services i.e. providing individuals with treatment for acute illness and preventive health care on an ambulatory basis is the most significant contribution to the health system's performance in the most developing countries. Ambulatory personal health care has the potential to contribute the largest immediate gains in health status in populations, especially for the poor. At present, such health care accounts for the largest share of the total health
expenditure in the lower income countries. It frequently comprises the largest share of the financial burden on households associated with health care consumption, which is typically regressively distributed.

Martin Mckee and Judith Healy(2000)\textsuperscript{83} the authors examined the evolving role of the hospitals within the health care system in industrialized countries and explores the evidence on which policy makers might base their decisions. They begins by tracing the evolving the concept of the hospital, concluding that hospitals must continue to evolve in response to factors such as changing health care needs and emerging technologies. The size and distribution of hospitals are matters of ongoing debate. The paper concludes that evidence in favor of concentrating hospital facilities, whether as a means of enhancing effectiveness or efficiency, is less robust than is often assumed.

Jorge Mendoza Aldana, Helga Piechulek and Ahmed Al-Sabir (2001)\textsuperscript{84} defined comprehensively the objective of the research was to assess user expectation and client satisfaction and quality of health care provided in rural Bangladesh. The researchers found that the most powerful predictor for client satisfaction with the government services was provider behavior, especially respect and politeness. For patients this aspect was much more important than the technical competence of the provider. Furthermore, a reduction in waiting time was more important than a prolongation of the quite short consultation time. The study underscores that the cultural background of the people determines client satisfaction. It shows the dilemma that, optimally care should be capable of meeting both medical and psychological need may fail to meet the client's emotional or social needs. Conversely, care that meets psychological needs may leave may fail the clients medically at risk. It seems important that developing countries promoting client-oriented health services should carried out more in-depth research on the determinants of client satisfaction in the respective culture.

T. Sahu, N.C. Sahani and T.R. Behera (2002)\textsuperscript{85} reviewed the implementation of the revised operational strategy in order to integrate the NLEP functions into primary health care activities. An interventional strategy, in the form of consensus on job responsibilities and capacity building through training of PHC staff, was developed and adopted in a rural block under Department of Community Medicine to strengthen the integration process. The impact was studied six months after the intervention by comparing it with the leprosy situation in the pre-intervention. By comparing it with the verification of registers at the block PHC and sub-centers levels. Analysis was done using different indices of leprosy such as new case detention, compliance rate etc. This integrated approach was found to be more community oriented and effective in early case detection in children and women. It also helped in
providing continuous MDT services because of the involvement of primary health care functionaries in the post intervention period.

Renu Paruthi and P.K. Dutta (2002) analyzed critically the Reproductive and Health Programme is an integrated and comprehensive programme based on decentralized are specific micro planning tailored to meet the local needs. The paper traces the genesis and evolution of the RCH programme is by its objectives, strategies and components. Various mechanisms for the implementation, monitoring and evaluation of the programme have been discussed.

M.M. Singh, R.K. Chadda and J.S. Bapna (2003) discussed the satisfaction perception of 45 patients and 59 family members selected from outpatient department of a Psychiatric hospital. A semi-structured questionnaire was used. The components, which were kept, are like efficiency, punctuality, behavior of doctors and other staff, waiting time, supply of drugs and diet and cleanliness of the hospital etc. were enquired. Most of the patients and their escorts appreciated the services provided. Most of them were satisfied with supply of drugs, quality of diet, clinical care and cleanliness in the hospital.

David H Peters, K. Sujatha Rao and Robert Fryatt (2003) discussed that India's health system was designed in a different era, when expectations of the public and private sectors were quite different. India's population s also undergoing transitions in the demographic, epidemiological and social aspects of health. Disparities in life expectancy, disease, and access to health care and protection from financial risks have increased. These factors are challenging the health system to respond in new ways. The old approach to national health policies and programmes is increasingly inappropriate. By analyzing, inter and intra-state differences in contexts and processes, they argue that the content of national health policy needs to be more diverse and accommodating to specific states and districts. More 'splitting' of India's health policy at the state level would better address their health problems, and would open the way to innovation and local accountability. States further along the health transition would be able to develop policies to deal with the emerging epidemic of non-communicable diseases and more appropriate health financing systems. States early in the transition would need to focus on improving the quality and access of essential public health services, and empowering communities to take more ownership. Better 'lumping' of policy issues at the central level is also needed, but not in ways that have been done in the past. The Central Government needs to focus on overcoming the large inequalities in health outcomes across India, tackle growing challenges to health such as the HIV epidemic, and provide the much-needed leadership on systemic issue such as the development of systems for quality.
assurance and regulation of the private sector. It also needs to support and facilitate states and districts to develop critical capacities rather than directly manage programmes. As India develops a more diverse set of state health policies, there will be more opportunities to learn what works in different policy environments.

Tikki Pang, Ritu Sadana, Steve Hanney etal. (2003) explained that health research generate knowledge that can be utilized to improve health system performance and ultimately health and health equity. The researchers propose a conceptual framework for health research systems (HRSs) that defines boundaries, components, goals and functions. The framework adopts a system perspective towards HRSs and serves as a foundation for constructing a practical approach to describe and analyze HRSs. The analysis of HRSs should in turn, provide a better understanding of how research contributes to gains in health and health equity. Its four principal functions are stewardship, financing, creating, and sustaining resources. In addition, producing and using research. The framework, as it is applied in consultation with countries, will provide countries and donor agencies with relevant inputs to policies and strategies for strengthening HRSs and using knowledge for better health.

P. V.T. Krishna Mohan (2003) explored the correlates of anemia and used statistical techniques like means, standard deviation of means and bivariate cross tabulation among various socioeconomic and demographic variables along With maternal and child health factors. The study has identified simple, easily recognizable maternal and fetal factors, which can be taught to all levels of health functionaries. All those important factors related to childcare and nutrition should be monitored. The study account of various parameters of maternal and healthcare reflects that availability of antenatal care results in better monitoring of the pregnancy course. Early detection of anemia and its correction by appropriate supplementation along with immunization, nutritional advice and follow-ups.

Monica Munjhal and Poonam Kaushik (2004) attempted to analyze the abortions district wise and look into various socio-cultural, demographic variables related to abortion seeking and post abortion scenario. Various aspects were analyzed based on the data limited in the RCH survey separately for urban and rural areas. The researchers found that in majority of districts especially in the rural areas, the practice of induced abortion was more in the other general castes than SC couples. Accessibility, availability, awareness and economic conditions influence the decision to continue with pregnancy or terminate. In the end, they feel that there is need to improve the overall reproductive health of the women as unsafe abortions lead to complications and pose serious health problems to our society.
Andy Haines, Shyama Kuruvilla and Matthias Borchet (2004) explained that there is widespread evidence of failure to implement health interventions. That have been demonstrated to be cost effective by high quality research; this failure affects both high income and low-income countries. Low-income countries face additional challenges to using research evidence including the weakness of their health systems, lack of professional regulation and lack of access to evidence. There is need to strengthen institutions and mechanism that can more systematically promote interactions between researchers, policy makers and other stakeholders who can influence the uptake of the research findings. The concept of public engagement with health research requires a public that is both informed and active. Even when systematic reviews are available, further work is needed to translate their findings into guidelines or messages that are understandable to patients and health professionals.

