Chapter 1: Introduction
1.1: The Background

Human resources constitute a country’s most important wealth. The successful achievement of a development plan in a country depends on the extent to which human resources are developed in terms of status of health, education and social services.

The concept of human resource development or investment in human capital is of comparatively recent origin. It was conventional to place more importance on the accumulation of physical capital in the process of economic development. In recent years, it has been increasingly admitted that the growth of tangible capital stock depends to a great extent on human capital formation. According to the World Bank’s assessment, while physical capital accounts for only 16 percent of total national income, natural capital accounts for 20 per cent and human capital accounts for 64 percent of the same (Human Development Report 1996). Professor Theodore W. Schultz mentioned the term ‘human capital’ in 1960 and pointed out that an important way of developing human resource is through improved health care services, broadly conceived to include all related expenditure that affect the strength, stamina, vigor, vitality and life expectancy of the people (Schultz, 1961). Thus economics of health today has become one of the most rapidly growing branches of economic studies. It has been recognized that health is basic to human development and investment in people must be made with special attention to health improvement.

Investment in health, an essential component of all developmental tasks, is a complex issue as multi-lateral linkages exist between health, social, cultural, economic and
political spheres. Developing economies including India are severely affected by vital problems like high population growth, illiteracy, poverty, hunger, malnutrition and ill health especially of women and children. Expenditure on health is a productive national investment. It can raise the level of income of the poor and bring about manifold benefits to the individual and to the society at large. Improved public health programmes are effective ways to improve national welfare in low-income countries. Quite obviously preservation of women's and children's health is an urgent socio-economic need of the day. A healthy mother would give birth to healthy children, who, in turn, would be an asset to the nation. It is unfortunate, therefore, that in spite of rapid advancement in scientific knowledge and technology and development of resources, vast majority of people, especially mothers and children, still continue to live in sub-human conditions. Planned efforts have been stated to have improved their lot, but the actual situation is far from satisfactory.

Proper health care is one of the most essential requirements for the growth and development of national economy. Countries that pursue egalitarian growth strategies are more likely to perform well on indicators of health and human well-being. The most effective way to obtain improved health outcomes may be direct spending that improves nutrition and direct spending on related sectors that also contributes to health and human development. Improving health is likely to have dramatic spillover effects in view of the close correlation between health, productivity and poverty. About 30% of the estimated per capita growth rate in the United Kingdom between 1870 and 1979 might be associated with improvements in health and nutritional status. In Indonesia, anemia
reduced male productivity by 20% (Human Development Report, 2004). Obviously, health care delivery must become a momentous social function and the nation’s basic investment. On the economic front, the economic reforms, initiated during the 1980’s, have important instruments of economic and social change, particularly since mid-1991. Reforms have been started to contribute to an acceleration of economic performance. On the social front, a strong women’s movement aiming at gender equity and equality at all levels has become a force to be acknowledged. All of these changes have both a direct and an indirect impact on human development parameters such as an access to mass education, primary and reproductive health care, life expectancy and fertility, employment and well-being.

The World Bank has been evolving Comprehensive Development Framework in an attempt to operationalize a holistic approach to development based on four areas of development – structural, human, physical and sectoral (WDR, 1999-2000). The goals of development to be reached by 2015 or earlier are to reduce extreme poverty by one-half, to ensure primary education, reduce child mortality by three-quarters while providing universal access to reproductive health services through implementation of national strategies for sustainable development. In recent years, the UN system has increasingly focused on monitoring and facilitating human development across the world, particularly in developing countries (Human Development Report, 1998). Such concerns are reflected in the recommendations of recent UN conferences such as the 1990 World Summit for Children, the World Conference on Environment and Development and the International Conference on Nutrition, both held in 1992, the 1993 World Conference on Human
Rights, the 1994 International Conference on Population and Development (ICPD) and the Fourth World Conference on Women, both held in 1995; The World Food Summit held in 1996 and the World Congress on Women’s Health in 2000. Each of these conferences has agreed on the need to achieve sustainable development, mass education (especially for women), gender equity, empowerment of women, and has recommended programmes that focus on women’s rights, her reproductive rights and health. At the International Conference on Population and Development (1994), the international community agreed that strong reproductive health programmes together with sustainable economic development and poverty eradication measures are needed to achieve population stabilization and to address new challenges to human development and health development. Development must pursue a range of outcomes, such as equality, education, health environment, culture and social well-being of people.

