INTRODUCTION

"Health and development have a two way relationship. While in the process of economic development, health forms an important variable, the development spreads its effect upon the health of the people."¹

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions and governments have a responsibility for the health of their people which can be fulfilled only by the provisions of adequate health and social services. Impressive advances in technology and modern machines have taken place, almost everywhere, during the last century. The goal of all health service activities and programs is to improve the health of people. Thus over the years, there has been considerable interest and activity in developing methods to measure quantitatively the health status of individuals and populations.

Generally an increase in the aggregate National Income and income per-capita is expected to increase the economic welfare of the individuals. But it may not be the case if improvement in wealth gets concentrated in the hands of groups, which are already relatively better off. To know whether there has been an enhancement in the welfare of the people, which is the ultimate objective of all schemes, plans and efforts concerning the development of a nation, it is essential to consider other indices of welfare too and to study the utilization behaviour of the various health schemes. Good health is the bedrock on which social progress is built. A Nation of healthy people can do those things which make life worthwhile and as the level of health increases so does the potential for happiness.

The increased attention by the Governments of many developing countries to the basic needs of their populations has motivated, a number of Econometric investigations into the
nutritional consequences of food price interventions. Capital formation is very important in determining the rate of growth of economy. Capital formation in the physical form like other factors depends on the persons behind capital formation. Their ability to add the physical wealth depends on their physical and mental capabilities. Such capabilities depend on their health, education and training. Health conditions of the persons and Economic development go hand in hand because the better the health conditions the higher the level of their capabilities to develop the economy. Health of an individual can be affected by general health conditions of the society and vice versa. Therefore health of the community needs higher attention while considering developments of a region or a country. In general the level of living of the people in a nation is affected by the health conditions of the people in it. According to the census of India 2001 about 74% of India population is living in the rural areas as against 26% in urban areas. There are nearly 5,96,000 villages in India which are scattered over larger areas as compared to urban areas. Urban areas are not only concentrated attractive centers for economic activities and for services like health, education, transport etc. Health problems of lower income group people are more than higher income group.

"Health affects every aspect of life. Our ability to work, to play, to enjoy with our families and to socialize with friends, all depend crucially upon our physical well-being. Serious illness creates enormous pain and suffering, even minor transient ailment can be depressing psychologically as well as debilitating physically. Ill health, which leads to health, makes all other services of satisfaction irrelevant."²

Health status is one of the important indicators of the welfare of the people. The issue of health is of great importance both from the point of view of the individuals and the nation as well. In any country it is the health status of the people that determines, their well-being and pace of economic and social development. Health is an important problem both in the
advanced and developing countries but it is a most serious problem in the developing economies and that is a reason why a great deal of attention is being paid to investment in health and other welfare schemes which are important components of investment in human capital. Health status of the people determines the average expectation of life, productive age, production, productivity, earning capacity, employment and well being of the people. On the other hand several economic variables like employment, income, purchasing power and poverty determine the health status of the people.

In the dynamic economy social services which gives much more productive capacity, since the expenditure of social services is of prime important among the government activity. Among the various social services the health and family planning, education, housing and rural and urban development are very important for the sake of the welfare of the people. Every nation is spending enormously the expenditure on health services, which increases year by year and plan period by plan period sufficiently. According to the Report of the Economic survey of India the expenditure on social services in 1975-76 was 686.9 crores, and it increased to 3,62,720 crores in 1999-2000.

