CHAPTER-1

INTRODUCTION

For most individuals the choice to live a healthy life-free from illness and ailments-and a reasonable life span are crucial attributes in the notions of personal well-being. Similarly for a society, a transition from high incidence of morbidity and mortality to a state where people generally enjoy long and disease free lives is considered a desirable and valued social change. It is only natural then, that indicators on health and longevity, as well as indicators that variously capture demographic concerns of a society are important constituents in the framework for evaluating the development process under the human development approach (National Human Development Report, 2001).

The health status of a population is relevant to the economic development of a country for three main reasons. First, as an indicator of economic development, it shows the ability and success or failure of a country to provide for the most basic needs of the people (food, clothing, shelter and adequate sanitary conditions). The correlation between such crude indicators as child mortality and life expectancy on the one hand, and per capita income on the other, is very robust and well documented in economic literature. Secondly, health as a form of human capital is an input for the further development of country. There is ample evidence to support that health plays an important role in school enrolment and school performance of children, and in labour supply and productivity of adults and in earnings. Therefore, improvements in health or better health would promote learning, reduce absenteeism, improve stamina and would contribute to improve the economic status of the poor. Thirdly, the high
infant and child mortality rates are among the most important factors related to high fertility rates, which in turn play a crucial role in development. A majority of countries which attended the Bucharest Conference on Population in 1974 strongly endorsed the notion that economic development and health improvements are pre-requisites for fertility decline.

Health is multi-factorial. There are numerous factors that influence health like hereditary factors, environmental factors, lifestyle, adequate housing, basic sanitation and socio-economic conditions including income, education, availability and quality of health infrastructure and per capita health expenditure (Park K, 1994). Expenditure on medical and public health per capita influence health status but it does not have a strong effect on reducing infant mortality, which is crucial in designing public policy to reduce excess mortality in developing economies (Kaushik Krishan K., Kurt K. Klein and Lawrence N. Arbensar, 2006).

Earlier analysis of the British experience in the nineteenth century (Mc Keown, Brown and Record, 1972) and the Latin American experience prior to 1930s (Arriaga and Davis, 1969) showed that mortality decline was closely related to improvement in living standards rather than medical breakthroughs. From the 1930s to the 1960s, however it was claimed that mortality reduction were largely independent of increase in living standards (Arriaga and Davis, 1969). Per capita income is the most widely discussed socio-economic determinant of mortality, primarily because it is considered a summary of the ability of an economy to meet the needs of its citizens (Cochrane et al, 1980). Well educated people experience better health than the poor educated, as indicated by high levels of self reported health and physical functioning and low levels of morbidity, mortality and disability (Ross and Wu, 1995). In contrast, low educational attainment is associated
with high rates of infectious diseases, many chronic non-infectious diseases; self reported poor health, shorter survival when sick, and shorter life expectancy (Feldman, Makuc, Kleinman and Cornoni-Huntley, 1989; Guralnik, Land, Fillenbaum and Branch, 1993; Morris, 1990).

India’s Case

Health Planning in India started, as early as in 1943, when the Bhore Committee was appointed to go into health and medical needs of India. At the time of independence in 1947, the health infrastructure was mainly urban and clinic-based, providing only curative services. On 2nd October, 1953, Rural Health Services were launched through a Primary Health Centre (PHC) in each block, covering a population of 66000. Along with setting up of Health Centre Complexes, a number of disease control programmes were taken up to be integrated with rural health services.

By the end of Third Five Year Plan, India laid the foundation of basic health services. Subsequent Five Year Plans focused on the need to integrate family planning with Maternal and Child Health (MCH) and nutrition services. The Sixth Five Year Plan (1980-85) adopted the goal of Health For All (HFA 2000 A.D.) and the Net Reproduction Rate (NRR) of unity by 2000 A.D. In 1983 the first National Health Policy was announced. In the Seventh Five Year Plan (1985-90), the major thrust was laid on the consolidation of health infrastructure already developed. The objectives of the Eighth Five Year Plan (1992-97) realized that the health facilities must reach the entire population by the end of the plan period.

The Ninth Five Year Plan (1997-2002) observed that inappropriate location, poor access, poor maintenance, gaps in critical manpower, mismatch between personnel and equipment, lack of essential drugs/
diagnostics, poor referred linkages were some of the factors responsible for sub-optimal functioning of primary health care institutions. Most recently, the Ministry of Health, Government of India prepared the National Health Policy (NHP) 2002. Its main objective is to achieve an acceptable standard of good health among the general population of the country.

