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ABBREVIATIONS

1. ANM  - Auxiliary Nurse Midwife
2. DHO  - District Health Officer
3. DPHC - Director of Primary Health Centres
4. DPH & PHE - Director of Public Health and Preventive Medicine
5. HI    - Health Inspector
6. WHO  - World Health Organisation
INTRODUCTION

The post-Independence era introduced sweeping changes in India, as the country underwent the process of modernization. The most important feature of this process was socio-economic development and reconstruction. Though the economic element gained gradual precedence for a while and was commonly regarded as the primary agent as well as index of development, the trend has begun to change. In recent times, developing nations have become increasingly conscious of the social aspects of economic planning. For it has been proved beyond doubt that unless directed towards the reduction of social inequalities and correlated with social development, mere economic growth would be accompanied by loss of social cohesion, insecurity, delinquency, mental stress and other social ills.¹

Thus the trend now is towards incorporating economic planning with social planning, i.e., planning for social welfare goals, with economic development as the means rather than as the end. Developing countries are confronted with a formidable array of social problems concerning population, urbanisation, industrialisation, health, environmental pollution, migration, regional

disparity and many others. These issues encompass a broad range of activities, for the enhancement of the entire community.

Secondly the emergence of new socio-political forces in many developing countries like India, have brought about pressing demands upon the state to provide competent leadership to improve standards of societal living and participation in matters - economic, social and political.\(^2\) Thus, the increased social consciousness leading to the generation of an array of social welfare activities and the increasing responsibility of the state, demand a new and improved method of fulfilling social needs. This requires an innovative conceptional and operational framework in the administrative process, planning devices and programming for the total objectives, so that natural development is feasible and proportionately balanced. Thus a progressive implementation of the socio-economic goals needs a dynamic process which Edward Weidner refers to as 'Development Administration.'

Discretely viewed, both the concepts of 'development' and 'administration' are significant in their own right. 'Development' indicates growth and directional change while 'Administration' is determined action involving organisation and

direction of human and material resources to achieve desired ends. Applied to the sphere of social welfare activities they acquire greater dimensions, involving social administration concerned with the study of welfare systems and particularly government sponsored social services. Social development administration, therefore, implies the close co-ordination of social welfare programmes with economic development to achieve an integrated national progress. It also provides the means of selecting and accomplishing progressive political, economic and social objectives that are authoritatively determined in one manner or the other.

This thesis deals with one of the important social welfare components which is also one of the most indispensable and pervasive areas of public administration, namely, 'health' and its administration. Health, both as a concept and as an activity has been experiencing perceptible variations in keeping with the socio-economic changes and the technological advances in the medical and health areas. The most significant aspect concerning this area is the shift in emphasis in denoting health as a mere physical component of an individual in terms of disease condition, to the environmental perspective subsuming the


4. Ferrel Hedy and Sybil Stokes (eds), Papers in Comparative Public Administration, University of Michigan, Michigan, 1962, p.98.
socio-economic and cultural factors of the entire population. The World Health Organisation aptly defines health as a "State of physical, mental and social well-being and not merely an absence of disease or infirmity."

"Health" or the maintenance of good health has thus become a prerequisite to human productivity and technological development. A healthy community provides the infrastructure for an economically viable society. This idea is clearly reflected in the Planning Commission's analysis of health as being fundamental to the national progress in any sphere. In terms of resources for economic development, nothing can be considered of higher importance than the health of the people, which is a measure of their energy and capacity as well of the potential man-hours for productive work in relation to the total number of persons maintained by the nation. For the efficiency of industry and agriculture, the health of the worker is an essential consideration.  

Economic Planners are beginning to realise that health is not something an individual desires to have in order to enjoy life. It is simply a basic requisite of every society if the individuals who constitute it are to be economically productive.

and not a drain on its limited resources. In terms of fiscal factors, studies conducted by the Institute of Development Studies in Sussex, England, have proved that for millions of rural farmers, illness at specific times of the year became an economic disaster and a cause of further poverty. This factor has greater bearings in India which possesses vast agricultural labour, the mainstay of the Indian economy, which is wholly dependent on the monsoons, and hence has to bear in good health throughout the year to seize the prospects of a good harvest as and when the monsoons oblige.