Healthy woman have important bearing on the health of all members of the family. As there is a close correlation between education, poverty and health, management of a family by educated and healthy mothers is expected to yield advantages to the income and health of the prospective children. While planning for investments in health, therefore, particular attention has to be given to women (mother and adolescent girls) and young children, especially infants. There are sound reasons for this. Special care to pregnant women brings double health benefits: first, to her as an adult member of society and second, to the product of her pregnancy. Besides these benefits, there are also other reasons. Pregnancy is a period of particular physical stress during which the women may face unusual risk. Undesirable influences during the prenatal period may jeopardize the
health of both the mother and the expected infant. These effects may result in health and economic disadvantages for the women and children and even for the rest of the family if the mother’s health is permanently impaired. In order to achieve sustained socio-economic development, we have to ensure the development of human resources of whom women and children constitute a large percentage.

1.2: The Relevance of the Study

India adopted the policy of “Health For All” by 2000 A.D enunciated by Alma Ata Declaration in 1978 but the goal remains unrealized. Of course, it is true that the health and medical care system has been reoriented and restructured extensively. Health is being viewed in its totality, as part of the strategy of human resource development. Emphasis has been placed on all the interrelated programme like environmental sanitation and hygiene, nutrition, education, family planning, maternity and child welfare, population control, poverty eradication, spread of elementary education, community health service schemes, and linkages are being established among all these interrelated programmes.

Realizing the importance of maternal and child health care services, the Ministry of Health, Government of India, took concrete steps to strengthen maternal and child health services in the First and Second Five Year Plans (1951-1956 and 1956-1961). The integration of family planning services was introduced as a part of the Minimum Needs Programme during the Fifth Five Year Plan (1974-79) (Fifth Five Year Plan Document, GOI). The primary objective was to provide minimum public health services to vulnerable groups of pregnant women, lactating mothers and pre-school children. Since
then, the promotion of health of mothers and children has been one of the most important aspects of the Family Welfare Programme in India. Recently this has been strengthened by the introduction of the Child Survival and Safe Motherhood Programme. The Ministry of Health and Family welfare has also sponsored special schemes under the Maternal and Child Health Programme, including the programme of Oral Rehydration Therapy (ORT). The development of Regional Institutes of Maternal and Child Health in states where infant mortality rates are high, the Universal Immunization Programme and the Maternal and Child Health Supplemental Programme within the Post-partum programme.

The 1980’s saw the emergence of a new perspective on family planning. It was argued that a reproductive health approach would strengthen existing family planning and health programmes as well as ascribe dignity and basic right to women and children. In the 1990’s the concept of reproductive and child health was integrated into the main stream of health and human development process with its wider acceptance by International donor agencies, the UN system, the World Bank and the World Health Organization. Following the Cairo ICPD in 1994, the current focus on reproductive health, including the shift in 1997 to the reproductive and child health programme, was reinforced.

From 1st April, 1996, the Family Welfare Programme was being implemented all over India on the basis of Target Free Approach. Keeping in view the shortcomings of the Target Oriented Approach followed since the First Five Year Plan, the Government of India (Department of Family welfare) introduced the decentralized participatory planning approach. In the health field later on, since 1998 it has been decided that the centrally
determined targets would no longer be the driving force behind the programme. The demand of the community for quality services would be expected to become the driving force behind the programme making it a people's programme. This programme based on the felt-needs of the people has been termed as Community Needs Assessment Approach.

