INTERNATIONAL JOURNAL OF RESEARCH IN COMMERCE, ECONOMICS & MANAGEMENT

IJRCM

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

Indexed & Listed at:

Ulrich's Periodicals Directory ©, ProQuest, U.S.A., EBSCO Publishing, U.S.A., Cabell's Directories of Publishing Opportunities, U.S.A.

as well as in Open J-Gage, India [link of the same is duly available at Inflibnet of University Grants Commission (U.G.C.)]

Registered & Listed at: Index Copernicus Publishers Panel, Poland

Circulated all over the world & Google has verified that scholars of more than 1500 Cities in 141 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

CONTENTS

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

FOUNDER PATRON

LATE SH. RAM BHAJAN AGGARWAL
Former State Minister for Home & Tourism, Government of Haryana
Former Vice-President, Dadri Education Society, Charkhi Dadri
Former President, Chinar Syntex Ltd. (Textile Mills), Bhiwani

CO-ORDINATOR

DR. BHAVET
Faculty, M. M. Institute of Management, MaharishiMarkandeshwarUniversity, Mullana, Ambala, Haryana

ADVISORS

DR. PRIYA RANJAN TRIVEDI
Chancellor, The Global Open University, Nagaland
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., HaryanaCollege of Technology & Management, Kaithal
PROF. S. L. MAHANDRU
Principal (Retd.), MaharajaAgrasenCollege, Jagadhri

EDITOR

PROF. R. K. SHARMA
Professor, Bharti Vidyapeeth University Institute of Management & Research, New Delhi

CO-EDITOR

DR. SAMBHAV GARG
Faculty, M. M. Institute of Management, MaharishiMarkandeshwarUniversity, Mullana, Ambala, Haryana

EDITORIAL ADVISORY BOARD

DR. RAJESH MODI
Faculty, Yanbu Industrial College, Kingdom of Saudi Arabia
PROF. SIKANDER KUMAR
Chairman, Department of Economics, HimachalPradeshUniversity, Shimla, Himachal Pradesh
PROF. SANJIV MITTAL
UniversitySchool 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
Head, Department of Economics & Rural Development, Dr. Ram Manohar Lohia Avadh University, Faizabad
DR. ANIL CHANDHOK
Professor, Faculty of Management, Maharishi Markandeshwar University, Mullana, Ambala, Haryana
DR. ASHOK KUMAR CHAUHAN
Reader, Department of Economics, KurukshetraUniversity, Kurukshetra
DR. SAMBHAVNA
Faculty, I.I.T.M., Delhi
DR. MOHENDER KUMAR GUPTA
Associate Professor, P.J.L.N.GovernmentCollege, Faridabad
DR. VIVEK CHAWLA
Associate Professor, Kurukshetra University, Kurukshetra
DR. SHIVAKUMAR DEENE
Asst. Professor, Dept. of Commerce, School of Business Studies, Central University of Karnataka, Gulbarga

ASSOCIATE EDITORS

PROF. ABHAY BANSAL
Head, Department of Information Technology, Amity School of Engineering & Technology, Amity University, Noida
PARVEEN KHURANA
Associate Professor, MukandLalNationalCollege, Yamuna Nagar
SHASHI KHURANA
Associate Professor, S.M.S.KhalsaLubanaGirlsCollege, Barara, Ambala
SUNIL KUMAR KARWASRA
Principal, AakashCollege of Education, ChanderKalan, Tohana, Fatehabad
DR. VIKAS CHOUDHARY
Asst. Professor, N.I.T. (University), Kurukshetra

TECHNICAL ADVISORS

MOHITA
Faculty, Yamuna Institute of Engineering & Technology, Village Gadholi, P. O. Gadhola, Yamunanagar
AMITA
Faculty, Government M. S., Mohali

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; Management 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 and 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 address: infoijrcm@gmail.com.

GUIDELINES FOR SUBMISSION OF MANUSCRIPT

1. **COVERING LETTER FOR SUBMISSION:**

DATED: _____

THE EDITOR
IJRCM

Subject: **SUBMISSION OF MANUSCRIPT IN THE AREA OF.**

(e.g. Finance/Marketing/HRM/General Management/Economics/Psychology/Law/Computer/IT/Engineering/Mathematics/other, please specify)

DEAR SIR/MADAM

Please find my submission of manuscript entitled '_____' for possible publication in your journals.

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 elsewhere.