Since Independence, India has made substantial gains in health. Life expectancy at birth of male and female population has increased from 37.2 and 36.2 respectively in 1951 to 62.6 and 64.2 respectively in 2002-06. The Crude Birth Rate (CBR) which was 40.8 in 1951 has reduced to 22.8 in the year 2008. The Crude Death Rate (CDR) has shown a remarkable decline and it has come down from 25.1 per thousand in 1951 to 7.4 per thousand population in 2008. The Infant Mortality Rate (IMR) has reduced from 129 per thousand in 1971 to 53 per thousand in the year 2008. In spite of such improved health indicators India’s health sector lags far behind other countries. India’s relatively poor performance in health sector is brought to light even more starkly when compared to international data on health care infrastructure and utilization. Number of physician, nurses, midwives and hospital beds per thousand population in India were 1, 0.9, 2, 0.7 respectively during 1990-1998. In low income countries the corresponding percentage was 1, 1.6, 0.3 and 1.5 respectively. Similarly the utilization of health care facilities in India is also lower than low-income countries (Human Development in South Asia, 2004).

The health infrastructure in India has a long way to go towards achieving 100 per cent quality technology and superior health-care delivery systems. The private sector provides 80 per cent of the health care services and only 20 per cent are provided by the government (www.buyusa.gov/india). The private health sector predominates in the
provisioning of curative services. India’s private health sector accounts for about (1) 80 per cent outpatient treatments for both rich and poor; (2) more than 55 per cent of all inpatient admissions or hospitalization i.e. curative services; (3) 40 per cent of prenatal care; (4) 55 per cent of institutional deliveries; and (5) as low as 10 per cent of immunizations delivered. It provides 40 per cent of hospitalizations for the poor and 60 per cent for the privileged (Mukhopadhayay Debes, 2006).

The condition of expenditure on health services is no less dismal. The total expenditure on health services in the country is estimated to be around 5 per cent of the Gross Domestic Product (GDP). Public expenditure on health services, however, constitutes just 0.9 per cent of GDP. This implies that more than 80 per cent of the health expenditure is borne by the private sector, and that too by the households in the absence of any significant contribution by health insurance. As compared to this, in most developed countries, public sector accounts for the major share of health expenditure. For example, in the UK more than 85 per cent of the total health expenditure is borne by the public sector. The United States is the only developed country where the share of private sector is more than that of public sector. Even in the USA the public sector accounts for about 45 per cent of total health expenditure, and the balance is mainly borne by the insurance sector. Further, public expenditure on health in India as a percentage of GDP at 0.9 is one of the lowest among all countries (Sathyamala, C. and N.J. Kurian, 2008). Throughout 50 years of plan period, allocation in health has not gone beyond 1.6 per cent (norm is 4 per cent) (Naidu K.M., L.K., Mohan Rao and K., Mahesh Naidu, 2006). According to Prof. Sen, India in 2005 spent a lower percentage of GDP on public health than almost any other country including those with similar income levels. There is an urgent need to
increase the expenditure on public health services by the government. However it is, also necessary that the spending on health is properly utilized such that it benefits the entire population, especially the underprivileged. The government expenditure must be properly managed so that there is an overall improvement in health indices (Rawat Deepa, Kalpna Aggarwal and Manish Dev, 2006).

**Punjab’s Case**

Punjab occupies an extremely important place in India (Punjab-Human Development Report, 2004). It is one of the richest states of India. The state’s per capita Gross State Domestic Product (GSDP) in 2009-10 was US$ 1423.6. The per capita GSDP grew at a compound annual growth rate of 9.8 per cent between 2001-02 and 2009-10. According to Planning Commission of India, the state ranks amongst the top five states in terms of per capita income (IBEF, 2010). It has the lowest incidence of poverty (8.4 per cent) as against all India incidence (27.5 per cent) (Ahluwalia Isher Judge, 2010).

The life expectancy in Punjab increased from 63.1 in 1981 to 70.2 in 2008. During 1981-2008, birth rate declined from 30.3 to 17.3, death rate went down from 9.4 to 7.2 and infant mortality rate reduced from 81 to 41.

