A.V.V.M. SRI PUSHPAM COLLEGE (AUTONOMOUS),
POONDI – 613503, THANJAVUR – DT.

STAFF PROFILE as on : 2012

1. Name of the Staff : **Dr. U.SELVAKUMARI**
2. Designation : **Asst. Professor**
3. Academic Qualification : **M.A, M.Phil., Ph.D.,**

Course	UG	PG	M.PHIL.	PH.D.
Year	1997	2000	2008	2017
College & University	KNGAC Thanjavur Bharathidasan University	Annamalai University	Bharathidasan University	Bharathidasan University

4. Date of Birth & Age : 21.07.1977

5. Date of Appointment :

		D	D	M	M	Y	Y	Y	Y
Self – Finance	:	0	6	0	7	2	0	1	1
FIP	:								
Aided	:	0	2	1	2	2	0	1	9

6. Total Service : 10
7. Teaching Experience in completed years : UG 10 PG 10 M.Phil. 6
8. Residential Address : Plot No.3, 8th Cross, Arulanantha Nagar, Thanjavur

   Mobile Number : 80567062387

   E-Mail Address : Selvisriithi05@gmail.com
9. No. of Orientation / Refresher Courses and Training Programmes attended : 1 Annexure – I
10. Whether FDP availed, if yes, furnish details : Nil Annexure – II
11. No. of Seminars attended : 2 Annexure – III
12. No. of Papers Presented : 4 Annexure – IV
13. No. of Papers Published : 8 Annexure – V
14. No. of Books Published : Nil Annexure – VI
15. No. of Guest Lectures delivered in other institutions : Nil Annexure – VII
16. No. of Research Projects undertaken : Minor _____ Major _____ Others (Specify) _____ Annexure – VIII
17. No. of Seminars organised : Annexure – IX
18. No. of. M.Phil. Scholars Guided : Completed _____ Ongoing _____ Annexure –X
19. No. of. Ph.D. Scholars Guided : Awarded _____ Ongoing _____ Annexure – XI
20. Participation in Academic Research Bodies in other institutions : Nil Annexure – XII
21. Service rendered in academic / Extra Curricular/ Extension activities within the College other than teaching : Nil Annexure – XIII
22. Service rendered in Professional bodies outside the College : Nil Annexure – XIV
23. Honors / Awards received : Nil Annexure – XV

Signature of the Staff

Note: Evidence should be produced at the time of verification of the Profile.

ANNEXURE – I

DETAILS OF ORIENTATION, REFRESHER COURSES AND TRAINING PROGRAMMES ATTENDED:

SL. NO.	COURSE	UNIVERSITY	PERIOD	TITLE
1.				
2.				
3.				
4.				
5.				
6.				

ANNEXURE – II

WHETHER FDP AVAILED, IF YES, FURNISH DETAILS

Name of the institution	Period of Study	Date of submission	awarded

ANNEXURE – III

SEMINARS/CONFERENCES, SYMPOSIA, WORKSHOPS, ETC ATTENDED

Sl. No.	Title of the Seminars/Conferences, Symposia, Workshops	Level (State / National / International	Sponsoring Agency and Name of the Institution	Date
1.	Food Insecurity	National Seminar	UGC J.M.C. Trichy.	23rd – 24th Sep-2011

