Chapter-I
Introduction: Conceptual and Theoretical Framework
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INTRODUCTION: CONCEPTUAL AND THEORETICAL FRAMEWORK

1.1 HEALTH SITUATION IN INDIA

The rights to basic education and primary health care have been recognized as human rights in the UN (United Nations) Charter of Human Rights prepared in 1948. Health is a fundamental human right, emphasized in the Alma-Ata declaration of 1978. Alma-Ata conference on health, has focused on equitable and cost-effective primary health care. After that health has become an important national concern in most countries, especially, in developing countries, where health status of large section of population is still very low. Health sector policies have also tended to lay stress on reducing population growth. India being signatory to the United Nations Covenant on human rights, it is the duty of government to provide primary health care to every citizen of the country. In India, a very large proportion of population lives in rural areas and in unhygienic conditions. The mortality rate, poverty and unemployment are major problems for the country. Health system of a country is a nucleus and development depends upon the efficiency of health delivery system.

The first all India Census was held between 1869 and 1872. This was during British India when many social, political and administrative changes were taking place. The British East India Company established its first hospital in Madras in 1664 A.D. The main purpose of this was to provide medical care to the British soldiers (Venkataratnam, 1974). The British civilians were also dependent on this hospital as they considered it more satisfactory than Indian source of medical care.
Subsequently, British government appointed a number of committees and commissions to develop and maintain a systematic administration on Public health as given below:

1. In 1825 ‘The Quarantine Act’ was passed and enacted to improve the health status of the people against communicable diseases.
2. In 1864, a Public Health Committee was appointed for surveying the health problems of Madras, Bengal and Bombay Presidencies.
3. In 1873, the ‘Birth and Death Registration Act’ was enacted to have the records of births and deaths.
4. In 1880, Vaccination Act was appointed to fight against plague and communicable diseases.
5. In 1886, Plague Commission was appointed to fight against plague and communicable diseases.
6. In Minto-Moarlay (1909) and Montague Chelmsford (1910) reforms, the issue of public health was included with a great priority.
7. In 1935, the Government of India Act was passed in which the States were fully responsible for health facilities and administration.
8. In 1940, ‘Drug Act’ was enacted.

However, Indian people were still more prone to indigenous medicines. During this period, people in India used home remedies for minor health problems and approached the services of indigenous medical practitioners for serious health problems. Two main medicine systems, two main literary traditions were prevalent i.e. Ayurveda, associated with Hinduism, written in Sanskrit and Unani Tibb (the medicine of Greece) associated with Muslims written in Persian, Arabic or Urdu (Jeffery, 1988). The practitioners of Ayurveda were called Vaidya and of Unani medicine were called ‘Hakim’. The system of Ayurvedic medicine and its principles and therapies were based on
Charak Samhita, Sushruta Samhita and Astanga Samhita, associated with Vagbhata.

Charak Samhita was originally composed by Agnivesha, who was one of the six students of Atreya. It was mainly based on Agnivesha Tantra. But with the passage of time, the revised edition of Agnivesha Tantra came to be called Charaka Samhita. Sushruta Samhita is the main source of knowledge about surgery in ancient India. The author Sushruta was a great surgeon. In Sushruta Samhita, he describes many surgical operations.

Ayurveda is the oldest medicine system. This system is mainly based on vegetables, metals and mineral – salts. This gives importance to the regulation of digestion. Ayurveda is not only a system of medicine but it is a way of life also. The emphasis is on both the body and mind. According to Ayurveda, Vata, Pitta and Kapha for physical betterment and Satwa, Rajas and Tamas are the psychic factors which should be balanced for good physical and mental health (Charaka Samhita, 1949). For Unani medicine, ‘The Qanun of Avicenna’ has been the main source and textbook. This was published in India in 13th century A.D. and was further reproduced and elaborated (Ullmann, 1978). The Unani Tibbi medicine is also widely practiced in India. This system was brought by Muslims in India. This Greek medicine system was modified by Arabian scholars. The first independent book on Arabic and Unani medicine was written by Abul Hasan Ali called ‘Firdaus-ul-Hikmat’ in 838 A.D. In India, the first remarkable book based on Unani medicine was ‘Kitab-ul-Saidana’ which was a Persian translation of Al-Beruni (Subba Reddy, 1969). It is based on the notion that there are four humours in the human body. These are phelegm (balgham), blood (khoon), yellow bile (safra), and black bile (sauda). If these four things are balanced in proportion in the body, it is well. But when the proportion is disturbed, the result is the loss of health. That is why the Unani drugs intend not only to overcome the disturbance in the body but to emerge after recovery with greater power of resistance to future disturbances.
Homeopathy is also an important and well-prevalent medicine system in India. It was introduced by Britishers and other European doctors in 19th century. Homeopathy was scientifically developed by Dr. Samul Hahenemann of Germany. Now in India, homeopathy is officially recognized. In the second half of 19th century, some homeopathic dispensaries and hospitals opened in Bengal and in the South. According to Hahenemann, the human body functions and is maintained by a vital force, while the disease means disorderly functioning of this vital force. The diagnosis in homeopathy does not mean the labeling of the patient with the name of a disease but it is in terms of drug reactions which would restore his vital equilibrium.

Siddha is also a medicine system which is similar to ayurveda in its basis of medicine. It is also based on minerals and salts. But besides medicine, it also included many miraculous acts which are performed by a Siddha which means a master. The most famous Siddha was Nagarjuna.

Allopathy came as a method of rapid eradication of diseases. Allopathy is considered to be a reliable and scientific method to cure even very serious health problems. This system is known as English medicine system. Britishers brought this system to India. In fact, during British rule, the government wanted to establish hospitals to provide health care to British soldiers and civilians too. They also wanted to show their false concern towards people to impress them. On that account Indian Medical Service (IMS) was established in 1880 (Jeffery, 1977). But this service was dominated by British doctors who were recruited in England. Later on, the government and bureaucracy started dominating the medical services, medical education, registration of doctors and medical staff etc. Even the less meritorious medical personnels were appointed due to interference of government and politics (Venkataratnam, 1987).