In terms of cost benefit analysis, a recent study in New York has concluded that an investment of 2.7 million dollars a year on improving pre-natal care for low income women could save between 10 to 12 million dollars a year in high cost intensive care for premature babies – not including the life long support for children born with mental or physical disabilities.

Internationally the successful campaign to eradicate smallpox to which the USA contributed 50 million dollars is already saving that country more than double that amount every year in immunisation, quarantine and surveillance costs.

8. ibid., p.6.
Both these factors again should be considered in the context of Indian conditions where diseases affecting vulnerable sections like women and children and communicable diseases pose the major public health problems.

It is, therefore, seen that the unique feature of the health component is that it influences the physical, social and economic aspects of the individual and the community. Above all it is evident that health is 'holistic' in nature and its promotion cannot be achieved by means that derive from any single discipline, nor can health measures be considered independent of the broader educational, social, economic and administrative factors that are crucial to human development. Therefore, the health component and other components of the total system necessarily interact. Health not only affects the remainder of the socio-economic complex but is also affected by it. This obviously necessitates an integrated and unified approach to the implementation of health measures, especially in the context of social or 'public health' and a more balanced consideration of the biological, social and cultural aspects of health is needed.

In the interpretation and administration of health, 'man' must be considered in relation to his social and physical environment. In a developing country like India the administration of health demands that one approach be on a wide basis so as to include a variety of factors such as housing, nutrition, education, poverty and ignorance of the hygienic mode of life.\(^{11}\) The field of 'public health', therefore, is the result of the recognition of these facts and the emergence of the concept of 'social medicine.' In the words of John A. Ryle, "the socio-medical survey, that is the combined social and clinical study of community health and sickness, often with special nutritional and economic assessments and careful sampling controls is coming to be accepted as the correct method of approach to such study.\(^{12}\)

Attempts to define Public Health, when arranged chronologically present a pattern of the evolution and progress of the field. Early definitions were necessarily limited to sanitary measures invoked against nuisances and health hazards with which the individual could not cope and which when present in one individual could adversely affect the others. Thus insanitation and communicability were the criteria used to decide the 'public health' nature of a problem. With the great bacterio-

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11. The causative organism of tuberculosis for instance is widely spread in highly industrialised and urbanised communities and yet the incidence of the disease varies depending largely on the variations in the socio-economic conditions, remedial and preventive measures will fail if these conditions are not neutralised.

logical and immunological discoveries of the 19th and 20th centuries and in the subsequent development of techniques for their application, the concept of prevention of disease was added. Public health thus came to be regarded as an integration of sanitary and medical sciences.¹³

However, as far back as 1847, Solomon Newmann propounded that medical science was essentially and intrinsically a social science.¹⁴ Despite this, it is only recently that medicine and indeed public health have been widely recognised as social sciences. This proves that though the social relation of health and disease had been recognised by physicians and laymen, a concerted effort had not been made to organise such a body of knowledge on a coherent basis and make it available for practical application. This is in part due to the highly technical and specialised orientation of medicine and in part due to the limited comprehension of the relevance of public health that has been prevalent till recently, and which persists to a certain extent in many a developing country.

During the past few decades, however, influences within medicine itself and in society as a whole have acted to overcome

¹⁴ ibid, p.17.
these factors. Within society, the ideology of the complacent individual has begun to wear thin, giving way to the emergence of the consciousness of social problems, including those involving health. This conception of health as a public function has resulted in the development of a co-ordinated scheme of preventive and curative health services and in the recognition of the need for providing an environment which will enable the body to remain healthy and resist disease. As such, Health services may broadly be divided into (i) preventive services and (ii) curative services.