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

NAME OF CORRESPONDING AUTHOR:
Designation:
Affiliation with full address, contact numbers & Pin Code:
Residential address with Pin Code:
Mobile Number (s):
Landline Number (s):
E-mail Address:
Alternate E-mail Address:

NOTES:

a) The whole manuscript is required to be in ***ONE MS WORD FILE*** only (pdf. version is liable to be rejected without any consideration), which will start from the covering letter, inside the manuscript.
b) The sender is required to mentionthe following in the **SUBJECT COLUMN** of the mail:
New Manuscript for Review in the area of (Finance/Marketing/HRM/General Management/Economics/Psychology/Law/Computer/IT/ Engineering/Mathematics/other, please specify)
c) There is no need to give any text in the body of mail, except the cases where the author wishes to give any specific message w.r.t. to the manuscript.
d) The total size of the file containing the manuscript is required to be below **500 KB**.
e) Abstract alone will not be considered for review, and the author is required to submit the complete manuscript in the first instance.
f) The journal gives acknowledgement w.r.t. the receipt of every email and in case of non-receipt of acknowledgment from the journal, w.r.t. the submission of manuscript, within two days of submission, the corresponding author is required to demand for the same by sending separate mail to the journal.

2. **MANUSCRIPT TITLE:** The title of the paper should be in a 12 point Calibri Font. It should be bold typed, centered and fully capitalised.

3. **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.

4. **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. Abbreviations must be mentioned in full.

5. **KEYWORDS:** Abstract must be followed by a 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.

6. **MANUSCRIPT:** Manuscript must be in ***BRITISH ENGLISH*** prepared on a standard A4 size ***PORTRAIT SETTING PAPER***. 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 every page. It should be free from grammatical, spelling and punctuation errors and must be thoroughly edited.

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 follow the following sequence:

INTRODUCTION

REVIEW OF LITERATURE

NEED/IMPORTANCE OF THE STUDY

STATEMENT OF THE PROBLEM

OBJECTIVES

HYPOTHESES

RESEARCH METHODOLOGY

RESULTS & DISCUSSION

FINDINGS

RECOMMENDATIONS/SUGGESTIONS

CONCLUSIONS

SCOPE FOR FURTHER RESEARCH

ACKNOWLEDGMENTS

REFERENCES

APPENDIX/ANNEXURE

It should be in a 8 point Calibri Font, single spaced and justified. The manuscript should preferably not exceed ***5000 WORDS***.

10. **FIGURES & TABLES:** These should be simple, crystal clear, centered, separately numbered & self explained, and **titles must be above the table/figure**. **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. 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 the 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, Nigeria.

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.

WEBSITES

- Garg, Bhavet (2011): Towards a New Natural Gas Policy, Political Weekly, Viewed on January 01, 2012 http://epw.in/user/viewabstract.jsp

RURAL HEALTH- AN ENGINE FOR ECONOMIC DEVELOPMENT

SHEETAL SHARMA
ASSOCIATE PROFESSOR
INSTITUTE OF INTEGRATED & LEARNING MANAGEMENT
ACADEMY OF HIGHER LEARNING
LUCKNOW

DR. PAVNESH KUMAR
PROFESSOR
INSTITUTE OF INTEGRATED & LEARNING MANAGEMENT
ACADEMY OF HIGHER LEARNING
LUCKNOW

ABSTRACT

The health of a nation is an essential component of development, vital to the nation's economic growth and internal stability. Health is increasingly seen as a robust predictor of economic growth and assuring a minimal level of health care to the population is a critical constituent of the development process. While rising incomes could lead to better health, the relationship also works in the opposite direction. Since independence despite focused health reforms and several growth orientated policies have been adopted by the government, the widening economic, regional and gender disparities are posing serious challenges for the health sector widening the gap between 'urban and rural'. While the urban middle class in India have ready access to health services that compare with the best in the world, even minimum health facilities are not available to a large majority of rural people, and wherever services are provided, they are inferior. This paper, based on secondary data research, attempts to analyze the relationship between investing in health and the economic development of a country. It also presents the statistical overview of rural health in India evaluating the extent to which advances have been made in rural health systems in the country and analyze the gaps .It focus on the major initiative taken by the government in the realm of public policy with special focus on NRHM, in order to reap benefits for economic development and poverty reduction.

KEYWORDS
gender disparities, poverty,economic growth.

JEL CLASSIFICATION
H-70, Z-18.

INTRODUCTION

Until the early 1990s, health was relatively neglected as a factor that influences national economic performance. But today, improvements in health constitute an important element of what has come to be known as 'pro-poor' economic growth strategies that have the potential of enhancing economic growth, while simultaneously reducing economic inequality. The policies implemented so far, which concentrate only on growth of economy not on equity and equality, have widened the gap between 'urban and rural'.

The country's Registrar General said in 2005, "India lives in its villages." A large majority of Indians live in relatively small localities and are engaged in farming or some activity related to farming. In 2001, the average Indian lived in a village of about 4,200 people; 72 percent of India's total population was classified as rural, and 58 percent of workers were engaged in agriculture.