After Independence, the government of India considered health as a primary responsibility. A major change was reconstitution of Medical Council
of India (MCI) in 1956. Another major step was the constitution of Dental and Pharmacy councils in 1948 and Nursing Council in 1947.

It was the time when Allopathy was accepted as 'standardized' medicine system. It was felt that modern medicine would be more effective in fighting communicable and other diseases. A number of policies, plans and committees were driven by the government of India to mitigate the health problems. Among these the five year plans play an important role.

If we have a look at the health chart of India revealed in different Surveys and Censuses conducted in different years, we find the real picture and trends related to the health indicators. The literacy, Infant Mortality Rate and Life Expectancy at Birth are considered to be the basic indicators of human development. This table below would show these indicators.

<table>
<thead>
<tr>
<th>Year</th>
<th>Life Expectancy at Birth (Years)</th>
<th>Infant Mortality Rate (Per Thousands)</th>
<th>Literacy Rate (Per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951</td>
<td>32.1</td>
<td>146</td>
<td>18.3</td>
</tr>
<tr>
<td>1961</td>
<td>41.3</td>
<td>146</td>
<td>28.3</td>
</tr>
<tr>
<td>1971</td>
<td>45.6</td>
<td>129</td>
<td>34.5</td>
</tr>
<tr>
<td>1981</td>
<td>50.4</td>
<td>110</td>
<td>43.6</td>
</tr>
<tr>
<td>1991</td>
<td>59.4</td>
<td>80</td>
<td>52.2</td>
</tr>
<tr>
<td>2001</td>
<td>63.2</td>
<td>70</td>
<td>65.4</td>
</tr>
</tbody>
</table>


It is worth mentioning here that India is in the second stage of health transition, where we need more efforts to get the standard state of health. Another thing that draws the attention is the increase in literacy rate and declining Infant Mortality Rate and Increase in Life Expectancy. It could be very interesting to understand that how the literacy, a crucial non health care determinant affects these factors.
The NSSO 60th round data gives the details of the untreated morbidity by Gender and Age-group.

**Table - 1.2**
Untreated Morbidity by Gender and Age-Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 5 years</td>
<td>7.03</td>
<td>6.40</td>
<td>13.42</td>
</tr>
<tr>
<td>5 to 14</td>
<td>7.10</td>
<td>6.78</td>
<td>13.87</td>
</tr>
<tr>
<td>15 to 45</td>
<td>12.60</td>
<td>17.12</td>
<td>29.72</td>
</tr>
<tr>
<td>45 to 60</td>
<td>6.57</td>
<td>7.63</td>
<td>14.20</td>
</tr>
<tr>
<td>60 to 70</td>
<td>9.32</td>
<td>10.07</td>
<td>19.39</td>
</tr>
<tr>
<td>Over 70 years</td>
<td>4.96</td>
<td>4.42</td>
<td>9.38</td>
</tr>
<tr>
<td>Total</td>
<td>47.58</td>
<td>52.42</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: NSSO 60th Round Data (2004-05)

This table presents the disturbing health situation of India. The untreated morbidity in males is 47.58 and in females 52.42 per cent. This is considered very high percentage of untreated morbidity. We also see that this is more high among females than males. This shows the neglecting attitude towards female’s health needs. According to the NSSO 60th round data, in rural males, this percentage is 48.02 and in rural females it is 51.98. And in urban areas this is 45.75 in males and 54.25 in females. This shows that even in urban areas, where health facilities are easily available, the percentage of untreated morbidity is very high and in females it is higher than the males. The National Family Health Survey – 3 (2005-06) also shows disturbing aspects of health in India. According to data in 2005-06 the Infant Mortality rate in India is 57 per thousand children, Neonatal Mortality rate is 39 per thousand, under-five mortality rate is 74 per thousand. The percentage of the children who had basic vaccinations is only 44 per cent. These figures show that childhood mortality rate in India is quite shocking and also the children who did not have full basic vaccination is quite considerable. NFHS-3 data also shows a very depressing picture of children’s health. In India as a whole, 70 per cent of children of the age-group of 6-59 months have some anemia. A shocking revelation is that the
prevalence of anemia has increased from 74 per cent as per NFHS-2 (1998-99) to 79 per cent according to NFHS-3 (2005-06). All these figures indicate that India needs efforts on a massive scale to counter the challenges in the field of health. In the words of C. Gopalan, ‘we are only prolonging the lives of those who are in the substandard state of Health.’

Table 1.3

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Health Indicators</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Crude Birth Rate</td>
<td>26.1</td>
</tr>
<tr>
<td>2.</td>
<td>Crude Death Rate</td>
<td>8.7</td>
</tr>
<tr>
<td>3.</td>
<td>Total Fertility Rate</td>
<td>3.2</td>
</tr>
<tr>
<td>4.</td>
<td>Maternal Mortality Rate</td>
<td>40.7</td>
</tr>
<tr>
<td>5.</td>
<td>Infant Mortality Rate</td>
<td>70.0</td>
</tr>
<tr>
<td>6.</td>
<td>Child Mortality Rate</td>
<td>22.5</td>
</tr>
<tr>
<td>7.</td>
<td>Couple Protection Rate</td>
<td>46.22</td>
</tr>
<tr>
<td>8.</td>
<td>Life Expectancy at Birth</td>
<td>60.4</td>
</tr>
</tbody>
</table>


According to this table, during 2001-02, the crude birth rate was 26.1, crude death rate was 8.7 and total fertility rate was 3.2 per cent. The figures of child and maternal health present a shocking picture as there was 40.7 per cent maternal mortality rate and 70.0 per cent infant mortality rate. The other health indicators also present neglected aspects of health.

