CHAPTER – I

INTRODUCTION

1.1 Introduction

विना दैन्ये जीवनम् ।
अनावासेन मरणम् ॥

“My life should not be at the mercy of the others; let me have a peaceful death” is an old maxim incorporated in our prayers to the almighty, which exemplifies the vital need of good health. Ill health is a curse, as it incapacitates a person and makes him / her to depend on the others.

Diseases torcher the people to suffer from untold pain and misery when they become sick, on the one hand and on the other it causes panic and hardships to those who have to take care of sick person. Every one wishes to be away from disease, disability and premature death. Good health and long life have traditionally been the most prized goals of mankind.

The health consciousness is not a recent phenomenon. It is as old as human beings. The Indian great epic “Mahabharata” illustrates the importance of good health in terms of a mythological episode in which ‘Yaksha’ asks the eldest Pandava brother “Yudhishthira’ लाभानाम् तु त्वम् किं स्थान? (What is the most valued gain in the life?) Yudhishthira replies “लाभानाम् श्रेयः आस्तेयम्” (The most valued gain in the life is ‘Good health’). The perception of Yudhishthira is apt to be quoted here because there is nothing parallel to health. Health is man’s valuable treasure. A diseased person can never be happy. A bed ridden person with plenty of money and other affluence will remain un-happy. Health is supposed to be a key factor for human happiness and prosperity. Healthy body with a healthy
mind is a happy blend which ensures healthy, disease free, long life which is considered as a cherished goal of human life.

As it is observed by Whipple an eminent economist, “A nation’s true wealth is not in its land and waters, not in its flocks and herds, not in its treasure of dollars, but in its healthy and happy men, women and children” (Swarnalata Sakhuja 2008, p.21.) This quotation clearly shows the intimate relationship between the health status of the people and economic development of a nation. However health aspect of the community became the focal point of World Health Assembly only in the latter part of the 20th century.

The first International Conference on Primary Health Care defined health as “essential health care based on scientifically sound and socially acceptable methods and technology made universally acceptable to individual 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 a spirit of self reliance and self determination”.

In 1978, the Alma-Ata international conference on Primary Health Care reaffirmed Health for All (HFA) as the major social goal of governments, and stated that the best approach to achieve the goal of HFA is by providing primary health care especially to the vast majority of underserved rural people and urban poor. In 1981 the global strategy for ‘Health for All’ was adopted by the World Health Organisation. In 1997 it was decided in the World Health Assembly to launch a movement known as “Health for All by the year 2000” (K. Park 2005, p.687) which articulates health as a fundamental human right. The Universal Declaration of Human Rights (UDHR) and International Covenant on Economic, Social and Cultural Rights (ICESCR) recognise this fact. (Dash L.N. 2007, p.201)
It would not be out of context here to mention that health issues in modern days are not only remained personal concern of an individual or his family but it has become a public issue. National Governments all over the world are striving to expand and improve their health care services (Park K. 2005 p.685)

Health care is a public right and it is the responsibility of governments to provide this care to all people. Health services should cover the full range of preventive, curative and rehabilitation services. In India health care services are provided at three levels viz primary care level provided by Primary Health Centres and their sub-centres, secondary care level provided by District Hospitals and Community Health Centres, and tertiary care level provided by regional or central level institutions like Medical College Hospitals, Regional Hospitals etc. (K.Prak 2005, pp. 685-686)

This research work is confined to primary care level. It makes an attempt to present a socio economic analysis of the myriad issues related to health care services provided by the Primary Health Centres on the one hand and the pattern of utilisation of these health care services by the rural community on the other.

1.2 Statement of the Problem

The socio economic development of any country to a greater extent is conditioned by the health status of the community. The proverb “Health is wealth” strongly supports the same. Infact healthy people are treated as the asset of the nation, where as diseased persons are mere a liability.

Ill health creates vicious circle by depleting human energy leading to low productivity and earning capacity, deteriorating quality and quantity of
consumption and standard of living. Therefore a nation ought to give adequate attention to the health care of its people (S. Sagaya Doss 2008, p.13)

The tenth five year plan has strongly proposed the provision of essential primary health care, emergency life saving services and family welfare programmes to needy people at free of cost. Since India has opted “Health for All” by 2000 AD, the primary health care system has been re-organised and strengthened to make the primary health care delivery system more effective (K. Park 2005, p.685)

It was expected that the health system would reach to the door-steps of the villagers in general and vulnerable classes in particular. Unfortunately substantial population has no access to minimally adequate healthcare services at all or whatever they receive is inadequate to alleviate their health problem. The problem is more severe in case of dwellers in interior corner of villages.

About 75 percent of the resources and infrastructure were concentrated in Urban India (Zakir Hussain 2011, p.53). Nearly 80 percent of Central and State Health out lay is spent on only 20 to 30 percent of the people who are urban residents, remaining 20 percent is spent on 70 to 80 percent of the people who are rural residents. (M.S. Gubbewad 2005 p.4) These facts clearly show that the health care delivery has skewed towards urban areas and hence rural community is largely deprived of their due share in health aspects.

