CHAPTER I

INTRODUCTION
If the development of health and medical services in India is critically examined, it can be recognised that there is a blend of both medical and public health services. The origin of health services in India began in the middle of the 18th century with the recruitment of Ship's Surgeons by the East India Company and with the establishment of Civil and Military Services. The health care services for the general population were of the nature of medical relief only, developed on doctor-patient relationship, without attempting to meet the requirements of the community as a whole.

Professor P. Ranganada Mudaliar sounded the tocsin as early as in 1890 that although Indian medical heritage was a glorious one, but a country that mortgaged its present to the dead past would in time find itself listed among the extinct races. He admitted with painful realism that, "There is small cause for wonder, though there is much for sorrow, in the fact that such large numbers periodically fall victims to cholera, small-pox and typhus. How is it possible for people to be healthy when they are ill-washed and ill-fed, when their houses are ill-drained and ill-ventilated, when their towns have narrow streets reeking with noxious odours from accumulated garbage, when the water they drink and the air they breathe contain the germs of disease and death? Is there ground to hope that the masses will, in their present state of ignorance, find out what it is that makes human-beings fall like grass beneath the mower's scythe, and hasten..."
to adopt remedies that science has devised for alleviating the human sufferings and prolonging human lives. Can they be made to feel that the houses require to be kept clean, and whitewashed, that their drains need flushing that their street needs widening? Are they likely to realize the need for preserving the wells and tanks that supply drinking water free from impurity from all kinds? What they are likely to say and do is what they have so often said and done that is to plead poverty and inability, and to submit themselves with such resignations as they can command to the decrease of an ever-ruling fate.

3. The story of rural setting in India is not much different even today in relation to health and environmental sanitation from what was described in 1890 by Mudaliar. The quality and quantity of medical care available in India have been extremely variable ranging from highly organised and advanced to most primitive and traditional. The medical systems, that are truly Indian in origin and development, were the Ayurvedic and Sidha systems, which are alive even today, although Allopathic medicine has been also correspondingly operating and spreading with ideological and financial support from the Government. It was only after the major political change from 1947 that the health services began to develop with the public health blend on the basis of Directive Principles of State Policy set forth in the Indian Constitution. In order to relieve the people of their ill health and disease, two-pronged attack was attempted:

i) through single process campaigns against major communicable diseases; and,

ii) multi-purpose health care delivery in rural areas through Primary Health Centres (P.H.C.), planned on long term basis, to stimulate efforts
of the community on a recognised frame-work which should provide for the continuous education of all health workers.

4. During the successive five-year-plans, there have been efforts to build up a massive institutional frame-work in rural set-up as P.N.C. As many as 5328 such P.N.Cs have been giving a coverage to the population ranging from one lakh to one lakh fifty thousand people as a unit of action for providing comprehensive and integrated curative, promotive and preventive health services. However, Banerjee (1976) has significantly pointed out that "despite all such multiple programmes and development of institutional network for the last thirty years, which involved investment of considerable resources, India has the unenviable distinction of being one of the last country in the world to have eradicated small-pox..... Over four-fifth of the mothers do not get even the most elementary obstetrical services from the community health organisations. Extensive problems of malnutrition and under-nutrition are one of the result of grinding poverty of vast masses of people, extremely poor conditions of living, unprotected water-supply and very poor condition of general sanitation...... such an ecological setting leads to very high rates of morbidity and mortality among the infants and children. The general population also continues to suffer from such communicable diseases like Malaria, T.B., Filaria, Leprosy, Trachoma, Dysentery, Enritic fever, Hookworms and other parasitic infestations." Source?

5. Various types of health problems in India that are widely spread inspite of considerable investment in health programmes, reflect what former Health Minister, Dr. Kean Singh, has described as "urban elitist's
orientation" of health services in the country. Health services are disproportionately concentrated in urban areas and they have a pronounced curative bias. The services that are being offered to rural population are not only grossly inadequate in quantitative sense, but much more important is that the personnel who man the rural health services have a strong antipathy for rural health work in particular and rural way of life in general. It has also been argued that the existing institutional medical and health set-up are responsible for creating more social distances between the receiver and provider of service and naturally a process of alienation has also set in. Another glaring shortcoming in health care system in India has been to confuse 'health services planning' with 'health planning'. It is apparent that the concern of all the five-year-plans has been more on 'health services planning' alone rather than on 'health planning'. It is now recognised that the health services are only one of the many factors that ultimately affects the health status of a given population. The health of a given population is also influenced, sometimes even more significantly, by such social and economic factors as nutrition, water-supply, water-disposal, housing, education, income and its distribution, etc.

6. It would be clear that a substantial amount of thinking and efforts has gone into the development of health services in India. The inspiration and motivation of such developments are said to have come through the valued recommendations of expert bodies like Bhore Committee, Mudaliar Committee, Multipurpose Committee, etc., which have critically examined the working of health system in the country. Most of the recommendations of these
committees have largely rested on impressionistic judgements rather than on hard data, generated from the field pertaining to different aspects of health services including its very strategy. However, they greatly lacked in experimentation with new ideas pertaining to development of strategies, development of operational systems and sub-systems to be able to maximise their productivity with available resources. They have been conditioned by conservatism rather than the desire to develop an approach based on radicalism in thinking and innovations arising from scientific evidence (Government of India, 1976).

