CHAPTER-I

HEALTH SITUATIONS IN INDIA

India, with a population of 685 million (1981), is the second most populous country in the world. It is supporting 15 per cent of the World's population with only 2.5 per cent of the total land area. In 44 years after Independence, the population has almost doubled from 340 million in 1947 — adding a "second India". The crude birth rate has come down from 39.9 per thousand in 1941-51 to an estimated 33.3 per thousand in 1982. The current annual growth rate of the population is 2.4 per cent (1981). At this rate of growth, the population is expected to cross the 1,000 million mark before the turn of the century, and will again double in about 31 years.

The population is a "young" population with a disproportionately large number of children (about 40 per cent) below the age of 15 years, and a low proportion of people (about 8.3 per cent) living beyond the age of 55 years. 80 per cent of the population live in villages. The density of population per sq.km. is 221. The successive Censuses have shown an adverse sex ratio (935 females per 1,000 males, 1981 Census), which is unfavourable to women. The overall literacy rate is 36 per cent.1

Mortality Profile:

The general death rate has come down from 27.4 per thousand

in 1941-51 to an estimated 11.7 per thousand in 1982. But there are large inter-state variations, viz., 7.2 in Kerala and 19.2 in Uttar Pradesh.\(^1\) The life expectancy at birth has increased from 32 years in 1941-51 to 52 years in 1980.\(^2\) Even then, our life span lags behind by almost 20 years, as compared to that in developed countries, wherein it is currently between 70 and 75 years. The infant mortality rate has come down from 135 in 1973 to 114 in 1980, whereas in Europe it is less than 20 per 1,000 live births, and even below 10 per 1,000 in some countries. Mortality in the age-group 1-4 years is around 30 per thousand as against less than one per thousand in developed countries.

Morbidity Profile:

The morbidity pattern during the past decade has not materially changed. The principal causes of morbidity may be discussed as:

(a) Infective and Parasitic Diseases: These are responsible for about 60 per cent of total admissions.\(^3\) Among viral diseases, small pox has been eradicated. Measles continues

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to be rife. Polio is frequent in occurrence, and so is viral hepatitis. Among bacterial diseases, cholera has significantly declined, but the other water-borne diseases (e.g., acute diarrhoeas, dysentery and enteric fever) have not abated. The prevalence of tuberculosis continues to be high, with an estimated 8-10 million cases of which approximately 2 million are infectious. The country has one-third of leprosy cases in the world. Tetanus and Diptheria are not yet under control. Among parasitic diseases, Malaria and Kala-azar have staged a come back. About 236 million people are exposed to the risk of Filariasis. Intestinal parasites are all too common.

(b) Malnutrition: From the nutritional standpoint, India is a dual society consisting of a small group of well-fed people, and a very large proportion of malnourished and undernourished people. Malnutrition is particularly severe among women and children, especially in the lower classes. 1-2 per cent of children below 5 years are estimated to suffer from Protein — energy malnutrition.¹ Iron deficiency anaemia is seen in almost 50 per cent of children below the age of 5 years, and in 30-43 per cent of women during their reproductive period of life.² Avitaminoses,

1. Ibid, 18, 156.
2. Indian Council of Social Science Research and Indian Council of Medical Research (1981), op.cit.
particularly Xerophthalmia leading to blindness and endemic goitre, are among the more important nutritional problems in the country.

(c) Non-Communicable Diseases: By comparison, non-communicable diseases such as Ischaemic heart disease and cancer would seem to be of secondary importance, but they are already posing a problem in some social groups. Occupational diseases such as silicosis and other pneumoconioses are on the increase. Environmental pollution, alcoholism, accidents and allergic disorders are also on the increase.

