CHAPTER ONE

INTRODUCTION:

HEALTH: A CHALLENGE OF DEVELOPMENT
CHAPTER I

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1. Health—A Comprehensive Concept

Health is a systemic virtue. It is important from the individual as well as from the organisational point of view. It indicates individual members' capacity to respond and come up to the expectations of their organisation. It equally indicates organisation's level of success in providing roles to its members to participate in the interactive growth process. A good organisation while updating its structural roles and designing avenues for participation in the form of administrative reforms, equally invests in its individual members through curative and preventive measures, who in the end perform these roles and add life to the otherwise procedural activity. System's concern for the individual is thus obvious and natural.
Individual is a form of human capital to a society. As such, nothing else could be of greater importance than his/her health in terms of resources for socio-economic progress of the country. The problem of health is therefore of greater significance both from the point of view of the individual and the country. Health status of the people is one of the key determinants of people's capacity to participate and thereby set pace to the overall development of the country. The concern for health has therefore a social relevance.

Health problems are common to all - both developed and developing countries. However, their nature and intensity differ indicating their stage of development. In developed countries, health problems normally relate to the problems of advanced age group, whereas in developing and underdeveloped countries these pertain to all age-groups and more seriously to the productive age group. These countries are characterised by a variety of diseases, especially those which are associated with bad living conditions, congestions, malnutrition and insanitation. Lack of basic amenities, like protected water supply and minimum environmental cleanliness make matters still worse in these countries. The situation is further aggravated by dominant traditional practices, inadequate modern facilities, and worsen most by their poverty, resulting in
a very low health status. In order to ensure happiness and well being, adequate attention needs to be paid to the issue of health, both in the advanced and less advanced countries. The situation however is grave in the less advanced countries.

"Health forms an essential pre-requisite of socio-economic development of the country. The ultimate development of a nation is determined by the quality of its human resources" (1). It is now widely accepted that human capital plays a dominant role in the context of development of a country as well as in the enhancement of the welfare of its people. In this context, Schultz emphasises upon the importance of investment in human capital. He raises a hypothetical question that "by some miracle, if a low income country were to acquire, as it were, overnight a set of natural resources, equipment, and structures; including the technique of production, what would the country do with them, given the existing skills and knowledge of the people"? (2). And he answers that the imbalance between the stock of human and non human capital would be tremendous, and it would affect development, its product and the processes. Human capital is an essential input in the country's social and economic development.
Buddha has said that of all the gains, those of health are the highest and the best. A healthy community provides the infrastructure for an economically viable society. The progress of the society is based upon the quality of its people. Here, health is a necessary and basic need. It leads to a happy life and at the same time to all productive activities in a society. Health covers physical and mental state of an individual, so also, it covers national as well as the social wellbeing. Health is thus, not only a physical wellbeing but a conditioning factor in the overall developmental process - a variety of shades, each meaningful, from the absence of disease to a productive input in social development. This makes the concept of Health, comprehensive and becomes as one of the main indicators of total development of a country.

II Health: Its Manifold Meanings

Truly, there is no widely agreed definition of health. In fact, there have been many definitions. To an ordinary person, health implies a sound mind in a sound body, a sound family in a sound environment. One of the fundamental rights of every human being, without distinction of race, religion, political belief, is the enjoyment of the highest attainable standard of health (3).
The World Health Organisation defines health as a "State of complete, Physical, Mental Social Well-being and the word does not merely refer to absence of disease or infirmity".

According to the WHO, Health envisages three dimensions—physical, mental and social wellbeing. A person who enjoys health in this sense is said to be in a state of "positive health". To this we may also add spiritual wellbeing. The positive Health advocated by the WHO says that a person must be in a position to express, as completely as possible, the potentialities of his genetic heritage. This is possible only when the person is allowed to live in healthy relationship with his environment - an environment that transforms genetic potentialities into 'pheno' type realities.

The concept of health is not static but dynamic. It moves on a scale that ranges from optimum health to positive health as defined by the WHO. It is basically that stage at which an individual is able to mobilise all his resources—intellectual, emotional and physical to attain optimum living.

In the First Five Year Plan, the Planning Commission says that "Health is a positive state of wellbeing in
which harmonious development of mental and physical capacities of the individual lead to the enjoyment of a rich and full life. It implies adjustment of the individual to his total environment physical and social. (7)

This adjustment makes health an essential co-ordinate of the overall social and economic development and links it with the larger nation building process. A soldier who is not keeping good health cannot be expected to defend the frontiers of his country even though he is provided with sophisticated weapons. Similarly, an unhealthy farmer with the best possible technological know-how would not succeed in producing the best, which is expected of him. No industry can expect the optimum output, if it does not employ healthy workers or does not make and provide adequate facilities for proper maintenance of their health. Professional efficiency, good health and productivity are interrelated. This interaction is obvious and inevitable.

S.C. Seal looks at health as a flexible state of body and mind and describes it, in terms of position in a range within which a person may sway from the condition where in he is at the peak of enjoyment of physical, mental and
emotional experiences, having regard to environment, age, sex and other biological characteristics due to the operation of internal or external stimulus and that he can regain that position without outside aid" (8).