The rural populations, who are the prime victims of the policies, work in the most hazardous atmosphere and live in abysmal living conditions. Unsafe and unhygienic birth practices, unclean water, poor nutrition, subhuman habitats, and degraded and unsanitary environments are challenges to the public health system. The majority of the rural populations are smallholders, artisans and labourers, with limited resources that they spend chiefly on food and necessities such as clothing and shelter. They have no money left to spend on health. The rural peasant worker, who strives hard under adverse weather conditions to produce food for others, is often the first victim of epidemics.

A pro-poor health approach includes quality public health and personal care services, with equitable financing mechanisms. But it goes beyond the health sector and includes policies in areas that disproportionately affect the health of the poor, such as education, nutrition, water and sanitation etc.

REVIEW OF LITERATURE

Understanding Health Wealth Nexus

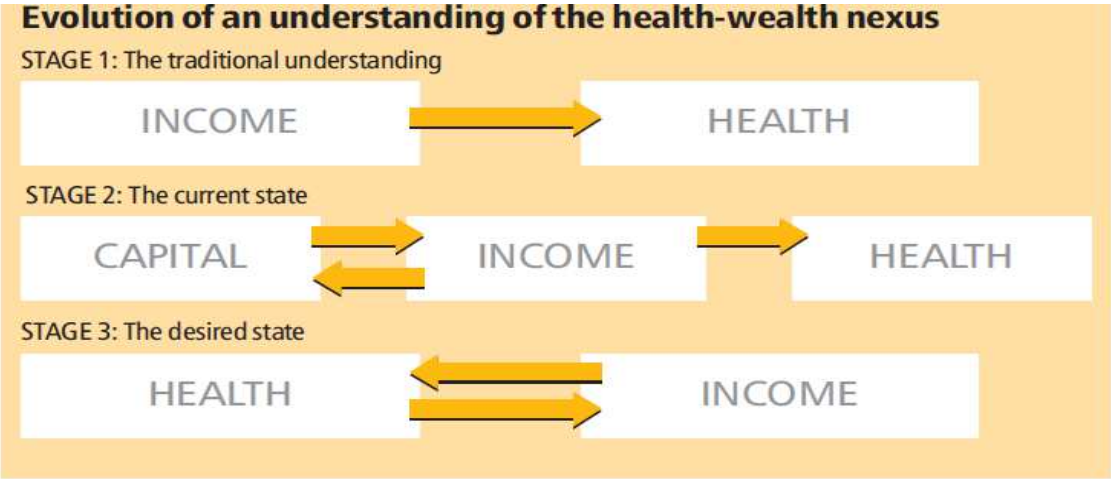
How does health influence economic growth? A recent survey of econometric literature on the link between health and economic growth suggests that a 5-year gain in life expectancy is associated with annual average rates of growth of real Gross Domestic Product (GDP) per capita that are higher by 0.06 to 0.58 percentage points.

One analysis found that countries with high levels of malaria had much lower levels of per capita income. Several studies demonstrate that the HIV/AIDS epidemic has either lowered, or will significantly lower, the rates of growth of income per capita .There is now a considerable body of international evidence that suggests that while improvements in national economic performance may positively influence health, there also appears to be a strong link running from improved health to improved economic performance. Good health contributes to development in a number of ways such as higher labour productivity, higher rates of domestic and foreign investment, improved human capital, higher rates of national savings and demographic changes.

According to WHO Commission on Macroeconomics and Health (CMH) report (Dec2001) the typical quantitative impact of life expectancy on economic growth was estimated to be of the following magnitude: a 10% increase in life expectancy at birth increases economic growth by at least 0.3–0.4% of gross domestic product (GDP) per year. The report also identified a number of cost-effective investments that would save millions of lives and result in billions of dollars worth of economic growth. It concluded that investment in essential health services for the poor would help millions of people to emerge from poverty as well as contribute in important ways to overall economic growth.

India is currently in stage 2 as depicted in **Box 1** below:

BOX 1: A RAPID TRANSITION IS NEEDED IN WHICH EFFICIENT HEALTH SYSTEMS IMPROVE QUALITY OF LIFE, WELL-BEING OF PEOPLE AND REDUCE BURDEN OF DISEASES, WHICH WILL IN TURN INCREASE PRODUCTIVITY AND GROWTH IN THE COUNTRY (STAGE 3).