Martin Buxton, Steve Hanney and Teri Jones (2004) highlighted that estimating the economic value societies of health research is a complex but essential step in establishing and justifying appropriate levels of investment in research. The practical difficulties encountered include identifying and valuing the relevant research inputs: accurately ascribing the impact. The researcher grouped the relevant studies identified from the literature into four categories based on the methods used to value the benefits of research. The first category consists of studies that value the direct cost savings that could arise from research leading either to new, less-costly treatments or to developments such as vaccines that reduce the number of patients needing treatment. The second category comprises studies that consider the value to economy of a healthy work force. The researcher feels that according to this "human capital" approach, indirect cost savings arise when better health leads to avoidance of lost production. The third category includes studies that examine gains to the economy gains to the economy in terms of product development, consequent employment and sales. The studies placed in the fourth category measure the intrinsic value to the society of the health gain, placing a monetary value of life.

Piroska Ostlin, Gita Sen and Asha George (2004) highlighted that despite the magnitude of the problem of health inequity within and between countries little systematic research has been done on the social causes of ill health. Health researchers have overwhelmingly focused on biomedical research at the level of individuals. Investigations into health of groups and the determinants of health inequalities that lie outside the control of the individuals have received a much smaller share of research resources. Ignoring factors such as socio-economic class, race and gender leads to biases in both the content and process of research. The researchers
have used two factors - poverty and gender - to illustrate how this occurs. They feel that there is a systematic imbalance in the medical journals: research into diseases that predominate in the poorest regions of the world is less likely to be published. In additions, the slow recognition of women's health problems, misdirected and partial approaches to understanding women and men's health, and the dearth of information on how gender interacts with other social determinants continue to limit the content of health research. In the research community, these imbalances in content are linked into biases against researchers from poor regions and women. Researchers from high-income countries benefit from better funding and infrastructure. Their publications dominate journals and citations. In addition, these researchers dominate advisory boards. The way to move forward is to correct biases against poverty and gender in research content and process and provide increased funding and better career incentives to support equity-linked research.

Kenneth L. Leonard and David K. Leonard (2004) analyzed that both government and private for-profit markets have been disappointing in meeting the needs of the African poor for health care. NGO services provide a much more attractive alternative for the clientele despite the fee they charge. They do so because they represent an institutional solution to the 'imperfect information' problem in the health care. Through simulations based on data from Cameroon, the authors demonstrate that if fee-charging NGOs replace the highly subsidized but poorly managed facilities operated by African governments, the poor would be better off. Those NGOs that are decentralized in their financial and personnel management are more effective. The politics of making the recommended changes are assessed.

K. Srinivasan and S.K. Mohanty (2004) analyzed the extent to which households use curative health services from different sources such as public, private and other health practitioners at different level of deprivation in India and major states, both for urban and rural areas. The study has used the deprivation index, based on simple measurement of deprivation of the households in three dimensions of deprivation: 1) basic economic assets; 2) basic amenities and 3) basic communication with the outside world. Among other findings, one of the major finding is that in the state of Bihar and Uttar Pradesh, the public sector as the sources of preventive and curative health is almost non-existent. However, in the states of Orissa and Rajasthan the people, by and large, seem to rely heavily on the health system during the time of their illness according to the NFHS-2. In this regards, there are substantial differences between the findings of NSS and NFHS.

Ian Greener (2004) critically analyzed in his article revisits the Harrison and Wood's account of health service organizational design in the UK to bring that account up to date. It
also attempts to broaden it through an increased use of political economy respectively it incorporated. Consequently, the paper presents a number of alternative findings to Harrison and Wood, reevaluating their analysis of organization from 'blueprint' to 'design'. Finally, the author is of the view that a political economy analysis examines the nature of power relations between the medical profession, the state, and the patients in a way that goes beyond a simple analysis of health organization design.

Jos Mooij and Sheela Prasad (2004) discussed the centralization and decentralization in the area of health in Andhra Pradesh and the extent to which decision-making powers have been decentralized from the state level to the district level. Based on the fieldwork and interviews in four districts and on questionnaire handed out to all main district level health administrators, the study concluded that the health policy implementation process is characterized by several conflicts and tensions within the bureaucracy. Moreover, many important powers are centralized in the state capital or the national capital and as far as they are decentralized to the districts, it is the district collector, rather than the health administrators, who holds the strings.

James N. Newell, Shanta B. Pande, Sushi I. C. Baral et al (2004) evaluated the public-private partnership to deliver the internationally recommended strategy DOTS for the control of Tuberculosis in Nepal where it is estimated that 50 per cent of patients with TB are managed in the private sector. It was found that a combination of the strengths of private practitioners, non-governmental organizations, and the public sector in a public private partnership could be used to provide a service that is liked by the patients and gives high rate of treatment success and increased rates of patient notification. Similar public-private partnerships are likely to be replicable elsewhere, as inputs are not large and so special requirements exist.

Mridula Ramanna (2004) explained comprehensibly that preventive medicine in the early 20th Century colonial India saw the conscious promotion of 'sanitary consciousness'. Several voluntary organizations attempted to educate the public on western notions of sanitation and tried to combat challenges posed by tuberculosis, infant mortality and venereal disease. The author, through a regional focus on Bombay looks at the hitherto unexplored role of semi-official and private bodies in health care. While their method was primarily educative and their reach limited to a few Cities. The collaboration between officials, doctors, and philanthropists in tackling public health challenges proved significant in the long run.

Muhammad Hasan Imam (2004) discussed the study which is a part of a larger project on the socio-economic background of female students in Rajshanshi University. The study
concludes that the concept of family physician. Which was part of the first generation educated urban middle class, does not now exist. Rapid growth of urban populace gradually impersonalized the relationship on one hand, and expanded the social demand of doctors and medicine on the other. It was found out that both ignorance and lack of interest in the treatment are considerably common. Students lack a sense of regular check up and continuation of the treatment. This lack of responsiveness is part of their socialization, families, irrespective of education and socio-economic background; lack a culture of regular medical checkup and taking preventive measures. This culture keeps them in darkness about the inherent health problems.

Eric G. Sarriot. Peter J. Winch. Leo J. Ryan etal. (2004)\textsuperscript{102} are of the opinion that the NGOs share key values about sustainability, but are skeptical about approaches perceived as disconnected from field reality. In their experience, sustainable achievements occur through the interaction of capable local stakeholders and communities. This depends strongly on enabling conditions like which NGO projects should advance. Sustainability assessment is multidimensional, value-based and embeds health within a larger sustainable development perspective. It reduces, but does not eliminate, the unpredictability of long-term outcome. It should start with the consideration of the local systems, which need to develop a common purpose.

Rajesh Kumar Aggarwal and Poonam Kaushik (2004)\textsuperscript{103} have analyzed the data at the district level to understand the pattern of public health delivery mechanism in Punjab and indicated about the level of client satisfaction.