Health has social relevance too. There can be no doubt that health is the base for national progress in terms of resources for economic development. Nothing could be of greater significance than the health of the people. Proper health of citizens must therefore be a prime objective of national development programmes. This is reflected in constitutional provisions of world bodies, too. Article 25 of the universal declaration of Human Right is particularly concerned with the right to health. Everybody has the right to a standard of living adequate for the health and wellbeing of himself and of his family including food, clothing, housing and medical care and necessary services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or lack of any other facilities essential to livelihood, in circumstances beyond his/her control. The preamble to the WHO constitution also states that, the enjoyment of the highest attainable standard of health is a fundamental right of every human being and that governments are responsible for the health of their people and should fulfill that responsibility by taking appropriate health and social welfare measures.
The relationship between socio-economic development and health development programmes is of extreme importance. In fact, every aspect of economy has a health component which has an important bearing on the overall socioeconomic development. Socio-economic development consists of various components which related to the productive shares of activities. Health development programmes influence both economic and social spheres and in return are influenced by these.

"Good health is a prerequisite to human productivity and the "development" process". However it cannot be bestowed upon people if they themselves do not make any effort to maintain a proper balance between their external and internal environments.

III Plight of Health Services in the Third World Countries

In the Third World Countries, there is little awareness and still little appreciation of the positive co-relationship between health standards and the overall socio-economic development. It is not surprising that the plight of health in these countries is measurable. About 800 million people in the developing world live in conditions of abject deprivation. With low income, it is
difficult to ensure basic nutrition level and provide access to services essential to health and life.\(^{(10)}\)

These countries are pursuing economic development in a sense but have unfortunately neglected aspects of health. This has resulted in overall malnutrition and insanitation irrespective of their thrust at economic development.

As health is essential for optimum socio-economic development, neglect of health problems in these countries has affected their efforts for total development too. Economic progress that has been a major factor in reducing morbidity, increasing life expectancy and thereby improving the quality of life. The developed countries stand witness to it. National per capita income supports the level of living, higher the per capita income, higher the level of living. Health and nutrition form one of the nine components of good living level as identified by the UN expert committees. The other components are housing, education, employment and working conditions, clothing, social security, recreation and human rights.\(^{(11)}\)

There is maldistribution of health resources, not only between the countries but also within the countries too. At least 450 million people in the world have less food than that is necessary for their basic survival.
About one-third of the people in developing countries have access to safe water and use sewage disposal system (12).

Housing conditions and educational opportunities are also unsatisfactory. The number of illiterate adults is increasing, so also the number of the unemployed. About 300 million adults are unemployed. (13) Considering the nine components of better living as identified by the U.N.O developing countries are rated low on each of it and more low, in rural areas than their urban counterparts.

Malnutrition is a countrywide problem in the Third World Countries. The recent estimate by the World Bank indicates that about 450 million do not receive sufficient food. They also estimate that 750 million people in these countries live in extreme poverty with an annual income of less than US dollars 75 (1980) (14). Low productivity coupled with maldistribution and low national output worsen the situation and hit hard the content and coverage of health programmes.

It is only high income countries with an annual per capita GNP of US dollars 4500 (in 1980) that enjoy a high health status. These comprise of Japan and countries in Northern America, Europe and Oceania and have a total population of about 1100 million. (15) Low rate of
population growth (between 0 to 10) per 1000 and low infant death rate between 0 to 10 per thousand help these countries to maintain their high health status.\(^{16}\)

The middle income developing countries (excluding China) from Africa, Asia and Latin America have a per capita G.N.P of 950 US dollars (1990)\(^{17}\) and contain 800 million population. The countries in this group experience the highest growth rate in population (2.8 per cent annually). Here, death rate has dropped lower than birth rate due to improved health services. Inspite of economic growth and increase in in food production, these countries have not experienced higher health status. Growth in population and defective form of distribution have wiped out fruits of economic growth. These countries, on the other hand, are suffering from malnutrition.

For poor countries, high health status would serve as an ideal, difficult to reach but worth aspiring. For a large number of developing countries, food production has hardly increased 42.3 percent \(^{18}\) no increase in some countries especially in Africa, on the other hand, it has decreased. On the back drop, improvement in health status in the Third World Countries, naturally receive high priority. This is reflected in various programmes initiated and organised by various international health agencies.
Health problems have received world wide attention and international co-operation in the field has been long back accepted. The origin of international health co-operation dates back to 1851, when an international sanitary conference - the first of its kind, was convened in Paris. The Conference was attended by European Countries. The objective of this conference was very limited, and it focused on problems of sanitation in main.

The First important milestone in international health work was the establishment of Pan American Sanitary Bureau in 1902 in America. It was primarily intended to co-ordinate health programmes in the American States. At the 1903 international Sanitary Conference, a step of fundamental importance was taken, that was to establish a permanent international health bureau. This decision was probably influenced by the fact that the American republics had already established a similar bureau, the Pan American Sanitary Bureau in 1902.

After the First World War (1914), the League of Nations was established to ensure a better world. It constituted a Health Organisation to initiate and co-ordinate in matters of international concern for the prevention and control of disease. Although the League of
nations was a failure on the political side, its Health Organisation, which was established in 1923, did a creditable work.

The United Nations Relief and Rehabilitation Administration (UNRRA) was set up in 1943 with the general purpose of organising recovery from the after-effects of the Second World War. UNRRA had health division to take care of health of the millions of displaced persons, to restore and help health services and to revive machinery for international exchange of information on epidemic diseases. By 1946 UNRRA was terminated and its assets and activities were taken over by the interim Commission of the World Health Organisation (WHO).