1.1. DEFINITION OF HEALTH AND HEALTH CARE

The term ‘Health’ is widely used in every day conversation, with little apparent ambiguity. However, on closer examination, it reveals various different interpretation of ‘health’, each with different implications for the role of the state. According to the oldest definition health is “the absence of disease.” An older definition of health is “the ability to function effectively within one’s environment.” The World Health Organization (WHO) defines health as “a state of physical, mental and social well being and not merely the absence of disease or infirmity” and indicates a clear shift away from a earlier narrow organic or functionally based definitions of health to a more holistic view. It seems the health of an
individual or community being concerned not only with physical and mental status, but also with social and economic relationships. A dictionary definition defines health as “Soundness of Body”. The term health care has been used to denote a wide variety of types of health care, ranging from public health services such as environmental sanitation through personal preventive services such as immunization, to personal curative services. Many developing countries (particularly those within Africa, Asia and Caribbean) find themselves with the state historically having a major role in the provision of all types of health care. “Twaddle 6 defines that from a biological standpoint, “perfect health might be seen as a state in which every cell of the body is functioning at optimum capacity and in perfect harmony with each other cell.” From a social standpoint “perfect health may be a state in which an individual’s capacities for taste and role performance are optimized. In Ayurved Swasthya as defined as “well balanced metabolism Dhatusamya plus a happy state of the being, the senses and the mind. Senses here mean the five organs of perception (smell, sight, taste, touch and hearing) coupled with five organs of action namely mouth, hands and feet, and organs of speech excretion and reproduction.”7

1.2. THE NEW PHILOSOPHY OF HEALTH 8

The following points express the new philosophy of health,

- Health is a fundamental human right.
- Health is the essence of productive life and not the result of ever increasing expenditure on medical care.
- Health is intersectoral.
- Health is an integral part of development.
- Health is central to the concept of quality of life.
- Health involves individual state and international responsibility.
• Health and its maintenance is a major social investment.
• Health is a worldwide social goal.

1.3. ECONOMIC IDEAS OF HEALTH

Health status of the people determines the average expectation of life, productive age, production, productivity, earning capacity, employment and well being of the people. On the other hand, several economic variables like employment, income, purchasing power and poverty determine the Health Status of the people. “A main social target of Government, International Organizations and the whole World Community was the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead socially and economically productive life.”

Health conditions of the persons and economic development of the people go hand in hand because, the better the health conditions, the higher the level of their capabilities to develop the economy. In a dynamic economy, social services give much more productive capacity since the expenditure on social services is of prime importance among the Government activities. Among the Social Services, the Health and Family Planning, Education, Housing and Urban Development and other Social Services are very important.

1.4. UTILISATION OF HEALTH CARE SERVICES

The demand for Health care is a derived demand. Health is demanded not just for its own sake but also to enable individuals to participate in the labour market. This insight was utilised in an important study by Grossman which represents a direct application to the demand for health and Health care. Such theories were themselves important extensions of the Neo classical approach to consumption theory. The earlier Revealed Preference Approach resting upon the Individual’s taste not changing and the member of simple accompanying assumptions
demonstrated that demand could be analyzed simply through observing how consumer purchases varied with prices and income.

This new approach to consumer behaviour suggested that the household becomes the basic decision making unit with regard to production as well as consumption. In applying this approach to health and health care, Grossman perceives health as a fundamental commodity. Consumers are held to demand health for two reasons. As an investment commodity, it determines the amount of time available for work, which allows consumers to produce money earnings, and the amount of time available for leisure with leisure time being combined with other commodities, which in turn produces commodities and directly enters the consumption function.

Becker suggested that consumers are simultaneously involved in production as well as in consumption activities. With the new framework for examining consumer behavior, a commodity, good health, is treated as a durable item. This treatment is adopted because 'health capital' is one component of human capital and the latter has been treated as a stock in the literature on investment in human beings. Education has a positive and statistically significant coefficient on health demand. Higher income persons would reduce the demand for health and increases the demand for medical care.

Many attempts to explore the utilization aspect of Health Services in India have been largely limited to micro level studies. Those studies have included various aspects namely distance of facility from patients, type of care, availability of facility, cost of treatment, quality of care, awareness about the existing facility as well as other socio-economic aspects of patients in a particular regional set-up. Micro level studies includes that of Yesudian –1980, 1988; Khan and Prasad 1988; Duggal and Amin 1988; Purohit 1992; Purohit and Siddiqui 1994. Recently four macro level studies have provided a good information base pertaining to
various aspects of health services in the country. - NSSO\textsuperscript{12} (1992); NCAERT\textsuperscript{13} (1992) and
NFHS\textsuperscript{14} (1993). A detailed analysis of this newly available database could help one to explore the present status in health services utilization