Punjab state does not have any independent health policy of its own. Health delivery system in the state, like in most other states, has continued to develop under the policies of Union Government of India. In Punjab state, health delivery system is dominated by public and private providers. In its large urban towns, hospitals attached with the Medical Colleges provide tertiary health care services. In medium/smaller towns and some larger villages, the state government runs an extensive infrastructure of district
hospitals, tehsil hospitals and Community Health Centres (CHCs)/ Rural Hospitals (RHs). The rural Punjab are provided both curative and preventive health care facilities through a network of Primary Health Centres (PHCs) and dispensaries. Thus the public health care delivery system in Punjab operates at three tiers: (i) at the first level care, PHCs and SHCs (Subsidiary Health Centres, popularly known as dispensaries) mainly provide curative, preventive and promotive care in the form of immunization, controlling of communicable diseases, maternal and child health, family welfare, etc.; (ii) at the second level care, tehsil and district hospitals cater the health care needs of the population in the form of many services to inpatient and outpatient care; (iii) at the level of tertiary care, hospitals attached to the Medical Colleges (both public and private owned) of the state, some hospitals established by the union government and many hospitals established by the private sector/voluntary organizations located in major cities provide specialized inpatient as well as outpatient care.

Private medical care is the chief health service provider in Punjab. Covering over 90 per cent cases of non-hospital care and over two-thirds of the cases of hospitalized care, private health services dominate and direct curative health. A greater majority of private health providers in Punjab dominantly provide clinic/office-based practice of general practitioners. Also, a large number of small-sized private hospitals/nursing homes, with an average size of 10-30 beds per hospital, provide basic as well as advanced surgical, obstetric and diagnostic care at a price. Indeed, they mostly concentrate on low risk cases and provide planned care where the chances of failure are very less. In addition, there are also a few large hospitals located in big towns and run by the trusts/societies/entrepreneur doctors/industrial houses, etc. All these hospitals provide an advanced and high-tech inpatient
and outpatient care at very high prices. In many instances the private sector operates without adhering to regulations and is often a hindrance to making health care accessible to all.

In Punjab, the health services along with the education continue to be one of the pillars of developing human resources and economic reconstruction of the state economy (Gill and Ghuman, 2000). During the 1970s and the mid-1980s, more public funds were pumped to develop health services in the state sector. Since the mid-1980s due to the political turmoil, severe resource crunch and non-responsive administration in the state on one hand, and the adoption of New Economic Policy (NEP) of 1991 at the national level that emphasizes the integration of nation’s economy into world economy through the forces of Liberalization, Privatization and Globalization (LPG), on the other, public investment in social sectors, especially the public health sector in Punjab, has gradually been withdrawn. This has led to a faster deterioration in the public health infrastructure and services, particularly in rural Punjab (Singh, 2005). The share of health services, as a percentage of Net State Domestic Product (NSDP) in Punjab never reached one per cent for most of the years against the normative ratio of 3 per cent of the state/ national income.

**Need of the Study**

All the citizens of a nation share an interest in health care services and it is in the national interest that resources available for health care should be spent efficiently. The government must allocate scarce resources between competing uses in a manner that priority sectors are not neglected. Mainstream economists consider that expenditure on health care and family welfare services is the most productive investment that enhance the
productive capacity of workforce by promoting and maintaining human health from diseases on the one hand, and by reducing pain and sufferings from ill-health on the other. The continued escalation of health care expenditure coupled with the growth of the egalitarian bias, implying that all citizens should have an equal access to arrangements, has spurred economists and other social scientists to study health care services from different angles. It is not surprising, therefore, that the analysis of health and health care services has become a topic of widespread interest. The significance of the present study is thus obvious.

In Punjab, studies analyzing the health sector are very much lacking. Health being one of the most important necessities of life these days, it is therefore important to have detailed information on health issues which could help the state in planning various health programmes. The study is mainly confined to Punjab state and can prove to be of great help for the policymakers. It takes into account a number of different and complementary perspectives of health status and health care services so that it may add to the knowledge base from which the planners of the economy can develop appropriate policies and measures to deal with the problems arising from and contributing to development. In particular, this study throws light on the health indicators, health infrastructure, health expenditure and the problems and challenges faced by the health sector. Within this framework, the specific objectives of the study have been formulated.
OBJECTIVES

The objectives of the present study are to:-

(i) examine the major indicators of health like birth rate, death rate, life expectancy and infant mortality rate, etc.
(ii) analyze the trends in health care infrastructure like number of hospitals, dispensaries, primary health centres, beds etc.
(iii) examine the trends and pattern of public expenditure on health.
(iv) analyze the distribution of health expenditure (inter-sector and inter-class analysis).
(v) study the various factors that limit the ability of the health sector to improve the health of the people.