V World Health Organisation

Of the many international agencies of health co-operation, the WHO occupies the place of pride. The WHO had its origin in April 1945, in the conference held at San Francisco to constitute the World body, the United Nations. Representatives of Brazil and China proposed that an international health organisation should also be established and that a conference to frame its constitution should be convened.
The WHO is a specialised non-political agency of the United nations with its headquarters at Geneva. In 1946, its constitution was drafted by the "Technical Preparatory Committee" under the chairmanship of Rene Saad and was approved in the same year by an International Health Conference attended by 51 nations.

The main objective of the WHO is the attainment of the highest level of health for all, it is set out in the preamble of the constitution. The work of the organisation is divided into two broad categories (A) Central Technical Services, (B) Advisory Services to Government. The WHO comprises of the following three organs:
1. The World Health Assembly
2. The Executive Board
3. The Secretariat.

The WHO organises programmes all over the world and undertakes detailed studies pertaining to health services. The public health services in the member states has been generally weak. Some activities such as national health planning and environmental sanitation have many times gone totally unattended.

However the WHO is not a supernational Ministry of Health, it is rather a worldwide co-operative through
which, nations help each other to help themselves, in raising health standards. Its activities are world wide. Its work mainly focusses on prevention and control of specific diseases. Its aim is strengthening of Health services, family health, environmental health, Health statistics, Bio-medical research, Health literature and information and the like.

Almost all communicable diseases are or have been at some time or the other the subject of the WHO activities. The global eradication of smallpox is an outstanding example of international health co-operation. Epidemicological surveillance of communicable diseases is an equally important activity of the WHO. The WHO is paying attention to non-communicable diseases such as cancer, cardio vascular ailments, genetic disorder, drug addiction and dental problems. Presently, immunisation has been one of the main programmes of the WHO. It covers six common diseases of children.

The WHO has laid stress on family health since 1970. This programme is broadly subdivided into maternal and childcare, human reproduction, nutrition and health education. Its chief concern is the improvement in the quality of life of the family as a unit. Similarly, concern has been about the promotion of environmental health and
the WHO advises government on national programme, for the provision of basic sanitary services. The WHO also acts as a clearing house for information on health problems. Its publication comprises titles on a wide variety of health subjects. The WHO library is one of the satellite centres of the medical literature analysis and possesses the retrieval system of the U.S. National Library of Medicine. Recently the WHO and UNICEF (United Nations International Children's Emergency Fund) jointly organised an international conference on Primary Health Care. (1978). In 1979, the Thirty-second World Health Assembly endorsed the report and declaration of this International Conference and launched a comprehensive and ambitious global strategy for Health for All by the year of 2000 A.D. (20). WHO has been thus playing the role of a leader in health programmes - the role for which it was conceived.

VI Health for All:

In spite of tremendous advances in medicine and health technology, the health status of the majority of the people in developing countries has remained low. Most of the health problems can therefore be seen in these countries, especially in African, Asian and Latin American countries. In fact, mortality rate, is still high in these
countries. Besides these, insanitation, malnutrition and poverty are the other major problems which affect these countries. In the Third World countries, people even die of hunger. To sum up, large segments of the world's population have limited or no access to health services. The 1978 the International Conference on Primary health care at Alma Ata in Soviet Union, therefore stated in unambiguous terms that the existing health problems in the Third World deserve common concern.

This international conference on primary health care was attended by delegations from 134 governments and by the representatives of 67 UN Organisations, specialised agencies and non-governmental associations related with the WHO and UNICEF. The conference was jointly organised and sponsored by the WHO and the UNICEF and was preceded by a number of national, regional and inter-regional meetings on primary health care, held throughout the world during 1977-1978. The main aim of the conference was to seek the way to achieve health for all by 2000 A.D.

'Health for all' is a comprehensive concept. It can be briefly stated as follows:

1. Health for all implies equity. It means that the present inequalities in health between countries and within countries should be reduced as far as possible.
2. It aims at giving people a positive sense of health so that they can make full use of their physical, mental and emotional capacities. (21) The main emphasis should therefore be on health promotion and the prevention of diseases in the community.

3. Health for all will have to be achieved by the people themselves. People would co-operate with community for attainment of the common goal. It requires co-ordinated action of all the sectors concerned. Health authorities can deal only with a part of the problem. Multi-sectoral co-operation is the only way for effectively solving the problem and ensuring prerequisites for health.

4. The 'Health for all' concept can be implemented if only the efforts start from bottom to the top. The focus of the health care system therefore should be on primary health care.

The targets of 'Health For All' are many and deal with major health aspects. By the year 2000 A.D, the main goal of the project is to reduce the actual difference in health status between countries by at least 25%. The other targets are as follows:

1. People should have the basic opportunity to develop and utilize their health potential so as to lead a socially and economically fulfilling life.
2. Disabled persons should have the physical, social and economic opportunities for fulfilling a creative life.
3. By the year 2000, the average number of years that people live free from major disease and disability should be increased by at least 10%.
4. The world should be free from indigenous measles, poliomyelities, neo-natal tetanus, congenital rubella, diphtheria, congenital syphilis or indigenous malaria by the year 2000 A.D.