Source: Report of the National Commission on Macroeconomics and Health

Recent research has established a strong causal association running from health to aggregate economic performance and from wealth to health. Higher incomes potentially permit individuals and societies to afford better nutrition and access to better health care; better health increases productivity, and enhances the ability to earn more income. The relationship between health and development is mutually reinforcing- while health contributes to economic development, economic development, in turn, tends to improve the health status of the population in a country. Health is also an important entitlement that enhances "capabilities" of the poor people leading to increase in "commodities" and further improvement in health status (Dadibhavi and Bagalkoti 1994; Bloom et al 2004). As investment on health increases, the productive capacity of the working population, and hence the level of income tends to rise and to that extent it contributes to a decline in the incidence of poverty (Reddy and Selvaraju 1994). With rapid improvement in health, particularly of the poor "vicious circle" of poverty can be converted into "virtuous circle" of prosperity (Mayer 1999;Mayer 2000;Bloom et al 2004). Although there has been a two-way relationship, a strong causal link from adult health to economic growth is observed by many studies (Mayer 1999; Knowles and Owen 1997; Jamison and Wang 1998). Further, Knowles and Owen (1997) and Jamison and Wang (1998) found that life expectancy contributes to economic growth more than education. In addition to its direct impact on productivity, health has other effects on economic development and demographic transition. Good infant health and nutrition directly increase the benefits of education (WB 1993; WHO 1999). Further, Barro (1996) points out that by increasing longevity, health reduces the depreciation rate of human capital, making investment in education more attractive.

RESEARCH QUESTION

The researches have established that, health is an asset individuals possess, which has intrinsic value (being healthy is a very important source of well-being) as well as instrumental value in the terms that health impacts economic growth in a number of ways. Since health is not only the absence of illnesses; it is also the ability of people to develop to their potential during their entire lives. This present paper attempts to review critically the current rural health status of India and probe -**Are we investing well in Rural Health development?**

STATISTICAL OVERVIEW RURAL HEALTH

The rural health system of India is plagued by serious resource shortfall and underdevelopment of infrastructure leading to deficient health care for a majority of India. The differences in urban-rural health indicators are a harsh reality even today; infant mortality rate is 62 per thousand live births for rural areas as compared to 39 per thousand live births for urban areas (2007). [(1)] Only 31.9% of all government hospital beds are available in rural areas as compared to 68.1% for urban population. When we consider the rural-urban distribution of population in India, this difference becomes huge. Based on the current statistics provided by the Government of India, we have calculated that at a national level the current bed-population ratio for Government hospital beds for urban areas (1.1 beds/1000 population) is almost five times the ratio in rural areas (0.2 beds/1000 population) [(2) (3)]

The strong link between poverty and ill health needs to be recognized. High health care costs can lead to entry into or exacerbation of poverty. The importance of public provisioning of quality health care to enable access to affordable and reliable heath services cannot be underestimated The country has to deal with rising costs of health care and growing expectations of the people.

Since Independence, India has built up a vast health infrastructure and health personnel at primary, secondary, and tertiary care in public, voluntary, and private sectors. For producing skilled human resources, a number of medical and paramedical institutions including Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) institutions have been set up.

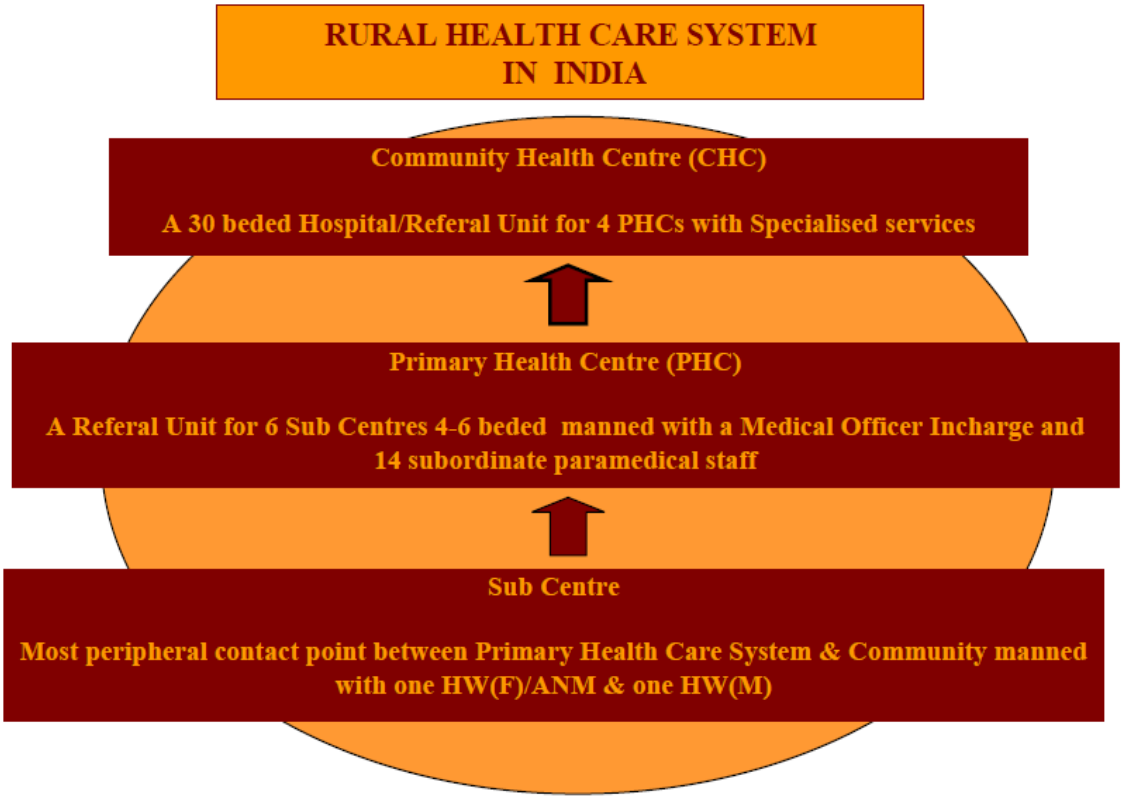
While a significant portion of the country's medical needs, especially in rural areas, have been attended to by the indigenous health systems such as Ayurveda, homeopathy, *unani*, naturopathy and folk medicine, it has been conveniently neglected by the policy makers, and planners. The draft of the new National Health Policy 2001, has also not given due importance to Indian systems of medicine.

