CHAPTER - II

REVIEW OF LITERATURE

There are various studies conducted at different points of time at various parts of the country on the issues of governance and good governance, health care, challenges of rural health care, women's health and policy etc., which need to be reviewed to get the link of the present study with the earlier one. Under Thematic Review of literature, here in this chapter efforts have been made to review thoroughly the literature pertinent to the research topic under various related sub-headings. The main objective of the literature review is to identify and evaluate the nature of the relationship between governance and health systems and how governance practices make influence on health systems performance specifically under National Rural Health Mission. It can give an insight into the research problem and help in establishing a meaningful rational for the present study.

2.1 Studies on Governance

Studies on Governance are discussed under the sub-headings of Governance and Development and Governance and Decentralization from Indian context.

2.1.1. Governance and Development: Some Experiences

Development is a major subject of debate in contemporary times because of the tremendous impact it has in terms of its consequences over the socio-economic lives of the people in general and political destiny of the nation-states in particular (Dhal, 2013). Development is among the core functions of any government since it is prescribed as something good and desirable. Governing development relates to the process of translating development goals into desirable benefits for producing the desired outcomes (Saxena, 2010). Governance stands for complete prevalence of ***rule of law*** with full accountability and transparency. It also prescribes for adequate democratisation, decentralization, devolution of funds, functions and functionaries and above all people's participation. There are some bottlenecks in having good governance like, corruption, coalition compulsion, undue political interference, criminalization of politics and politicization of crimes, decline in social and moral

values, paid-media, structural weakness, lack of computerization etc. Under this backdrop, active and aggressive people's participation, complete and coherent decentralization of powers, responsible and responsive administration determined and dedicated political will are some of the steps to ensure efficient and effective good governance (Singh &Singh, 2012). People's participation is a key ingredient to ensure Good governance, especially in developing countries like, India. To ensure accountability and transparency in Indian administration, system needs to be reviewed and there is a need to utilize the natural and human resources of the country judiciously (Nisar, 2012). According to Nisar (2012) there are two flaws in Indian governance structure. Firstly, good behavior is not adequately rewarded by the state. Secondly, Power defined in terms of ability to influence events, resources and human behavior for the larger public good is severely restricted among state functionaries at every level. This limitation causes depletion in the capacity of government actors to deliver good governance. In connection to that Sukla (2010) stated that in India, political party should be increasingly democratized, bureaucracies should become more efficient and responsive and the judicial system ought to become speedier and more effective. Similarly, Ragabhan (2007) suggested that governance should be free from the clutches of bureaucracy and politicians to secure a higher growth for the better delivery of services to the poor and needy. Furthermore, in order to fight corruption, the state is expected to promote integrity, honesty and responsibility among its public officials in accordance with the fundamental principles of its legal systems (Sarma, 2012). Moreover, Kamla (2012), Yadav & Bhagal (2009) and Sarma & Sarma (2010) have supported the opinion that there is a link between People's Right to Information with good governance. Democracy needs to be institutionalized within the governance System. The bureaucrats should be encouraged to give their opinion fearlessly and not succumb to any undue pressure from politicians and other sections of society (Sarma &Sarma, 2010). Good governance is essential for equitable development and deepening spirit. Governance is about processes, not about ends. There is a strong connection between people's right to know and equity in administration (Kamla, 2012). However, the governance pattern is not uniform in the whole country which is reflected in the study conducted by Rajashekar et al (2007), Sarin (2010) and Nair (2007). The study conducted by Rajashekar et al (2007) in Madhya Pradesh tries to explore a link between good governance and Swarnajayanti Gam Swarozgar Yojana (SGSY). The findings of the

study shows that inadequate functional assignment, inter governmental transfers, bureaucratic attitude, limited decentralization were responsible for the poor implementation of SGSY programme in Madhya Pradesh. The author further suggests that development challenges should be addressed collaboratively by building partnership among the state, market and civil society. In addition, by drawing upon the Kerala's experience Nair (2007) highlights that Kerala urgently need to reinvent good governance that has a local flavor, instead of going for externally driven regimen for governance reforms.

2.1.2 Governance and Decentralisation: Issues and Concerns

Decentralization is a process through which legislative, judicial and administrative responsibilities transferred from a higher level of government to a lower level. A successful model of decentralization needs to ensure people's participation in various capacities at all levels of political and economic processes of planning and development (Dhal, 2013). The system of governance in India has undergone big challenges during the last two decades with the implementation of decentralized governance through 73rd Amendment Act 1992. Today, the Gram Panchayat members face two major problems. Firstly, they are not able to mobilize the required resources by way of imposing and collecting taxes, and secondly, Gram Panchayat members hardly participate in planning and governance process due to lack of resources, skills and education. So the grass root organization like NGOs/CBOs need to take up the capacity building programme since most of the training programmes initiated by government are not resulting in continuous commutation of knowledge among panchayat members (Aziz, 1999). Similarly, Panda (2009) and Ram (2011) pointed out that decentralized governance pattern is operational in the whole country, still there is having number of obstacles and problems in both our governance and administrative process. However, Ekbal (2007), Sangita (2009) and Singh (2011) have highlighted the fact that the experience of decentralized governance in contemporary societies is invariably dependent upon the political system in which they operate. Ekbal (2007) pointed out that decentralization process in Kerala is qualitatively better than the concepts favored by international agencies like World Bank because the former is much politicized whereas the latter favors a depoliticized process. Based on the experience of Karnataka and Andhra Pradesh, Sanghita (2009)

concluded that devolution of powers, responsibilities and resources to local government promotes good governance and better service delivery. Furthermore, the system of decentralized governance can be strengthened through the improvement of public institutions and judicial independence at all levels followed by effective parliamentary system (Roy, 2005). Gulati, (2011**)** states the need for achieving good governance through the Panchayati Raj Institutions by empowering the citizens through RTI and E-Governance. Roy (2011) advocates meaningful participation of the people in the decision making process for ensuring good governance.

From the discussions stated above, it can be said that the characteristics of good governance need to be ensured for smooth running of Indian administration; and decentralisation is one of the foremost factor for the same. Health care services received highest priority, for which government of India has designed a huge infrastructure and allocated funds. Therefore, it is obvious that proper governance is required to implement health care programmes in India.

