CHAPTER 1

CONCEPT OF HEALTH & ITS SIGNIFICANCE
The human development is a function of three critical dimensions: longevity – the ability to live long and healthy life; education – ability to read, write and acquire knowledge; and command over resources – the ability to enjoy a decent standard of living and have a meaningful life.\(^1\) Being healthy is clearly one of the most important objectives of human beings. According to Nobel Laureate Amartya Sen, health is among the basic capabilities that give value to human life.\(^2\) Health also includes the ability to lead a socially and economically productive life. Dr. Halfdan. T. Malher, Director General of WHO (1973 – 1988) argued that we must consider health in the broader context of its contribution to social development and expanded the definition of health to include the ability to lead a socially and economically productive life.\(^3\) Health is a fundamental right, emphasized the Alma-Ata declaration of 1978.\(^4\) Since the Alma-Ata conference on health, which focused on equitable and cost-effective primary health care, health has become an important national concern in most countries, especially in the developing countries in improving the quality of life for individuals, and profitable for an entire community as health is the engine that drives economic development.\(^5\)

**1.1 Concept of Health**

According to Oxford dictionary, the meaning of health is ‘*the state of being free from illness or injury.*’ But, numerous studies in the area of the health have been broadening the definition of health. Within the social science research community, the concept of health has broadened beyond the presence or absence of illness to incorporate the notion of well-being— including social, economic and psychological well-being.\(^6\) This broad concept of health has roots in the World Health Organization’s 1948 definition of health: *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or* 

infirmity. This definition although well accepted does not lend itself to direct measurement of health of a given individual or community. It is argued that health cannot be defined ‘as a state’, but ‘a process’ and there is no satisfactory definition of the term ‘well being’. Unless we are able to measure (in some quantitative terms or indices) the health status of the people, we cannot assess the benefits of health services. However, to measure the level of health, some comprehensive and some specific indicators have been advocated by a WHO study group and many more indices have since been developed. There is also no satisfactory definition of disease. It has been well conceptualized that multiple factors e.g. biological, genetic, nutritional, physical, chemical, mechanical, environmental, social, cultural, human behaviour, psychological and economic, play a role in the health or disease status of the individuals and the community. Underlying this broadening conception of health as growing knowledge of integral role that physical and mental health play in the causes and consequences of social and demographic behaviour, social and emotional development, and social and economic status across the life course. Thus health is multidimensional such as Physical – implies the notion of perfect functioning of the body, Mental – one who is free from internal conflicts, firm sense of self identity, good sense of self control, deals with the needs and problem with balanced mind, Social- implies harmony and integration with in the individual, between each individual and other members of the society and between individuals and the world in which they live, Spiritual dimension – it refers to that part of individual which reaches out and strives for meaning and purpose in life.

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1. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. (The Definition has not been amended since 1948).
1.2 Role of health

Health is not only a basic human right, but it is most desired. In a global survey commissioned for the Millennium Summit of the United Nations by UN Secretary General Kofi Annan (Millennium Poll, United Nations 2000), good health is consistently ranked as the number one desire of men and women around the world. It is also a key precondition to economic development. Health is central to well being and a prerequisite for individual and national progress. Data\textsuperscript{14} shows that the countries that have good national health indicators have a greater economic progress and development. In addition, health has an intrinsic value in creating the human capital of the country. Health is significant factor in the development of nation, as high levels of population health go hand in hand with national income. Health and socio-economic progress are very much inter-dependent and health has been accepted as one of the welfare component.\textsuperscript{15} Higher incomes promote better health through improved nutrition, better access to safe water and sanitation, and increased ability to purchase more and better quality health care. However, health may be not only a consequence but also a cause of high income. Economic capabilities affect health, as low income constraints access to health care and health promoting opportunities. Equally significantly, ill health limits people’s ability to earn higher incomes and contributes to poverty. The two way causal relationship between economic development and health has been highlighted by the commission on microeconomics and health, in order to underline the crucial role of health in economic growth. Improvements in health are important in their own right, but better health is also prerequisite and a major contributor to economic growth and social cohesion. Conversely, improvement in people’s access to health technology is a good indicator of the success of other development process.

1.3 Health, Human Capital, Economic Growth and Development

The wisdom of every culture teaches that “health is wealth”. For individuals and families, health brings the capacity for personal development and economic security in the future.

