CHAPTER VII

SUMMARY AND CONCLUSIONS

Social and economic organisation determines the pattern of health and illness, as well as the type of medical care available in societies. The present study is built on this premise and examines the nature and growth of health care development among tribals in Kerala with special reference to Wynad.

In differentiated societies where economic organisation is profit centred the development of health care assumes certain inevitable patterns. These societies, in the first place, encourage health care systems that perpetuate the existing social and economic relations with its concern for profit. This results in the growth of a medical practice that is heavily curative, thus undermining the importance of preventive and promotive functions. Individuals develop a health culture in such situations that makes them depend debilitatingly on medicine and other medical interventions. The specialisation and the sophistication which medical care acquires in this pattern of growth then pushes the cost upward restricting the benefits largely to the richer sections. The poorer sections inevitably become victims of this growth. The curative
orientation of medical care, in the second place, in conjunction with its bias favouring the richer sections, results in an uneven growth of health care facilities discriminating backward rural regions against urban centres. This further distances the poor who are concentrated in rural areas from the health care system.

The health care system in India during the Post Independence period conforms to this pattern.

There are two distinct phases in the history of health care development in India. The first phase begins with the five year plans and spans over a period of twenty five years. It ends with the fifth five year plan which coincides with the international conference on primary health care at Alma Ata in 1978. The conference and its declaration on primary health care provided a new orientation and commitment to health care the world over. The second phase imbibes this spirit and begins with the sixth five year plan. The National Health Policy in 1982 also marked the beginning of this phase.

The developments during the first phase, the pre Alma Ata phase, were confined largely to developing medical infrastructure for reaching out to the people. The initial thrust was on providing basic health care which was defined as a comprehensive package of preventive, promotive and curative health care to all on an equitable basis. The
achievements, to a certain extent, were remarkable. Curative facilities such as hospitals and other medical care institutions grew several fold during this period; so did trained man power both medical and paramedical. Growth in the production of drugs and medical equipments was even more remarkable. Several communicable diseases such as small pox and plague were eradicated and others were brought under check. Consequently, indicators on health status especially life expectancy and infant mortality rates began showing improvement at the macrolevel.

The achievements, though remarkable in the above respects, fall short of expectations. The commitment given in the beginning ensuring basic health care to all remained unrealised even after two and a half decades. Instead, the health care system alienated itself from the masses and concentrated in developed urban centres. The orientation was curative and it permitted a lopsided growth in medical technology which favoured sophistication and specialisation. This further widened the gap between the rich and the poor. The problems of the poor such as nutrition, water supply, sanitation and unhygienic health habits were consistently ignored by the health care system. Indigenous health systems were discouraged and a new health culture was promoted that forced the individual to depend on modern drugs and other medical interventions. The marginal populations such as the
scheduled castes and scheduled tribes were increasingly eased out of the framework of health care except in the case of family planning.

The crisis of the health care systems, reflected mostly in its inability to solve the problems of the rural masses, reached its zenith towards the end of the fifth plan period. Several initiatives such as the Community Health Volunteers Scheme and the Minimum Need Programme were introduced towards the end of the phase. The Alma Ata conference ultimately provided a break and put primary health care once again at the centre of health care systems. The sixth five year plan and the National Health Policy imbibed the spirit incorporating these changes and a concerted effort was planned to correct the imbalances created in the past.

The development of health care in Kerala followed the national pattern though it enjoyed a unique historical advantage in terms of health infrastructure and health status. The pre Alma Ata phase in the state was marked by growing imbalances among regions and populations, lopsided emphasis on curative practices, neglect of indigenous medical systems and the growth of a medical culture that depended on expensive drugs and sophisticated hospitals. The inequalities between regions were particularly pronounced because the growth in health care facilities during this
phase was confined largely to the districts of Travancore and Cochin. Malabar region with a concentration of marginal communities like the Scheduled Tribes was consistently ignored. The disparities between regions reflected the disparities between groups of populations also.

The changes during the second phase beginning with the sixth five year plan drew inspiration from the approach suggested by the Declaration of Alma Ata. At the planning level the concept of 'health for the people' was replaced with the concept of 'health by the people'. Regional disparities received special attention and were brought down considerably during the two plan periods. The infrastructure as a result grew substantially improving accessibility to all categories of populations. The emphasis on curative health care, however, persisted without change. There was also disproportionate emphasis on family planning activities which, at the primary health centre level, eclipsed the importance of other activities. The effort undertaken during this phase, thus largely aimed at consolidating the gains of the past. The indicators on health status like the life expectancy and infant mortality rates therefore, continued to remain at a commendable level. The achievements in this regard, however, conceal the neglect of the poor sections.

