Chapter 4
THEORETICAL FRAMEWORK

4.1 Introduction

The fundamental principle of ‘Health for All by 2000’ (HFA) strategy is equity. This would mean an equal health status for people and countries is ensured by an equitable distribution of health resources. Health is considered as a fundamental human right which would imply that the State has the prime responsibility to ensure the health care services to cater to the health needs of the citizens. Across the world the governments have programmes striving to expand and improve the health care services. But there are many criticisms against the WHO’s slogan of HFA and there was a parallel conference, called ‘Peoples’ Health Assembly’ in 2000 held in Daka, Bangladesh where the Assembly put forward the new slogan ‘Health beyond 2000’.

The challenge that exists today in many countries is making available of adequate health care services to the whole population and ensuring their utilization. The ‘large hospital’ which are chosen for the delivery of health services cater to a small portion of the population and that too people living within a small radius of these institutions. Moreover these institutions render mostly of curative services than preventive and promotive aspects of health. Therefore it has been rightly said that these large hospitals are more ivory towers of diseases than the centers for the delivery of comprehensive health care services. Rising costs in the maintenance of these large hospitals and their failure to meet the total health needs of the community have led many countries to seek ‘alternative’ models of health care delivery with a view to provide health care services that are reasonably inexpensive, and have the basic required by rural population.
The current criticism against health care services shall be summed up as:

1. Predominantly urban-oriented
2. Mostly curative in nature, and
3. Accessible mainly to a small part of the population.

The present concern in both developed and developing countries is not only to reach the whole population with adequate health care services, but also to secure an acceptable level of Health for All, through the application of primary health care programmes.

Since health is influenced by a number of factors such as adequate food, housing, basic sanitation, healthy lifestyles, protection against environmental hazards and communicable diseases, the frontiers of health extend beyond the narrow limits of medical care. It is thus clear that ‘health care’ implies more than ‘medical care’. It embraces a multitude of services provided to individuals or communities by agents of the health services or professions, for the purpose of promoting, maintaining, monitoring, or restoring health (Last J M., ed. 1993).

The term ‘medical care’ is not synonymous with ‘health care’. It refers chiefly to those personal services that are provided directly by physicians or rendered as the result of physicians’ instructions. It ranges from domiciliary care to resident hospital care. Medical care is a subset of health care system.

Health care is a public right, and it is the responsibility of governments to provide this care to all people in equal measure. These principles have been recognized nearly by all governments of the world and enshrined in their respective constitutions. In India, health care is completely or largely a governmental function.

Health services are designed to meet the health needs of the community through the use of available knowledge and resources. It is not possible to define a fixed role for health services when the socio-economic pattern of one country differs so much from another (K Park, 2005)
Three majors themes have emerged in recent years in the delivery of health services:

1. The health services should be organized to meet the needs of entire populations and not merely selected groups. Health services should cover the full range of preventive, curative and rehabilitation services. Health services are now seen as part of the basic social services of a country (WHO, 1971).

2. It is now fully realized that the best way to provide health care to the vast majority of underserved rural people and urban poor is to develop effective ‘primary health care’ services supported by an appropriate referral system. The social policy throughout the world was to build up health systems based on primary health care, towards the policy objective of Health for All by 2000 AD (Bhore Committee, 1946).

3. Community participation is now recognized a major component in the approach to the whole system of health care – treatment, promotion and prevention. The stress is on the provision of these services to the people – representing a shift from medical care to health care and from urban population to rural population (K Park, 2005).

4.2 Levels of Health Care

It is customary to describe health care service at 3 levels, viz. primary, secondary and tertiary care levels. These levels represent different types of care involving varying degrees of complexity. Based on the recommendations of the various committees, the nation follows the three tire system of providing health care to the public.