2.2 Health Care Issues and Concern in India:

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 (Advani&Akram, 2007). Indian society is characterized by multiple inequalities. Whereas, caste and gender divides further increase the hiatus in access to health care, which ultimately leads to health inequality (Akram, 2014). The similar opinion is echoed in the study conducted by Nagla (2008) and Koperty (1994). Nagle (2008) conducted a study to explore the attitudes and beliefs towards medicine and medical care systems and organization into two different settings, i.e. urban and rural setting of Haryana. In this study total 104 respondents has been taken equally from the rural and urban settings randomly. The result of the study shows that cultural structure of a particular society regarding perceptions, preferences, evaluation and satisfaction has direct relationship with the pattern of health care practice adopted by people. Koperty, (1994) initiated a study on "Social Inequality and Health Care '' to explore the relationship between healthcare and social stratification in a rural community of Andhra Pradesh. The result of the study reveals that minor illness was found more in the low caste and class groups than in the high caste and high class

groups. Moderate illness was found more in the high class group than in any other group. This reflects some inequalities in health services and the pattern of governing the health care system. Therefore, to raise the health status and quality of life of people particularly women, a focused approach need to adopt for holistic development. Mukherjee & Menon (2014) stated that health literacy promotes a scientific approach to health care decision making and encourage preventable behaviors, which ultimately reduces health cost and public health problems. Therefore, the promotion of health literacy is important in developing countries like India where much of the information residents receives unscientific and does not have validity. India as a nation has been growing economically at a rapid pace particularly after the advent of New Economic Policy of 1991. However, this rapid economic development has not been accompanied by social development particularly health sector development. Health sector has been accorded very low priority in terms of allocation of resources. The meager resource allocation to health sector has adversely affected both access and quality of health services. The unequal access to health services is reported across strata, gender and location (Guman & Mehta, 2009). Later on, this opinion is also supported by Vijayalakshmi (2011). Vijayalakshmi (2011) analysed the relationship between the health care expenditure and per capita GDP among the major states in India with the help of data taken from secondary sources. The result of such analysis shows that the reform process initiated by the states has definitely affected the health care spending among the states. The poor states particularly Bihar, Uttar Pradesh which have significantly lower Human Development Index (HDI) in comparison to Kerala and Gujarat have reduced the health expenditure more. The author further added that during the process of reform the gap between the poor and rich states is rising, indicating that the poor states are not in a position to allocate more and more resources towards health sector. In India there is a disparity in healthcare services between Rural and Urban areas. To revamp the existing public health system in India; there is a need to strengthen existing health manpower, an adequate supply of drugs and vaccines, good transportation facility, improved infrastructure of health sector and implying better system of management and supervision along with transparency and accountability towards the users are the minimum requirements. In this connection, Das (2010), Sekaran & Rajendran (2011), Begam (1997) and Sodani (1997) have highlighted that the rural-urban disparity is one of the major challenge faced by the health care system in India.

Sekaran & Rajendran (2011) explore that in Tamil Nadu there is a high discrepancy between government and private hospitals in the delivery of health care services and a high discrepancy is also found between rural and urban areas in regard to the average health expenditure per hospitalisation. The study conducted by Sodani (1997) shows that due to the lack of accessibility and availability of health care services rural people spend relatively more on health care than urban individuals. The study further added that people in rural areas are dependent on the traditional practitioners for health care; however, the major share of household health care expenditure is related to the purchase of medicines in both rural and urban areas. Das (2010) conducted the study on "Rural Urban disparity in accessing the Health care Services in Assam". The result of the study shows that overall Rural Urban Disparity Index for health output shows an increasing trend where as Rural Urban Disparity Index for health input shows a falling trend both for states and national level. Further the study also added that there is a bias of the policy makers in favour of urban people which ultimately affects the overall health scenario of the country. Economic status or class is one of the important determinants of health status of the people. Similarly, the study carried out by Begum (1997) in Andhra Pradesh, shows that during the study period there is an increase in the number of hospitals, hospital beds and doctors in all regions in Andhra Pradesh. But Telangana Hospital seems to be doing better in almost all indicators of health care delivery system. But the improvements are not heartening in other parts of the state. The study further added that curative health care facilities have always lagged behind demand for such services. The author, have recommended that equity in health care is very much essential for eliminating inter regional variations particularly between rural and urban areas. Further, the study conducted by Yasudian (1988) analysed the inequalities existing between different social classes in the utilization of health services in urban community and also to identify some of the factors responsible for such inequalities. The result of the study shows that Low and very Low income group households suffered from severe communicable diseases in greater proportion than the High and Middle classes relatively. High and Middle classes perceive the needs for health services better than the Low and very Low classes. The study further identified that Private Health Centres were the major source of health services to the High and Middle classes, and the Low and very Low Classes mostly consumed health services from the public health centres. The result of the study, further added that availability of the free health was the major criterion for the

Low and very Low class households to consume health services. On the other hand, the high and middle classes expected personal care from the doctors. Despite India's impressive economic performance after the introduction of economic reforms in the 1990s, progress in advancing the health status of Indians has been slow and uneven. Large inequities in health and access to health services continue to persist and have even widened across states, between rural and urban areas, and within communities. Three forms of inequities have dominated India's health sector. Historical inequities that have their roots in the policies and practices of British colonial India, many of which continued to be pursued well after independence; socio-economic inequities manifest in caste, class and gender differentials; and inequities in the availability, utilisation and affordability of health services (Baru et al, 2010). All these factors create major challenges in India to ensure 'Health for All' along with quality care in near future.

The literatures stated above have discussed the health care scenario of India. However, the rural health care is also under the consideration of various studies discussed below.

