CHAPTER – II

REVIEW OF LITERATURE

For any study, review of literature is of much essential. It helps the researcher to get an adequate knowledge on works, thereby opening new frontiers of knowledge. It involves reading and evaluating reports on other researcher about similar research problem. Review of literature helps to acquire comprehensive view of the topic and also the relevance, significance and practicability of the topic. It also shows the research gap existing in the field of study and thus can provide proper direction to the present study. From time to time several researches were conducted and books have been published on health related issues. Number of studies has been conducted by the researchers and they have reviewed the health care service utilization in India. In this part review of some of such works is attempted.

Gupta Rajendra Pratap (2016)[1] in his book laid down the comprehensive methods need to be followed to attain excellence in healthcare industry. According to him practice oriented healthcare organizations can gain a competitive edge through superior operations. He opined that there will be huge benefits if the entire healthcare industry is aligned with the parameters. The study precisely depicts that how negotiation to be made

between various prospective of clinicians and administrators by offering a uniform platform so that competitive advantage can be enjoyed. He also identified various tools that will aid in bringing solutions to the problems and improve the healthcare facilities.

P.Michael Pagano (2016)[2] in his book emphasized the need for maintaining of good and healthy relationship with patients, peers and colleagues as cornerstone of effective utilization health care services. The study described the theories and abilities needed by all healthcare providers like nurse medicine professional, physiotherapist, pharmacist, dentist, physician and opticians. It incorporates recommendations for specific multimedia, suggestions for class discussion and interactive case studies to provide a rich and multi-perspective learning experience for gaining optimal expertise in effective health communication. It teaches about the behavioral aspect of healthcare service providers in diverse healthcare context and assesses its efficacy.

Nancy Borkowski (2015)[3]according to writer healthcare industry continues to grow and change dramatically. In recent years this industry has experienced dynamic changes that health care service providers have seen. Further suggestions are put forward to overcome the challenges and to achieve value based healthcare. He also highlighted that the health care providers who are every day motivating and leading others in a constantly changing, complex environment. He introduces the reader to the behavioral science literature relevant to the study of individual and group behavior, specifically in healthcare organizational settings. Using an applied focus, it

provides a clear and concise overview of the essential topics in organizational behavior from the healthcare manager's perspective.

Singh Vijai Kumar and Lillrank Paul (2015)[4] examine innovations that can bring about real advances in the healthcare industry and explores recent innovations in healthcare from a global and Indian perspective. As stated in the study emphasizing the importance of healthcare and innovation, it presents low-cost, high-volume solutions that improve access to healthcare. The study includes of actual results in healthcare innovation from three continents that highlight a specific global scenario trends in healthcare system innovation. The study describes how to organize resources and flows so that given targets, such as cost, quality of the clinics, and patient personnel experience, can be achieved with available resources. The study also covers nontraditional ecosystems of innovation that move outside of expected medical equipments innovations, such as innovations in social persuasion, rural health delivery, and the planning and design of rural as well as urban hospitals and maintains a focus on key issues across the healthcare industry—such as access to care; demand creation, patient experiences, and data—to help research implement new ideas and new models of delivery of affordable care in healthcare systems in India.

Raje V.N. (2014)[5] in his book he discussed about evolution of healthcare industry in India. He also recognized different institutions that paved the way for healthcare industries in the country. These institutions deliver healthcare services, finance healthcare services and manufacture products which are being utilized in these services. This study also discussed about

the innovative efforts to raise the capital for the development of healthcare sectors.

Burns R .Lawton (2014)[6]introduce the concepts of health information technology and management. In the age of the electronic health record, staying on top of the latest trends in technology and it is a must for today's health care professional. The study reveals that comparison' of basic human indicators will developed nation in various aspect of healthcare service.

Tweedy T. James (2014)[7] identifies common factors that are often precursors to accidents in the healthcare industry and examines the latest OSHA and Joint Commission Emergency Management Requirements and Standards and patient safety, hazardous substance safety, imaging and radiation safety, infection control and prevention, and fire safety management. The study revealed that the utilizing a proactive hazard control approach based on leadership involvement and identifies the organizational factors that support accident prevention. The study also examines organizational dynamics and supplies tips for improving organizational knowledge management in healthcare service professional.

Goyal S (2013)[8]reveals that the use of scientific techniques can improve the services of the hospital and ultimately benefit the patients as well as the hospital itself. In this book the author mentioned about new concepts and new ideas and takes into account the contemporary challenges of hospitals in the human resource management area. The study also revealed that

vividly covers the principles and objectives of management including the financial administration of a hospital.

