CHAPTER- I

INTRODUCTION

1.1 Health as a Metaphor and Reality in India:

Since the Enlightenment there have been discussions on the relationship between economic and social development. These discussions suggest that mere emphasis on economic development and neglect of social development result in distorted development and ultimately slowing down the progress of economic development. Guman & Mehta (2009) states that mere emphasise on the development of economic sector and neglect of social sectors results in economic prosperity along with social poverty. Social poverty particularly in the fields of health will ultimately have negative impact on economic development and quality of life. Health is a multidimensional concept. Good health can bring development of society from different perspective. Good health and good society should go hand in hand (Basu, 1994). Hence, it is not possible to raise the health status and quality of life unless such efforts are integrated for bringing wider transformation in society. Health is the foremost priority in individual's life. Its importance is evident in old saying "Health is wealth". Health is not only basic to lead a happy life for an individual, but it is also necessary for all productive activities in society (Goel, 2002). Health is a valuable asset of individuals and nations. The key indicators for the measurement of development are related to health. Access to appropriate food, shelter, education, and a productive socio-cultural life is related to health and wellbeing (Gish, 1983). Sen (1999) in his keynote address have highlighted the importance of promoting health for ensuring development. According to him, good health is a prerequisite to human productivity. Health is man's greatest profession as it lays a solid foundation for his/her happiness. The World Development Report (1993) points out that "Improved health contributes to economic growth in four ways: it reduces production loses caused by worker's illness; it permits the use of natural resources that had been totally or nearly inaccessible because of disease; it increases the enrolment of children in school and makes them better able to learn and it frees for alternative use of resources that would otherwise have to be spent on treating illness." The right to the highest attainable standard of health should be the primary goal of any country and this goals lies on an effective and integrated health system encompassing medical care and the

underlying determinants of health, which is responsive to national and local priorities and accessible to all (Hunt &Backman, 2008). Health is a basic need like food, shelter and education and it is a pre condition for productivity and growth. Health intervention can lead to economic prosperity and reduce inequality especially in developing countries (WHO, 2001). The Commission on Macro Economies and Health (2001) have highlighted that "Health is a creator and prerequisite of development, with an extension in the coverage of health services and improved health care. Here, the priority is not only to improve Health outcomes and reduction in poverty, but also to Increase productivity, and hence growth in poorer countries". Realising the philosophy of Health, Article 25 of the Universal Declaration of Human Right (UDHR) in 1948 proclaimed that everyone have the right to standard of living, adequate for the health of himself and his family including food, clothing, housing, medical care and necessary services. The Preamble to the Constitution of WHO also recognised that Health is one of the Fundamental Rights of every human being for attaining highest standard of life. The formulation of India's Constitution was influenced by the ideology of UDHR and this is reflected in the Fundamental Rights and the Directive Principles of State Policy. Article 47 of the Directive Principle of State Policy proclaims that it is the duty of theState to raise the level of nutrition and the standard of living and to improve public health of its citizens. Moreover, Supreme Court of India, in the year 1970 has broadened the scope of Article 21 of the constitution, which proclaims that "No person shall be deprived of his life and personal liberty except according to the procedure established by law." So it can be said that Health is a metaphor for well being in India.

India's health care is characterised by a universal health care system governed by constituent's states and Union territories. Health care services in India have various dimensions. Multiple systems, various types of ownership patterns and different kinds of delivery structures make the development of an organised health system difficult in India (Duggal, 2005). Moreover, in India Government sector is understaffed and underfinanced, poor quality of services at state-run hospital force many people to rely on private medical practitioners (llango & Sebastine, 2011). This situation inevitably creates a big market for the private sector in health care. Studies show that expenditure for getting treatment for disease is the most common cause for rural indebtedness in India (Banerji, 2001; Baru et al, 2010). Furthermore, India is being

pressurised by the international banks to reduce public expenditure in health through increasing privatisation. Baru (1994) have pointed out that public sector continues to be the single largest provider of in-patient services in India. Health care expenditure cuts poor households budgets in two ways. They have to spend a large amount of money and resources on medical care and at the same time they are unable to earn during the period of illness (Sodani, 1997). The private sector in India accounts for 82 percent of outpatient care, 56 percent of hospitalisation, 46 percent of institutional deliveries and 40 percent of pre-natal care visits; whereas, it provides only 10 percent of immunization (NSSO, 1998). World Bank (2002) have pointed out that private sector in India accounts for more than 80 percent of all health spending, one of the highest proportions of private spends around the world. In India more than 70 percent of its total population lives in rural areas, where only 20 percent of the total hospitals beds are located. On the other side, it has been found that India is also catering 'Health tourist' from developed countries of the world. From this paradox it can be assessed that the advances in health care are accessible to the richer sections of Indians (John, 2005). The existence of this situation paralyses the government health institution. Health inequality i.e. unfair, unjust and avoidable causes of ill health ultimately leads to inequalities in the health functioning of individuals, social groups, and national populations, which again raises fundamental social justice questions (Sen, 2002). Pande & Bish (2008) made an attempt to review some of the misgivings about the contours of public health reflected in the thought and action of Indian planners. They have highlighted the fact that at present Government of India is concerned about achieving Vertical Health Programme (VHP) for two reasons. Firstly, most of these VHP are financed by inter-national agencies such as WHO or UNICEF. Second reason is that politicians want wider publicity of the masses and strengthen their position by taking up VHP. Furthermore, majority of secondary and tertiary health services are being run by the private and corporate sectors in India but due to the heavy operational costs of these services most of the people in India have failed to access this. The existence of this situation speaks for the mismatch between demand for and supply of health services in India.

1.2 Health and Health Care: Conceptualisation

Health is the way of life. The concept of Health has different connotations. The widely accepted definition of health is given by WHO (1948) in the preamble to its constitution. It is defined as "Health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity". The definition given by WHO has recognised that it is the concern of society to create an environment where people can attain highest satisfying standard of life which ultimately leads to the overall development of human being. As stated in the 1st Five Year Plan, (GOI, 1951) "Health is a state of positive well-being in which harmonious development of mental and physical capacities of the individual leads to the enjoyment of a rich and full life. It implies adjustment of the individual to his total environment- physical and social.'' The development of health is the continuous process that leads to the progressive improvement of health status of the population. Its ultimate aim is to raise the highest level of human happiness not only by reducing the burden of the disease but also by the attainment of positive physical and mental health. Good health leads to satisfactory economic functioning and social integration. According to J.M (1987) Health Care is defined as "multitude of services rendered to individuals, families or communities by the agents of the health services or professions, for the purpose of promoting, maintaining, monitoring or restoring health". Thus, health care cover not only medical care but also covers all aspects preventive care. It cannot be limited to care provided within the government sector alone but must include all initiative for self care paid by citizens to get over from ill health.

1.3 Public Health: Conceptualisation

Public Health system is composed of government- run programmes that ensure access to clean drinking water, basic sewage and sanitation services and inoculation against infectious diseases (Akram, 2014). Public health refers to the health of a population, the longevity of individual members and the extent to which people are free from disease or illness. Its main aim is protecting and promoting the health of the population (Baggot, 2000). According to Smith & Jacobson (1988) Public Health involves "promotion of health, the prevention of disease, the treatment of illness, the care of those who are disabled, and the continuous development of the technical and

social means for the pursuit of these objectives." Public Health is defined by Winslow, (1920) as the "Art and Science of protecting and improving the health of a community through an organised and systematic effort that includes education, provision of health services and protection of public from the exposures that will cause harm". Public health approach is holistic approach as it covers all the determinants of health which requires multi sectoral collaboration and interdisciplinary coordination (Chauhan, 2011). The definition of public health incorporates the combined practice of promotive, preventive, curative and rehabilitative services (Qadeer, 1998).

1.4 Public Health Historical Background:

Historically the quality of life and the acquisition of good health for individuals and populations are not solely depended on medical care. Since the dawn of mankind, the wish to influence health and prevent disease has occupied people's mind and it depends on multiple factors that directly and indirectly related to health (Bruycker, 2001). Health Care systems throughout the world are shaped by the historical patterns of their countries as well as by political, economic and geographical conditions.

1.4.1 Public Health in Ancient Periods:

Rosen (1993) has highlighted that many of the ancient civilizations were concerned about cleanliness because of religious beliefs and practices.In ancient culture disease was often associated with the cosmos and divine distribution. Public health during the 19th Century was largely a matter of sanitary legislation and sanitary reform aims at the control of man's physical environment such as, water supply and sewerage disposal (Park, 2013). The most rational and scientific approach to public health began to emerge in Greece in fifth Century B.C.E. due to the revolutionary work of Hippocrates and his followers. They described the diseases in objective terms and rejected supernatural causes. Their book on "Airs, Waters and Places" has discussed the importance of the ecological balance between man and the environment as well as the role of climate, soil, water and nutrition in the maintenance of good health (Kitto, 1957). The Romans were also aware of the health implications of the environment, in particular sanitation. They not only built sophisticated public bathing facility and sewerage system but also devised innovative techniques to purify water supply

(Baggot, 2000). In London, some regulations were introduced in the later part of the twelveth and thirteenth century including restrictions on pigsties and stray animals, regulations for offensive trades, street cleaning and the dumping of waste and rules concerning the slaughter of animals. These measures were taken to control the range of activities that were believed to be hazardous to health (Simon, 1890).

