



INTERNATIONAL JOURNAL OF RESEARCH IN COMMERCE, ECONOMICS AND MANAGEMENT

CONTENTS

Sr. No.	TITLE & NAME OF THE AUTHOR (S)	Page No.
1.	LACK OF INFRASTRUCTURE AND VISION 2020 IN NIGERIA <i>OLOWE, OLUSEGUN</i>	1
2.	IMPACT OF SELECTED ISSUES ON WORK-FAMILY BALANCE: EMPIRICAL EVIDENCE FROM PRIVATE COMMERCIAL BANKS OF BANGLADESH <i>AYESHA TABASSUM, JASMINE JAIM & TASNUVA RAHMAN</i>	5
3.	A STUDY ON TOTAL QUALITY MANAGEMENT & DEVELOPING A COMPREHENSIVE MODEL FOR QUALITY IN HIGHER EDUCATION <i>HARINI METHUKU & HATIM R HUSSEIN</i>	9
4.	FISCAL POLICY AND ECONOMIC GROWTH IN PAKISTAN <i>ZEESHAN AHMED</i>	14
5.	A NON-PARAMETRIC APPROACH TO FINANCIAL INCLUSION ANALYSIS THROUGH POSTAL NETWORK IN INDIA <i>NITIN KUMAR</i>	19
6.	SECURITIZATION AND ITS RELATIONSHIP WITH REAL ESTATE GROWTH – AN ANALYSIS <i>VIVEK JOSHI</i>	25
7.	EXPLORING HRM PRACTICES IN SMEs <i>PUJA BHATT & DR. S. CHINNAM REDDY</i>	32
8.	ELECTRICITY EXCHANGE IN INDIA: A STUDY OF INDIAN ENERGY EXCHANGE <i>DR. Y. M. DALVADI & SUNIL S TRIVEDI</i>	42
9.	SMALL SCALE INDUSTRIAL UNITS: PAST AND PRESENT PROBLEMS AND PROSPECTS <i>DR. K. VETRIVEL & DR. S. IYYAMPILLAI</i>	48
10.	'MEDICAL TOURISM' – THE NEW TREND OF REVENUE GENERATION: IMPACTS ON INDIAN ECONOMY AND THE GLOBAL MARKET RESPONSE <i>DR. S. P. RATH, DR. BISWAJIT DAS, HEMANT GOKHALE & RUSHAD KAVINA</i>	61
11.	A STUDY ON DECIDING FACTORS OF WOMEN ENTREPRENEURSHIP IN VIRUDHUNAGAR DISTRICT <i>C. MANOHARAN & DR. M. JEYAKUMARAN</i>	70
12.	EARNINGS ANNOUNCEMENTS: DO THEY LEAD TO EFFICIENCY? <i>SANTOSH KUMAR, TAVISHI & DR. RAJU. G</i>	74
13.	CLIMATE CHANGE, ADAPTATION AND MITIGATION EFFORTS IN THE TRIBAL AREAS OF INDIA <i>DR. S. THIRUNAVUKKARASU</i>	78
14.	A STUDY ON THE DETERMINANTS OF EXPORT DEMAND OF INDIA AND KERALA <i>DR. L. ANITHA</i>	82
15.	INDIA'S FUTURE CONSUMPTION OF COAL RESOURCES & INDONESIA AS A POTENTIAL PROCUREMENT DESTINATION <i>DR. CH. VENKATAIAH & SANTHOSH B. S.</i>	87
16.	AN EMPIRICAL INVESTIGATION OF THE TRADE-OFF AND PECKING ORDER HYPOTHESES ON INDIAN AUTOMOBILE FIRMS <i>DR. A. VIJAYAKUMAR</i>	94
17.	SHG - BANK LINKAGE – A HELPING HAND TO THE NEEDY POOR <i>DR. A. S. SHIRALASHETTI & D. D. KULKARNI</i>	101
18.	ANALYSING SOCIO DEMOGRAPHIC EFFECT ON CONSUMER'S POST PURCHASE BEHAVIOUR: A STUDY ABOUT HOME APPALIANCES <i>DR. DHARMENDRA KUMAR</i>	105
19.	ETHICAL HUMAN RESOURCES WITH SUSTAINABLE RESPONSIBLE BUSINESS LEADING TO EMPLOYEE ENGAGEMENT <i>R. MANJU SHREE</i>	110
20.	JUDGING THE SHORT TERM SOLVENCY OF SELECTED INDIAN AUTOMOBILE SECTOR COMPANIES <i>BHAVIK M. PANCHASARA, KUMARGAURAV GHELA, SAGAR GHETIA & ASHISH CHUDASAMA</i>	114
21.	INSOLVENCY RISK OF SELECTED INDIAN COMMERCIAL BANKS: A COMPARATIVE ANALYSIS <i>SANTI GOPAL MAJI, SOMA DEY & ARVIND KR. JHA</i>	120
22.	SOCIAL RESPONSIBILITY OF ENTERPRISES IN A GLOBALISED INDIAN ECONOMY - AN ANALYSIS <i>DR. KUMUDHA RATHNA</i>	125
23.	CSR PRACTICES AND RATINGS IN INDIAN BANKING SECTOR <i>JAYASHREE PATIL-DAKE & NEETA AURANGABADKAR-POLE</i>	129
24.	POVERTY, INEQUALITY AND INCLUSIVE GROWTH IN RURAL INDIA: AN ANALYSIS <i>DR. JAMIL AHMAD</i>	134
25.	EMPOWERMENT OF WOMEN THROUGH MICRO FINANCE IN THE UNION TERRITORY OF PUDUCHERRY <i>B. ELUMALAI & P. MUTHUMURUGAN</i>	139
	REQUEST FOR FEEDBACK	143

A Monthly Double-Blind Peer Reviewed Refereed Open Access International e-Journal - Included in the International Serial Directories

Indexed & Listed at: [Ulrich's Periodicals Directory](#) ©, [ProQuest, U.S.A.](#), [The American Economic Association's electronic bibliography](#), [EconLit, U.S.A.](#),

[Open J-Gate, India](#) as well as in [Cabell's Directories of Publishing Opportunities, U.S.A.](#)

Circulated all over the world & Google has verified that scholars of more than eighty-one countries/territories are visiting our journal on regular basis.

Ground Floor, Building No. 1041-C-1, Devi Bhawan Bazar, JAGADHRI – 135 003, Yamunanagar, Haryana, INDIA

www.ijrcm.org.in

CHIEF PATRON

PROF. K. K. AGGARWAL

Chancellor, Lingaya's University, Delhi
Founder Vice-Chancellor, Guru Gobind Singh Indraprastha University, Delhi
Ex. Pro Vice-Chancellor, Guru Jambheshwar University, Hisar

PATRON

SH. RAM BHAJAN AGGARWAL

Ex. State Minister for Home & Tourism, Government of Haryana
Vice-President, Dadri Education Society, Charkhi Dadri
President, Chinar Syntex Ltd. (Textile Mills), Bhiwani

CO-ORDINATOR

DR. BHAVET

Faculty, M. M. Institute of Management, Maharishi Markandeshwar University, Mullana, Ambala, Haryana

ADVISORS

PROF. M. S. SENAM RAJU

Director A. C. D., School of Management Studies, I.G.N.O.U., New Delhi

PROF. M. N. SHARMA

Chairman, M.B.A., Haryana College of Technology & Management, Kaithal

PROF. S. L. MAHANDRU

Principal (Retd.), Maharaja Agrasen College, Jagadhri

EDITOR

PROF. R. K. SHARMA

Dean (Academics), Tecnia Institute of Advanced Studies, Delhi

CO-EDITOR

DR. SAMBHAV GARG

Faculty, M. M. Institute of Management, Maharishi Markandeshwar University, Mullana, Ambala, Haryana

EDITORIAL ADVISORY BOARD

DR. AMBIKA ZUTSHI

Faculty, School of Management & Marketing, Deakin University, Australia

DR. VIVEK NATRAJAN

Faculty, Lomar University, U.S.A.

DR. RAJESH MODI

Faculty, Yanbu Industrial College, Kingdom of Saudi Arabia

PROF. SIKANDER KUMAR

Chairman, Department of Economics, Himachal Pradesh University, Shimla, Himachal Pradesh

PROF. SANJIV MITTAL

University School of Management Studies, Guru Gobind Singh I. P. University, Delhi

PROF. RAJENDER GUPTA

Convener, Board of Studies in Economics, University of Jammu, Jammu

PROF. NAWAB ALI KHAN

Department of Commerce, Aligarh Muslim University, Aligarh, U.P.

PROF. S. P. TIWARI

Department of Economics & Rural Development, Dr. Ram Manohar Lohia Avadh University, Faizabad

DR. ASHOK KUMAR CHAUHAN

Reader, Department of Economics, Kurukshetra University, Kurukshetra

DR. SAMBHAVNA

Faculty, I.I.T.M., Delhi

DR. MOHENDER KUMAR GUPTA

Associate Professor, P. J. L. N. Government College, Faridabad

DR. VIVEK CHAWLA

Associate Professor, Kurukshetra University, Kurukshetra

DR. SHIVAKUMAR DEENE

Asst. Professor, Government F. G. College Chitguppa, Bidar, Karnataka

ASSOCIATE EDITORS**PROF. ABHAY BANSAL**

Head, Department of Information Technology, Amity School of Engineering & Technology, Amity University, Noida

PARVEEN KHURANA

Associate Professor, Mukand Lal National College, Yamuna Nagar

SHASHI KHURANA

Associate Professor, S. M. S. Khalsa Lubana Girls College, Barara, Ambala

SUNIL KUMAR KARWASRA

Vice-Principal, Defence College of Education, Tohana, Fatehabad

DR. VIKAS CHOUDHARY

Asst. Professor, N.I.T. (University), Kurukshetra

TECHNICAL ADVISORS**AMITA**

Faculty, E.C.C., Safidon, Jind

MOHITA

Faculty, Yamuna Institute of Engineering & Technology, Village Gadholi, P. O. Gadholi, Yamunanagar

FINANCIAL ADVISORS**DICKIN GOYAL**

Advocate & Tax Adviser, Panchkula

NEENA

Investment Consultant, Chambaghat, Solan, Himachal Pradesh

LEGAL ADVISORS**JITENDER S. CHAHAL**

Advocate, Punjab & Haryana High Court, Chandigarh U.T.

