CHAPTER – II
CONCEPTUAL FRAME WORK AND REVIEW OF LITERATURE

2.1 Introduction

Health status of people and economic development of a country always go hand in hand. Healthy community is considered as a sine-quo-non for economic development and social welfare. Hence it is aptly remarked that, “Health is both an instrument and product of development.”

The prevention of diseases and promotion of good health are the basic goals of public health. The Declaration of “Alma Ata” states that, the best way to achieve the goal of “Health For All” is providing “Primary Health Care” especially to rural communities and urban poor who are devoid of these facilities.

India is one of the signatories to the “Alma Ata” Declaration 1978, was committed for the goal of “Health for All” through “Primary Health Care Approach.” The National Health Policy is the direct outcome of the land mark declaration of “Alma Ata” towards health care. Primary Health Centres occupy a prominent place in this regard.

Health sector has attracted many scholars in the latter part of the 20th century. Various studies on rural health aspect at micro as well as macro level have been conducted by number of researchers in India and abroad.

In the course of study of literature of Primary Health Centres and related health aspects, the researcher has noticed a number of issues relating to the performance, progress and problems of PHCs. The researcher is also swayed by
the earlier related literature pertaining to choice and pattern of utilisation of health care and family welfare services by the needy people.

The Review of Literature is made under the following three heads.

Section I: In this section an attempt is made to present the definition of various basic health concepts.

Section II: This section concentrates on earlier studies on various relevant aspects of health care and family welfare services of PHCs.

Section III: This section deals with a few concluding observation.

SECTION – I

2.2 Definitions of Basic Health Concepts:

1. Health Economics

The study of health economics involves the application of various micro economic tools such as demand or cost theory, to health issues and problems. The goal is to promote a better understanding of the economic aspects of health care problems so that corrective health policies can be designed and proposed. (Santerre and Neun 2000, p.4)

2. Health

Generally health implies a state of sound mind in sound body in a sound family in a sound environment. The widely accepted definition of health is given by the World Health Organisation. According to WHO - “Health is a state of complete physical mental and social well being and not merely an absence of disease or infirmity. (Preamble to constitution WHO 1948)
3. **Health Care**

It covers a broader spectrum of personal health services ranging from health education and information through prevention of diseases early diagnosis and treatment and re-habilitation. (S. Sagaya Doss, 2008, p.2)

4. **Health Care Services**

Can be defined as services rendered by labour viz. personnel engaged in medial occupations such as doctors, nurses plus other personnel, physical capital like plant and equipment used by these personnel e.g. hospitals, x-ray machines etc and intermediate goods like drugs, medicines, bandages etc., (S. Sagaya Doss op.cit, p.22)

5. **Public Health Care Delivery System**

It denotes the health care services provided by the government agencies free of cost. It includes not only medical curative measures but also services for promotion of health, prevention of diseases and epidemics and other measures taken in the sphere of hygiene, sanitation and to reduce pollution and other ecological problems. (Swarna Latha Sakhuja 2008, p.49)

6. **Primary Health Care**

This is the first level of contact between the individual and the health system where “essential” health care (Primary Health Care) is provided. A majority of prevailing health complaints and problems can be satisfactorily dealt with at this level. This level of care is closest to the people. In the Indian context this care is provided by the primary health centres and their sub centres with community participations. (K. Park 2005, p.27)
7. Medical Care

The term medical care denotes the “Science or Practice of the Diagnosis, Treatment and Prevention of Diseases” As a profession, medical care means the services rendered by a doctor or physician to develop better system of health care for the people in society. (Swarna Latha Sakhija 2008, p.47)

8. Medical Care System

The primary goal of any medical care system is to organise the health services in such a manner as to optimally utilise the available resources, knowledge and technology with a view to prevent and allivate diseases, disability and sufferings of the people. (S. Sagaya Doss 2008, p.26)

9. Health for All

Alma Ata conference reaffirmed “Health for All” as the major social goal of the governments. It has been defined as the “attainment of a level of health that will enable every individual to lead a socially and economically productive life”. (K. Park 2005, p.687)

10. Choice of Health Care

It is the probability of choosing a private medical practitioner, public medical treatment or traditional treatment. (S. Sagaya Doss 2008, p.27)

11. Perception

It is defined as a process by which one becomes aware of changes (through the senses of sight hearing etc) and act or power of perceiving. (S. Sagaya Doss 2008, p.28)
12. **Preventive Health Care**

Preventive health care is made up of those aspects of health services which deal with the prevention of ill-health. Health supervision or health check-up immunisations against communicable diseases are the important areas of study of health care. (CAK Yesudian 1988, p.3)

13. **Curative Health Care**

Curative health services is that aspect of health services which repairs the damage caused to one by illness and put him back to normal life. (CAK Yesudian 1988, p.5)

14. **Curative Medicines**

Its primary objective is the removal of diseases from patient (rather than from the masses). It employs various modalities to accomplish this objective by diagnostic techniques and treatments. (K. Park 2005, p.5)

15. **Preventive Medicines**

Is applied to “Health people” customarily by action affecting large number of populations. Its primary objective is prevention of diseases and promotion of health. (K. Park 2005, p.5)

16. **Morbidity** According to Taber’s cyclopedic medical dictionary (1962, p. 1492). Morbidity refers to the number of sick persons or cases of disease in relationship to a specific population.

17. **Mortality** (According to Taber’s Cyclopedic Medical dictionary 1962, p. 1494). Mortality refers to the condition of being mortal. It also refers to the number of deaths in a population.
SECTION – II

2.3 Review of Literature:

Research work in any discipline depends on theoretical formulations. The review of literature provides sufficient information and insight in this regard. The pioneering and independent studies on various aspects and problems of health care sector have been directly or indirectly found useful in the selection of the problem and area of the present study.

In the following pages, a brief discussion and main findings of those researches, books, articles and reports is presented which may be useful for our study.