**Preventive Services:**

These may be collectively termed as public health activities. They are oriented towards 'social medicine' and are directed towards the creation of conditions and environment favourable to healthful living. They embrace many fields in which state action is essential for the provision of required facilities and enforcement of legal measures the responsibility for which in all countries rests with the public authority. These activities in the early stages were mainly confined to environment hygiene, but later began to embrace various personal services particularly in relation to certain vulnerable groups like women and children. These developments brought in their

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train the need for providing adequate facilities for the diagnosis and treatment of disease in relation to these sections of the population as an essential part of the public health programmes.

Curative Services:

These services are concerned with the diagnosis and treatment of disease in general. Curative services are highly specialised clinical and hospital oriented. They include organised medical services including teaching and training medical institutions for the diagnosis and treatment of diseases. Curative services combine the state and private medical services in varying degrees and measures.

Health administration, therefore, is a complex and multidimensional area which deals with matters relating to the promotion and delivery of health services, preventive services, medical care, development of health manpower through medical education and training and rehabilitation. In other words, it implies the application of the combined knowledge of medical and behavioural services for the enhancement of the quality of life of the individual and the community through an efficient administrative process based on rational and viable policies
and pragmatic planning. One of the most comprehensive and fitting definitions of public health which neatly sums up the meaning of health administration in all its dimensions have been given by Winslow who states that "Public Health is the science and art of -

1) preventing disease;

2) prolonging life;

3) promoting health and efficiency through organised community effort for -

   a) sanitation and environment;

   b) the control of communicable disease;

   c) the education of the individual in personal hygiene;

   d) the organisation of medical and nursing services for the early and preventive treatment of diseases; and

   e) the development of social machinery to ensure for everyone the standard of living adequate for the maintenance of health, so organising these benefits as to enable
every citizen to realise his birth right of health and of longevity. 16

This definition also clearly presents the immensity of the problem and the nature of the organisational, personnel and administrative machinery required to achieve the goals of public health, and clearly establishes that unless approached in an integrated manner with a highly result oriented method, health administration cannot effectively deliver even a part of the goods.

The general condition of health administration in India, however, falls far short of these requirements and principles. Although health is accepted as a basic human right in the social and constitutional system, a large proportion of India's population still does not have access to a reasonable level of health care delivery both in terms of quality and quantity.

This is mainly due to the persistent adherence to the principles of a curative, clinical and hospital-based health system. While hospitals are indispensable and essential institutions and maintain pride of place in the overall health/medical scheme they turn out to be fortresses of highly technical

and sophisticated skills and far removed from the masses both rural and urban in terms of accessibility and cost. Hospitals in India have always fulfilled the important community function of providing medical treatment to patients who resort to them. This, however, constitutes a negligible percentage of the population and hospitals are oriented mostly towards biochemical aspects of medical and health care and shy away from facing their responsibilities towards the general health problems of the community.  

Hospitals are complex, labour intensive organisation, as the number of personnel working in a hospital is twice the number of its in-patient beds and a well-equipped hospital costs over Rs.50,000/- per head for construction. They are heavy cost centres. Further the system of medical education is highly disease-oriented and directed towards the study of specialised medical care. There is a felt need to promote vocational training and continuing education, especially in the sphere of social and preventive medicine and tropical diseases.


Presently in most teaching hospitals the departments of social and preventive medicine are completely divorced from curative areas and function as exclusive areas of operation. Thus most of the medical personnel especially doctors are isolated from and even ignorant of the pressures and realities of rural and community health problems.  

In this context it is important to analyse some of the major health problems faced by India which are typical of any developing country and which call for an urgent change of the prevalent emphasis on clinical services.

The first feature is the scarcity of resources in terms of manpower, material and money. India is a low income country with an average per capita Gross National Product (GNP) of Rs.1,064/-  

with 70 per cent of the population classified under 'absolute poverty' (income per capita of less than Rs.600/- a year).  