1.2 HEALTH FACILITIES AND HEALTH MANPOWER

Health manpower planning is an important aspect of community health planning. It is based on a series of accepted ratios such as doctor-population ratio, nurse population ratio, bed-population ratio etc. The norms suggested by Mudaliar Committee (1961) have been the basis of health and manpower planning in India. At present, there are 271 medical colleges in the country and
these colleges are admitting 31,172 students at MBBS level. More than 6 lacs experts of other medicine systems are presently working in India and the number of registered allopathetic petitioners are 6,83,582. The total doctor population ratio is 1:870 at national level (Govt. of India, 2007). There is also misdistribution of health manpower between rural and urban areas. Studies have shown that 80 per cent of health practitioners are working in urban areas and rural areas are devoid of health facilities and manpower.

1.3 PRIVATE HEALTH SECTOR IN INDIA

In India, with public health spending accounting for less than 20 per cent of total health spending and out of pocket expenditure amounting to 98 per cent of all private health expenditure, health and health care access is not only poor but also highly inequitable. The National Family Health Survey – 3 data brings this out very clearly. The extent of inequity between the top and bottom quartile for some key indicators is huge – under five years morality 2.97 times; access to doctor for antenatal care 3.8 times; delivery in a health facility 6.59 times; full immunization 2.9 times; no immunization 10.11 times (NFHS-3). This is because the public health expenditure accounts for less than 1 per cent of the gross domestic production in contrast to private health expenditure of over 5 per cent of gross domestic production.

While private medical practice and the dispensation of medical care for a price have been known for long time, the commercialization, corporatisation and marketisation of health care are a phenomenon of the last quarter of the 20th Century. The process received a boost during the late 1970s and early 1980s. Global recession imposed a fiscal constraint on government budgets and encouraged them to cut back on public expenditure in the social sectors. This increased the space for the growth of the private sector in provisioning of health care. This process was accelerated during 1980s and 1990s with the growth of pharmaceutical and medical equipment industries and their seeking
out markets for their products. The marketisation of health care in the 1990s is characterized by the increased influence of multinational corporations in pharmaceutical industry, the emergent exporters of hi-tech medical technology, international insurance firms and health care corporation. With shrinking budgetary support and fiscal problems, the government is finding difficult to expand their public facilities to cater to the growing health care needs of their populations. There is a considerable demand on the government to expand and upgrade its facilities to fulfil the requirements of health care.

The involvement of the private sector in health care is an important option to augment resources in the health sector. To mitigate the problem of the health sector, the policy documents have recommended that the state governments should encourage the establishment of private medicare and investment by non-government agencies in establishing curative centres. The 'National Health Policy, 2002' observed that in most urban areas public health services are very meager. To the extent that such services exist, there is no uniform organizational structure, said the policy observation. There is the problem of lack of staff, absence of staff from duty and no attention to the patients. All these factors paved the way for privatization of the health sector. Even at the time of independence, there was a significant presence of private sector. As per the estimates of Bhore Committee, the proportion of allopathic doctors in private sector was 73 per cent and 27 per cent doctors were working in government sector (Baru, 1998). In 1996, the proportion of private hospital beds was 61.0 per cent and public hospital shared 32.0 per cent beds. The data suggest that 80 per cent of allopathic doctors registered with Medical Council of India and 6,50,000 providers from other systems of medicine are working in private sector (Yesudian, 1990; Visaria and Gumber, 1994). The utilization data collected by NSSO (National Sample Survey, 1998) indicates that the private health sector pre-dominates in terms of quality of care, with 80 per cent of ambulatory care and 60 per cent of in-patient care (Nandraj and Khot, 2003).
Privatization is very much the flavour of the day. Many enthusiasts of privatization seem to believe that privatization will automatically make space for improved performance. If we take a look at the present situation, we can very well understand this fact that private health sector is the one which has great importance in present situation as, there are 271 medical colleges in the country, out of which 138 are government colleges and rest of the 133 colleges are run by private groups. At the M.B.B.S. level these colleges have the capacity to admit 31,172 students per year. The number of available seats in different colleges at postgraduate level is 11,005 per year (The Tribune, March 20, 2008).

Presently, there are 6,83,582 registered allopathic practitioners in the country and the proportion of doctor to population is 1:1634. Apart from this, there are more than 6 lakh experts of homeopathy, ayurveda and other indigenous medicine system. Thus the total doctor-population proportion is 1:870 in the country (The Tribune, March 20, 2008). The data also show that most of these professionals are working in private sector.

Another important fact attached to the process of privatization of health sector is that expansion of private health facilities is expanding rapidly in urban areas. With the growth of middle class and their growing health care needs, most of the private practitioners preferred urban areas. Even the report of Bhore Committee (1946) pointed out that about 80 per cent private practitioners are working in urban areas.

It is also very important that both the suppliers and the consumers of private services are largely drawn from middle class (Baru, 2003). During 1980s, the government formally recognized private health care sector as an industry. During the same period, import duties on medical equipments slashed. The land was leased at extremely low rates to many of the large private hospitals. Import duty concessions and subsidies benefited large and
multi-specialist hospitals (Baru, Qadeer, Priya, 2000). During the union budget of 2000-01, the private hospitals claimed that they are not making profits and government subsidies can help them to improve their conditions. In their demands they also included more financial support in terms of infrastructure, loans facility, more reduction in import duties on medical equipments and giving nursing homes the status of small-scale industry (Baru, Qadeer and Priya, 2000). They also demanded tax-exemption for those doctors who were ready to practice in rural areas and wanted to set up their clinics and nursing homes in backward areas. These demands were articulated by the promoters of large private enterprises in Chennai (The Hindu, Feb., 28, 2000). They clearly reflect the situation that large private corporates constitute only 1-2 per cent of private health market but are powerful in influencing government policies during last two decades.

There are some conditionalities for private hospitals prescribed by the government. One of them is that 20 per cent of in-patients and 40 per cent of out-patients should be from among the poor and must be treated free of cost. But many of them have been found to be flouting these conditionalities. Due to these problems, a committee was set up by Delhi government to examine these issues. The reports suggest that private sector has proved poorly on these bases (Baru, Qadeer and Priya, 2000).