Public expenditure on health as a percent of government expenditure has been declining over the years. For instance in the First Five Year Plan (1951-56) budget allotted to health sector was 3.33 percent of total plan investment out lay has been reduced to 2.09 percent in the Tenth Five Year Plan (2002-2007) (L.N. Dash 2007, p. 204).
According to NRHM report out of 23391 Primary Health Centres, only 6239 i.e. 27 percent are fully functioning, out of which 16 percent of the PHCs do not have doctors. (Shantaram 2011 p. 35)

Primary Health Centres are widely criticised for their poor performance in improving health status of rural people. Lack of infrastructure, shortage of qualified health personnel, lack of adequate training facilities, irregular and inadequate supply of essential medicines, poor infrastructure, unwillingness of staff to work in remote rural areas come in the way of rendering qualitative services.

The present research problem is stated as “Primary Health Centres and Health Care Services - A case study of Uttar Kannada District”.

To be more specific and precise the following questions are taken-up for investigation in the study area.

1. What are the Health care and Family Welfare Services ought to be provided by the Primary Health Centres and are actually provided by themselves.

2. What are the problems faced by PHCs in providing Health Care and Family Welfare Services?

3. What are the common morbidities found in the study area?

4. What are the factors influencing the pattern of utilisation and choice of Health Care and Family Welfare Services by the households?

5. What are the perceptions of the Health Care providers and the consumers of health care services?
The problems stated here above are found at the very surface, however many more may be hidden at the bottom. Hence this study will throw light on the problems faced by the Primary Health Centres on the one hand and inconvenience if any faced by the consumers on the other.

1.3 Importance of the study

The present study is mainly focused on the role of PHCs in mitigating the health related problems of rural community. The relevance of the study can be summarised as follows.

1. India is one of the signatories to the Alma-Ata declaration and committed to the goal of ‘Health for All’. Primary Health Centres are integral part of the health care system. They are the providers of primary health care at the grass-root level. They have an important role to play in realising the goal of “Health for All”. Many norms are imposed on PHCs for their effective functioning. Hence the study is expected to find out strength and weakness of PHCs.

2. Primary Health Centres are the first contact points available to the rural people. Demand for health care services is growing with the increasing population. This has and would definitely increase the burden on PHCs. Hence it is necessary to explore the adequacy or otherwise of the PHCs.

3. PHCs are widely criticised for their inherent drawbacks like shortage of qualified health personnel, lack of adequate training facilities to staff, irregular and inadequate supply of essential medicines and unwillingness of staff to work in remote rural areas. In view of these, people are discouraged to fully utilise the PHCs. Study of the working of the PHCs
would give an insight in the understanding of the inherent problems and to suggest possible solutions.

4. According to the constitution of India, state shall consider improvement of public health as one of the important primary duties. Private medical service providers are concentrated in urban areas. PHCs are the main if not the only medical service providers in rural areas. Being important means of health providers, their efficient functioning would improve health status of rural people.

5. Demographic structure of the population exhibits the characteristics of increased utilisation of health care and family welfare services. This in turn would increase the burden on PHCs in rural areas. Hence revitalisation of PHCs would go a long way in meeting the health needs of the rural people.

6. If the PHCs are freed from all the bottlenecks and are well-equipped, would enhance the quality and reliability of them. This will attract more needy people to utilise PHCs. This in turn would minimise the pressure and over burdening otherwise would have been imposed on the higher level of health care system.

7. Many diseases and epidemics affect the have-nots in very serious proportion. Infact, poverty and diseases usually go hand in hand. Therefore the PHCs should be qualitatively up graded so as to insulate the vulnerable section of the rural community.

The findings of this study are expected to provide a constructive feed back to the government and the planners.
1.4 Objectives of the Study

The present research work "Primary Health Centers and Health care Services - A case study of Uttar Kannada District" endeavours to examine the performance of the state patronaged Primary Health Centres as the chief health care providers in the rural areas. The study also intends to verify the pattern of utilisation of health care services and family welfare programmes by the people.

On the whole the study has been designed to focus on the supply side as well as the demand side of health care services and family welfare programmes. From the supply side, the study exposes the gaps if any between the health care services and family welfare programmes which are ought to be and actually provided by the primary Health Centres comprising the causative factors relating to such gaps. From the demand side, the study explores the reasons for pattern of utilisation of health care services by the sample population in the study area.

The specific objectives of this research work are listed here below.

1. To study the Health Care and Family Welfare Service which are ought to be provided by the PHCs and are actually provided by themselves in the study areas.

2. To know the impact of the socio-economic status of the people on the choice between Primary Health Centres and private health care providers.

3. To analyse the impact of the socio-economic status of the people on the pattern of utilisation of health care and family welfare services provided by the PHCs.