The doctor-population ratio which is an accepted indication of the development level of health services, reveals


that the increase in medical personnel has barely kept pace with the increase in population. It has changed in India from 5644 persons to one doctor in 1960 to 3884 to one in 1978. The situation is no better in the case of other health personnel. Further only 2.1 per cent of the total expenditure is earmarked for health with a per capita health expenditure of Rs.9-44. These figures register as one of the lowest in the world today. The inadequacy of the hospitals is evident from the fact that the bed population ratio is at 0.5 beds per 1000 persons and accounts for the overcrowding in hospitals preventing effective provision of medical services.

The second feature is the large percentage of the rural population in the demographic picture of India. The rural population lives in 5,67,000 villages which constitute 80 per cent of the total population of the country. The majority of the population (74.4 per cent) is made up of cultivators and agricultural labour whose meagre sources of income varies with the vagrancy of the monsoon. This leads to widespread poverty and mal-nutrition. A recent UN report contends that widespread mass poverty is the most difficult and serious problem in India.

This factor deprives the majority of our population of both the inclination and the resources to resort to medical aid, even when these are available.

The third and perhaps the most vital factor is the population problem and high birth and fertility rates. India's population in 1981 was 583 million (583,810,051). This marks an increase of 136 million or 24.75 per cent over the last decade. If the present trend in the fertility rate continues, the population will be 950 million by 2001 A.D. The life expectancy at birth has increased from 45 years in 1971 to 54 years in 1981. During the decade the population density has increased from 177 per sq. km. to 221 in 1981. This exerts a heavy pressure on the health delivery system in keeping pace with the rising tide of population. Most national resources are diverted to other priority sectors such as agriculture. This emphasizes the need for health services to be co-ordinated with related sectors of the economy to achieve the desired health goals.

Fourthly, 'urban orientation' is a great malady of the health delivery system. Most hospitals and medical personnel are located in urban or metropolitan centres. This is coupled with problem of the migration of trained health personnel.

especially doctors. Of the 1.39 lakh medical graduates registered in the country, 20,000 have gone abroad. Of the rest 50,000 have established private practice and 60 per cent of the remaining are serving in urban centres or in military service. Thus hardly 20 per cent of the medical personnel are available to serve 80 per cent of the total population which is in the villages.

Finally, the general sanitary conditions of the rural areas are in a deplorable condition. 60 to 70 per cent of Indian villages do not have safe drinking water-supply and drainage facilities. The primary reason for the occurrence of most diseases in the villages is the sanitary environmental condition. This greatly facilitates the vectors of air-borne and water-borne communicable diseases to spread with ease and speed leading to outbreaks of epidemics. These constitute the major reason for the high rates of infant mortality in the rural areas. Further the rural population suffers the geographic disadvantage of inaccessibility. Dispersed over a large area of rough terrain, most villages do not have reasonable road and transport facilities. This adds to their problem of health care reaching them on time or in proper proportion.

25. Dr. Bhardwaj, M.K., "Hospital and Integrated Health Services" Hospital Administration, Vol.XV, No.5, June 1978, p.16.
These problems, to mention a few, pose a formidable opposition to the health care system and demand efficient administration, management and delivery of health care services adapted to local conditions. A system that can surmount these obstacles and reach out to the rural community is the need of the hour and primary health care services should be provided as close as possible to the rural population. It is in recognition of this factor that the Government of India since the Third Plan period in 1965 embarked upon the strategy of 'Primary Health Care'. Primary Health Care is about the only and most effective system that embodies all the principles of health care delivery in a developing society and constitutes the solution to many a health problem, especially if India is to achieve the goal of "Health for All by 2000 A.D."