Efficiency and quality of health care is also an important issue when we discuss the expansion of private health care. To make private sector more efficient, it is felt that like other industries, health sector should also adhere to rules and regulation. The rules regarding employment conditions, minimum wages for all levels of staff, fees paid by the patients, maintenance of medical records and ensuring transparency must be followed by the private health sector. The rules and regulation for the practitioners are framed by respective State Council and Indian Medical Council Act for various systems of medicine.
The Medical Councils are statutory bodies that set the standard of medical practice and check any malpractice. The practitioners have to register, themselves with the council and the renewal of registration must be made periodically. The doctors who are not registered with the council can not practice. But the data collected by ‘Health Information of India’ reveals that many state councils have failed in regulating private practitioners and maintaining and updating registers of doctors (Nandraj, 1994). The experience of privatization of health services across the states in India shows some common trends and also differences across states. The variation in trends can be explained by the social structure interaction process and at large socio-political contexts of individual state. Thus, we have decided to study the structure and pattern of private health care in terms of facilities provided to the users by the private health institution and how people view these services. We would also like to know the functioning of government in terms of regulating the private health care institutions. This would give scope to know the mechanism of intervention for the regulation of private health care.

1.4 HEALTH SECURITY

Gumber and Kulkarni (2000) made an effort to explore the need and availability of health insurance for the poor and women. It is estimated that a large number of families depend on informal sector for their livelihood. These workers neither have fixed employer-employee relationship nor do they obtain statutory social security benefits. It is estimated that only a small fraction i.e. less than 9 per cent of the India workforce is covered by some form of health insurance through central government health scheme, employees state insurance scheme and mediclaim. A majority of the covered population belongs to the organized sector.

The low level of health insurance coverage is due to the fact that government policies have been designed to provide free health services through
the public sector. The reality, however, is that the public sector health agencies, on the one hand charge for their services and on the other hand have a poor outreach both in terms of quantity and quality. The reality is that majority of rural and urban slum population in India remains outside the health insurance system regarding available health insurance schemes or because the mechanisms used by the health insurance providers are not suitable to them. Mainly health insurance provides health security. Health insurance, which addresses only the financing aspects, in itself is not sufficient to ensure that poor people who need healthcare actually receive it. It is necessary that appropriate and good quality services, delivered efficiently, are available to the poor (Gumber, 1998). A number of private insurance companies have come up after the liberalization of insurance market in 2000, but no remarkable change has been observed. The two new health insurance policies, namely, mediclaim, which is for general public and Jan Arogya for the poor were launched but they have not shown any significant growth (Ahuja, 2004). As a major initiative for providing social security, Employees’ State Insurance Act (ESI Act) in 1948 was promulgated by Parliament. As of March 2003, the ESIS covers about 0.25 million factory units and provides benefits to 25.3 million beneficiaries through the widespread network health facilities.

The CGHS (Central Government Health Scheme) was introduced as a contributory plan in 1954, to provide medical coverage to central government employees (retired also) ands their families. This was initially started in Delhi and then it extended to other cities. Presently, it covers 23 cities. The ESIS and CGHS together cover about 3 per cent of population, including beneficiaries and their families (Gupta and Trivedi, 2005).

Certain ministries like Railways, Defence and Coal give health coverage to their employees as a benefit. There are some government sponsored schemes also that provide health coverage to specific employment target population. The Ministry of Defence provides a comprehensive health coverage service to
the armed forces personnel and their families of all three wings i.e. army, navy and air force. These services are provided by an inter-service organization called 'Armed forces Medical Services (AFMS). The total beneficiaries add up to 6.6 million. In this scheme, the entire finance comes from the budget of ministry of defence, there is no contribution from the beneficiaries (Gupta and Trivedi; 2005).

Another newly introduced scheme, namely, Ex-servicemen Contributory Health Scheme (ECHS) is for ex-servicemen, war widows and their dependents. All types of diseases are covered by this scheme. Inpatient and outpatient services are provided through empanelled civil hospitals and polyclinics. 95 such medical institutions were established in 2003-04 and some other medicare centres will be constructed in phased manner by 2008 (Gupta and Trivedi, 2005).

In recent years, a new trend has emerged, that is of the partnership between government and insurance companies. This partnership is described under Public-Private Partnership because of the autonomous structure of the companies in the privatized insurance sector. Some of the important schemes under these Public-Private are : Employees group mediclaim Policy (Government of Jammu and Kashmir): This scheme is for the every government employees of Jammu and Kashmir (J & K) which provides the facility of reimbursement like any other state’s employees. The J & K government has started this scheme with National Insurance Company. It covers 0.35 million beneficiaries.

Universal Health Insurance scheme for below-poverty – line (BPL) population : The Government of India introduced this scheme in 2003 for poor population. Rag-Picker’s scheme (Pune) Community Health Insurance scheme of Karuna Trust (Karnataka) are also examples of partnership among government, insurance companies and NGOs.
Students’ Health Home (West Bengal) is a special scheme extensively for students. This covers 1.6 million students in the state (Gupta and Trivedi, 2005).

The National Rural Health Mission documents (2006) say that Rs. 1 is spent on the poorest 20 per cent population and Rs. 3 is spent on the richest quartile. And only 10 per cent of population in India have any form of health insurance. On the whole, it can be said that health sector in India needs great attention and continuous efforts.

NGO’s (Non-Governmental Organization) are also working in the health sector. It appears that an NGO has nothing to do with government but the fact is that they have to get approved and registered by the government and they get financial assistance also. The voluntary organizations get themselves registered under ‘Society Registration Act of 1860’. This act is still working with some minor amendments.

A significant growth of NGO’s is noticed during 90’s. The new NGO’s started working on the concept of community health along with other programmes.