\textsuperscript{14} www.dcp2.org
Health is the basis for job productivity, the capacity to learn in school, and the capability to grow intellectually, physically and emotionally. In economic terms, health and education are the two cornerstones of human capital, which Nobel Laureates Theodore Shultz and Gary Becker have demonstrated to be the basis of an individual’s economic productivity. As with the economic well-being of individual households, good population health is a critical input into poverty reduction, economic growth, and long-term economic development at the scale of whole societies.16

Poor countries tend to be unhealthy and unhealthy countries tend to be poor. Across the broad swath of history, improvements in income have come hand-in-hand with improvements in health. Health is a kind of human capital as well as an input to producing other forms of human capital.17 Being unhealthy depresses the ability to work productively and/or the ability and incentives to invest in human capital. Clearly it implies that worse health implies lower income.18 The first is the role of health in labour productivity. Healthy workers lose less time from work due to ill health and are more productive when working. The second is the effect of health on education. Childhood health can have a direct effect on cognitive development and the ability to learn as well as school attendance. In addition, because adult mortality and morbidity (sickness) can lower the prospective returns to investments in schooling, improving adult health can raise the incentives to invest in education. The third is the effect of health on savings. A longer prospective lifespan can increase the incentive to save for retirement, generating higher levels of saving and wealth, and in addition, a healthy workforce can increase the incentives for business investment. Also, health care costs can force families to sell productive assets, forcing them into long term poverty.19 Investing in health should be a priority for the country, even when the resources are otherwise limited, owing to the high returns from such investments and to reduce the financial risk inherent in an unhealthy population. In a society undergoing great

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economic and social transition, such as India, improvements in health carry an added importance and correspondingly, constitute a greater challenge.

### 1.4 Determinants of health

Many factors combine together affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. The social and economic environment, the physical environment, the person’s individual characteristics and behaviours and availability / access and utilization of health care services have considerable impact on health.

Social and Economic determinants

- Income and social status - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.
- Education – low education levels are linked with poor health, more stress and lower self-confidence.
- Social support networks – greater support from families, friends and communities is linked to better health.
- Culture - customs and traditions, and the beliefs of the family and community all affect health.

Psychological Determinants

- Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses.
- Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life’s stresses and challenges all affect health.
- Gender - Men and women suffer from different types of diseases.
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Physical Determinants

- Physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health.
- Employment and working conditions – people in good working condition employment are healthier, than those who have less control over their working conditions.
- Health care services – availability / access and utilization of services that prevent and treat disease influences health.

It is the availability of the health care services at the accessible distance with effective and complete utilization of the Health Care Services, which plays a significant role as the prominent determinant in achieving the nation’s health. Access is important but people’s experiences of what the facility has to offer in terms of medical care and whether it is worth their while to use it are equally important in utilizing healthcare facilities. People’s perceptions of ‘free’ care is that of it being of low quality, and therefore, even the available infrastructure is grossly underutilized, i.e. the public healthcare system in India suffers from gross supply side distortions that go beyond physical availability. The simple availability of a building designated as a public health facility is no guarantee that it is functional. Even if it is functional, socio-economic barriers to access, the delivery of quality healthcare services, poor quality of infrastructure, and severe lack of even basic drugs and equipment are significant factors in accepting and utilizing the available facility. This is especially true for rural areas and with regard to women’s and children’s health. Maternal, infant and child morbidity and mortality rates are intolerably high in India. Not only social justice but economic efficiency is being compromised as India does little to protect the health and well-being of its future generations.²⁰

1.5 Importance of the study

In 1978, in a landmark global conference organized by WHO and UNICEF at Alma Ata (erstwhile USSR), a revolutionary strategy based on primary health care was put forward to

²⁰ Nirupam Bajpai, Ravindra H. Dholakia and Jeffrey D. Sachs, Scaling up Primary Health Services in Rural India, Centre on Globalisation and Sustainable Development, Working paper No.29, 2005.
reach the goal of Health for All by 2000. After more than three decades, it is the time to critically evaluate where India as a nation stands in providing healthcare to its people.

