CHAPTER - I

INTRODUCTION

1.1. Origin of Human Resource:

Human resources\(^1\) are the basic foundation stone upon which the economic development\(^2\) of every country is built. Not until the late 1950’s did economists and other social scientists paid much attention to the role of investment in human beings as an important determinant of economic development. The birth of this idea can be dated from the presidential address of Prof. Theodore W. Schultz to the American Economic Association in December 1960\(^3\). As a result, the concept of human capital formation\(^4\) came to limelight. (Gandhi, 2004:6) By the early 1970’s

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\(^1\) Human resource is the set of individuals who make up the workforce of an organization, business sector or an economy. ([http://en.wikipedia.org/wiki/Human_resources](http://en.wikipedia.org/wiki/Human_resources))

\(^2\) Economic development generally refers to the sustained, concerted actions of policymakers and communities that promote the standard of living and economic health of a specific area. Economic development can also be referred to as the quantitative changes in the economy. Such actions can involve multiple areas including development of human capital, critical infrastructure, regional competitiveness, environmental sustainability, social inclusion, health, safety, literacy and other initiatives. ([http://en.wikipedia.org/wiki/Economic_development](http://en.wikipedia.org/wiki/Economic_development))

\(^3\) The importance of investment in human beings for the first time was propounded by T.W.Schultz in his presidential address at the Seventy Third Annual Meeting of the American Economic Association, Saint Louis, December 28, 1960. In his speech, he concentrated on the scope and substance of human capital and its formation. (T.W.Schultz, 1961, “Investment in Human Capital” American Economic Review, volume LI, Number 1)

\(^4\) Human capital formation takes different forms and passes through various stages in parallel with the human life cycle. The core of human capital formation is acquisition of new knowledge and skills and health. ([http://www.ifpri.org/sites/publications/rr169pdf](http://www.ifpri.org/sites/publications/rr169pdf))
the concept of human capital formation had moved to the centre stage of development priorities.

One of the significant transformations to occur in recent years in the analysis of economic growth and development is a greater recognition of the role of what is called “human capital”\(^5\), as opposed to physical capital.\(^6\) In some ways, this is a return to an earlier approach to economic development—perhaps even the earliest systematic attempt in this direction—the approach developed in Adam Smith’s Wealth of Nations\(^7\). However, more recent moves towards the recognition of the far-reaching role of human skill and its development have had the effect of re-establishing an old tradition that had been temporarily overshadowed. (Sen, 1998:733-742)

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\(^5\) In economics physical capital refers to any already manufactured asset that is applied in production, such as machinery, buildings or vehicles. In economic theory, physical capital is one of the three primary factors of production, also known as the inputs in the production function. The others are natural resources and labour. ([http://en.wikipedia.org/wiki/Physical_capital](http://en.wikipedia.org/wiki/Physical_capital))

\(^6\) Adam Smith defined human capital as “Fourthly, of the acquired and useful abilities of all the inhabitants or members of the society. The acquisition of such talents, by the maintenance of the acquirer during his education, study or apprenticeship, always cost a real expense which is a capital fixed and realised, as it were in his person. These talents, as they make a part of his fortune, so do they like wise that of the society to which he belongs. The improved dexterity of the workman may be considered in the same light as a machine or instrument of trade which facilitates and abridges labour, and which, though it costs a certain expense, repays that expense with a profit.” ([http://en.wikipedia.org/wiki/Human_capital](http://en.wikipedia.org/wiki/Human_capital))

\(^7\) The focusing on the development of human ability and competence, and the emphasis on exchange and on economies of scale in supporting skill formation, were among the central points of departure in Smith’s analysis of the expansion of the Wealth of Nations. That perspective was rather neglected in the early models in the post-war revival of growth theory and even in early neoclassical analysis of the process of growth. Solow, 1956, “A contribution to the Theory of Economic Growth” *Quarterly Journal of Economics*, p: 70)
Most Asian countries are growing at fast rates. A by-product of this growth is an increased demand for high quality human resources both by industry and by the population itself. The engine of economic growth requires more productive labour and individuals desire a higher quality of life. (Gertler, 1998:717)

The most important factors which lead to human resource development are health, education, housing, nutrition, better environment, improved socio-economic opportunity with regard to under privileged sections of society like scheduled caste, scheduled tribes, women, children, aged persons etc. Among these factors health occupies a unique and prime most position in moulding human resources of a country. That is, health is a vital indicator of human development. \(^8\) (Singh, 2004:614)

Sound health has been accepted as a universal social goal. This was articulated in the resolution adopted by the Thirtieth World Health Assembly, 1977. \(^9\)