1.5 HEALTH SECTOR IN HARYANA

Haryana state came into existence on November 1,1966. Before this, it was a part of Punjab. It has 44,222 sq. Km. area and its total population is 21.14 million. It has 21 districts namely; Ambala, Punchkula, Yamunanagar, Kurukshetra, Kaithal, Karnal, Panipat, Sonipat, Rohtak, Jhajjar, Faridabad, Gurgaon, Mewat, Rewari, Mahendergarh, Bhiwani, Jind, Hisar, Fatehabad, Sirsa, Palwal. Total patients treated in Haryana in 2005-06 are 1,16,85,082, out of which 4,32,857 are in-door patients and 1,12,52,225 are outdoor patients. In 2006-07, total 1,30,58,910 patients are treated, out of which 4,81,071 are in-door patients and 1,25,77,839 are out-door patients (Director General of Health Service, Haryana, 2008).
During 2006, total patients treated in government institutions in Haryana were 2,49,121. Out of these patients 12,809 are in-door patients and 2,36,312 are out-door patients (Director General of Health Service, Haryana). There is a sharp difference between the number of treated patients and the patients treated in government institutions. We find that a large number of patients are treated in other than government institutions. In 2006-07, total number of government allopathic institutions in rural areas were 2,881. There are 6 hospitals, 364 PHCs (Primary Health Centres), 31 Dispensaries, 47 CHCs (Community Health Centres) and 2,433 sub-centres. The total number of government allopathic institutions (2006-07) in urban areas are 299, out of which there are 55 hospitals, 45 PHCs (Primary Health Centres), 162 dispensaries and 37 CHCs (Community Health Centres) (Director General of Health Services, Haryana, 2008).

There are 14 institutions per 1,00,000 population in Haryana according to 2006-07 data and number of beds are 41 per 1,00,000 population. The number of Ayurvedic institutions in Haryana in 2006-07 are 477, Unani institutions are 19 and Homeopathic are 21 in numbers (Director, Ayurveda, Haryana, 2008). Total number of patients treated in these institutions during 2006-07 are 35,31,687 and the number of Vaidya, Hakims and Homeopathic doctors are 419 (Director Ayurveda, Haryana, 2008).

According to 2006-07 data, there are 107 family welfare clinics and centres out of which 93 are in rural areas and 14 in urban areas.

If we look at the NFHS-II (1998-99) and NFHS-III (2005-06) data, we can notice the prevailing health problems in Haryana, particularly among women and children.
Table 1.4

Health Situation in Haryana with reference to NFHS-II and NFHS-III

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Health Situation in Haryana</th>
<th>NFHS-II (In per cent)</th>
<th>NFHS-III (In per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Under Weight Children below age 3</td>
<td>35</td>
<td>42</td>
</tr>
<tr>
<td>2.</td>
<td>Wasted Group</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>3.</td>
<td>Malnutrition</td>
<td>25.9</td>
<td>27</td>
</tr>
<tr>
<td>4.</td>
<td>Anaemia in Pregnant women under age 15-49</td>
<td>55.5</td>
<td>69.7</td>
</tr>
<tr>
<td>5.</td>
<td>Any anaemia in women</td>
<td>47</td>
<td>56.1</td>
</tr>
</tbody>
</table>

This table shows that health problems in Haryana are increasing with the passing years. The percentage of Anaemic pregnant women has increased from 55.5 to 69.7 per cent and malnutrition has increased from 25.9 to 27 per cent.

All these data show that efforts on a large scale are needed to develop and maintain the health status of the people. In these efforts, private health institutions can play an important role. So, it is important to know the structuring and functioning of private health care institutions.

1.6 HEALTH INFRASTRUCTURE IN ROHTAK DISTRICT

Rohtak is one of the advanced districts in Haryana in terms of education, infrastructure and health care facilities. In Rohtak district, in the year 2007-2008, there were 157 allopathic institutions, out of which 137 are situated in rural areas and 20 are located in urban areas. These institutions include 6 hospitals, 22 PHCs (Primary Health Centres), 12 dispensaries, 6 CHCs (Community Health Centres) and 111 sub-centres. Total 728 para-medical staff is working in these institutions. Total patients treated in these institutions are 1611834, in which 88014 are in-door patients and 1523820 are outdoor patients. In these institutions 1633 beds are available. The proportion of beds to
one lakh population is 156 beds and one medical institution is working per 11 sq. km. in the district. At present 28 Ayurvedic and Unani institutions are working wherein a total of 204092 patients were treated in 2007-08. The number of births in the Rohtak district in 2008 is 24192 and number of deaths is 10646, while in 2007, the number of total births is 24088, out of which 12901 are males and 11187 are females (District Statistical Office, Rohtak, 2008). According to 2001 Census, the sex ratio of this district is 847 females per 1000 males which is very low. And the sex ratio by birth is 871 per 1000. The total number of sterilization operations in the district in 2007-08 was 4775 and the number of DPT/ Polio immunized was 26005 (District Statistical Office, Rohtak, 2008). At present P.G.I.M.S. (Post Graduate Institute of Medical Science), 2 Ayurvedic, 1 Homeopathy, 1 Pharmaceutical and 1 Physiotherapy College are running in the district, where 4061 students are admitted. Out of which 3013 males and 1048 females are getting medical education (District Statistical Office, 2008).

1.7 FORMULATION OF RESEARCH PROBLEM

India is the second most populous country in the world. To maintain the health status of such a big population is a great challenge. The Government of India spent Rs. 100 per capita per year for health. This is one of the lowest health expenditure by any government (Peters et al., 2002). The common complaints against these under-funded government health services are poor quality of care, over-crowding at the secondary and tertiary health care facilities, lack of adequate drugs, man power and equipments (Gupte, 1993). Due to all these problems most of the patients go for private health care. About 85 per cent of patients use the private health sector for primary care while 40 to 60 per cent go for private sector for in-patient care (Peters et al., 2002). Looking at the affordability of the people in India, the majority of people are not in a position to spend on private health care, however non-availability of
government facilities push them to go for private health care. Thus, it becomes important to understand the structural and processual aspect of private health service in India.