CHANDER BHUSHAN SHARMA

Advocate & Consultant, District Courts, Yamunanagar at Jagadhri

SUPERINTENDENT**SURENDER KUMAR POONIA**

CALL FOR MANUSCRIPTS

We invite unpublished novel, original, empirical and high quality research work pertaining to recent developments & practices in the area of Computer, Business, Finance, Marketing, Human Resource Management, General Management, Banking, Insurance, Corporate Governance and emerging paradigms in allied subjects like Accounting Education; Accounting Information Systems; Accounting Theory & Practice; Auditing; Behavioral Accounting; Behavioral Economics; Corporate Finance; Cost Accounting; Econometrics; Economic Development; Economic History; Financial Institutions & Markets; Financial Services; Fiscal Policy; Government & Non Profit Accounting; Industrial Organization; International Economics & Trade; International Finance; Macro Economics; Micro Economics; Monetary Policy; Portfolio & Security Analysis; Public Policy Economics; Real Estate; Regional Economics; Tax Accounting; Advertising & Promotion Management; Business Education; Business Information Systems (MIS); Business Law, Public Responsibility & Ethics; Communication; Direct Marketing; E-Commerce; Global Business; Health Care Administration; Labor Relations & Human Resource Management; Marketing Research; Marketing Theory & Applications; Non-Profit Organizations; Office Administration/Management; Operations Research/Statistics; Organizational Behavior & Theory; Organizational Development; Production/Operations; Public Administration; Purchasing/Materials Management; Retailing; Sales/Selling; Services; Small Business Entrepreneurship; Strategic Management Policy; Technology/Innovation; Tourism, Hospitality & Leisure; Transportation/Physical Distribution; Algorithms; Artificial Intelligence; Compilers & Translation; Computer Aided Design (CAD); Computer Aided Manufacturing; Computer Graphics; Computer Organization & Architecture; Database Structures & Systems; Digital Logic; Discrete Structures; Internet; Management Information Systems; Modeling & Simulation; Multimedia; Neural Systems/Neural Networks; Numerical Analysis/Scientific Computing; Object Oriented Programming; Operating Systems; Programming Languages; Robotics; Symbolic & Formal Logic; Web Design. The above mentioned tracks are only indicative, and not exhaustive.

Anybody can submit the soft copy of his/her manuscript **anytime** in M.S. Word format after preparing the same as per our submission guidelines duly available on our website under the heading guidelines for submission, at the email addresses, infoijrcm@gmail.com or info@ijrcm.org.in.

GUIDELINES FOR SUBMISSION OF MANUSCRIPT

1. **COVERING LETTER FOR SUBMISSION:**

DATED: _____

THE EDITOR

IJRCM

Subject: SUBMISSION OF MANUSCRIPT IN THE AREA OF _____.

(e.g. Computer/IT/Finance/Marketing/HRM/General Management/other, please specify).

DEAR SIR/MADAM

Please find my submission of manuscript titled ' _____ ' for possible publication in your journal.

I hereby affirm that the contents of this manuscript are original. Furthermore it has neither been published elsewhere in any language fully or partly, nor is it under review for publication anywhere.

I affirm that all author (s) have seen and agreed to the submitted version of the manuscript and their inclusion of name (s) as co-author (s).

Also, if our/my manuscript is accepted, I/We agree to comply with the formalities as given on the website of journal & you are free to publish our contribution to any of your journals.

NAME OF CORRESPONDING AUTHOR:

Designation:

Affiliation with full address & Pin Code:

Residential address with Pin Code:

Mobile Number (s):

Landline Number (s):

E-mail Address:

Alternate E-mail Address:

2. **INTRODUCTION:** Manuscript must be in British English prepared on a standard A4 size paper setting. It must be prepared on a single space and single column with 1" margin set for top, bottom, left and right. It should be typed in 8 point Calibri Font with page numbers at the bottom and centre of the every page.
3. **MANUSCRIPT TITLE:** The title of the paper should be in a 12 point Calibri Font. It should be bold typed, centered and fully capitalised.
4. **AUTHOR NAME(S) & AFFILIATIONS:** The author (s) full name, designation, affiliation (s), address, mobile/landline numbers, and email/alternate email address should be in italic & 11-point Calibri Font. It must be centered underneath the title.
5. **ABSTRACT:** Abstract should be in fully italicized text, not exceeding 250 words. The abstract must be informative and explain the background, aims, methods, results & conclusion in a single para.
6. **KEYWORDS:** Abstract must be followed by list of keywords, subject to the maximum of five. These should be arranged in alphabetic order separated by commas and full stops at the end.
7. **HEADINGS:** All the headings should be in a 10 point Calibri Font. These must be bold-faced, aligned left and fully capitalised. Leave a blank line before each heading.
8. **SUB-HEADINGS:** All the sub-headings should be in a 8 point Calibri Font. These must be bold-faced, aligned left and fully capitalised.
9. **MAIN TEXT:** The main text should be in a 8 point Calibri Font, single spaced and justified.
10. **FIGURES & TABLES:** These should be simple, centered, separately numbered & self explained, and titles must be above the tables/figures. Sources of data should be mentioned below the table/figure. It should be ensured that the tables/figures are referred to from the main text.
11. **EQUATIONS:** These should be consecutively numbered in parentheses, horizontally centered with equation number placed at the right.
12. **REFERENCES:** The list of all references should be alphabetically arranged. It must be single spaced, and at the end of the manuscript. The author (s) should mention only the actually utilised references in the preparation of manuscript and they are supposed to follow **Harvard Style of Referencing**. The author (s) are supposed to follow the references as per following:
 - All works cited in the text (including sources for tables and figures) should be listed alphabetically.
 - Use (ed.) for one editor, and (ed.s) for multiple editors.
 - When listing two or more works by one author, use --- (20xx), such as after Kohl (1997), use --- (2001), etc, in chronologically ascending order.
 - Indicate (opening and closing) page numbers for articles in journals and for chapters in books.
 - The title of books and journals should be in italics. Double quotation marks are used for titles of journal articles, book chapters, dissertations, reports, working papers, unpublished material, etc.
 - For titles in a language other than English, provide an English translation in parentheses.
 - The location of endnotes within the text should be indicated by superscript numbers.

PLEASE USE THE FOLLOWING FOR STYLE AND PUNCTUATION IN REFERENCES:

BOOKS

- Bowersox, Donald J., Closs, David J., (1996), "Logistical Management." Tata McGraw, Hill, New Delhi.
- Hunker, H.L. and A.J. Wright (1963), "Factors of Industrial Location in Ohio," Ohio State University.

CONTRIBUTIONS TO BOOKS

- Sharma T., Kwatra, G. (2008) Effectiveness of Social Advertising: A Study of Selected Campaigns, Corporate Social Responsibility, Edited by David Crowther & Nicholas Capaldi, Ashgate Research Companion to Corporate Social Responsibility, Chapter 15, pp 287-303.

JOURNAL AND OTHER ARTICLES

- Schemenner, R.W., Huber, J.C. and Cook, R.L. (1987), "Geographic Differences and the Location of New Manufacturing Facilities," Journal of Urban Economics, Vol. 21, No. 1, pp. 83-104.

CONFERENCE PAPERS

- Garg Sambhav (2011): "Business Ethics" Paper presented at the Annual International Conference for the All India Management Association, New Delhi, India, 19–22 June.

UNPUBLISHED DISSERTATIONS AND THESES

- Kumar S. (2011): "Customer Value: A Comparative Study of Rural and Urban Customers," Thesis, Kurukshetra University, Kurukshetra.

ONLINE RESOURCES

- Always indicate the date that the source was accessed, as online resources are frequently updated or removed.

WEBSITE

- Garg, Bhavet (2011): Towards a New Natural Gas Policy, Economic and Political Weekly, Viewed on July 05, 2011 <http://epw.in/user/viewabstract.jsp>

'MEDICAL TOURISM' – THE NEW TREND OF REVENUE GENERATION: IMPACTS ON INDIAN ECONOMY AND THE GLOBAL MARKET RESPONSE

DR. S. P. RATH

**PROFESSOR- MANAGEMENT STUDIES
INSTITUTE OF HOTEL MANAGEMENT,
(UNIVERSITY OF HUDDERSFIELD, U.K.)**

**TAJ HOTELS, RESORTS & PALACES (IHCL) – A TATA ENTERPRISE
AURANGABAD – 431 001**

DR. BISWAJIT DAS

**PROFESSOR - MARKETING
SCHOOL OF MANAGEMENT
KIIT UNIVERSITY**

BHUBANESWAR – 751 024

HEMANT GOKHALE

**ASSOCIATE DEAN (CULINARY ARTS)
INSTITUTE OF HOTEL MANAGEMENT,
(UNIVERSITY OF HUDDERSFIELD, U.K.)**

**TAJ HOTELS, RESORTS & PALACES (IHCL) – A TATA ENTERPRISE
AURANGABAD – 431 001**

RUSHAD KAVINA

**ASSOCIATE DEAN (HOTEL MANAGEMENT)
INSTITUTE OF HOTEL MANAGEMENT
(UNIVERSITY OF HUDDERSFIELD, U.K.)**

**TAJ HOTELS, RESORTS & PALACES (IHCL) – A TATA ENTERPRISE
AURANGABAD – 431 001**

ABSTRACT

Medical Tourism in the global context is at the rising trend in the third world because of affordability, cost, facility and expertise of some countries from the first world and also from the third world countries too. Third world countries like Cuba, Argentine, Mexico, Hungary, South Africa, Thailand, Singapore and India are the major players in the world. Developed world look for cost savings for treatment outside the country, developing countries are looking for expertise and the cost factors for considering a neighbouring country. Health tourism, in the Indian context is at par with other industry in the domestic sector. Medical tourism has many implications and impacts on the national economy, professional ethics, and medical practices and on the local economy. Non availability of the regulations in this sector in India leads to many rackets, scams and news making events. With adequate regulatory measures this sector has ample tourism business to contribute to the national economy and regional employment in direct and indirect terms. India can grow as the Asian tiger in medical treatment with the available support and the resources with expertise. Only in this decade the concept has taken corporate medical business, catering to Africa, Middle East, Europe, Asian neighbours and America. Out of many rising tourism concepts this has shown the power punch in the business trend, by making India a favoured treatment destination. Impacts, problems, issues, and opportunities of the medical tourism are examined in this article.