2.3 Rural Health Care: Issues and Challenges

There is a disparity in India's health care with regard to health indices, health care expenditure, infrastructure and personnel between rural and urban areas due to poor design of health policies and programmes, unfair economic arrangements and distorted political system. So there is a need to have paradigm shift from the current 'biomedical model' to 'Socio-cultural' model to bridge the gaps and to improve the quality of rural life (Arunachandran , 2011) According to Goal & Yadav (1979), Sayeed (2011), George (2010), and Mathiyazhagan (1999) effective and responsive health system of a country depends on the quality of health work force. George (2010) tried to explain the reflections of rural health assistant on the challenges faced by them in providing primary health care in rural communities of India. The study is based on the data collected in 2004 and drawn from nine months of participant observation of government health services at Primary Health Centres, Sub-centres and from qualitative responses drawn from a survey administered to sixty government paramedical staffs. The result of the study highlights that how health assistants

perceive and negotiate gender norms, curative hierarchies, market pressures and community Scepticisms with varying success. The study shows that health workers are social being embedded in a myriad of informal relationships that influence their positions within their families and also in health department and the community they serve. In connection to that, Sayeed (2011) stated that Indian health system specifically rural health system faces 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. In this connection, Seetharamu (2004) states that rural hospitals do not have a continuous supply of clean drinking water and the irregular power supply affects the life of certain drugs, which need refrigeration. Even essential medical equipments are obsolete. Mathiyazhagan (1999) conducted a study to analyse people's choice on health care provider in Karnataka state. The result of the study shows that private health care provider has emerged as the people's choice in Rural India and this choice is determined by the socio-economic status and physical accessibility of the sample household. The analysis further suggests that there should have been a synergic approach of Public–Private mix for regulatory and supportive policy intervention. Furthermore, in India the number of doctors allotted to a health centre is decided without making any study of the health needs cater by these centres (Goyal &Yadav, 1979). Goyal & Yadav (1979) have conducted a study on the problem of allocation of doctors to various medical institutions in Haryana. A mathematical model has been used for maximizing the expected number of patients seen by doctors of health centres of Haryana. The authors have studied the usefulness of this model on a random sample of nine health centres run by the Department of health services Haryana. The result of the study shows that the number of doctors allotted to a health centre should be decided based on the health needs of the area served by the health centre and the model highlights that absenteeism among doctors reduces the effectiveness of health services. The study further added that allocation of more doctors to health centers increases the effectiveness of the health services. The rate of inpatient care utilization is substantially increasing in India and this increase is higher among poor than rich. There are certain states like Bihar, Uttar Pradesh, Madhya Pradesh and Punjab show high level of poor rich gap in utilization of health

care services. Inequality in distribution of health care is more in those states which have little capacity to provide health care (Mukherjee & Leveque, 2010). So it can be said that the experience of rural health care is different based on the economic strength and political stability of particular area. Soman (2002) conducted a field study in the Birbhum district of West Bengal aims to explore the dichotomy that prevails in rural health care initiatives. The result of the study shows that, well of upper caste consult qualified allopath in private clinics and poor section of people prefer 'village doctors' or 'self- trained healers in the informal network. Further, the study also shows that women in the poorer households who also had to bear the economic crisis of their families, reported to visit the self-trained 'village doctors' followed by the religious healers more frequently as compared to the better off. Similarly, the case study conducted by (Neelima & Reddy, 2009) highlights that the nature of accessibility of utilization of health care services in rural areas of Andhra Pradesh. The result of the study reveals that majority of the people in rural Andhra Pradesh prefer allopathic medicine because of its quick response to cure diseases and availability of doctors and medicines. Furthermore, the respondent have reported that due to the lack of government health facility within their own village for getting treatment people mostly depend on Registered Medical Practitioners and private hospital which are far away from their house and cost of such treatment is also not affordable to them. So, to overcome this problem there is a need to have accessibility and affordability of services by the rural people and for these government needs to strengthen the existing health centers by adopting innovative techniques. Sankar & Kathuria (2004) analyses the performance of rural public health systems of sixteen major states in India. The result of such analysis shows that not all states with better health indicators have efficient health systems. Relative efficiencies differ across states and this is due to differences not only on health sector endowment, but also its efficient use. The analysis further shows that the performance of Kerala is better only in comparison with the other fifteen states in the analysis. From the above experience, it can be said that state should not only increase their investments in health sector, but also manage it efficiently to achieve better health outcomes (Sankar& Kathuria, 2004). Availability of health care services in rural areas is much lower than that in urban areas (Das, 2012). In recent years government has launched a revolutionary mission mode programme i.e. NRHM to transform the rural health scenario of the country. However, despite of measures taken by government of India

for providing health care to rural people through NRHM, there are many deficiencies like improper physical infrastructure, shortage of equipments and medicine; deficiencies of manpower are still prevailing in many states in India (Zakir, 2011). With the launch of NRHM government health spending has increased significantly at central level but this increase is not sufficient to reach the pinnacle in health sector. Increased spending on health is not sufficient rather the way money has been spend to cater the health needs of the masses is important. Therefore, NRHM needs to put more focus in the lagging states, where the traditional health mechanisms may not work. India's government health spending needs to be matched by proper skills in both centre and states government to plan and manage health spending (Banerjee & Ahuja, 2013).

2.4 Governance and Health Care: A Global Overview

Governance issues in health sector emerge from the processes of setting policy goals, laying down strategies and structures for rendering health services and the social environment impinging the decision making in this regard (Saxena, 2010). In recent years, numerous experiences have shown an association between governance and health system performance (Kaufmann, Kraay& Zoido, 1999; Gupta, Davoodi &Tiongson, 2000; Rajkumar & Swaroop, 2008). Kaufmann et al (1999) performed cross-sectional regressions of 150 countries, applying governance indices from the World Bank. This analysis shows a strong negative association between infant mortality and each of the six aggregate governance indicators, suggesting better governance might improve development outcomes. Later on, Wagstaff &Claeson (2004) addressed the adverse impact of governance quality on child mortality in a comprehensive report from the World Bank, "Rising to the Challenges", suggesting that increased public spending on health would only reduce child mortality if governance indices were above certain minimum levels. This suggestion is also supported by Rajkumar &Swaroop (2008) who explore the link between public spending, governance and health outcomes by applying indices from the International Country Risk Guide (International Country Risk Guide, 2011). The results of that study indicates that governance quality has a significant impact on how efficiently increases public health spending improved health outcomes and suggest that public spending had virtually no impact on health outcomes in poorly governed