1.5. DIFFERENT PERESPECTIVES ON HEALTH

HEALTH AS A RIGHT

Health has been treated as a right, analogous to justice or political freedom. Indeed the \textit{WHO} constitution states that ‘the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political, belief, economic or social condition.’ Few would, however, believe that equal health status is attainable in the same way that equal political freedom may be. However, health is seen as so fundamental that constraints to its full attainment must be minimized. Part of this involves ensuring access to health care. Indeed for many, this, rather than the unattainable equality of health, is seen as right. The state is seen as having a responsibility to ensure this, comparable with its role in ensuring equal justice. Under such a view a government will be particularly concerned with issues of equity in health and health care\textsuperscript{15}.

HEALTH AS A CONSUMPTION GOOD

For others health is seen as an important individuals objective, which is not comparable with ‘justice’, but rather with material aspects of life. Such a view often refers to health as consumption good. The state here has no special responsibilities in the promotion of health, but leaves decisions as to its comparative importance to an individual. The state role under such a view might be limited to ensuring that the health care provided is of an adequate quality (such as ensuring professional standards), in the same way that it would monitor the quality of any goods or services, such as food.
HEALTH AS AN INVESTMENT

A third view of health is that it is investment, largely because it affects the productive ability of the workforce. Illness may affect overall production, either through absenteeism or by lowering productivity through its debilitating effects. The development strategies for many developing countries (both colonial and post-colonial) during the 1950s and 1960s saw this prime factor as indicator of development. These strategies were reflected in the emphasis placed by the state on the productive sector- industries, agriculture, and mineral extraction. To compete for attention (and funding) the apparent effects of ill health on productivity were often stressed by advocates of the health sector.

Such a view of health, as primarily an investment good or a means to an end rather than as an end in itself, persists in some quarters, although its influence has been reduced by variety of factors. First, the recognition of the growth in GNP does not by itself lead to the form of development many would wish to see, but often leads to a widening of inequalities in society, with little alleviation of the condition of the poorest. Second comes the recognition that the health status of an individual, particularly within an agricultural economy affected by a seasonal variations, with periods of underemployment and family-based labour systems, may not have the expected effects on production levels. And third is the fact that the effects of such a strategy, if taken to its logical conclusion, on provision for health for non-productive groups, such as the elderly, would be unacceptable.

1.6. NEED FOR DISTRICT AND BLOCK LEVEL HEALTH PLANNING

As in the case of general planning the theoretical justification of district and block level health planning is based on the well-known arguments for macro level planning. Theoretical arguments also hold good when we see that any national and state level plan programs being micro in character cannot be substituted for a macro health plans formulated at the local
There are many health activities in relation to which an intimate knowledge of local conditions and local requirements is very much needed for District and Block level health plan arises because,

a) It serves as a guide for suitable locational decisions about Health care Services, facilities, investment, and resources tapping.

b) The national health policy objectives and programs goals like Health for all' (HFA) or significant moderation in mortality, morbidity and fertility with in a period of 12-15 years (if not rigidly by 2000AD) will not be possible unless a detailed health planning right at and from within the block and district level is attempted.

c) It is in a district rather more emphatically in block level health planning lies the possibility of intensifying extension efforts for developing the result potentials by bringing their people in greater actions.

d) Taking the inherent points of selectively or focus on, most needy area on one hand and percolating decentralization on the other the block and district level health planning will fulfill both the dimensions of integrated area development i.e., functional and spatial.

e) Spatial framework, in case of multi level health planning viz., at Block feeded through village or village cluster health plans can be seen expressing the accessibility and distributional equality.

f) Spatial health planning; a planning from below and within finding expression in block and district health plan is a HFA strategy of locating services at places where they can be most effectively used by people who can be as close as possible to health facilities.
1.7. HEALTH CARE SERVICES IN INDIA

If we go back to history, we will see that our leaders were concerned about the health of the population even before independence. The National Planning Committee of the Indian National Congress was set up in 1938. The then President of the Congress, Subhash Chandra Bose, nominated Jawaharlal Nehru, Chairman of the committee. This committee set up a sub committee on National Health that made a penetrating assessment of the then health situation and health services in the country and called attention to the need to have a state controlled free health system, which balanced curative and preventive care. The health of the people was seen as the responsibility of the State. Promoting health as a right of every individual The National Planning Committee's goal was "an organized public service discharging a common obligation of society towards its members."\(^{18}\)

Then the Health Survey and Development Committee (Bhore Committee\(^{19}\)) was set up by British Government in 1943, which submitted its report in 1946. Though it was set up by colonial Government its members have been in the forefront of the struggle for independence. This committee suggested that health services should be within easy reach of people and the unit of health administration "as small as is compatible with practical considerations."