1.4.2 Medieval Period:

In the middle ages, epidemics struck regularly and with terrifying severity. The most important disease of the period was leprosy and this wide endemic was started in the beginning of sixth century and lasted through the fifteenth century. During this era, due to the fear of contamination harsh regimes of isolation were imposed to the lepers (Sundar, 2009). During 1347 and 1351 Black Death or plague swept over Europe; followed by these two new diseases, Syphilis and the 'English Sweat' took the form of epidemics and was wide spread in Europe. Efforts to analyse the causes responsible for disease has increased during the Enlightenment period and as a result numerous public health interventions also emerged. However, during this time concern for public health also arouse out of prison reform movement (Patterson, 1948). During this period, in Germany the first major contribution to public health occurred. Between 1779 and 1816, Johann Peter Frank, a leading medical educator published a six volume treaties, namely System of a Complete Medical policy, in which he proposed a scheme of government interventions to protect the population against disease and to promote health (Sundar, 2009). At the same time, in England Bentham (1789) has proposed a similar humanitarian philosophy in his book on 'Introduction to the Principles of Morals and Legislation'. The author has proposed radical legislation for dealing with the issues of prison reform, the establishment of a ministry of health, birth control and variety of sanitary reforms. Chadwick who had been the secretary of England's Poor Law Commission, established in 1834 took a lead role in a study undertaken by the commission to explore the prevalence and causation of preventable diseases, particularly of the poor working class. The report of this study is called Chadwick's report and it is titled as "General Report on the Sanitary Condition of the Labouring People of Great Britain". In united State a Similar such survey was undertaken by Lemuel Shattuck in 1850 and it was named as " The Report of a General Plan for the Promotion of Public and Personnel Health" This study put forward a fifty recommendation for improvement of public health situation (Sundar,

2009). With the discoveries of pathogenic bacteria by Louis Pasteur in French and Robert Koch in Germany in late 1870s and early 1880s, the concept of preventive medicines has emerged. Lewis (1992) have pointed out that in the latter part of the Victorian period 'Preventive Medicine' has replaced sanitary idea as a dominant philosophy of public health and as a result of this focus has shifted its attention from the general population towards specific sub-groups and individuals.

From the sixteenth through the nineteenth century European countries had completely colonialised. The prevalence diseases of the colonized area threatened the invaders. Therefore, colonial sanitation and medical care was originally designed to serve the interest of the colonists. Moreover, after the establishment of bio medical sciences many initiatives were taken to control the communicable diseases through preventive measures.

1.4.3 Early Twentieth Century:

At the beginning of twentieth century the concept of 'Health Promotion' has emerged and it has widened the scope of public health. In addition to disease control activities one more goal was added with public health that is heath promotion of individuals (Park, 2013). The high rates of occupational diseases and industrial injuries led to the initiation of programmes for industrial hygiene and occupational health. Mother and Child Health (MCH) aspect also got wide recognition during this era and MCH was identified as a public health issue. The first School of Public Health in the United States was established in 1916 at Johns Hopkins University. By the Mid century , the basic activities of public health has been recognised by the industrial World and as a result number of activities such as MCH services, environmental sanitation, communicable disease control activities etc has started . The Wilson's (1920) definition of public health has expanded state's responsibility for the promotion of health.

1.4.4 Late Twentieth Century:

During the half of the present century two great movements were initiated for human development. One is the provision of "Basic Health Services" through the medium of Primary Health Centres and Sub Centres for rural and urban areas and second movement was the Community Development Programme to promote village

development through active participation of the whole community (Park, 2013). The Bhore committee (1946) in India has also recommended the establishment of health centres for providing integrative, curative and preventive services (Goel, 2002). The creation of National Health Security (NHS) in 1948 is regarded as one of the revolutionary step of public health achievement. This service was inclusive and free at the point of delivery (Baggot, 2000). However, Public health entered a new phase in the 1960s described as the phase of "Social Engineering". As a result of this new approach, social and behavioural aspect of disease has got more priority under the arena of public health (Park, 2013).

However, despite the advancement of medicine and new technology in the field of health care the health gap between rich and poor within the countries and between countries has increased. Against this backdrop, in 1981 the members of the WHO have come to the common consensus to fulfil the target to provide "Health for all" by the year 2000. The main aim of this goal is to the attainment of a level of health that will permit all people "to lead a socially and economically productive life" (WHO, 1978). In September, 2000 representatives from 189 countries met at the Millennium Summit in New York and they have adopted Millennium Development Goals (MDGs). The MDGs (2000) place health at the top of development and represent commitment by all member state throughout the world to reduce poverty and hunger, tackle ill health, gender inequality, lack of education, access to clean drinking water and environmental degradation. So it can be said that three of the eight goals are directly related to health and all other goals have important indirect effects on health (Park, 2013).

1.5 Contemporary Scenario of Public Health Care in India:

India is one of the fastest growing countries of the world. Therefore, the public health system of India is attracting the attention of many developed countries around the world. At the time of independence, India's public health status was dismally low in regard to both manpower and infrastructure. At this modern era, India has a powerful material and technological base of advanced system of public health services. But despite these achievements lack of basic amenities, disease burden, shrinking investment, regional disparity and poor health status of women and child are the

major challenges for public health in India. The various kinds of disparities inherent in the field of public health in India are briefly discussed in the points below.

1.5.1 Inadequate Sanitation Facilities*:* There exists a huge disparity in access to safe drinking water and improved sanitation facility in India in both rural and urban areas and among the different communities and age group. In rural areas, local government institutions in charge of operating and maintaining proper sanitation are seen as weak and lack of financial support to carry out their functions. In addition, no major city in India is known to have a continuous water supply and an estimated 72 percent of Indians still lack access to improved sanitation facilities (Akram, 2014). According to UNICEF (2010) 638 million Indians defecate in the open and 44 percent mothers dispose their children's stool unsafely in the open. The report has further highlighted that 21 percent of all the communicable diseases in the world are water related and 88 percent of the 4 billion annual deaths occur due to diarrhoea are due to the result of unsafe water, unimproved sanitation and lack of hygiene. As per the report 88 percent population receives water from improved sources in India but among these figures only a quarter has water in their premises. The report has also indicate that in India women and girls spend more than 1.6 hours per day to carry water for their families and this leads to the poor health condition of women and girls. Lack of water supply near home affects the girl child as it forces her to sacrifice personal hygiene which ultimately affects her dignity of life.

1.5.2 Shrinking Investment in Health Sector*:* As per the data from Sample Registration System (2009) Public health expenditure in India has declined from 1.3 percent of GDP in 1990 to 0.9 percent of GDP in 2009. The Union Budgetary allocation for the health is 1.3 percent while the States' Budgetary allocation is 5.5 percent. Furthermore, the Union government contribution to public heath expenditure is 15 percent where as state's contribution is about 85 percent. As per the World Development Report (2009) the percentage of total expenditure in health sector in India is only 2.5 percent. It is also observed that the performance of Srilanka, Bangladesh is more satisfactory compared to India. Government expenditure in Bangladesh is about 5.3 percent, Srilanka, 6.2 percent, Pakistan 2.05 percent, UK 15.7 percent, and USA 18.6 percent and in Germany it is 20 percent. So from the above data it is clear that public spending on health in India is amongst the lowest in the World. However with the launch of NRHM the level of public spending on health has

increased from RS. 14,702.76 crore in 2009-10 to14, 988.02 crore in 2010-11, to R.S. 18,115 crore in 2011-12 and further increased to 20,822 crore in 2012-2013 (NRHM, 2009-2013). Out of pocket expenditure on health care forms a major barrier to health seeking in India. As in India people do not have any form of financial protection so they are forced to make out of pocket expenditure when they fall sick. This is regressive and has both economic and social consequences (Annual Report to the People on Health, 2010).

1.5.3 Disease Burden: India has one of the highest numbers of TB cases in the world. Out of 9.2 million cases of TB that occur every year, nearly 1.9 million cases occur in India which accounts for one fifth of the global TB cases. Experts estimate that about 2.5 million persons have HIV infection in India, which is world's third highest. More than 1.5 million persons are affected by malaria every year. Nearly half of the leprosy cases detected in the world in 2008 were contributed by India. In addition, more than 300 million cases of acute diarrhoea occur every year in India in children below 5 years of age (MoHFW, 2010). Beside these, non- communicable diseases are second only to communicable diseases in terms of their contribution to the disease burden in India. Further, National Commission on Macro Economics and Health (2005) highlights that Diabetes is emerging as an important health condition in India, with an estimation of 310 lakh cases in 2005. Cancers have been attributed to 3.3 percent of the disease burden in India and approximately 9 per cent of all the mortalities.

1.5.4 Scanty Infrastructure*:* Public health care infrastructure in India has made a remarkable reform. It has been observed that due to the implementation of strong public health policy Malaria has been controlled, Small pox and Guinea have been completely eradicated and leprosy and polio are reaching towards elimination (Dwaraknath, 2012). In this connection, Vijayalakshmi (2011) states that though the number of health infrastructure has increased but there is a lot of variation about the availability of such infrastructure, both inter- state and intra –state. As per the available data from Economic Survey (2009), it has been observed that the number of people served per government hospital bed during 2006 was 1172,849 in Tamil Nadu, 3409 in Madhya Pradesh and 28959 in Bihar against the national average of 2257. This is reflected in the basic indicators like death rate, IMR and also in life expectancy. For instance, in 2006, IMR in Kerala was 14, 37 in Tamil Nadu and 76 in Madhya Pradesh. In the same states the rate is different in rural and urban areas as in

Kerala the rate of IMR in rural areas was found to be 15 and in urban areas it was 12 and similarly 39- 34 in Tamil Nadu and 80 and 54 in Madhya Pradesh respectively.