II. THE NEED TO STUDY THE BEHAVIOURAL ASPECTS OF HEALTH

7. The understanding of the reasons for the so called under-utilisation of the available health facilities, the mechanisms evolved by the people to manage the existing load of disease, illness or sickness by themselves, are some of the questions to which little attention has been paid so far. Most of the studies conducted on health care are addressed to the ‘service’ components rather than to the behavioural aspects of health. In view of the fact that there has been very little systematic research work conducted in India on these areas except the partial coverage given by studies of Roy and Kivlin (1968), Shastri and Goel (1969), Madan (1969) and the Narangwal as well as the Khanna studies, it is proposed to delineate in detail the processes involved in seeking medical care and draw upon the important and significant areas of medical behaviour management in rural areas.

8. It is a known fact that the differences in decision-making in seeking medical care under people’s varying perceptions of disease, illness or sickness events are still continuing to be the subject of extensive
investigation in medical sociology, psychology and anthropology. Although it has not been possible to formulate the exact processes involved in making decision to seek medical care as yet, in Western countries enough data supports that further probes in this direction would add valuable chapter to the history of health behaviour. The question of what influences, encourages or discourages a person from seeking medical care is of great significance not only to the planners, implementers and organisers of health care delivery systems, but also for developing a series of theoretically sound propositions to develop certain viable models of health behaviour. Such efforts would yield better results in curative behaviour because most of the activities undertaken for the management of disease, illness or sickness by an individual are amenable to measurement. An understanding of medical care seeking behaviour can have tremendous impact upon the utilization of health and medical services by persons living in a community, both in terms of providing better medical care and making that care accessible to the people who need it the most.

9. It may be noted that medical care and public health care are confusing terms and if one defines public health clearly, the medical care would require no separate definition. Smillie writers, "Public health encompasses those activities that are undertaken for prevention of disease and promotion of health which are primarily a community responsibility." A very comprehensive definition of public health comes from C.E.A. Winslow who states, "Public Health is science and art of preventing disease, prolonging life, and promoting health and efficiency through organised community efforts for the sanitation of environment, the control of communicable infections, the education of the individual in personal hygiene,
the organisation of medical and nursing services for early diagnosis and preventive treatment of disease and development of social machinery to ensure everyone a standard of living adequate for maintenance of health so organising these benefits as to enable every citizen to realise the birth right of health and longevity. In this way, medical care is curative based and addresses itself to the disease, illness and sickness from socio-biological orientation.

Unfortunately, in an era of increasing and justified disenchantment with the current health delivery system, it is astonishing to observe that so many well-meaning and intelligent reformers propose as a solution the bureaucratisation of health promotion and maintenance activities. In addition, the majority of activities are tending to be secondary and tertiary in nature; that is, we are still placing major and perhaps disproportionate emphasis on 'curative services' (medical care). The statement "Health is the crown on the well man's head, but the only one who sees it is a sick man" is illustrative of the emphasis on curative services. Strictly speaking, if a health care system can be defined as a group of curative and preventive service components—organised, co-ordinated, and controlled to achieve certain goals—then it is apparent that there is national crisis in this country. The problem, in fact, is insidious and permeates every level of health care activity, prevention, cure and rehabilitation. The health care predicament is insidious basically because it is 'individual' in nature, affecting each person and individual groups of people differently. Hence an informed citizenry, as well as an informed cadre of health care professionals, is necessary to combat health conservation problems intelligently and efficiently.
Health is a positive attribute of life and its definition, treatment and maintenance is socially and culturally determined. The greatest handicap of health programme evaluation and health planning has been the lack of a comprehensive measure of health status. There still continues to be a gap between the theoretical concept of health and its empirical measurement. The term frequently used to define health includes both positive and negative states such as well, normal, asymptomatic, dissatisfied, disabled, diseased, sick and ill. These terms do not tell where "health" begins or where it ends. Thus, the major conceptual difficulty in operationalising a definition of health is in measuring the value judgments that distinguish illness from health. The definitions proposed by Lewis (1953), Parsons (1958), Machanic (1968) and Wilson (1976) continue to be vague in measurement and global in nature. Even the definition proposed by W.H.O. and accepted by most of the countries of the world that "health is a state of complete physical, mental, and social wellbeing, not merely the absence of disease and infirmity" evokes ambiguity and lacks in precise measurement. Perkins (1962) defines that "Health is a state of relative equilibrium having interaction of various forces in the body and outside, working towards readjustment. The condition of health is due to various forces which are continuously reaching and disease occurs by interaction of multiple causes influencing the agent host relationship in particular environment." The widely acceptable sociological interpretation of the concept of health as given by Parsons (1951) claims that "health is
the state of optimum capacity of an individual for effective performance of the roles and tasks to which he has been socialised.