The review is presented in five subsections. The subsection 2.3.1 introduces Health Economics. The subsection 2.3.2 presents a note on the health status and health infrastructure in India. The subsection 2.3.3 identifies the causes relating to demand for and choice of health care and family welfare services. The subsection 2.3.4 of the review of literature concentrates on the pattern of utilisation of health care and family welfare services. The sub section 2.3.5 elucidates factors influencing ill health.

2.3.1 Health Economics

Scarcity of resources becomes the fundamental problem to which economists address themselves. Infact economists are concerned with better choices and making the optimum use of existing resources. Health economics being one of the family members of economics, attempts to explain economic aspects of health care.
According to Santere, Rexfort Neun (2000, pp. 4-5) “How micro economic tools like demand or cost theory can be applied to understand the health care problems and design proper health policies to overcome such problems”. The authors have also made an attempt to define health economics in terms of determination and allocation of health care resources Highlighting the relative scarcities of resources and unlimited wants, the authors remark that “each society must make important decisions regarding the consumption, production and distribution of goods and services both medical and non medical”.

The Mosby Medical Encyclopedia (1992, p 361) defines health economics as “Health economics …… Studies the supply and demand of health care resources and the impact of health care resources on a population.”

K. N. Reddy (1994, p.4) has analysed health economics as a branch of economics concerned with the allocation of scarce resources that have alternative uses. He also opines that how the resources are allocated between health promoting activities, efficient utilisation of resources by the health providing institution and the effects of health services on the community etc are the other areas of study.

Barbara M.C. et. al. (2002, pp. 5-8) Stated that like economics in general, health economics also having two branches, the positive branch which is concerned with describing and explaining how choices are actually made, and normative branch which is concerned with judging which choices should be made. Further they opine that the government funded health care system should take into account differences in needs in different parts of the population such as age, gender and morbidity pattern while allocating resources.
Yashodha Shanmugasundaram (1994, pp. 11-12) In her study she has pinpointed that there is a need for better utilisation of resources already provided as resources are not unlimited. Therefore the basic principle applicable to the health care system should be obtaining the maximum benefit from the resources used. The author opines (Ibid p. 12) “Health economics seeks interalia to quantify time, the resources used in health care, their organisation and their funding; the efficiency with which resources are allocated and used for health purposes; and the effects of preventive, curative and rehabilitative health services on individuals and society”.

2.3.2 The Health Status and Health Infrastructure in India

Health Infrastructure and health status of people are closely related with each other. Adequate and improved health infrastructural facilities coupled with their even spread would improve the health status of the people if not remove the health related problems completely. A review of health situation provides information of health status relating to region, sex, age and diseases on the one hand and availability of health care facilities on the other.

2.3.2. A The Health Status in India:

According to Yashodha Shanmugasundaram (1994, p.62) “Health is an area tinged with emotion and enveloped in esoteric technology and vocabulary”. Measurement of health levels follows a negative approach because it is but human nature to express more clearly what is wrong with one self, than what is right. Following this method health state is measured by indicators of ill health.

Mortality and morbidity are considered to be yardstick of health status. Certain measures have also been used like Life Expectancy, Infant Mortality
Rate (IMR), Child Mortality Rate (CMR), Maternal Mortality Rate (MMR), Crude Death Rate etc., (CDR)

Ruddar Datt and KPM Sundharam (2009, pp. 163-164) have expressed optimistic view on health scenario of India. Today life expectancy of an average Indian is 65 years. It is 63.9 years in case of male and 66.9 years in case of females which was 37.2 years and 36.2 years respectively in 1951. The crude birth rate which was 40.8 per thousand in 1951 has been reduced to 23.8 per thousand in 2005-06. Crude death rate which was 25 per thousand in 1951 has been reduced to 7.6 per thousand in 2005-06. Infant mortality rate which was 146 per thousand live births in 1951 has declined to 58 per thousand live births in 2005-06. Maternal Mortality Rate was 437 per lakh live births during 1992-93 has progressively declined to 301 per lakh live births during 2001-02.

Economic Survey (2007-08, p.252) points out that, though India has improved with respect to some important health indicators over the years it compares poorly with countries like China and Sri Lanka. Life expectancy of India was 62.9 years in 2004-05 where as it was 72 in case of China and 70.8 in case of Sri Lanka during the same year. Under 5 mortality rate was 74 per thousand live births in 2005 in India whereas it was 27 in China and 14 in Sri Lanka. Infant Mortality rate was also more unfavourable to India. In 2005 IMR was 56 per thousand live births in India but it was 23 in China and 12 in Sri Lanka. Even in case of Maternal Mortality Rate India is much above that of China and Sri Lanka. MMR per lakh live birth was 450 in India, where as the figures were 45 in China and 58 in Sri Lanka in 2005.

Dinesh P.T. et al (2008, p.82), in their article observed that, Human Development Index value of China and Sri Lanka is far better than India.
J. Jayanti (2008, pp. 65-66) has quoted that according to epidemiological transition theories, as a country moves up the economic ladder, communicable diseases become relatively less prevalent and non-communicable ones become more important. The Indian situation is still highly biased towards communicable diseases.

LN Dash (2008, p. 167) in his unique study has observed the extent of disease burden in India. According to his observations, India’s share of world death is about 17 percent, which is equal to India’s share of 16.7 percent of world population. India accounts for 26 percent of the childhood infectious diseases such as pneumonia, diarrhea, measles and tetanus. India has the discredit of having 20 percent of the maternal death and 68 percent of leprosy and 30 percent tuberculosis cases of the world. About 10 percent of the HIV infected persons are in India. Communicable diseases account for 50.3 percent of the burden of diseases in India compared to only 7 percent in high income countries. The author has remarked (Ibid p.178) that though the life expectancy in India has been doubled in the last fifty years i.e. from 30 years to over 63 years in 2001, the improvement is still below the international norms. India’s life expectancy figure is even lower than many developing countries.