Sinha Harendra (2013)[9] discussed all below poverty line families to be covered under Rashtriya Swasthya Bima Yojana is an important step towards prioritization of health within developments plans. In terms of rural health infrastructure, doctors-nurses per thousand population, SCs, PHCs, CHCs, drugs and laboratory, presence of doctors, health workers and health expenditure of gross domestic product etc. are inadequate. In the North Eastern States in India including Tripura, there is a major variation in health services across states, between urban and rural areas, in hilly terrains and so on. As in many other states, primary health care provided in North Eastern Region is generally poor in quality, inaccessible and unavailable. Rural public healthcare services are especially abysmal with high levels of absenteeism, shortages of skilled medical and para-medical staff, an absence of medicines and supplies and inadequate supervision and monitoring.

Reddy (2012)[10] expresses concern over high out-of-pocket spending on health in India. India is one among the developing countries where households spend a disproportionate share of their consumption expenditure on health care. With the government's contribution being minimal, it is difficult to reduce the out-of-pocket spending on health from 67 per cent in 2012 to around 33 per cent by 2022.

Robert Burns Lawton (2012)[11] examined wide-ranging of business trends in the manufacturing segment of the healthcare industry. The study provides thorough overview and introduction to the innovative sectors fueling improvements in healthcare: pharmaceuticals, biotechnology, platform technology, medical devices and information technology. For each sector, the study examines the basis and trends in scientific innovation, the business and revenue models pursued to commercialize that innovation, the regulatory constraints within which each sector must operate and the growing issues posed by more activist payers and consumers. The study also shows healthcare sectors are such an important source of growth in any nation's economy.

Sen (2012)[12] says that high hospital expenses push many people into below poverty line. In 2006, 28 per cent of rural residents and 20 per cent of urban residents had no fund for health care. More than 40 per cent of them had to borrow money or to sell assets to pay for their medical care, while more than 35 per cent of them fell below the poverty line because of hospital expenses.

Usha Manjunath (2012)[13] pointed out that healthcare industry is among the most rapidly growing service industries in the world today. The central theme of all healthcare systems is "quality". Operationalization of the concept of quality at the organizational level has led to several innovations in quality management from the traditional Quality Assurance to implementation of the philosophy of Total Quality Management. The book highlighted that the quality assurance, audit methods, ISO, quality award

criteria and total quality management in healthcare. Most recent developments like NABH accreditation for hospitals are also discussed. The writer concentrates on the research on quality dimensions and investigations which finally led to the development of an integrative framework on total service quality management for hospitals.

Husain (2011)[14] the high cost of medicine and non-availability of health care facilities is the root causes for poor health in Uttar Pradesh, Madhya Pradesh, Chhattisgarh and Himachal Pradesh. In these states, non-availability of facilities like mobile units, blood storage and emergency care facilities is quite rampant. Moreover, non-availability of medicine and material at the health centres forces the patients to purchase medicine from private sources, where the cost of medicine is substantially higher. It traps the poor people in the debt burden and also pushes them below the poverty line. It further leads to high infant, child and maternal mortality rates, especially in rural areas. His main point of contention is that India's health expenditure of less than one per cent of the GDP is the root cause for poor health facilities.

Subramonian (2011)[15] reveals that the right to health should be an integral part of everyone's life. In constitution of India, The Right to Health though not explicitly included, but judiciary has widely interpreted the scope of right to health under article 21, (Right to Life) and has thus established right to health as an implied fundamental right. Not only article 21 but some other articles of fundamental rights can also be linked to right to health.

Tharamangalam (2011)[16] observes that high cost of medical expenses pushed many people into below poverty line in Kerala. Fourteen per cent of rural and 11 per cent of urban people in Kerala incurred catastrophic expenses for health care. The expense on health care exceeds 15 per cent of their income. Such expenditures pushed 3.5 per cent of households in rural and 4.5 per cent in urban Kerala into below poverty line.

Thersia and Mohindra (2011)[17] point out that out-of-pocket spending for medical care has been steadily rising in Kerala. Kerala ranked the highest in both out-of-pocket spending and impoverishment due to inpatient and outpatient services. Poor people are more vulnerable to medical impoverishment. High health care costs, increasing out-of-pocket spending and a slow public sector response to the changing disease burden adversely affect the access to health care services of the poor in Kerala.

Das A.S (2011)[18] point out that high medical cost leads to switch over from one medicine to another and the cost of treatment itself can add to stress and trigger high blood pressure. For example, a marginal farmer from Nagpur was admitted to the hospital for treating his hypertension but after two months he discontinued the treatment because he was unable to bear the cost of treatment. Then he suffered with paralytic attack. Treatment for paralytic attack is not possible without controlling the blood pressure, but for each visit he has to pay 2450 to Z 500. So the high medical cost compelled him to switch over to herbal medicine.

Baru *et* al (2010)[19] emphasize that immunization coverage in rural nd urban areas has a wide inequities among socio-economic groups across the country. The rural-urban differential was substantial, with a coverage rate of 39 per cent in the rural areas and 58 per cent in the urban areas. While, the all India immunization coverage is low (44 per cent), the immunization coverage among the highest income group is 71 per cent which is three times higher than the lower income group (24.4 per cent). There is also a substantial gap in immunization coverage between STs (31.3 per cent) and other's (53.8 per cent) in 2005.