For achieving these goals, the Conference suggested that there should develop within a country a well organised primary health care system to ensure effective epidemiological surveillance, vaccination coverage, malaria control measures, extension education on the risks of syphilis, screening and when necessary, treatment of expectant mothers. The life expectancy in the Third World should be at least 75 years and infant mortality in the region should be less than 20 per 1000 live births. Maternal mortality in the region also should be less than 15 per 1000 live births.

These are the major targets of 'Health for All by 2000 A.D.' Health campaign for achieving the target, shows more stress on primary health care. The strategy believes that 'Primary Health Care is the essential health care
based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.\(^{(22)}\) Primary health care reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities. The importance of Primary Health Care is therefore obvious in the total health development of a society.

VII Health Profile in India

Before Independence, the Health Survey and Development committee (The Bhore Committee) was appointed by the Government of India in October 1943, to conduct a survey of the existing position with regard to health conditions and health organisations. The committee was to make recommendations for development of health. However, if found that it had to confine itself mainly to the statistics of ill health and death, in the absence of data on positive health.

The Committee submitted its report in 1946. It found that the general death rate in 'British India' was 22.4
while the infant mortality rate was 162, and that the
expectancy of life at birth was 26.91 for males and 26.56 for females (per 1000 population). Nearly half the total
number of deaths were among children under 10 years of age
and in this age-group, one-half of the mortality took
place within the first year of life.

Epidemic diseases like leprosy, guinea worm and hook
worm, though not contribut ing, to a large extent, to the
mortality figures, cause considerable morbidity. The
curative and preventive health services, were too
inadequate. There was only one doctor for 6,300 people and
one nurse for 43,000, one Health visitor for 40,000 and
one Midwife for 60,000 people. Around one-fourth the
number of doctors were in government service, the rest
being mostly settled in urban areas as private
practioners. Again, there were only a total of 70 to 80
women medical officers in public service, engaged purely
in maternity and child welfare work and very few of these
were medical graduates.

Hospitals and dispensaries for providing medical
relief to the people, particularly in the rural areas,
were grossly insufficient and the quality of the services
were very poor. There were only 0.24 bed per 1,000
population. Such was the state of affairs, in every aspect
of health administration, on the eve of independence.
After independence, the situation changed radically. In 1990 the present birth rate was 33.1 per 1000 population (25) and annual growth rate is 2.3 percent (1991). Population composition indicates a disproportionately large number of children below the age of 15 years and a low proportion of people living beyond middle age.

VIII Health Programmes

Since independence, the government has launched a number of health programmes with an aim to improve the health status of the people. Most of these programmes have been aided by the International Agencies such as the WHO, UNICEF and USAID. The following national health programmes are currently in operation in India.

1. National Malaria Control Programme:
   It stated in 1953 during the first Five Year Plan. The programme went on well. It is still continued under the 'Malaria Eradication Programme'. The programme has helped to control the disease to some extent.

2. National Filaria Control Programme:
   A National Filaria Control programme was launched in 1955. The NFCP is a centrally sponsored scheme and
union states get 100 percent assistance from the Central Government. At present 142 filaria control units, 3 filaria clinics, 4 rural research cum training centres 12 Headquarter units and 3 regional Filaria Training and Research Centre, are functioning in the country.

3. National Leprosy Control Programme:
The National Leprosy Control Programme was launched in 1954. The main objective of the programme has been the early detection of leprosy cases and their treatment with sulphone drugs.

4. V.D. Control Programme
Veneral diseases by human nature are not so much seen on the surface, they are hidden in the community. Under the national V.D. control programme, one V.D. clinic is to be established in every district in the country.

5. National Programme for Prevention of Blindness:
The Government of India launched a mass programme for the prevention of blindness in November 1976. A National Institute of Ophthalmology has been established at New Delhi to monitor and guide the programme.
6. **National Water Supply and Sanitation Programme:**

The National Water Supply and Sanitation Programme was initiated in 1954, with the object of providing safe water supply and adequate drainage arrangements for the entire rural and urban population of the country.

IX  **The Major Health Programmes:**

The administration of the following major health programmes is picked up for the present research.

1) **Family Planning**

Family Planning gets a priority, as over population is one of our major problems. The main services covered under the family planning are varied and numerous. To enumerate a few, would include the spread of the message of small-family concept and family planning to the community and to motivate eligible couples to small family norms.

There is a separate Department of Family Planning in the Central Ministry of Health and Family welfare. The goal of the national family planning programme is to reduce the birth rate from the present 34 per 1000 population to 21 per 1000 by 2000 A.D.
2. **Health Education**

Health education is an essential tool of community health. The object of health education is to win friends and influence people. Health education aims at bridging the gulf between the health knowledge and health practices of the people.

Health Education is carried out at three main levels - individual, group, general public. The methods used for Health Education are Lecture Films, charts, exhibitions, group discussion, symposium, seminars etc.

3. **Immunisation**

Immunisation programme is an important programme, since it gives emphasis on prevention of diseases. This service includes administering vaccines like DPT, DT, TT, Polio and Typhoid. It also covers conducting immunisation camps in schools and educating community about the importance of immunisation.