KEY WORDS

Incredible India, Health Sector, Corporate Hospitals, Public Healthcare, Foreign Patients.

TOURISM & RISING TREND OF MEDICAL TOURISM- INDIA

Tourism can indeed be one of the most powerful engines for economic growth, income redistribution, employment generation and social integration. Tourism can alleviate poverty and underdevelopment and generate employment in backward, isolated and remote areas. Incredible India campaign has lived up to its promises of engaging and catching the imagination of domestic and inbound tourists. The number of foreign tourists arrival has gone up from 2.38 million in the year to 5.58 million in 2010, while number of domestic tourists has gone up from 269.60 million in 2002 to 650.04 million in 2009. The incredible India campaign is largely responsible for this increase along with the growing economic trends of India in macro and micro level. India has tremendous potential to host the maximum number of visitors in the world. (TNN, 2011) The country has excellent tourist products and now there are efforts to make them world class facilities. Focus is on development of state-of-art infrastructure, accompanied by world class services. Of late there has been a very positive change in the attitude of service providers and they have become customer friendly. For the country to offer world class tourist products technology and innovations are key drivers. The major challenges are lack of proper transport and accommodation in and around several lesser known places but popular destinations. These are destinations which have the potential of drawing a large number of domestic as well as foreign tourists. Tour operators and destination management companies are developing strong partnership with counterparts abroad for increasing inbound tourism to India. Government is also taking steps to position India as 'value for money' destinations among domestic tourists. With the cultural shift taking place in the Indian tourism landscape, families are are opting for shorter but more frequent holidays both within and outside the country. This shift is taking place worldwide and people are opting for shorter and more frequent holidays.

Tourism of India has potentialities which needs innovative destination design and strategies to incorporate in to the tourist map. Out several options available for the nation, a potentiality of 'Religion Tourism' of Buddhism needs strong exploration to cater to the rich Buddhist countries especially Asia-Pacific Region that

includes Japan, South Korea, China, Thailand, Sri Lanka, and other Asian countries. As compared to Saudi Arabia which generates every year to a tune of US \$ 29 billion, India comparatively with appropriate facilities can generate to a tune of 44 billion US \$ every year with selected Buddhist sites of high religious importance. Secondly, the North-East part of India has the world's finest potentiality of nature and mountain tourism endowed with several extra ordinary advantages of the Himalayan nature. Insurgency and lawless public practices in this region are acting as the biggest hurdle for tourism development of the North-East. Perhaps the argument of many Indians are to be taken for granted, with adequate infrastructure and facilities this part of India can replace the Scotland and Switzerland like nature tourism sites due to its pristine beauty and nature. This part will attract the European and other international tourists with the advantage of more value for money i.e. economy in tourists spending. Smaller but contributing tourism to national economy are Education tourism, Medical Tourism, Rural Tourism, Island Tourism etc. Many such new tourism concepts are springing up with business validations for the new destinations and horizons in India. Every tourism concepts are related to economic upliftments and new product developments. Micro ideas are taking up full fledge shape of business through conventional tourism and unconventional tourism. Medical Tourism's glorified version started ten years before as a private initiative and today is a part of the India's macro tourism facet.

Rampant and deep-rooted underdevelopment of the many (persistently large number) amidst the presence of plenty of a few (though substantial and growing of late). Unequal access to (and often absence of) health care is familiar variant, yet nonetheless more tragic because of it, of the iniquitous dualism that even after six decades of 'development' still characterizes social and economic structures in India. (Nair, 2009) The more novel phenomenon of the citizens of the 'First World', rich and developed nations, choosing to undergo medical procedures or treatment in a 'Third World Country' such as India, albeit in multi specialty hospitals. These well equipped hospitals with state of the art equipment, often staffed with doctors and nurses with substantial work experience acquired from working from hospitals abroad, boast and deliver medical care comparable or superior to what is available in most of the developed country hospitals at a fraction of the cost. These hospitals advertise and offer 'medical package tour' that not only include medical operations and procedures but also travel to and from the hospital, stay and recuperation at 'five star facilities' to attract the attention and custom of the first world patients as well as well-heeled domestic ones. This phenomenon is commonly termed health or medical tourism. (Nair, 2009) As an aside on terminology, for our current purposes we shall treat health and medical tourism as similar though in its proper sense they may differ in the domain of activities that each encompasses. For instance medical tourism may sometimes be narrowly defined as involving only a subset of those activities limited to the medical procedural-pharmaceutical complex while health tourism may sometimes be more broadly understood to involve activities that include 'alternative' medical treatments, therapies, lifestyle and health resorts etc. The distinction is sometimes useful as and when we focus on issues related to 'medical insurance' and the 'health care industry' and at other times less useful when we try to discern the larger social and economic impact of health or medical tourism. In one sense medical tourism is hardly a new phenomenon. For long, people have traveled to other places in search of better medical treatment. The presence of reputable medical services has often acted as a spur to local economic activity either directly or as a spin off. Look at the hive of small business bustling around the location of any medium large hospital to realize the truth of this statement. You not only find pharmaceutical laboratories and medical supply stores but also number of eateries, hotels, lodges, hotels, banks, general stores and transportation hubs. India has also for many decades now served as a destination for those seeking better medical treatment or facilities within the SAARC and West Asia region. In general, most Indians themselves are likely to be medical tourists at some level determined primarily by their disposable income. Depending on their economic circumstances Indians are no less likely to travel long distances, even abroad, seeking better medical treatment as the experiences of many politicians and film stars can duly attest. Having established that medical tourism itself is not a new thing, even in India, it is still important to point out what is new about the latest manifestation. In a nutshell what differentiates the Indian medical tourist is the focus on not 'better' treatment but on 'cheaper' treatment. What prompts the global medical tourist, for example the American patient, to fly half way around the globe to a hospital in India is better but the costs of standardized medical and surgical procedures in India is far less.

India's record compares poorly with that of Japan, China and United States which have TFRs (Total Fertility Rate) of 1.3, 1.7, and 2.1, respectively. As per population projections, the population of India in the year 2025 will be 143.1 crore as compared to 145.3 crore of China.

TABLE 1: HEALTH INDICATOR OF SELECT COUNTRIES

Country	GDP per capita PPP US \$	Infant Mortality Rate (IMR) (Per 1,000 Live Births)	Life Expectancy at Birth M/f (in years) 2009	Maternal Mortality Ratio (MMR) (per 1,000 live births 2005)	TFR (Total fertility rate) 2007
india*	2753	53	62.6/64.2	254	2.6
China	5383	19	71.6/75.1	45	1.7
japan	33632	3	79.4/86.5	6	1.3
USA	45592	7	77.1/81.6	11	2.1
indonesia	3712	25	69.2/73.2	420	2.2
vietnam	2600	13	72.6/76.6	150	2.2
bangladesh	1241	47	65.5/67.7	570	2.9
pakistan	2496	73	66.5/76.2	320	3.5
sri lanka	4243	17	70.6/78.1	58	1.9

Source : * India- Registrar General of India, Govt. of India (GOI) (SRS 2008) and abridged life tables 2002-06 (2008); - 'State of World Population' (2009) and 'State of the World Children' (2009). GDP per capita – HDR, 2009.

The table above clearly indicates the national medical and health care facilities and India's health care economic indicator. This clearly justifies the health care industry in its new proposition of medical tourism to the world market of services.

MEDICAL TOURISM & GOVERNMENT POLICIES

India has emerged as a significant destination for treatment and tourism is not a new story. The country offers great value for money in terms of medical treatment for both visitors from developed countries as well as developing countries. India offers treatment at between half and one-third the cost of similar treatments in neighbouring medical tourism hotspots such as Singapore and Thailand. And that is why some intrepid patients started flocking to India almost a decade ago in search of treatment and cure. India has an edge over South-East Asian countries. Singapore is two to three times more expensive than India; Thailand is 50-80 percent more expensive, while Malaysia is not a strong player right now. As an industry, medical tourism in India has always suffered from official apathy- and it continues to do so. (Tondon, 2011) The problem is that it falls between three ministries – all of which look the business with a degree of suspicion. The tourism ministry in India hasn't really figured out any plan for this niche. The foreign ministry issues visas to medical travelers but wants to have nothing to do with the sector otherwise. And the health ministry has enough domestic issues to sort out without getting in to the complexities of attracting medical tourists. To a large extent, therefore, travelers in search of treatment in India came only because they had spent a considerable amount of time researching the destination and its facilities on their own and shown a degree of initiative. In contrast, in countries such as Thailand and Singapore, the government went out of their way to attract medical travelers after realizing the revenue potential. Visas are becoming a nuisance; if our basics are not in place, how can we talk of beating Thailand and Singapore, which give visa on arrival? The complexity of the medical visa, given once the patient gets in touch with the hospital and his case reviewed. Another shortcoming is that you cannot re-enter the country 60 days after you exit post operation or cure. This hinders the post operative care or reconciliation. Over the past few years, the medical tourism story has changed dramatically in India. Not because the government has figured out the solution. But purely because of private enterprise – with a few corporate hospitals, chemists, freelance agents all working in tandem to build a thriving ecosystem that educates, facilitates and ferries medical tourists from across the world. Last year, this ecosystem was responsible for about 600, 000 patients

travelling to India and spending INR 4,500 crore in getting treated here as per the industry statistics. Corporate hospitals such as Apollo, Fortis hospital and Max as well as business associations estimate that the business is growing by 40 percent year-on-year. In the process it is not only providing good revenues and profits to hospitals, but also giving rise to employment opportunities for a host of people connected peripherally with the business.