Baru *et al* (2010)[20] reveals that in India, the investment made on public health sector is the lowest (19 to 20%) among the world ·00untries. The low public investment is the main reason for not only the poor functioning and utilization of public services but also impoverishment of individuals. Individuals have taken medical treatment in private hospitals as the quality of services in public hospitals/centres is very poor. This view was endorsed by Rajagopal (2004). They further tell that expenditure on consumption of health care is higher in the rural than in the urban areas. In 1993-94, household consumption expenditure on health is 5.4 and 4.6 per cent in rural and urban areas respectively, while in 2004-05, the household expenditure has increased to 6.6 per cent for rural areas and 5.2 per cent for urban areas. The author notices that poorer sections carry higher burden of health expenditure compared with the better-off.

Biswas Badal (2010)[21]in his paper remarked that health is one of the important parameters for Social and human resource development in both

urban and rural parts of our country. Human development and well being of individual is the primary objective held by our country in the form of implementing monitor able plans and policies. In this age of Information Technology where present world has shifted to a global village, the process of advancing developmental priorities has doubly reinforced. The rural parts of the country have been facing socio-economic problems mainly characterized by poverty, gender inequity and low participation in developmental initiatives. This will inspire implementation of various programmes related to poverty elimination intervening in the areas of livelihood opportunities, access to education and of course access to health care services and facilities. Health is one of the vital elements that determine human development and progress. He had revealed that health care delivery system now-a-day is confronting various challenges; the need for cost-containment and focus on effectiveness and efficiency of the delivery mechanism is felt urgently. Different strategies are formulated for providing better health care services in India. Under the constitution health is a state subject. But in the present context, central Government's initiatives to assist the State Government is commendable in the areas of control of major communicable and non-communicable diseases, broad policy formulation and awareness activities for prevention of diseases. Several National Health programmes are being implemented as centrally sponsored schemes aimed mainly at reduction of mortality and morbidity causes by major diseases.

Foy (2010)[22] brings to lime light the desperate situations of starving people in western Africa. About 10 million people face starvation across the region and 2 lakh children need treatment for malnutrition in Niger alone. He reminds the famine in Ethopia during 1984 which takes over 1 million life of people and he warns the same situation is prevailing now among 10 million people. People are eating wild fruit, leaves and animal fodder to stay alive. Sadly, they search ant hills to collect the tiny amount of food grains that the ants have collected and stored.

John (2010)[23] explains that the ever rising health expenditure is the major cause for indebtedness in India, particularly in rural areas. The out-of-pocket health care expenditure is about 70 per cent of the total annual expenditure.

Meeta and Rajivlochan (2010)[24] also narrate that public spending on health in India is the lowest among nations. In India, only one per cent of the country's GDP is spent on health and 73 per cent of health expenditure is financed by out-of-pocket payment by the people, while in the USA 13 per cent of GDP is spent on health sector. Further, they observe that there is wide disparity in medical expenditure between poor and rich and rural and urban.

Purohit (2010)[25] narrates the per capita budgetary expenditure on health among different states in India. Per capita budgetary expenditure on health is highest in Gujarat with 785.96, Maharashtra with 780.49 and Karnataka with 763.05 in 2007. On the contrary, per capita budgetary expenditure is

lowest in states like Punjab and Bihar with 711.28 and 715.35 respectively in the same year. In Tamil Nadu, per capita budgetary expenditure is 743.50 in 2007. It is further observed that Uttar Pradesh, Rajasthan. Madhya Pradesh and Orissa with low per capita budgetary expenditure are poorly performing states.)

Chatterjee (2009)[26] shows the dismal picture of India's public spending on health. India spends only 0.9 per cent of the GDP and it ranks 171st out of 175 countries in terms of public spending. At the same time, private spending on health is 4.2 per cent of the GDP and the rank is 18' in 2004. China spends 2.3 per cent of its GDP on health, Nepal 1.5 per cent.

Mishra S.K & V. R Puri (2009)[27] explains that healthcare services in India were highly inadequate at the time of independence. At the time of independence, healthcare infrastructures were mainly urban and clinic based, but in rural areas very few preventive and curative medical services is there. To improve the health status, the central and state government made efforts to build up primary, secondary and tertiary healthcare institution.

Kanmony in Kanmony (Ed.) (2009)[28] the total expenditure on health was 4.9 per cent of GDP (including private expenditures) against 13 per cent in the USA in 2000. The per capita expenditure on health was only $3 in India against $4499 in the USA. The government expenditure on public health infrastructure has declined especially after globalization. As a percentage of

GDP, the public health investment has declined from 1.3 per cent in 1990 to 0.9 per cent in 1998.