Rajib Dasgupta and Imrana Qadeer (2005)\textsuperscript{104} have analyzed the concept of National Rural Health Mission including the role of the Common Minimum programme and the structural Adjustment Programme. They have also examined some of the main features of the NRHM from the perspective of theoretical frameworks of decentralization, integration of programmes, Primary health care, community health workers and standards.

Deoki Nandan (2005)\textsuperscript{105} is of the opinion that the NRHM holds a great hope and promises to serve the deprived and underserved communities of the rural areas. He feels that ASHA is to play a great role in spite of socio-cultural clusters in the community, which is a novel concept to melt the ice among the various cluster community groups. Regardless of constraints faced by the ASHA and success of cluster community approach in UNICEF supported community bases Maternal Child Health and Nutrition (MCHN) project. It is quite reasonable to state that inclusion of community mobilisers (Bal Parivar Mitra) from within the cluster community group might well be an asset to the programme, who may actually bring about the
task of spreading the spirit of NRHM. No doubt, it was to bring about the fee community participation and ownership.

Snehalata Panda (2005) has focused some health issues faced by the tribal women in Orissa. She assumed that inadequate medical facilities is not only the reason for dismaying condition of tribal women but there are many related problems, such as, socio-economic factors, nutritional and hygienic awareness and economic reasons etc.

Bharti Sharma (2005) has analyzed the rural health care system of the Indian village. Author says that despite numerous programmes and policies initiated by the government of India, there are still disparity and inadequacy in the rural health care system. Thus, the changes in the rural health care scenario he finds that, cohesive action and participation of concerned is needed. Without which no reforms in health sector can be expected. Any programme to improve rural health is to have the desire to have improved outcome.

Abhay Shukla (2005) has examined the programme National Rural Health Mission was declared recently. He was of the view that the programme was a significant move by the Government of India. It is to enable the public health systems in the rural areas to function, which have been long overdue and strengthen the weak link. He also ascertain that the programme was declared recently. He was of the view that the programme was a significant move by the Government of India. It is to enable the public health systems in the rural areas to function, which have been long overdue and strengthen the weak link. He also ascertain that the community to be involved in the planning and utility of health services. However, Jan Swasthya Abhiyan (JSA) has been involved in analyzing various aspects of the programme.

Medical journal of India (2005) in one of the study conducted on tribal health model for health care delivery: a clinical and epidemiological approach concluded that have faith in health care system and diet. Mortality and morbidity still exists and investigation with the help of epidemiological studies is required. A nutritionist demographic study was conducted in Negrito tribe of Andaman and Nicobar, where was present in 36%, vitamin A deficiency in 51% of people.

R.Jaishankar and C.P. Jhonson (2006) have discussed that the geometric technological tremendous potential to address public health issues particularly under the circumstances of global climate change and climate or technology induced human migration. Which results in the geographical extent and re-emergence of vector borne disease also presented an overview of the science of geometric, describe the potential impact of climate change on vector borne diseases and review the application of remote sensing data to disease vector surveillance.
B.M. Sakharkar (2009) have discussed in his publication of principle of administration and planning about the medical administration as emerging specialty, the role of the planner and administrator and medical care. Das Gupta (2009) in his publication have discussed about the hospital administration and management, biomedical engineering and human element in hospital administration as important elements.

Mary A. Nies and Melanie McEwan (2011) in their title have discussed about the community health nursing and promotion of the health of the population by using the preventive approach to public health, health promotion and risk reduction.

Joel B., Tartel Baun and Sara E. Wilensy (2012) have discussed about the health policy and law. Emphasis has been given on quality health care, policy formulation and public health preparedness for better health.

Heimer & Kevin Grunbach (2012) in their publication of understanding health policy a clinical approach has discussed about the health policy and education of health professional for the provision of better affordable health services.

Yashpal, R.K. Sharma, Libert and Anil Gomes (2013) in their publication of hospital administration, principles and practices have discussed about the areas of clinical care nursing services, hospital hazards, medical social and legal services and responsibility of hospitals for patient care. Emphasis has been given on human relations and procedural guidelines for patient care.

Thesis

Kreinkrai Klinoubol (1984) has explained about the health and family welfare administration in Thailand: A case study of Lampang province, has explained about the setting of the village fund for supporting volunteers in giving all services in primary health care to their members in the villages.

O.P. Ghai (1985) defined comprehensively the management of primary health care, has assessed the needs of the people in relation to primary health care. The focus in this publication is on discussion of principal of management and delivery of health services.

J. Meewen (1985) has discussed about peoples’ participation in the light of healthcare. He says that participation in health care is a process whereby, a person can function on his or her own behalf in the maintenance and promotion of health, prevention, detection, treatment, care etc. Participation can be in the form of self-help i.e. active involvement by the individual demedicalisation or deprofessionalisation and democratization taking responsibility for decision with regard to social policy and health care provision. He further remarks...
government, professionals and individuals to be exponents of the principles of participation but more importantly, it is seen that development in participation inevitably are not comprehensively organized. Since they are frequently the result of individual enthusiasm or concern. If participation has to be effective, we have to make full use of new education initiatives; public awareness and professionals are to accept new responsibility and challenged to meet new needs.

D.N. Kakar (1988) has published his survey and analyzed on therapeutic of traditional medical practitioners in a community development. He has also explained the role of medical practitioners playing in primary health. He also suggested that India as a vast country need to integrate the medical resources to meet primary health to all the rural population.

Meera Chatrgee (1988) has explained in her study of primary health care focus on implementing of health policy in India. It also dealt with important aspect of community participation in health care. However, this study does not deal with primary health care administration.

Sumathy S.R. (1990) has explained about The Health Practices of Tamil Nadu tribes. Study found that there is need to create the awareness about the health practices.

R.S. Goyal (1990) has discussed in his study on community participation in primary health care. The study deals with the study of the Indian efforts to involve people in the primary health care. According to this study, primary health care is essential requirement for universalisation and achievement of objectives. Primary health care is an integral part of social development, which in turn is integrated with economic development. Community participation is crucial to the concept of Primary Health Care.

R.N. Pati (1992) has discussed in his study of health, environment and development. He discussed the various issues of environment, health and development.

Sarkar S., Mandal S.K.et al (1992) carried out a study on prevalence of diarrheal Diseases among tribal is of Nicobar Island. It was found that prevalence is associated with the hygienic practices among the tribals

Srivastava M.M. and Pate N.V. (1992) has studied and explained the nutritional status of tribal and urban slum pre-school children. Regional Medical Research Centre carries out a study for Tribal Health, Jabalpur about Health seeking behavior among the BHILS and BHILLAS of Madhya Pradesh.

Adele M.E. Jones (1993) outlined the health programmes and health education initiative and approach to participatory training in south Pacific Countries. Author strongly
recommended that community health programme can be one of the most important and available type of education for the community.

Mirta Roses Pariago (1995) had written a paper on health in Tripuza district of Bolivia. Community took up some strategic line of actions such as strengthening the district health organization, providing essential drugs, other important material and training the health care staffing primary health care, developing the managerial capacity of the district team, making better use of resources through social security and promoting the social participation.