Table-1.1: Public Health Facilities in India from 2001- 2010

Facilities	2001	2010
Hospital	15588	19786
Hospital with dispensary beds	719861	816274
Dispensaries	23065	24847
Primary Health Centres	22842	23390
Sub-Centres	137311	146006
Community Health Centres	3043	4276
Voluntary Organisation	3182	7002

Source: *National Commission of (MOHFW) Govt. of India, New Delhi, 2010.*

It can be said though the public health infrastructure has increased in India over the period of time but still there is a shortfall of 36346 SCs (20%), 6700 PHCs (23%) and 2350 CHCs (32%) across the country as per the Rural Health Statistics (RHS) 2014.

1.5.5 Poor Health Status of Women and Child:

Better provision of health care services can be measured by the level of health outcomes such as the Infant Mortality Rate (IMR), Under Five Mortality Rate (U5MR) and Maternal Mortality Rate (MMR). These outcomes are also related with the health indicators including immunization of children and infants, malnourishment among children, ante-natal and post-natal care and number of institutional deliveries which form an integral part of the primary health services. As per the available data , India's MMR is 437 as compared to Srilanka's 30, China's 115, Thailand's 200, Pakistan's 340, Indonesia's 390, Bangladesh's 850 and Nepal 1500. With 16 percent of the World's population, India accounts for over 20 percent of the world's maternal deaths (National Population Policy, 2000). So from the above facts it can be assessed thatthe health picture of Indian Women is not satisfactory. According to the third NFHS (2005-2006), the IMR and U5MR in India were estimated at 57 and 74 per thousand live births. In addition it is further estimated that only 43.5 percent children in age group of 12-23 months received all basic vaccines and about 5 percent children in the same age group have not received a single vaccine. Beside these, almost one

out of every five women in India did not receive any antenatal care for their last birth in the 5 years preceding the survey. The proportion of institutional deliveries was only about 39 percent in 2005-06. However, though the scenario is changing eventually but still today, half of young women in India get married before the legal age of 18. Teenage mothers face more risk in pregnancy and related health problems. The marital fertility in the age group 20-29 years is very high, adversely affecting the Women's health and their nutritional status (Rani, 2011).

1.5.6 Regional Disparity:

India's performance in terms of life expectancy, child survival and maternal mortality has improved steadily, but there is a wide divergence in the achievement across the states. Life expectancy in India is increased from around 30 years at the time of independence to over 63.5 years in 2002-06. The inter-state variation in performance is depicted in the table below.

Table 1.2: Regional Disparity on Health Indicators

High Focus States (EAG)	Life Expectancy at Birth (2002-2006)	IMR 2008	MMR (2004-06)	TFR 2008
Bihar	61.6	56	312	3.9
Madhya Pradesh	58	70	335	3.3
Orissa	59.6	69	303	2.4
Rajasthan	62	63	388	3.3
Uttar Pradesh	60	67	440	3.8
Assam	--	64	480	2.6
Kerala	74	12	95	1.7
Maharashtra	67.2	33	130	2
Punjab	69.4	41	192	1.9
Tamil Nadu	66.2	31	111	1.7
West Bengal	64.9	35	141	1.9
India	63.5	53	254	2.6

Source: *Register General of India; Planning Commission, (2008).*

From the above discussions, it can be said that India's public health system is facing huge hurdles. The first malady that public sector is facing is related to the failure of state to stabilise the population growth. The second is due to the political interest,

India's public health system has given priority on high-tech specialized services then the delivery of minimum public health services to the beneficiaries to cater their needs. In addition the third big challenge of public health in India is related to health management and man power planning (Candra, 2012). Public health approach deals with all the determinants of health which require multi sartorial collaboration and interdisciplinary coordination (Chauhan, 2011). To understand the challenges faced by India's health status there is a need to understand the role of donor agencies in setting program priorities and its effects on health program integration. Public health in India are often measured and expressed in terms of quantities rather than qualities. So from the above discussion, it can be said that India's health system face contradictions , as in one side the public health expenditure in India is not up to the mark in comparison with other country and on the other hand, India has the latest and most sophisticated information technology in the world (Krishnamoorty, 2008; Singh and Bajpai, 2008). There is a need to require serious rethinking of its institutional design and the structure of incentives provided to the health personnel. Proper coordination among the service providers as well as among different health facilities (Sub Centre, PHC, CHC and District Hospital etc.) will bring transparency and accountability in the delivery of health services.

Primary Health Care system is a holistic one which looks after the entire health care system of the country. In India, to meet the basic health needs of the population specifically in rural areas, Primary Health Care Approach has been introduced.

1.6 Primary Health Care Approach:

The International Conference in Alma Ata in the year 1978 have expressed the need for urgent action by all the governments, all health and development workers and the world community to protect and promote the health of all the people of the world under the broad umbrella of Primary Health Care Approach. It has all the hallmark of a primary health care delivery, first proposed by Bhore Committee (1946) and now recognised world-wide by international agencies and national governments. Before Alma –Ata Primary Health care was regarded as Synonymous with "Basic Health Care Services", "First Contract Care", "Easily Accessible Care", "Services Provided by Generalists" etc. (Park, 2013). The Alma- Ata conference has expanded the

meaning of primary Health Care. The Alma-Ata conference defined Primary Health Care as " Primary Health Care is essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and country can afford" (WHO, 1978). The concept of Primary Health Care Approach has been accepted by all the countries as key to the attainment of "Health for All" goals by 2000A.D.

1.7 Elements of Primary Health Care:

The Alma- Ata (1978) has highlighted eight specific elements of Primary Health Care. These are:

- Promotion of food supply and proper nutrition
- Education about health problems and their controls
- Safe water supply
- Basic Sanitation
- Mother and child health, including family planning
- Immunisation against infectious diseases and injuries
- Prevention and control of locally endemic diseases
- Treatment of common diseases and injuries.

Qader (1998) points out that the declaration of Alma-Ata highlights a "Health for All" strategy in which Primary Health Care was not seen as an elimination of diseases by targeted technological advancement alone rather it means a complex of strategies that determined people's livelihood and quality of life. The major principles of Primary Health Care are discussed below:

- ***Equitable Distribution:*** In India Primary health care aims at correcting Urban-rural imbalance and bringing health services as near people's home as possible. It should be supported by higher level of health care to which the needy can be referred.

- ***Community Involvement:*** The involvement of individuals, families and communities in planning, implementation and maintenance of health services is an essential ingredient of primary health care.

- ***Multi-Sectoral Approach:*** One of the basic tenets of primary health care is that full health cannot be provided by the health sector alone. It requires the joint efforts of health sector and other health related sectors. Primary health care should be set in the context of integrated development to include health, housing, transport, water and sanitation, nutrition, agriculture, education, community development including women's development.

- ***Appropriate Technology:*** This does not mean cheap, primitive technology for the poor. It calls for scientifically sound materials and methods that are socially acceptable, directed against relevant health problems.

- ***Prevention of Diseases and Promotion of Health:*** This is the basic strategy of primary health care. All activities use this strategy as it is cost effective to prevent diseases than to treat the same.

So from the above discussion it can be said that Primary Health Care refers to the first contact care and it furnishes continuous care for specific kind of disease or illness. This approach emphasises the importance of the establishment of longitudinal relationship between patient and health care providers. Primary Health Care is both family-responsive and community oriented programme and it depends on the core principle of community participation. An important aspect of the development of this strategy is to the reassessment of the role of traditional practitioners and Para-medical workers. Emphasis has also been placed on the importance of local health workers to carry out simple preventive activities such as vaccinations and immunization, and provide simple remedies for common diseases or condition and at the same time they may advise on other health-related matters, e.g. nutrition, the provision of clean water and family planning (Madeley, 1983).

1.8 Evolution of Primary Health care In India:

The evolution of Primary Health Care Approach in India can be discussed under the two broad headings. These are i) Pre- Independence Era and ii) Post- Independence Era.

1.8.1 Evolution of Primary Health Care in Pre- IndependenceEra:

Throughout the history it has been observed that human being have made its efforts to deal with illness both individually and collectively. The declaration of Alma-Ata in 1978 was an unprecedented and far reaching commitment. Its main aim is to attain acceptable level of health for all within a time frame (Deodhar, 1982). Historically the concern in the field of primary health care in India was seen in Vedic period. As far as the 3000 B.C the Indus valley civilization had put emphasise on sanitation programmes such as provision of underground drains, public baths, etc., in cities (Rao & RadhaLakshi, 1960). Arogya or health was given high priority in day to life. The goal of primary health for all was enshrined in an ancient Sanskrit Verse that is "SarveSantu niramayaha" which literally means "Let all free from disease". During the ancient time the life style that was followed was conducive to health promotion (Deodhar, 1982). Daily activities such as personal hygiene and habits, health education, exercise, code of conduct and self discipline, food sanitation, environmental sanitation, civic and spiritual values etc., were termed as Dinacharya (Roy, 1985). In 1400 B.C Ayurveda put emphasised on health promotion and health education. Despite these innovations, this period was called as Dark Age as Ayurveda has failed to serve the health needs of majority of people and it was also not accessible to all section of people (Banerjee, 1976). During the middle of the 18th Century the British Government have setup western model of medical services in India. As a result our own traditional method of treatment that is Ayurveda, Unani and other local health facilities were neglected. The services were basically curative in nature and were available at the hospital located in big cities (Banerjee, 1976). However, during this time some preventive measures were taken specifically to control the epidemics but these are also not available to all. Advance technology driven treatment facility was provided during the British period in India but in practice this model has failed to cater the needs of rural and urban poor (Deodhar,1982).