countries. To develop good models for health care governance there is a need for more resources and better use of existing resources, careful planning and monitoring, as well as a wide array of other facilitating factors, ranging from generating greater awareness, promoting transparency to ensure greater participation and more actively enforcing regulations (Ronocrati, 2009). However, various studies have been conducted across the countries to evaluate the impact of governance on health system performance like (Juma & Manongi, 2009; Koivusalo, 2001; Halabi, 2009; Bork et al, 2011). Juma & Manongi (2009) conducted a study with an objective to assess users' perceptions on quality of care given in Out Patient Department (OPD) at Kilosa District Hospital in Central Tanzania. For the purpose of this study hospital based exit interviews were conducted to adult patients or caregivers of children attending the hospital. In addition, Focus Group Discussions (FGD's) were conducted among community members in selected villages within the hospital premise. Information on behavior of care provider, cost of service, availability of medicines & equipment and health personnel were collected from the respondents. The result of the study shows that overall OPD was perceived to have some lacunas in the delivery of services including verbal abuse of patients by care providers, lack of responsiveness to patients' needs, delays, inadequate examination, irregular supply of medicines, lack of confidentiality and favoritism in health care provision. The author suggests that efforts should be made to address the shortcomings so as to improve quality of health care delivery and users perceptions. Globalization is often presented as a one-way track without any exit and it often offers very ideological arguments. It tends to right –size the government and shift the burden of risks and costs to individuals rather to government and employers. Under this situation, it is crucial importance to demystify the ideological arguments presented in the garb of globalization and discuss and analyse its implications of different national policy choices being thrust upon the public sector and ultimately upon the health and social security of people around the world (Koivusalo, 2001). Few years later, Bork et al (2011) tried to explore the problems urban health care system in the city of Guangzhou of China. For the study, Primary data were collected through several fieldworks between December 2006 and January 2009 and it includes 27 in-depth interviews with administrative officials, health care providers and NGO representatives. In addition, 70 in-depth interviews and a quantitative survey were conducted with 450 rural-urban migrants. The study suggests that it is necessary to restructure the functions of stakeholders in the health

system for improving public health. Further, added that reform should aim towards the establishment of an embracing health governance framework, which ensures continuous supervision and monitoring along with more profound integration of all stakeholders. Decentralization of health care decision making promises greater participation through people's involvement in setting priorities, monitoring service provision and funding new and innovative ways to finance public health programmes (Hilabi, 2009). This opinion is consistent with the findings of Attanayake (2001) who examines the experiences of decentralization in the health sector of Sri Lanka. The author has given a description of the implementation of decentralization and examines the changes in health care services, financing and provision before and after implementation of decentralization. The result of such analysis reveals that decentralization in Sri Lanka was truncated with narrow political objective of containing the ethnic conflict. In addition, health sector decentralization is represented towards a non-purposive direction of change, in which neither central level administrators nor politicians had the motivation to accelerate the process of decentralization in Srilanka. Globalization in its current form, have both positive and negative consequences, creating new patterns of health and disease in population group across the world. These changes are posing fundamental challenges to the determinants of health and health outcomes. Therefore more attention is needed to ensure the current forms of globalization become more equitable, sustainable and guided by appropriate forms of governance (Poku & Whiteside, 2002).

2.5 Health Care and Governance in India:

Health care and governance in India is discussed under the sub headings of Experience of Health Sector Reforms in India, Studies on Service Delivery Mechanism of Health Providers and Effects of Decentralization in Health Care Services.

2.5.1 Experiences of Health Sector Reforms in India:

Health is universally being considered as an important index of Social development and it is both a cause and effect of poverty, illiteracy, ignorance and mal-administration (Khandelwale, 1996). Commercialisation was furthered during the period of liberalisation and structural adjustment through the health sector reform

initiatives during the 1990s. These reforms introduced market principles in the public health services in order to improve the efficiency and quality of care. Many of these initiatives were introduced through the health sector reform initiative as a part of the Structural Adjustment Programme (SAP) of the World Bank during the 1990s. A range of measures, such as the introduction of user fees, contracting out of clinical and ancillary services to the private sector, decentralisation and public-private partnerships were introduced (Duggal, 2005) However, Several studies have been undertaken in this regard to assess the impact of NEP on health sector such as (Quader, 2001; Banerjee, 2001; Sen, 2001; Baru, 2001; Prabhu, 2001, Kutty, 2001). Quader (2001) stated that under the New Economic Policy (NEP) Indian subcontinent is being pushed to choose a restrictive paradigm, which offers sophisticated methodologies for the collective good, but in reality this approach has failed to provide better services to the masses. However, Banerjee (2001) and Sen (2001) points out that current reform have ignored the empirical evidence on the problems with cost benefit model in health services. New Economic Policy have transferred health care into a profitable market, leaving only underfunded and poor quality essential package for the poor (Baru, 2001). However, new empirical evidences have suggested that the impact of reform on health sector is not uniform in the whole country. A study conducted by Prabhu (2001) compares and constructs the investments in health services and the health indicators of two states, Maharashtra and Tamil Nadu under the new economic reform. The result of the study shows that services provided by government primary health Care delivery system were considered to be unsatisfactory by a majority of the respondents in selected villages and the perception of respondents have indicated that there was no change in the quality 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 study suggests that for sustained benefit there is a need to have synergetic relationship among different factors of health. Kutty (2001) provides an overview of Health Sector Reform (HSR) in Kerala and result of his analysis shows that user charges in health care imposed by Kerala state as a remedy undermine the promises of universal access to health care. A few

years later, Kumar (2009) have explored the features of health sector reform under implementation across the states of India. The result of his analysis shows that user fee has been introduced in a large number of states and there is state wide variation in implementation of this provision. State like Madhya Pradesh, user fee is at 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 active community involvement in furthering the cause of both reforms and decentralisation. The author further pointed out that Gujarat has adopted innovative technique of GO-NGO partnership model to reach the unreached and to fulfill the health needs of masses. However, Kundu (2009) have pointed out that health sector reforms initiated in Orissa have increased the trend of private participation in health services sector.

From the above discussions, it can be said that globalisation has created an impact on the health services all over the world. The health infrastructure increases, better services offered. However, the costs of burden were shared between government and the public. Due to the increase of cost, government makes part of its services under the supervision of private sector, which directly and indirectly increases the health care burden on public. In India, the scenario is not different in case of health care services. But, government of India is committed to provide health services specifically primary health care services to its citizens. Further, various studies have shown the importance of rural health care. Since Independence, the country has tried to balance the cost of health care to a great extent. In India, though the cost of health care services has increased in many folds due to globalisation (due to number of cases increased, cost of medicine increased etc.). Still government is eager to take care of the basic health structure of the rural areas.

2.5.2 Service Delivery Pattern of HealthCare Providers in India:

The service delivery mechanism of health care provider is one of the prime concerns in the discourse on health governance as good governance is related with efficient delivery of services. Since independence a number of developments and expansion has occurred in the delivery of health services in the country and various parameters of health have improved considerably through different programmes and reforms.