(d) Sickness Load: Surveys have shown that as much as 7 to 13 per cent of the rural population may be sick at any given point of time. On an average the number of new episodes of sickness per person per year were found to be ranging between 2.6 and 3.9.1

Health Facilities and Health Manpower:

Health manpower planning is an important aspect of community health planning. It is based on a series of accepted ratios such as doctor-population ratio, nurse-population ratio, bed-population ratio, etc. The norms suggested by the Mudaliar Committee (1961) have been the basis of health manpower planning in India. The country is producing annually, on the average 12,000 Allopathic doctors, 3,500 Ayurvedic graduates, 600 Unani

1. Government of India (1974), Swasth Hind, op.cit, 18, 156.
graduates; 70 Siddha graduates and 9,000 Homeopathic graduates.¹

There are today nearly 7,369 hospitals; 21,874 dispensaries; 11,000 primary health centres; 83,008 sub-centres with a total bed capacity of 5.1 lakhs. There are 106 medical colleges with an intake of 12,000 to 13,000 per year. There are nearly 2.9 lakhs of Allopathic doctors registered with the Medical Council of India and over 3.8 lakh doctors trained in traditional systems of medicine including Homeopathy. Ayurveda, Unani and Siddha; nearly 1.6 lakh nurses, 5.1 lakh trained dais and 3.7 lakh village Health Guides. Their numbers are on the increase. In 1983, the national average of doctor-population ratio is 1:2610; population bed ratio is 1:1447; and nurse-population ratio is 1:2251. Although the averages are satisfactory on a national basis, they vary widely within the country. For example, in the case of doctors, there is one doctor per 11,000 to 13,000 population in Andhra Pradesh, Assam and Rajasthan, whereas there is one doctor per 1252 population in Pondicherry, one per 1712 in Karnataka,¹ and one per 1362 in Haryana.² There is also maldistribution of health manpower between rural and urban areas. Studies in India have shown that there is a concentration of doctors (upto 80 per cent) in urban areas where only 20 per cent of population


². Ibid.
Statement of Problem:

The health situation of the country, as the preceding narration indicates, is miserable indeed. This has an important bearing on the progress of the country which we expect to attain through various Five Years Plans and schemes of modernization. There are broadly two approaches to the maintenance of health, i.e. prevention of disease and the cure of ailment. During the British Raj not much attention was paid to problems relating to health. If any epidemic had an outburst some remedial measures were taken. Very little attention was given to the preventive side of disease. The development of health delivery systems is a post-Independent phenomenon. The budget outlays for successive Five Year Plans and the extension of medical infra-structure, even in the interior parts of villages, manifestly show the concern of the national government.

An analysis of the budget outlays, recruitment of personnel, training for medical education for doctors, nurses and health visitors very clearly indicate that government has been spending much more money on the development and consolidation of Allopathic System of Medicine. The government policy in this respect seems to be based on the argument that allopathy has an

advanced status compared to other indigenous status of medicines all over the world. The global development of allopathic medicine both in the area of technology, skills of the doctors and invention of drugs helps the patients in the country on par with the world population. This argument appears to have prompted the National government to construct its policy of health delivery and the care of diseases. With massive investment in the development and spread of allopathic medicine or system of disease treatment, it is expected that the system would reach to the doorstep of the villagers — the masses of people living in the interior parts of the country. But the data as have been put earlier do not confirm to this kind of hypothesis. Naturally one is prompted to pose the question: If the allopathic system has a potency for effectively curing a disease as well as preventing it, how is it that it has not been widely acceptable to the people?

In fact, the allopathic system of treatment appears inherently to suffer from a number of weaknesses. Theoretically perhaps the potency and effectiveness is illusory only so far the permanent cure of a disease is concerned. It may be that the treatment is capital intensive, being quite out of reach of the poorer segments of the society. It may also be possible that in its effort of curing the disease, it creates a number of side effects which end up with another kind of disease. It could also be argued that the system is largely inconsistent with the
cultural configuration of the concerned society. Hypothetically if the other systems of medicine, for instance, Ayurvedic, Unani and Homeopathic, would have got patronage from the government perhaps better results could have been yielded. These systems comparatively are not much capital intensive. They have their roots in the cultural syndrome of the containing society. However, the other systems have also been given some patronage. Ayurvedic dispensaries are found available even in the interior parts of the country. Among some segments there is availability of Unani dispensaries. Unfortunately with the lesser patronage given to these systems — Ayurvedic and Unani, they are alleged to have been related to religious groups. It is said that the Ayurvedic system is the product of Hindu social organisation and the Unani that of Muslim society. The historical stigma of communalism attached to these systems have come in the way of their rapid growth. Not much research activity has been promoted in these systems. Is it that despite of the lack of promotion and development, the people show all willingness to express their faith in these systems?