CORPORATE HOSPITAL PLAYERS – FORTIS, MAX AND APOLLO & THE FACET OF GLOBALISATION OF MEDICAL TOURISM

Fortis chain (29 hospitals in 11 cities) armed with high powered marketing professionals. Executives of Fortis by travelling to the far ends of Africa and Middle East, and turned it into a thriving business growing at a scorching pace. Fortis decided to take the business seriously. A team was recruited and they funded out to the major cities of the geographies with most potential – Africa and Middle East – to tie up with local doctors, set up facilitation centers, and drum up business. From a turnover of INR 9 crore in 2008, it has a possibility of closing INR 100 crore in 2011, which will be 10 percent of the entire business of Fortis. Africa is the most fertile market for the group given the decrepit medical facilities in the continent. In Europe the medical costs are sky-high and the waiting list is very long for African patients. The trouble turn spots of Afghanistan and Iraq are also great places for making a sales pitch as the top executives of the Fortis hospital executives believe and argue. (Tondon, 2011)

Max has seen a 500 percent growth in medical tourist arrivals over the past three years, in 2008 it received close to 600-700 international patients, the number touched 4,000-4,500 in 2011 (in-patients only, out patients would be close to 20,000). The international cell accounts for 20 percent of the business for the hospital. For Max the bulk of the patient inflow is from South Asia, Middle East and Africa. The developed world – North America and Europe – accounts for barely 5 percent of the Max's international patients.

After treating 60,000 patients (both in-patient and out-patients) overseas patients in 2010, the Apollo group claims to have the biggest share of the medical tourism pie in the country. The group generated the revenue of INR 350 crores last year. Apollo hospitals in different cities have loyal clientele from different geographies. Apollo Chennai attracts patients from Sri Lanka and Canada, and some from Bangladesh as well. Apollo in Ahmadabad gets a lot of traffic from U.K. The Delhi Apollo gets most of its patients from Africa and Middle East, while Kolkata gets the bulk of the Bangladeshi patients. Not a day goes by without a flight from Sri Lanka to Chennai carrying one patient from Sri Lanka, same for Apollo Kolkata with a Bangladesh patient. Special initiatives at Apollo Hospitals with the Apollo Munich Health Insurance services are expected to enhance the business to new heights. Another estimation of the industry justifies the large potential market from Commonwealth of Independent States (CIS) the former Soviet Union.

Compared to the countries like UK or the US, procedure like heart bypass surgery or angioplasty comes at a fraction of the cost in India, even though the quality of doctors and medical equipment is comparable to the best in the world. A heart bypass surgery in India costs USD 6,500, while in the US it costs between USD 30,000 and USD 80,000. The great emphasis placed on keeping costs down makes medical tourism part and parcel of the process of globalization. Once we recognize that health care is a service industry just like the 'call centers' in India that fulfills the needs of the various customers in the United States and other first world countries much of the radicalism of medical tourism seems very ordinary and common place. It is not different from business process outsourcing (BPO) model that underpins the rapidly growing information technology (IT) sector in India. The same cost cutting impulses that led multinational corporations to off-shore and outsource business process and production to other countries, also compels private and national health insurers to encourage their customers to consider undertaking certain medical procedures in India. According to the non-profit Kaiser Family Foundation, a leading health policy foundation in the US – expenditure in the US health care surpassed \$ 2 trillion in 2006 and accounted for 16 percent of the nation's Gross Domestic Product (GDP). Total health care expenditures grew at an annual rate of 6.7 in 2006, a slower rate than recent years, yet still outpacing inflation and growth in national income. (SWP-2009, UNFPA) It is therefore no wonder that health care providers actively exploring facilities in India to reduce costs. Other adjacent countries have opened the doorsteps for the Americans are Mexico and Cuba. South Africa is a very large player in receiving medical tourists from US and UK. Medical costs have been a national concern for US as was observed from the speeches of American president Mr. Obama in 2011.

Ten years ago, medical tourism was hardly large enough to be noticed in India. Today more than 250,000 patients per year visit Singapore alone – nearly half of them from the Middle East. This year approximately half a million foreign patients will travel to India for medical care, where as in 2002 it was only 150,000. In monetary terms experts estimates that medical tourism could bring India as much as \$ 2.2 billion per year by 2012. Argentina, Costa Rica, Cuba, Jamaica, South Africa, Jordan, Malaysia, Hungary, Latvia and Estonia all have broken in to the lucrative market as well, or are trying to do so, and more countries to join this list every year. Medical tourism will be particularly attractive in US, where an estimated 43 million people are without health insurance and 120 million without dental coverage- these numbers that are both likely to grow. Patients in Britain, Canada and other countries with long waiting lists for major surgery will be just as eager to take advantage of foreign health care options. India is relatively newer to medical tourism but quickly catching up with Thailand, by the recent estimates the number of foreign patients is growing 30 percent each year. India has top-notch centers for heart surgery, hip and knee replacement, cosmetic surgery, dentistry, bone marrow transplants and cancer therapy, and virtually all of India's clinics are equipped with the latest electronic and medical diagnostic equipment.

For North America patients, Costa Rica is the chosen destination for inexpensive high quality medical care without trans-Pacific flight, and it is a particular mecca for westerners seeking plastic surgery. South Africa also draws many cosmetic surgery patients, especially from Europe. South Africa offers post-operative care in luxury hotels and safaris or other vacation incentives. Because the South African rand has such long standing low rate on the foreign exchange market, medical tourism packages there tend to be perpetual bargains as well. Additionally, Argentine ranks high for plastic surgery, and Hungary draws large numbers of patients from Western Europe and the US for high quality cosmetic and dental procedures that cost half of what they would cost in Germany or US.

More than 40 years, Cuba, the largest island of West Indies group has been a popular medical tourism destination for thousands of patients travelling particularly from Latin America and Europe. Cuba's USP (Unique Selling Proposition) are the remarkable reputation of the medical practitioners, affordable prices and the beautiful beach resorts where the patients can recuperate. Statistical figures reveal that in 2006, Cuba attracted nearly 20,000 health tourists. Cuba offers a wide range of affordable medical treatments which include joint replacement, cancer treatment, eye surgery, cosmetic surgery, neurological disorder such as multiple sclerosis, Parkinson's disease, orthopedics, addictions rehabilitation. Such treatments are cheaper in Cuba by about 60 to 80 percent than in the United States. Reports say that medical tourism in Cuba generates more than USD \$ 40 million a year. This success in health care is nothing new to Cuba. History reveals that Cuba has made significant contributions to the world health since the 19th century. (HDR -2010, UNDP) It also boasts of a high caliber and high number of medical personnel. To reach Cuba residents of UK, Canada and other countries just need a tourist visa. USA resident case is different due to the US trade policy towards Cuba. Americans travelling to Cuba can obtain US government approval. Or they can travel to Cuba from the Bahamas, Jamaica, Dominican Republic, Canada or Mexico.

The medical tourism is on the rise in Mexico. US residents especially those residing near Mexican border find it easier to travel to Mexico for medical treatments. Many US employees especially those near Mexico have acquired insurance plans that send their works to Mexico for routine care or for regular. Most common treatments being availed in Mexico are dentistry, plastic surgery and bariatric surgery. Tijuana is the largest city of the Mexican state of Baja California and is situated on the US Mexican border. The US Mexico border is considered as one of the busiest medical tourism destinations. Mexico boasts of its medical experts and staff, majority of who have completed training in the US.

FOREIGN MARKETING PRESENCE OF HOSPITAL SERVICES OF INDIA

If the trickle of the medical tourists a decade ago has turned in to flood today in India, much of it has to do with the facilitation centers, the bases, and the tie ups that these hospitals have developed in potential markets. All the big hospital chains have crafted focused strategies to attract patients from target countries. To take the example of Apollo Hospital, this opened first international center in Oman in 2008. It now has three. By the middle of this year, it will have three more clinics in the African countries of Kenya, Tanzania and Ethiopia. It has tie-ups with local hospitals, government agencies and doctors in African countries. It has also plan to open a hospital in Nigeria soon. All these – the facilitation centers, clinics, and local hospital tie-ups – help in publicizing and making things easier for the patient looking to go to abroad for treatment. There basic tests are conducted at these clinics and detailed advice given to them. Other staff helps work

out costs, apply for visas, etc. The centers are used by patients to refer reports to doctors back in India and get approval for medical travel. Fortis and Max have also been working on broadly similar initiatives. The sales efforts in these countries are focused on building brand familiarization and educating the potential patients about the facilities in the hospitals. Hospitals organize regular outreach programmes in target countries. 'Health Camps' are the most popular – that is, taking doctors from India to these areas on a regular basis and treating patients. The local clinics and facilitation centers are run by the locals of the particular city on a franchise basis but training and backend support is provided by Indian hospitals. Tie ups with non government organizations (NGOs) or government organizations play a significant role, for example Afghan Red Crescent Society sends 20-30 patients a month to the Max facility. A host of medical travel companies that have sprung up around the world also work with hospitals in India. Max centers are already present in Bangladesh, Nigeria, Afghanistan and Nepal, where the chain is a well known brand. By the year 2012, Max will add five more regional centers in Ethiopia, Zambia, Oman, Kenya and UAE. (Tondon, 2011) Fortis has gone a step further in brand building by engaging with medical colleges in Africa. They provide for students to be trained under surgeons in India. Every year, batches of students come from Congo, Kenya, and spend between 45 and 60 days working under a specialist from Fortis. Fortis will 11 more centers – five in Iraq, two in Russia, with another two in Nigeria and one each in Ethiopia and Tanzania. These are the growth markets for Indian health care industry. Fortis have five dedicated facilities for international patients across India with Delhi seeing almost 85 percent of the patient inflow, while it's other centers treat the rest. Individual doctors and fertility centers do not have such an organized approach. Many of them get a fair amount of traffic through either word of mouth publicity or their internet presence. Gujarati patients of East Africa and South Africa are very good medical tourist traffic to Ahmadabad. The city hospitals get 25 to 30 percent of international patients' inflow growth every year.