1.8.2 Evolution of Primary Health Care in Post-Independence Era:

On the eve independence, the Bhore committee had submitted its report to the then government in 1946. This revolutionary report has given a new approach to the health service in India. This report has recommended first time for the delivery of health

services in India through the Primary Health Care Approach (Roy, 1985). The planning commission was set up in 1950 for improving the pace of development of the country. Health programmes has got immense priority in the successive Five Year Plan of India. The community Development Programme was launched in 1952, which has provided the option for providing comprehensive health services through Primary Health Centres (Deodhar, 1982). Moreover, before the declaration of Alma-Ata India's health sector has got transformation followed by the recommendation of a number of expert committees, namely the Mudaliar Committee (1961), the Mukherjee Committee (1966), the Kartar Singh Committee (1974), and the Srivastava Committee (1975). Acceptance of the recommendations of Shrivastav Committee report led to the launching of Rural Health Scheme in 1977, wherein training of community health workers, reorientation training of multipurpose workers and linking medical colleges to rural health was initiated. Furthermore, to initiate community participation the Village Health Guide (VHG) scheme was launched on 2nd October 1977**.** India is a signatory to the Alma -Ata Declaration of 1978, and it is committed to attaining the goals of 'Health for All' (HFA) by the year 2000 through the Primary Health Care Approach (Roy, 1985). The report of Study Group on "Health for All – an alternate Strategy" commissioned by Indian Council of Social Science Research(ICSSR) and Indian Council of Medical Research (ICMR) in the year 1980 under the chairmanship of Dr. V. Ramalinga swami highlighted that the health needs of the majority of Indian population were not possible to being solved at the Primary Health Care level through community participation so the report recommended an alternative health care system that is accessible, culturally acceptable and cost effective in the delivery of health care services to the beneficiaries. The Mehta committee reviewed the then system of medical education in all its aspects and highlighted the issues of lack of availability of Health manpower data in India (Mehta committee Report, 1983). Soon after the declaration of Alma-Ata, India's first health policy has come up in the year 1983 with an objective of the provision of universal and comprehensive primary health care services with special emphasis on the preventive, promotive and restorative aspect (Goel, 2002). An "Expert Committee for Health Manpower Planning, Production and Management" was set up in 1985 under the leadership of Dr. J.S. Bajaj to discuss in details the different components of primary health care, manpower requirement at different levels and catering the demand by introducing vocational training and managing the manpower (Bajaj Committee Report,1987). Few years later in 1996,

the Ministry of Health and Family Welfare (MOHFW) constituted an Expert Committee on Public Health Systems under the chairmanship of Dr. J.S. Bajaj, to comprehensively review the existing public health system in the country and recommended the review of health policy (Bajaj Committee Report, 1996). The National Population Policy (NPP,200) was announced in the year 2000 with an objective to address the unmet needs of contraception, health care infrastructure and health personnel and to provide integrated delivery for basic reproductive and child care services (NPP, 2000). National Health Policy (NHP, 2002) aims at achieving an acceptable standard of good health amongst the general population of the country and increasing access to the decentralized public health systems by establishing new infrastructure in deficient areas and upgrading the infrastructure of existing institutions (NHP, 2002). To improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children the Government of India has launched the National Rural Health Mission (NRHM) in April 2005. Its main aim is to carry out necessary architectural correction in the delivery of basic health care services (NRHM, 2005). However, in the year 2013 UPA government has launched National Health Mission (NHM) which encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM). The NHM envisages achievement of universal access to ***equitable, affordable & quality health care services*** that are accountable and responsive to people's needs. The main aim of NHM is to improve the service delivery of Health System in both rural and urban areas. Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCH+A) interventions and control of Communicable and Non-Communicable Diseases are the main components of NHM (NHM, 2013).

Table 1.3: Milestone for the Promotion of Primary Health Care in India

Years	Milestone
1946	Bhore Committee Report on Health Survey and Development
1948	Sokhey Committee Report on National Health
1952	Community Development Programme
1962	Mudaliar Committee Report on Health Survey and Planning
1963	The Chadha Committee Report
1965	Mukherjee Committee Reports on Basic Health Services
1967	Jungalwalla Committee Report on Integration of Health Services
1973	Kartar Singh Committee report on Multipurpose Health Workers
1975	Shrivastav Committee Report on Medical Education and Support manpower
1977	Rural Health Scheme: Community Health Volunteer Scheme-Village Health guides
1978	Alma Ata Declaration – Health For All by 2000
1980	ICSSR and ICMR Report – "Health for all- An alternate Strategy"
1983	First National Health Policy
1985	Bajaj Committee on Health Manpower Planning, Production and Management
1996	Bajaj Committee on Public Health Systems
2000	National Population Policy
2002	Second National Health Policy
2005	National Rural Health Mission (NRHM
2013	National Health Mission (NHM)

The declaration of Alma-Ata has brought a paradigm shift in the domain of health care by introducing the concept of Health care through which the health needs of the World population are addressed by placing emphasize on self –reliance, self-determination and social justice (Maridos,1994). India has shown its concern for the promotion of Primary health care starting from the ancient period to modern globalized era. The genesis and evolution of Primary Health Care in India is the result of different committees, commissions and national programme launched by the government in different points of time. Despite all these initiatives it has been observed that the Primary Health Care Approach in India put more emphasis on family planning. Therefore, it ultimately lost orientation and curative health delivery service were neglected (Kumar, 2009). There is an urgent need that the people working at different levels in the field of health and other related socio-economic development sectors should be properly trained through different skill up gradation

programme and they should be motivated to develop a sense of social commitment for achieving the set goals. Health services research should play an important role in the process of planning, implementation, monitoring and evaluation with the object of strengthening primary health care approach in India. Verma (2008) states that for an improvement in the performance of the Primary Health Care System only those having an intrinsic motivation to mix with and serve the common man should be appointed as Multi Purpose Health Workers (MPHWs) and Health Supervisors. All employees right from the Medical Officer to the grass root level health workers need to undergo new packages of training so that their overall efficiencies and competencies may be improved in order to achieve better performance.

1.9 Rural India in 21st Century: The Health Profile

As per 2011 census total 83.5 crore populations in India live in rural areas. The large magnitude of rural population, their prevailing socio- economic condition and quality of life calls for all round development in rural areas (Tripathy, 2014). Since independence India's policy makers and planners have put emphasized on the holistic development of rural areas through different strategies. The rural health is the interdisciplinary study of health and health care delivery in the context of a rural environment or location. The rural health includes some of the fields of study such as health, geography, midwifery, nursing, sociology, economics, telehealth/ tale medicines etc (Vijayalakshmi, 2011). Rural India suffers from the lack of basic amenities such as electricity, appropriate drainage and sewage facility, safe drinking water and improved sanitation facility. These factors contribute to the poor hygiene and ultimately increase the susceptibility of diseases. The basic challenge that rural health care have been facing in India is related to poor development of heath indicators such as IMR, MMR, life expectancy etc. Beside these, there is a lack of required man power and health infrastructure in rural areas (Kumar, 2009). Further, Duggal (2005) states that the curative hospital services are mostly located in the cities where only 25 percent of the one billion populations reside. Rural areas have mostly preventive and promotive services like family planning and immunization.

Table1.4: Major Heath Indicator in India

Indicator	Outcome achieved (2010-2011)	Remarks
Sex Ratio	940 per 1000 person	933 per 1000 persons in 2001
Child sex ratio	914 per 1000 boys	927 per 1000 boys in 2001
Life expectancy at birth	22.1 per 1000 population	63.5 years in 2004-2005
Crude birth rate	22.1 per1000 persons	Rural areas it was estimated at 23.7 and in Urban areas it was 18.0
Crude death rate	7.2 per 1000 population	In rural areas it was estimated at 7.7 and in urban areas it was 5.8
Child mortality rate	13.3 per 1000	Rural areas it was 14.9 and urban areas it was 7.8
Infant Mortality rate	47 per 1000	Rural areas it was 51 and in urban areas it was 31

Source: *Results frame work documents, Ministry of Health and family welfare, 2012-2013*

From the above table, it is revealed that the crude death rate in rural areas was 7.7 and in urban areas it was 5.8. Again the IMR was estimated at 51 in rural areas and 31 in urban areas. In case of child mortality rate rural areas are lagging behind then the urban areas as in urban areas it was estimated at 14.9 and in rural areas it was estimated at 7.8. So from the above mentioned data, it is revealed that there is a huge disparity in the delivery of health care services in rural-urban areas and rural areas are lagging behind then the urban areas almost in all sectors. In India there is a misdistribution of health manpower in rural and urban areas. The table (1.5) shows the current stock of total manpower in rural areas. As per the available data, in the year 2000 there were over 550,000 registered allopathic doctors and over 700,000 non- allopathic doctors; and out of the total of 1.25 million about 1.04 million were estimated to be in the private sector (Health Profile of India, 2001).