ANNEXURE – IV

PAPERS PRESENTED IN SEMINARS/CONFERENCES, SYMPOSIA, WORKSHOPS, ETC

Sl. No.	Title of the Paper	Level (State / National / International	Sponsoring Agency and Name of the Institution	Date
1.	Food Insecurity	National Seminar	U.G.C. A.V.V.M. Sri Pushpam College (Aut), Poondi	24th & 25th March-2012
2.	Public expenditure on Health sector in India – Recent trend	National Seminar	Jamal Mohamed College (Aut), Trichy	25th Feb. 2014
3	Agricultural problems in Health care	National Seminar	Jamal Mohamed College (Aut), Trichy	25th & 26th Aug. 2014
4	Caesarean Section Delivery – Indian Scenario	International eminar	Rajah Serfoji Govt. Arts College (Aut), Thanjavur	9th J6an. 2015 ISSN0974-8709
5	Women and Fertility behaviour	National Seminar	Jamal Mohamed College (Aut), Trichy	10th Feb. 2015
6	Economic of Investment in Health sector	International Seminar	Sengamala Thayar Educational Trust & College, Mannargudi	4th Sep. 2015 ISBN:978-81-931094-96
7	Tamilnadu integrated Child Development	AET	Kandhasamy Kandar College, Vellore	28th & 29th Nov. 2015 ISSN 0976-8270
8	Pathway to reforming health care	AET	Urumu Dhanalskshmi College, Thiruverumbur	23rd Sep. 2016
9	Health status of Tamilnadu	AET	Erode Arts and Science College, Erod	19th Nov. 2016 ISSN 0976-8270
10	Nutrition and Health care	National Seminar	Govt. Women's Arts College, Kumbakonam	15th & 16th Dec. 2016
11	Women and The Environment of Decent Work	National Seminar	A. V. V. M Sri Pushpin College, Poondi	20---21 March 2015 ISBN: 978-93-81429-57-0
12	Health status	IARA	Queens college, Thanjavur	Sep-27-2019 ISSN:2250-1940

ANNEXURE – V

RESEARCH PAPERS PUBLISHED:

Sl. No.	Title of the Paper	JOURNAL			Page Number
		Name	Volume	Year / Month of Publication	
1	Health care – An emerging industry in India	Shankya Intl. Journal of Business Mgmt.	Vol – III Iss (II)	Sept. 2012	300-302

ANNEXURE – VI

BOOKS PUBLISHED:

Sl. No.	Name of the Book / Title of the Article / Book / Editor	Publisher	Place and Year of Publication

ANNEXURE – VII

GUEST LECTURES DELIVERED:

Sl. No.	Title of the Guest Lecture	Place	Date

ANNEXURE – VIII

RESEARCH PROJECTS – ONGOING AND COMPLETED:

SL. No.	Title of the project	Minor/ Major	Name of the Funding Agency	Period	Amount Sanctioned	UC Submitted If Yes, Date and Year

ANNEXURE – IX

SEMINARS, CONFERENCES, SYMPOSIA, WORKSHOPSORGANIZED:

Sl. No.	Title of the Seminar/Conference/Symposia Workshop	Name of the Sponsoring Agency	Amount Sanctioned	Period	UC submitted If Yes, Date and Year

ANNEXURE – X

Research Experience (M.Phil.) – Guided and Guiding

Sl. No.	Name of the Scholar	Title of the Dissertation	Year of Study	University

ANNEXURE – XI

Research Experience (Ph.D.) – Awarded, Submitted and Guiding

Sl. No.	Name of the Scholar	Title of the Thesis	Year of Study	University

ANNEXURE – XII

PARTICIPATION IN ACADEMIC RESEARCH BODIES IN OTHER INSTITUTIONS:
(Mention the period in the relevant column)

Name of the Institution	Academic Council	BOS	Research committee	Academic Audit committee	Member in University committee	Any other (specify)