Jack Jones, Ilona Kickbusch and Desmond O’ Byrne (1995) emphasized the importance of schools in imparting the health care. School can help young people to acquire basic skills to create health, which can improve the life style. Apart from this, school health programme, which provides safe, low cost health services, and health educationist one of the most cost effective investment that a nation can make to improve health.

K. Jagga Rajamma et al. (1995) have discussed in their study on health seeking behavior, acceptability of available health facilities and knowledge about tuberculosis in tribal areas. This study was carried out in Buttayagudem district of Andhra Pradesh. This study showed that health services utilization is associated with socio demographic factors such as age, gender, and socioeconomic status. Main factor is the need felt for the health services by the people based on health status. 61% had superstitious beliefs about diseases.

Constance A. Nathanson (1996) has discussed and given three propositions i.e. public health policy plays a critical role in disease prevention and mortality decline. He is of the opinion that comparative demographic research has focused on decline in mortality from communicable diseases. Public policies are equally relevant to the prevention of exposure to tobacco etc. change in the public policy intended to affect these behaviors.

Shreekant V. Khandewala (1996) has discussed in his publication on health administration and the weaker sections in an Indian metropolis states that utilization of health facilities revealed that the people availed the medical treatment only when illness affected their day to day life.


N.K. Arora (1998) has explained in her study on public health for national agenda for governance Administrative Dimensions “has rightly mentioned the dismal state of health situation in the country to quote her “In 1978 with signing of Alma Ata declaration, India has not witnessed any major improvement in respect of health over the recent years. India remains 136 the among 174 country of the world. Public sector health care system is faced
with resource problem, administrative bottleneck, and infrastructure gap. Availability of health through public institution is confined to certain regions and inadequate equipments and manpower as well as the supply of drugs also make it difficult for the poor, especially in the rural areas to rely on public health institute. Public health system needs a complete overhauling.

**P.K Dutta (1998)** has examined that due to lack of proper career planning, among different categories of health functionaries especially working in the rural areas. It is felt that there is a need to initiate clear-cut action plan to improve motivation, efficiency and performance of health workers. The author feels the rural health services are far from satisfactory. To resolve this problem he urged to established Education Commission in health Sciences and University of Health Sciences.

**S.K.Chawla (1999)** has highlighted the primary health care administration in Himachal Pradesh. He has stressed upon the difficulty faced in the primary health care administration in the state. In addition, government institution must not be held responsible for the same.

**Rajnesh Goel (2000)** has critically analyzed primary health care administration in Karnataka. It was found that over all the primary health care administration was pathetic. There was lack of reliability on the health providers, lack of cooperation between the health personnel's, lack of health equipment in the rural areas and infrastructure wise, it was not enough to run a health centre in the rural areas. It was also found that there were no proper transport facilities for the patients as well as for the health workers. The Panchayati Raj Institution which was supposed to be the pivotal in providing and managing the health care in the rural area was not effective at all. He suggested there is a need of drastic change in health administrative system to bring a better health in the rural areas. In his study of Analysis of primary health care administration in Karnataka has emphasized the role of NGO in primary health care at all the levels especially at the first referral needs to be supported and encouraged in the backward and remote regions.

**Shyam Ashtekar (2001)** has emphasized the need to develop a rational curative package in the Primary Health Care (PHC) system by resurrecting community Health Workers (CHW). Taking into account the Indian context, PHC is inseparably linked with the issue or village health workers. This is so because much of the population lives in villages, so the CHW at large is evidence of its indispensable nature. However, seeing the ground realities he laments of any alternatives for effective implementation of health care. He proposed an alternative community health worker scheme, operationally managed by the people, who are also to make a small financial contribution, but supported largely by the state.
R.K. Sharma (2002) explained in his publication on “organization and working of health and family welfare administration in Himachal Pradesh: A critical analysis, explains about the various suggestions to improve the working of health care system in Himachal Pradesh. He emphasized the role of proper referral system and adequate supervision.

Shushma Chandra (2002) has highlighted some of the features of the National Health Policy. The National Health Policy announced recently aims at reviving the ailing health system and increasing the primary health sector outlay to ensure a more equitable access to health services across the social and geographical expanse of the country. Some of the features are like increase expenditure on health sectors of centre and state, a two-tier structure, funding and upgrading existing government medical colleges, fund for medical research, improving the ratio of nurse vis-a-vis doctors and infrastructure. Amidst of these all development, he also suggested to health authorities in the country to check and pay more attention on excessive drug prices and spiraling cost of health services to provide aid to a vast section of the population in the low income group when they may need these facilities.

Abusaleh Shariff and Geeta Singh (2002) has discussed the issues associated with the demand and supply of the five measures of maternity care antenatal care, blood pressure check up, place of delivery, use of trained help at all time of delivery and postnatal care. Econometric analyses is undertaken to find out the determinants of the use of reproductive health care services among rural Indian households. Analysis shows that the education and information variables significantly increase the utilization rates for prenatal, child delivery and postnatal health care.

H. Peters David, K. Sujitha Rao and Robert Fryatt (2003) discussed that India's health system was designed in a different era, when expectations of the public and private sectors were quite different. They are of the view that all together the India's population is undergoing transactions in all the aspect of health. The health care, life expectancy, disease and finically has been rampant with disparities. They suggested that with the change of time the content of National Health Policy needs to be more dynamic and diverse for meeting the needs of all the states and districts. They also suggested 'Splitting' or India's health policy at the state level would better address their health problems and would open the way to innovation and local accountability.

R.D. Sharma and Hardeep Chahal (2003) have analyzed the dealings with the patients in area of Jammu district. The various factors determining consumer satisfaction in rural health service among the outdoor and indoor patients have been empirically studied. For assessing the satisfaction of consumers it has been drawn from three main domains namely...
staff behavior, physical condition, infrastructure, and administrative work. The study shows low patient satisfaction in rural health. They suggested that the patient satisfaction can increase if the health care facilities are efficiently managed and effectively delivered.

Mamata Swain (2003) explained that, rural drinking water supply is a public utility delivering a basic service and an essential consumer goods to the community. Therefore, it is imperative that the users should participate in the planning, design, maintenance, construction and operation of the system. The system should be such that demand-oriented focus on what ushers want and are willing to pay for. Keeping in mind the cost recovery aspect of water services has been emphasized for sustainability.

Mohanty Bijoyini (2004) has discussed the scope and extent of problems to health administration in Orissa where the paucity of funds to run government health centre and dispensaries has brought the medical services to a dismal state. Seeing the pathetic condition of health care system the author fined it a worthy of study. The author also highlighted the health administration in Orissa and its desirability of health sector and health care infrastructure. He also highlighted certain critical Issues like medical administration, inadequate public healthcare system maintenance of qualitative healthcare institution: medical treatment other then public medical institutions and new drugs are beyond scope of provision the state exchequer. He concluded by suggesting some measures for improved healthcare.