Table: 1.5: Health Care Providers in Rural India as on March 2011

Serial No	Category	In position
1	ANM at Sub-Centre and PHC	207,868
2	Multi-purpose Health Worker (MPW) (Male)	52,215
3	Health Assistant (Female)/ LHV	15,908
4	Health Assistant(Male)	15,622
5	Doctors in PHCs	26,329
6	Health Specialists at CHC	11,798

Source: *Report on Rural Health Statistics, 2011*

Development of health care infrastructure in India is urban centric and there is a huge shortage of manpower in health sector. To come out from this problem there is a need to upgrade the skill of existing unlicensed rural manpower to take additional tasks (Das, 2012). Gupta & Gumber (1999) states that Government – run rural health services in developing countries including India are highly centralised. This has raised several problems like: a) services are unresponsiveness to local demands and needs. b) Overall coverage of services is low as there is excess capacity in infrastructure with corresponding shortage of supplies and manpower. c) Staffs are assigned, rooted and paid with no relation to output of services and client satisfaction, are often inadequately or undertrained , ill- equipped and commonly indulge in private practice d) Referral system do not work properly under the centralised system of governance. Disadvantaged rural health in India is reflected by significantly higher mortality rates in rural areas. The public expenditure on health sector in India is inadequate. Access to high quality of health care services plays an important role in improving the health status of rural people. The underutilization of existing rural hospitals and health care facilities can be addressed by a market-cantered approach and it requires more government intervention for horizontal and vertical programme integration (Chillimuntha et al, 2013). An effective and responsive health system of a country is based on the available health work force. India's Health system specifically rural health system faced shortage of human resources. There is a need to have strategic planning for human resource for public health at state/ national level. A comprehensive national policy for human resources is required to achieve Universal Health care in India. The public sector needs to redesign appropriate packages of

monetary and non-monetary incentives to encourage qualified health workers to work in rural and remote areas (Sayeed, 2011).

1.10 Overview of Rural Health Systems in India: Critical Appraisal

Health System constitute the management sector and its main tasks include planning, determining priorities, mobilizing and allocating resources, translating policies in to services, evaluation and heath education which are intended to deliver quality health services (WHO,1972) Health system are the part of the fabric of social and civic life and it deserve the highest priorities to improve the health of the people as they provide life saving and life enhancing interventions to those who need them (Sankar & Kathuria, 2004). WHO (2000) has emphasised that the primary goal of health system is to provide better health in a responsive manner and with fair financial distribution. After gaining independence in 1947, India has adopted the welfare model of development. The health care services are divided under state list and concurrent list in India. While some of the items such as public health and hospitals fall in the state list, others such as population control and family welfare, medical education, and quality control of drugs are included in concurrent list. MoHFW is the central authority responsible for implementation of various programmes and schemes in the areas of family welfare, prevention and control of major diseases.

India's health sector could be divided into three broad categories (Park, 2013). These are: Primary Care level, Secondary Care level and Tertiary Care level.

- Primary Care Level: In Indian context, Primary Health Care is provided by the complex of Primary Health Centres and their Sub-Centres.
- Secondary Care Level: In India, the District hospitals come under the secondary care level where it deals with more complex problems and health issues.
- Tertiary Care level: The tertiary level is more specialized level. In India this care is provided by Medical College institute, All India institute, Regional Hospital, Specialized Hospitals and other Apex institutions.

The first tier that is the Primary Health Care has been developed to provide health care services to the vast majority rural people. The rural health care infrastructure has been developed to provide Primary Health Care services to the beneficiaries to cater their basic health care needs.The rural health system in India, consist of pyramid type of structures at whose bottom is the Sub-Centres which moves upto the second tier called the Primary Health Centres, thereafter to the third tier known as Community Health Centre. The rural health care infrastructure has been developed to provide primary health care services to the beneficiaries to cater their basic health care needs.

Table 1.6: Rural Health Structures

Health Facilities	Population Norms	
	Plain Area	Hilly/Tribal/Difficult Area
Sub-Center	5000	3000
Primary Health Center	30,000	20,000
Community Health Center	1,20,000	80,000

Source: *6th Five Year Plan, GOI*

1.10.1 Sub Centres (SC):

The Sub-Centre is the peripheral health unit of the existing health delivery system in rural areas. They are being established on the basis one sub centre for every 5000 population in general and every 3000 population in hilly and backward region. Sub-Centre provides interface with the community at the grass –root level and it is intended to provide a wide ranges of Primary Health Care services such as immunization, antenatal care and post natal care, and prevention of malnutrition, common childhood diseases, family planning services and counseling. At present a Sub-Centre is not run by qualified doctors but run by one Female health worker known as Auxiliary Nurse Midwife (ANM) and one Male Health Worker known as Multi Purpose worker (Male), one Health Assistant (Female) known as Lady Health Visitor (LHV) and one Health Assistant (Male) located at PHC level are entrusted with the task of supervision of six sub-centres under a PHC. The Ministry of Health and Family Welfare, Govt. of India is providing 100 percent central assistance to all sub-centres in the country since 2002 in the form of salaries of ANMs and LHVs and other contingencies.

1.10.2 Primary Health Center (PHC):

PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. PHCs mainly runs out patient care, with only minimum facilities for in-patient care.The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services Programme (BMS). At present, a PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 Sub-Centres. It has 4 - 6 beds for patients. The activities of PHC involve curative, preventive, promotive and Family Welfare Services. The Primary Health Centre in India covers the following essential elements of health care.

- Medical care
- MCH including family planning
- Safe water supply and basic sanitation
- Prevention and control of locally endemic diseases
- Collection and reporting of vital statistics
- Education about health
- National Health Programmes- as relevant
- Referral Services
- Training of Health guides, heath workers, local dias and health assistants
- Basic Laboratory Services

1.10.3 Community Health Centre:

CHCs are being established and maintained by the State Government under MNP/BMS Programme. Each CHC covers a population of 80,000 to 1.20 lakh with 30 beds and specialist in Surgery, medicine, obstetrics and gynecology and pediatrics with X-Ray and laboratory facilities. The in -patient care and treatment by specialists are available at CHCs level.

Rural India is suffering from long –standing health care problems. Studies have shown that lack of availability of standard infrastructure in health sector raises serious concern about the quality of services. It has been observed that the standard of

services in terms of cost, diagnostic procedures and therapeutic treatments differs with different providers and in different region. This disparity increases with urban -rural and interstate divide which ultimately leads to low customer's satisfaction. It is estimated that total 17,000 hospitals, 25,670 dispensaries and one million beds were there for the country as a whole in the year 2000 & 2001. However, as per the figure provided by the MoHFW (2005) there were 146,026 sub centres, 23,236 PHCs functioning in the country. Though the numbers appear to be increasing but still there is a shortfall of 12 percent Sub Centres and 16 percent PHCs as per the government norms (MoHFW, 2005). It is further observed that urban areas have 4.48 hospitals, 6.16 dispensaries and 308 beds per 100,000 urban populations in comparison to those rural areas have 0.77 hospitals, 1.37 dispensaries, 3.2 PHCs and 44 beds per 100,000 rural populations (Health Profile of India, 2001). The city hospitals and civil hospitals are basically curative centres providing out-patient and in-patient services for primary, secondary and tertiary care. Whereas, the rural institutions provide mainly preventive and promotive services like communicable disease control programs, family planning services and immunization services. Curative care in rural health institutions are the weakest component in spite of very high demand for such services in rural areas (Duggal et al, 2005).

From the various discussions, reports and the literatures it appears that India's health care structures, administrative setup and machineries are designed to provide accessible and affordable health care services to its citizens. This system depends on the pattern of governance through which the services are offered and managed. Therefore, it is in need to understand the governing pattern of health care services in India.

1.11 Governance and Good Governance: A Conceptual Understanding

Over the past decade, the concept of governance has got wider recognition in every field and it has integrated a number of key elements and principles. Governance is a broad and complicated term; therefore it is difficult to find a unanimous definition of governance. There is no consensus among researchers about the agreed upon indicators of governance, different scholars have defined governance in a different way. The concept of governance varies substantially and it is evident from the views

of International organization who introduced the new modes of governance in modern era. According to UNDP (1997) Governance is viewed as the exercise of economic, political and administrative authority to manage country's affairs at all levels. It comprises mechanisms, processes and institutions through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences. UNDP has identified nine elements of governance, these are: participation, rule of law, transparency, responsiveness, consensus oriented, equity, effectiveness and efficiency, accountability and strategic vision.

World Bank (1994) defined governance as "the manner in which power is exercised in the management of country's economic and social resources for development". The World Bank has identified six governance indicators. These are: voice and accountability, political instability and violence, government effectiveness, regulatory quality, rule of law and control of corruption. According to OECD (1995) the concept of governance denotes the use of political authority and exercise of control in a society in relation to the management of its resources for social and economic development. This definition encompasses the role of public authorities in establishing the environment in which economic operators function and in determining the distribution of benefits as well as the nature of the relationship between ruler ad the ruled. The main aspects of good governance defined by OECD are: legitimacy of government, accountability, competence of governments to make policy and deliver services and respect for human rights and rule of law are the guiding principles of governance. Commission on Global Governance (1995) defines governance as the sum of many ways through which individuals and institutions manage their affairs. It is a continuing process through which conflicting or diverse interest may be accommodated and co-operative action may be taken. It includes formal institutions and regimes empowered to enforce compliance, that people and institutions either have agreed to or perceive to be in their interest. Governance is the basic tool for achieving fast, inclusive and equitable growth and development. It involves the political, economic and administrative power in managing the administrative affairs of a country and it involves the process of formulation and implementation of decisions (Dutta & Ramanathan, 2014). Governance refers to the process of exercising continuous authority over a group of people, an agency, an

institution or an independent entity with an aim to bring proper administration within the system (Satustowicz et al, 2014).