However, despite of all these India's health sector presents a mixed picture in terms of quality and reach. Therefore effective production, distribution and management of health care services are becoming increasingly important in order to bring good governance in health sector to meet the needs of people (Manjunath, 2012). Several studies have been conducted to assess the service delivery pattern of different health care providers in India such as (Iyengar & Dholakia, 2011; Sinha & Gupta, 2008; Verma, 2008; kumar et al, 2008; Muhondwal et al, 2008; Rashid N et al, 2012; Ranganna et al, 1968; George, 2007; Dey & Dutta, 2012 and Banerjee et al, 2004). Ranganna et al (1968) have conducted one study with the objectives of determining the productivity of Primary Health Centres (PHC) and the perception of patients towards the services of this PHC. The study was undertaken at one of the PHC from Sarojini Nagar Community Development Block of Lucknow established in 1956. For the purpose of this study observations were recorded at the Primary Health Centre, Sarojini Nagar, for one month in March 1967, to determine the average daily work load on various section of the centre. The questionnaire method was used to assess the perception of patients towards the services. The result of the study shows that the daily average attendance of patients in March 1967 was 62. In addition, it has been found that the 86 percent of outpatients came within five miles of the centre and among them the numbers of male patients were more in compare to the women folk. The study reveals that medical care facility provided by PHC is inadequate as the area and the population to be served by this centre is large. Further, a study on health care delivery in rural Rajasthan by Banerjee et al (2004) carried out a facility survey in which 143 public facilities were visited weekly during regular hours for an entire year. Around 45 percent of doctors were found absent from primary health centres. It was also found that at Sub Centres doors were closed 56 percent of time. Considering the result of the study, the authors have concluded that there is a serious lack of administrative action towards effective service provisioning. Later on, George (2007) has conducted a case study on Koppal district of Karnataka with a view to assess the service delivery pattern of primary health care institute at public sector. The study has covered 60 villages including 82,000 people accessing eight primary health centres in Koppal district. For collecting data the author has used case study method and participant observation method. The result of the study highlighted that weak information system, discontinuity in care; unsupported health workers, poor referral system and distorted accountability mechanism are the common issues responsible for

poor service delivery. In addition, the study has highlighted that maternal deaths are not reported and not reviewed; antenatal care and institutional delivery are not linked to post-partum or emergency obstetric care. The author has concluded that only increased budgetary allocation will not ensure better service delivery rather proper management of services through decentralization and community mobilization will bring better result to improve women's health. The hospital market has today changed from a seller's market to a buyer's market where the patients are all important. Therefore, to achieve the customer satisfaction, the hospital has to develop itself technologically, as well as need to become more service oriented. (Sinha & Gupta, 2008). Sinha & Gupta (2008) have conducted a study with an aim to explore the attendant's satisfaction index for both private and semi private hospital in Lucknow. The findings of the study reveal that the quality of facilities available for attendants is different with respect to different hospitals and quality of service has strong association with the satisfaction of attendants. However, in the same year similar studies have been conducted by Kumar et al (2008) and Muhondwal et al (2008). Muhondwa et al (2008) has conducted a case study to examine the patient's satisfaction level with the services and care received by the Muhimbili National Hospital (MNH). For this study, the authors used Exit interview method to determine patient satisfaction. The result of the study found that most of the patients were satisfied with the services and care they received from MNH and as patients they perceived the services provided by MNH as superior. However, only a small proportion of patients expressed dissatisfaction with the pattern of services they received from MNH. The dissatisfaction is basically related to the long waiting times before receiving services, the high costs of treatment and investigations charged at MNH, poor levels of hygiene in the wards, and lack of supportive attitudes of staff towards patients. The author has pointed out that MNH used to maintain a strategy where they view patient as a consumer of health service. Kumar et al (2008) have conducted a study in four districts of Haryana where Health and Family Welfare Societies are functioning. A multistage random sampling design was adopted for the study. The study used exit-interviews to collect information about the quality of services available at health care facilities. For the purpose of the study a total of 528 OPD patients (82.1%) and 115 indoor patients (17.9%) from four selected districts were interviewed. The findings of the study show that more than one-third of the patients (37.8%) have availed the services from District Hospital; 22.9 percent from

sub-divisional hospital, 17.7 percent from CHC and 21.6 percent from PHC. The distance of health facility for 55.5 percent of the patients was less than 5 KM. Only half of the patients (50.2%) were aware of availability of the free services. Awareness level in this regard was high among the patients in Narnual district (61.3%) and low in Panipat district (38.6%). At the institutional level, it can be observed that more than 90 percent of the patients were satisfied with the availability of doctors/nurses as well as with their behavior. No significant difference was seen among the selected health institutions. About 63% of the patients were satisfied with ANC, delivery and immunization services. The highest proportion of such patients was from CHC (70.2%) and the lowest was from sub divisional hospital (57.1%). The authors have also highlighted the fact that the money generated through user charge is not being retained at the facility level uniformly in the State which is disturbing the spirit of reforms as envisaged. Moreover, the BPL population is not aware of the fact that their user fee is exempted from payment of any charges. The authors have suggested that Partnership with the private health providers is also one of the effective ways to increase the coverage and accessibility of health services in remote areas. According to them, the services of quack doctors by developing their capacities through proper training will be a useful tool for creating more trained manpower in the health sector in the country. Iyengar & Dholakia (2011) have conducted a study with an objective of exploring the situation of primary health care and its provision among the weaker section of the population from rural areas in six states of India in different time periods including Madhya Pradesh (MP) and Uttar Pradesh (UP) in 2005, Rajasthan in 2006, Andhra Pradesh (AP) Karnataka in 2007 and Tamil Nadu in 2008. The result of this study shows that the availability of basic household amenities was found to be quite low among the poor households. The drinking water sources of most of the households were found to be unsafe specifically in the northern states. A large proportion of households in MP and UP used sources such as a pond, canal or a tank which are considered unsafe sources of drinking water and are prone to contamination. In addition it is also revealed that the poor households spent on an average about 14 percent of the household income on healthcare. Moreover, this percentage significantly varied from about 1.3 percent in Tamil Nadu to about 37 percent in Jalore (Rajasthan). Further it is observed that northern states a large proportion of people used the private health facilities in case of sickness. The Per-Capita expenditure made by the poor households for using the private health services