Monica Munjhal and Poonam Kaushik (2004) have analyzed the case of abortions in Punjab based on the data RCH survey separately for urban and rural areas. They analyzed intensively for which abortions are seeking. In their findings, it was the rural areas who seeks more abortion and no exceptional with the other general caste and schedule caste couples. The reason is accessibility, availability, awareness and economic conditions influence the decision to continue with pregnancy or to terminate.

K. R. Nayar (2004) has asserted the rural health mission as absence of mission or absence of vision. The country's public sector health system stands discredited by constant neglect and lack of effective and efficient governance. Added to these cut backs, preferential treatment for the private sector and the lack of an epidemiological vision for rural health have added to the misery or public sector services. Thus, in its present form, the proposed rural health mission adds to the confusion about the country's approach to health care.

A.Benergee, Angus Deaton & Esther Dufflo (2004) explained in their study on health care delivery in rural Rajasthan. The study showed that health is poor besides the health care
facility. Quality of services is abysmal and unregulated. 80% of population goes to private practitioners.

Nirupam Bajpai and Sangeeta Goyal (2004) in their study on primary health care in India: coverage and quality issues stated that PHC in India is dysfunctional. While extensively, it is waste full, inefficient and delivers very low quality of health services. It is also pointed out that people are more likely to use health care facility if it is closely located especially in rural areas.

Abhay Shukla (2005) examined the programme of NRHM. He is of the opinion that program is a significant move by GOI. It will enable the public health system to function in the rural areas, which has been long overdue. It will also empower the community, which will be involved in planning and utilization of health care system.

Ajit K. Dalai and Subha Ray (2005) highlighted the place of social science in control treatment and betterment of health in the context of significant research contributions. They also provided an overview of the state of social science literature, particularly in reference to India social context, and bring out some of the factors critical to improving health status and a sense of well-being. They also segmented four sectors that cover most of the areas and disciplines of social sciences such as socio-economic concomitants of health, health services and systems. Health care practices and health attitudes and perceptions.

Kuldip Kaur and B. K. Pattanaik (2005) has discussed about a case study, which they carried out in about 30 villages (Saharanpur district in UP). The study covered extensively in the field of the reproductive Child health and community health aspects. Study, also reveals the socio-economic conditions of the schedule caste and backward caste among the Hindus and Muslims in the project area. The authors also studied to ensure the participation of representative of the community in generating awareness about the health and related information. Capacity building of the functionaries of Panchayati Raj Institutions and the district administration on the other hand.

Sarwan Singh (2005) discussed in his study that the patients were displeased over the system how they have to wait for long to see the doctors. The inpatients were also not satisfied how they were treated and taken care during their stay in the wards. There was lack of inter personal relationship between the patients and the health personnel. However, the doctors found that the patients were not following their prescription properly. The researcher also found that there was lack of proper channel in monitoring health and administration. There were also no proper records as well. The researcher suggested rising up the standard of
infrastructure, maintaining proper records and filling up adequate experience staff to be employed.

**B. Hema Malini (2005)** highlighted the importance of spatial data analyses in understanding the distribution patterns of various natural and cultural phenomena and their cause and effect relation and consequent environment implications. The findings for the cause of Goiter were consequence of the non-availability of iodine from the ground water and it was largely influenced by physical factors such as relief soils, climates etc. of the region.

**Barun-Mukhopadhyya (2005)** has studied the changing socio-cultural environmental milieu in the eastern Himalayas. Especially in the Sikkim-Darjeeling Himalayan region that bring forth changing community health profile. He addressed that the changing scenario of health needs to be addressed through appropriate health care delivery systems, for which reorientation of primary health care strategy may be necessary.

**M.V.S.S. Prakasa Rao (2005)** has studied about health care and health services in tribal areas. He assimilated the problems and conditions or health care and health services in tribal areas. Despite the great advances in medical science and technology and various health programmes, the changes in tribal are less visible rather many health problems had been pop up in recent past. Realizing these situations, he suggested selecting and utilizing health technology and the provision of health services. This is to make more relevant and appropriate to the needs or the community and the health care system.

**Dinesh Kumar (2005)** conducted a study on Tribal literacy disparity in India and showed that literacy rate is below average than national comprehensive area. Related health studies are lacking.

**Dina Krishna Joshi (2006)** carried out a study on health care practices of tribal. This study was carried in Orissa. Study showed that tribal has used folklore and traditional methods for their treatments.

**T.Vijay and R.K. Rao (2006)** carried out a study on malnutrition and anemia in Tribal pediatric population of Purnia district of Bihar. Study showed that 72.6 % children were malnourished and 78.1 % were anemic.

**Ramesh Bhat and Nishant Jain (2006)** have examined the relationship between public and private healthcare expenditures in India. A comparison has been drawn between public healthcare expenditure and private healthcare expenditure as per the status. The finding states that the ratio of healthcare expenditure to GDP increased as countries developed economically and industrially.
Ravinnora Nath Ojha (2006) stated health, as a prerequisite for all round development and also highlighted some of the objectives and suggested how to streamline National Rural Health Mission in the process. He considered community participation forms the cornerstone of the concept of primary healthcare to achieve the goal of health for all.

M. Gopinath Reddy (2006) elucidated the health sector reforms based on the study of primary health care delivery system in tribal areas of Andhra Pradesh. He stressed on the context of health sector, which was rampant by corruption, accountability failure, significant referral problem, and tremendous logistical problem and politicized. He also emphasized on the key problems in the health sector delivery, health sector reforms and vision 2020 in tribal areas of Andhra Pradesh. He viewed the reforms in the health sector in the last decade had failed to addressed the problems faced by the people in the rural tribal and backward areas. It was inadequate quantitatively as well as qualitatively.

C. Sathyamala (2006) has explained the setting up of the Public Health foundation in India which was to be modeled on the national academy of sciences in the US. The foundation plans to set up five "world class" institutes to provide training and conduct research in prioritized, "high impact" areas of public health as an extension of American interest. It is to be governed by technocrats / bureaucrats, nominated NGOs, and are subjected to little or no accountability / scrutiny by the Indian polity.

M. Gopinath Reddy, K. Jayalakshmi and Anne-Marie Goetz (2006) has studied the health sector in Andhra Pradesh especially the primary health care system in tribal areas of Vishakapatnam. The article was focused on the 'chain of referral' from community health workers. The study also considered how the local political dynamics shaped by competition between parties and between authorities representing the tribals. However, the credibility for poor health care in tribal areas is due to poor state machinery and health officials.

Harcharan Kaur (2006) in her study of Tertiary Health Care in Punjab: A case study of Rajindra Hospital Patiala was conducted. The success of promotion of health at secondary level depends upon organization and working of health care administration at all levels.

Suman Bala Sharma (2007) Narrated in her study about the acute shortage of the staff in the government set up. Apart from that, services provided by the private practitioner are questionable. However, NGO can play an important role in the same

Biker Singh (2007) found in his study that primary care in Rural Area of Punjab is as per the norm laid down by the government but not in term of efficacy as there is acute shortage of the field level workers.
Sunil Amrith (2007) discussed a historical perspective on the political culture of public health in India. He examined the genesis of states commitment to provide health services to people. The depth of the public health was unmatched by infrastructure and resources.