The present scenario in India is of medical pluralism. This can be defined as the co-existence of several medical systems and the relatively greater choice available for everyone. There are three streams of health providers that have emerged in the post-independence India i.e. the qualified allopathic doctors, the qualified doctors from Indian systems of medicine i.e. Ayurvedic, Unani and Siddha etc. and the unqualified health providers. Homeopathy is also an important part of India's health structure. However, qualified allopathic doctors (both working in public and private sectors) occupy the dominant position in the plural medical systems in India. Even before independence, the health sector was dominated by private individual practitioners. According to Bhore Committee, 73 per cent allopathic doctors are in private sector and 27 per cent in government service (Bhore Committee, 1946). The dependence on private sector is considerable. The utilization studies also show that one-third of in-patients and three-fourth of out-patients utilize private health care facilities (Yesudian, 1990: Visaria and Gumber, 1994).

The private institutions started growing in India during 1970s and had a boom after 1980s. During 1980s, the government formally recognized private health sector as an industry. During this period, import duties on medical equipments were slashed and land was leased at extremely low rates to many of large private hospitals. These types of facilities and subsidies largely benefited multi-specialist hospitals in private sector (Baru, 1998).

To create a balance in providing health services, it is very important that there should be an appropriate doctor-population ratio and bed-population ratio. There is a rapid growth in private health sector after independence. In 1973, the percentage share of beds in private hospitals is 28.8 and 71.2 in public
hospitals. In 1983, it is 40.7 in private and 59.3 in public hospitals. There is an increase in percentage share of beds in private sector as it came to 57.7 per cent and 42.3 per cent in public hospitals in 1993. But a remarkable increase is seen in 1996 as private hospitals shared 61.0 per cent while public hospitals had 39.0 per cent. And this number in private sector is on continuous increase (Government of India, 1999).

The Private health care expenditure is estimated to have grown at the rate of 12.5 per cent per annum during the period 1960-95, while the growth in per capita income has been only 8.5 per cent during the corresponding period (Bhat, 1996).

The NSSO 58th round data (2002) revealed that a large proportion of total ailments treated in private hospitals is 78 per cent in rural areas and 81 per cent in urban areas (NSSO 58th round data, 2002).

The NSSO 60th round data (2004) has revealed that out of 1000 hospitalised cases, 583 cases in rural areas and 618 cases in urban areas are treated by non-governmental institutions. Among the cases where treatment is taken, the most important source of treatment before hospitalization is private doctors. It is 48 per cent before hospitalization, while it is 44 per cent after hospitalization (NSSO 60th round data, 2004).

According to Monthly Per Capita Consumption Expenditure (MPCE), the households having MPCE of less than Rs. 380 come under BPL (Below Poverty Line), households having between Rs. 380 to Rs. 470 have been categorized as NBPL (Near - BPL) and households having MPCE more than Rs. 470 have been categorized as APL (Above Poverty Line). In this survey, the probability of visiting a public or private source by these three different categories is shown in table 1.5 (NSSO: 2004).
Table – 1.5  
Probability of Visiting Either a Public or a Private Provider in Various Socio-Economic Groups

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public</td>
<td>Private</td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>BPL</td>
<td>1221276</td>
<td>1150624</td>
<td>1114261</td>
<td>942739</td>
</tr>
<tr>
<td></td>
<td>(0.51)</td>
<td>(0.49)</td>
<td>(0.54)</td>
<td>(0.46)</td>
</tr>
<tr>
<td>NBPL</td>
<td>881069</td>
<td>888031</td>
<td>690365</td>
<td>834335</td>
</tr>
<tr>
<td></td>
<td>(0.50)</td>
<td>(0.50)</td>
<td>(0.54)</td>
<td>(0.46)</td>
</tr>
<tr>
<td>APL</td>
<td>1919943</td>
<td>3506357</td>
<td>1651828</td>
<td>3118872</td>
</tr>
<tr>
<td></td>
<td>(0.35)</td>
<td>(0.65)</td>
<td>(0.35)</td>
<td>(0.65)</td>
</tr>
<tr>
<td>Total</td>
<td>4022288</td>
<td>5545012</td>
<td>3456454</td>
<td>4895946</td>
</tr>
<tr>
<td></td>
<td>(0.42)</td>
<td>(0.58)</td>
<td>(0.41)</td>
<td>(0.59)</td>
</tr>
</tbody>
</table>

Source: 60th round data (NSSO), 2004.
(Number of BPL Males – 191515422, Females – 178621709)
(Number of N-BPL Males – 112229154, Females – 104673363)
(Number of APL Males – 254609424, Females – 237467928)

From the above data, it can be seen that a substantial number of the poor is also being hospitalized in private sector hospitals, suggesting inadequacy of the public infrastructure.

This is a fact, that in Andhra Pradesh, Kerala, Maharashtra, Gujarat, Punjab and Haryana, the proportion of private beds is higher than public beds. As we see that in 1973, there are only 32.2 per cent of beds in private sector which increased to 67.2 per cent in 1983. Similar trend can be seen for Gujarat, Kerala and other states where the share of private sector increased to more than 60 per cent after 80s (Baru, 1998). In case of Haryana also, there are less number of patients treated in government institutions as compared to private institutions. In 2006-07, out of total 1,30,58,910 patients, only 2,49,121 patients are treated in government institution. This reveals that the increasing share of private sector in Haryana is also tremendous. Other states like Bihar, Uttar Pradesh, Rajasthan, Orissa and West Bengal witnessed little growth in private health sector during 1990s and later (Baru, 1998). Since Haryana is in the list of the states where private health sector has rapid and significant
growth, therefore, it has attracted the attention of the researcher to see the structuring and functioning of private health care services in Haryana.