Rajib Dasgupta (2009, pp. 10-11) in his article “Eradicating polio; making a short story long” observed pulse polio in India is currently plagued not only by missed deadlines but also by the crisis of confidence. In 2008, there were 1625 globally reported WPV (wild polio virus) cases, 557 cases were reported in India.

Rajiv Misra et. al. (Ed) (2003, p.46) in their report, they have mentioned that scheduled caste and scheduled tribe children record 1.3 to 1.7 times more deaths
than others. Rural SC, ST, children die in larger number than their urban counter parts. This clearly shows that levels of mortality among children of disadvantaged sector are very high.

L. N. Dash (2008, p.167) has pinpointed that burden of diseases count, not only deaths but also years of healthy life lost due to disability adjusted life years (DALYs). India’s share of world’s total burden of DALY’s lost was 19.5 percent which is larger than its share of world population. The author has observed the relative neglect of women’s health reflected in reproductive health indicators (Ibid pp. 174-176)

Manisha Chawalal (2007, p. 112) in her article ‘Referral Transport Scheme for Emergency Obstetric Care under RCH – phase – I Rajasthan” observed that India accounts for the highest estimated number of maternal deaths in the world (1,36000) and has a very high mortality rate 407 per lakh live births.

Amarjit Singh (2006, pp. 77-80) Opined that India is still far from achieving the target and tangible results do not seem to be discernible in the near future in connection with maternal mortality rate. In India nearly 1,20,000 women die every year due to pregnancy related complications.

L. N. Dash (2008. pp. 169-170) has pointed out that India accounts for 40 percent of the world’s malnourished children. 60 percent of the Indian women are anemic. About 47 percent of children under five are under weighted. More than 75 percent women, adolescent girls, and children below three years suffer from nutritional anemia.

Subhash Morab (2006, p.71) has quoted few statistics about deadly disease. 12 million children are suffering from AIDS, 14 million children are HIV infected. Majority of them are below 15 years old. Between 1987 and 2006 by and large
5 lakh HTV infected cases were estimated in Karnataka state. Among them 62708 persons are identified as HIV infected and 9509 AIDS patients.

A. Balsubramanian (2007, pp.80-82) in his article “Health status of the Elderly in India” has focused on the health problems faced by elderly people and attracted the attention of the policy makers in this regard.

Hemadevi (2002, pp. 17-22) quoting a survey report has mentioned 44.44 percent male and 44.59 percent of female senior citizens reported that they were suffering from ill health.

Chandrashekharyya B. M. (2001, pp. 18-20) Quoting the report of study conducted at Mumbai, Colcatta and Chennai has shown that girls are suffering from Grade II and Grade III malnutrition compared to boys. The health status of girls is neglected for various reasons.

Ruddar Datt and KPM Sundharam (2009, p. 164) The authors have thrown the light on burden of diseases in India. 1.8 million persons develop tuberculosis, 130 million persons are exposed to the risks of Kala-azar. 7 to 9 lakh cancer cases occur every year.

India 2009 (2009, pp. 451-456) The report shows that fight against the diseases particularly leprosy and T. B. have met with sufficient success. Concentrated efforts are being made in case of vector borne diseases. The general conditions of India’s population have improved since 1990’s. Deaths due to malaria were eliminated by 1965-66. (Ibid p.454) Dengue is increasingly being reported from peri-urban and rural areas (Ibid, p.456). Japanese Encephalitis has acquired serious magnitude in the states like Uttar Pradesh, Goa, West Bengal, Assam, Tamil Nadu, Karnataka, Kerala, and Bihar (Ibid, p.456).
India 2007 (2007, p.452). According to this report, India presently ranks second country in the world as far HIV infected persons are concerned. The report shows that HIV prevalence rate in India is 0.91 percent. More than 71 million persons are suffering from goiter and other iodine deficiency disorder (Ibid, p.455).

India 2009 (2009, p.455). The report sketches a dismal picture of diseases. The Lymphatic Filaria has been reported from over 250 districts in 20 states and UTs. Chikungunya a debilitating non-fatal viral illness which has occurred in out break form in India. The number of suspected cases was 1.39 million in 2006, increased to 64548 till July 2008 (Ibid p.456) India accounts for one fifth of the global T.B. incidences. Every year there are approximately 18 lakh new cases in the country of which approximately 8 lakh are new smear positive and therefore highly infectious (Ibid p.457)

A total of 1.38 lakh leprosy cases were detected during 2007-08 with an annual new cases detection rate of 11.70 per lakh population (Ibid p.458). There are nearly 25 lakh cases of cancer in the country (Ibid – 474)

Shrinivas G. K. (2000, p.30) in his article, pointed out that not less than 14 million T. B. patients are there in India. Every year the number of T.B. patients is increasing by 22 lakhs.

Sudheendra H. R. (2002, p.59) in his article focusing on polio cases observes 1600 polio cases were recorded in India in 2002. 30 cases were identified in Karnataka in 2003.

Sandeep Berwal (2008, pp.360-361) has observed HIV positive cases in India estimated in 2004 were 5.134 million. The cumulative number of AIDS cases in
country has risen from 61201 (as on December 2003) to 103857 (as on 31st March 2005).

Christopher J. et al. (Ed) (1996, p.15) have highlighted that communicable diseases still dominate in India and in Sub Saharan Africa (51 percent and 61 percent respectively).

M. S. Gubbewad (2005, p.27) in his study pointed out that prenatal mortality and maternal mortality are high in Karnataka.

Basappa K. (1982, p. 43) in his article has pointed out that growing population in India is inviting diseases like malaria, influenza, plague etc and problems like malnutrition.

Nadakarni Vimala and Soletti Ashabanu (2006, pp. 52-53) in their article have pointed out 2.8 million people have died of AIDS in India from 1980 to 2000. Further the authors have also mentioned that most of those dying of AIDS were in the age group of 15 to 49 years.

Hema Swaminathan et al. (2009, p.101). The authors have pointed out that despite the down ward revision of AIDS large numbers of people in India continue to be affected by HIV/AIDS.