Apart from this shortfall in infrastructure, shortfall in trained medical practitioners willing to work in rural areas is also one of the factors responsible for poor health care delivery systems in rural areas. The number of trained medical practitioners in the country is as high as 1.4 million, including 0.7 million graduate allopaths. [(4)] However, the rural areas are still unable to access the services of the qualified doctors. A total of 74% of the graduate doctors live in urban areas, serving only 28% of the national population, while the rural population remains largely unserved. **[(4)]** There's shortfall of 8% doctors in Primary Health Centres (PHC), 65% for specialist at Community Health centres (CHC), 55.3% for health workers (male), 12.6% for health workers (female) (2007). [(5)]

HEALTH CARE HUMAN RESOURCES AND INFRASTRUCTURE: THE GAPS

To address the gaps in health infrastructure and human resources, the National Rural Health Mission (NRHM) was launched on 12 April 2005. A generic public health delivery system envisioned under NRHM from the village to block level is illustrated in chart 1 given below:

CHART 1



Source: Bulletin of Rural Health Statistics in India, Special Revised Edition, MOHFW; GoI (2006)

Since the mid-twentieth century, physicians have favored urban and suburban practice locations over rural areas. Physicians often need lucrative practices to repay high education debts, and they have been trained to use costly new technologies in diagnosis and treatment. Rural practice locations typically generate lower income for the physician and have fewer and older technology resources than urban and suburban locations. Modern medical school graduates are rarely well prepared to practice in rural environments. Consequently, rural communities suffer chronic physician shortages. Rural environments present unique challenges for health care access. There are often shortages of medical personnel in rural areas, as well as transportation and distance barriers to care and an increasing economic destabilization of rural health care services.

Availability of appropriate and adequately trained human resources is an essential concomitant of Rural Health Infrastructure. The present position, requirement, and shortfall regarding public health care human resources have been shown in the table given below:

TABLE 1: SHORTFALL IN HEALTH PERSONNEL-ALL INDIA

For existing Infrastructure	Required (R)	Sanctioned (S)	In Position(P)	Vacant(S-P)	Shortfall (R-P)
Multipurpose workers(Female)/ANM at Subcentres and PHC	1676567	162772	149695	13126 (8.06%)	18318 (10.93 %)
Health workers(Male)/MPW's (M) at Sub- Centres	144998	94924	65511	29437 (31.01%)	74721 (51.53%)
Health assistants(Female)/LHV at PHCs	22669	19874	17107	2781 (13.99%)	5941 (26.21%)
Health Assistants(Male) at PHCs	22669	24207	18223	5984 (24.72%)	7169 (31.62%)
Doctors at PHCs	22669	27927	22273	5801 (20.77%)	1793 (7.91%)
Total specialist at CHCs	15640	9071	3979	4681 (51.60%)	9413 (60.19%)
Radiographers at CHCs	3910	2400	1782	620 (25.83%)	1330 (34.02%)
Pharmacists at PHCs and CHCs	26579	22816	18419	4445 (19.48%)	4389 (16.51%)
Lab Technicians at PHCs and CHCs	26579	15143	12351	2792 (18.44%)	9509 (35.78%)

Note: For calculating the overall percentages of vacancy and shortfall, the states/UTs for which the human resource position is not available, have been excluded. Also all India shortfall is derived by adding State wise figures of shortfall ignoring the existing in some of the States.