ANNEXURE – XIII

SERVICE IN ACADEMIC / EXTRA CURRICULAR/ EXTENSION ACTIVITIES

Sl. No.	Name of the Activity	Period
.	Tutor	Since 2011 To 2021

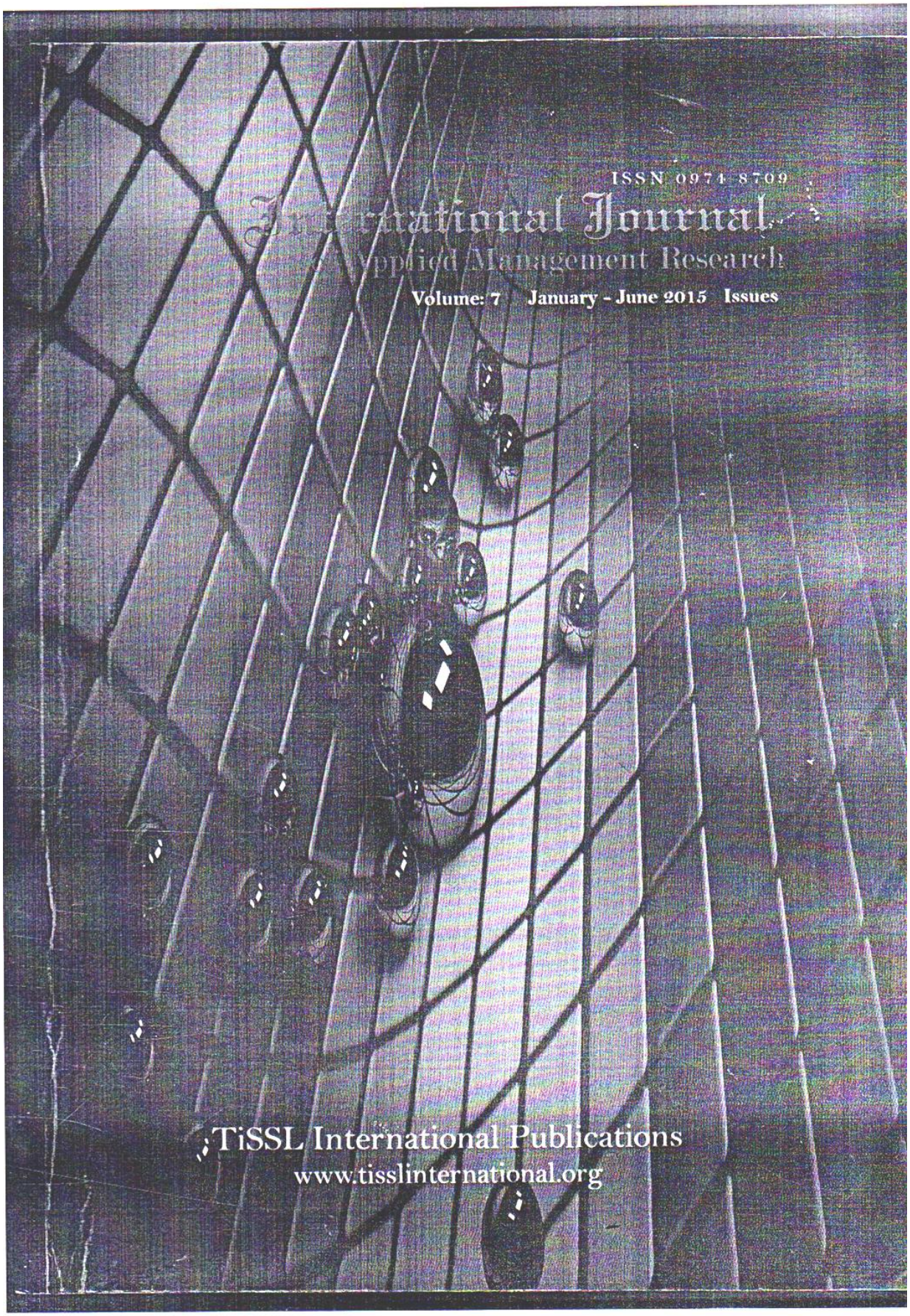
ANNEXURE – XIV

MEMBERSHIP IN PROFESSIONAL BODIES

Name of the Professional Body	National/International	Period

ANNEXURE – XV

HONORS AND AWARDS RECEIVED



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2. Improving efficiency and the quality of care in the health sector by fostering competition.
3. Supplying high technology services which the public sector cannot afford and
4. Offering health consumers a choice to supplement and to enlarge the field through innovation.

On the other hand private providers are often more technically efficient than the public sector and offer a service of higher quality but are not regulated and supported by Government policies. That is why in these low income countries out-of pocket spending accounts for more than half of total spending for health. Governments must concentrate in health, welfare, income growth and all aspects of development. Emphasis needs to be placed on education for girls, allocating more resources in highly cost effective public health activities that can substantially improve the health of poor and financing of essential health care and clinical services. There is substantial scope for reduction of waste and inefficiency in government health programmes especially in drug management.