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8 Human development is a process of enlarging people’s choices. In principle, these choices can be infinite and change over time. But at all levels of development, the three essential ones are for people to lead a long and healthy life, to acquire knowledge and to have access to resources needed for a decent standard of living. If these essential choices are not available, many other opportunities remain inaccessible. (UNDP, 1990, p: 10)

9 Health for All was the primary theme of the 30th World Health Assembly held in 1977; the idea was reaffirmed at the Alma Ata International Conference on Primary Health Care in 1978 and currently serves as the goal of the World Health Organisation and those individual states, including Rwanda, which form its membership. The Health for All campaign is directed toward the maintenance of primary health care within an established national health care system. It encourages planned action in the health care system and promotes coordination and integration of health care with other sectors. (http://www.ncbi.nlm.nih.gov/pubmed/12313760)
according to which “the attainment of all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life” should be the main social targets of all national governments in the coming decades. (Panikar and Soman, 1984:2)

Health as fundamental human right began with the international conference on Primary Health Care at Alma Ata in Kazakhstan of Soviet Socialist Republic in 1978. The Alma Ata Declaration of 1978 specifically was aimed at the following goals. a) equity, b) accessibility c) emphasis on promotion and prevention, d) inter-sectional action, e)community involvement f) integration of health programme, g)co-ordination of separate health activities. Equity in access to health care is now accepted as a basic ethical principle for human development.

Health is a major concern of every society and every country. It is fundamental to human progress. People in sound health can accelerate the pace of economic and social development. The constitution of World Health Organisation

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10 The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care(PHC), Almaty (formerly Alma-Ata), Kazakhsthan (formerly Kazakh Soviet Socialist Republic), 6-12 September 1978. It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. It was the first international declaration underlining the importance of primary health care. The primary health care approach has since then been accepted by member countries of the World Health Organization (WHO) as the key goal of “Health for All”. (http://en.wikipedia.org/wiki/Alma_Ata_Declaration)
(WHO)\textsuperscript{11} says, “enjoyment of the highest standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic and social condition.” (Thomas, 2007:72)

In India, Right to Health is part of Right to Life enshrined under Article 21\textsuperscript{12} and has been interpreted in this way in several rulings of the Supreme Court of India. What this means is that it is the state’s primary responsibility to ensure primary health care in a socially just and equitable environment. Primary health care system is the backbone of the Indian health system. (Hazra, 2010)

Thus, good health is a prerequisite to human productivity and the development process. A healthy community is the infrastructure upon which an economically viable society can be built. Unhealthy people can hardly be expected to make any valid contribution towards development programmes. Better health may contribute to the productive capacity of the economy. It may do this by increasing the supply of potential man hours through a reduction in mortality and decrease in time lost because of illness and disability. Thus the healthy citizens are the wealth of a nation.

\textsuperscript{11} The World Health Organisation (WHO) is a specialized agency of the United Nations (UN) that is concerned with international public health. It was established on 7\textsuperscript{th} April 1948, with headquarters in Geneva. (http://en.wikipedia.org/wiki/World_Health_Organisation)

\textsuperscript{12} Article 21 of the Indian Constitution states, “No person shall be deprived of his life or personal liberty except according to the procedure established by law.” (http://www.lawisgreek.com/tag/article-21-indian-constitution-on-personal-liberty-2)
Health and health care need to be distinguished from each other. The concept of health keeps changing from time to time. Health is not the mere absence of disease. The most accepted scientific definition of health is by World Health Organisation in 1948 which states “Health is a state of complete physical, mental and social well being and not merely the absence of disease and infirmity”. (Dash, 2005:109) Good health confers on a person or groups’ freedom from illness and the ability to realize one’s potential. Health care covers not merely medical care but also all aspects of pro preventive care too. It cannot be limited to the care provided by the government sector but also includes incentives and disincentives for self care and care paid for by private citizens to get over ill health. Health care at its essential core is widely recognized to be a public good. Its demand and supply cannot, therefore, be left to be regulated solely by the invisible hand of the market. (Srinivasan, 2004:327)

Four criteria are generally suggested for a just and fair health care system. Firstly, universal access, access to an adequate level, and access without excessive burden; secondly, fair distribution of financial cost for access and fair distribution of burden in rationing care and capacity and a constant search for improvement to a more just system. Thirdly, training provided for competence, empathy and accountability. Lastly, special attention must be vigilantly provided to vulnerable groups such as children, women, disabled and the aged. (Ramachandrudu, 2004:365)
Thus the role of health and health care utilization is far reaching. Many studies in India have highlighted the role of health care utilization. (Bhat, 2004; Baru, 1998; Narayana, 1997; Dash, 2005; Mishra, 2005; Sarma, 2004; Nayanar, 2000; Panikar and Soman, 1994)