After independence many committees were set up by the Government of India to look into the health aspects of the population. The most important of these were the Mudaliar Committee\(^{20}\) which surveyed the progress over the first decade and recommended the strengthening of primary health centers; the Kartar Singh Committee\(^{21}\) which recommended the retraining of unipurpose workers as "Multi purpose Workers"; the Srivastava Committee\(^{22}\) on Medical Education and Support Manpower which reiterated the need for community health
workers, and the ICSSR-ICMR (Ramlingsswani Committee)\textsuperscript{21} which gave shape to the Alma Ata "Health for All" Declaration (WHO-UNICEF, 1978).

Population stabilization is an essential pre-requisite for sustainable human and social development with more equitable distribution. National Population Policy (NPP-2000) recognizes the fact that the population stabilization is as much a function of making reproductive health care affordable as other life quality improving services such as primary and secondary education, sanitation, drinking water, housing, transport, communication and empowering women and enhancing the scope for their employment\textsuperscript{24}. It outlines the policy framework for advancing goals and prioritizing strategies during the next decade to meet the reproductive child health needs of the people to achieve net reproduction rate of unity or replacement level of fertility by 2010. It recognizes the need to simultaneously address issues of child survival, maternal health and contraception while increasing outreach and coverage of a comprehensive package of reproductive and child health services by Government, industries and the voluntary non-government sector.

With the launching of a Reproductive and Child Health programme (RCH) in October 1997 the focus is on decentralized area specific macro planning and implementation with emphasis on approving quality and coverage of family welfare services. Child survival, safe motherhood, control of sexually transmitted infections (STI) and reproductive tract infection (RTI) are some of the welfare measures to improve quality and coverage of health care for women children and adolescents.

The NPP 2000 outlines immediate, medium term and long term objectives. The immediate objectives are to address the unmet needs of contraception, health infrastructure, and health personnel and to provide integrated services delivery for basic reproductive and child health care. The medium term objective is to bring the total fertility rates to
replacement level by 2010. The long-term objective is to achieve a stable population by 2045. Some progress has been achieved in improving demographic indices.

Ninth Plan (1997-2002) Outlay for the department of Family Welfare has been fixed at Rs.15, 120 crores, of which Rs.10, 758 crores has been provided in the first four years of the Plan. The funds allocated for the schemes in the annual plans have been almost fully utilized. Rs.3520 crores has been provided for various schemes of Family Welfare for the year 2000-2001. At the first meeting of the National Commission on Population on 22nd July 2000, the Prime Minister announced

i. The formation of an Empowered Action Group within the Ministry of Health and Family Welfare to focus particular attention on those states which have deficient national socio-demographic indices,

ii. Setting up of National Population Stabilization Fund with seed money of Rs.100 crores to provide a window for canalizing funds from National voluntary sources.

iii. The Prime Minister appealed to the corporate sector, industry, trade organizations and individuals to generously contribute to this fund and thus contribute to this national effort of population stabilization.

NATIONAL POPULATION POLICY, 2000

The following points are concentrated in the National Population Policy 2000;

- Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.

- Make school education up to age 14 free and compulsory, and reduce dropouts at primary and secondary school levels below 20 percent for both boys and girls.

- Reduce infant mortality rate below 30 per 1000 live births.
• Reduce maternal mortality ratio below 100 per 1,00,000 live births.

• Achieve universal immunization of children against vaccine preventable diseases.

• Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.

• Achieve 80 per cent institutional deliveries and 100 percent deliveries by trained persons.