INTERMEDIARIES AND AGENTS ROLE IN MEDICAL SERVICE – FOREIGN PATIENTS

If the bases abroad of Indian hospitals build brands, there is a thriving population of service providers of every kind that has cropped up to help patients negotiate India and Indian health care system. For Afghan patients Max New Delhi has full time translators for the last three years. There are plenty of translators floating around, doubling as facilitation agents. A random Google search for medical travel assistants will throw up plenty of suggestions. A bulk of clients for treatment in New Delhi comes through referrals, which account at large from Iran, Iraq and other Middle East countries. Freelance agents make good money in Delhi which count to a tune of 10% of the surgery costs in the local private hospitals. Translator services for Afghan patients are large in Delhi due to the 40,000 strong refugee populations from Afghanistan. Delhi caters to Nigerians and other African nations, while still others are hangouts for people from the CIS countries. Of course, as all these are unregulated, there is plenty of scope of for unscrupulous touts to thrive as well. They often prey on the numerous unsuspecting patients who have now come through a hospital facilitation center in their country, and whisk them to private hospitals and nursing homes for bigger commission. Big hospitals such as Apollo and Fortis are aware of these people but helpless to do anything about them. (TNN, 2011)

AN ECOSYSTEM OF MEDICAL TOURISM IN INDIA

Many Indian hospitals have set up facilitation centers abroad to highlight the advanced medical facilities available in India at cheap rates. These facility centers act as the first line contact of the patients for treatment in Indian hospitals. An international patient takes about 30-40 interactions with the Indian hospitals before travelling to India. After assessing the medical reports, Indian doctors recommend what treatment is best for the patient. Unlike a regular travel visa, medical visas are issued on a priority basis. Medical visa is open to residents of all countries including Pakistan, Bangladesh, China, and Sri Lanka, with a validity of one year. This is extendable under certain conditions, subject to approval by the home ministry. There are usually guest houses that thrive around hospitals. Almost 80 percent of the clientele comprise people traveling with patient. Locals also rent out smaller rooms, at almost double the rentals. Translators earn anything between INR 500 and INR 1000 a day. In Delhi most of the translators comprise students and refugee living in the city. International patient centers are a part of hospitals. Patients are often seen with translators. Some hospitals even have in-house doctors from West Asian countries. Medical travelers usually buy medication for longer durations – sometimes one to one and half years. It is a common sight for medical shops around hospitals to spot sign boards in Arabic language. (Tondon, 2011) To cater international medical travelers there are region – specific restaurants and food stores. Most of these are operated by refugees or students studying in India. Bupa and Allianz provide international insurance packages that cover treatment in different countries. These are the part of the large ecosystem of New Delhi in India for medical tourism.

ECONOMICS OF MEDICAL TOURISM

International medical travelers are good for corporate hospitals because these people often spend more than the same procedure than Indian patients. That is because medical procedures are often sold as packages, which include consultation in home country, facilities within Indian hospitals (mobile phone, accommodation etc.) and could therefore be anywhere between 20 percent and 30 percent higher than the cost that an Indian patient would bear. Down in the south patients arrive in large numbers from Bangladesh, Sri Lanka at Manipal Hospital in Bangalore. There isn't lack of patients within India and some of the hospitals are 100 percent occupied. But international patients often occupy high-end beds and are therefore a clear revenue generator for the hospitals. A US \$ 2,000 procedure for Indians on a single room basis would cost an international traveler about US \$ 3,000 (\$1,000 extra) as part of the package or 20-30 percent hike in costs. The whole economy of this system will only be successful if it helps hospitals get higher revenues for the same bed and procedure. That can help upgrade the facilities of the general ward. International patients are different as they come mostly from Bangladesh and Sri Lanka and do not pay significantly more than what Indian patients do. Though the Indian medical treatment costs are reasonable by developed world standards, they are often a burden for the international people who do come for treatment. Apollo is a household name in Nigeria. The bigger chains take great care to sort out problems faced with the medical travelers. But it is still a work in progress – and the industry will take some time to settle down. (Tondon, 2011) almost all Indian hospitals serving medical tourists are accredited either by Joint Commission International (JIC) or National Board for Accreditation of Hospitals and Health Care and follow international safety standards. That's why India remains a safe and preferred medical tourism destination. Indian hospitals are generally much less expensive than those in Singapore or other medical tourism destination Thailand or Philippines. For instance, a hip replacement that costs \$ 43,000 in the US could cost \$ 12,000 in Singapore and costs \$ 9,000 in India. India is market for price sensitive customers and Singapore is for higher- end customers aiming for more luxury, out of the first world price sensitive customers. In the macro tourism statistics of foreign tourist arrivals in India, medical tourism has a significant contribution for tourists from Bangladesh and Sri Lanka. Medical tourists from developed first world of Germany, France and Japan are negligible, which constitutes the top ten tourists arrival in the national tourist statistics. Language and national income are barriers to opt for India as a preferred destination. Evaluating the large senior populations of these countries a very high potential target market lies in these countries and can be tapped through suitable positioning. Many corporate hospitals are gearing up for these niche markets. Medical tourism cannot be considered as major force of changing India's position in the global market of international tourism, but the contribution to national economy in pockets are significant.

TABLE 2: TOP 10 SOURCE COUNTRIES FOR FOREIGN TOURIST ARRIVALS (FTAs) IN INDIA IN 2009

S. No.	Source Countries	FTAs *(In Millions)	Percentage(%) Share
1	USA	0.803	15.72
2	UK	0.749	14.66
3	Bangladesh	0.458	8.97
4	Sri Lanka	0.241	4.72
5	Canada	0.221	4.33
6	France	0.195	3.82
7	Germany	0.194	3.80
8	Australia	0.149	2.92
9	Malaysia	0.134	2.62
10	Japan	0.124	2.43
Total Top Ten Countries		3.268	63.98
Others		1.840	36.02
All Countries		5.108	100.00

Provisional

Source:- Bureau of Immigration, Government of India.

ADVERSE IMPACT OF MEDICAL COMMERCIALISATION

India is a developing country with very low per capita income by any method of economic calculation in the world. National concerns of BPL (Below poverty Line) population and their benefits is in any manner is the biggest challenge for the policy planners and implementers. Medical services for the masses are provided by the national government through government hospitals at nominal costs to make the masses to afford the service. As a general proposition, much of the performance under the critical indicators of Life Expectancy, IMR, MMR, TFR etc. correlates with economic wealth and levels of poverty. The reasons for such adverse health indicators may relate to high level of malnutrition and anemia, and lack of access to essential health services. Not surprisingly, the states which are weakest in terms of life expectancy, maternal and infant mortality and total fertility areas are also lowest in terms of economic wealth and highest in terms of poverty levels and total health expenditures.

TABLE 3: KEY DEMOGRAPHIC HEALTH INDICATORS AND RELATIONSHIP TO POVERTY AND WEALTH

High Focus EAG States	Life Expectancy at Birth (2002-06)	IMR (2008)	MMR (2004-06)	TFR (2008)	Poverty Level (2004-05)	Per Capita NSDP (2008-09) in INR	Per Capita Health Expenditure (NHA – 04-05)
Bihar	61.6	56	312	3.9	41.4	10206	513
Chhatisgarh	-	57	-	3.0	40.9	19521	772
Jharkhand	-	46	-	3.2	40.3	16294	500
Madhya Pradesh	58.0	70	335	3.3	38.3	13299*	789
Odisha	59.6	69	303	2.4	46.4	18212	902
Rajasthan	62.0	63	388	3.3	22.1	19708	761
Uttar Pradesh	60.0	67	440	3.8	32.8	12481	974
Uttarakhand	-	44	-	-	39.6	25114	818
High Focus NE States							
Arunachal Pradesh	-	32	-	-	17.6	22475	1454
Assam	-	64	480	2.6	19.7	16272	774
Manipur	-	14	-	-	17.3	16508	673
Meghalaya	-	58	-	-	18.5	23069	894
Mizoram	-	37	-	-	12.6	20483	1133
Nagaland	-	26	-	-	19.0	17129*	819
Sikkim	-	33	-	-	20.1	30652	1507
Tripura	-	34	-	-	18.9	12481	1486
General Category States							
Himachal Pradesh	67.0	44	-	1.9	10.0	32343	1511
Jammu & Kashmir	-	49	-	2.2	5.4	17590*	1001
Andhra Pradesh	64.4	52	154	1.8	15.8	27362	1061
Goa	-	10	-	-	13.8	60232*	2298
Gujarat	64.1	50	160	2.5	16.8	31780*	953
Haryana	66.2	54	186	2.5	14.0	41896	1078
Karnataka	65.3	45	213	2.0	25.0	27385	830
Kerala	74.0	12	95	1.7	15.0	35457	2950
Maharashtra	67.2	33	130	2.0	30.7	33302*	1212
Punjab	69.4	41	192	1.9	8.4	33198	1359
Tamil Nadu	66.2	31	111	1.7	22.5	30652	1256
West Bengal	64.9	35	141	1.9	24.7	24720	1259
INDIA	63.5	53	254	2.6	27.5	25494	1201

Note: IMR: Infant Mortality Rate, MMR: Maternal Mortality Ratio, TFR: Total Fertility Rate, NSDP: Net State Domestic Product (Per Capita Income) at constant (1999-2000) Prices

*:2007-08

Source: (col. 2) to Col. (4): Registrar General of India; Planning Commission; for col. (6), NHA 2004-05, for Col.8 table 1.3, Col. 7 - CSO

India for the last five decades has invested in the medical and health care sector by the national control of education. The issues of national significance were 'Brain Drain' of doctors to foreign countries in search of higher earnings. Since 1991 liberalisation Indian education has also gone through privatization and the corporate investments in this industry has gone up. Higher salaries and job shifting trend has attracted Indian doctors to come back to the country for lucrative jobs as specialist physicians. At the same time pharmaceutical sector at domestic front and foreign investment in the industry is a mega attraction.