Effective and safe immunisation is available against a number of communicable diseases, viz. smallpox, diphtheria, whooping cough, tetanus, polio, tuberculosis, Typhoid, measles and the like. Hence the programme assumes importance as a positive preventive measure.
4. **Mother and Child Health**

In every country, mothers and children constitute a priority group. They not only constitute a large group, but they are also vulnerable or special risk group. The risk is connected with child bearing in the case of women, and growth and development in case of infants and children. Much of the sickness and deaths among mothers and children is largely preventable. By improving the health of mothers and children, we contribute to the health of the general population. This has led to the provision of special health services for mothers and children all over the world. The M.C.H. comprises Ante-natal and Pre-natal care, Intra-natal care, post-natal care, care of the new born, family planning services etc.

5. **Environmental Sanitation**

Much of ill health in India is due to poor environmental sanitation that is, unsafe water, polluted soil, unhygienic disposal of human excreta and refuse, poor housing, insects and rodents. Air pollution is also a growing concern in many cities. The high death rate, infant mortality rate, sickness rate and poor standards of health are in fact largely due to defective environmental sanitation. Improvement of environmental sanitation is therefore crucial for the prevention of disease and promotion of health of individuals and community.
These health programmes are planned and controlled by the Central government and administered through the state government. The Central government allots fund for the health activities in the country and makes provision in each plan period. The following table shows the pattern of investment of Health, Family welfare, Water Supply etc. (Plan Outlays) in Different periods in public sector - Centre, States and union territories.

Table 1.1 Investment on Health and F.W (Plan Outlays)

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Period</th>
<th>Total plan Investment outlay (all heads of development)</th>
<th>Health</th>
<th>Family Welfare</th>
<th>Sub-total</th>
<th>Water supply and sanitation</th>
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<tr>
<td>1</td>
<td>First plan</td>
<td>1,960.0</td>
<td>65.2</td>
<td>0.1</td>
<td>65.3</td>
<td>11.0</td>
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<tr>
<td></td>
<td>(1951-56)</td>
<td>(100)</td>
<td>(3.3)</td>
<td>(-)</td>
<td>(3.3)</td>
<td>(0.56)</td>
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<tr>
<td>2</td>
<td>Second plan</td>
<td>4,672.0</td>
<td>140.8</td>
<td>5.0</td>
<td>145.8</td>
<td>74.0</td>
</tr>
<tr>
<td></td>
<td>(1956-61)</td>
<td>(100)</td>
<td>(3.0)</td>
<td>(0.1)</td>
<td>(3.1)</td>
<td>(1.58)</td>
</tr>
<tr>
<td>3</td>
<td>Third plan</td>
<td>8,576.5</td>
<td>228.9</td>
<td>27.0</td>
<td>252.9</td>
<td>105.7</td>
</tr>
<tr>
<td></td>
<td>(1961-66)</td>
<td>(100)</td>
<td>(2.61)</td>
<td>(0.3)</td>
<td>(2.9)</td>
<td>(1.2)</td>
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<td>4</td>
<td>Annual plans</td>
<td>6,626.4</td>
<td>140.2</td>
<td>82.9</td>
<td>223.1</td>
<td>102.7</td>
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<td></td>
<td>(1966-69)</td>
<td>(100)</td>
<td>(2.1)</td>
<td>(1.3)</td>
<td>(3.4)</td>
<td>(1.6)</td>
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<td>5</td>
<td>Fourth plan</td>
<td>15,778.5</td>
<td>336.5</td>
<td>285.8</td>
<td>621.3</td>
<td>458.9</td>
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<tr>
<td></td>
<td>(1969-74)</td>
<td>(100)</td>
<td>(2.1)</td>
<td>(1.8)</td>
<td>(3.9)</td>
<td>(2.9)</td>
</tr>
<tr>
<td>6</td>
<td>Fifth plans</td>
<td>39,425.2</td>
<td>760.8</td>
<td>497.4</td>
<td>1258.2</td>
<td>1091.6</td>
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<tr>
<td></td>
<td>(1974-79)</td>
<td>(100)</td>
<td>(1.9)</td>
<td>(1.3)</td>
<td>(3.2)</td>
<td>(2.8)</td>
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### Health Profile in Kerala

Health Picture in Kerala is very promising as compared with other states of India. "The Physical environment in most parts of Kerala has a long tradition of medical and health care system. The continued
improvement in the health of the people has been related to their educational attainment and to health policies which have brought medical facilities both within their reach and their means". (26)

The main factor in the development of health in Kerala is a very high level of literacy achieved by the state. Hospitals in Kerala are evenly distributed throughout the state. The easy access to medical facilities, relatively low cost of medical services are also some of the important reasons for better health condition in Kerala.

It is a fact that Kerala has achieved most of the major health indicators like infant mortality rate, maternal mortality rate, crude death rate and life expectancy targeted by the country as its ultimate goal of "Health For All by 2000 A.D". Kerala leads the rest and various indicators of health progress show this lead. A comparative graph of growth rate in India and Kerala from 1901-1991 are given below:
DECENNIAL PERCENTAGE GROWTH RATE OF POPULATION 1901-91 KERALA AND INDIAN.