was found to be significantly greater than that for using the public health services in these states. The coverage of children of the poor households under the immunization was found to be as per with the state average in all the states other than MP, where it was quite low, and in AP, where it was found to be marginally better. The health facilities in northern as well as the southern states faced a lack of adequate number of doctors. In the northern states, many of the Primary Health Centre (PHCs) were found to be working without the presence of a regular doctor and were run with only paramedical staff. Most of the Community Health Centres (CHCs) in all the states functioned without required number of specialist doctors. The author here used BPL as criteria for defining 'Weaker Section' and concluded that there is a need to adopt inclusive development in social sector especially in health sector. Quality of services shows effectiveness in service delivery and variation between the client and the provider (Rashid N et al, 2012). Rashid N et al (2012) have conducted one cross sectional study with an aim to assess the utilization of health services and client's satisfaction for services provided by a PHC of New Delhi. For the purpose of the study exit interviews were conducted among 400 patients of Outdoor Patient Department (OPD) services of the PHC palam, New Delhi. The result of the study shows that most of the respondents were satisfied with the quality of services offered to them. The PHC was the preferred health facility (98%) for treatment seeking in comparison to the other health care facilities in the area. The study has highlighted that the main factors affecting utilization of primary health care services provided by government were easy accessibility, low cost, less waiting time and presence of cooperative health personnel. The authors have concluded that provision of quality health care services to client through primary health care approach can result in better utilization of services and thereby reducing the expenditure of government in secondary and tertiary sector. Further, Dey & Dutta (2012) have conducted one study with an objective to understand the service delivery mechanism in Out Patient Department (OPD) of Silchar Medical College and Hospital (SMCH) and to explore the demographic characteristics of the Patients taking services from SMCH. Furthermore, the paper aims to ascertain the patient's perception towards the services provided by OPD of SMCH. For the purpose of this study the authors have used both primary and secondary data sources. Interview schedule has been employed for collecting information from the 60 patients. The result of the study shows economical and good infrastructure are the foremost reasons (71.66%) for choosing the public

health facilities by the OPD patients. Majority of the patients (43.33%) said that the main sources of information about the hospital were family members/relatives. In addition it was observed that respondents were not fully satisfied with the basic amenities such as seating arrangement for the patients and attendants, cleanliness, fans, toilets, drinking water, and telephone facility at OPD of SMCH. The authors have concluded that though most of the patients receiving treatment from the OPD of SMCH are from economically poor family but their opinions on certain basic facilities are need to be taken care for improving the service delivery pattern of SMCH.

From the above discussions, it is observed that gaps are prevailing in India's health care system in terms of insufficiency of building, human resources, provision of adequate and timely supplies of resources like drugs, contraceptives equipments etc.

2.5.3 Effects of Decentralisation in Health Care Services:

The experience of decentralisation is not uniform in all areas as it depends on the type of political context and the social domain in which it is implemented. Several studies have been conducted in different parts of India to examine the role of grass root governance in the delivery of health care services such as, (Sen, 2001; Kumar, 2009; Ghosh, 2009; Elamon, 2009; Das & Roy, 2012; Roy, 2014; Pradhan, 2014). Sen (2001) demonstrated that community based approaches linked to people's movement provide an alternative framework for addressing contemporary health issues in the absence of state provisions. He analyses the experience of an innovative trade union in Delhi Rajhara among the mine workers of Chhattisgarh that attempted to provide health care to the workers by focusing on demystification of technology, rational therapeutics and people friendly ways of hospital management. Nayar (2001) stated that Kerala has a unique experience of decentralisation, where in the state made an effort to give power and resources to the people in order to enable them to collectively participate in shaping their future by identifying problems and evolving programs according to local needs. Community participation, accountability and responsiveness are some of the important benefits of decentralisation in the delivery of health care services. The initiatives of decentralisation are relatively successful in case of Kerala state because of the continuous process of capacity building of the community members (Geowissenschaftn, 2006). Few years later, Elamon (2009) have

discussed the major initiatives of decentralization and public private partnership approaches adopted in Kerala for heath sector reforms. The authors have analyzed the situation of Thrikakkara Cooperative hospital and Mangalapuram Primary Health Centres. The results of such analysis shows that decentralize planning ensure accountability of public health care institutions with local bodies in managing the health care institutions. He further highlighted that in Kerala 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 has affected the smooth and efficient running of the health institutions. Further, he has also added that decentralization in health sector needs to be strengthened, but not in isolation. It has to be integrated with multilevel planning process. Das & Roy (2012) have conducted a case study in Karimganj district of Assam to review the performance of panchayat in the delivery of health care services among the rural people. The result of this study shows that PRIs are only active in selection of ASHAs then organising health awareness camp for the rural masses. One of the limitations of PRI in active participation for promoting health condition is that they are vested with the powers of administrative control only. The study further added that the government has been incurring huge expenditure for improvement of health but existence of socio- cultural political problems restrict the community participation in accessing the better functioning of PRIs , which ultimately leads to the negative effect of decentralisation. Later on, a similar kind of study is conducted by Ray (2014) to examine the role Gram Panchayat (GP) in the delivery of health services in Himachal Pradesh .The result of the study shows that only about 6 percent of the sample villagers said that they had gone to the GP with a health issue and just about 3 per cent reported lodging a complaint against the health staff with GP. About 60 percent of GP pradhans reported having discussed health issues in the Gram Sanshad meetings. Further the study also revealed that about 45 percent of the ANMs and MPWs reported getting support from G.P in community mobilization and related health activities. The author has concluded that there is a gap between decentralization approach to health service delivery on paper and in its proper implementation. He further added that inadequate capacity building and poor involvement of active civil society groups are key factors responsible for the poor performance of GPs in the study area. political decentralization and ‘Civic

decentralization' are essential for improving the services of the grassroots level health care institutions and for ensuring wide accessibility of rural households to the various health care services (Ghosh, 2009).Studies recognised that the weaknesses in the structures for decentralizing health services, the lack of inter-sectoral coordination and the absence of community participation in the health service delivery process are some of the hurdles in achieving the goals of the National Rural Health Mission (Ashtekar, 2008). However, Pradhan (2014) conducted a case study to understand the role of Village Health Sanitation and Nutrition Committee (VHSNC) under NRHM in the delivery of health care services in Kolhapur district of Maharashtra. In this study, purposive sampling method is used. In-depth interviews and focus group discussions are used for the collection of data. The analysis of the data shows that the socio-political context of the rural settings has an influence on the functioning of VHSNCs. The dominance of local political party also replicates in the functioning of the committee. It has been found that the committee members having some kind of political background try to dominate and influence other committee members specially the marginalized candidates during the decision making process. Further it has been observed that women participation gives more importance in the formation and functioning of the committee. It has also found that, there is not a proper coordination between all the committee members and all members are not fully aware of their role and responsibility. The author has recommended that there is a need to have continuous capacity building programmes for the committee members and addressing the administrative issues to improve the rural health care delivery system. Similarly, Geowissenschaftn, (2006) stated that to achieve better outcomes from decentralisation, training of the lower level management is required to allocate adequate human resources.