L. N. Dash (2007, p.163). In his article “Health, Education and Human Development” opined, many women in India suffer from ill-health as a result of pregnancy. The author further remarks, some of the communicable diseases cause mortality while others are responsible for significant morbidity. These diseases account for 50.3 percent of the burden of diseases in the country. (Ibid p.203)
L. N. Dash (2008, pp. 170-174) has pointed out wide variations in Infant Mortality Rate in India. State wise variations show that a lowest of 11 deaths per thousand live births in Kerala, highest of 83 in Orissa and 52 in Karnataka were recorded in 2003. IMR stands 83 among SCs, 84.5 among STs, 76 among other disadvantaged groups and at 61.8 among all others in the year 2000. 10 percent of the urban and 5 percent of the rural adult population suffers from hypertension. It is estimated that there are 2 to 2.5 million cases of cancer in India and 7,00,000 new cases are being detected every year. It has also been projected that the rate would be double by 2026. Tobacco-related cancers form more than 50 percent of the overall cancer burden in the country. (Ibid p.185).

2.3.2B. Health Infrastructure in India:

The term infrastructure can be divided into two words viz. infra and structure. Infra refers to something which lies beneath the structure. In case of health, the term infrastructure has been used in a wider sense. It includes physical infrastructure like buildings, machineries, tools etc., personnel which comprises medical as well as paramedical staff, and facilities available in the health centres like medicines, operation theatres, specialised services, curative preventive and promotive and referral services etc. An attempt has been made to review the literature, related to health infrastructure.

L. N. Dash (2008, pp. 174-176) has stated that health facilities are inadequate in India more particularly emergency obstetric care is lacking.

Om Prakash Sharma (2000, p.119) in his study concluded that Primary Health Centres and sub-centres are deficient in respect of staff and availability of medicines. The author has also emphasized the negligible maternity facilities found in PHCs and SCs.
S. Sagaya Doss (2008, p.147) in his study identified a dismal picture of health infrastructure. He confirms there was less than one doctor on an average for 1000 population in the government hospital in the study area.

Ruddar Datt and K.P.M. Sundharam (2009, pp. 164-165) have shed light on inadequate rural health infrastructure. The authors point out that there is a shortage of 18.5 percent of PHCs and 13.2 percent of sub centres of the total requirement reveals primary health care is seriously affected.

J. Jayanti (2008, pp. 72-73) According to the author there is one qualified doctor for 802 people and 1 hospital for 11744 people and 1 bed for 693 people in the country (Ibid, p.75) Lack of systematic and well functioning referral system is affecting accessibility of the poor (Ibid, p.76)

Dinesh P.T. et al (2008, pp. 86-87) have depicted poor conditions of health infrastructure in India. Quoting Human Development Report – 2002, the authors point out that in India there is only one hospital for every 68881 people and 1 hospital bed for every 1498 people and 51.8 doctors for every one lakh population. Only 38 percent of all Primary Health Centres have all the critical staff.

CAK Yesudian (1988, p.15) in his study found that, most of the health centres in India mostly provide curative health services and their role in providing preventive health care is limited.

L. N. Dash (2007, pp. 189-190) in his study, traces several interesting observations. Under staffing and vacant positions are commonly seen in the PHCs and CHCs. In Gujarat and Madhya Pradesh more than 20 percent of the PHCs do not have a single doctor. Absenteeism of doctors in Uttar Pradesh was to the extent of 58 percent. A survey conducted by NSSO in 43 districts from 14
states in the country confirms only about one fourth of all the PHCs surveyed had a tap in the premises.

Akshaya K. Panda (2008, p.205) observed that providing health care for all has all along been a challenging task, curative health care is dominating over the preventive health care. The author pinpoints that there is a huge gap in specialist doctors, Block Extension Educators, Lab-technicians, X-ray technicians. (Ibid, p.2006)

M. S. Gubbewad (2005, p.18) in his study identifies that the government’s network of PHCs and SCs have been more involved with preventive health care with a marginal component of curative out-patient care.

Economic Survey (2007-08, pp. 254-256) emphasizes that the health services provided by AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy) is largely focused on primary health care. 3203 hospitals and 21351 dispensaries across the country are rendering the health care services.

George et al. (1993) in their study confirm that Kerala state exhibits good infrastructural indicators.

Swarnalata Sakhuja (2008 p.39) Citing a study by Usha Mehta and Alka Aggarwal shows, utility of PHCs and maternity centres for poor class, women and children which are inadequate in the country in number and quality.

S. Sagaya Doss (2008, p.40) in his study citing World Bank Health Policy Statement (1980) explained that health care utilization in developing countries is characterized by low coverage. Poor communities are not being reached by modern health care.
Economic Survey (2007-08, p 254) identifies almost 50 percent of the existing health infrastructure is in rented buildings. Poor up keep and maintenance and high absenteeism of man power in rural areas have imposed a road block in rendering the health services.

Laveesh Bhandari and Siddhartha Dutta (2007, p.266) present a dismal picture of health infrastructure. Large shortfall of male health workers, lack of water and electricity, lack of repairs, inadequately functioning equipment etc have became rampant.

Choudhury et al. (2006, pp. 266-267) explained the shortage of service providers on the one hand and absenteeism among health providers on the other. The data provided by them clearly shows that in India absentee rates among health providers of primary health centres is as much as 40 percent.

L.N. Dash (2007, p.188) emphasizes that in some remote areas no functional PHCs exist to meet dire need of health care. Further the author points out that a large number of PHCs do not have minimum infrastructure and inputs. Only 77 percent of PHCs have an infant weighing machine, 65 percent had a deep freezer, 16 percent had a refrigerator and less than 20 percent had facility for medical termination of pregnancy. About one-third of the PHCs had stock of iron and folic acid tablets. About one third of the PHCs provided delivery care.