Commercialization has resulted in artificial and unethical hike in the prices of lifesaving drugs. Higher profit margins and has cost the patients to pay very high prices in return making the common masses unaffordable to pay for the medication. Insufficient monitoring agencies of the government and the profit motive of the medical care and the pharmaceutical industry has made life of the common masses tough for the medical care. High levels of profit orientation motives of the industry has resulted in the medication price rise by four times in the last six years as the experts of the profession view. To counter such practices the regulatory authorities are proposing the rate control measures in various forms for the medical industry. Active participation of the government in opening up of outlets of medicine "Jan Ausadhi" at several places in the country is a beginning attempt. Government pharmaceutical companies in these outlets are selling generic and therapeutic medicines at a price of 10% of those available in the commercial market. Domestic medical care and practitioners motives are moving towards commercialization by tasking the common masses. The generic medicine market in India is INR 68,000 crore by the end of 2008. Jan Ausadhi campaign may bring a hope of reduction and controlled prices of the medicines of common diseases of the national population. Medical tourism has also provided the government hospitals to provide upper cost medical care for the patients of those segments who can afford such services. Today medical tourism is controlled by the corporate hospitals in India. Government medical colleges and hospitals are competent and equipped enough to boast the medical tourism through government's direct participation in this drive rather than the industry.

AYURVEDA (INDIAN MEDICARE) – AND AYUSH ADVANTAGES (AYURVEDA, YOGA & NATUROPATHY, UNANI, SIDDHA & HOMEOPATHY)

The aim and goals of AYUSH department are the promotion and propagation of traditional systems of medicine especially in the background of increasing chronic disorders due to modern day lifestyles. In order to meet this commitment the department of AYUSH has taken up steps for mainstreaming of AYUSH at all levels in the health care system, improving access to and quality of public health delivery, and promoting health and the prevention of diseases. Under mainstreaming of AYUSH over 2,368 doctors and 2,184 para-medics have been achieved in 93 hospitals upgraded and essential drugs supplied to 6,074 dispensaries. For taking AYUSH to the people a number of public health campaigns have been started like 'Homeopathy for Mother and Child Care', 'Unani for Skin Disorders', 'Yoga for Health', 'Ayurveda for control of Anaemia' and 'National Campaign on Amla'. AROGYA fairs have been organized in all the North-Eastern states for the first time in addition to Srinagar, Patna, Bhatinda etc. Ensuring quality assurance in the AYUSH sector has continued to be a priority area for which the department in collaboration with the Quality Council of India (QCI) has developed a scheme for voluntary certification for AYUSH products and also for accreditation of laboratories, colleges and hospitals to provide quality services to the people. Regarding AYUSH education a number of reforms have been initiated including modernization of institutes, revision of syllabi and introduction of new courses. Over 15,000 doctors have been trained under Re-orientation of Training Programme (RoTP). Collaborative Research projects on prevention and treatment of cancer, Diabetes, Kala Azar, Chikungunia etc. with top level institutions within and outside the country have been taken up. A Center for Research in Indian Systems of Medicine (CRISM) has been set up at the University of Mississippi (USA) to facilitate scientific validation and dissemination of information on Ayurveda, Siddha and Unani Medicine through collaborative research and advocacy. (NRHM -2005-10) The Traditional Knowledge Digital Library (TDKL) was set up by the department in collaboration with Council for Scientific and Industrial Research (CSIR). So far a total of 218000 formulations from classical texts have been transcribed in to patent compatible format. Agreements have been signed with European Patent Office (EPO) and US Patent & Trademark Office (USPTO) enabling them to gain access to this database in order to prevent bio-piracy. This is an important milestone in the protection of Traditional Knowledge globally.

Further, it has been decided by the government to establish AYUSH hospitals in all the states of the North East. Setting up of new AYUSH integrated universities / institutions are also envisaged in the new future. AYUSH industry clusters will be expanded and efforts for propagation of AYUSH systems both within and outside the country will be stepped up. There must be further efforts for integration of various systems medicine, with emphasis on developing synergy between modern and AYUSH systems of medicine and offering choice of systems of treatment to patients. There is a need to institutionalize courses in various medical systems for practitioners belonging to other systems, e.g., government to courses for training in basic allopathic care for AYUSH practitioners who desire to acquire these skills.

Ayurveda is the 5,000 year old Indian medicine. The young, educated urban Indian is waking up to the possibilities of Ayurveda (ayur: life; veda: knowledge), with growing research in this area and the many therapeutic benefits that it is offering, ayurveda have come to mean much more than wellness massages, herbal shampoos, sweet-smelling moisturizers and grandma's remedies. Given that chronic ailments are striking earlier than ever before, they are taking ayurveda seriously for therapeutic and pharmacological management and prevention of conditions raising from cancer, heart disease and diabetes to toothache. Apart from vaccines, they feel mainstream medicine does not have a strong enough preventive approach. Though Ayurveda works at its own pace when compared to mainstream medicine, the perception of fewer side effects perhaps works to its advantage. If ayurveda has to re-emerge as a powerful therapeutic option with global appeal, in scientific merit needs to be validated through a series of well designed clinical trials. (Thomas, 2011)

INDIA – THE PREFERRED ONE FOR MEDICAL TOURISM

Advantages that India offers as a destination for medical tourism are similar to those that make it an attractive option for IT off shoring. Much like the legion of engineers that dominates the IT sectors, Indian doctors are educated in English under a medical curriculum that was closely modeled on the British system. After independence the Indian government expanded medical education starting a number of new medical colleges at the state level and also financing medical centers of excellence such as AIIMS (All India Institute of Medical Sciences). In the last decade or so there has been growing private investment in medical education as well, with a number of private medical colleges being started. The cost of medical education has been relatively cheaper in India with a bulk of the expense being subsidized by the government. A peculiar feature of medical education in India is that the numbers have been skewed disproportionately in favour of graduating doctors rather than nurses compared to other countries. Consequently India has exported doctors to other developed countries, such as United States, the United Kingdom and those in West Asia, atypical example of brain drain and the subsidizing of first world health by the tax resources of an improvised third world country. No doubt these physicians have been able to acquire greater skill by working with the state of the art technology and being exposed to the latest developments and best procedures in medical science. Indeed major selling point of medical tourism is precisely its ability to attract these Indian doctors to return from abroad to work (either full time or part time) in these multi specialty hospitals where they would not lack for the latest and the best in equipment and technology. Newly returned Non Resident Indian (NRI) physicians have served not only as poster boys (and girls) of medical tourism in India but in some cases have been prime movers in setting up such hospitals incorporating the latest medical technology and medical practices, and often bringing with them their entire support staff in order to replicate in minute detail the environment of a first world facility.

This reverse brain drain of NRI physicians could not have taken place without certain enabling factors. These relate to the process of opening up of the Indian economy itself, involving the ability to undertake larger quantum of private investment (including foreign investment) in health sector (multi specialty hospitals require heavy capital investment upfront), more permissive rules on importing medical technology and improvements in transportation and communications infrastructure. The potential to establish backward and forward linkages with a maturing Indian pharmaceutical industry and growing sophistication of indigenous medical equipment manufacturers may well be another reason that makes India an attractive destination. The attraction of foreign tourists are not the only USP of the corporate hospitals, domestic medical tourists are the largest chunk of the patients inflow due to the availability of health insurance services and open policy of the government in allowing foreign insurance companies to operate in the wider areas of services. (HRH, JLI, WHO 2006-15) Many corporate hospitals have their largest revenue from the insurance companies insured patients and also from some government insurance agencies. Metro cities corporate hospitals see their future with the expanded business of the insurance companies. That's the reason no hospitals want to be blacklisted by the insurance companies, ultimately that may lead to the closure of the sophisticated business. In an interesting correlation, hotel industry sees the right future through a lowest risk by investing in the city center tower hotels, as the trend in many metro cities that, corporate hospitals find the business tower hotels as the finest property for the future hospitals. Medical tourism has reduced the risk of the investment in the metro city business hotels as some experts of the industry argue. Examples are evident in Hyderabad.