Conclusion

The private health sector should serve the top 20 per cent of the population who would pay from out pocket or insurance. The rich who mare a tiny majority in these developing countries should be encouraged to get their problems treated in private health care units so that the poor have easy care. On increasing public spending on basic clinical interventions and public health measures, governments need to encourage economic growth which increases the ability of households to access health services. In fact there is a mutually reinforcing cycle from improved health standards to higher productivity and stronger economic growth.

CAESAREAN SECTION DELIVERY - INDIAN SCENARIO

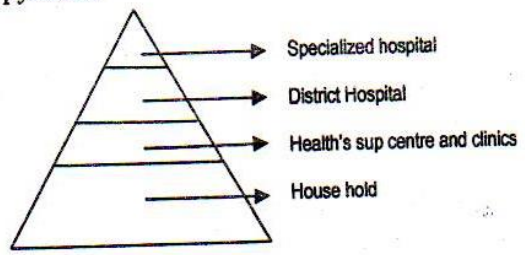
U. SELVAKUMARI * & Dr. T. J. JAYASHOLAN **

Introduction

Health care is an important determinant of the quality of life and there by the welfare of the population in a society. Health facilities in many low and middle income countries face several types of barriers in delivering quality of health services. Women are 'high risk' population from health point view. It is only since 1970's and Alma Ata Declaration of Health For All by 2000 A.D., issues relating to women's have attracted the attention of the academicians, policy makers and international organization.

Health system in India

In every developing country, facilities, equipment human resources and drugs are skewed towards the top of the health system pyramid



The Cost effective public Health and clinical services are best delivered at the level of district hospital or below. But in practice they, are often delivered through tertiary hospitals which increases the cost without improving quality. *The framework identifies three levels of barriers*

- The community and household level
- The health service delivery level and
- The health sector policy and strategic management level

Demand side barriers

At the community and household level the use of health services is limited by physical, financial and social barriers, which are also known as demand side barriers. Income, distances to the health facility and socio economic characteristics influence the use of health care by Indian house hold.

Supply side barriers

Operate at service delivery level. They are characteristics of the health system that exist outside the control of potential health services users and hinters uptake by individuals, house hold or the community while many studies have described severe shortage essential supplies, medications, and human resources across countries, including India, there is a gap in knowledge as to how these observed supply side bottlenecks affect service provision.

Role of health facilities

The rate of caesarean childbirth is more in the states with higher institutional birth. The proportion of caesarian birth is higher in private facilities than in public ones which may be a reflection of the increasing privatization and greater role of the profit. Motives in the provision of health care facilities in recent times.

Table 1: Percentage of women undergoing caesarean section delivery among institutionalized by birth states

States	Institutional birth	Delivery by caesarean	Birth in public health facilities	Delivery by c-section public health facility	Birth in private health facilities	Delivery by
Uttar Pradesh	24.7	23.9	6.4	12.4	18.3	
Madhya Pradesh	38.3	17.7	20.8	9.7	17.5	
Goa	92.2	27.8	44.0	18.1		
Andhra Pradesh	75.6	36.4	27.7	25.3		
Tamil nadu	90.1	25.5	53.8	19.3		
Karnataka	64.1	23.9	34.8	17.2		
Kerala	99.3	30.3	35.6	26.0		
India	44.8	23.7	23.4	18.1		

Source: National Family Health

Above table shows that the rate of institutional birth have increased in most of the Indian states from 1998-99 to 2005-06 increased in seen in states like Andhra Pradesh, Kerala, Tamilnadu, and Goa. It is

*Research Scholar, P.G. & Research Dept. of Economics, A.V.V.M. Sri Pushpam College (A), Poondi, Thanjavur
** Research Advisor, P.G & Research Dept. of Economics, A.V.V.M. Sri Pushpam College (A), Poondi, Thanjavur

portant to consider that states with rapid demographic transition show high incidence of caesarean childbirth in comparison to other states. In India there is a large rural-urban difference in the occurrence of c-section deliveries. Proportion of c-section deliveries is higher in urban areas, elucidating also the inequality in health service.