Primary Care Level

It is the first level of contact of individuals, the family and community with the national health system, where ‘primary health care’ (essential health care) is provided. As a level of care, it is close to the people, where most of their health problems can be dealt with and resolved. It is at this level that health care will be most effective within the context of the area’s needs and limitation (WHO, 1984). In the Indian context, primary health care is provided by the complex of primary health centres and their subcentres through the agency of multipurpose health workers, village health guides and trained dais. Besides providing primary health care, the village ‘health teams’ bridge the cultural and communication gap between the rural people and organized health sector. Since India opted for “Health for All”
by 2000 AD, the primary health care system has been reorganized and strengthened to make the primary health care delivery system more effective.

**Secondary Care Level**

The next higher level of care is the secondary (intermediate) health care level. At this level more complex problems are dealt with. In India, this kind of care is generally provided in district hospitals, community health centres which also serve as the first referral level. The State of Kerala possesses a wide spread health care system and facilities to cater to the health requirements of the people. Kerala is looking after the basic health needs in the State at the grass root level. Kerala Health Services is the second largest department under the government. There are 1253 institutions and 36787 beds under the Directorate of Health Services. Institutions include 144 hospitals, 839 primary health centres, 244 community health centres, 23 TB clinics/centres and 3 leprosy control clinics/units. Out of the total beds, 20228 (55.0 per cent) beds are in hospitals, 5823 (15.83 per cent) in primary health centres, 7146 (19.43 per cent) in community health centres, 1916 (5.21 per cent) in Leprosy Control Clinics/Units and 1674 (4.56 per cent) in TB clinics. (Economic review 2009)

**Tertiary Care level**

The tertiary level is a more specialized level than secondary care level and requires specific facilities and attention of highly specialized health workers. This care is provided by the regional or central level institutions e.g. Medical College Hospitals, All India Institutes, Regional Hospitals, Specialized Hospitals and other Apex Institutions.

A fundamental and necessary function of health care system is to provide a sound referral system. It must be a two-way exchange of information returning patients to those who referred them for follow-up care (WHO, 1984). It will ensure continuity of care and inspire confidence of the consumer in the system. For a large majority of developing countries (including India) this aspect of health system remains very weak (K Park 2005).
4.3 Determinants of Health

Health is multifactorial. The factors which influence health lie both within the individual and externally in the society in which he or she lives. It is a truism to say that what a person is and to what diseases he or she may fall victims to depends on a combination of two sets of factors his or her genetic factors and the environmental factors to which he or she is exposed. These factors interact and these interactions may be health promoting or deleterious. Thus, conceptually, the health of individuals and whole communities may be considered to be the result of many interactions.

**Biological determinants**: The physical and mental traits of every human being are to some extent determined by the nature of his genes at the moment of conception. The genetic make-up is unique in that it cannot be altered after conception. A number of diseases are now known to be of genetic origin. The state of health therefore depends partly on the genetic constitution of man. Nowadays, medical genetics offers hope for prevention and treatment of a wide spectrum of diseases thus the prospects of better medicine and longer, healthier life.

**Behavioural and socio-cultural conditions**: The term “lifestyle” is rather a diffuse concept often used to denote “the way people live”, reflecting a whole range of social values, attitudes and activities. It is composed of cultural and behavioural patterns and lifelong personal habits that have developed through processes of socialization. Lifestyles are learnt through social interaction with parents, peer groups, friends and siblings and through school and mass media. Health requires the promotion of healthy lifestyle. In the last 20 years, a considerable body of evidence has been accumulated which indicates that there is an association between health and lifestyle of individuals.

**Environment**: Environment is classified as “internal” and “external”. The internal environment of man pertains to each and every component part, every tissue, organ and organ – system and their harmonious functioning within the system”. Internal environment is the domain of internal medicine. The external or macro – environment consists of those things to which man is exposed to after conception. It is defined as ‘all that which is external to the individual human host’ can be divided into physical, biological and psychosocial components, any or all of which can affect the health of man and his susceptibility to illness.
Socio- Economic Conditions:

• **Economic Status**: The per capita GNP is the most widely accepted measure of general economic performance. The economic status determines the purchasing power, standard of living, quality of life, family size and the pattern of disease and deviant behaviours in the community. It is also an important factor in seeking health care.

