INTRODUCTION

Chapter I

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1.1 Introduction

Access to health care is an important component of an overall health system and has a direct impact on the burden of disease that affects many developing countries. Measuring accessibility to health care contributes to a wider understanding of the performance of health systems within and between countries, which facilitates the development of evidence based health policies (Black et al. 2004). 

Access to health care has multiple definitions and its meaning in a given context is too often assumed (Khan and Bhardwaj 1994). The access to health care is defined as the potential and actual entry of a group of population into the health and health care delivery system (US Congress 1988). Health care for the preservation and promotion of health is one of the most basic human rights, as declared in the Universal Declaration of Human Rights (Article 25).

It would depend on availability, awareness, affordability and accessibility to health care services (Uplekar and George 1994). The factors of accessibility can be grouped into (i) affordability (ii) availability and (iii) acceptability and with

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socio-economic dimensions like ethnicity, religion; gender, age; caste (Penchansky and Thomas 1981⁵; Oliver and Mossialos 2004⁶).

The physical existence of health care facilities is necessary but not a sufficient condition for access. Apart from the physical existence, the people's ability to utilise those facilities and the quality of care available effectively determine the actual access. Further, the access to health care is influenced by the attitude of the people to receive the medical service, the knowledge about the disease and the awareness of the medical facilities. In short, access to health care is the combination of affordability, availability and acceptability of health care.

In Alma Ata Declaration in 1978, 134 countries subscribed the goal of "Health for all by the year 2000" and they affirmed World Health Organisation's broad definition of health as "a state of complete, physical, mental and social well-being". Sadly the year 2000 has passed and the goal of health for all in some ways seems farther than ever from being reached (Werner 2005⁷).

While a few health indicators have improved modestly since 1978, for billions of people, health and quality of life have actually deteriorated. This is partly because of the decreasing access to costly health services. But it is also because the world’s neediest people have been increasingly marginalised by the dominant model of economic development (Werner 2005⁸). Even though, India has a large network of health care systems of the world, this is not adequate and

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affordable to the people in a country, with more than 50 per cent below poverty line (World Development Report 2000-01).

Health is a fundamental human right and is inculcated in the Indian Constitution. The Constitution directs the state must stand for the improvement of public health as one of the primary duties (John 2005).

The relationship between health and social condition is a constantly changing one. It is said that social conditions primarily determine the health status of various group of people.

Kerala is one of the few regions having an active policy of providing health care efficiently and equitably. Kerala’s governments have pursued a pro-active role in the provision of health care for the past several decades to all its needy at the public facilities in all the three systems – allopathy, ayurveda and homeopathy. However, the Kerala situation in the provision and the use of health care services is complex. This complexity is due to the diversity – plurality and multiplicity – of systems, sectors and institutions of health care services. The state has recognised and institutionalised three major systems of medicines. Along with the government provision and the private provision, there is a hidden sector also – the practice by government doctors which may be referred to as ‘private in public’ (Sankar 2001)

1.2 Rationale of the Study

Kerala’s development experience has been differentiated by the dominance of the social sectors. Kerala has achieved remarkable progress in human

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development, as reflected in the high levels of education and health of its population. Crude death rate, infant mortality rate and life expectancy at birth in Kerala are comparable even to those of the developed regions. The state health development is generally attributed to spread of basic education, public awareness through specific activities of state and advances in infrastructure facilities. The availability of medical care facilities at easy access, along with factors such as education, has helped the state in attaining a higher rate of health care utilization than other parts of India (CDS-UN 1975\textsuperscript{11}; Nag 1983\textsuperscript{12}; Krishnan 1985\textsuperscript{13}; Navaneetham and Dharmalingam 2003\textsuperscript{14}).

However, the rosy picture of the health status in the state is based on aggregates and they conceal rather than reveal the inequalities that exist in the health conditions in the state. Even with its universally known distinctiveness of ‘development experience’, disparities exist between the main stream and some sections of the society. The inequality in health status among socio-economic groups and better health status is associated with higher socio-economic status and the rate of morbidity was higher than the rate for the better off (Kannan et al. 1991\textsuperscript{15}). Kerala’s achievements have not been uniform across the different geographical locations of the state and have also eluded some of the marginalised sections like fishermen and tribal (Vimalakumari 1978\textsuperscript{16}; Kurian 1995\textsuperscript{17}; Shyjan


2000\textsuperscript{18}). For the real development of the state, these outliers have to be included in the development process (Shyjan and Sunitha 2007\textsuperscript{19}). Outliers with respect to accessibility is an important aspect in this regard. Existing literature deals with the disparity (outliers) with respect to health care and other social sectors, but not accessibility to health care. Against this background, the present study becomes relevant.