The above studies on the issues of health care system in India have revealed the infrastructural facilities, service delivery process, the perception of beneficiaries on health care facilities at various parts of the country. In the area of decentralisation it has found that local government's support and participation was necessary. Later on, government of India has introduced Mission mode programme to revamp the existing rural health scenario through NRHM. NRHM has emphasised the importance of rural health care where Local Self –government has a specific responsibility to perform in the area of women health.

2.6 Women's Health Issues and Concern:

Gender related barriers affect access of women to health care. These is due to the inaccessibility of health facility, insensitivity of health care providers, indifference attitudes of family towards their problems and attitude of self denial by women themselves and failure of the existing health programmes to address health problems faced by women. Various studies have shown that despite the tremendous expansion of health services in India there is an increase in hazards of the people's health, and in this regard women are the worst hit and need special attention such as (Sabana, 2012; Barua & Kurz, 2008; Goyal & Bandhari, 2008; Joshi et al, 2008). A reproductive health problem is one of the foremost health treats to the life of the young women. Health is influenced by a number of factors like Socio-economic, Cultural and political factors in society which negatively influence the lives of women in Society (Shivani, 2011). Shivani (2011) has conducted a comparative study to understand the perception of rural Women with regard to their reproductive health problems in the developed and less developed villages of Kurukshetra District of Haryana State. A stratified random sampling was used to include Women across Socio-economic categories. The findings of the study reveals that women in the developed villages had better accessibility to reproductive health services in compare to the women from less developed villages. Women in the less developed village had no accessibility to services of trained qualified practitioners and Auxiliary Nurse Midwives (ANM) within the village for the treatment of complications during pregnancy. Considering the result of the study, the author suggested that government should give proper consideration towards the health needs of women and the entire focus should be shifted from family planning measures to the services based on the needs and problems of women. Further, Barua & Kurz (2008) conducted an empirical study in Maharashtra to gain insight into whether and how the reproductive health needs of young married woman are met-most notably for gynecological problems, family planning and perceived fertility problems. The result of the study shows that women were treated quickly for illnesses that interfered with domestic work, in contrast to most menstrual disorders and symptoms of reproductive tract infection, which often went untreated. The study further shows that household work, protection of fertility and silence arising from embarrassment related to sexual health problems were the strongest factors inhibiting health care seeking. The study conducted by

Chandrasekhar (2011) in the Sunami affected coastal Blocks in Cuddalore district of Tamil Nadu shows that housewives due to their lack of economic independence suffered without medical care and agricultural laborers suffered for not taking proper healthy care. The same opinion was found in the study conducted by Sabana (2012) on Health Problems of Women in Backward Regions like Hyderabad- Karnataka, Telangana and Marathwada. In this study, data were collected from the selected sample villages and urban areas through personal interview method. Total 900 women were interviewed for the study. The result of the study shows that about 68 percent of Women in rural areas and 39.3 percent women in urban areas prefer to visit Government hospital and PHC when they get sick. The region wise distribution of data for rural areas reveals that 67.3 percent and 24.6 percent in Hyderabad, Karnataka region and 68.6 percent and 26.6 percent in Telangana region and 68 percent and 23.3 percent in Marathwada region desires to visit government Hospital/ PHC and Private Hospital when they get sick respectively. The author concluded that excess burden of family works and unfavorable conditions in work place cause the health problems which is the cause of concern of the study areas. New empirical evidence has shown that there are number of factors that lead to poor health status of women in India. The study conducted by Mukhopadhyay et al (1997) has made an attempt to explore the overlap between poverty, gender inequality and reproductive choice as manifested through observed fertility behavior using household survey data from five districts of rural Uttar Pradesh. For this study a few indices of poverty and gender inequality were chosen to consider their impact on male and female reproductive behavior and choices. The result of the study reveals that poverty as measured by per capita household income is a strong determinant of fertility behavior. Media exposures, is another factor that has significant linkage with use of contraceptives. Similar result is found in the study conducted by Sagar (2001) shows that economic factor as well as the issues of social status and traditions plays dominant role in the construction of women's health. It has been observed that employed women due to the increase workload suffered more. The author further recommended that to address the issues of women's health there is a need to adopt package of reproductive health services to cater the multi sectoral needs of women. Rishyasringa & Ramasubban (2008) conducted a qualitative study on the treatment seeking behaviour of gynecological problems among a sample of Women in Mumbai Slum. The findings of the study reveal that poverty represents a major barrier to

treatment seeking among women as financial pressure causing many women to forego seeking medical care. Further the study shows that there was an absence of support from the family, specially the husband, which accords women's health concerns insufficient priority to seek prompt treatment. The author describe that these factors lead women to seek home remedies or treatment from local private and often unqualified providers and only seek formal medical treatment when conditions become severe and intolerable.

The above studies on Women's health have put their extensive focus on reproductive health problems. As NRHM is mainly focusing on the Reproductive and Child Health, so the above studies have contributed to the knowledge on women's health and the treatment offered by various states as a part of government responsibility**.**