As the name denotes 'Primary Health Care' constitutes 'the front line' or 'first level' component of the health care system. To adduce a comprehensive definition, it is essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community. Thus Primary
Health Care is the point of entry for the individual, in the rural areas to the national health system. It integrates the preventive, curative, promotive and rehabilitative measures at the community level, through the basic and simple institution, the Primary Health Centre. Thus the important features of Primary Health Care are as follows:

1. An integrated approach involving the elements of preventive and curative health measures.

2. Manageable proximity to the people.

3. Adaptation of the health personnel to the local needs and the disease pattern of the community.

4. A team approach, which involves the staff of the Primary Health Centres to constitute medical, para-medical and social work personnel working in co-ordination to deliver curative and promotive services. This also includes the enlisting of the services of local members of the community who have been imparted basic health training and skills in keeping with the prevalent local conditions.

5. Community participation, i.e. increasing through motivation and health education the social consciousness of the local residents and involving them in the planning, implementation and monitoring various health care programmes.

6. The target group' approach which aims specially strengthening and directing the health programmes to meet the demands of the most needy and vulnerable groups of the population, especially women and children. This ensures that they avail themselves of the services rendered at the community as well as at the institutional levels.

The Primary Health care strategy involves a co-ordinated system of action amongst the Primary Health Centre personnel and the members of the community based on the principles of preventive service to maintain a high standard of environmental hygiene, apart from rendering conventional curative services. The most unique feature of this system is the personal rapport it seeks to establish between the health staff and the people, in order to enhance the self-reliance of the community and reduce their dependence on the official health machinery for
preserving their physical and social quality of life. Thus the basic requirements of primary health care are availability, accessibility and continuity. And no health service could function efficiently or serve the needs of the people unless it has a well-organised system of primary health care.

Objectives of the Thesis:

The purpose of this thesis is to objectively study the administration of Primary Health Care and the methods of organisation and management of Primary Health Centres in Tamil Nadu.

The specific aims are —

1. to present a comprehensive profile of Tamilnadu, in terms of the socio-economic and demographic factors which are highly significant in determining the environmental conditions and the health needs of the people especially in the rural areas;

2. to analyse the health policy and planning structure in Tamilnadu along with a national perspective, to trace the development of the planning process from the pre-Independence period and the extent to which it has enhanced and strengthened the primary health care process;
3. to study the evolution of the organisational structure and administrative process of the health department in Tamilnadu and its existing patterns of health care delivery; and

4. to examine the health programmes and schemes that offer various preventive control and curative services directed towards particular diseases and certain vulnerable sections of the population. It also seeks to study the role of voluntary health agencies in assisting the primary health structure in the state.

Finally to describe the performance of the Primary Health Centres with reference to the organisational pattern, personnel, finance and public relations and to observe the extent to which it is able to achieve the primary health objectives in a typical rural area.

Methodology:

The thesis is a descriptive study based on the historical methodology. The primary sources of data consisted of all archival records, such as -

a) Government Orders

b) Memos
c) Reports including the documents of the world health organisation.

d) Government Reports, the most important of which are:

i) The Health Survey and Development Committee (Kore Committee) 1946;

ii) Health Survey and Planning Committee (Jumgalwala Committee) 1959;

iii) The Committee on 'Integration of Health Services' (Jumgalwala Committee) 1967;

iv) Committee on 'Multi-purpose Workers under Health and Family Planning, (Kartar Singh Committee) 1973.


vi) Acts and legislations relating to the State and Central Government including the Tamil Nadu Public Health Act 1939 (revised version 1980);

vii) Manuals of operations; and

Personal interviews were conducted with officials and other functionaries at all levels of the health hierarchy. These include the Health Secretariat, Tamil Nadu; Directorates of Public Health; Primary Health Centres; Medical Services, Tamil Nadu; District Health Office, Chinnalpur, Tamil Nadu; National Institute of Public Health, New Delhi. Unstructured schedules of enquiry were employed for this.

Personal observation of legislative proceedings during the debate over health demands, Ministry of Health, Government of Tamil Nadu was made. The case study technique was adopted in making a detailed study of the structure and functions of a typical primary health centre. The Primary Health Centre at Alipur was selected for this purpose.

Secondary sources consisted of an extensive reading of books, journals and magazines, health pamphlets and brochures. The project publications of the World Health Organisation, UNICEF and the United Nations Organisation also provided valuable data.