1.2. Health and economic Development:

There is a certain relationship between health and economic development. The association between health and development is complex. The interaction is a two-way phenomenon with health, both being influenced by and influencing economic development. (Sorkin, 1975:43) By and large there is a positive association between the levels of economic development and health improvement. (Panikar, 1993:2)

Healthy persons can benefit the society in many ways. Like education, health has many types of positive externalities or spillover effects like a healthy person is less contagious than a sick one. (Ghosh, 2008:23)

There is long term impact of health on economic growth. A study for the period 1950-1990 by using quinquennial data base for 18 countries of Latin America with regard to the long term relation between health and economic growth gives new, strong evidence that there exists long term impact of health on economic growth. The study reveals that the channels of causation from health to income are diverse and need to be identified in microeconomic studies that should, however,
include a wide variety long term phenomena to account for the economic effects of
health. (Mayer, 2001:1025-1033)

There are four principal ways by which health programmes can effect
the pace of economic development in the developing countries. They are:
1) increasing the number of man-hours of work available; 2) increasing the quality or
productivity of the existing workforce; 3) making feasible the development of
previously unsettled regions; and 4) changing the attitudes towards innovations and
entrepreneurship (growth creating activities). (Reddy and Manjunath, 2006:32)

Thus, the most fundamental aspect of human life is health. It forms an
integral component of overall socio-economic development of any nation. As health
is of utmost importance for any individual and society, it becomes a priority or a
subject that has to be given full attention and focus. The famous saying “Health is
Wealth” stands true to the fact that the level of development achieved by a society is
often determined on the basis of the level of health and the system of health prevalent
in the society. Health has evolved from being only an individual concern to that of a
major social goal and an important factor which encompasses the quality of
community life.

1.3. Importance of the Present Study:

Kerala is a state that has achieved remarkable progress in the health
sector. As far as Kerala is concerned, among the Indian states, it has the highest rank
that the state is far ahead of other states in the country and health standards achieved are even comparable to those of developed nations. Kerala’s achievements in key areas of human development have been widely appreciated. However, on deeper scrutiny it would appear that the progress is only in the periphery and is not sustainable in the long run. Even though Kerala’s key health indicators have always been way ahead of the national average, in recent times it has been unable to either improve or even sustain its indicators, while many other states have made significant gains on the health front. This reveals the hidden danger of various problems associated with our health sector. There is poor health care utilization in the state. Even though we have committed to the goal ‘Health for All’, there is severe social inequality in health care utilization. There is also a high degree of undernutrition and health care costs are increasing at a rapid rate.

As far as the area of health care utilization is concerned, it needs continuous research because every day new problems are arising. Though Kerala’s health sector is a topic of continuous research among researchers, many of these studies are on the general framework. There are not many studies which analyze the health care scenario of a particular region or district. That is grass root level studies are very rare in the health sector of Kerala. The northern district of Kerala, Kannur, is also not an exception to this situation.

Even though there are some studies on health and health care utilization in Kannur which analyzed certain aspects of various issues associated with
health care, none of these studies give a clear and complete picture of the health scenario of the district. Most of them are carried out in the general framework of health care utilization. And as far as the present study area i.e, Kannur district is concerned, the studies are very much limited. None of the studies touched the core realities of health issues in the district like social inequality in health care utilization, high under nutrition among children, mounting health care cost, inadequacy of public healthcare infrastructure and the like. Again, at present, there is no study which gives an overall health scenario of the district. The role of health insurance in reducing health care cost is yet another untouched area.

It is in this context that the present study is designed which tries to analyze the above mentioned problems in the health scenario of Kannur district. It is hoped that the study will reveal the strengths and weaknesses of the healthcare scenario of the district.

1.4. Objectives of the Study:

Main Objective:

The main objective of the study is to analyze the existing health care facilities and the extend of benefit accrued to the people in the study region.

Sub Objectives:

1. To analyze the extent to which health insurance helps to reduce the burden of health care cost of households.
2. To assess the nutritional status of children in the study region in 0-3 age groups.

3. To explore the intensity of social inequality in health care utilization among the community.

1.5. Hypotheses of the Study:

The following hypotheses have been formulated.

1. Majority of the households spends about one fourth of their income for health care needs.

2. Most of the children in the age group of 0-3 years in the study area do not possess sufficient weight and height.

3. The low levels of access to health care facilities are the result of occupational backwardness rather than caste backwardness.

1.6. Research Methodology and Data Sources:

The methodology that is being followed is empirical and analytical. The study is based on both primary and secondary data collected from different sources. It is given in separate heads.