1.5.1 Health Profile of India

India has achieved considerable improvements in human development factors. According to Human Development Report 2011 of UNDP, the HDI for India is 0.547 in 2011 with an overall global ranking of 134 out of the 187 countries. Life expectancy at birth in India was 65.4 years in 2011 as against 55.1 in 1980. Infant Mortality Rate has declined considerably, 71 per 1000 live births in 1997 and reached 47 per 1000 live births in 2010. But the rural (77 in 1997 and 51 in 2010) & urban (45 in 1997 and 31 in 2010) differentials are still high. However, there should be no room for complacency as India is still in the medium human development category with countries like China, Sri Lanka, Thailand, Philippines, Egypt, and Indonesia. The existing gap in health indicators as compared to developed countries and also many of the developing countries indicate a need for much faster and wider spread of basic health.

When it comes to healthcare, there are Two Indias –

(1) India, which provides high-quality medical care to middle-class Indians and medical tourists, and (2) India, in which the majority of the population lives—a country whose residents have limited or no access to quality care.

India lives in its almost 6.5 Lakhs villages and if basic health care is not to reach the rural areas, then no matter how much progress achieved in the urban and semi-urban areas, as overall growth as a nation will be retarded. India has made significant progress in improving healthcare, but improving access to basic healthcare services to the rural population is perhaps one of the most pressing—from a straightforward human development perspective as well as to ensure a solid foundation for future economic growth. Despite India’s dazzling recent economic performance, persistent widespread poverty means that malnourishment and

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22 Human Development Report 2011-Sustainability and Equity: A better future for all, United Nations Development Programme (UNDP)
23 *Sample Registration System Bulletin*, Office of Registrar General of India, April 1999; 33(1): 1
24 *Sample Registration System Bulletin*, Office of Registrar General of India, December 2011; 46(1): 1
communicable diseases remain serious problems. Healthcare indicators vary widely across states, partly reflecting the differing levels of resources available to state governments, but one trend that is totally consistent is that indicators are much worse in rural areas than in urban ones. The problem is, first and foremost, one of access.

India's healthcare system rests on a primary healthcare system that is grossly inadequate and falls woefully short of what it should be to ensure that our people have access to at least basic healthcare. According to the Economic Survey 2009-10, only 13 per cent of the rural population has access to a primary healthcare centre with 33 per cent having access to a sub-centre, 9.6 per cent to a hospital and 28.3 per cent to a dispensary or clinic. India has a rudimentary network of public hospitals – there is a shortage of 4,504 primary health centers and 2,135 community health centers in 2009. According to a study conducted by the Confederation of Indian Industry, the formal healthcare system reaches only about 50% of the total population. India is also desperately short of doctors, with only 1 doctor per 1,700 people in 2006.

Anemia, infant and child malnutrition, malaria, tuberculosis and diarrhea remain widely prevalent, despite being preventable and curable. Huge population has led to unhygienic surroundings which, in turn, have given rise to vector-borne and water-borne diseases. Many of these can be easily prevented by providing access to clean drinking water and improving sanitation facilities. The World Health Organisation estimates that overall disease burden would fall by 15 per cent with improved access to clean water and sanitation facilities, while the World Bank estimates that 21 per cent of communicable diseases in India are water-related. India needs to focus on preventable rather than curative measures where the costs are higher.

India also carries the world's largest burden of maternal, newborn and child deaths. At the beginning of this Millennium in year 2000, 189 countries and 23 international health agencies had pledged to reduce child under-5 mortality by two-third (Millennium Development Goals 4) and to reduce maternity mortality by three-fourths (Millennium Development Goals 5).

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28 Paul Vinod Kumar et al, Reproductive health and child health and nutrition in India: meeting the challenge, The Lancet, 2011; 377 (9762): 332 -349.
Development Goal 5) by 2015. Reproductive health and child health and nutrition are core priorities for any country, more so for India with the world's greatest burden of maternal, newborn, and child deaths. According to The First Report on maternal mortality in India (1997-2003), maternal mortality ratios (MMR) per 100,000 live births was about 400 in 1997-98, 301 in 2001-03, 254 in 2004-06 and 212 in 2009 showing declining trend. Even though the achievement of almost 50% reduction gives satisfaction, it also tells at the same time that reducing MMR to 109 by 2015 envisaged by Millennium Development Goals is going to be a real challenge. Further, with respect to maternal health, only 52% of Indian mothers received three or more antenatal checkups and only 41% of deliveries were conducted in medical institution while 49% deliveries were assisted by medical professional and 43.5% of children in India received all vaccinations. India also has the greatest number of undernourished children, with about 52 million stunted children (age <5 years). Progress in reproductive health, and child health and nutrition does not compare favourably with other countries in Asia that gained independence at about the same time as India and at international level. With only four years left for the target year, India still has a long way to go to reach its declared goals.