Olsen (2009)[29] explains the relationship existing between a country's wealth and its health care spending. Poor countries have better reasons to spend relatively more of their GDP on health care than rich countries. But, in Norway, the proportion of GDP spent on health care has increased from 3 to 10 per cent over the last 50 years. It appears that the rich countries spend relatively more of their GDP on health care.

Ramanujam P.G (2009)[30]expressed his view to the healthcare sector has become very competitive and is changing rapidly. The rise of the patient as a consumer, the introduction of innovative technologies and a new breed of entrepreneurial managers are the main factors behind this industrial metamorphosis. Today's healthcare market has become consumer-driven. Patients are better informed and they know more about health and medical services. He also pointed out that the how works overview of services sector, healthcare services in India and healthcare marketing and presents the socio-economic factors relating to the customers of healthcare services. In this book he reviewed choices and preferences of the customers of health services and the factors influencing them in the selection of hospitals and highlights the importance of marketing of healthcare services and examines the marketing practices of the selected corporate hospitals. All the important hospital activities concerning the services marketing mix are measure the service quality in selected hospitals with a quantitative approach.

Singh (2009)31 assert that per capita income affects maternal and child healthcare significantly. High economic class of people leads to low child mortality and low income is the cause for high child mortality in various country particularly in India.

Phelps Charles E. (2009)[32] expresses his view regarding current economic theory and health policy problems into a comprehensive overview of the field. In this study he highlights the importance of the empirical studies to develop essential methodological foundations and how basing on these core concepts, such as the structure and effects of medicare reform, insurance plans, and new technologies in the health care community are to be focused. The study also pointed out that, focus on lifestyle choices—such as alcohol consumption, obesity, and tobacco use—explores how individual choices affect everyday health and the health care system at large.

Vujicic *et al* (2009)[33]tells that Kenyan health care system needs more attention. Government spending fell significantly from 2000 to 2004, decreasing from 9.0 per cent in 2001 to 6.1 per cent in 2004. Due to this reduction in health spending Kenyan health care system is weakened because of inadequate numbers of personal in key areas of the health sector, inequitable distribution of health personal and lack of highly trained health workers. Moreover, they estimated that the health sector requires 7,000 additional health workers to deliver essential services to the population. Hence, health spending should be raised to 11 per cent in 2009.

Yazbeck (2009)[34] correctly points out that health inequality is rampant among 56 low and middle income countries, representing 2.8 billion people. The author compares the well-off 20 per cent of the population with the poorest 20 per cent and finds that an infant from the poorest is more than twice likely to die than that of the richest before reaching the age of one. A child belonging to the poorest family has a chance to suffer three times more than a child belonging to the richest family by severe stunting. In case of pregnant women, a poor pregnant woman is three times likely to deliver a baby at home instead of at a health centre than rich pregnant women. He observes that the poorest 20 per cent of the population captured only about 10 per cent of the total net public subsidy, but the wealthiest quintile benefited three times more than the poorest. There is wide disparity in immunization coverage also. Only 20.2 per cent of the poorest quintile children receive routine vaccinations whereas the wealthiest quintile receives 59.8 per cent.

Gangolli, Duggal and Shukla(2008)[35] have pointed out that hospital management and strikes, poor working of the MCI (Medical Council of India) and corruption in recognition of colleges dramatic cases of spurious drug supply etc. have been debated but there has been no sustained attention on such issues as why malaria recrudescence is so common in some parts of India or why complaints about absence of informed consent or frequent in testing on women, or on the variations in prices and availability of essential drugs or for combating epidemic attacks in deprived areas seldom draw attention. The role to be assigned to private sector in

medicine, the need for a good referral system or the irrationality in drug prescriptions and sue has seldom been the point of political debate. Indeed the lack luster progress of Plans shows political disinterest and the only way for politics to become more silent to the health of the poor and the reduction of health inequalities is for a much greater transfer of public resources for provision and financing – as has happened in the rural healthcare services in India.

Lynn, Godkin (2008)[36] has reported that rural hospitals are at a distinct disadvantage in an environment where identification and transfer of effective patient safety practice is demanded. This article has emphasis on the increase concern for patient safety and the peculiar problems which rural hospitals have, in locating such information in a timely, accurate fashion. Selected issues which administrators of rural hospitals might consider and the means through which they might leverage institutional absorptive capacity to identify the health care services. Beyond the need to understand the technological components of patient safely improvement efforts is also under health care service in different areas.

Srikrishna (2008)[37] observes that in urban areas health awareness increases rapidly. Private hospitals and private hospital industry are lead to vast improvements in infrastructure and quality of healthcare services. There is a demand for doctors, nurses and good hospital administration in urban areas as well as rural areas also. Thus both areas experience huge growth in healthcare industry. The study also highlighted that in rural areas there is lack of proper concept.

The author discussed that the primary Health care declaration the operational aspects of integrating the other sectors of development related to the multi-sectoral approach that is much needed and the inter-sectoral linkages that are for a vibrant health system have not been well thought out, and there has been no plan drawn out for it later. The outline of plan documents and their implementation have been incremental rather than being holistic. It is important to question whether it is only the low investment in healthcare services that is the main reason for the present status of the health system or is it also to do with the framework, design and approach within which the policies have been planned.