The following compilation gives the comparative picture of Kerala within the country and its achievement in health field. Kerala, it seems has realised a number of targets fired under the ambitious programme 'Health For All by 2000 A.D.'.
Table 1.2 : Health Profile in Kerala

<table>
<thead>
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<th></th>
<th>India</th>
<th>Kerala</th>
<th>National goal</th>
</tr>
</thead>
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<tr>
<td>6. Rural population (%)</td>
<td>76.7 (1981)</td>
<td>81.3 (1981)</td>
<td></td>
</tr>
<tr>
<td>7. Birth rate per 1000</td>
<td>33.6 (1983)</td>
<td>24.9 (1983)</td>
<td>21</td>
</tr>
<tr>
<td>population</td>
<td></td>
<td>(1983)</td>
<td></td>
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<tr>
<td>population</td>
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<td>(1983)</td>
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<tr>
<td>per 1000 live births</td>
<td>(1984)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>per 1000 live births</td>
<td>(1982)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Expectation of life at</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>birth (yrs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Percentage of couples</td>
<td>32.3 (1985)</td>
<td>40 (1985)</td>
<td>60</td>
</tr>
<tr>
<td>effectively protected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>by permanent methods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Mean age at Marriage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(yrs)</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Kerala</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Rate</td>
<td>19.9</td>
<td>31.3</td>
</tr>
<tr>
<td>Death Rate</td>
<td>6.2</td>
<td>10.9</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>27</td>
<td>94</td>
</tr>
<tr>
<td>Maternal mortality rate</td>
<td>1.3</td>
<td>3.4</td>
</tr>
<tr>
<td>Expectation of life at birth (in years of age)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>67</td>
<td>55.6</td>
</tr>
<tr>
<td>Female</td>
<td>70</td>
<td>56.4</td>
</tr>
<tr>
<td>Couple Protection Rate</td>
<td>58</td>
<td>37.5</td>
</tr>
</tbody>
</table>

Source: Health Profile Kerala, Dept. of Health & F.W. 1990, p.1
Death rate in Kerala has always been much lower than that of the country. The crude death rate was estimated to be about 25 per 1000 population in 1930 and about 6.4 in 1986 (27). This could be possible because of the largest gain over mortality experienced in the infant ages.

Overall health profile of Kerala is satisfactory. However, there are problems to be tackled so as to make health services more effective and community based. The higher level officials in health services are medical practitioners (Directorate of Health Services and District Medical Officer). They need support of a competent health administration as many of the problems are by nature less professional and more administrative like excessive centralization, inadequate staffing, insufficient medicines and unsafe water supply and the like.

Health care differs from other social activities in the greater service content in addition to technical component. Personnel should imbibe this abiding service spirit. Individuals are subjects and not its objects. It is with this realization that problem areas in health programming and implementing need to be identified, nature of the problem clearly ascertained and strategy to deal with it finalized, health administration becomes crucial in this context and the present study becomes relevant.
XI Importance of the study:

Health status and its development is basic to national progress in any country. Nothing else could be of greater importance than health of the people in terms of resources of nation's socio-economic progress. It is one of the important components of human capital and also forms an essential prerequisite for socio-economic development of a country.

Health sector has wide and varied relationships with other sectors of the social system. It is reflected in the multiplicity of factors, such as nutrition and other basic biological requirements, personal and psychological security, culturally supported behavioural patterns, legislation and education. The community participation also has a bearing on health planning and its effective implementation.

Today, health is recognised as a fundamental right of every human being. In all civilised society, the state assumes responsibility for the protection and promotion of the health and welfare of its citizens. The Constitution of India has laid down that, 'The State shall regard raising of the level of nutrition and standard of living of its people and the improvement
of public health as among its primary duties". \(^{(28)}\)

It is unfortunate that Indian health situation is still in a grave condition. Even today, as many as the four-fifth of the population of the country does not have access even to the most elementary health care services. It is true that there has been a steady decline in death rate (the trend had begun even earlier in the decade 1921-31), from 27.4 in 1941-51 to an estimated 15.2 in 1971 \(^{(29)}\), in 1983 it further reduced in to 11.4 and 10.9 in 1990. \(^{(30)}\) This has naturally resulted in a corresponding increase in the expectation of life at birth. Half a century ago, an average Indian could at birth expect to live only upto 26 years. Today, one can look forward to a life span of about 56 years. This indeed is an achievement. But compared with that of developed countries and even with countries like Sri Lanka, China and Cuba, this achievement is very less. There are also some negative aspects in the health profile of India. Mortality rate among women and children is still awfully high. About one-third of the total deaths occurs among children under five. Infant mortality rate is still about 94 per 1000 in 1990 (National Goal is below 60). \(^{(31)}\) This is far higher than that of Sweden (9) USA (16) UK(17) Thailand (27) and Sri Lanka (45). \(^{(32)}\) (in 1981)
Education is one of the important tools of health care. An individual can be educated so as to acquire essential information skills and values to take good care of his health. The component of health education in primary education is meagre. Health education is an essential function for the health care personnel. In fact, health education of the people may be described as one of the most neglected areas in health field.

It is true that there are creditable achievements in the form of reduced mortality rates or increased life expectancy, expansion facilities in medical research or expanding network of primary health centres or programmes like Control of Communicable diseases or provision of M.C.H services, all is not well with health programmes even including family planning programme. However the country has still a very long way to go in control of several communicable diseases that have almost disappeared from the developed world. The morbidity pattern has not materially changed and the rates of mortality among women and children are still aw fully high, further, there is no programme of health education worth the name.