The healthcare in a country as a whole is facing many challenges. India desperately requires tremendous magnitude of India's healthcare needs and the immense investments required to improve the health status of people from all parts of India and across all strata of society. In addition, there is also an urgent need to raise the availability of qualified doctors, nurses and paramedical staff and to create an infrastructure and a system for them to work in rural areas. Further, general lack of awareness on healthcare issues and the low public consciousness of hygiene and sanitation norms will need to be addressed as a starting point and with it the lack of accessibility to healthcare services.

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31 International Institute of for Population sciences (IIPS) and Macro International 2007, Report of National Family Health Survey (NFHS-3), India: Mumbai: IIPS.
32 Paul Vinod Kumar et al, Reproductive health and child health and nutrition in India: meeting the challenge, The Lancet, 2011; 377 (9762): 332-349.
India’s health problems are two-fold –

(1) **Inadequate and inaccessible healthcare services and infrastructure and**

(2) **Non-utilization of available healthcare services due to low awareness and poverty.**

Hence, India faces the daunting challenge of meeting health care needs of its vast population and ensuring accessibility, efficiency, equity and quality of healthcare and thereby achieving the objective of growth with equality and social justice. It calls for sustained efforts and planning, as well as coordinated action from public and private players and community involvement. About a sixth of the world’s population lives in India and thus, the progress on priority health outcomes in the country as well as in the world depend to a large extent on the progress of health standards at the state and district levels in India. The government has begun taking steps to improve rural healthcare. The government launched the National Rural Health Mission (NRHM) 2005-2012, in April 2005. *The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children,* that have low public health indicators and/or inadequate infrastructure in improving the health at grass root level.

Majority of country’s population lives in rural areas and does not have awareness about the diseases generated by water and bad sanitation. Further, some of the myths, old beliefs and practices are detrimental to the development of the society, especially in child birth and maternal care. Situation calls for the creation of mass awareness among the rural masses to minimize the magnitude of the problem and bring in social change. The application of social marketing principles could be made use of to improve health status of the rural community. This is especially true for rural areas with regard to women’s and children’s health, as maternal, infant and child morbidity and mortality rates are intolerably high in India.

In the light of the India’s health status outlined above, the present study is designed to *explore the availability of health care services, gaps in the current health care facilities, the level of acceptance of the available services and the social marketing of different*

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Health programmes to create awareness, educate the rural community in increasing the utilization of the available facilities in the rural parts of Anand and Kheda districts of state of Gujarat with a special focus to Maternal and Child Health.

1.5.2 Health Profile of Gujarat

Gujarat state, situated on the west coast of India, accounts for 6% of the area of the country and 5% (51 million) of the population of India making it rank tenth in the country. Gujarat has 26 districts subdivided into 226 blocks, 18,618 villages, and 242 towns. The decadal population growth rate (1991-2001) of the state has been 22.6%, which is higher than that of India (21.5%). Gujarat is one of the most urbanized states in India, with 37% urban population. Gujarat has been ranked third in the country in terms of growth during the 10th five year plan (2002-2007). The state has registered an overall Gross State Domestic Product (GSDP) growth rate of 12.99 percent. Gujarat has remained among the top three of the 15 largest states in India in attracting industrial investments all through the 90s and the early part of this decade. Based on the wealth index, the state of Gujarat is wealthier than the nation as a whole. Almost one-third of Gujarat’s households (56% of urban households and 15% of rural households) are in the highest wealth quintile, compared to one-fifth of households in India. Only 7 percent of households in Gujarat (1% of urban households and 12% of rural households) are in the lowest wealth quintile. However, the state's economic growth could not get translated into human development. Gujarat which ranked 4th in 1981 slipped to the 6th position in 1991 and 2001 despite improvement in its value terms. It is inappropriate to presume that economic growth directly results in overall development of its people. Report, prepared for the state government by the Gandhi Labour Institute says, "The state has reached only 48 per cent of the goals set for human development. Further, it comes in the category of low human development as per the United Nations Development
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Programme (UNDP) definition, where entities with an index value of less than 0.500 are called countries with low human development. According to the report, Gujarat’s Index value is 0.478, placed sixth after - Kerala (0.533), Maharashtra (0.530), Punjab (0.528) and Tamil Nadu (0.512) with a high index value and Karnataka (0.497). It explains that the state has fallen behind in most of the categories — income, education, health and gender participation. The report says, "The state is ranked at the sixth position because of its good performance in the housing index, where it ranks second. In the income index, the state is sixth, in education sixth, in health ninth. Good performance in housing is offset by the dismal performance in gender participation, where Gujarat ranks eleventh."