2.7 Women's Health and Public Policy:

From public health perspective two things are important. Firstly, within Reproductive Health, priorities should be clearly articulated and reflected in the budgetary allocations. Secondly, Mother and Child Health, nutrition, contraceptive services, and communicable disease control must be integrated, as this will provide a solid foundation for women's health including their Reproductive Health. Health care service system needs supportive environment that will bring social, economic and legislative action favoring women (Quader, 1998). In India, MCH services are poor across classes in both rural and urban areas. The failure of this programme was also caused by mismatch of Centre-State priorities as health is a state subject while health policy and planning is done at the centre. Government should create a single system which assures universal coverage with equity. To provide better services public health sector need to be accountable to the local community and private facilities also need to be monitored, standardized and relocated if necessary (Duggal, 1997). Since the early 1990s, 'decentralization' and 'integration' seem to be the popular words underlying the implementation of various social development programmes in India (Srinivashan et al, 2007). The author has analysed the effectiveness of RCH programme implemented since 1997, both from the point of view of decentralization and integration of services. The study used the compiled data of RCH surveys carried out during 2002-04, wherein information of various RCH parameters were collected

at the district level from the representative samples from 562 districts and from the three services of NFHS 1, 2 and 3 respectively. The result of this analysis shows that state-level effects of various RCH services are significantly higher than those at the district level. The study further reveals that the pace of progress after 1998 in many indicators is slower than the pace of progress before 1998 despite the expenditure on the programme being doubled. The author has pointed out that decentralization and integration of basic health care services may not be effective unless monitored centrally and backed by full time health (medical/paramedical) professionals, medical and Para medical personnel and grass root workers at the delivery level. Soman (1997) attempted to explore the nature and implications of planning for Women's health in India. The author traces the strategies and priorities in planning during and after independence, followed by the evolution of MCH programme. He further discusses some major implications of planning for women's health, and examines the role of Non-Government Organization (NGOs) in health development in India. He concluded that if the infrastructure remains ineffective and inadequate reproductive programmes will fail to meet its target. Kumar (1997) examined the extent of gender inequality in human capabilities across Indian states, and argues that ensuring a more equal expansion of capabilities is important for advancing women's well-being. He pointed out that the lack of services like health and education also affects women's health. He cited the example of Kerala, where 90 percent of all deliveries are done with qualified medical assistance while as Bihar, Orissa, Uttar Pradesh and Rajasthan considered as poor health states where 80 percent of women do not receive medical assistance. To him, a high income level is not essential for good health and he further correlated Women's health in India with greater freedom. The author has cited the case study of Manipur and Kerala two 'Good Health' states where women enjoy greater freedom in material and occupational choice and established the fact that political participation and collective action by women are necessary for improving social and economic condition. Maternal mortality presents a critical area of concern for underdeveloped and developing nations. UNDP has recognized the declining rate of maternal mortality as an important index of human development (Dutta, 2012). The author has discussed about the problems in brief and different initiative adopted by government of Gujarat, West Bengal and Assam respectively to combat Maternal Mortality. He further recommended that a community level investigation of all maternal deaths should be undertaken in all districts of the state, and for raising

community awareness on the issues of maternal health there is a need to have synergetic approach between NGOs and local panchayat.

The above studies analysed the pros and cons of the policies and programmes related to women health and it has found that specific concern on reproductive Health has emerged after the phases of programmes introduced. Gender-Sensitive health policies and programmes can bring transformation in the health scenario of the country leading to enhanced human development and growth.

2.8 Discussions:

Since the introduction of globalization and liberalization policy India's health system has experienced deep changes and is still in an on-going evolutionary process in which it is constantly challenged by the growing influence of globalization, rapid economic and social development, dispersal of market forces, and increasing autonomy of public health care providers as well as the flourishing private sector and private practices. From the above literature, it has found that various kind of health services under various administrative models have been offered to the beneficiaries or citizens in our country. The effectiveness of these models provides a guideline through which the holistic approach on health care administration is drawn to implement health programmes successfully at state, district and local level. It has been observed by these studies that the outcome of health care services varied due to the pattern of governance under which health services offered. The variation of results noticed in different parts of the country as well as in other countries. One reason for this is the absence of appropriate assessment methods, and therefore an evaluative research on governance models and implementation strategies is highly contextual. The above mentioned studies have mainly focused either on the role of administration, planning and regulation, i.e. government, or on health care providers and their relationship with the government. A comprehensive comparison of stakeholder influences and the relationships between all stakeholder groups in the health system is found to be lacking so far. So there is a need to contribute to a deeper understanding of problems in India's health care system and governance by comparing levels of influence and the roles of different stakeholder groups Local government bodies, public & private health care providers, patients and their social

networks, funding institutions, social organisations, and civil society in the production and reproduction of the layout of the health care system in India. The issues of Women's health especially the Reproductive Health have received attention by the government in recent years, and for that new programmes and policy has also been formulated. Studies conducted on women's health/ Reproductive Health have concentrated on the challenges that occurred due to the influence of government initiatives, Reproductive Health challenges faced by women specifically rural women and the recommendations for implementation of these conditions also found. But there was a gap identified in the government initiatives, contribution by its implementing agencies on Reproductive Health and its service impact in the literatures.

2.9 Overview of Studies

After the exhaustive survey of thematic Review it is imperative to summarize the findings of the review work so as to derive implications for the primary data collection and analysis. In this section the researcher endeavors to highlight the findings of Literature review under three broad heads namely the gap, overlap and contradictions. The table below attempts to conclude the findings of secondary data to draw parallels from and derive background information for the primary data collection, analysis and inferences:

Table 2.1: Overview of Literature

Theme/Area	GAP	OVERLAP	CONTRADICTIONS
Governance and Development	While most of the studies based on governance were found to be generic, Issues of governance focusing the specific requirements and societal context of the developing nations were not highlighted adequately.	Majority of studies (post 2005) have focused on people's participation and Right to information as important criteria of ensuring good governance.	Decentralized process of Governance has been criticized as well as appreciated in the available literature. A balanced view on positives and negatives of decentralization has been a rarity in the universe of available literature on the issue.
Health Care	Issues on health care were though found in abundance, the opinion and perspective of service providers have largely been found to be dominated in the studies reviewed. The status of health from the perspective of service users and that from different sections of the society has largely been missing in India (a society characterized by graded inequalities).	Almost all the studies have maintained that variation of health status depends either on socio - economic condition or there is a regional variation in service delivery.	Contradictions have been found on the process of special focus on Rural Health Care, as majority of the researchers have been unable to appreciate the specific nuances and largely been limited to a generic view of the issue.

Governance and Health Care	With regard to Governance in health care, Studies have focused largely on theoretical suggestions viz. transparency, accountability etc. but have by and large not acknowledged the need for a practice based guideline for the same.	Most of the studies have discussed the major administrative and management issues related to service delivery.	Ideas differ on the impact of economic reform on health sector. There are contradictions on the impact of decentralization on health care governance in India.
Women's Health	Contributions of implementing agencies on Reproductive Health have been not adequately highlighted in studies.	Most of the studies have focused on Reproductive Health Issues of women	Contradiction exists on the involvement of stakeholders and other partners like NGOs for the promotion of Mother and Child Health infrastructure and service delivery. Constructive opinions on alternative policies to NRHM have also been missing in various discussions and primary studies in India.