1.8 CONCEPTUAL FRAMEWORK

The ‘Alma-Ata Declaration, 1978’ pledges ‘Health for all by 2000 A.D.’ This declaration came as a hope, especially for the poor and deprived masses in the developing countries of the world. But before talking about the health facilities and health structure we should understand ‘What is Health’? The meaning of ‘being healthy’ differs from person to person. It is generally viewed that different people have different views regarding aspects of ‘being healthy’. The most common view about being healthy may just mean ‘absence of illness.’ Generally health is taken for granted. People feel concerned only when health problems affect their everyday lives. It is very difficult to define ‘what is health’ and ‘who is healthy’? The World Health Organization, at its inception in 1946, defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.’

It is to feel in good form, happy, contented, with a good appetite, sleeping well, wanting to be up and doing, it is to feel well and strong” (Herzlich, 1973). A Different definition given from a sociological perspective comes from Talcott Parsons (1964) who describes health as a state of optimum capacity of the effective performance of valued tasks. He focused on the social importance of health. Healthy individuals are able to function well, to perform social roles, ill-health reduces their ability to do so.

Health should be viewed in time framework and in context of physical and socio-economic environment as any person may be healthy at one time and the next moment, the same person may become unhealthy.

Health may be seen as absence of disease. It is a background feature of routine living and a person’s display of his essential normality (Mehta, 1996). In the first Five Year Plan, health has been defined as a positive state of well-
being in which harmonious development of mental and physical health lead to
the enjoyment of rich and full life. It also implies a person’s adjustment to his
physical and social environment.

Thus, the health can be considered as balance of body and mind and
rational adjustment to the total environment. Health has been given an
important place in the policies of all the nations and even UN Agency. Article
25 of Universal declaration of human rights is directly related to right to health.
It has been stated that everyone has the right to a adequate medical care. It has
also been stated in the preamble of WHO Constitution that good health is
fundamental right of everybody and government should fulfil their
responsibility by constructing health policies and taking welfare measures.

Health and social welfare measures should be targeted at the
development of health status of the population. The concept of health is
directly related with the social and cultural milieu. So it should also be
considered in terms of economic functioning and social integration. WHO has
emphasized on primary health care which has been defined as essential and
accessible. Health care which means the health care acceptable to people
through their full participation and at a cost that the community and country
can afford. The complete social and economic development of a country
depends upon country’s health system.

One should view the total health in context of physical, mental,
emotional, spiritual and social health.

1.9 WHAT AFFECTS HEALTH?

In order to work towards better health, it is very much important to
know and identify influential factors. These can be genetic make-up, gender,
family, culture and religion, income, social life, age, education, working
condition, employment status, environmental pollution, delivery and
accessibility of health care services and prices for getting public or private
health care. Most of the studies regarding public health facilities are focused on
access and quality issues, which deter people from utilizing government health services. Absence of medical staff during duty hours and presence of other informal medical facilities also affects health (Benerjee, Deaton and Duflo, 2004).

In broader sense, we can say that social, education and economic, physical and administrative factors influence health to a great extent. The relationships between socio-economic development and health progress is of great importance. The WHO has clearly stated on public health that ‘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, sometimes unfavourably (Goel, 2005). The concept of health and illness becomes institutionalized within the socio-cultural setup of each society and its progress and development.

Data collected in National Sample Survey (NSS) 60th round (2004-05) reveal some very important factors and key determinants of demand for healthcare that can be categorized under the generic title of human development – age profile, income group and literacy level. Data collected in NSS (National Sample Survey) 52nd round for urban sample, there is 3 to 4 per cent gender gap for respondents citing financial reasons and self assessment of their illness. (Sen, Iyer and George, 2002).

In the NSS0 60th round data, gender bias is reflected, as in rural areas 48.02 per cent males while 51.98 per cent females cited different reasons for not seeking medical treatment and in urban areas 45.75 per cent males and 54.25 per cent females did not seek any medical treatment for their ailments (NSSO, 60th round data). It is also found that elderly female members like mothers and mother-in law of household have far higher rates of untreated morbidity as compared to elderly male members. The difference is found nearly 6 per cent between the untreated morbidity rates of elderly male and female members of the family. The social set-up and dynamics may be reasons
1.10 HEALTH BEHAVIOUR IN SOCIETY

A state of health or ill-health is the result of a combination of factors having a particular effect on a particular individual at any one time. Health related decisions are taken in the social context in the light of competing priorities. David Robinson (1971) in his study of South Wales Families found that respondents often had quite clear ideas of priority and evaluated the importance of health – risks accordingly. In the classic study of Koos (1954) respondents very neatly expressed their views that health consideration have to compete with other priorities of life. Titmuss (1968) argued that the experience of 15 years of National Health Services had shown that higher – income group know how to make better use of health services than do low-income groups, especially the unskilled working class families. Thus it becomes more valuable to know that how do social factors such as life style, income etc. affect health and illness and what kind of behaviour characterize these people who are consumers of health care? Advani (1980) in his doctoral study regarding ‘Doctor – patient Relationship in General Hospitals’ identified the behaviour pattern of doctor- patient relationship, dimensions of existing hospital system and perception and interaction of doctor and patients. In his study he found that most of the patients are affected by the previous experiences. The socio-economic status determines their choice of hospital, mode of treatment and level of satisfaction.

1.11 HEALTH EDUCATION AND HEALTH PROMOTION

The World Health Organisation has taken a leading role in action for health promotion in 1980s and 1990s. World Health Organisation stated in 1977, at the 30th World Health Assembly that ‘the main social target of governments and WHO in the coming decades should be the attainment of all
citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.' This is the beginning of what has come to be known as ‘Health for All’ movement which led to the development of a regional strategy for the World Health Organization in 1980. This regional strategy called for fundamental changes in health policy of member countries, including a much higher priority for health promotion and disease prevention. The themes of the health quoted by WHO are known as ‘Health for all Principles’:

(i) Reducing inequality in health.
(ii) Positive health through health promotion and disease prevention.
(iii) Community participation.
(iv) Co-operation between health authorities, local authorities and others with an impact of health.
(v) A focus on primary health care as the main basis of health care system.

All these principles are especially for the developing countries who are far behind in health promotion.