Duval Tara (2007)[38] has reported that providers of human services in behavioral health care organizations, such as nurses, social workers, case managers and counselors, are often interested in assessing the effectiveness of their efforts. Behavioral health care organizations provides unique environment for the implementation of performance measurement system, in part because practioners are aware of pitfalls associated with measuring health care service. At outlined in this paper, acceptance of performance measurement of health care services and activities in a publicly founded hospital for children and adolescents was facilitated by implementing a number of these strategies.

Garg and Nath (2007)[39] have pointed out that the Indian healthcare sector can be viewed as a glass half empty or a glass half full. The challenges the sector faces are substantial from the need to improve physical infrastructure to the necessity of providing health insurance and ensuring the availability

of trained medical personnel. But the opportunities are equally compelling from developing new infrastructure and providing medical equipment to delivering telemedicine solutions and conducting cost-effective clinical trials. For companies that view the Indian healthcare sector as a glass half full, the potential is enormous.

Nundy Madhurima (2007)[40] pointed out that primary health care is a term that is used extremely worldwide by policy maker. The writer suggested that the spirit of primary health care has been reduced to just primary level care. The health reports and plans mostly concentrated on building the health services infrastructure and even this lacked a sense of integration' Most of the policy reports miss out on the Importance of a strong referral system. Instead, there has been more emphasis on building the primary level care and even that has lacked proper implementation.

Majumder Amlan (2006)[41] has pointed out that demand for different types of health care have been changing very rapidly among Indian population. The fact could be understood from the dwindling public health facilities on the one hand, and flourishing of the numerous private sources of health care on the other. The study provided us with interesting results; on the demand side, in most of the models, likelihood of utilizing public health facilities decreases sharply with education as well as affordability of households. According to him, public health care, in the Indian context, is an inferior commodity and, its acceptability is concentrated among some ethnic minorities who generally occupy lower stratum in the social hierarchy, and also among mothers with higher order of birth. Among the

factors on the supply side, he has pointed out that availability of plant and equipment contributes negatively towards utilization of public health facilities for most of the cases. In other words, in the urban areas, where both public & private facilities are easily available, people are likely to avoid public health facilities. Availability of drugs works positively and very strong towards utilization of public health care. However quality of health care goes in support of private health facilities. If other thing remain the same, prospects of public health care system are better in the eastern region as compared to the southern one. To sum up the paper find out, people with higher social & economic status are seen to prefer private health care. On the contrary, people who are lagging behind, are still seem to be must depend on public health care .The paper thus very clearly traces a transitional phase with changing demand for different types of health care by people with varying socio economic profile, and consequently draws attention of the policy makers, who have to evolve an appropriate strategy, for delivering health care in India in such a transitional phases.

Murthy and Lahiri (ed) (2006)[42] brings to light the low level of spending on health care during 1990s in India. During this period, 6 per cent of the GDP was spent on health care, which is higher than many other developed nations. Out of the 4.7 per cent borne by the private sector, that too mostly towards curative care. Now a day, public spending on health care has narrowed to 0.91 per cent of the GDP. He emphasizes that public health spending should be raised to curtail down the increased out-of-pocket expenditure on health.

Porter (2006)[43] highlighted the crisis of health care system. In his study he set forth the obstacles on the way of development of healthcare services. The author opined that there is a competition among various healthcare service providers with regard to shifting cost; accumulate bargaining power, and restricting the services rather than enhancing value for patients. He also highlighted that competitions often takes place at the wrong level among health plans, networks, and hospitals rather than where it supposed to be like diagnosis, treatment, and prevention of specific health conditions. In spite of huge competition, the patients' care which is expected to be off utmost importance gets minimum importance here and thus poorly coordinated. This lacuna generally undermines both efficiency and quality of outcomes.

Wagestaff and Jamison *et al* (ed) (2006)[44] observe that spending on health continues to grow at the world level. Health expenses become burdensome for households. Government spending is the sole way to reduce the out-of-pocket expenditure. They notice that the importance of government intervention and explained that health expenses in different countries.

Dhar Aarti (2005)[45] says that the main problem faced by rural people is the lack of doctors and medical personnel in health centres. So the Accredited Social Health Activists must create awareness on health and mobilize the community towards health planning in Indian population.

Acharya and Kent (2005)[46] clarify that health indicators in India may have seen substantial improvements in recent years but quality and affordable

health care services to uplift the condition of poor people. Government provided health services meet partially the needs of the rural and the urban poor in the informal sector and making equitable and affordable medical care accessible to this segment remains a challenge.

Bhat (2005)[47] considered that health is a fundamental human right indispensable for exercise of other human rights and makes provision to protect the health of infant and mother by maternity benefit.