• Achieve universal access to information/counseling, and services for fertility regularization and contraception with a wide basket of choices.

• Achieve 100 per cent registration of births, deaths, marriage and pregnancy.

• Contain the spread of Acquired Immunodeficiency Syndrome (AIDS), and promote greater integration between the management of reproductive trace infection (RTI) and sexually transmitted infection (STI) and the National AIDS Control Organization.

• Prevent and control communicable diseases.

• Integrate Indian System of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.

• Promote vigorously the small family norms to achieve replacement levels of TFR.

• Bring about convergence in implementations of related social sector programs so that family welfare becomes a people center program26.
Recoveries of user costs are essential ingredients of economic reforms. Health sector reforms are inevitably a part of economic reforms. Economic reforms and privatization of the health services in Eastern European countries had resulted in reduction in access to health services for the poor in these countries and this in turn had adverse effects on health indices of the population. There is a lesson to be learnt from this and efforts have been made to ensure that this does not happen in India.

National Health Programmes are implemented to control communicable and non-communicable diseases like Malaria, Tuberculosis, Leprosy, Blindness, AIDS, Cancer etc. Strengthening of disease surveillance and response systems has also been undertaken to prevent outbreak of infectious diseases.

Peak annual incidence of 6.47 million malaria cases in 1976, declined to about 2 million by 1985 and thereafter contained at the level of 2-3 million in spite of increasing population burden and rapid urbanization. There has been a declining trend in incidence of malaria since 1997\(^2\). The Enhanced Malaria Control Project (EMCP) launched in September 1997 with World Bank assistance has gained momentum. Covering a population of 62.2 million in 100 districts, this project is supplementing the ongoing strategies under the National Programme by way of using a better mix of interventions like synthetic pyrethroid and medicated mosquito nets, bio-larvicides etc.

World Bank supported National Leprosy Eradication Programme (NLEP) was successfully completed at the end of September 2000 after six and half years. Nine States have achieved level of leprosy elimination and seven other States are very close to achieving elimination. It is proposed to implement the second phase of the World Bank consolidation NLEP Project focusing on the 5 endemic states of Bihar, M.P., Orissa, U.P., and W.B. for
another 3 year period in order to reach elimination level of 1 per 10,000 at the national level by end 2003.

Under the Revised National TB Control Programme (RNTCP), the cure rate has improved to 8 out of 10 patients from about 4 out of 10 in the earlier programme. By October 2000 the RNTCP had placed nearly 4,00,000 patients on RNTCP treatment saving more than 60,000 lives. The coverage is expected to be 500 million by the end of 2002.

Better performance has been achieved in Cataract Operations, which have gone up over the years. During 1999-00, 3.5 million Cataract Operations were performed (of which 46.5 per cent were IOL, ensuring superior vision), as compared to about 3.3 million in 1998-99. The target for the current year is 3.96 million.

HIV/AIDS is now sought to be projected as a socio economic issue and not merely as a public health issue. The 2nd phase of National AIDS Control Programme was launched in November 1999 at an estimated cost of Rs.1425 crore over the next 5 years. The key objectives of the programme are to reduce the spread of HIV infection and to enhance the capacity to respond to the menace of HIV/AIDS on a long-term basis. A major concern has been to achieve zero incidents of polio by the end of the year 2001. During 2000-2001, India has deviated from the existing program of action in the Pulse Polio Program, in order to meet the challenge of continuing incidence of polio in pockets within the country. The incidence of polio has sharply declined with many States reporting not a single case or only one or two cases of wild polio virus.

The National Health Policy a major emphasis is on ensuring primary health care to all by the year 2000, it nevertheless identifies certain areas, which need special attention. These areas are:
Nutrition for all segments of the population,
The immunization programme,
Maternal and child health care,
The prevention of food adulteration and maintenance of the quality of drugs,
Water supply and sanitation,
Environmental protection,
School health programmes,
Occupational health services, and
Prevention and control of locally endemic diseases.

Active community participation has been considered to be one of the most important supportive activities for the successful implementation of the health programmes.