A. K. Shiva Kumar (2007) has analyzed the case of child malnutrition with reference from third National Health Survey. He found the NFHS-3 clearly shows limited progress in insuring universal health services and care for children less than three year of age and to mothers and women. He also observed the continuing neglect on health care services, the failure of strategies to reach newborn children and those under three years and administrative weakness to assure children their right to adequate nutrition and health.

Renu Khanna (2008) emphasized the need for formation of teams of ANMs, ASHAs and MPWs at the ground level, with greater convergence between the three. She suggested that MPWs can play an important role in NACP and RCH convergence and can act as a role model for the male community in areas of ARSH and prevention of STDs.

S. Chandramouli, (2009) analysed that Positioning of one MPW Male at every sub centre with clearly defined role may be supported by NRHM in the 12th Five Year Plan. Training and Career progression for ASHA, ANM, and Nurses needs to be emphasized. District wise assessment is required to analyze the differential achievement between districts (facility wise monitoring, data validation).

Kapil Yadav, Prashant Jarhyan, Vivek Gupta and Chanderkant S Panday (2009) have analyzed about the state of rural health care delivery in India. It is found that health system of India is plagued with serious resource shortfall and under development of infrastructure leading to deficient health care for majority of India. The rural population of India still does not get the basic quality of primary health care as stated in Alma-Ata conference, attended by the governments of 134 countries and various other voluntary organizations in 1978. Indian health system is stagnated today and it needs out of box thinking, a jump-start to revitalize itself. It is right time to recognize and integrate RHP with existing health care delivery system in rural areas. They can be solution for the tackling of the short falls in health care delivery system.

Freny Manecksha (2010) conducted a pilot project in community based monitoring of the NRHM in three districts of Jharkhand which provided the encouraging results. Study indicated that increased awareness and demand for antenatal care and for monetary incentive given for JSY has increased.
Anupam Hazra (2010) discussed the state of health in India. He explains about the availability and accessibility of health services in India. He is of opinion that Indian health scenario is full of contrast.

S. Vineeth (2010) discussed the NRHM and its objectives. He addressed some of the challenges and issues faced by NRHM programme.

Deoki Nandan (2010) defined comprehensively that: A Cadre of public health specialists should be set up to address the shortage of trained public health staff. There is a need of an interface between teaching institutions and public health services. There should be an investment in supportive supervision for ASHAs with one facilitator for 20 ASHAs. ASHAs should identify local influencers in cluster communities who can facilitate BCC and IEC for which they can be incentivized. Capacity building of district level staff for data management and analysis is required.

Anil Kumar (2010) stated that Integrative system of medicine should be instituted so that patients should have the right to choose the form of therapy. Curative part of PHCs should be strengthened.

P. K. Shah, (2010) analyzed that Janani Surksha Yojna scheme has laid to dramatic increase in institutional deliveries. However, this has not been accompanied by decreasing MMR. Increasing caseload of normal deliveries at tertiary centre has burdened the staff and indirectly diverted attention from complicated cases. Teams of Gynecologist, Anesthetist, Neonatologist, and the requisite infrastructure must be made available at the PHC level in order to rein in MMR and IMR. Drugs like injectable iron sucrose, Magnesium sulphate and Misprostol must be widely available at all maternal health facilities to reduce maternal mortality.

Prema Ramachandran, (2010) highlighted that Health Management and Information System is important but the quality and reliability needs to be prioritized. Local capacities should be developed to improve HMIS (health management and information system).

Anita Das (2010) is of the opinion that better evaluation and assessment studies for NRHM are required. Rational deployment of the seven-lakh AYUSH trained manpower should be done to provide better traditional health care.

Nerges Mistry (2010) is of opinion that ASHA - Shortage and replenishment of ASHA, drug kits remains an issue. Career growth, accreditation, and training of ASHAs needs to be defined. A holistic approach to Infrastructure Development should include provision of power, water and ensure road connectivity for all public health facilities.
N.K. Arora, (2011) critically analyzed that: A comparative analysis of public and private sector health facilities in 16 districts, has reported that the public sector has better infrastructure, trained HR and supplies. However, it lags behind the private sector in terms of efficiency and utilization of resources. This needs to be rectified. The available HMIS needs more investment. Real time analysis of HMIS data should be done.

Population Research Centre, Institute of Economic Growth to evaluate performance of NRHM (2011) critically analyzed in the Evaluation Study of National Rural Health Mission (NRHM) in 7 States. A study was carried out in Uttar Pradesh, Madhya Pradesh, Jharkhand, Orissa, Assam, Jammu and Kashmir and Tamil Nadu. The objective of the study was to evaluate and assess the availability, adequacy and utilization of health services in the rural areas, the role played by ASHAs, AYUSH in creating awareness of health, nutrition among the rural population and to identify the constraints and catalysts in the implementation of the NRHM programmes

Suresh Kumar Patra, L. Annam & Prof. M. Ramadass (2013) in their opinion on National Rural Health Mission (NRHM) & Health Status of Odisha: An Economic Analysis indicated that better secondary care was provided. Accountability for delivering the health services still needs to be ensured.

Ram Milan Prasot, J.V. Singh, A.K. Srivastava, Monika Agarwal (2014) in their study on the performance of ASHAs in MCH care under NRHM in rural Lucknow. The findings indicated that though nearly two third of ASHAs were assessed into good category of overall performance but most of them were performing average to poor for motivating to pregnant women for early registration, providing post natal care, motivating to eligible couples for adopting Tubectomy/ IUDs and networking with stakeholders.

**Inference Drawn from the Review of Literature** Review of literature indicates that there has been a sweeping leap in the health care system. Many health programmes has been launched. However, on looking the health status from every aspect it is clearly indicated that standard is not up to the mark. Health care in India still need a change in order to achieve the Millennium Development Goal.

After the extensive study of literature, it is found that there is intense planning and funds allocation for the tribal’s by planning commission and in five-year plans. However, their assessment for implementation and evaluation is the need of the hour so that necessary reforms and policies can be carried out in order to have the efficacy and achieving the targets of health for all or we say Universal Health Care.
Reviews of literature indicate that researches have been carried out on health and health problems. However, it needs to give emphasis on primary health care especially to the rural population, as maximum population of India is rural. The tribal population is more vulnerable because of different problem associated with tribal due to lack of knowledge, ignorance regarding diet and treatment and cultural taboos associated with health seeking behaviors.

There is disparity and inadequacy in delivery of tribal rural health care. Analysis of above cited literature reveals that various authors have studied the different aspect of health covering globally at rural as well as urban areas. The areas like client satisfaction and effectiveness of the various programmes have been only mentioned. Very less research has been conducted on the area of delivery of primary health care especially in tribal areas of Himachal Pradesh under NRHM. The study was to analyze the delivery of health care in tribal areas of Himachal Pradesh where more than seven percent are tribal live in far off and geographically difficult terrain. Moreover the under NRHM (NHM) the IPHS standards are incorporated in order to provide health Care for all by 2020 i.e. MDG (Millennium Development Goal) and universal health care (UHC). The study is to cover the role of primary health care, panchayati raj institutions in the delivery of health care services in tribal areas of Himachal Pradesh. Apart from that, sufficient documentary evidences are there to indicate that manpower is deficient in these tribal areas, which ultimately compromise with the quality of delivery of health care services in those far-flung areas.