Rao G N Nutritional (2005) narrates that more than 50 per cent of injections administered are unsafe especially in the developing countries. He points out the WHO Report in support of his view. The WHO estimates that of the 1,200 to 1,600 crore injections administered in the world every year at least 50 per cent are unsafe. In India it is nearly 63 per cent. It is very clear that the health care system especially public-health care in India requires a complete overhaul and a serious consideration from the governments to enjoy better health indicators

Chinai and Rahul (2005)[49] tell that there has been a misplaced emphasis on maintenance and strengthening of private health care services at the expense of the public health care system.

Lal G Pranay and Byword (2005)[50] focused on critically evaluating the current status of the health system that is organizational structure, financing mechanisms, regulatory frameworks etc. The three key drivers of health costs which are mainly human resources, drugs and technology were specially pointed out in detail as the main concern for the future is going to

be the rapid escalation of costs. Such analysis highlighted and reiterated several out comings represent in the India's health care system and have been recognized for long term. The study also pointed out that well-conceived and sequenced system of reform emerged to be the priority area for policy attention so as to develop the capacity to absorb the promised funding also emerged was that solutions for many of the issues have been known for long, but routinely ignored and not acted upon. The study highlighted that the healthcare system need not be so inefficient, insensitive, dysfunctional and in such a crises as facing problems now a days.

Ahuja, Rajib and Narang, Alka (2005)[51] points out that government health service expenditure is often enjoyed by the richest quintile people in Africa. It is reported that 30 per cent of total government health care expenditure goes to benefit the top 20 per cent of the population, while the poorest quintile people benefit only 12 per cent of the total government health care expenditure. The same view was stated by Belli in Parker and John (Ed.) (2005).

Bajpai, N;Sachs,J D, Volavka, NIndias (2005)[52] explains that staff shortage at government hospitals causes severe hardship to patients who throng them from far off places.

Ahren M (2005)[53] tell that there has been a misplaced emphasis on maintenance and strengthening of private health care services at the expense of broadening and deepening of a public health care system.

Singh V.P (2005)[54] by indicating the World Bank report reveals that one episode of hospitalization accounts for 58 per cent of the per capita annual expenditure and it pushes 2.2 per cent of the population into below poverty line. The percentage of persons unable to avail health care doubled between 1986 and 1996 due to financial reasons.

Bardoloi G (2005)[55] point out that not all states with better health indicators have efficient health systems and investment in the health sector alone will not result in better health indicators. Hence, the need of the hour is efficient management of the investment.

Maggie Black (2005)[56] observes that India has the highest number of cases of anaemia in the world. In developed countries hardly there is adolescent anaemia, while in India as per the district level health survey by the Ministry of Health and Family Welfare and Department of Women and Child Development 95 per cent of adolescent girls and 92 per cent of children less than three years are anemic.

Malik, A R (2004)[57] illustrates that the use of Information Technology (IT) has a significant impact in healthcare industry. But there is still a need for more research on how IT affects costs of diagnosis and treatment with regard to specific diseases in healthcare services.

Banerjee Abhijit (2004)[58] point out that the quality of public health service is extremely poor and it has an adverse influence on the people's health. But, the private health providers, who account for the bulk of health care provisions in rural areas, also seem to lack sufficient qualification.

Pandey (2004)[59] expressed his opinion that lots of ideas for the architect, who conceives of a viable plan for the hospital. It addresses the various issues which must be kept in mind by consultants, planners and administrators who subsequently run the hospital. The writer also highlighted that health professionals who are responsible for planning and designing hospitals and those who subsequently manage, maintain and operate them efficiently the task of managing this health professionals are quite challenging.

Rao G.N (2004)[60] is of the view that in many States of India there is shortage of doctors and buildings in primary health centres and community health centres.

Baht, R and Nishant Jain(2004)[61] tells that as a ratio of GDP public expenditure on health in India is the lowest among countries and this neglecting tendency gets intensified in the period of liberalization. This view is upheld by Sharma, 2004, R.C. Mishra, 2003and P.R. Panchmuki, 2004.

Rais Akatar (2004)[62] brings to light that unless much importance is given to public health by central and state governments of India and people will face a series of health problems. To ensure better health, the involvement of people through Panchayat Raj Institutions should be ensured.

Basu A (2004)[63] asserts that the primary health care is utterly neglected and it leads to a worsening epidemiological profile in the country. We require a cost effective intervention, and such rational distribution of medical and financial resources.

Bajpai Nirupam (2004)[64] says that the healthcare status related and determined by numerous factors such as per capita income, way of life, marital status, infrastructure, social organization education, structure of economy healthcare services provided by the government. This study also highlighted that higher literacy rate, high level of per capita income improved healthcare services facilities both in public and private sectors in India.

Rajagopal (2004)[65] complains that public health sector is completely neglected. The buildings meant for health centres are not properly planned to house a health care institution. The primary health centres focus only on family planning and immunization and other urgent issues like epidemic control.