**Survey of Literature:**

There are no adequate comprehensive and detailed studies of the existing conditions of health administration with the
personnel, organisational and managerial aspects of the primary health delivery in Tamil Nadu. The available material is in the form of committee reports and project reports submitted by governmental, quasi-governmental or voluntary agencies. This material concentrates only on specific areas or issues of health care delivery. Most books in the field adduce general theories and definitions of public health either from the national or international perspectives. These general theories, however, are indispensable for providing the framework in understanding and achieving the primary health care objectives.

A detailed survey of the rural health services in India is presented by P.R. Dutt, who discusses the various problems and issues of health in Indian rural conditions.27 C.M.E. Mathews has made a sociological study of the influence of certain cultural issues on health activities in a village in North Arcot District of Tamil Nadu. He stresses the importance of understanding local beliefs and practices in order to establish meaningful communication with the people.28 The Danish International Development Agency (DANIDA) conducted a study to suggest

27. Dutt, P.R., Rural Health Services in India, Ministry of Health, Government of India, New Delhi, 1962.

improvements in the health and family welfare status of the population in Salem and South Artoot Districts of Tamil Nadu. J.P. Naik has suggested an area-based delivery of primary health care after a thorough study of the local health problems.\textsuperscript{30} Ashwin J. Patel presents an anthology of studies addressing certain vital issues of health ranging from the evolution of health services in India to nutrition problems in the rural areas.\textsuperscript{31} John Bryant spells out some of the major problems of health care delivery in developing countries and discusses the approaches to tackle them.\textsuperscript{32} Another significant work in this area is the collection of papers edited by Maurice King.\textsuperscript{33}

The modern processes and issues of public health and its administration with comprehensive definitions have been well

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\textsuperscript{30} Naik, J.P., An Alternative System and Health Care in India, Some Proposals, ICSSR, New Delhi, 1975.

\textsuperscript{31} Ashwin, J. Patel (ed.), In Search of Diagnosis, Analysis of the present system of health care, Medico Friends Circle, New Delhi, 1977.


\textsuperscript{33} Maurice King (ed.), Medical Care in Developing Countries, Oxford University Press, Nairobi, 1966.
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expounded by Davies and Hanlon. Davies has based his work in the British context while Hanlon presents the American system.

Chapterisation:

The plan of the thesis is distributed in the following chapters:

As Tamilnadu is the physical area in which the research is based, the first chapter sets forth details of the social, cultural, economic and demographic parameters of the State. This provides valuable insights into how these issues prove to be significant determinants in shaping the health care delivery pattern.

The general policy and planning for health in India and especially in Tamilnadu constitute the contents of the second chapter. It discusses the extent to which the health plan in this State has incorporated the principles of primary health care.

The third chapter sketches the organisational structure and administrative practices of the health delivery system in

Tamilnadu both at the state and at the District levels. It also
discusses the personnel pattern of the health department along
with the financial allocation for health in the state.

Primary Health Care is an integrated scheme which delivers
a package of curative and preventive services to the rural
population. The fourth chapter surveys the various control and
eradication programmes which emanate from the primary health
centres.

Community participation is the most important factor in
the successful and rapid attainment of the primary health care
objectives which requires institutional and individual moti-
vation from both governmental and non-governmental agencies.
The fifth chapter addresses the role and methods of the quasi-
governmental, private and international agencies in rendering
assistance to the departmental machinery in providing certain
health services.

Chapter six makes a detailed analysis of the admini-
strative structure and functioning of the Primary Health Centres.
The Primary Health Centre constitutes the nucleus institution
from which the entire curative, preventive and promotive
services radiate. This chapter studies all the functions of
technical and non-technical nature of a typical Primary Health and the other factors involved.

The seventh chapter presents the findings and conclusions of the thesis. These are broadly classified under financial organisational and personnel spheres. It presents the major drawbacks of the health care delivery system in the State and suggests remedial measures along with alternate methods to offset these drawbacks.