MEDICAL TOURISM – AN ADVANTAGEOUS REVENUE RESOURCE MODEL AND SOME DARK SPOTS OF THE BUSINESS TREND

There certainly large sums being bandied about the full potential of medical tourism in India. A much cited CII-McKinsey study estimates that medical tourism can contribute INR 5,000 – 10, 000 crore additional revenue for up market tertiary hospitals by 2012. Leaving aside these astounding figures for the moment, a few preliminary remarks may be in order here regarding the larger effects of medical tourism for Indian economy and society. There is legitimate concern that medical tourism, much like economic liberalization, will further exacerbate the divisions between the haves and the have-nots which now will include those with access to the medical facilities and those whose lives will be tragically cut short because of the continuing lack of access to basic preventable health care. Thus far medical tourism has benefited from the being neglect of the government which has saved it from being smothered in its infancy by overregulation. However it is inevitable that in the coming years due to the sheer potential size of this service sector the government will have to shake off its habit of indifference. There exist classes of medical tourist who see India as an easier source to obtain transplant organs such as kidneys for which they have to wait for years in their own countries. Going by the frequent reports in the medical about organ and kidney rackets there is cause to believe that this kind of predatory medical tourism is a serious problem. Given the enormous social and economic inequality and deprivation prevalent in India the possibly of exploiting weaker off sections in this medical organ trade is only too real. It is also not inconceivable that despite protestations to the contrary, even the most reputed of hospitals may play a passive facilitating role in this organ trade. It is imperative that the government should take a more active regulatory role in order to prevent medical tourism from descending in to an extension of the illegal organ trade. There is a strong case to be made for greater government regulation and vigilance in order to protect medical tourism from its own worst excesses. Skeptics may well point out that providing low cost health options to foreigners does little to improve health overall for Indians. Be an excuse for continued government neglect of public health or retreating further from this arena pleading financial and budgetary constraints. (Nair, 2009) If medical tourism is indeed a net revenue generator for the government it would do well to increase its allocation for public health. The more durable gains of medical tourism may be more imperceptible gains that are difficult to precisely quantify. One of the immediate benefits may be that of reversing the brain drain, with more trained personnel opting to stay back in India as opportunities for employment and professional advancement increase. To attract a reliable stream of clients, Indian hospitals catering to medical tourism have willingly adopted (and have had to maintain) very high standards of practice. This may spur greater efforts towards effective self regulation among these hospitals as they realize the importance of protecting 'market brand' where the short-sighted practices of few renegade members can cause industry wide damage and loss of confidence which may be impossible to regain. Hopefully along with medical technology, better medical practices; it is more than likely that Indian consumers will demand better quality in their own care. Economy in costs being the bedrock of medical tourism, this capital intensive service industry cannot sustain itself on temporary cost advantages. In order to ensure that costs remain lower, the industry will have to encourage, directly or indirectly, investment in medical education and research. This may take the form of lobbying the government or the accreditation bodies such as Indian Council of Medical Research (ICMR) to periodically raise the quality of medical and nursing graduates and the standard of the medical curriculum. It may take the direct form of setting up new medical colleges with updated educational curricula and facilities, increased focus on research and developments of various kinds, or more plausibly greater avenues for apprenticeships and training of medical personnel so that skills are continually updated. The question of sustainability allows one to consider another possibility that will have a more direct bearing on health care for the Indian masses. In a globalizing world of cut-throat competitions this new medical industry may soon discover that its most valuable asset is its pool of domestic customer. This trend is evident in the city of Hyderabad as the experts of the industry agree with evidences. The Indian state instituted some form of comprehensive health coverage for its population as part of its social safety nets, similarly state of Karnataka do offer comprehensive coverage to its population. It is possible to contemplate a future when this may well dovetail with a government that takes its own rhetoric of economic and social justice seriously. (AR, MHFW, 2005-10) With certain kind of central government employees already being allowed to avail themselves of treatment at these private multi-specialty hospitals, it may prove politically and morally untenable for the government not to offer some kind of coverage for the rest of the population. It is not an impossible dream that the migrant workers which is briefly referred in the beginning and the medical tourists from the first world who today seem to belong to two different universes, may ultimately both manage to live in the same one.

A NATIONAL MACRO PERSPECTIVE OF HEALTH CARE IN INDIA- THE FACTS

a. Health workforce of India

Is India is having adequate number of health workers? One international norm is a minimum of about 25 skilled health workers per 10, 000 population (doctors, nurses, and midwives) in order to achieve a minimum of 80 percent coverage rate for deliveries by skilled birth attendants or for measles immunization as seen in cross country analysis (JLI, WHO, 2006) standards. Workforce estimates based on the census 2001 suggests that there are around 2.2 million health workers in India but these are based on self-reported occupation which is susceptible to unqualified providers being counted as qualified ones. Adjusting for this, the density of health workers falls a little over 8 per 10, 000 population of which allopathic physicians are 3.8 and of nurses and midwives are 2.4 per 10, 000 population. Allopathic doctors comprising of 31 percent of the workforce, followed by nurses and midwives (30 percent), pharmacists (11 percent), AYUSH practitioners (9 percent) and others. The workforce estimates do not include the substantial number of community health volunteers and workers introduced under the NRHM after 2005. The nurse-doctor ratio in India is heavily skewed in favour of doctors. According to a computation from census there are approximately 1.2 nurses and midwives per allopathic physician. In comparison, developed countries such as USA and UK have nurse-physician ratios of 3 and 5 respectively. (NRHM-2005-10) Almost 60 percent health workers reside in urban areas. This mal-distribution is substantially exacerbated when adjusted for the larger share of the population residing in rural areas. The majority (70 percent) of health workers are employed in the private sector. The density of health workers per 10, 000 population in urban areas (42) is nearly four times that of the rural (11.8) areas. The majority of the health workers are employed in the private sector. Indian states with the greatest human resource needs also have the lowest capacity of producing the health workers. The distribution of medical and nursing colleges across the country is highly skewed. The five south-western states of Andhra Pradesh, Maharashtra, Karnataka, Kerala and Tamil Nadu (with 31 percent of the country's population) account for 58 percent medical colleges in India, both public and private, and 63 percent of the GNM nursing colleges in the country, 95 percent of which are private. States with poor health records like Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh have nurse densities lower than the national average, and account for only 9 percent of the nursing schools in the country.

Better economic and professional opportunities and better working and living conditions make for an urban preference. Specializations make government employment and rural services even less attractive. Public sector efforts to recruit and retain health workers to rural posts are also compromised by a number of workforce management issues. However these problems, including central problem of getting skilled professionals to work in rural areas, are amenable to solution, and the achievements of the last few years show the general directions needed. The launch of the National Rural Health Mission (NRHM) in 2005 marked a turning point in human resource for health. This led to the appointment of almost 1,06,949 more skilled service providers in the public health system by March 2010, of which 2,460 were specialists, 8,624 were doctors, 7,692 were AYUSH doctors, 26,993 were nurses, 46,990 were ANMs and 14,990 were paramedical. This was one of the largest increments to the public health workforce in recent times. Unfortunately needed it most was unable to make use the opportunity afforded by NRHM simply because there were not enough ANMs or nurses or doctors available for recruitment. NRHM funds have also enabled the revitalizing of the community health workers programme in India, and the over 7,00,000 ASHAs signifies a massive increase in health workers in the country.

b. Expansion of Medical and Nursing

The last one year has seen major advances in expansion of medical and nursing education. These include Medical Council of India (MCI) regulations have been amended to revise norms for setting up of medical colleges and increasing Post Graduate seats. Over 4,000 PG seats have been increased during this period consequent to revision teacher- student ratio. Central scheme of an amount of INR 1,350 crores has been approved for funding state government medical colleges to start/ increase PG medical seats. The scheme for setting up 132 ANM and 137 GNM schools at a cost of INR 660 crores and INR 1,370 crores, respectively has been approved. Schemes for upgrading about 25 nursing schools attached to medical colleges in to nursing colleges have been announced. State nursing councils and state nursing cells have been provided with INR 1 crore each to improve their capacities and faculty development programmes to train 300 faculty members for expanding schools in difficult states has been put in place. A paramedical and physiotherapy central council bill and a scheme to

set up a National Institute of Paramedical Sciences and eight regional institutes are under active consideration. There is a need to produce a large number of trained health workers across all categories of health work force. (AR, MHFW, 2005-10) A national health human resource policy which maps the current deficits, and also projects the need for 2020, will help define the number and location of new institutions needed for training doctors, nurses, dentists, paramedics and other health workers. Appropriate monetary and non monetary incentives are critical to encourage qualified health workers to serve and remain in remote rural areas. These could involve providing health workers with packages of monetary and non monetary incentives to attract them to serve in underserved areas. The expansion of professional education and the improvement in quality professionals require systems of continuing education, accreditation and regulation. This calls for improved governance and reform of current regulatory bodies and professional councils.

c. Private Health Sector vs. NRHM

Over the years the share of private sector in the provision of health care has at about 80 percent of all outpatient care and about 60 percent of all in-patient care. The private sector in India has a dominant presence in all the sub-markets – medical education and training, medical technology and diagnostics, pharmaceutical manufacture and sale, hospital construction and ancillary services and, finally, the provisioning of medical care. Over 75 percent of the medical human resources and advanced medical technology, 68 percent of an estimated 15,097 hospitals and 37 percent of 623,819 total beds in the country are in the private sector. Of these most are located in urban areas. The private sector's predominance in the health sector has led to inequities in access to health care.