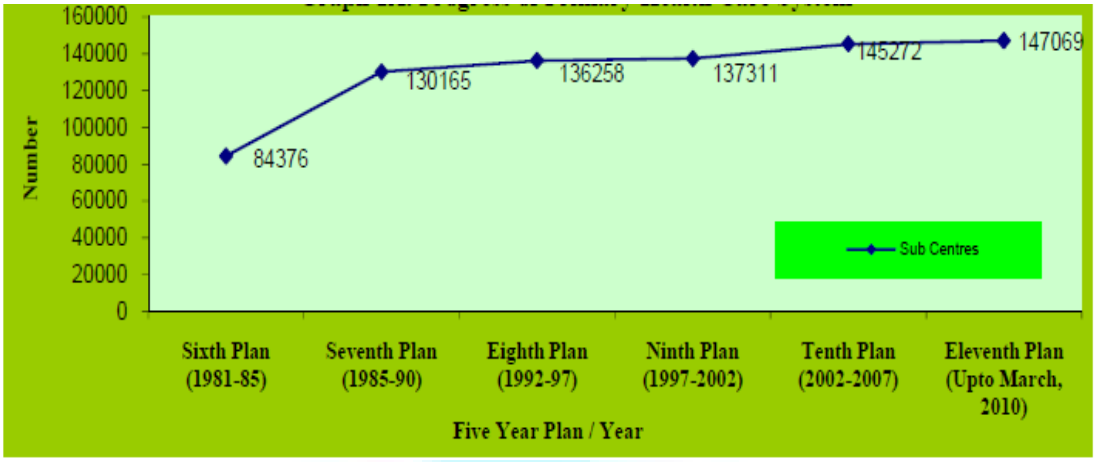
Source: Bulletin of Rural Health Statistics in India, Special Revised Edition, MOHFW; GoI(2006)

RURAL HEALTH INFRASTRUCTUE-A STATISTICAL OVERVIEW

The Primary Health Care Infrastructure has been developed as a three tier system with Sub Centre, Primary Health Centre (PHC) and Community Health Centre (CHC) being the three pillars of Primary Health Care System. Progress of Sub Centres, which is the most peripheral contact point between the Primary Health Care System and the community, is a prerequisite for the overall progress of the entire system. A look at the number of Sub Centres functioning over the years reveal that at the end of the Sixth Plan (1981-85) there were 84,376 Sub Centres, which increased to 1,30,165 at the end of Seventh Plan (1985-90) and to 1,45,272 at the end of Tenth Plan (2002-2007). As on March, 2010, 1,47,069 Sub Centres are functioning in the country.

Percentage of Sub Centres functioning in the Government buildings has increased from 50% in 2005 to 57.8% in 2010 Percentage of PHCs functioning in Government buildings has increased significantly from 78% in 2005 to 88.6% in 2010 The % of CHCs in Govt. buildings has increased from 90% in 2005 to 93.4% in 2010.

GRAPH 1: PROGRESS OF PRIMARY HEALTH CARE SYSTEM



Source : www.mohfw.nic.in- Rural Health Statistics 2010

TABLE 2: RURAL HEALTH INFRASTRUCTURE-NORMS AND LEVEL OF ACHIEVEMENTS (ALL INDIA)

SNO.	INDICATOR	NATIONAL NORMS		PRESENT AVERAGE COVERAGE
1.	**Rural population(2001)covered by a :**	**GENERAL**	**TRIBAL/HILLY /DESERT AREA**	
	SubCentre	5000	3000	5049
	Primary Healthcare centre(PHC)	30,000	20000	31364
	Community health centre(CHC)	1,20000	80000	163725
2.	**No. of Sub Centre**	6		5
3.	**No. of PHC per CHC**	4		5
4.	**Rural population (2001)covered by a:**			
	Health worker F (HW) at Sub centres & PHC	5000	3000	3878
	Health worker M (HW) at Sub centres	5000	3000	14069

Source: www.mohfw.nic.in, Rural Health Statistics 2010

RURAL HEALTH INITIATIVES

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system**.**

The State has taken following new initiatives and innovative programs within NRHM framework a few are discussed below:

1**. Reproductive and Child Health, Phase II (RCH II),** is a comprehensive sector wide flagship programme, under the bigger umbrella of the Government of India's (GoI) National Rural Health Mission (NRHM), to deliver the RCH II/NRHM targets for the reduction of maternal and infant mortality and total fertility rates. RCH II aims to reduce social and geographical disparities in the access and utilisation of quality reproductive and child health services. It was launched in April 2005 in partnership with the State Governments; it is consistent with the Government of India's National Population Policy-2000, the National Health Policy-2002 and the Millennium Development Goals.

2. **Janani Suraksha Yojana (JSY)** is a flagship programme of the GoI to promote institutional deliveries among poor pregnant women. It is a 100% centrally sponsored scheme, JSY integrates cash assistance with delivery and post-delivery care. Other demand-side financing options, as in the use of vouchers, also appear to be popular with both the private and public sectors being involved. Chiranjeevi Yojana in Gujarat is the frontrunner in adapting the JSY model for involving the private sector in providing safe delivery services. This model (JSY/Chiranjeevi model)has been awarded by several other the to further provide services in areas not covered by JSY or to boost the gains from JSY, including Saubhagyawati Scheme (Uttar Pradesh), Janani Suvidha Yojana (Haryana), Janani Sahyogi Yojana (Madhya Pradesh), Ayushmati Scheme (West Bengal), Chiranjeevi Yojana (Assam) and Mamta Friendly Hospital Scheme (Delhi).