Our premise of inquiry basically lies in the argument that any system of medicine which is for the prevention of diseases and their cure among the masses should emerge from the social structure. If the medical system springs from the roots of social structure or if it confirms to the normative and value structures of the society, its relevance is well established. It is within
this broader theoretical framework, namely, that a system of medicine needs to be consistent and in full conformity with the social structure, that it receives fuller acceptance from the people. We have not made any comprehensive inquiry which could tell us with all scientific rigour that a particular system of medicine is commonly acceptable to the wider masses of people.

The problem of our inquiry therefore, is to plug the structural units of allopathic system which are acceptable to the people and which are appropriate looking to their economic status and cultural ethos. The society on the other hand has various patterns of social stratification. We have to relate the structural units of medicine to the different units of stratification. This plugging of allopathic system provides basic thrust to our inquiry. The problem has yet another frontier. We also want to identify the "strains" and "weaknesses" of the other medical system such as Ayurvedic, Unani and Homeopathy. The major problem, therefore, is to bring the diverse systems of medicine face to face with the different strata of society or the communities — rural and urban.

The thrust of our problem has relevance to the national policy of health sanitation and disease situation in the country. If it could be known by similar researches as our own that the particular segments of society have a willingness to adopt and practice a particular kind of medical system, the planners would
get a constructive feedback for revising and reformulating their health policy. Strictly speaking, we have no bias for and against any system of medicine which the masses of people identify for their acceptance.

Objectives of the Study:

The present inquiry tries to understand the health delivery system as is in vogue in different medical systems from the perspective of social structure, culture and above all the wider societal point of view. In other words, its endeavour has been to examine the nexus which exists between diverse social segments and medical systems. While doing this we always refer to the plans, policies and perspective of the government along with the voluntary agencies. Clearly we examine the nexus in terms of acceptance of a particular system with these perspectives: The perspective of the practitioners of health care; the perspective of the beneficiary of medicine or treatment; and the perspective of government in terms of providing state patronage to a particular system of medicine.

In other words our stress has been to find out the consistency and correspondence of a particular medical system vis-a-vis the social differentiation of society under study. Some of our major objectives which have provided focus and direction to the inquiry are given below:
1. To inquire about the detailed units of the structure of all the medical systems found prevalent in a particular region. To enquire as to what extent the units are on par with the wider development of the system in the world.

2. To find out the nature of a particular system in terms of its capital intensiveness, effectiveness and potency within the background of the people for which the system is meant.

3. To find out the social and economic background of the practitioners of a system. How does this socio-economic background correspond to the socio-economic background of the people?

4. To study and establish the relation between disease and culture in different social segments. It also attempts to identify the folk medicine which has traditionally been in practice for the diseases found in the social segment. Has the introduction of allopathic system of medicine weakened the folk medicine?

5. To inquire about the credibility of Ayurvedic system which has sprung from the roots of Indian society, on comparative plane with other systems of medicine.

6. To find out the ethnic status of various social segments of society in terms of the availability of health delivery systems.

7. To study the ethnic configuration of a particular medical system along with its existential reality. This part of
inquiry would help us to find out the way commercialization crept into a particular medical system.

8. The study attempts to inquire into the professional structure of the allopathic system. It tries to dwell on the consolidation of the professionalization of the occupation.

9. It inquires to find out the broad prospects of development as envisaged in the national health and disease policy of the government vis-a-vis the extent of the spread of disease and the maintenance of health.

10. Allopathic system in particular has developed the form of a complex social organisation. It carries all the attributes of a modern organisation. The inquiry tries to identify the structural units which develop and thwart the spread and development of other systems of medicine. In other words, it attempts to identify the vulgar aspect of the system.

11. At the level of people the inquiry studies the personal hygiene and the epidemiology of diseases in terms of the social and cultural formations of a particular group.