Srinivisan R (2004)[66] pointed out that the health care covers not merely medical care but also all aspects pro preventive car too. Nor it can be limited to care rendered by or financed out of public expenditure within the government sector alone but must include incentives and disincentives for self-care and care paid for by private citizens to get over ill health. Where, as in India, private out-of-pocket expenditure dominates the cost financing health care, the effects are bound to be regressive. Health care at its essential core is widely recognized to be a public good. Its demand and supply cannot therefore, be left to be regulated solely by the invisible had of the market. Nor can it be established on considerations of utility maximizing conduct alone.

Rajan S. Irudaya and K.S. James (2004)[67] explain that the proportion of underweight children under three years of age is very high. More than one third of the women in urban areas who maintain high standard of living are either overweight or obese, while the same proportion of women in low income households is underweight in rural areas.

Upadhyay and Majumder (2004)[68] discussed that in rural India the people are more dependent on the doctors who play a dominant role. But if consider the elasticity coefficients as a measure of productivity then in the rural health care system paramedical staff are more productive than the doctors. If these coefficients are used to determine the programme's efficiency then within the labor input category paramedical staff are performing efficiently. So, productivity or efficiency in such a rural public sector service economy does not necessarily increase with the technical qualification or education of service providers. Geographical factors, social structure, family characteristics, and quality of care also work as the main determinants of the utilization of health care services. Education of the acceptors is also an important factor though its impact is negative. The study reveals that as education increases people are likely to avoid public health facilities for reproductive health related services. This may be due to poor quality of services provided at the health centers. He suggested that they should consider other qualitative factors also. Some of the other factors are privacy maintained while doing medical examination, average waiting time at the health centres, time spent by a staff with a client, etc. Otherwise primary health care system in India will lose its credibility even among

poor rural people who are not in a position to attend private health care facilities.

Das and Choudhury (2003)[69] discussed that the rural people having low income prefers to be treated by the Quacks because of their poverty but they do not take the risk to let their children be treated by them. Yet, it can be said that for the rural poor people, medical services by Quacks are the alternatives to medical services offered by Allopathy. According to them the cost of treatment is an important part, which influences one's choice of medical care. But the effectiveness of any sort of medical treatment also plays another important role in making a decision regarding medical care. When Cost Effectiveness Recovery (CER) is considered, treatment by Quacks is found to be cost effective at least for cold and cough, fever (excluding Typhoid and Malaria), diarrhea and dysentery. On the other hand, to judge the efficacy of the services provided by the Quacks, another aspect is to be taken into consideration. It is often found that the patient, whose state of heath does not improve under any type of medical service, tends to shift to other medical services for recovery. Such transitions also form an alternative measure of effectiveness. It has been observed that the proportion of shifted patients who were initially treated by Allopathic doctors was least and that by Quacks was most. Thus, in spite of low cost of treatment under Quacks (which is the main cause of lower CER) effectiveness (that is recovery) cannot be assured as in Allopathy.

Mishra R.C (2003)[70] points out that in less developed countries less investment is made on health care service and research and only a small

percentage (10%) of investment is allotted to research on diseases which affected majority of the people (90%).

Parks (2002)[71] brings to light that there is vast inequality in health care provisions between various social sectors. The health care expenditure is continuously increasing. Due to low government expenditure, the out-of-pocket expenditure takes away a significant portion of individuals' income. It has its own impact on the patient, the patient's family and the economy.

Goswami Pranay Jyoti (2002)[72] compares some of the health indicators of North East India with that of India as a whole. He has also decreased the factors affecting health and nutrition of the people of north east. The population served per bed in India in 1-1-1992 was 1324 where as in case of Tripura it was l647. He has put forward certain suggestions for improvement of health in Northeast India. He has suggested that provision should be made for low cost medicine particularly Homeopathic and Ayurvedic and research on indigenous medicine/medicinal herb. According to him, effort should be taken to raise female literacy rate and to control environmental pollution. He also suggested that health education should be given to the households by organizing seminars, fairs, posters and also by community meeting.

Banerji Debabar (2001)[73] discussed the Health Service Development after independence. In the first two decades of independence, some far reaching developments in the health services took place. Some improvement is noticed in the areas like Primary health centers, social orientation of

medical education. But in the next three decades there was a sharp decline in the quality of health services in the country. The major forces contributing to this decline according to him were obsessive preoccupation with the family planning program at the cost of serious neglect of the health service needs of the people, particularly the poor. He further stated that the imposition of so called "International initiatives in health" during the last two decades, by a formidable combination of "development aid" agencies of many western countries & organizations and the involvements of these countries in shaping social, economic & political policies of the country in the form of pressures for privatization in the structural adjustment program from the late eighties onwards.