3. **First Referral Units (FRUs)** is an essential component for the utilisation of services, particularly during emergencies. It aims at establishing referral linkages between the communities and in this regard flexibility has been given to the States for establishing such referral linkages. The States are coming up with their own innovative models to address the issue of delays in care, seeking for obstetric emergencies through the provision of transport in the form of various ambulance schemes. While originally envisaged as a readily available transport scheme for women with obstetric emergencies, ambulance services now cater to all emergencies. The Emergency Management and Referral Institute (EMRI) model has shown good results in Andhra Pradesh and is now being adopted by several States, including Chhattisgarh, Delhi, Gujarat,Jammu and Kashmir, Karnataka, Madhya Pradesh, Maharashtra, Orissa and Tamil Nadu.The Public Private Partnership (PPP) model is being used in Madhya Pradesh and Orissa (Janani Express Yojana) and in West Bengal (through NGOs).

4. There exist a major skilled manpower gap across states for Availability of providers skilled in management of obstetric emergencies is a. The GoI modified its policy to enable multi-skill training for selective interventions under specific emergency situations to save the life of the mothers. MBBS doctors are being trained in life saving anaesthesia skill and emergency obstetric care. The GoI has awarded a grant to the Federation of Obstetrics and Gynaecology Societies of India (FOGSI) to build the capacity of selected State medical colleges as nodal training centres for training MBBS doctors in emergency obstetric care. The Enhancing Quality Care in Public Health Care (EQUIP) programme in Chhattisgarh is the forerunner of this initiative.

5. **The Monthly Village Health and Nutrition Day (VHND)** is a major intervention of the GoI, rolled out nationwide, that provides comprehensive outreach services for pregnant women and children at their doorstep. Muskaan in Bihar is a variation of this. Assam, Bihar,Chhattisgarh, Madhya Pradesh and Uttar Pradesh are conducting bi-annual month-long campaigns for addressing child health and malnutrition through Vitamin A supplementation,provision of micronutrients, promotion of exclusive breastfeeding, de-worming, immunisation,etc. Nutrition rehabilitation centres have been established in Bihar, Chhattisgarh, Madhya Pradesh, Maharashtra and Rajasthan, for treating severe acute malnutrition in children.

West Bengal is piloting a 'Positive Deviance Approach' to identify the families with healthy babies (that is, 'positively deviant') and share their knowledge and practices with others in the same community.

6. **Saubhagyavati Yojana:** This is a Public Private Partnership, in which 133 nursing homes have already been registered in peri urban and rural areas. For every 100 deliveries conducted by any nursing home of BPL beneficiaries, Rs. 1.85 lacs will be paid. So far 2230 such deliveries have been conducted including 317 cesarean section.

7.**Comprehensive Child Survival Program:** Under this scheme IMNCI training is being given to ASHAs, ANMs and other workers with the help of FOGSI. Currently this scheme is operational in 17 districts spread over 17 divisions. So far 458 MOs, 812 ANM/HV & 4068 ASHAs have been trained. Training in Infant & Young Child Feeding is also conducted under this program in all the districts.

8. **Bal Swasthya Poshan Mah Strategy:** This is a month long program to be conducted twice a year. The first such program was held in December 2008.

9. **ASHIRVAD School Health Program**: In this program, 50 lakhs children are covered. The program was launched on 1 October 2008 and expected to cover 40 schools per block in all 813 blocks. This will comprise of health check up, health card for every student, and distribution of deworming drugs and Iron Folic Acid Tablets.

10. **Village Health & Nutrition Day:** To be observed twice a week at each health facility on Wednesday and Saturday. The activities will have emphasis on routine immunization and nutrional rehabilitation.

11. **SALONI: Swasth Kishori Yojana:** This scheme has been launched from 12 December 2008 and covers 10 lacs school going girls and 5 lacs non school going girls in 10 to 19 years age group. The non school going girls will be covered by locally selected NGOs. The package consist of counseling and personal hygiene and distribution of Iron & Folic Acid tablets and deworming drugs.

12**. Scheme for Adolescent Counseling for Health:** In order to provide information and counseling to 15 to 19 years of adolescents regarding reproductive & sexual health, nutrition and personal hygiene. The scheme is currently being implemented in 18 districts. The counseling centers will be opened at sub center level as Youth Information Center, at block level as Youth Information and Counseling Center (1 male and 1 female counselor)

CONCLUSION

The above analysis based on secondary data depicts that in India, there has been a gradual shift in the organization, structure, and delivery of health care services. Starting from the 1990s till now, reforms have focused on coordination between different sectors, involvement of Panchayati Raj Institutions in planning and monitoring health programmes, and making health services equally available to all. Health care is financed primarily by State Governments, and State allocations on health are usually affected by any fiscal stress they encounter. Besides chronic under funding, the sector has been plagued with instances of inefficiencies at several levels resulting in waste, duplication, and sub optimal use of scarce resources adversely effect. the public health sector's ability to provide health care services to the people.