In India, governance deals with two aspects –Micro and Macro. Micro level deals with the relation between legislation, executive and judiciary and Macro level deals with the constitutional reforms which includes the entire government functioning (Nisar, 2012). The Second Administrative Reforms Commission in its report entitled "Citizen Centric Administration: The Heart of Governance"(2009) identified five barriers to good governance in India including attitudinal problem of civil servants, Lack of Accountability, Red tapism, Low Levels of awareness of the rights and duties of citizens and inefficient implementation of laws and rules. The term governance covers a wide variety of spheres.Government refers to the machinery and institutional arrangements of exercising the sovereign power for serving the internal and external interests of the political community, where as governance means the process as well as the result of making authoritative decisions for the benefit of society (Mukhopadhyay, 1998). Further, Prasad (2002) state that governance is purposive and development oriented administration as it is concerned with the improvement of the quality of the life of the mass people. Governance is considered the citizen-friendly, citizen caring, responsive-goal and result oriented administration. It requires effective participation of people in all spheres that are conducive to human development.Governance is a process whereby public institutions conduct public affairs, manage public resources and guarantee the realization of human rights (Gulati, 2011)

The World leaders had concluded at World Summit (2005) that good governance is integral to the economic growth, eradication of poverty and hunger and sustainable development (Gulati, 2011). Good Governance deals with the capacity of government to design, formulate and implement policies and to discharge government functions. Good governance is associated with efficient and effective administration in a democratic framework. The UN Secretary General Kofi Annan states that Good governance is the single most important factor in eradicating poverty and promoting development.Good governance refers to the ability to deliver goods to the stakeholders. Good governance means a mechanism that enhance the ability of people to gain a better and dignified life, greater options to choose from and ensuring transparency in administration (Yadav, 2009). Good governance is associated with

efficient and effective administration in a democratic framework. Good governance is related to purposive and development, oriented administration which is committed to the improvement of quality life of the mass people. It refers to the adoption of new values of governance with an aim to establish greater efficiency, legitimacy and credibility of the system (Kalia, 2004). Good governance stands for complete prevalence of rule of law with full accountability and transference. It prescribed for adequate democratization, decentralization, devolution of funds and the people's participation. It means a responsible and responsive administration (Singh& Singh, 2012). Moreover, Nisar (2012) stated that Good governance includes the provision of basic services and securities. Its aim is to build strength and integrity in citizens which ensures and promote country's soul and its most sacred values and ideas.

Good governance is a combination of efficiency concerns of public management and accountability aspect of governance. It is prerequisite for promoting people-centred development (Dutta & Ramanathan, 2014).

So from the above discussion it can be said that Governance can be used in several contexts such as corporate governance, international governance, national governance and local governance. In simple sense governance is the process through which administration runs its activities and good governance aims at achieving efficient and effective management in administration for improving the quality of life.

1.12 Evolution of the Concept of Governance and Good Governance:

There are historical roots of the evolution of governance concept and it has brought in various studies on governance. This has been discussed below.

In this globalized era, governance has become a fashionable term. It has been observed that developing countries like India, has failed to achieve the pinnacle despite the adoption of neo-liberal policies imposed on them by the IMF and the world Bank in 1989. The term governance has been coined by World Bank first time in the year 1989. Governance is important for all countries at all stages of development. In ancient times governance referred to the forms of political system and the manner in which power is exercised in utilizing the country's economic and social resources for development (Yadav, 2009).

The idea of good governance is as old as the discipline of political science as Plato has mentioned an ideal framework for good governance in his work titled as 'The Republic' through the concept of justice, rule of philosopher kings, an elaborate system of slavery, an elaborate system of educational and communisms of wives and property (Ray, 2011).

Kashyap (2010) stated that 'Arthashastra' is filled with precious gems of Wisdoms and Principles, and it embodies the values, norms and belief pertaining to the governance in ancient time. It has proved to be of perennial significance to the administrative systems, irrespective of the form of government in which it functions. To him, the Arthashastra asks a Ruler to maintain law and order, judiciously exercise coercive powers, ensure discipline, promote justice, create congenial climate for service to the people, stimulate an ethical order, strengthen accountability, facilitate an integrated development of the socio-economic system, and encourage decentralization in governance, regulated planned development of urban and rural areas.

Weiss (2000) have analysed the ideas and concepts, both good and bad, have an impact on international public policy. He states the emergence of governance, good governance and global governance, as well as the UN's role in the conceptual process. According to the author 'governance is as old as human history and further explores some earlier UN-related ideas as decolonization, localization and human rights, which has been played an important role towards generating a modern thinking on governance. The author further points out that there is a contradiction between many academics and international practitioners who employ 'Governance' to connote a complex set of structures and processes, both public and private, while more popular writers tend to use it synonymously with 'Government'.

The British rule in India rest on three pillars-the civil service, the army and the police. The whole British India was divided into districts to maintain efficiency, responsiveness and sensibility in the administration. The credit of establishing the modern form of governance in India based on democracy, equality before law, rule of law and participatory form of government goes to British rule in India despite of its some harmful effects on Indian administration(Kalia, 2004). Nehruian model of governance was earlier tried in India from 1947 to 1991. This model of governance is

based on secularism, democratic, participation, decentralisation of powers on the basis of federalism, command, regulated and planned economy. During this period governance was directed towards socialist pattern of society and economic development. To achieve these goals a complex network of governmental institutions, organizations and agencies was set up for bringing planned development in the country (Bhardwaj, 2011). However, in the late 1980s, it was realised that this model of governance failed to bring good results. The then Prime Minister, Narasimha Rao, have recognised the weakness of Indian economy and governance during these era. So he embraced the philosophy of economic reform in 1991 and brought the attention of the group of intelligentsia. Since then India has adopted a new model of development integrated with the basic principles of accountability, justice, rule of law, transparency and participation (Kumar, 2008). The concept of "Good- Governance" assumed significance since 1990s with the publication of two reports by the World Bank. In the first report entitled "Sub – Saharan Africa: From Crisis to Sustainable Growth" (1989) where Bank emphasized upon the need for good governance. While in the second report entitled as 'Governance and Development' (1992), the Bank identified a number of aspects of good governance. These are political, legal and administrative in nature. Laxmikanth (2011) have mentioned some initiatives that were taken in India for ensuring good governance in the country. The major among these are: i) the 73rd and 74th amendments (1992) provided the opportunity to people to participate in the governance process ii) rights-related to statutory bodies such as the National Commission for Women(1992), the National Commission for Minorities(1993) and the National Human Rights Commission (1993) have been set up.

The Eleventh Five Year Plan (2007-2012) has identified some of the good governance initiatives taken during tenth Five Year Plan (2002-2007) in India. These are: i) Right to information Act, 2005 ii) initiatives on participatory governance were introduced in India's two big currently run programmes i.e. NRHM and MGNREGA iii) The second administrative reforms commissions was constituted to prepare a detailed blue print for revamping the public administration system in India.

It is basically the governance pattern through which the administrative reforms have been made in the delivery of health care services in India. This has been discussed below:

1.13 Governance and Health Care in India:

Commercialisation of health care in a globalised world has raised many issues. Negligence and neglect on the part of health care professionals and wide scale organ trade has frightened people all over the world. As health is one the important aspect of life that it should not be commercialized to the extent of converting it as a commodity for the large chunk of people. Health care and pharmaceutical industries are becoming highly expensive day by day is a growing concern for entire world (Bajpai, 1998). India is a country where more than 70 percent of the people live in rural areas have little access or no access to modern medicine and health care. This situation arises not only due to the lack of health care professional working in rural areas, but due to poor administration of health services (Goel, 2004). Governance in health care provide the opportunity whereby knowledge and skills of professionals can be use in an effective manner for the delivery of services and it also ensures optimum utilization of resources with minimum cost. The low level of investment and allocation of resources to the health sector over the years and the uncontrolled and incredibly rapid development of an unregulated private health sector in the recent past is responsible for lack of governance in health sector. Reform of public sector is based on the premise that the public sector is unable to act as a sole provider of services within a context of economic recession. Greater competition among the service provider is the only means of improving quality and efficacy in the delivery of public services (World Bank, 1993). Domodaran (2007) highlights the fact that globalization has been restricted to developed nations and it is recognised as concrete terms for the developing and least developed group. He visualises that the whole episode of globalization is capitalism per se and maintains that its vulgarity has even produced critics who were its own beneficiaries.

Bhattacharya (2001) points out that the main concern of third world is that its substantial portion of people continues to live in poverty, malnutrition and in subhuman conditions. Globalization therefore has to reckon with the survival strategy of the third world against the backdrop of iniquitous global economic structure. The globalization of India was speeded up under the Structural Adjustment Program (SAP) designed with World Bank's assistance to reform India's economy. A large part of the middle class has benefitted from the SAP and related initiatives but it has widened the gap between rich and poor and added the misery of the already

impoverished masses (Duggal et al, 2005). Reform of health services in developing countries aimed at altering pre-existing inequalities in the organization and distribution of health services established during the colonial era. However, during the past decade, the term reform has been restricted to an exclusive focus on the cost and economic value of health services (Sen, 2011). There are two major reforms that affect public sector rural health services in India. One is the introduction of user fees with varying degrees of local control over their use and other reform is the devolution of central responsibilities to lower levels of government (Gupta & Gumber, 1999). Due to SAP, there was a sharp cutback in the public expenditure during the nineties. As a result, developing countries which were dependent on government's budget suffered. However, World Bank has tried to restore the cutbacks through its intervention for specific Disease Programme (Baru, 2001). Quader et al (1994) state that the decline standard of public health services in nineties is responsible for the slashing of budgets for communicable diseases in the early nineties.