Research Design:

The general nature of the present inquiry is empirical. Data have been generated from the field which consist of both rural and urban sectors. Purposively we have taken the district of Rohtak in the State of Haryana as our universe of study. Haryana state is rich in its physical resources. It has fertile
land. It is equipped with a network of irrigation facilities. Being close to the union territories of Delhi and Chandigarh there is enough general awakening among the people about the benefits which accrue from the programmes and schemes floated by the government. There is enough sense among the people to respond to development changes. All these characteristics of modernization and development constitute Rohtak as one of the best laboratory for the exploration and verification of some of our objectives of the study. The field work data were generated during the year 1986-87.

Besides generating primary data from the field we have also freely drawn secondary data from published monographs, research works, state Gazetteer, and learned Journals. Wherever necessary the knowledgable persons, both from rural and urban areas, have also been contacted and subjected to intensive information.

The research design divides the universe into two purposively sampled urban and rural clusters. For urban sample we have drawn Rohtak, a district headquarter of the state for representing the former's way of life. And for rural communities, we have included all the villages which represent diverse types of villages in terms of the domination of Jats who constitute the most influential group as sub-sample representing the countryside. We have adopted quota sample design for intensive study of two clusters of respondents each representing the rural and urban
centres. The quota sample group in total consists of 150 respondents. Out of it half of the respondents, namely 75 have been on purposive sample design drawn from the clusters of the village of the district. And the remaining 75 from the city of Rohtak.

Though we have not taken any proportionate sample from different segments of social groups in terms of caste and ethnicity from urban and rural communities, however, it has been our earnest objective endeavour to include all the representative attributes of the two sets of lives. For instance we have taken a representative sample village for intensive study which has multi-caste groups, different economic and occupational diversification and having most of the health delivery services. The village is such from where the benefits of Ayurvedic, Homeopathic and better Allopathic facilities are also not far away. The sample village thus is put in a situation where if the villagers like the benefits of most of the systems of medicine available in the district are within their reach. The village drawn by us is named Dhandhlan. Besides conducting intensive study in the sample village and the city, we have drawn aggregate data for the whole district. In fact, some of the data and interviews have been conducted from the different parts of the district. For larger and under wider information we have never isolated our sample village in city from the district as a whole. The study of city and village is only meant for intensive study. Our orientation
thus have been to look at urban and rural life with the perspective of making a precise comparison between the two to get an overall picture of health and illness of the state.

Tools and Techniques:

After having decided the basic logic of our inquiry and the sample groups we have prepared the tools for generating data. For this purpose we have administered a schedule to both the sets of respondents. The schedule is meant for collecting factual data about the social background of the respondents which includes both the beneficiaries of medical system and its practitioners. A community schedule has also been filed in to get comprehensive information in terms of population, demography, transport links, government institutions, and community services for both the sectors of the state's life.

The tools of interview and case studies have been used to get focussed data on the problem of our inquiry. Some of the leading doctors, well known at country and city life, have been interviewed for protracted duration of hours. Some case studies of doctors, patients, medical administrators, social workers and political activists have also been conducted. We must admit that the application of these tools have provided a feed-back to our intensive study of urban and countryside.

Limitation of Our Study:

No study could be termed a perfect one. It also applies to
the present inquiry. We have our own limitations which are partly pedagogical and partly personal and financial. Some such constraints have limited the scope of our inquiry. Its field could also have been expanded to the neighbouring union territories and states for a much wider comprehensive analysis. But we have not moved beyond the frontiers of a single district. This has delimited the scope. Further, the intensive study of the communities is spread over to a span of one year only. Had it been extended to a period of 2-3 years perhaps a stable pattern of medical behaviour could have been brought out. In some situations, it is also found that some respondents have been partial to one or the other systems of medicine. We however, could not identify such prejudicial responses. Yet another constant limitation of the inquiry, which has puzzled us all the time, has been the secretive behaviour of the people. They tend to keep close any information which pertains to their personal health hygiene. This has come in the way of exactly identifying the nature of diseases prevalent and the type of treatment sought. However, despite this difficulty we have tried our best to elicit as much information as was possible.