In Himachal Pradesh, Health and Family Welfare department is providing services, which includes promotive, preventive curative and rehabilitative services through a network of 50 civil hospitals, 66 community health centers, 439 primary health centers, 22 civil/ESI dispensaries and 2069 sub-centres. To provide better easily accessible, affordable and comprehensive health services to the people, the government is strengthening the existing infrastructure by providing modern equipments, specialized services, increasing the strength of the medical and paramedical staff in the medical institutions and upgrading the status of the existing medical institutions.

Therefore, as from the discussion, it is clear that under rural health mission in India, Himachal is one of the states for mission out of 18 focus states chosen. Himachal has its tribal areas in district Kinnaur, Lahaul & Spiti and part of district Chamba and Mandi, where the health care system needs to be assessed for implementation of the various programmes of government under national rural health mission, so that the efficacy of the system can be assessed for accessibility affordability and quality health care services provided.
Scope of the present study

In developing countries like India, there is a disparity between availability, equality, accessibility of health care services. Health care cost heavily to the underprivileged and many cases, they go without the health care. Focusing on problems in health and human rights as a result of a situation of vulnerability, involves identifying its three components (accessibility, affordability, quality), and indicating its likely future performance. The communities, households, or individuals through empirical analysis. The components require the study of diverse factors (social, economic, cultural, etc.), mostly contingent to the case consideration. To find out, people are served by one health centre and from what distance the capabilities of the medical staffs treating the illness they encounter, the stock levels of essential medicines, and ability to cater to the needs of the patients. Of the total tribal population, maximum tribal population is distributed in these two select districts of the state. However, the most unfortunate fact is that the primary health care facilities are available accessible to desired extent in every remote village among the backward communities, whom health facilities have been envisaged.

The studies in the different parts of the country largely deal with the quantitative analysis of health services. The present study has analyzed the administration and delivery of health care services in the tribal districts by assessing the perception of health care providers. The present study assessed the infrastructure of the regional hospitals; community health centers, primary health centers, and subcentres in the delivery of health care services to the people of the tribal areas living in difficult geographical terrains. The satisfaction of the patients in terms of health care delivery has been assessed.

Objectives

1. To study the organizational structure of the health care system in select tribal areas in Himachal Pradesh.
2. To assess the adequacy of Health Care services in terms of infrastructure, supplies, manpower and services availability at various health care levels.
3. To examine the perception of health providers with health care administration and services provided in select tribal areas.
4. To assess the level of satisfaction among the indoor and outdoor patients in the select tribal areas.

Statements:

Statement 1: The health care institutions providing health care to the tribal people in Himachal Pradesh as per the norms of the tribal/hilly area.
Statement II: The availability of health care services is adequate in terms of
A) Infrastructure, equipment and supplies,
B) Health services availability and
C) Manpower in various health care institutions (hospitals, CHCs, PHCs and SCs of selected tribal areas).

Sub-Statement II (1A): The availability of health care services is adequate in terms of infrastructure, equipment and supplies in select hospitals of the district under study.
Sub-Statement II (1IA): The health care services are adequate in terms of availability of services provided in the hospitals under study in selected tribal areas.
Sub-Statement II (IIIA): The availability of health care services is adequate in terms of manpower in the hospitals under study in selected tribal districts.
Sub-Statement II (1B): The health care services are adequate in terms of availability of infrastructure, equipment and supplies in the Community Health Centers (CHCs) under study in select tribal districts.
Sub-Statement II (1IB): The availability of health care services is adequate in terms of provision of health care services in the community health centers under study in selected tribal districts.
Sub-Statement II(1IB): Adequate manpower is available in the community health centers under study in selected tribal districts.
Sub-Statement II(1C): The health care services are adequate in terms of infrastructure, equipment and supplies in the primary health centers (PHCs) under study in selected tribal districts.
Sub-Statement II(1IC): Adequate health care services are available in the primary health centers under study.
Sub-Statement II(1IC) Adequate manpower is available in the primary health centers under study.
Sub-Statement II(1D): The health care services are adequate in terms of infrastructure, equipment and supplies in the Primary Health Centers under study.
Sub-Statement II(1ID): The health care services are adequately available in sub centers under study.
Sub-Statement II(1ID): Adequate manpower is available in sub centers under study.

Statement III (I): Health care providers (Doctors) are satisfied with the work environment of the health care institutions.
Statement IV (I): Health care providers nurses are satisfied with the work environment of the health care institutions.

Statement V (I): MPWs (male and female) are satisfied with the work environment

Statement VI (I(1)): The indoor patients are satisfied with the provision of Health care services.

Statement VI (I(II)): The outdoor patients are satisfied with the Health care services provided by the institution.

**Hypothesis**

1. **Hypothesis III (a):** Higher is the age of the doctor's more is the satisfaction with work environment.
2. **Hypothesis III (b):** longer is the length of service more is the satisfaction with work environment
3. **Hypothesis IV (a):** More is age of Nurses more is the satisfaction.
4. **Hypothesis IV (b):** More the years in the job higher is the satisfaction.
5. **Hypothesis V (a):** More the age higher is the satisfaction with work environment.
6. **Hypothesis V (b):** Longer the service (more than 12 years) higher is the satisfaction with working environment.
7. **Hypothesis V (c):** MPWs female are having more satisfaction with work environment as compared to MPWs male.
8. **Hypothesis VI-I (a):** Lower the income higher is the patients’ satisfaction with provision of health care services. (IPD)
9. **Hypothesis VI-I (b):** Higher is the age lower is the patients satisfaction with the provision of health care services. (IPD)
10. **Hypothesis VI-I (c):** Higher is the age lower is the patients satisfaction with provision of health care services. (OPD)
11. **Hypothesis VI-I (d):** Male gender is having more patients’ satisfaction with provision of health care services. (For IPD patients)
12. **Hypothesis VI-I (e):** Higher is the qualification lower is the patients satisfaction with provision of health care services. (IPD)

**Research Methodology**

The present study has been carried out in the two tribal district of the Himachal Pradesh. As already discussed, these two districts are difficult domain for the habitation and population of these two areas is only 7% of the total population of the state. These two districts are having health challenges and problems different from the rest of the state. The
total population of these two districts is 109862 (84298 for Kinnaur and 31528 for Lahaul and Spiti) and bed strength is sufficient as per the set guidelines for the mentioned population i.e. 1381 for district Kinnaur and 184 for Lahaul & Spiti as compared to set guidelines of 1:1000. However now the set norms are not as per the population but as per the village and panchayats in geographically difficult terrain where travelling time to the health institution should not be more than 30 minutes and two hrs for the first referral unit. Problem still remain with under utilization of the services by the households. Challenge of customs and tradition, which directly or indirectly affect the utilization and availability health services in turn.