Health care development among tribal communities assumes significance in this context because it brings to
sharp focus the nature and content of health care system.

The tribal communities in Kerala constitute only one per cent of its total population. They are concentrated in the hilly and backward districts and are historically isolated from the mainstream populations. The tribal situation in the state is characterised by extreme poverty and exploitation by non tribals. The developmental efforts initiated during the post Independence period facilitated a favourable resource flow to tribal regions but its benefits however, bypassed them.

Wynad district which is the focus of the study provides a microcosm of the tribal situation in the state. It has the highest concentration of tribals among the districts and is regarded as a tribal district. The tribal situation here is characterised by poverty, exploitation and deprivation. They are either landless or owners of little land. Many are unskilled agricultural labourers and earn poorly for their survival and are thus caught in a vicious circle of landlessness, low income, illiteracy and low health.

The economic conditions and living environment of tribal households in our sample is miserable. They earn income that is barely adequate for their survival. They also lack opportunities and this coupled with lack of skill pulls them down into a perpetual state of poverty. The added
disadvantage of ignorance due to illiteracy, along with the unhygienic circumstances and personal habits, the contaminated water they drink and the lack of other basic amenities make the tribals susceptible to a variety of health problems. This is reflected in the high incidence of disease among the sample households (90 per cent). The major health problems on the basis of the symptoms reported by the tribals are fever, diarrhoea, skin diseases and T.B. The relationship between poverty, living environment and diseases is obvious and the tribals, especially the women and children, are conspicuously undernourished and malnutritioned.

Illness has a definite role and meaning in their life. The tribals perceive illness as a state where he becomes dysfunctional, that is, he is unable to perform his routine work. They also associate continuous medication with illness. Tribals are mostly fatalistic and believe that illness is a punishment for their sins. This attitude to diseases results in a set of responses that are superstitious and bordering on faith healing. The belief also develops a sense of helplessness and indifference towards diseases. This coupled with the pressures of poverty and struggle for survival force the tribals to ignore their health problems unless it reaches an exploding level. They are also ignorant of diseases and consider their existence
as normal inspite of intense suffering.

The responses of tribals to the health problems combine both traditional and modern health care practices. The initial response in most cases is to fall back on the traditional system of giving homemade remedies or seeking the help of a medicine man who provides more specific treatment of folk medicines. He also practises traditional methods of appeasing deities and spirits which are crucial in their belief systems. If the illness persists the tribals seek the help of modern medical institutions even if they are distantly located and involve expense. Traditional practices, considered as a deterrent in spreading the message of modern health care, coexist peacefully in their scheme of things. The intensity of their faith in traditional systems however is on the decline.

The health care delivery system for tribals has two streams, the first that functions as part of the Directorate of Health Services and the second, that operates under the Directorate of Tribal Development. The first set-up which is comprehensive and covers the entire district is hierarchical and centralised and allows little freedom for planning and innovating at gross-root level. The primary health centres which is considered as the basic health care unit and which is designed to cater to the health needs of people at primary level are reduced to mere implementing
units of programmes decided at national or state level. This tends to ignore local needs and priorities resulting in lopsided emphasis on activities and programmes. The second set up which supplements the first concentrates entirely on tribal communities but, like the other arrangement, functions in a routine way without direction and planning. Most of the facilities under this category are Ayurvedic dispensaries which are involved mainly in curative activities.

The activities undertaken by the primary health centres are indicative of the emphasis the health care delivery system places on the problems of tribals. In the present setup it devotes nearly 30 per cent of its time and resources on clinical and curative activities, 50 per cent on family planning and the rest 20 per cent on preventive and other programmes. The undue emphasis on family planning is glaring. This is inevitable in the present arrangement where the primary health centres are rated for their efficiency on the basis of their achievement in family planning. The primary health centres faced with the pressures to fulfill the targets on family planning, ignore other aspects of health care that are more immediate and relevant. An attitude has also developed among health staff to exclude from their focus communities or groups who are considered to be negative to family planning. Tribals are a
victim of this attitude as they are believed to be indifferent to family planning.

The attitude of health personnel in primary health centres and other medical institutions towards tribals is unsympathetic and negative. They are ignorant of tribal culture, its specificities and the historical reasons for their backwardness. They consider the tribals as irrational, superstitious and hence as a category who are apathetic to modern medical practices. This attitude again works against the tribals and distances them from the health care delivery system.