Health education is to give information regarding health and working towards individual attitude and behaviour changes. But now health promotion is a term widely used and health education is seen as an important element in health promotion.

1.12 HEALTH CARE SERVICES

This includes the activities and workings of health services like treatment, cure and care in primary care and hospital settings. This also includes medical services which aim to prevent ill-health such as immunization, family planning and personal health checks etc. Today the health care services are categorized into two broad categories i.e. services provided in private health sector and services provided in public health sector.
and there is an unending debate on the issue that which one is better and how they can be mended to complement each other.

1.13 THEORETICAL FRAMEWORK

Different sociologists have different perspectives regarding health and medicine. Durkheim's contribution, especially in the study of suicide, crime, religion and health and illness is well-marked. Durkheim was mainly concerned with the structure that lies behind observable phenomena. He has explained it in relation to the specific context of health and illness (Cresswell, 1972). He has attempted to explain some of the relationships between society and diseases. He was of the opinion that structure itself contains certain factors that decide pattern of diseases and relationship between suicide and religion, domestic and political orders. Thus, a realist approach to the possible relationship between society and disease would attempt to use abstract theoretical construct to reveal structures that generate observable phenomena and relationship between them (Taylor and Ashworth, 1970).

Weber emphasizes an objective description of social system. He says that every social system consists of its administrative organizations. He describes human history in terms of dynamics, effects of religious ideas, economic structure and human action and interest and his particular concern is the transition to modernity in the west (Touraine, 1974). According to Weber, modern western world was different because of its specific and peculiar rationalism. Rationalisation is the process of 'intellectualisation'. Rationalisation in areas related to health and illness are also considered particularly technocratic dominance and the nature and limits of rationality to medicine. Illness would, therefore, be defined as the failure of workings of mechanical system. He says that health services are bureaucratically organized. A large number of proportion of health services are dispensed by individual practitioners and the administration of medical and social programme. Weber
emphasizes on the rational thinking about illness, well organized bureaucracy that manages health services and eradication of irrational thinking and practice regarding health and medicalization (Hillier, 1987).

Hebermas talks about social system that contains cognitive development with reference to cultures. According to Hebermas, cultures undergo an analogous process of transformation. Hebermas argues that critical social theory must acknowledge that a genuinely emancipated society is one in which individuals actively control their own lives through an enhanced understanding of their material and psycho-social circumstances (Scambler, 1997). He has talked about two types of rationalization, involving 'purposive-rational' and 'communicative' action and the second is between the concepts of 'system' and 'life-world' in detailed account of their relevance to contemporary medical practice (Habermas, 1979). First two terms refer to empirical efficiency of technical means and reciprocal relations between patients and doctors. The term 'life-world' deals with the whole system of medicines. He suggests that current clinical practice is based on asymmetrical power relationship between physicians and patients. He says that proper communication between physicians and patients is important for patient's true interests (Giddens, 1985).

Talcott Parsons deals with structure functionalism. He describes social structure and system in terms of roles. Roles mean that different people are related with each other in terms of roles played by them to maintain structure. He discussed the concept of sick-role in terms of doctor’s role. The two duties making up the doctor’s role are those to serve but the patient’s welfare and to ensure that this is done with the utmost professional competence. If there is any problem on the part of doctors, that may be called sick-role (Gerhardt, 1987).

Kennedy thesis provides a vide range of analysis of illness behaviour like escape behaviour, emergency behaviour, rehabilitative services, precautionary behaviour and acceptance behaviour etc. The thesis is that within any aggregate setting, human being have discovered different patterns of
behaviour that provides a workable adaptation to the threat of a disease and other health related problems for the survival of both the individual and the system (Mehta, 1996).

Rosenstock (1966) talks about ‘Health belief model’ to study the preventive aspects of health behaviour. According to this model, an individual’s perception that he is personally susceptible and that the occurrence of the disease would have severe implication of a personal nature motivate him to go in for preventive practices to avoid illness.

Foucault’s work in social sciences and humanities has been truly phenomenal. The study of health and medicine is no exception and his influence is so profound that we can not think of many great topics without some reliance on his work. Foucault was of the opinion that social life and social problems had become more and more ‘medicalised’ or viewed through the prism of scientific medicine as ‘diseases’ (Zola, 1972 and Friedson, 1970). From his perspective, power as it operates in medical encounter is a disciplinary power that provides guidelines about how patient should understand, regulate and experience their bodies. Foucault has emphasized that the field of medicine is diverse and heterogeneous, taking place at sites such as work places, schools, clinics, hospitals or surgery and the state is directly involved in reproduction of medical dominance and regulation the conditions for licensing of medical practitioners (Lupton, 1997).

Models, the subject of sociology has witnessed many different perspectives (micro, macro and synthesis) through time. Prominently however, the macro perspectives of classical sociological traditions are considered to be still relevant. The researcher would heavily rely upon the structural – functional perspective. Functionalism, begins with the observation behaviour in society which is structured. Relationship between members of society are organized in terms of roles and these relationships, therefore, are patterned and recurrent. The structure of the society can be seen as the sum total of normative behaviour
which is governed by norms. The main parts of the society, through its institutions such as family, kinship, economy, political system, education are the major aspect of social structure. An institution can be seen as a structure made up of interconnected roles and interrelated norms. Health, as an important part of social structure, has to be understood through its interrelated norms or inter-connectedness of culture, political and economic institution. Further, the functional analogies turn to a consideration of how a structure functions. This involves the examinations of the relationship between different parts of structure and their relationship to the society as a whole. In simple terms, functions mean effect. Thus, the function of health, as an entity, is the effect it has on the other parts of the social structure and on society as a whole. In practice, the term function is usually used to indicate the contribution an institution makes to the maintenance and survival of the social system. Here, in our research, the function of health as an important entity would require to be understood through its contribution to the maintenance of society. Following the macro functionalist perspective, we will opt to use the perspective to assess the level of health care of the target group who are receiving private health care.