12. Over a period of time, the concept of health has moved from its individual attributes to community viewpoint. It has been realised that health must be approached in an integrated and comprehensive manner at the community level. The concept of Community Health, which has now almost come to stay, is being visualised as encompassing all those activities which individually or collectively contribute to the maintaining, protecting and improving the health of the people. Gunnar Myrdal cautions against over-simplifying the understanding of health by isolating it from the other socio-economic institutional policy factors of development. Considerable evidence has also been gathered by the authors like Dubos and Ivan Illich to affirm that it is the interaction between man and his environment in a region and the way of life of people living there which is decisive in determining the health status of the community. It can thus be maintained that "health culture" of a community is a component of its overall culture. Ivan Illich also points out that health is "a culturally shaped reaction to a socially created reality". From ancient times in our texts also the concept of health has been visualised as "Dharmastha Kama Lokam Arogyam Moola Uthanaa", the first pre-requisite for artistic, ethical, economic and spiritual development of man and society. Incidentally, this version of health is very close to what has been proposed and accepted by the World Health Organisation.

13. In contrast to the concept of health is 'disease', 'illness' and 'sickness'. These three terms depict an experience of unhealthy status and
are often being used as interchangeable terms. Analytically, sociologists have clearly made a distinction between these terms so as to avoid confusion. Since these terms will often be used in the present study, it would be in the fitness of things to discuss such distinctions here. For example, a disease is a socio-biological state. Being unhealthy has biological dimensions in which there is some alteration of society functions that result in reduction of capacities or a shortening of the normal life span. These events are of varying degrees and are objectively measurable and can also be said to exist whether or not they are recognised by anybody. Thus such events are called 'disease'. The identification and labelling of a person having a disease is the province of specialised roles.

14. Similarly, people have a tendency to define themselves as unhealthy because of subjective feelings, and reporting these feelings can result in others defining them as unhealthy. Experiences such as 'pain', 'weakness', 'dizziness', 'anxiety' fall into this category. Illness is normally assumed to be caused by a 'disease'. It is not however the same as disease, since feelings of illness can take place in the absence of a disease, and disease can take place at least at some stages in the absence of ill health.

15. When people are defined by others as being unhealthy or they publicly define themselves as unhealthy, a shift in social identity takes place. Such a social identity is called as 'sickness'. One may thus observe that whereas disease is a socio-biological status, illness is a socio-psychological status and sickness is a social status. The events that lead to the definition of sickness may be either disease or illness or functioning in the social order. It must also be said that sickness
is usually presumed to reflect disease or illness although it can occur independently also. These distinctions have been drawn by Twaddle & Messler (1977).

16. From the above discussion, it should be clear that there is a wide variety of criteria for defining health and sickness, that different sections of a society tend to respond to different symptoms, and that some people may respond to different symptoms at different times. It is evident that universal consensus on what is health, who is healthy and who is sick, ill or diseased is very difficult to achieve. Keeping this variety in mind, it can be argued that a state of perfect health can only be conceptualised as an ideal towards which people are oriented but not the one which they expect to achieve. Thus, from a social point of view, 'perfect health' may be a state in which an individual's capabilities for participation in social systems are optimal.

17. It may thus be noted that contrary to commonsense impression, 'health' is not easily defined as its attributes are interwoven with other non-health aspects of human behaviour. Secondly, health, disease, illness, and sickness are always defined with reference to social norms, no matter what specific definitions are used. And, finally, a variety of cues may be used to start the process of redefining healthy people as sick.

18. The set of behaviour that is thus intimately linked to either disease, illness, sickness or maintenance of health would naturally be as complex and diffuse as the terms themselves. Health behaviour is also formulated, shaped, and maintained through the norms of society and can
broadly be classified in three main categories, viz.: Curative, Preventive and Promotive. Whereas curative health behaviour would mostly deal with the management of disease, illness or sickness from socio-biological point of view only, the preventive and promotive health behaviour is intimately linked with the socio-psychological and social aspects of disease, illness and sickness. In precise terms, health behaviour is an activity undertaken by a person who believes himself or herself to be healthy for the purpose of preventing disease, illness and sickness. Similarly, illness or sickness behaviour could be an activity undertaken by a person who feels ill, sick or diseased for the purpose of defining that illness, sickness or disease and seeking relief from it. The health behaviour to be discussed in the present study will therefore be more concerned with that set of curative health behaviour which an individual will undertake from the onset of disease, illness or sickness to its termination. The health seeking behaviour defined above cannot usually be elicited without the individual becoming aware and motivated to seek relief. Medical seeking behaviour is much narrower than health seeking behaviour as in the former case only those activities connected with curative aspects of disease, illness or sickness are taken into consideration and not the preventive and promotive aspect. Therefore, medical seeking behaviour defined for the present study would relate to the activities undertaken by a person from the onset of disease, illness, or sickness to the point of contact with formal or informal (organised or unorganised) type of health facilities usually falling outside the jurisdiction of one's own family.