Thus it can be concluded that the challenge of quality health services in remote rural regions has to be urgently met.. In order to do this, a comprehensive approach is needed that encompasses individual health care, public health, sanitation, clean drinking water, access to food, and knowledge of hygiene, and feeding practices. Health sector reforms need to broadly address reorganization and restructuring of the existing government health care system with the involvement of communities in health service delivery and provision, financial reforms, Health Management Information Systems-e- health, quality of care & public-private partnerships. Transformational approaches are desired in public health care system for an **accountable, accessible, and affordable health** for people, specially the poor and the underprivileged.

REFERENCES

REPORTS

1. Central Bureau of Health Intelligence, Ministry of Health and Family Welfare, Government of India. National Health Profile - 2007. 2008.
2. Ministry of Health and Family Welfare, Government of India, Bulletin on Rural Health Statistics, 2007. Available from: www.ijcm.org.in
3. Ministry of Health and Family Welfare, Government of India. Report: Task Force on Medical Education for the National Rural Health Mission. Chapter I: Overview of the National Health System. p. 9.
4. Registrar General and Census Commissioner, India. Projected Population. 2007.
5. Registrar General of India. Sample Registration System Bulletin; Vol. 42. 2007. p. 1-6

JOURNALS

6. Barro, R. (1996), "Health and Economic Growth", Annex I of the Convocatoria para propuestas de investigacion sobre Inversion en Salud y Crecimiento Economico de la Organizacion Panamericana de la Salud.
7. Bloom, David E., David Canning and Dean T. Jamison (2004), "Health, Wealth and Welfare", Finance and Development, Vol. 41, No. 1, March.
8. Dadibhavi, R. V and S. T. Bagalkoti (1994), "Inter-State Disparities in Health Status in India", Yojana, December 31.
9. Dynamics of Brazil, 1980-1995", paper presented at the conference on Population Dynamics and the Macro Economy organised by Harvard Centre for Population and Development Studies and IFS. September.
10. Jamison, Lau and Wang (1998), "Health's Contribution to Economic Growth, 1965-1990", in Health, Health Policy and Health Outcomes: Final Report, Health and Development Satellite WHO Director-General Transition Team.
11. Knowles, S. and Owen, P. D. (1995), "Education and Health in an Effective-Labour Empirical Growth Model", Economics-Record, Vol. 73 (223), April.
12. Mayer, D. (1999), "The Long-Term Impact of Health on Economic Growth in Latin America", in Health, Growth and Income Distribution in Latin America and the Caribbean: A Study of Determinants and Regional and Local Behavior, Project Report for the Pan American Health Organisation.
13. Mayer, David (2000), "On the Role of Health in the Economic and Demographic
14. Panchamukhi, P. R. (2000), "Social Impact of Economic Reforms in India: A Critical Appraisal, Economic and Political Weekly, March 4.
15. Reddy, K. N. and V. Selvaraju (1994), "Determinants of Health Status in India: An empirical Investigation, The 76th Annual Conference Volume of the Indian Economic Association, Indira Gandhi Institute of Development Research, Bombay.
16. W B (1993), "World Development Report 1993: Investing in Health", Oxford University Press, New York.
17. World Health Organisation (WHO) (1999),"World Health Report: Making a Difference",Geneva.

WEBSITES

18. Registrar General, India, Census and You (New Delhi: Government of India, 2005): 14./accessed on 14.5.2011
19. www.cbhidghs.nic.in accessed on 17.3.2012
20. www.censusindia.gov.in accessed on 17.3.12
21. www.censusindia.net, Registrar General and Census Commissioner, India /accessed on 21.5.11
22. www.mohfw.nic.in accessed on 2.2.12
23. www.nfhsindia.org ,National Family Health Survey Ministry of Health and Family Welfare, New Delhi/ accessed on 10.1.12
24. www.oecd.org/dac accessed on 2.2.12

REQUEST FOR FEEDBACK

Dear Readers

At the very outset, International Journal of Research in Commerce, Economics and 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-mail **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

ABOUT THE JOURNAL

In this age of Commerce, Economics, Computer, I.T. & Management and cut throat competition, a group of intellectuals felt the need to have some platform, where young and budding managers and academicians could express their views and discuss the problems among their peers. This journal was conceived with this noble intention in view. This journal has been introduced to give an opportunity for expressing refined and innovative ideas in this field. It is our humble endeavour to provide a springboard to the upcoming specialists and give a chance to know about the latest in the sphere of research and knowledge. We have taken a small step and we hope that with the active co-operation of like-minded scholars, we shall be able to serve the society with our humble efforts.

Our Other Journals