Jeannine Coreil, Bryany and Henderson (2001)[74] have pointed out that the immediate and future nature of public health and aging is a mystery. It is a mystery because there has never been a time in this nation's history or in the world that so many people are living so long. There was no modal on which to base action plans for this future. However, according to them, there are numerous projections based on thoughtful use of present knowledge that provide some illumination for responding to the needs of an aging society. This includes improved education in the health and social sciences in the rural areas and health for public health specifically; the importance of prevention is great and capitalizes on the life span perspective. To the degree that public health takes a multidisciplinary approach to health, practitioners of the future can integrate knowledge

from across the main public health disciplines to fashion a superior plan of action for national age related health and well-being, the report added.

Qader Imrana (2001)[75] experiments contributed to the emergence of the concept of primary health care which reflected a paradigm shift. It is shift from the bio-medical model to one that looks at human beings as groups of individual affected by their total environment. The author gives opinion that Primary Health Centre is not just a descriptive term denoting the first level of health care but it is a comprehensive view of health that emerges from the most critical conceptual advances of public health. The writer also pointed out that unlike the techno centric approaches that derive from the bio-medical sciences such as the linear campaigns against disease. The important observation made by the author was that Primary Health Centre approach comforts complex socio economic, political and technological relationship and therefore within this framework the emphasis of PHC is an - (a) equity in health care services (b) need-based, socially acceptable services with full participation of people (c) state responsibility for incorporating PHC into national development plans through inter-sectoral strategies and (d) affordable technologies ensuring self-sufficiency and effective basic health care services in rural India.

Webster Charles (2001)[76] considers the historical development of health care. The study adopts a broad interdisciplinary framework to draw on the healthcare professional and medical and social history. The study focusing primarily on the health care on the colonial territories in the past and its echoes in the relationship between the advanced economies and the

developing world today's healthcare delivery system. The study also highlighted only by reference to the historical record is it possible to understand the reasons for the dominance of acute hospital specialties, the prejudice against alternative medicine, the difficulties experienced in regulating the medical profession.

Baru *et al* (2000)[77] reveals that thelight on the efficiency of the private sector in providing health services to the people. The private sector is more efficient and provides better quality care. At the same time, private hospitals are having many loopholes. Profit motive of private hospitals leads them to increase the medical costs, which has direct bearing on the patients. Then for quick turnover, they follow all fraudulent practices.

Kristin Baird (2000)[78] pointed out that the culture of service excellence requires planning, preparation, and persistence. The writer has designed to provide readers with the fundamental information and skills to start or strengthen a customer service initiative within a health care organization. The study also highlighted that tools for establishing and measuring customer service team goals, creating customer service standards unique to the organization, strategies for maintaining top-of-mind awareness of customer service among employees, customer service techniques for physicians and nurses and an overview of customer service as an essential component of business development and marketing. The study concentrates on action as opposed to theory. It offers a practical, step-by-step process for creating a culture shift toward customer service excellence at all levels of an organization, and presents the essentials to improving

performance that will bring the individuals closer to the mission, values, and standards.

De Bruycker (1996)[79] discussed that historically the quality of life & the acquisition of good health for individuals and for populations was not necessarily solely due to medical care or dependent only on medical technology. The author has pointed out that since the dawn of mankind, the wish to influence health and to repair or prevent disease has occupied people's minds and has created multiple environments where a variety of medical professional professions could flourish, often without regulation. Taking advantages of the explosive progress in science and technology medical services have taking huge strides into the golden century of medicine. The inadequacies of multiple vertical programs as a strategy for sustainable health care were revealed. According to him, some developing countries had more than ten separate and largely autonomous vertical programs and at the same time had to cope with health problems for which there were no services.

Padke A R (1996)[80] with the help of specialty prepared prescription analysis, guidelines and scoring system, the prescription of doctors with varying educational qualifications were analyzed and given marks. The performance of doctors in the private sector was worse than that of public sector doctors with respect to all parameters of drug use. The drug supply also showed that the drug supply to the public sector is grossly inadequate at the primary health centre and rural hospital level. Hence any further cutback in the budget on health/medical care at PHC level would further

erode whatever credibility PHCs have as centers for symptomatic health care. The result of his study contradicts the rationale of privatization of medical care and health care from the view point of adequate rational drug treatment of the population.

Research Gap: From the review of various literatures mentioned above, it is clear that in certain areas of health care India is making significant developments from time to time, but there are some areas where it is lagging behind many other countries. People suffer from various health issues. Economic and educational level of people influences on the occurrence of diseases and mortalities. There is correlation between standard of living of the people and of health. The rural urban division in healthcare facilities also reduces the accessibility and availability of healthcare services in rural areas.

There is a research gap in the study of healthcare utilization service in rural Tripura. Not a single field study has been designed to analyse the quality of healthcare services exist in selected rural villages. Hence the present study is to find ever attempt to through light on the various health related issues in rural Tripura. The findings of the study will help the policy framers to suggest suitable policies to improve the inclusive healthcare services in the rural Tripura.