1.3 Objectives of the study

The specific objectives of the study are as follows:

(i) To analyse the pattern of morbidity and hospitalisation in Kerala

(ii) To explore the various factors determining affordability, availability and acceptability of health care, and

(iii) To examine the disparity in health care accessibility among different socio-economic groups at disaggregate level.

1.4 Data Source and Methodology

1.4.1 Data source

The study is based on cross sectional analysis with the help of both secondary and primary data. The unit level data of National Sample Survey Organisation’s 60\textsuperscript{th} Round ‘Morbidity and Health Care’ were extensively used for the analysis. In order to supplement the results of NSSO data, primary data from


600 households in Thrissur district of Kerala with an adequate representation from rural and urban areas (27:33 ratio) were collected following probabilities proportional to their size. Further, secondary data collected from different sources like Directorate of Economics and Statistics, Directorate of Public Health, Planning Board, District Medical Offices, periodicals, journals, books, etc. were also used.

1.4.2 Sample selection

The household survey was conducted in Thrissur district of Kerala. The rationale for selecting Thrissur district was that it stands in the midway while considering many socio-economic and health variables. A sample of 600 households from Thrissur district was selected for the study. For giving adequate representation to rural-urban areas, 435 households from rural area and 165 households from urban area were selected. The sample panchayats were selected on the basis of probability proportion to size method. For this purpose, the existing information of caste structure and health infrastructure facilities were taken into account. The data were collected with the help of a detailed survey schedule during the period July – November 2005.

<table>
<thead>
<tr>
<th>Area</th>
<th>Panchayat</th>
<th>ST</th>
<th>SC</th>
<th>OBC</th>
<th>Other</th>
<th>Total</th>
<th>Grand Total</th>
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<td>70</td>
<td>22</td>
<td>9</td>
<td>8</td>
<td>109</td>
<td>435 [72.5]</td>
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<tr>
<td></td>
<td>Nattika</td>
<td>1</td>
<td>23</td>
<td>37</td>
<td>1</td>
<td>62</td>
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<td></td>
<td>Pazhayannur</td>
<td>8</td>
<td>48</td>
<td>21</td>
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<td>Puthoor</td>
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<td>39</td>
<td>53</td>
<td>46</td>
<td>159</td>
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<tr>
<td></td>
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<td>132</td>
<td>120</td>
<td>83</td>
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</tr>
<tr>
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<td>-</td>
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<td>44</td>
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<td>165 [27.5]</td>
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<tr>
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<td>8</td>
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<tr>
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<td>68</td>
<td>52</td>
<td>45</td>
<td>165</td>
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<tr>
<td></td>
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<td>200</td>
<td>172</td>
<td>128</td>
<td>600</td>
<td>600 [100.00]</td>
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</tbody>
</table>
For analysing the data, suitable statistical and mathematical methods have been used. Apart from simple statistical tools like graphs, percentages and tabular analysis, various methods like indices, correlation, multiple regression, ordinal and multinomial logistic regression techniques have been used.

1.4.3 Major definitions

Health

Health is a state of complete, physical, mental and social well being and not merely the absence of disease or infirmity.

Health care

Health care is the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical, nursing, and allied health professions. According to the World Health Organization, health care embraces all the goods and services designed to promote health, including “preventive, curative and palliative interventions, whether directed to individuals or to populations”.

Health care accessibility:

Health care accessibility is the combination of health care affordability, health care availability and health care acceptability.

Health care affordability

Health care affordability is the capacity to buy a health care service.

Health care availability

Health care availability is the condition of existing health care facilities. Availability to health care is concerned with the ability of a population to obtain a specified set of health care services (Oliver and Mossialos 2004\(^20\)).

Health care acceptability

Health care acceptability is the willingness to buy a health care service.

1.5 Scheme of the study

The study has been divided into seven chapters. In the present chapter, importance, conceptual discussion, rationale of the study, objectives and methodology have been discussed. The second chapter deals with the theoretical framework and detailed review of literature. The third chapter analyses the health care scenario at national, state and district level. The fourth chapter is dealing with analysis of secondary level data especially from NSSO rounds. In the fifth chapter detailed analysis of the primary data collected from 600 households from Thrissur district is done. The sixth chapter focuses on the model building in order to measure the extent of disparity in affordability, availability and acceptability in deciding accessibility to health care. The seventh chapter concludes the study with major findings and further scope of the study.