• **Education**: A second major factor influencing health status is education. The world map of illiteracy closely coincides with the maps of poverty, malnutrition, ill health, high infant and child mortality rates. Studies indicate that education, to some extent, compensates the effects of poverty on health, irrespective of the availability of health facilities. The small State of Kerala in India is a striking example. Kerala has an estimated infant mortality rate of 14 compared to 71 for all-India in 1999. A major factor in the low infant mortality of Kerala is its highest female literacy rate of 87.86 per cent compared to 54.16 per cent for all India.

• **Occupation**: The very state of being employed in productive works promotes health, because the unemployed usually show a higher incidence of ill health and death. For many, loss of work may mean loss of income and status. It can cause psychological and social damage.

• **Political System**: Health is also related to the country’s political system. Often the main obstacles to the implementation of health technologies are not technical, but rather political. Decisions concerning resource allocation, manpower policy, choice of technology and degree to which health services are made available and accessible to different segments of the society are examples of the manner in which the political system can shape community health services.

**Health Care Services**: The term health and family welfare services cover a wide spectrum of personal and community services for treatment of disease, prevention of illness and promotion of health. The purpose of health services is to improve the health status of
population. Health services can also be seen as essential for social and economic development. It is good to remind ourselves that ‘health care does not produce good health’.

**Ageing of the population:** By the year 2020 the world will have more than billion people aged 60 and over and more than two thirds of them living in developing countries. Although the elderly in many countries enjoy better health than hitherto, a major concern of rapid population ageing is the increased prevalence of chronic diseases and disabilities both being conditions that tend to accompany the ageing process and deserve special attention.

**Gender:** The 1990s have witnessed an increased concentration on women’s issues. In 1993, the global commission on women’s Health was established. The commission drew up an agenda for action on women’s health covering nutrition, reproductive health, the health consequences of violence, aging, lifestyle related condition and the occupational environment. It has brought about an increased awareness among policy makers of women’s health issues and encourages their inclusion in all development plans as a priority. (Park K, 2005).

**4.4 Approaches to Assess Health Status and Health Care System**

With political independence, there was a national commitment to improve the health status of the population in the country. Against this background different approaches to providing health care came into existence. There is transition from institutional care to village health care and to more integral than compartmentalized. The WHO proposes the following approaches:

**Comprehensive Health Care**

Even before the WHO’s recommendation to comprehensive approach to promote health care of the public, the term “comprehensive health care” was first used by the Bhore Committee in 1946. By comprehensive services, the Bhore committee meant provision of integrated preventive, curative and promotional health services from “womb to tomb” to every individual residing in a defined geographic area. The Bhore Committee defined comprehensive health care as having the following criteria:
(a) Provide adequate preventive, curative and promotive health services.
(b) Be as close to the beneficiaries as possible,
(c) Has the widest cooperation between the people, the service and the profession,
(d) Is available to all irrespective of their ability to pay,
(e) Look after specifically the vulnerable and weaker sections of community; and
(f) Create and maintain a healthy environment both in homes as well as at work places.

The Bhore Committee suggested that comprehensive health care should replace the policy of providing more medical care. This concept formed the basis of national health planning in India and led to the establishment of a network of primary health centres and subcentres. The Government of India, during the successive 5 year plans has built up a vast infrastructure of rural health services based on primary health centres and subcentres. However, experience during the past 45 years has indicated that the primary health centres were not able to effectively cover the whole population under their jurisdiction, and their sphere of service did not extend beyond a 2-5 km radius. These facilities often did not enjoy the confidence of the people because they were understaffed and poorly supplied with medicines and equipment; as a result, there was growing dissatisfaction and stigma towards these centres and the delivery of health services (K Park 2005)