The concerns in the governance in health sectors arise from different factors in India. It has been observed that there is a low level of development of health indicators in India specially the high rate of MMR and IMR. Further vary large section of population have no access to Primary Health Care facility despite a huge investment in health services and health care infrastructure. Beside these, there exist a huge rural-urban and inter regional disparity in the distribution and quality of health services (Saxena, 2010). In India, user charges in public hospitals have been introduced due to the implementation of SAP but in practice this reform strategy varies from state to state. Under SAP there is a strong push towards charging for outpatient, inpatient, and diagnostic services in government hospitals. SAPs are transferring the profitable elements of Health care into the market, leaving only underfunded and poor quality essential package for the poor (Baru, 2001). In health sector, the implications of ineffective health institutions is related with the absence of medico and Para-medico personnel in remote areas, negligence on the part of health bureaucracy and medico personnel and lack of required infrastructure in rural areas (Kumar, 2009). So from the above discussion, it can be said that inefficiency in existing health system need to redefine the function of government in order to provide better delivery of services which ultimately lead to satisfaction of consumer choice and demand. A specific measure adopted as reforms in health services varies from state to states. The study

conducted by Kumar (2009) shows that state like Madhya Pradesh has adopted user fee as the base of reform, there are other components, including a new broad – based management structure to manage day- today functioning of hospitals at local level and also oversee the use of additional resource generated. The experience of West Bengal and Kerala, on the other hand shows an active community involvement in furthering the cause of both reforms and decentralization. The author also points out that Gujarat has adopted innovative technique of GO-NGO partnership model to reach the unreached and to fulfil the health needs of masses. Decentralized planning helped to institute a more direct accountability of public health care institutions with local bodies in managing the health care institutions. The study further analysed that in Kerala state of India, these local self-government practically have failed to professionally manage the heath institutions transferred to them due to the lack of management skills. Moreover, the issues of duel control where the state departments have technical control and the local-self –governments have the administrative control which has affected the smooth and efficient running of the health institutions. Decentralisation in health sector needs to be strengthened, but not in isolation. It has to be integrated with multilevel planning process (Elamon, 2009). Further, Kundu (2009) tries to give an overview of some of the reform experiences being undertaken in the health services sector in the Indian State of Orissa. The author points out that reform initiated in Orissa such as introduction of user charges, creation of District Cadre for Paramedics, Multi-Skilling of Health Personnel, Drugs Reform, Handing over PHCs to NGOs, Mandatory Pre-PG Rural Service have shown an increasing trend of people's participation in health services sector. Prabhu (2001) compares and constructs the investments in health services and the health indicators of two states, Maharashtra and Tamil Nadu. According to him, these two states are being affected by current reforms. The result of the study shows that services provided in the government primary health delivery system were considered to be unsatisfactory by a majority of the respondents in the five selected villages in two states. The perception of respondents in the selected villages indicated that there was no change in the quality of services of the Primary Health Care services during the economic reform period, though a distinct deterioration of services of the public distribution system was perceived, particularly by respondents belonging to the lower income group. The study further explored that neglect of primary health care in Tamil Nadu and the high importance given to family welfare have resulted high morbidity rates among women

despite of improvement of the key indicators of health. The Maharashtra experience suggests that for sustained benefit there is a need to have synergistic relationship among different interrelated factors of health. So it can be concluded that health sector should address the issues related to the allocation of priorities as well as governance of expenditure, ensuring transparency and accountability in service delivery and participation of people at local levels. In order to bring good governance in health sector there is a need to adopt multi- sartorial policies that will allow better community participation and decentralize the functioning of authority.

So, from various experiences under different schemes and programmes over a period of time, a new era of health development has started in India through the implementation of NRHM. NRHM has brought a paradigm shift in the delivery of health care services by reaching to the unreached section of society.

1.14 NRHM and Good Governance:

Govil & Puruhit, (2011) stated that India was ranked 118 among 191 member countries of WHO on overall health performance. Further, in case of Human Development Index, India has secured 134th rank among 182 countries (UNDP, 2009). This rank indicates the overall status of India. In India there is clear urban – rural, rich- poor divide which makes many sections of society vulnerable to health care. The disadvantages have its worst impact on Women and Children who are the victims of discrimination. Under this backdrop, there is an urgent need to deal with multiple health related crisis that the rural poor face in our country. There is a need to bring good governance in health system by transforming the health system in to an efficient, transparent and accountable system (NRHM, 2005). Acknowledging the considerable gaps in health infrastructure and deficiencies in the health care system in rural areas the government lunched NRHM for meeting the health needs of rural people on April 12, 2005. NRHM is one of the pioneering initiatives to provide health care access through bringing various public health machineries under one umbrella (NRHM Evaluation Report, 2010). NRHM is a centrally-driven programme of the government which has tried to address some of the key issues like underinvestment in financing, human resources, status of physical infrastructure and delivery of quality health care services in the public sector. It has also initiated several

measures for accountability such as political checks and balances, administrative procedures and auditing (DasGupta, 2005). The NRHM mandates to provide effective health care to rural population, especially women and children, with special focus on 18 states which have weak public health indicators (NRHM, 2005). The main objective of the Mission is to carry out necessary technical correction in the basic health care delivery system. It aims at provision of comprehensive and integrated Primary Health Care to the people, especially to the rural poor, women and children .The main thrust areas of NRHM are: a) increasing public expenditure on health, reducing regional imbalance in health infrastructure. b) Decentralization and district management of Health Programmes. c) Community participation and ownership of assets and d) upgrade the health facilities as per Indian Public Health Standard (IPHS) (Dholakia et al, 2009). Health Status of a nation is difficult to define only in terms of some identified indicators. Health of a nation is a product of many factors and forces that combine and interact with each other. NRHM has introduced several new variables to ensure health for all and Public Private Partnership as a new strategy (Advani & Akram, 2007). Further, Seem (2009) points out that NRHM is about people's health in people's hand as it takes the public health challenge of every household through a network of community participation and adopting decentralized health care system. He further states that NRHM have rejuvenated the Public Health Delivery System in India in recent past. The key features to achieve the goals of the mission include making the public health delivery system fully functional and accountable to the community. This would be achieved through human resource management, community participation, decentralization, community monitoring and evaluation against standards, convergence of health and related programs, innovation and flexible financing (Govil &Puruhit, 2011).

Some of the major reform initiatives undertaken under NRHM are discussed below:

1.14.1 Improved Health Status of Women and Child: MMR has reduced from 301 per 100,000 live births in 2001-2003 to 254 in 2004-2006 and IMR has reduced from 58 per 1,000 live births in 2005 to 55 in 2007 (SRS, 2007). In addition, DLHS (2005-2006) has reported that institutional deliveries have increased from 40.9% in 2002-2004 to 54.1% in 2005-2006. Further, immunization coverage has also increased from 45.9% in 2002-2004 to 54.1% in 2005-2006. However, most significant improvements have seen in under covered areas such as Bihar, Jharkhand, Rajasthan,

Orissa and Madhya Pradesh. The national infant mortality rate has declined from 57/1000 live births in the year 2006 to 50/1000 live births in the year 2009. Of this the decline of rural areas was more from 62/1000 live births in 2006 to 55/1000 live births in 2009. In urban areas, the decline in IMR was from 39/ 1000 live births to 34/1000 live births. The rate of decline across the sexes, in both urban and rural areas was the same (Review of 11th Five YearPlan, 2011). According to the National Rural drinking water programme data for July 2011 show that out of 1,66,1,058 habitations about 1,180,648 habitations have 100 percent drinking water coverage, 43,963 habitations have 0 to 25 percent drinking water coverage, 97,119 habitations have 25-50 percent drinking water coverage, 153,256 habitations have 50-75 percent drinking water coverage and 69,716 habitations have no drinking water coverage.

1.14.2 Comprehensive Rejuvenation of Public Health Infrastructure*:* NRHM has given focus on infrastructural issues of the health sector. The effort has been provided for up gradation of physical infrastructure, equipment logistics and supplies protocols and the human resource in a coordinated manner and facility service has been the basis for allocation of funds so that service guarantees from the institution could be provided. Under NRHM the up gradation of facilities at all level in all states has been a major achievement. From 2009-10, it is being observed that new buildings for 9,144 Sub-Centres, 1,009 PHCs, 435 CHC and 57 District Hospitals has been set up. In addition, 8,997 Sub-Centres, 2081 PHCs, 1,255 CHCs and 357 District Hospitals have had their infrastructure renovated. Further, 8, 324 PHCs have reached 24x7 functionality status and 2, 463 are being upgraded into FRUs (NRHM Annual Report, 2010). Arunachalam (2011) points out that comparing the situation in 2005 and in 2009, that there is a remarkable increase of human resources of all categories and improvement in the physical infrastructure of the Sub-Centres, PHC and CHC after the launch of NRHM, 2005. As per the available data, it has been observed that from 2005 to 2009 total 15,364 SCs in government building, 4084 PHCs and 1228 CHCs have increase (Rural Health Statistics, 2009).