To sum up, the women (mothers and adolescent girls) and children constitute the vulnerable group in terms of malnutrition, illness and death connected with pregnancy and child birth. As the state and the society in general has vital responsibilities in stabilizing population of the country at a level consistent with the sustaining capacity of national development and in providing adequate care for women and children in the process of health development, human development and socio-economic development of a nation, the improvement in the health status of the people and other allied health related programmes are also being tried to be ensured in the decentralized participatory planning process through the Minimum Needs Programme and they have yielded considerable benefits.

Despite the programmes initiated and extended during the planning era, some glaring inadequacies prevail in the general health scenario and especially in the arena of women and children health care facilities in India and West Bengal. There is a tendency for the available health facilities, although they are not adequate enough, to be concentrated in the urban areas. Even after sixty two years of attaining independence, there has not been any proper provision of clean water supply and environmental sanitation and also to preserve the health of women and children. Focusing on the state of West Bengal we find
significant lacuna persisting in health and medical care facilities for women and children. We have crossed the target year of “Health For All” in 2000 and in the meantime, “Reproductive Health For All” by the year 2015 has been announced. Against this background, we attempt to undertake an economic analysis to consider all these questions. We also make an assessment of the progress achieved so far in the health field specified for women and children. The study considers the relevance, strength and weakness of the health system with special reference to the overall development of health for women and children on the basis of a field survey of Panskura II (Kolaghat) community development block in Purba Medinipur district West Bengal and also indicates guidelines to be followed in future for the development of the system.

1.3: The Hypotheses

In course of the development of the major those of the proposed study: the following hypotheses would be tested:

A) The women and children health status of India is in a very poor position not only internationally but also in comparison with different South Asian countries like Sri Lanka, Nepal, and Maldives etc.

B) The women and children health status of West Bengal is not in a sound position in comparison with some major Indian states like Kerala, Gujarat, Haryana, Maharashtra, Punjab etc.
C) Women and children health status (both in international and national level) is determined by not only demographic factors but also by many socio-economic factors.

D) Non-economic factors rather than economic factors play a more important role in determining women and children health status.

1.4: Objective

The objectives of the present study are in numbers. They are as follows:

A) To evaluate the women and children health status at international, South-Asian and national level.

B) To attempt a broad review of the health care delivery system.

C) To identify different economic and non-economic factors which determine women and children health status in different levels.

D) To asses the relative importance of different types of women and child health determinants.

1.5: Data and Methodology

The investigation has been undertaken using the data collected from both primary and secondary sources. The secondary data base consists of the reports of the Health Directorate, Department of Health and Family Welfare, Government of West Bengal, reports of important health committees, National health and population policies of the Government of India, health and medical education reports of the ICMR, National Family Health Survey I and II, Government of India and annual reports and others of the World Health Organization.
Information has also been collected from primary sources through primary field survey using a structured questionnaire. The survey was undertaken in Panskura II Block (Kolaghat) of Purba Medinipur District to assess the performance of health care delivery system especially to women and children. After completing data collection, it is analyzed with the help of different statistical tools, for example, correlation, multiple regression, probit analysis etc.

1.6: The Plan of the study

Title: Economics of Health Care for Women and Children: A Case Study of Panskura II (Kolaghat) in Midnapore (West Bengal).

The study has been divided into seven chapters including the introductory chapter. The background analysis, the relevance of the study data and methodology and the plan of the study are discussed in Chapter I. Review of the literature are discussed in Chapter II. Socio-economic development and the state of health of international scenario has been presented in Chapter III. Health status of women and children in India has been examined in Chapter IV. The Health Care Delivery System in India and West Bengal, are analyzed in Chapter V. Socio-economic profile and health status in West Bengal are focused in Chapter VI. The entire primary data analysis with the help of different statistical tools has been completed in Chapter VII. Summary of findings, conclusions and policy recommendations are presented in Chapter VIII.