**Basic Health Services**

In 1975 the term ‘basic health services’ was used by UNICEF/WHO in their joint health policy (UNICEF/WHO 1975). They defined the term as follows, ‘A basic health service is understood to be a network of coordinated, peripheral and intermediate health units capable of performing effectively a selected group of function essential to the health of an area and assuring the availability of competent professional and auxiliary personnel to perform these functions’. The change in terminology from comprehensive to basic health services did not affect materially the quality or content of health services. The handicaps or drawbacks of the basic health services are those shared by the comprehensive health care services, viz., lack of community participation, lack of intersectoral coordination and dissociation from the socio-economic aspects of health.
Primary Health Care
A new approach to health care came into existence in 1978, following an international conference at Alma-Ata (USSR). This is known as ‘primary health care’. It has all the hallmarks of a primary health care delivery, first proposed by the Bhore Committee in 1946 and now espoused world wide by International agencies and National governments (Ashish Bose 1984).

Before Alma-Ata Declarartion, primary health care was regarded as synonymous with ‘basic health services’, ‘first contact care’, ‘easily accessible care’, ‘services provided by generalists’, etc. The Alma-Ata International conference gave primary health care a wider meaning. The Alma-Ata Conference defined primary health care as follows (WHO, 1978)
‘Primary health care is essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and country can afford’.

The primary health care is equally valid for all countries from the most to the least developed, although it takes varying forms in each of them. The concept of primary health care has been accepted by all countries as the key to the attainment of Health for All by 2000 AD. It has also been accepted as an integral part of country’s health system.

Elements of Primary Health Care
Although specific services provided will vary in different countries and communities, the Alma-Ata Declaration has outlined 8 essential components of primary health care (Brelet C., 1985):

- Education concerning prevailing health problems and the methods of preventing and controlling them;
- Promotion of food supply and proper nutrition;
- An adequate supply of safe water and basic sanitation;
- Maternal and child health care, including family planning;
- Immunization against major infectious diseases;
- Prevention and control of locally endemic diseases;
- Appropriate treatment of common diseases;
- Provision of essential drugs.
Principles of Primary Health Care

There are four principles in the primary health care model and they care considered as proper means to ensure a better well being of the people and health care within their vicinity. Since this is highly promoted by WHO for making the health care very much appropriate and accessible to the ordinary population, especially of people in the marginalised area like fisherfolk.

1. Equitable distribution

The first key principle in the primary health care strategy is equity or equitable distribution of health services, i.e., health services must be shared equally by all people irrespective of their ability to pay, and all (rich or poor, urban or rural) must have access to health services. At present, health services are mainly concentrated in the major towns and cities resulting in inequality of care to the people in rural areas. The worst hits are the needy and vulnerable groups of the population in rural areas and urban slums. This has been termed as social injustice. The failure to reach the majority of the people is usually due to inaccessibility. Primary health care aims to address this imbalance by shifting the centre of gravity of the health care system from cities (where three quarters of the health budget is spent) to the rural areas (where three quarters of the people live) and bring these services as near as people’s homes possible.

2. Community Participation

Notwithstanding the overall responsibility of the Central and State Governments, the involvement of individuals, families, and communities in promotion of their own health and welfare, is an essential ingredient of primary health care. Countries are now conscious of the fact that universal coverage by primary health care cannot be achieved without the involvement of the local community. There must be a continuing effort to secure meaningful involvement of the community in the planning, implementation and maintenance of health services, besides maximum reliance on local resources such as manpower, money and materials. In short, primary health care must be built on the principle of community participation or involvement.
One approach that has been tried successfully in India is the use of village health guides and trained dais. They are selected by the local community and trained locally in the delivery of primary health care to the community they belong to free of charge. By overcoming cultural and communication barriers, they provide primary health care in ways that are acceptable to the community. It is now considered that health guides and trained dais are essential features of primary health care in India. These concepts are revolutionary. They have been greatly influenced by experience in China where community participation in the form of bare foot doctors took place on an unprecedented scale (K Park 2005).

3. Intersectoral Coordination

There is an increasing realization of the fact that the components of primary health care cannot be provided by the health sectors alone. The Declaration of Alma-Ata states that ‘primary health care involves in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communication and others sectors’ (WHO, 1978). To achieve such cooperation, country may have to review their administrative system, relocate their resource and introduce suitable legislation to ensure that coordination can take place. This requires strong political will to translate values into action. An important element of intersectoral approach is planning with other sectors to avoid unnecessary duplication of activities.