Maya Reddi (1993) in her article points out that, the problems of shortage of essential drugs in Primary Health Centres are aggravated due to allotment of drug items to all the PHCs is not according to the size and structure of disease pattern.
Zakir Hussain (2011, p.27) shows that in 2008-09 only 56 percent of ASHA's had received drug kits. Kits are not adequate and contain drugs close to the expiry date.

M.K. Rana (2003, pp. 464-465) concludes that over burdening of the ANMs has been a strong reason for poor quality of service delivery.

2.3.3 Demand for and Choice of Health Care and Family Welfare Services:

In our country co existence of Public and Private Health Care Providers is not uncommon. The growth of population coupled with increase in morbidity have pressurised the health care services, both government run health infrastructure as well as that of the private. In connection with the choice of public and private health care facilities, several interesting observations emerge from the existing literature. These observations shed light on the vital reasons for demanding and in making the choice of health care services supplied by the government and private health care providers.

According to India Infrastructure Report (2007, p.269) private sector has become the dominant source of health care services. Quoting the N.S.S.O. (2004) survey the report shows that 78 percent of rural and 81 percent of urban patients are availing private outpatient facilities and 58 percent of rural and 62 percent of urban patients are going to private hospital to avail inpatient services.

M.S. Gubbewad (2005, pp.17) Citing a study by Bhat (1991), points out that private health facilities are preferred by all social classes and income groups in both rural and urban areas.

G. M. Vishvakarma (2004, p.30) has cited the predictions of National Health Policy 2002 report that the number of persons who go to the private health
providers will increase by 2010 and hardly 20 to 35 percent of population will go
to government primary health centres.

Srinivasan S. (1987, pp. 25-52) observed that the apathy towards Allopathic Medical practitioners, limited capacity to pay the cost of treatment etc influence on the choice of health care services of rural community.

David M. Cutter (1994, pp. 14-29) in his paper vividly explains the helpless position of poor people, as far as their choice of health care services is concerned. Private hospitals are beyond the reach of the poor, public hospitals are inefficient. Therefore in majority cases when they need health care they neither go to private hospitals nor the public hospitals.

Jayanti J. (2008, p.76) in her article examined the fact that the usage of public facilities is declining. She found that private health care provision through hospital and non hospital treatment has been growing rapidly since 1986-87. In case of outpatient treatment both the rich and poor are increasingly shifting to non-government health providers for treatment.

Shubhra Singh (2008, p.214) pointed out that about 20 percent of services are being provided by the public health sector while the private health sector provides almost 80 percent of the health care services naturally, wide coverage of private health care facilities positively influence the choice of health care services.

A. Annapoorni (2007, pp. 211-212) in her study analysed the pattern of utilisation of public and private health care services. She confirms that the number of inpatients treated in selected Primary Health Centres increased from 15000 to 31776 representing 111.84 percent increase during 2000-2005. Moreover 48 percent of the selected respondents were using the services of
Primary Health Centres alone and 52% of the respondents were using both primary health centres and Private Hospitals.

Ramesh Bhat (1993 p.172) citing a study of Duggal and Amin (1989) shows that over three fourth (77 percent) of illness episodes, the patients chose private practitioners and hospitals. 13 percent patients used government hospitals. Evidence suggests that differences in income do not have much influence on the propensity to use different type of facilities.

Vishwanathan and Rohde (1990 p.173) in their study observed that 65 percent of Diarrhea cases go for medical consultation of these 80 percent go to private practitioners and 20 percent go to government practitioners.

Laveesh Bhandari and Siddhartha Dutta (2007, p.270) observe the private health care provision is better attuned to consumer requirements in rural areas.

Madhu Nagla (1997, p.100) Citing a study of van Deer Veen K Lass W (1982) showed that, though the majority of the rural population and tribal communities are dependent on the services of the Primary Health Centres, the state health centres are still under utilised.


The choice of health care services is influenced by number of factors such as level of education, income, awareness, caste, cost of treatment, transportation facilities, nature of disease and facilities at the health centres. The following studies confirm the same.
Michael Grossman (1972 pp.223-225) observed that price and education are the two important factors which determine the demand for health care.

A.D. Sharma (1986, pp.9-13) observes demand for health care is influenced by awareness, attitudes and level of education.

Matthews CME (1979) in his study observed that villagers prefer traditional healers for children’s diseases.

Madhu Nagla (1989, p.69) points out social status of people influences choice of health care.

S. Sagaya Doss (2008, pp. 145-146) in his study found that low income group had taken treatment from government hospital, middle income and high income group had taken treatment from private hospital.

Yesudian (1981) revealed that poor financial background of low and very low social classes was the major reason to compel them to have government health services where the treatment is offered free of cost.

Shashank Bhide (1991 pp.13-25) shows people are particular about quality of treatment and medicines. Hence they prefer private health care providers with increase in their financial capacity.

M. Felix Moneler and B. Murgesan (1990, pp.35-41) observed in their study that public health care facility is the choice of low income category. People belonging to higher income category were found using both private as well as government health care services.

institutions. 80 percent or more of inpatients receive treatment from public health care system in less developed states while the corresponding proportion is 40% in more developed states. Private health care institutions accounts for a much smaller proportion of illness treated in backward states with regard to inpatient care, government facilities are more intensively used than private facilities. Citing a study of Sonya (1987) the author highlights that more than 50 percent of the rich in many states were using government hospitals both in rural and urban areas. (Ibid p.18)

**Om Prakash Sharma** (2000, p.11) Citing a study of Mathews (1979) depicts that lower casts in Kodiur in Tamil Nadu, mostly used the services of PHCs because they were free.

**Rao** (1981) emphasized that most of the scheduled caste and schedule tribe groups compelled to get the treatment at government hospitals.

**Ravi Duggal** (1990, pp. 5-8) in his study observed that usually people are not ready to compromise with quality of health care. They prefer private doctors even if they have to borrow funds to meet their medical expenses. Poor people due to no other go utilise health services provided by government.

**Germona M. Mwabu** (1989, pp. 384-391) observes transportation costs hinder the people to make use of services rendered by government hospitals.