Family welfare services, including maternal and child health schemes, are offered through the existing network of Primary Health Centers (PHCs), sub-centers, and referral centers called Community Health Centers (CHCs), and also through Village Health Guides and Traditional Birth Attendants at the village level. According to the present infrastructure plan, there is one sub-center for every 5,000 population, one PHC for every 30,000 population and one CHC for every 100,000 to 120,000 population. In tribal and hilly areas, one sub-center is planned for every 3,000 population and one PHC for every 20,000 population. As of March 1992, there were 20,719 Primary Health Centers and 131,464 sub-centers, providing health and family welfare services to the rural population (Government of India, 1994). In cities and towns, the health and family welfare services are provided through a network of government or municipal hospitals and dispensaries, and urban family welfare centers. Private hospitals, clinics and dispensaries also play a major role in providing these services in urban areas.
India was the first country to have an official family planning programme, which was initiated in 1952. However, even during the preindependence period, a birth control movement was started by a number of social activists including R.D. Karve, Dr. A.P. Pillai, Lady Cowasji Jehangir, Shakuntala Paranjape and others. A review of the eight development plans adopted since 1951 indicates that family planning as a measure of population control has been given a high priority in each five years plan.\textsuperscript{30}

The long-term demographic goal\textsuperscript{31} is to achieve replacement-level fertility (net reproduction rate of 1.0) by 2016. As a part of this goal the country aims to reduce crude birth rate to 21 per 1000, the crude death rate to 9 per 1000 and infant mortality rate to below 60 per 1000 live births, and to increase the effective couple protection rate to 60 percent. In addition the recently introduced National Child Survival and Safe Motherhood Programme accelerates the goal for infant mortality and introduces additional health goals. The programme aims to reduce infant mortality from 80 to 75 by 1995 and 50 by 2000, reduce the child mortality rate (at ages 1 to 4) from 41 to less than 10 by 2000, reduce the maternal mortality rate from 400 to 200 per 100,000 live births by 2000, eliminate tetanus among neonates by 1995, prevent 95 percent of deaths due to measles and reduce measles cases by 90 percent, prevent 70 percent of deaths due to diarrhoea and reduce diarrhoea cases by 25 percent and prevent 40 percent of deaths due to acute respiratory infection by 2000 (Ministry of Health and Family Welfare, 1992b).

1.8. STATEMENT OF THE PROBLEM

In recent years health reform has shot up to the top of political agendas throughout the world for the industrial countries and many middle income developing countries. Reasons include rapidly raising costs, the large number of people still not covered by insurance and fear of AIDS for developing countries, the main reason is a better understanding of the importance
of health for improving the productivity of workers and of the potential for enormous gains in health at very low cost. Countries worldwide spent huge sums on health about $1700 billion a year or roughly 8 percent of global income. But world development report 1997 shows that these moneys could be spent much more wisely in the process thereby helping a great deal to help the world's one billion poor.

Economic productivity and human well being are vitally related in the poor countries as well as in the rich ones. Prof. Schultz demonstrates that a decisive factor in securing human well being is investment in people and knowledge. He shows that the acquired abilities of people - their education, experience, health and skills are basic in achieving economic progress. The decisive factors of production in improving the welfare of poor people are not space, energy and cropland. The decisive factors are the improvement in population quality and advances in knowledge.

The standard of living of the people in a country is determined, by the basic necessities of life such as nutrition, clothing, housing and some qualitative services such as health, education etc. It is obvious that in a developing country like India whose population goes on increasing these basic needs and services cannot be produced in the same proportion. To support the existing standard of living itself needs much more investment. The rapid rate of population increases adversely affecting progress in providing more health, medical and social services and requires more capital investment.

It is true that there is a broad correspondence between the level of overall economic development attained by a country on the one hand and the educational, health and housing status of its population on the other. Several recent studies have shown that production has increased at a much faster rate than what can be explained in terms of the labour force and physical capital. Becker, Correa, etc have clearly brought out the part played by human
capital in the growth of an economy. Investment in human capital can take many forms like expenditure on medical, family planning, public health sanitation and water supply etc. As health is one of the basic problems of a developing country, the pattern of utilization in our country had some desirable outcomes, namely, growing popularity of indigenous non-allopathic systems of medicines and growth in private sector involvement in this expensive tertiary care. As against the national health policy guidelines the regional disparities in health services utilization among different expenditure groups of states as well as rural urban disparities tend to continue. The relationship between economic and health variables can be properly identified by studying the existing condition in the real world situation besides analyzing the secondary data.