It is again this backdrop of health profile that the study assumes significance. In the overall endeavour of promoting health as a community welfare measure, it
provides the missing link as a focus on administrative dimension of the programme as distinct from technical component that go into the service. As services become complex consideration about administrative set up. Its staffing, regular and adequate supply line, environmental inputs, community support mechanism become equally crucial in the best administration of a service. Even Kottayam district, the study unit is no exception to this consideration.

Reports and projects which deal with the implementation of health programmes in the Indian situation are very few. Health problems cannot be ignored and more and more studies and research reports need to be taken up in this field. It seems that some of the earlier literature has not adequately dealt with administrative problems of health programmes. A study of this kind with a focus on organisation and administration of health programmes has its own utility in the context of appraisal of programmes and also as a timely input while formulating policy for the future.

XII Objectives

The major objectives of the study are:

1) To identify problems in administration of health departments especially in government hospitals and
suggest means to improve their administrative efficiency.

2) To examine the effective mix of generalised and specialised hands in hospital administration.

3) To throw light on the way for integrating the three major functions in the health department viz promotive, preventive and curative.

4) To ascertain factors that contribute to a decentralised and participatory system of health administration.

5) To study the contribution of community participation in health activities and indicate ways for its effective mobilisation.

XIII Hypotheses

The hypotheses of the study are:

1) Efficient implementation of health programmes needs administrative decentralisation.

2) Hospital administrator, specialised in managerial skills will improve efficiency in administration than a medical practitioner presently holding this post.

3) Community participation is a pre-requisite for successful implementation of health programmes.

4) Introduction of management communication system is essential for efficient monitoring of the various health programmes.
The Indian government is implementing various health programmes like family welfare, health education and immunisation. However, these services are not properly executed due to administrative shortcomings. Concentrating powers in one or two authorities would always create difficulties in reaching the advantages of health programmes to the grassroots level. District health administration also suffers from the concentration of powers in a few officers. It seems that efficient administration of health programmes needs administrative decentralisation.

At present, public hospital is run by a seniormost physician or surgeon known either as Civil Surgeon or Superintendent. He is not exposed to management concepts. It is important to note that a good doctor may not always be a good administrator. Most of them are also not much interested in the administrative side. A civil surgeon, himself a doctor, has to look after many administrative matters. It is difficult for him to attend to both kinds of duties effectively. If a hospital administrator is a specialised managerial person from administrative side, it would lead to an efficient administration and contribute more effectively to the implementation of health
programmes. It seems to be the need of the hour.

Through methods of community participation, hospital staff helps members of the community to get voluntarily involved in the programmes of the health. This means that:

The community is made aware of the positive implications of various programmes viz;
(a) Prevention of communicable or other diseases
(b) cure, (c) health education (d) family welfare,
(e) environmental sanitation and personal hygiene.

When people are not aware of the services which are rendered through the hospitals, they are unable to take the advantage of these. On the other hand, if people participate with government in health activities, the results would be an effective and widely covered campaign. Community participation thus, is a pre-requisite for successful implementation of health programmes, and non-governmental organisation have a positive role to play.

Communication is as necessary to an organisation as blood stream is to a living person. It covers exchange of ideas, opinions and information with the same understanding from one person to another. Health organisations cannot exist without a proper communication system. In the absence of it, the authority of a hospital cannot receive necessary information inputs and
consequently can not issue appropriate instructions. Similarly, co-ordination of health activities would become difficult and organisation would collapse for want of a proper communication system. Therefore, such a system covering vital management information is essential for efficient monitoring of various health programmes.

Considering the present state of health status prevailing in the country, health administration assumes critical significance in evolving appropriate programme and appropriate action strategy to tackle and tame the issues while realising 'Health For All'.

XV Review of literature

There is a good amount of literature on health and health administration. But most research publications pertain to developed countries. A quick survey of literature shows that the publications do not adequately focus on and reveal problems of health administration and programme implementation as such.

In titles like 'Principles of Hospital Planning' edited by Robert Jefford, 'Operations Management in Health services' by Carl W. Nelson, the authors state that hospital services should reach places where the common
people live. The significant goal of operation management functions in health organisations encompasses planning, co-ordinating and controlling clients need. However, both the authors miss crucial importance of community participation in extending health programmes effectively.

In 'Health Objectives for the Developing Society' edited by E.Croft Long and 'Health Planning and Community Participation' by Susan B. Rifkin, we come across the role of rural health care and the importance of community participation for successful implementation of health programmes. These two works are basically an examination of rural health and its relevance in developing societies. However, both the authors hardly say anything regarding the implementation of health programmes and its administration at grassroots level. This gap need to be bridged and more stress be given on the decentralization of powers from top to grassroots level.

'District Health Care' by Amonoo Lartson brings out the importance of management requirements for successful primary health care. This depends on a number of factors like clarity in developing health strategy, local level planning leading to district planning and a well-structured team with clearly defined rules- according to different types of health institutions. Though the book refers to
western countries, it serves a useful guideline for health care programme in India.