In government the upgrading facilities at all levels in all states has been a major achievement. In infrastructure alone, this period has seen new buildings for 9,144 sub-centers, 1,009 PHCs, 435 CHCs and 57 district hospitals. Another 8,997 sub-centers, 2,081 PHCs, 1,255 CHCs and 357 district hospitals have had their infrastructure renovated or upgraded. Every public health facility now receives an annual untied fund as grant for local initiatives to upgrade it. With addition of new human resources and skills over 8,324 PHCs have reached 24x7 functionality status and 2,463 are being upgraded to FRUs. (NRHM, 2005-10) This reflected in the increasing figures of out-patient attendance and institutional deliveries across all states. Programmes and facility management has been strengthened by the addition of management- and accounts – trained contractual staff in every district and in a large number of hospitals. Further, a large number of health officers playing administrative roles have completed or are undergoing training in public health management.

d. Funding of Health Sector

From a public policy point of view, it is desirable that health financing is so arranged that it reduces the overall out-of-pocket (OOP) expenditure on healthcare, and protects against financial catastrophe related to healthcare. The global standard related to the 'desirable' limit of OOP to protect people from financial catastrophe is less than 15 percent of total health spending. In contrast, in India, the OOP is to the tune of 71 percent of total health spending. The per capita public health spending is low in India, being among the five lowest in the world. The public expenditure in the country over the years has been comparatively low, and as a percentage of GDP it has declined from 1.3 percent in 1990 to 0.9 percent in 1999, increased marginally to 1.1 percent by 2009. The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 percent, but has almost doubled to 2 percent by 2008-09. As per the NHA (2004-05), the total health expenditure in India, from all the sources, was INR 1,33,776 crores, constituting 4.25 percent of the GDP. Of the total health expenditure, the share of private sector was the highest at 78.05 percent, public sector at 19.67 percent and external flows contributed 2.28 percent. The provisional estimates from 2005-06 to 2008-09 show that health expenditure as a share of GDP came down to 4.13 percent in 2008-09. Though health expenditure has increased in absolute terms, the proportionately higher growth of GDP has resulted in a moderate increase in the share of health expenditure to GDP over the years. But the share of public health expenditure in the GDP has increased consistently from 2005-06 to 2008-09. The central and state governments in India have been increasing their expenditure on health, especially since 2005-06, due to the focus on health with the launch of NRHM. The union health budget increased from INR 5,255 crores in 2000-01 to INR 8,086 crores in 2004-05 and INR 21,680 crores in 2009-10 while that of states for 2009-10 was INR 43,848 crores. (NRHM, 2005-10)

Out-of-pocket expenditure (OOP) on healthcare forms a major barrier to health seeking in India. According to National Sample Survey Organisation, the year 2004 saw 28 percent of ailments in rural areas go untreated due to financial reasons – up from 15 percent in 1995-96. Similarly, in urban areas, 20 percent of ailments were untreated due to financial reasons – up from 10 percent in 1995-06. Those who access 'free' government health services are expected to purchase medicines from private pharmacies; pay user fees for laboratory tests and of course the ubiquitous informal fees.

Apart from public expenditure on direct provision of healthcare, the central and state governments have also initiated various innovative schemes to increase access and choice of healthcare provider (public and private) to the people, especially in the form of various subsidized health insurance schemes. Launched in 1st October 2007, the RSBY provides coverage to workers in the unorganized sector who come in the category of Below Poverty Line (BPL) with a total assured sum of INR 30,000 per family per annum. Of the estimated premium of INR 750 per family, the government of India contributes 75 percent and the remaining 25 percent comes from the state government. In the year 2008-09, the central government outlay for the RSBY was INR 205 crores; and until December 2009, 22 states and union territories had initiated the scheme across 172 districts covering 2.98 crore households. Many state governments have initiated health insurance schemes for the BPL population and unorganized workers. Some of the notable schemes are the Arogyasri Yajona (Andhra Pradesh), Kalaingar Insurance Scheme for Life-Saving Treatments (Tamil Nadu), Suvarna Arogya Surakshya Scheme (Karnataka), and Mukhya Mantri BPL Jeevan Raksha Kosh (Rajasthan). The focus of these schemes is to cover identified tertiary care diseases which involve catastrophic expenditure and are not covered under any other pre-existing health programmes. Further many states have adopted RSBY / Arogyasri model to suit their requirements and launched health insurance programmes. Haryana, Maharashtra, Pondicherry, Tamil Nadu, Karnataka, Assam, Himachal Pradesh, Kerala, Sikkim, Uttarakhand, and Jammu and Kashmir have initiated various models of health insurance schemes in 2008-09 and 2009-10. India should reiterate its commitment to achieving a target of increasing public spending on health to 3 percent of the GDP. Public expenditure falls short of the target of 2 percent of the GDP, as suggested in the Eleventh Five Year Plan document. In order to achieve that target the public expenditure on health will have to increase to around INR 1,60,000 crores by 2011-12 as against the budgeted amount of INR 66,000 crores in 2009-10 by the center and the state put together. This will imply that the annual expenditure in health sector will have to increase by 56 percent per annum in the next two years. The Tax/ Revenue- GDP ratio in India is 12.7 percent as against the 27 percent global average. This clearly shows that increasing tax-to-GDP ratio may go a long way in raising the level of public health spending to the desired levels, along with increasing the absorptive capacity in the states.

REFERENCES

1. Adams, A., and Castle, S., 1994, Gender relations and social dynamics' in G. Sen and A. Germain (eds), Population policy reconsidered: Health, Empowerment, and Rights, Boston, Harvard School of Public Health.
2. Aga Khan Foundation, 2007, Non-state providers and public private community partnership in education – contribution towards achieving EFA: A critical review of challenges, opportunities and issues, background paper for EFAGlobal monitoring report 2008.
3. Ahluwalia, M.S., 1978, Rural poverty in India: 1956-57 to 1973-74, World Bank Staff Working paper, Washington DC.
4. Annual Report of Ministry of Human Resource Development (MHRD), 2009-10, GOI, New Delhi.
5. Asian Development Bank (ADB) 2007, Key indicators 2007: Inequality in Asia, Manila, ADB.
6. Banerjee, A., Rohini, S. & Iyer, L., 2005, History, Social Divisions and Public Goods in Rural India, Journal of the European Economic Association, 3(2-3): 639-47.
7. Bhagwati, J., 1993, India in Transition: Freeing the economy, Oxford, Clarendon Press.
8. Bhor Committee Report, 1946, (Health Survey & Development Committee), Government of India, New Delhi.
9. Census India, 2001, Registrar General of India, New Delhi.
10. Chatterjee, G.S. and Bhattacharya, N., 1974, Between state variations in consumer prices and per capita household expenditure, in T.N. Srinivasan and P.K. Bardhan (eds), Poverty and income distribution in India, Calcutta, Statistical publishing society.
11. Deaton, A. and Dreze, J., 2002, Poverty and inequality in India, Economic and political weekly, 37 (36): 3729.

12. Deolalikar, A., 2005, Attaining the millennium development goals in India, New Delhi, Oxford University Press for the World Bank.
13. Eleventh Five Year Plan, (2007 – 2012), Planning Commission, Government of India, New Delhi.
14. Five Years of NHRM, 2005-2010, Ministry of Health and Family Welfare, Govt. of India, New Delhi.
15. Human Development Report 2010 - UNDP.
16. Human Resource for Health, Overcoming the crisis- Joint learning initiative (JLI), WHO, 2006-2015.
17. International Institute for population Sciences and Macro International (2007). National Family Health Survey (NFHS- 3) 2005- 2006, India: Volume 1, Mumbai, IIPS.
18. Khawaja, R.H., 2011, 19th June, Amazing Potential, the Times of India, Pune edition, India.
19. Ministry of Tourism, Government of India, 2010, Tourism statistics at a glance 2009, New Delhi, India.
20. Mohanty, M., 2006, Social inequality, labour market dynamics and reservation, Economic and Political Weekly, 41: 3777 -89.
21. Nair, R.S., 2009, Medical Tourism in India, Manorama, Kochi, India, PP – 572-577.
22. National Family Health Survey, 2005 – 06.
23. Population living below poverty line, 2004-05, Planning Commission, GOI, New Delhi.
24. PRATHAM (2005), Annual status of Education Report, New Delhi, Pratham documentation center, pratham.
25. Raghavan, N., 2010, December, Brain Wave, the Week – Anniversary special, Kochi, India, PP – 92-94.
26. Report of the National Commission on Macroeconomics and Health.
27. Sample registration system statistical report 2008 office of the Registrar General, India, Ministry of Home Affairs, New Delhi.
28. Sen, A.K., 1999, Development as freedom, Oxford, Oxford University Press.
29. Sharma, A., 2011- May, Alarming State of Child Nutrition in India, Kurukshetra, New Delhi, PP – 35-38.
30. State of World Population 2009- UNFPA.
31. State of World's Children 2009 – UNICEF.
32. Thomas, M.P., 2011, June, Silent but steady: A rediscovery of Ayurveda and its management of chronic ailments, the Week – Health, Kochi, India, PP – 17-25.
33. TNN, 19th June, 2011, For Body Mind & Soul, the Times of India, Pune edition, India.
34. TNN, 19th June, 2011, Sky's the limit, the Times of India, Pune edition, India.
35. Tondon, S., 2011, World health opportunity, Business World, April, India, PP- 28-34.
36. World Health Organisation [WHO], 2001, Private sector involvement in city health systems, Proceedings of a WHO conference meeting 14-16 Feb. Dunedin, New Zealand. www.who.int
37. World Health Report, 2002, Reducing risks, promoting healthy life, Geneva, WHO, www.who.int/whr/2002/en/.

REQUEST FOR FEEDBACK

Dear Readers

At the very outset, International Journal of Research in Commerce, Economics & Management (IJRCM) acknowledges & appreciates your efforts in showing interest in our present issue under your kind perusal.

I would like to request you to supply your critical comments and suggestions about the material published in this issue as well as on the journal as a whole, on our E-mails i.e. **infoijrcm@gmail.com** or **info@ijrcm.org.in** for further improvements in the interest of research.

If you have any queries please feel free to contact us on our E-mail **infoijrcm@gmail.com**.

I am sure that your feedback and deliberations would make future issues better – a result of our joint effort.

Looking forward an appropriate consideration.

With sincere regards

Thanking you profoundly

Academically yours

Sd/-

Co-ordinator