**Venkateswara Rao** (1991, pp. 37-38) also opines high cost of treatment and distance play important role in making the choice of health care services.

**S. Sagaya Doss** (2008 pp. 146-148) finds choice of health care services for treatment depends on nature of diseases. He observed that majority of the low income group had taken treatment from government hospital for common
ailments, whereas middle and high income group had taken treatment from private hospitals. Timings, cleanliness, immediate treatment etc are the other factors which compel the people to choose the health care providers.

L. N. Dash (2007 p.193) has identified distinctive pattern of utilisation of health care facilities. Private health providers are opted for outpatient curative care for minor ailments when it comes to obtaining immunisation service or antenatal care most people went to government institutions.

J. Jayanti (2008, pp. 76-77) pointed out that many slum dweller preferred private sources for minor ailments, even if they can ill afford it. Public facilities are more likely to be utilized for the lack of any other option.

Madhu Nagla (1997 pp. 96-97) citing the paper of Bhatnagar G. S. (1978) explained that people in the study village were not utilising the medical facilities provided by the government health agencies because of improper care and non availability of medicines.

2.3.4 Pattern of Utilisation of Health care and Family Welfare Services

This section is expected to throw light on two important areas. Firstly to know the reasons for utilisation of health care facilities provided by the government patronaged Primary Health Centres. Secondly the reasons for non utilisation of those services. The following studies provide information in this regard.

The health facilities provided by the government are under utilised. L. N. Dash (2008, p 203) citing the targets of National Health Policy 2002 emphasizes ‘utilisation of public health facilities should increase from less than 20 percent to more than 75 percent by 2010.'
S. Siva Raju (1991, p.55) in his article observed that inspite of the availability of government health care facilities, their utilisation is very meager hardly 10 to 20 percent.

A large share of health resources up to 50 percent in some countries are wasted because of poor management. In many rural areas health facilities operate for only two or three hours a day (Fortieth World Health Assembly Geneva May 1987, p. 71)

J. Jayanti (2008, p.75) quotes, out of every 100 people reporting an ailment amongst the urban poor about 13 do not receive any kind of treatment for one or the other pretext like ailment is not serious, lack of funds etc.

L. N. Dash (2008, pp. 178-181) citing NFHS-2 highlights how poorly the government health care services are utilised. The data reveals less than two third of mothers received antenatal checkups. A large portion of women belonging to the Scheduled Caste and Scheduled Tribe and other back ward castes do not receive antenatal check-up. Only 29.3 percent of rural children had been provided with all immunisation under Universal Immunisation Programme(UIP). About 33.6 percent of the deliveries in rural areas take place with the help of trained assistants.

Shantaram (2011, p 35) observes 6 major immunisation schemes are underfunded (Rs. 618 Cr. In 2009-10 to Rs. 511 Cr. In 2011-12)

Santerre and Neun et al (2000, p 60) and Martin Field Stein (1995 pp. 28-31) opine that inclination to pursue a healthy life style and attitudes towards health risks play important role in choosing and utilising health care services.
John S. Akin et al. (1986) in their paper have stressed about income and time costs as important factors determining utilisation of health care services.

Debebar Banergi (1989, p 178) examines two factors viz. perception of health problems and access to various relevant institutions. He also confirms that finance is also an important factor in this regard.

Ashok Sahni (1982, pp. 76-77) in his article quantitative and qualitative aspects of demand for health care observed that factors like age structure, economic position of the community, educational attainment, awareness about availability of health care, travel time and resource availability are of great importance in demanding and utilising health care services.

Madhu Nagla (1997, P.97) citing the study of Dhillon H.S. and Sri Vastav V. P. (1972) shows that curative behaviour is influenced by the way how people perceive illness. They utilise health care services if diseases are perceived to be serious and abrupt.

Many studies emphasise on correlation between income level of the consumer and pattern of health care utilisation.

D. K. Mishra et. al. (1993, pp. 283-287) in their article observed positive correlation between income level of the households and percentage of treated cases. Citing the study of Shelly I. Whit et al. (1995)

Sagaya Doss (2008, p.42) citing the study of Shelly I. White et.al. (1995) pinpoints, how annual income of the people is related with their annual medical expenditure. The author confirms that as the income increases the number of visit to hospital either for treatment or for consultation also increases. (Opcit p. 145)
CAK Yesudian (1988, p. 205) in his study observes that most of the high and middle class mothers utilised private health care for prenatal, child delivery and post natal care, where as low and very low class mothers used the public health centres for the aforesaid facilities.

Shubhra Singh (2008, p 214) in his study demonstrates that curative services largely favour the rich.

Om Prakash Sharma (2000, p.12) citing a study of Karna M. N. (1981), points out lower castes spend on curative aspects of health because of their poor financial conditions, where as high castes think more of preventive and promotive aspects of health because of their good financial background.


Some studies shed light on aspects like knowledge, education and awareness among the people in connection with utilisation of health care services.

Swarnalata Sakuja (2008, p.35) citing a study of Koos, ES, (1958) shows that there is a definite link between low status of women coupled with deficiencies in the knowledge and utilisation of preventive health services.

Panikar P.G.K. (1979, pp 1803 – 1809) in his study identified that spread of education especially among women in the rural parts of Kerala was a crucial factor contributing to the high degree of awareness of health problems and fuller utilisation of the available health care facilities.
Manisha Chavla (2007, p.115) in her study found that only 5 percent of respondents reported knowledge about the “Referral Transport Scheme” under RCH-I in 1999-2000 out of 60 only 47 heard about the scheme while 37 women received the cash benefit.

Shweta Upadhyay and A. K. Jain (2007, p 226) in their study revealed that health care awareness even among urban educated females is very low. Authors also inferred that the level of awareness and health care among the educated urban females would not be more than that of the uneducated females. This factor obviously comes in the way of proper utilisation of health care services.

Mark R. Rosenzwig and T. Paul Schultz (1991, pp, 473-500) have listed some factors like literacy level of people in general and women in particular, woman with husband, and economic background determine the level of utilisation of health care services.