4. Appropriate Technology

Appropriate technology has been defined as ‘technology that is scientifically sound, adaptable to local needs, and acceptable to those who apply it and those for whom it is used, and that can be maintained by the people themselves in keeping with the principle of self reliance with the resources the community and country can afford’ (Newell K W, 1975). The term ‘appropriate’ is emphasized because in some countries, large, luxurious hospitals that are totally inappropriate to the local needs are built which absorb a major part of the national health budget and effectively blocking any improvement in general health services. This also applies to using costly equipment, procedures and techniques when cheaper, scientifically valid and acceptable ones are available, viz, oral rehydration fluid, standpipes which are socially acceptable and financially more feasible than house connections, etc.
It is clear from the above discussions that primary health care is qualitatively a different approach to deal with the health problems of community. Unlike the previous approaches which depend upon taking health services to the doors of the people, primary health care approach starts with the people themselves. This approach signifies a new dynamism in health care and has been described as Health by the people, placing health in people’s hands (Banerjee D, 1980) The ends of the Primary Health Care approach are the same as those of earlier approaches but the means adopted are different (WHO, 1981), that is more intersectoral coordination and more community involvement in health care goes beyond the larger concept of human resources and development.

4.5 Sen’s Human Capability Approach and New Paradigm in Public Health

The States or Nations exist for the welfare of the people. Welfare is basically nothing but the healthy living of each and every person in the family, society and at large in the nation. Health care provisions are basically the welfare programmes of the governments. This is to be purchased by the individual themselves. Therefore it is said that to ensure better health status, the purchasing capacity of the individual and family is to be enhanced. The purchasing capacity means the ability of the individual and community to make a choice in their life. There are certain sections of population like fisherfolk who are not able to make choice in their life due to deprivation. This can be money deprivation, material deprivation, service deprivation, voice deprivation etc. In other words leading an economically and socially a productive life (WHO) is the health of people. Thus it is understood that the role of social and economic factors are very decisive in promoting the health status of the people. Hence we consider the principle of expanding the human capability which is the basis of development or welfare (Sen 2000) of any population especially marginalised groups like fisherfolk.

Amartya Sen holds the view that the human capability approach to human well-being emphasises the importance of freedom of choice, individual heterogeneity and the multi-dimensional nature of welfare. In significant respects, the approach is consistent with the handling of choices within conventional economy of life, although its conceptual foundations enable it to acknowledge the existence of claims, like rights, which normatively dominate utility based claims. People are the real wealth of nations. Indeed the basic purpose of development is to enlarge human freedoms. The process of development can expand human
capabilities by expanding the choices that people have to live full and creative lives. And people are both the beneficiaries of such development and the agents of the progress and change that bring. This process must benefit all individuals equitably and build on the participation of each of them. This approach to development - human development - has been advocated by all Human Development Reports since the first in 1990.

The capability approach is a broad normative framework for the evaluation and assessment of individual well-being and social arrangements, the design of policies, and proposals about social change in society. It is used in a wide range of fields, more prominently in health studies, welfare economics, social policy and political philosophy. It can be used to evaluate several aspects of people’s wellbeing, such as inequality, poverty, the wellbeing of an individual or the average wellbeing of the members of a group. It can also be used as an alternative evaluative tool for social cost benefit analysis, or as a framework within which to design and evaluate policies, ranging from welfare state design in affluent societies, to development policies by governments and non-governmental organisations in developing countries. In academia, it is sometimes being discussed in quite abstract and philosophical terms, but also used for applied and empirical studies.