Sampling Technique
Both primary and secondary data is used. The primary data is collected from the patients, doctors’ nurses, and MPWs male and female. Observations and survey were carried out to collect data on availability of infrastructure, health care services and manpower in the public health care system.

Sample selection
Selection of Communities: Tribal areas of Himachal Pradesh viz Kinnaur and Lahaul Spiti
Selection of Health Care Services: Available health care agencies in allopathy system of medicine i.e. government agencies in specified tribal area
Study sample: Health care institution of the two select tribal districts were taken for study viz. two district hospitals, one civil hospital, seven CHC, 33 PHC (out of 37 PHCs) and 57 Sub Centers, (out of total 69 SCs). There were total 69 subcentres in both the select tribal districts and out of those 57 SCs have been chosen for the study. The remaining SCs were out of bond and could not be located as these were situated at far-flung remote areas.
Health care personnel: People serving at various governments health care agencies at various levels at different capacity i.e. doctors, nurses, MPWs.
Selection of Doctors: All the government medical practitioners under allopathy were taken as sample of the study.
Selection of The Registered Nurses: All registered nurses posted in the select tribal area.

Chart 1.4: Selection of the Health Care Providers (Nurses)

Selection of the MPW Male: All health worker male and female working in the select tribal area were taken as sample.

Chart 1.5: Selection of the Health Care Providers MPW Male
Selection of the MPW Female: All health workers female working in the select tribal area were taken as sample.

Chart 1.6: Selection of the Health Care Providers (MPW Female)

Selection of the Beneficiaries Client: people of the communities receiving health care services OPD patient included in the study were on random basis on the day of visit (those who were willing to respond to interview schedule) as following. The sample selected randomly was from RH 30 patients from each hospital, 20 from Civil Hospital Chango, 9 from each CHC, 4 from each PHC.

Chart 1.7: Selection of the OPD patients
Selections of IPD Patients  
IPD patient included in the study were 20 patients from each hospital, 15 from CHC Kaza, and 5 from Pooh were selected making total of 60 numbers of patients.

Data collection

Primary and secondary data was used in the present study. For primary data, set of interview schedule were developed. They are developed for registered medical practitioner, registered nurses, MPW male and female. Apart from this, two sets for client satisfaction were also developed i.e. for OPD and IPD patients. A checklist for basic infrastructure was prepared as per the guidelines of IPHS as per the recommendation of NRHM for rural health care system. Apart from that expert opinion were incorporated for editing the standard guidelines Observation checklist as per IPHS Norms for the assessment of health care institutions. The health institution were Regional Hospitals, Civil Hospital, CHCs, PHCs and Subcentres

Development of research tools:

Different set of interview schedule were developed

I. Interview schedule for the Doctors (annexure 1)
II. Interview schedule for the Nurses (annexure 11)
III. Interview schedule for the Multiple Health Workers (annexure iii)
IV. Interview schedule for IPD patients (annexure iv)
V. Interview schedule for satisfaction among OPD patients (annexure v)
VI. Observation checklist for various health care institutions in the districts for infrastructure, services provided, and health care professional (annexure vi)

The respondents were asked to rate each statement on three-point scale i.e. agree undecided and disagree. Observation checklist which were prepared were again on three point scale i.e. yes, to some extent/not sure and no. Secondary data was collected from records available in the various head offices and regional offices, annual reports and policy guidelines etc.

Data Analysis and Interpretation: Data has been analyzed by using SPSS and relevant statistical packages. Data is presented in tabular and graphical forms.

Limitation and assumption of the study: National Rural health Mission in itself is a broad coverage of the health programs. The districts which were taken for the study were only 7% of population but largest in geographical distribution and with very difficult geographical terrain, harsh weather conditions and total tribal population.

The term registered nurses, staff nurses and nurses have been used synonymously.

The term registered medical practitioners, doctors and allopathic doctors have been used synonymously.

The term FHWs, MPWs female and ANMs have been used synonymously.

The present study is conducted only in the allopathic health care institutions of the select tribal area, whereas the ayurvedic and naturopathy institutions are not incorporated.

Proportion of responses

Table 1.5: Assumptions considered for analyzing the proportion of response in percentage

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Range of percentage</th>
<th>Proportion of response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>30-40</td>
<td>Fairly</td>
</tr>
<tr>
<td>2.</td>
<td>41-50</td>
<td>Moderately</td>
</tr>
<tr>
<td>3.</td>
<td>51-60</td>
<td>Simple majority</td>
</tr>
<tr>
<td>4.</td>
<td>61-70</td>
<td>Fair majority</td>
</tr>
<tr>
<td>5.</td>
<td>71-80</td>
<td>Higher majority</td>
</tr>
<tr>
<td>6.</td>
<td>81-90</td>
<td>Significant majority</td>
</tr>
<tr>
<td>7.</td>
<td>91-99</td>
<td>Highly significant majority</td>
</tr>
<tr>
<td>8.</td>
<td>100</td>
<td>Cent percent</td>
</tr>
</tbody>
</table>

Assumption used for analysis of primary data

Pearson’s R and approximate significance

Table 1.6: Assumptions considered for analyzing the Test of Significance

<table>
<thead>
<tr>
<th>Positive R value</th>
<th>Approximate positive significance</th>
<th>Negative R value</th>
<th>Approximate negative significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0</td>
<td>No relationship</td>
<td>(-)0.0</td>
<td>No relationship</td>
</tr>
<tr>
<td>Below 0.4</td>
<td>Low relationship</td>
<td>Below (-)0.4</td>
<td>Low relationship</td>
</tr>
<tr>
<td>0.5 to 0.7</td>
<td>Moderate relationship</td>
<td>(-)0.5 to (-)0.7</td>
<td>Moderate relationship</td>
</tr>
<tr>
<td>0.8 to 0.9</td>
<td>High relationship</td>
<td>(-)0.8 to (-)0.9</td>
<td>High relationship</td>
</tr>
<tr>
<td>0.9 to 0.99</td>
<td>Significant high relationship</td>
<td>(-)0.9 to (-)0.99</td>
<td>Significant high relationship</td>
</tr>
<tr>
<td>1</td>
<td>Perfect positive relationship</td>
<td>(-)1</td>
<td>Perfect negative relationship</td>
</tr>
</tbody>
</table>

Assumption used for analysis of primary data. Negative and positive value will indicate the relationship
Scheme of Chapters
CHAPTER 1: Introduction, Scope and Methodology.
CHAPTER II: Organizational Structure: Himachal Pradesh and Select Tribal Districts
Chapter III: Perception and Satisfaction of Doctors with the Work Environment.
Chapter IV: Perception and Satisfaction of Registered Nurses with the Work Environment.
Chapter V: Perception and Satisfaction of Multipurpose Health Workers Male and Female with the Work Environment
Chapter VI: Patient’s Satisfaction with the Provision of Health Care Services in OPD & IPD
Chapter VII: Conclusion and Recommendations.
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