1.14.3 Human Resources Based on Indian Public Health Standard: Earlier, GOI support was limited to the ANM at the Sub-Centres and a few posts of family welfare. Under NRHM the support of the GOI has been expanded to fill the gap as per IPHS. After the launch of NRHM, 82 medical colleges have been added, and 9751 seats have been increased. Further, 595 ANM schools, 1227 GNM schools, 1026 B.Sc

nursing courses, 405 post basic B.Sc nursing courses and 327 M.Sc nursing courses have been added. It has also added 148361 contractual skilled service providers (as on 31/3/2011) to the public health service. Of these 60268 are ANMs, 33667 are staff nurse, 21740 are paramedics, 11575 are AYUSH doctors, 4616 AYUSH paramedics9432 are medical officer and 7063 are specialists (Review of 11th Five Year Plan, 2011)

1.14.4 Governance and Accountability under NRHM: Ensuring governance and accountability in the management of public health system is one of the core strategies of NRHM. At the national level, the NRHM is placed under a Mission Steering Group (MSG), chaired by the health minister and with representation of other key ministries at both the ministerial and secretary level. MSG has the powers of the cabinet to make changes in the scheme and it takes such steps as and when necessary (Mission Document, 2005). At state level, there are three structures- the State Health Mission (SHM), the State Health Society (SHS) and the State Program Management Unit (SPMU). The SHM is a consultative body at the ministerial level. The SHS has a Governing Board chaired by the Chief Secretary or equivalent and the Health Secretary as the secretary. It has an executive committee with the Health Secretary, as chair and the mission director as member secretary. The SPMU functions as the secretariat of this executive committee and reports to the mission director. The Governing Body is a governance institution, which meets once in a year, both the executive committee and the SPMU meet more often and it is the management organisations which are accountable and also ensure the adequate coordination and participation of the directorate of health services. At the district level, the Governing Body of the District Health Society exercises governance functions and the Executive committee and the District Programme Management Unit (DPMU) are the management organisations. The district panchayat members are usually represented and serve as Chairpersons or Vice-Chairpersons of the governing board (Mission Document, 2005). Rogi Kalyan Samitee (RKS) have been constituted at the facility level under NRHM to improve functioning of health facilities, facilitate inter- sectoral coordination and increase public participation in decision making. The RKS provides for involvement of Panchayati Raj members, civil society organisations and officers of various government departments whose cooperation is needed for effective functioning of health facilities. The RKS supervise the use of untied funds and funds

from other sources, thus working as a community monitoring mechanisms for ensuring financial transparency (Mission Document. 2005). Village Health, Sanitation and Nutrition Committees (VHSNCs) have been constituted at the revenue level with leadership from the gram panchayat. VHSNCs play an important role as a part of community monitoring and accountability mechanisms. They are also an important element of decentralised planning as they involve Gram Panchayat leaders in monitoring and evaluation. As per the available data, up to 2011 there are 5, 01335 VHSNCs have been constituted and 4, 43,928 i.e. 88 percent of these constituted VHSNCs have operational joint bank accounts (Review of 11th Five Year Plan, 2011). So it can be said that, Community ownership and participation in management is seen as an important pre-requisite within NRHM.

1.14.5 Decentralized Planning and Management: District health plans have always been the core of decentralization planning under NRHM. District health plan has included the core areas like water supply, sanitation, hygiene and nutrition (Mission Document, 2005). In the year 2011-12, 636 districts prepared plans as compared to 310 in the first year of the NRHM. The plans have helped to integrate the activities under vertical programs and different departments including Disease Control, RCH, HIV/ AIDS and AYUSH (NRHM Report, 2007-2011).

1.14.6 Public – Private Partnership under NRHM: Non-Government Organization (NGOs) has an important role to play for the success of NRHM. The mission has already established partnership with NGOs for establishing the rights of the households to health care. With the mother NGO program scheme, 215 MNGOs have already been appointed for covering 300 districts. The Disease Control Programmes, the RCH-II program, the immunization and pulse polio program, the JSY involve variety of NGOs for its successful implementation. Beside advocacy, NGOs have already been involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, developing innovative approaches to health care delivery for marginalized sections or in underserved areas and aspects, working together with community organizations and Panchayati Raj Institutions and contributing to monitoring the right to health care and service guarantees from the public health institutions (MOHFW, 2005-2012).

1.14.7 Mainstreaming AYUSH: It is one of the core strategies of NRHM so that people have better access to AYUSH, choice between systems and the human resource and infrastructure can be shared and synergized for reaching NRHM goals. Under this Scheme 11575 AYUSH doctors and 4616 paramedical staff have been appointed. In addition 18222 health care facilities have been merged AYUSH facilities and this include 416 district hospitals, 2942 CHCs and 1246 other Sub-District hospitals, 9559 PHCs and 4059 equivalent primary health care facilities. Besides, there are 3360 secondary level AYUSH hospitals and 21769 dispensaries as well as 7 national institutes which offer tertiary level care (Review of 11th Five Year Plan, 2011).

1.14.8 ASHA Programme: NRHM has introduced the component of Accredited Social Health Activists (ASHA). ASHA act as a bridge between the ANM and the village and they are selected by and accountable to the panchayat. From the available data, total of 849331 ASHAs have been selected across the country up to 2010; of which 492784 ASHAs have been selected in the high focus states, 53619 in the NE states, 298286 in the Non High focus states and 4642 in Union territories (Review of 11th Five Year Plan,2011).

1.14.9 Improved Financial Management: NRHM has increased the public expenditure on health as the central government has made a total of Rs. 52,832 crores release under NRHM for the purpose of financing their state plans to strengthen public health services with a focus on primary health care. The total expenditure by the central government in this period 2005-2006 to 2009-10 was Rs 73,606 crores of which the total NRHM component was RS 38,420 crores, that is 52.2 percent. The Central government budgetary expenditure for health increased by 21.45 per cent per year in the post NRHM phase 2005-06 to 2009-10 as compared to 10.85 percent per year in the pre-NRHM period 2001-02 to 2004-05(Public Accounts Committee Report, 2010-2011)

1.14.10 Management Support: One of the major achievements under NRHM is the establishment of Health Management Information System (HMIS). Under NRHM experts in the fields of planning, accounting, computers, Monitoring and Information System (MIS), Human Recourse (HR) and Insurance specialists have been positioned in the states and districts in programme management units. This strategy has

improved the capacity of field offices in key programme management themes. At present, data is flow regularly from all of India's 600 plus districts into a national web-portal. In 2010, the mother and child tracking system –a name based reporting system was launched to ensure quality and completion of care in pregnancy and immunization which is currently being implemented in all starts (Review of 11th Five Year Plan, 2011).

From the above discussion, it has been observed that under NRHM a well organised governance framework has been adopted for ensuring better services delivery and resource utilisation. NRHM lunched by government of India holds great hopes and promises to serve the deprived communities of rural areas.

Way Forward:

Duggal (2009) points out that health and health care in India are primarily state subjects and hence the union government has continuously a limited role. Under the NRHM strategy it has made some efforts at raising its financial stake in the public health sector but they have so far failed. First because they encountered the problem of flexibility with the states, and second the union government took the larger control of health resources by raising the proportion of the budget within its discretionary control. some of the own key programs of government under NRHM like immunization and RCH programmes pool funding a large volume of resources remained unutilized and this in turn affects the performance and outcomes. In addition central and state bureaucracy are unwilling to lose control over health care delivery system, as they will never transfer fiscal, governance and management autonomy and control units to those who directly provides care. Ashtekar (2008) stats that NRHM is an antithesis of Primary Health care in India. It is costly and irrational donor tonic for the sick health system of India. Nayar (2004) states that proposed rural health mission adds confusion about the country's approach to deal with the health care. Cost-effective interventions, such as the rational distribution of medical and financial resources, should be the part of the vision but they are often ignored in favour of privatisation. Advani &Akram (2007) state that despite the adoption of various innovative initiatives a proper coordination between health, hygiene, population and political economy is still lacking to make the health facilities both available and

accessible. Sinha (2009) defends the case for NRHM stating that "Public Health is a marathon and not a Spirit" and feels that consistent efforts of NRHM strategies will improve the health indicators over time. Merhotra (2006) believes that NRHM has potential to solve the problems regarding health infrastructure and man power, but so far it has not been successful in improving any major health outputs and outcomes. Dholakia et al (2009) state that though NRHM has created some impact in a few selected spheres, but to a large extent its desired impact is yet to be felt. So it can be said that , increases spending on health is not sufficient rather the way money has been spend to cater the health needs of the masses is important NRHM need to put more focus in the lagging states, where the traditional health mechanisms may not work as well as they do in the more advanced states. India's government health spending need to be matched by proper skills in both centres and states government to plan and manage health spending (Banerjee & Ahuja, 2013). Moreover, Zakir (2011) states that despite of many innovative reform strategies adopted by government of India for providing qualitative health care services to rural people through NRHM but in practice it has failed to cater the needs of rural people. The author has pointed out that there are deficiencies in physical infrastructure, shortage of equipment and medicines and furthermore shortage of manpower is still prevailing in many states of India. In addition he has viewed that within limited period this programme has succeed in putting the issues of public health in top agenda of government and it has also put pressure on state government to divert resources to health sector thereby substantially strengthening public health system including its manpower and infrastructure.