The nature of interaction of tribals with the health care facilities, however, contradict many of the above accepted assumptions about them. The tribal households in the sample display a high level of awareness about health care facilities available around them (93 per cent), so also the degree of utilisation (78 per cent). They accept and utilise facilities if these are available within accessible distance and also if services are affordable to their income status. They are also influenced by the type of services and feel encouraged by the reassuring responses from institutions and staff. The presence of institutions in their midst and their various activities, even if centred around family planning, brought about changes in their health culture and traditional practices. Their willingness
to accept modern medical facilities in deliveries is an indication of these changes. Tribals, contrary to the belief expressed by the health personnel, accept the concept of family planning. But the immediate reasons that forced those in our sample for accepting the methods are basically economic compulsions.

To sum up, the health problems of tribals, their responses to those problems and the interaction with the health care delivery systems reflect clearly their unique backwardness and their relative position in society. The diseases are largely diseases of poverty and they arise out of inadequate income and other social and economic disabilities such as lack of skill, lack of education and lack of political consciousness. These factors form a vicious relationship and pulls the tribals down to a state of perpetual backwardness of which illhealth is a natural outcome. These conditions also force them to treat illhealth as normal till it explodes as a medical catastrophe. They are crippled further when they confront an indifferent if not a hostile health care delivery system. The modern health care system has several inherent tendencies such as its curative orientation undue concern on family planning and the urban bias of health personnel that force it to exclude the tribals from their focus. The tribals on the other hand, are evolving a health culture that make them depend
increasingly on modern health care delivery system.

These observations about the health problems of tribals and the health care delivery system in the study are suggestive of certain trends that explain the nature of health development among tribals in Kerala.

The pattern of utilisation of health care facilities in a society is a function of two sets of factors: availability and accessibility. Each of these aspects represent a system that is internally coherent but shaped by a number of factors that interact with each other. Availability manifests itself in the provision of health care institutions and services. The nature and extent of availability of health care facilities at the national level is determined in accordance with the equations of various interests and their relative bargaining ability. Even at the micro level the magnitude and distribution of facilities to a group or a location is largely a function of their economic and political strength, the level of awareness, the ability to articulate and the quality of leadership. Accessibility which reflects the extent of utilisation of facilities is also decided by a set of variables that are economic, social and cultural. It varies between groups in a hierarchical society, such as ours, on the basis of income, caste, customs and practices. Availability and accessibility favours those at the top while those at the bottom are
deprived in both respects. The tribal communities who rank the lowest in the social hierarchy are one of the worst affected in this regard. These communities in Wyanad are socially, economically and politically weak. They lack awareness and above all lack a sensitive leadership to bring in facilities to their locations. The accessibility on the other hand is limited by the lack of availability, lack of income, cultural practices and the various expressions of dominance-dependence relationship which discourages them to use the health care system. These constraints expressed through availability and accessibility evolved a health care system over the years that was indifferent to the health needs of tribals.

The inequalities in health status which is a reflection of the social and economic inequalities is accentuated under the present system which emphasises after-event interventions using expensive drugs and sophisticated equipments. The production of health care, primarily of drugs and equipments, and its inherent concern for maximising profits exerts pressure on the health care system to expand according to the logic of profit. Curative orientation at the cost of preventive and promotive health is the inevitable outcome of this. It also promotes a differentiated social arrangement to have a constituency among the richer sections. The public health care system
which was introduced to overcome the economic and social disabilities of poorer sections to enable them to have access to medical care was also a victim of this orientation. The health care institutions in this set up confine themselves largely to curative and family planning activities. This ignored the health problems of the poor and the social conditions of their origin.

The inequalities in society and the inability of the poorer sections to bring facilities to their regions and to their advantage has resulted in a tendency that promoted uneven development of health care facilities benefiting the influential sections. In Wynad this tendency was conspicuous in that the health care facilities are concentrated in towns and developed regions without considering the intensity of the problems faced by tribals. The curative orientation of modern medicine reinforced this uneven development.

The health care system has developed a health culture in society, irrespective of divisions within it, that made individuals depend exceedingly on modern medicine and medical facilities. In the case of tribals, the eventual growth of health care facilities around them visibly disturbed their traditional health culture. The use of tribal medicines though popular as first level interventions is gradually declining in importance. This destruction of indigenous systems is inevitable in the present system
because of its orientation to profit.

The low status of health among tribal communities thus reflects mainly their social and economic disabilities. The public health care delivery system that was developed after Independence concentrated mainly on improving the infrastructure among them. The growth in terms of number of institutions and number of health personnel was remarkable both in Kerala and in Wyanad, especially during the post Alma Ata phase. But this improvement without any structural change in the society did not yield the desired results. The health problems in all probability, increased several-fold consistent with their poverty and deprivation. The health care delivery system was largely irrelevant to these problems as it did not address the basic reasons from which these problems originated. Structural changes abolishing the existing social and economic disabilities of tribals are, therefore, essential prerequisites and unless it takes place the tribals shall remain continuously out of the present health care framework.