Good health as people have from their own experience is a crucial part of well being but spending on health can also be justified on purely economic grounds. Improved health contributed to economic growth in four ways:

- It reduces production losses caused by worker illness.
- It permits the use of natural resources that had been totally or nearly inaccessible because of disease,
- It increases the enrollment of children in school and makes them better able to learn,
- It frees resources for alternative uses that would otherwise have to be spent on treating illness. The economic gains are relatively greater for poor people, who are typically most handicapped by the ill health and who stand to gain the most from the development of underutilized natural resources.

From the above discussion one can understand that health of the people is not only a desirable goal but is also an essential attention in human resources. Primary health care has
been accepted as the main instrument for achieving this goal. Accordingly, a vast network of institutions at primer, secondary and tertiary levels has been established. Control of communicable diseases and development of trained health man; powers have received special attention.

In the above paragraphs emphasis has been laid on utilization of health care services and social sector spending. Since there is a set of policy instruments available for equal utilization of health care services, in developing countries. A long-standing question had been how effective social sector expenditures are in reaching the poor. Studying the social consumption would provide the necessary light on this key question. Of special interest is who utilized the Government sponsored health care services.

This study intends to analyse the inequalities in utilization of Health Care Services among different income and in urban and rural areas. In India nearly 23% of the population living in urban areas have the facilities of 70% of the total hospital beds and 76% of the doctors in the country. However though all varieties of health services are available in the urban areas, not all the sections of the community utilize these facilities. In the rural area, only limited facilities are available, which are also not equally utilize by all the people.

Therefore an attempt has been made in this study to analyze the utilization of the health care services on rural and urban households in Coimbatore District at the Community Development (CD) Block level along with an understanding with block level secondary data to derive the conclusion and suitable measures.
1.9. OBJECTIVES

The present study aims

i. to study the growth and trends in the supply side variables of health care services in Tamil Nadu with special reference to Coimbatore District;

ii. to measure the inequalities in the utilisation of health care services among different social classes in the study area;

iii. to identify the determinants of the inequalities in the utilisation of health care services;

iv. to study the awareness and adoption of family planning methods in the study area;

v. to analyze the health care utilisation behaviour in the study area.

1.10. HYPOTHESIS

On the basis of the above objectives the following hypotheses are formulated for empirical study.

i. the high and middle classes utilize health services better than the low and very low class;

ii. there is inequality in utilization of Health care Services between social classes and regions;

iii. an increase in income and mothers education reduces the inequality in the utilization of Health Care Services;

iv. the level of education and income determine the priority of medical expenditure;

v. low and very low classes are willing to pay for Government Health services;

vi. family planning adoption is more in the developed area.

1.11 METHODOLOGY

The present study attempts to study various aspects of health care services in Tamil Nadu. This study is based on both primary and secondary data. The study was carried out in Coimbatore Revenue District of Tamil Nadu. The secondary data pertains to the period from 1981 to 1999.
1.12. DESIGN OF THE SAMPLE

The primary data were collected at the Community Development block level. A multi-stage stratified random sampling procedure has been used to collect the primary data. In the first stage Coimbatore District is selected purposively for the sake of convenience since it is the researcher’s native place. In the second stage the ranking and indexing methods are used for the selection of sample blocks taking into consideration 32 development indicators (Appendix - A) for all the 21 blocks in the district. The ranking and indexing score of the development indicators are given in Appendix – B1. Three blocks, which are developed, and three blocks, which are backward from among the 21 blocks have been chosen for the study.