The capability approach has also provided the theoretical foundations of the human development paradigm, which is the people-centred development approach, advocated by the United Nations Development Program (1990-2004) in their annuals Human Development Reports. The capability approach is not a theory that can explain poverty, inequality or wellbeing instead it rather provides a tool and a framework within which to conceptualise and evaluate these phenomena. The core characteristic of the capability approach is its focus on what people are effectively able to do and to be, that is, on their capabilities. This contrasts with philosophical approaches that concentrate on people’s happiness or desire-fulfilment, or on income, expenditures, or consumption. The approach has been pioneered by the Nobel Prize winning economist and philosopher Amartya Sen (Sen 1985, 1992, 1999). It is also often associated with the philosopher Martha Nussbaum (2000) and with an increasing number of other scholars.

The capability approach evaluates policies according to their impact on people’s capabilities. It asks whether people are healthy, and whether the means or resources necessary for this capability are present, such as clean water, access to doctors, protection from infections and
diseases, and basic knowledge on health issues. It asks whether people are well-nourished. It asks whether people have access to a high quality educational system, to real political participation, to community activities which support them to cope with struggles in daily life and which foster real friendships. For some of these capabilities, the main input will be financial resources and economic production, but for others it can also be political practices and institutions, such as the effective guaranteeing and protection of freedom of thought, political participation, social or cultural practices, social structures, social institutions, public goods, social norms, traditions and habits.

The capability approach thus covers all dimensions of human wellbeing. Development, wellbeing, and justice are regarded in a comprehensive and integrated manner and much attention is paid to the links between material, mental and social wellbeing or to the economic, social, political and cultural dimensions of life. Obviously the capabilities that make up human wellbeing are irreducibly multidimensional.

4.6 Theoretical Framework of Present Study

The expanding of human capability is understood as freedom of an individual, community and state to make choices in their life. The choice will enable them to remove the unhealthy life situations and give economic and social foundations for the integral development or better healthy living of the people. This innovative approach in the health scenario will improve not only the health status but will bring down the so called IMR, MMR, Morbidity, and will enhance literacy, better occupation, income, high longevity and favourable sex ratio. Hence WHO’s new notion of placing health as inter sectoral and holistic approach and Amartya Sen’s theory of human capability approach are taken as theoretical frame work of this study. The majority of people like fisherfolk need not be seen primarily as passive recipients (health care seekers) of the benefits of development programs designed by the State (health care providers) but through promoting better facilities and opportunities to achieve the goal ‘people’s health’ in ‘peoples’ hand’.

There is a paradigm shift in the very understanding of health care and health status of the people. There is shift from medical model to social model of health; from individual to community health; from doctor to people centred; from institution to village centred; from patient to person centred; from selective health care to comprehensive health care; profit
oriented to service oriented; from curative to preventive and promotive health; from high
technology treatment and medicine to locally available and indigenous systems of treatment
and medicine etc. These paradigm shifts in the very conceptualisation of health will enable
the people especially of the marginalised to bargain for their healthy living. This will make
them to lead economically and socially a productive life.

4.7 Conclusion

There is always a challenge before the nation or a state to continue the achieved better health
status. Once we strive to improve the health status, which is improved again poses challenges
to maintain the same. In the process of sustaining the better health status, the future focus of
the State can be limited or deviated or focussed to within certain prominent sections of
population or area. Hence there are more chances to neglect and keep apart of marginalised
groups. It is basically the question of struggle for existence of the marginalised or subaltern
groups like fisherfolk in Kerala. This chapter basically substantiates the theoretical
foundation of the research problem by applying the Sen’s famous theory of Human
Capability approach and aninterdisciplinary approach of WHO in pursuing the concept of
health. The WHO’s theoretical basis of public health and its gradual growth of the concept
is well explained with the documents of WHO’s series of reports from its very proclamation
of HFA 2000. The levels and the various approaches to health care are explained. This would
help to address the basic question of health care and strategies of achieving better health
status. The WHO and Government of India propose the best and practical approach will be of
promotion of primary health care. The components and principles of Primary health care are
reviewed from the World development reports of United Nations.

The Human Capability Approach of Sen and the paradigm shifts in the understanding of
health, sets direction to the whole study and helps to develop a model of health care
intervention for a marginalised group of population like the fisherfolk.