1.6 A brief on the study

The present “Rural Healthcare Services” study is undertaken to explore current healthcare system and health facilities in the Anand and Kheda district of Gujarat, India. The research is designed to study the significant aspects of health care such as - availability, accessibility, and acceptance of the health care services. The study is based on the primary data and the secondary data. The primary data is collected through the structured questionnaire as well as the interviewing the households, key informants, who are working in the area of health of the village like Taluka Health coordinators, Village Health Workers of Tribhuvandas Foundations, ASHA of the village, doctors and / or ANMs of Primary Health Centres / sub centers. The study covers total of 49 villages of 18 talukas of both Anand and Kheda district of Gujarat, India.

The secondary data relating to health indicators, health infrastructure and other statistics relating to health are taken from Ministry of Health and Family Welfare of Government of India, Ministry of Women and Child development of Government of India, Five Year Plans of Planning commission of India, Annual budget of Government of India, Population Census of India-Office of the Registrar General and Census Commissioner of India, Sample Registration System Bulletin from Office of the Registrar General of India, Findings of National Family Health Surveys (1, 2 and 3), Findings of District Level Household Surveys (I and II) from International Institute of Population Science, statutory bodies like Medical Council of India, Dental Council of India, Indian Nursing Council, Pharmacy Council of India, Directorate General of State Health Services, Central Bureau of Health Intelligence,

1.7 Organization of chapters

The thesis presents a piece of work of an attempt to explore the rural health care system in the country in general and to know the availability of health care facility with respect to infrastructure, manpower and the acceptance level or the utilization pattern of the different health care facilities in rural areas of Anand and Kheda districts of Gujarat. The entire thesis is divided into six chapters to cover all the dimensions of rural health care delivery system.

Chapter 1 discusses the Concept of health, Role of health with respect to the economic development and human capital of the nation and Determinants of the health. It also discusses the importance of the study by understanding the health profile of the country through the health indicators and health status of India. Further, it briefly describes the Gujarat’s profile and bird’s eye view of the study.

Chapter 2 presents in detail the Rural Health Care System and reviews the situation of the health care in the country from pre independence era to the current date (1946 – 2010). It briefly reviews

(a) The different committee reports, recommendations and policies, commitment to assure health care facility in India, Primary Health Care Approach adopting the main principles and values of Equitable distribution, Universal access to coverage on the basis of the need and Community participation

(b) Primary Health Care resources in India in terms of physical infrastructure, manpower and financial resources needed to implement the primary health care.

(c) The current situation presenting the situation analysis of the different programmes, progress made in respect of different dimensions of primary health care focusing on maternal and child health including immunization, nutrition, safe water, basic sanitation and health education.
Chapter 3 completely deals with the literature review with respect to different dimensions of the Health Care Services like availability, accessibility, acceptance through utilization, perception and satisfaction and health care services delivery; Maternal and child health like antenatal, intranatal, postnatal, safe motherhood, infant or new born health, under 5 year children health, immunization, nutrition, maternal mortality, Infant mortality and Adaptation of social marketing for different health related issues in giving health education and in bringing the awareness and gradually achieving behavioural transformation in accepting and adopting the desired change.

Chapter 4 deals with the Research Methodology. It gives the complete details of the way the research is designed including the sampling design, size and administration of the surveys. The research design adopted here is Exploratory and Descriptive. This chapter discusses research design about the two different surveys:

(i) House Hold survey
(ii) Health Care Facility survey

Chapter 5 discusses the analysis, different statistical tools that are used in analyzing the data, discussion of the results with respect to Gujarat indicators followed by the interpretation of the results and findings from the study.

Chapter 6 summarizes the findings of the research with conclusions and suggestions with respect to doable and deployable, limitations of the study and future possible study in the area.
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