In the third stage, before selecting sample villages, some remote villages and forest and hilly regions are deleted from the sample frame. The average of the number of households in the blocks were worked out. Then the villages that have households more or less equivalent to the average number of households in the block have been identified. Among the average villages identified in the blocks, two villages from each block have been selected at random making the total number of sample villages twelve. On the fourth stage about 5 percent of households from each sample village has been selected by using the Tippet’s Random Number Tables making the sample size as 513 (Appendix – B2). The list of household in each of the selected village is prepared from the household list available with the Village Administrative Officer. The single person households and the household without even one married couple have not been considered in the sample.

The sample households are classified into very low, low, middle and high classes. The basic assumption of this study is that the higher the social class the better would be the utilization of Health Services. In this study the terms High Class, Middle Class, Low Class, and Very Low Class are used to differentiate the strata based upon a composite index of their
income, education and occupation characteristics. This study intends to study about both developed and backward block. The study area map is given in the Appendix – C.

1.13. SOURCES OF DATA

For the primary data the block level information have been collected. A pilot Survey was conducted in order to test and finalize the schedule to suit the needs of the present study. The primary data has been collected for the study during June 10th and September 30th 2000. The study period ranges for a span of five years prior to June 2000. This period of study has suffered no major devastation either natural or man-made.

The data on household size, religion, community, type of house, level of education of both father and mother, utilization of kind of health services, type of health center, kind of help received, stay in hospital, number of times hospital used, medical expenditure, priority of medical expenditure, demographic factors like sex, age, marital status, socio economic factors like income, occupation and education. Above all knowledge of adoption of family planning, adoption of family planning method, sources of information, knowledge of immunization, reason for utilization and non-utilization of government hospital, reason for utilization of private hospital, awareness of medical care, (i.e., preventive or curative), postnatal care, perceptual diseases, willingness to pay for Government health care services, insurances, etc were collected. The data pertaining to individual households have been collected by the interview method from the head of the household. The information collected in this survey is mainly based on ‘recall method’. Therefore it is found to be somewhat biased. The completed questionnaires were checked the next day for response and non-response errors. In case of omissions and ambiguous or inconsistent answers, another trip was made to collect unambiguous and consistent information from the same household. All possible efforts have been taken to get the accurate information as far as possible from the respondents.
The secondary data has been collected from the following source,

(i) Department of family welfare. Ministry of Health and Family Welfare,

(ii) National Family Health Survey Report-1995,

(iii) NFHS Report 1998-99,

(iv) Directorate of Medical Services Reports, Chennai,

(v) Various issues of Health information of India,

(vi) Various issues of Economic Survey,

(vii) Various issues of World Development Report,

(viii) Various issues of Tamil Nadu- An Economic Appraisal,

(ix) Reports from District Family Welfare office, Coimbatore and

(x) Deputy Directorate of District Health and Family Welfare Department and


1.14. METHOD OF ANALYSIS

In order to study the growth of health care services in Tamilnadu the researcher has employed Annual growth rate, Compound growth rate, Log quadratic and Multiple Regression techniques. To study the utilization of health care services 'Chi-square Test' is used. Lorenz curve and Gini coefficient were used to understand the inequality in the Utilisation of health care services. To identify the determinants of utilization of health care services 'Multinomial Logit Analysis' has been used. The relevant hypotheses were tested using chi-square test, F-ratio, t-test and adjusted $R^2$.

1.15. LIMITATIONS

The present study is based on the primary data collected through interview method which generally suffers from recall bias. Even though adequate care has been taken at every stage to eliminate this error through cross checks, the presence of it cannot be totally ruled out. Since,
the study is confined to utilization of health care behaviour of households in the developed block and backward block the results and final implications of this study have to be generalized with caution.

1.16. CHAPTER SCHEME

Chapter I introduces the topic of the research, presents the problem, objectives, methodology and method of analysis.

Chapter II presents a socio-economic profile of the study area.

Chapter III is devoted to theories and review of related literature.

Chapter IV analyses the trend and growth of supply side variables in health care services in Tamil Nadu and Coimbatore District.

Chapter V analyses the issues involved and determinants of utilisation of health care services and it brings to light the various aspects in the inequalities of utilisation of health care services in the study area.

Chapter VI identifies and discusses the determinants of health care utilisation behaviour in the study area.

Chapter VII presents the summary of findings, conclusion and policy recommendations of the study.
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