4. To know the availability and adequacy of Health Care Services provided by the PHCs in the study areas.
5. To examine the problems and perceptions of the people and that of personnel of PHCs regarding health care and family welfare services provided by the PHCs.

6. To identify the reasons for utilisation and non-utilisation of the health care services provided by the PHCs in the study areas.

7. To suggest suitable remedial measures in improving the quality of health care and family welfare services provided by the Primary Health Centres.

1.5 Limitations of the study

Human enterprise is said to be not hundred percent perfect. This research study is also not an exception to this. We have our own limitations which are partly pedagogical and partly personal. Some such constraints have imposed ceilings on the inquiry.

1. The study is restricted to only one district viz. Uttar Kannada. We have not moved beyond the frontiers of two taluks Siddapur and Kumata in the district. Hence generalisation of the findings can only be done with utmost care.

2. Only 400 sample households are drawn from population as sample size. This small sample size came in the way of wider comprehensive analysis and hence findings in the study may not represent the entire population.

3. The intensive study of the communities is spread over to a span of one year only i.e. January 2010 to December 2010 which imposed constraints on better understanding of medical behaviour of the community.
4. The primary data collected from the field survey may not be hundred percent reliable because responses of the respondents were mainly based on their memory power to the large extent.

5. Care has been taken to the extent possible to minimise usual statistical errors incorporated in statistical tabulations and calculations.

6. This study basically deals with only the allopathic medical care system.

7. Only physical ill health is considered in the analysis, mental ill-health, and accidents are not focused in the study.

8. Respondents usually hesitate to report diseases associated with stigma like leprosy, TB, AIDS etc. Hence the datas relating to such diseases if any be there in the study areas either be not reported or under reported.

9. The study is concentrated only on Primary Health Centres. However a passing reference of Community Health Centres and Sub-Centres is also made.

1.6 Chapter Scheme

The entire research study has been grouped in to eight chapters. The first four chapters are the introductory chapters. The next three chapters are based on the primary datas collected from the field survey in the study areas. The final i.e. the eighth chapter deals with the summary of the research study followed by the main findings and suitable suggestions to rectify the problems.

The chapterwise scheme of the study is as follows.

Chapter 1 : Introduction

This chapter is devoted to explain the theoretical frame work of the study on which the entire analysis of the study is dependent on. It deals with the
statement of the problem, the need and importance of the study, objectives, limitations and chapter schemes of the study.

Chapter 2: Conceptual Framework and Review of Literature

This chapter mainly deals with definitions and explanation of various concepts and technical terms. Reviewing the available literature in connection with the study has been made.

Chapter 3: Research Design and Methodology

This chapter introduces the research methodology adopted for the present study. Selection of study areas, selection of Primary Health Centres, selection of the sample population, sampling procedure, collection of data and tools of analysis etc are explained in this chapter.

Chapter 4: Primary Health Care and Family Welfare Programmes in India

In this chapter an attempt has been made to connect the theoretical base widely utilised in the study with its practical counterpart. At the very outset a brief account of health and economic development linkage has been given. Origin, structure and functions of Primary Health Centres in India coupled with how these centres are focused in various health review committees, health policies and in Indian Five Year Plans have been briefly explained. A few family welfare programmes implemented in the country as well as in the state have also been mentioned in this chapter.

Chapter 5: Socio Economic Status of Respondents and Morbidity Profile

This chapter comprises general socio-economic characteristics of respondents of the study area. In addition to this the chapter also provides an over-view of morbidities found in the study areas.
Chapter 6: Availability and Utilisation of Health care and Family welfare services

This chapter outlines the various health care and family welfare services available at the selected PHCs in the study areas. Besides this the chapter examines whether these services are utilised or not utilised and also observes the number of households who have gone to private health care providers.

Chapter 7: Health Care and Family welfare Services; Perceptions of people and Health Care Providers

In this chapter attempts are made to explore the ground realities pertaining to level of utilisation of public and private health care facilities coupled with the causes of utilisation and non-utilisation of the health care services provided by the PHCs. Parallel to this the chapter also focuses on perceptions and problems of households as well as personnel of Primary Health Centers in connection with the health care and family welfare services of PHCs in the study areas.

Chapter 8: Summary and Suggestions.

This chapter relates to major findings, suggestions and conclusions pertaining to health care and family welfare services provided by PHCs.

Conclusions

'Health is Wealth' is an age old saying stresses the importance of health of the people in the creation of wealth. Healthy people are always creative, dynamic, active and more productive. Labour is the highly perishable among all the goods. A day of a labourer lost without work due to ill health is lost forever.
There is a dire need of studying the health problems of the people. It's so because many people go to medical centres only when they fall sick. Moreover many of them do not know the causes of certain diseases and their symptoms.

The present study is an attempt to analyse, generalise and to arrive at some concrete conclusion about the health problems, programmes and policies of the government.