Siva Raju (1991, pp. 60-61) in his study pin pointed the reasons for utilisation of private health care services. Extra ordinary shrewdness and tact, quality drugs, dependable rapport and providing treatment on credit were some of the plus points of private providers in attracting the patients.

D. K. Mishra et al. (1993 pp. 283-287) observed literate took treatment more often than illiterate. Literate adults had greater probability of being treated.

Gopalkrishna N. (1996, pp. 35-36) in his article points out the need of communication in controlling and promoting health status of the community.

Om Prakash Sharma (2000, p. 120) in his study observed that most of the programmes related to health and medical care have been running on the papers and rural folks were not even aware about these programmes.
Neelam Sukharamani (1998, pp. 634-644) in her study shows poor health care facilities and little awareness about health care prevent the community from participating at every stage of the programme.

Many researchers have quoted distance factor in utilisation of health care facilities provided by PHCs.

D.K. Mishra (1993, pp. 289-291) in his article observed that people who are nearer to the PHCs may postpone the visit to PHCs and consume traditional medicines. If the PHC is far away people may find it difficult to come to PHC more often therefore may spend more on medicines, special diet and medical check-up for quicker relief. He has also quoted another interesting incident that people usually go to PHCs between July and October when their financial position becomes relatively worse off. These observations indicate that people’s awareness, faith in treatment at the PHCs is poor.

Laveesh Bhandari and Siddhartha Dutta in their article ‘Health Infrastructure in Rural India’. India Infrastructure Report (2007, p.271) remark people residing in the far off villages are hindered by the geographical non accessibility.

Yashodha Shanmugasundaram (1994, p.11) in her study observed time and distance and cost play important role in utilisation of health care facilities.

Kakar D.N. (1981) in his paper explained how social inequality plays an important role in the utilisation of health services. He identifies lower social class or schedule caste status itself acts as a barrier in the proper utilisation of health services. He also found that government health service is still top down.

Some studies show the relation between gender and utilisation of health care services.
Swarnalata Sakhuja (2008, p.25) citing a study of Dandekar and Kumudini (1957) observes that, percentage of getting medical treatment was higher in males than females.

Dinesh P.T. et al. (2008, p.86) explains that poor women are almost vulnerable to diseases and deprived to have health care facilities.

D. K. Mishra et al. (1993, pp. 283-287) observed that probability of treatment was more for male patients. Further the authors pointed out that in general families give first priority to treating the illness of earning members (Ibid p. 293)

Debebar Benergi (1989 p. 184) found that limited capacity of PHCs makes them unable to meet the villager’s demands.

Siva Raju (1991, p.59) points out that cultural acceptability, low cost and easy accessibility of indigenous medical practitioners divert the healers from going to government health care institution.

Vijay Kumar and Chakrapani (1995) points out poorly developed curative health system, and poor management has resulted in losing faith in government health services.

Ruddar Datt and KPM Sundharam (2009, p.165) have also listed reasons like, shortage of health personnel, inadequate incentives absenteeism of health staff, long wait, inconvenient clinical hours etc., appear to be the main reasons for low utilisation of government health services and people’s growing lack of trust in the public system.

Srinivasan S. (1987, pp. 24-53) in his study shows that the primary health care facilities were not available to the people living in interior corners of rural areas. The study also emphasizes short comings of rural health infrastructure like under
staff of medical and paramedical personnel, lack of proper accommodation and amenities for PHCs and SCs, unwillingness of doctors to work in rural area etc.

Om Prakash Sharma (2000, p.103) points out inappropriate location, shortage of staff at the critical posts, are supposed to be the causes of sub optimal functioning of PHCs.

Laveesh Bhandari and Siddhartha Dutta (2007, p 267) have depicted health workers (mostly the doctors) who were found to be absent from the public clinics during the survey were mostly engaged in private medical practice. Excessive focus of public facilities towards reproductive and child health have consumed the opportunities of provision of curative care (Ibid p.270).

Panikar P.G.K. (1979, pp. 1803-1809) in his study has stressed the need of proper health policies and priorities lead to improved health status

2.3.5 Factors influencing health.

Santerre and Neun (2000, p.59) in their study observe that each person is assumed to be endowed with a given stock of health. Over the period the stock of health depreciates with age and may be augmented by investments in medical services. The rate at which health depreciates also depends on many factors such as individual’s age, physical make-up and life style, environmental factors and the amount of medical care consumed.

According to many researchers level of income of the household is a prime factor in determining morbidity and mortality.

R.P Mishra (2007, p.1) opines poverty and poor health go hand in hand. Sick person cannot work hard hence his income declines as a result he cannot get either medicines or food which leads to further deterioration in his health.
Barbara M.C. et al. (2002, p.9) poverty leads to ill health and constrains access to health care. He also observes life expectancy and infant mortality rates are more associated with the income level.

Nanda A. R. and Almas (2006, p.27) confirm that financial constraints have badly hit the poors in utilising health services. Untreated diseases among the poor have increased.

S. Sagaya Doss (2008, p.35) in his study observes household income plays important role in utilising health care services and hence on health conditions.

Shashank Bhide (1991, pp.13-25) found that poor people are worst affected. They cannot afford for better treatment and medicines due to their high prices.

Environment, insanitation, polluted water are focused in many studies as the major causes of diseases. According to Global strategy for “Health for All by the year 2000” WHO Geneva (1981 pp.19-20), in developed countries most of the deaths result from infectious and parasitic diseases insects and vectors are main causes for wide spread of diseases.

Archana Sinha (2008, pp.20-25) shows that around 7 lakh children die each year due to diarrhoea and other water sanitation related diseases. 70 to 80 percent of illness is related to water contamination and poor sanitation.

Akshaya K. Panda (2008 pp.205-206) in his article highlights approximately 50 percent and 12 percent of the Indian population are affected by diarrhea and worm infection in respectively in 1990.