Table 2 :Percentage of births in rural and urban areas by caesarean section delivery NFHS-3 India and states

States	Percentage of women who have caesarean delivery		
	Total	Rural	Urban
Andhra Pradesh	27.5	19.4	32.2
Haryana	5.0	3.1	12.1
Karnataka	15.3	11.6	22.6
Kerala	30.1	28.4	33.5
Madhya Pradesh	15.6	7.7	19.9
Tamil nadu	23.0	19.8	26.0
India	10.6 (N-51,555)	6.2	17.8

Source: National Family Health Survey 2011

The table shows that the percentage of births by c-section is much higher in urban areas than in rural areas and in states like Andhra Pradesh. Kerala and west Bengal over 30 percent if the delivery in urban takes place through c-section.

Conclusion

In India, the private sector plays an important role in delivering health care. Due to poor quality of healthcare in public hospital, many household prefer to visit private clinics to seek maternity care. As per DLHS 2007-2008 about 17% of the institutional deliveries were performed at private health clinics. The proportion of caesarean birth is higher in private health facilities than in public ones, the increasing privatization and greater role of the profit motive in the provision of health care facilities in recent times.

Reference

India health report (2005) Oxford University press-new Delhi

Adam son PC Krupp m, et.al.(2012) are marginal women being left behind? A population based study of institutional deliveries in Karnataka, India BMC Public Health 12.30 doi 10.11.86/147-2458-12.30

Hanson k, Ranson.k.oliveria- (Ruz.V.Mills A (2003) expanding access to priority health i9ntervention a framework for understanding the constraints to scaling-up journal of international dev3lpment 15; 1-14 doi 10.2002\jod -963

ECONOMICS OF INVESTMENT IN HEALTH SECTOR

*U. Selvakumari

Introduction

Good Health confers on a person or groups freedom from illness-and the ability to realize one's potential. Health is therefore best understood as the indispensable basis for defining a person's sense of well being. The health of populations is a distinct key issue in public policy discourse in every mature society often determining the deployment of huge society. They include its cultural understanding of ill health and well-being, extent of socio-economic disparities, reach of health services and quality and costs of care land current bio-medical understanding about health and illness.

Continued Health Problems

The link between economics and health care is evident in both the developing and the developed world. Health has been defined as the state of perfect physical, social and mental wellbeing. The health of its people is reflected in the economy of a nation- healthy people produce healthy economies. It is unfortunate that in our country the effects of ill health on economy have not been fully appreciated. It is now widely recognised that investment in health fields contributes to economic growth of countries by stimulating growth in "human capital formation" and by preventing economic loss due to sickness, disability, premature death and cost of treatment. An integrated plan in which investment in certain key areas in health field is made side by side with investment in similar areas in other social and economic fields. This is essential for reversing the vicious circle of poverty and sickness in developing countries. Hence Health Economists will have to work in close collaboration with social planners in other fields in order to develop certain common units for measuring health and other social and economic problems and to identify those areas for investment in health fields which have considerable bearing on social and economic development.

Need For Expenditure of Health

Spending on health is considered a productive investment. It raises the income of the poor and reduces the toll of human suffering from ill health. Many experiments, social programmes and research studies have attempted to identify costs and determine ways of achieving better health. Some of these efforts are designed to test the effect of a minimum package of essential services to the people. Early health professionals have undoubtedly created a better understanding of the more efficient utilisation and more equitable distribution of resources in health services.

Investments in Health

The case for investing in health may be seen in the background of health status and health care services available in these countries. The information sought relate to population, income per capita, estimated cost of the minimum package of public health, essential [38]clinical services, public and private health expenditure as a percentage of GDP and total flows from the external assistance in the countries taken for study.

Private Sector Strategy

1. Filling the resource gap for health development by providing coverage and access of essentially private groups.

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[38] **Asst. Professor of Economics**
A.V.V.M.Sri Pushpam College (Autonomous) Poondi.