Another important document which deserves mention is 'Health For All: An Alternative Strategy', published by Indian Council of Social Science Research and Indian Council of Medical Research. The major aim of this study is to bring the attention of medical practitioners and administrators to the issue of improving health status of the people. In the alternative strategy, a plea is made for a more democratic and decentralised set up. A good recommendation relates to the combination of preventive and curative functions according to the tradition and culture of the people of India and these operate within the framework of modern science and technology. The present research study takes these recommendations in their full spirit and tries to put these down in a practical manner in the light of the findings of a survey based knowledge.

J.P. Naik in "An Alternative system of Health care services in India: some proposals" explains political dimensions of health status and health services and recommends an alternative rural health care system for India. However it fails to recommend an alternative strategy for improving health programmes and its administration in our country.
In 'Public Health administration' by S.L. Goel and 'Hospital Administration and Management' (a set of three volumes edited by S.L. Goel and R. Kumar), the authors deal with nature, scope, role of health care administration and its relationship with socio-economic development. The first book also analyses the process of policy making and planning for health care administration, while the latter suggests measures for improving the functions of the public hospitals. The concepts like health planning process developed in these books deserve to be further applied and their suitability tested for different people and areas, viz., rural, urban slums, tribal belts.

Nalini V. Dave, in her work on 'Hospital Management' endeavours to study current practices and concerned problems in public hospitals. Two major problems that attract her consideration are (a) how far the medical services provided in our public hospitals are 'professional and (b) how far are these professionally managed. In the study, the author restricts her observations to the importance of professional and professional management in hospitals. She does not say anything about administrative and technical problems in the hospital organisational system which are a crucial issue in the health department.
In 'Management of Hospitals', Oommen Philip provides the idea of how a hospital administrator should be. The emphasis of the book is on the role of the hospital administrator and not on various tools in hospital administration. He adopts a behavioural approach to hospital administration. He however, does not elaborate on the desirability of the type of the administrator - whether a 'professional' administrator would do well or not.

The expert committees like Bhore committee (1947), Mudaliar Committee (1962) Mukerji Committee (1965-1966) Jungalwala Committee (1967) reviewed health situation and policies in India. They put emphasis on the urgency and importance of the basis level of health administration. The importance of study of health, administration and management of health programmes is very relevant in India. Problems of health cannot be neglected. Much of the literature while highlighting areas of weakness in health programmes and suggesting remedial measures have not paid adequate attention to health administration as an important variable in the success of the programme. More studies and more research need to be there in this field, The present study tries to fill this gap.
XVI Methodology

The findings of this study have been derived from the primary data collected through a schedule and questionnaire method and secondly through interview method. The researcher mainly relied on the questionnaire and schedule method. The questionnaire was divided into four headings viz., (a) officials (b) non-officials, (c) knowledgeable persons and (d) clients. The total sample worked out of 250 (officials - 50, non-official-50, knowledgeable persons -50 and clients- 100). The respondents were selected by random sampling technique and they belonged to different government and private hospitals in Kottayam district of Kerala State. The study covered the private hospitals (with 200 and above bed strength) and twenty government hospitals in the district. (the district hospitals, medical college hospital, all the 4 taluk headquarter hospitals and 14 major primary health centres).

The schedule was administered to all the hospital administrators in the district major hospitals. The non-officials were the members of the Hospital Development Committee, Members of Legislative Assembly, District Council Members and Panchayat Committee Members. Knowledgeable persons who were interviewd included Health
Inspectors, lady Health Supervisors, Medical Practitioners and Social Workers in the district.

The questionnaire and schedule method were used among clients on different hospitals in the district. The total number of clients covered is 100. Out of these, 30 respondents are those clients who visit private hospitals and 70 include those clients who usually visit government hospitals. Three respondents were selected from private hospitals (10 in number) by random sampling technique from the out patient queue (10x3 respondents - 30 i.e. 10:1 out of 30 patients during the time between 10 a.m. and 11 a.m.). The interview schedule was also extended to the patients who visited government hospitals (The total number of government hospitals is 20. 3 respondents from each hospital (20 x 3 = 60). They were also selected by the same random sampling technique from the out patient queue between 10 a.m. and 11 a.m.). Besides, the interview schedule covered clients who usually visit district hospital and medical college hospital - 5 patients selected from each hospitals (i.e. 5x2 = 10 from the out patient queue between 10 a.m. and 11 a.m.). The total number of clients covered by the questionnaire and schedule thus comes to 100. This was further supported by unstructured interviews of same hospital administrators.

To strengthen the data collection through the questionnaire and schedule, information was collected
through government records pertaining to health services and the beneficiaries. The researcher also made use of the literature from various libraries: Smt. Hansa Mehta Library at the M.S. University of Baroda, K.G. Patel Hospital Library, Baroda, the Indian Institute of Public Administration Library, New Delhi, World Health Organization Library, New Delhi, National Institute of Health and Family Welfare Library, New Delhi, Institute of Management in Government Library Trivandrum, Family Welfare Study Centre, Trivandrum and South Gujarat University Library, Surat.

XVII Universe of the Study;

The study unit is located at Kottayam district in Kerala State. The district is situated almost at the central part of Kerala. The reasons behind the selection of Kottayam district is, that is a typical district. It has achieved 100 percent literacy and has bagged many awards declared for the best implementation of health programmes. Kerala leads the country in administration of health programmes and Kottayam is in the forefront in the state. Even with this, the health administration faces problems viz. managerial and operational. These need to be identified and attended to make health programme more extensive and more effective.
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