P.G.K. Panikar and C. R. Soman (1984, p - 72) in their study revealed that environment is a major factor for spread of diseases. They observed that
infection rate is highest among the people in the coastal villages. Humid tropical atmosphere is conducive to the spread of respiratory infection.

**Ruddar Dutt** and **KPM Sundharam** (2009, p.164) point out, high density and congestion, poor housing condition, lack of sanitation, poor quality of drinking water lead to high incidence of diseases like asthma, T.B. malaria and heart diseases.

**Yashodha Shanmugasundaram** (Ed) (1991. p.123) observed changes in cultural patterns and environmental pollution due to accelerated pace of industrialisation causes morbidity.

**Yashodha Shanmugasundaram** (1994. pp. 12-13) has depicted that a decline in health status over a period of time can occur despite provision of health services. If the environment is generating more ill health more services are needed to prevent cure and care.

**Shipra Saxena** and **Anjal Prakash** (2008, pp. 3-4). In their article have drawn the attention that 80 percent of all sickness and diseases are due to lack of safe water and sanitation. Only 22 percent of rural households are estimated to have toilet facilities. Women in rural area often suffer from privacy and need to walk large distances to find a suitable place for defecation causing health problems such as urinary tract infection. They have also observed that 60 percent of child morbidity is caused by unhygienic environment.

**Malini Karkl** (1991, p.15) **Sanjay Sangole** (2008, pp. 346-347) pointed out nutritional deficiency, protein energy malnutrition and outdoor sleeping habits are the causes of health problems.
Editorial of Economic and Political weekly (May 9, 2009, p5) cautioned that the influenza-A (H1N1) epidemic once again shows that lack of hygiene, clean drinking water, inaccessibility to sanitation and living in proximity to live stock are risk factors that almost all poor countries face.

David Hamburg and Norman Sartorius (1989, p.206) in their study observed that 50 percent of mortality from the ten leading causes of death can be traced to behaviour such as smoking, drinking alcohol, eating inappropriate foods.

B. K. Kiranmayee (1996, pp.26-28) listed factors like air pollution, noise pollution, cigarette etc are directly responsible for heart diseases.

Christophar J. and L. Murray (Ed) (1996, p.3) have pointed out that by 2020 tobacco is expected to kill more people than any single disease, surpassing even the HIV epidemic.

Some studies have attempted to find the causes of maternal deaths.

Manisha Chawla (2007, pp. 112-113) characterised that 80 percent of maternal deaths are due to the direct result of complications arising during pregnancy. Delay in deciding to seek medical care, delay in reaching medical facilities with adequate care, delay in receiving quality emergency obstetric care, and untrained birth attendants who are forced to conduct delivery inspite of identification of complications.

L. N. Dash (2007, pp. 162-163) explained that maternal deaths are due to lack of adequate health facilities during pregnancy and child birth and lack of emergency obstetric care.

Some studies have examined socio-political factors influencing health aspects.
Green Anderson (1986, p.3) in his work “Community Health” observed form of government plays an important role in determining community health. He has examined how Mosaic Law or code provided for personal and community responsibility for health in the fields of maternal health, control of communicable diseases, protection of water supplies and disposal of wastes and sanitation of camp sites positively influence the health status. (Ibid pp. 5-7)

Sumit Guha (2001, pp. 70-72) in his study observed isolated and stable communities do not suffer much because they have developed a natural immunity to old infections. He also depicts Indians were unusually exposed in prewar decades to dangerous microbes due to new ecology associated.

Evaluation of the strategy “Health for All by the Year 2000” Seventh Report (pp. 1-6) on the world health situation observes the health development of the African Region is hampered by the world wide climate of insecurity, regions own political, economical and social problem.

Some studies have shed light on behaviour of the community as a crucial factor in determining health status.

Sushila Nayar (1982, p. 24) in her article explained that health of a community or a country does not depend merely on the adequacy of accessibility of health services. She points out ignorance, apathy and poverty are major hurdles in the way of healthy life.

Om prakash Sharma (2000, p. 118) characterises health consciousness of rural folks who usually do not take immediate step to get treatment for illness. He confirms that 84 percent of the respondents waited for severity of illness.
B.N. Hemadevi (2004, pp. 26-27) reveals that ignorance about immunisation and curative facilities have resulted in rise in morbidity.

R. P. Mishra (2007, p.5) emphasized heredity factor has its own sway health aspects. A sedentary man is more prone to ill health.

Dean T. Jamison et al. (2006, p.5) in their work “Accounting for Health Gains” pinpoints that growth of income alone cannot account for the dramatic improvements in health. Any advance in knowledge that leads to practical improvements has been and can be the basis for substantial health gains.

SECTION-III

Concluding Observation:

The review of available literature related to the field of health care services enabled us to bring out major trends. All the researchers unequivocally accepted the fact that health is the man’s valuable treasure. It is commonly observed that health care services provided by government are either under utilised or not utilised. It is more so in case of chronic and major diseases. The community belonging to poor section is left high and dry because they simply cannot afford to get treatment. The flood of clinics and nursing homes which are concentrated in urban centres and in cities are biased towards richer section.

The studies are deeply focused on pattern and extent of morbidities, the availability of health care services, the choice and extent of utilisation of available health care services. The available literature has recognised the importance of bringing drastic changes in public health care system.

Most of the studies are predominantly macro based. They provide information which is useful in understanding general conditions and trends of
the problem. However they do not touch the ground reality. The researcher is not arguing that macro level studies are not useful, what is intended, is to focus on new micro level studies on healthcare in new areas will provide socio-economic situation of the respondents, health institutions and their services. This will be helpful to have several new facts and insight in the formulation of innovative measures to gear to cope with development in health sector.

The researcher found that a very little work has been done specifically on 'Primary Health Centres and Health Care Services'. None of these studies have focused on PHCs and the health care services of the Uttar Kannada district. So it may fairly be hypothesized that the study in this area is unexplored. Hence there is much scope for conducting research work in this area.