1.6.1. Identification of the Study area:

The district of Kannur is famous for educational status and well functioning of Panchayathi Raj institutions with proper support and co-operation from all people. Moreover, the district has a comparatively good atmosphere in the field of healthcare infrastructure and facilities in the early years of its formation itself. These
facilities expanded prodigiously during the subsequent years. But recent observations shows that the health scenario of Kannur is frequently disturbed by a lot of diseases like dengu fever and the like. And also every year a large number of populations are troubling due to these epidamica. Visit of some panchayath in the district revealed that these diseases are by and large the result of and the absence of preventive care among the people. Also, these frequent visits of diseases are resulting in huge financial burden to household. In this situation, it is felt that a detailed study will reveal the core realities in the health scenario in the district. Accordingly eight panchayaths and one municipality were selected for a detailed study.

1.6.2. Sources of Data:

1.6.2.1. Secondary Data:

Secondary data were collected from District Medical Office, Kannur, nine block offices in Kannur district, various anganwadis, Census of India, Economic Review, hand books published by various departments, district panchayath office, Economics and Statistics Office, Cente for Development Studies, Thiruvananthapuram, Kerala University, Thiruvananthapuram, Kannur University Central Library, library of Palayad University Campus, Libraries of various colleges, various journals, DELNET, news papers and various websites.
1.6.2.2. Primary Data:

Primary data were collected from 315 households of different panchayaths in Kannur district by using sample survey method during the period 2009-2010. The data were collected using structured pre-tested questionnaire. Before the actual survey, a pilot study was conducted and necessary modifications have been made to the questionnaire. Out of 81 panchayaths and six municipalities in Kannur district, eight panchayaths (10%) and one municipality were selected using two digits random table. The panchayaths selected are: Madayi, Kalliasseri, Chapparappadavu, Padiyoor, Muzhappilangad, Thillankeri, Mangattidam and Muzhakkunnu. The municipality selected was Mattannur municipality. From this eight panchayaths and one municipality, 35 households each were selected using stratified random sampling. 35 households each from eight panchayaths and one municipality are comprised of different castes based on the proportion of different communities in the district’s population. The households selected were strictly having child in 0-3 age group. The households/families were selected using simple random sampling from anganwadi records. The social and economic aspects were then quantified for analysis. To get detailed information about willingness towards health insurance, Contigent Valuation Method was used. The C.V method uses survey questions to elicit people’s preferences for public goods by finding out what they would be willing to pay for specified improvements in them. There are three steps/parts in C.V
method. a) detailed description of the good being valued, b) questions which elicit the respondent’s willingness to pay, and c) questions about respondents’ characteristics.

The households interviewed includes educated and less educated, financially fit and less fit, head of the family, mother of the child in 0-3 age group etc.

In order to assess the nutritional standards of children below three years of age, standard weighing machine and measuring taps were used. The collected data were compared with WHO stipulated growth conditions and National Centre for Health Statistics (NCHS) growth records.

1.6.3. Analysis of data:

The study uses various statistical tools for the analysis of data. Statistical tools like percentage analysis, averages, graphs, charts, diagrams, frequency curves have been used for the analysis.

1.7. Limitations of the study:

The present study is subject to the following limitations.

1) Out of 81 panchayaths and 6 municipalities in Kannur district, 8 panchayaths and one municipality are selected for sample survey. Therefore the findings of the study cannot be generalized fully for the entire district.

2) The findings of the study are entirely based on the responses of the sample households. Therefore their personal bias may enter into the answers. Also some of the respondents were reluctant to give actual data on income,
expenditure etc. However, maximum efforts have been made to collect actual information.

3) As far as the details of birth weight of all children and present weight of the babies in the range of 0-8 months are concerned the estimate is fully based on the details furnished by the mother.

4) The data supplied by various institutions show variations. The result of the study is based on the reliability of data obtained from secondary sources also.

1.8. Organisation of the Study:

The study is organized in nine chapters. The first chapter is an introductory chapter. In this chapter an introduction of the topic, interrelation between health and economic development, importance of the study, objectives, hypotheses formulated, detailed methodology and data source, organization of the study and limitations of the study are given. In the second chapter a detailed health care scenario of world, India and Kerala are presented. Chapter three gives a detailed account of the review of existing literature in separate headings and also identifies the research gap. The fourth chapter presents a detailed account of the profile of the study area, Kannur district. In this chapter a historical background of medical and public health in the district is also given. Fifth chapter gives a clear picture of present health care infrastructure scenario in the district comprising both government and private sector. It also examines the gap between what is required and what is availed in the health
infrastructure front of Kannur. Chapter six analyses the scope of health insurance in reducing health care of the family in the study area. Seventh chapter analyses the nutritional status of children in 0-3 age group in the study area. Eighth chapter analyses the problem of inequality in the health care use among households. The last chapter gives summary and conclusions, major findings, and policy recommendations of the study.