CHAPTER SCHEME

The chapter scheme of the study is given below:-

1. Introduction
2. Review of Literature
3. Health Scenario in India
4. Status of Health in Punjab
5. Trends in Health Infrastructure in Punjab
6. Trends and Pattern of Public Expenditure on Health in Punjab
7. Distribution of Health Expenditure of Sampled Households in Punjab
   (a.) Inter-sector Analysis
   (b.) Inter-class Analysis
8. Problems and Challenges Faced by Health Sector in Punjab
9. Summary and Conclusions
METHODOLOGY AND SAMPLING DESIGN

The study has been based on both primary as well as secondary data. The secondary data has been collected for the period 1981-2008 from various issues of Statistical Abstract of India, Statistical Abstract of Punjab, Health Information of India / National Health Profile, Report on Currency and Finance, Economic Survey and Plan Documents etc. For analysis the data has been disaggregated into three time periods i.e. 1981-1990, 1991-2000 and 2001-2008. Various mathematical and statistical tools like percentages, growth rates and semi-logarithmic trend etc. have been used for the purpose of quantitative analysis. Graphs, pie-charts and bar diagrams have also been used for presentation of data.

Primary data has been collected for the period 2008-09. The sampling design has been generated through a comprehensive survey and a multistage stratified random sampling has been used. A sample of 200 households has been selected out of which 120 are from rural areas and 80 are from urban areas on the basis of proportion of rural-urban population of Patiala district in 2001 census. The sampling design for the rural areas consists of following three stages:

1. Selection of Development Blocks
2. Selection of Villages
3. Selection of Households

1. Selection of Development Blocks

There are eight development blocks in the Patiala district. The final ranks to Borda scores show the levels of development of these blocks in terms of ten socio-economic indicators of development. The indicators used for calculating the level of development of blocks are literacy rate, density of population, percentage of SC population to total population, percentage of
workers to total population, cropping intensity, number of tractors per 1000 hectares, population served per medical institution, population served per bed, population served per bank and population served per educational institution. The blocks have been classified as developed, semi-developed and less developed blocks. On the basis of ranking, Samana, Nabha and Bhunerheri have turned out to be developed, Patiala and Ghanour as semi-developed and Sanour, Rajpura and Patran as comparatively less developed. One development block has been randomly selected from each developed, semi-developed and less developed blocks which turn out to be Nabha, Patiala and Rajpura respectively.

2. Selection of Villages

The next step is selection of villages. In Nabha block there are 174 inhabited villages and 32824 households. Patiala block has 108 inhabited villages and 20687 households and Rajpura has 149 inhabited villages and 28234 households. Two villages have been selected from each block. The villages have been selected keeping in view their distance from the Primary Health Centre (PHC). One village is selected which is near the PHC i.e. within the radius of 5 km from the PHC and the other village is the one which lies beyond the radius of 5 km from PHC. The villages selected from Nabha are Gadaia and Durgapur; from Patiala, Kauli and Bahadurgarh; from Rajpura, Jansui and Khanpur Khurd.

3. Selection of Households

All households of the selected villages have been listed, and ultimately a proportionate random selection of households has been made to represent each stratum. In this manner, 120 households have been selected from the rural areas.
Table 1.1: Block-wise Socio-economic Indicators of Development in District Patiala

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Socio-economic Indicator</th>
<th>Samana</th>
<th>Nabha</th>
<th>Bhunerheri</th>
<th>Patiala</th>
<th>Ghanour</th>
<th>Sanour</th>
<th>Rajpura</th>
<th>Patran</th>
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<tr>
<td>1</td>
<td>Literacy Rate (2001)</td>
<td>46.29</td>
<td>55.89</td>
<td>52.24</td>
<td>57.41</td>
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<td>2</td>
<td>Density of Population (2001)</td>
<td>353</td>
<td>329</td>
<td>331</td>
<td>313</td>
<td>257</td>
<td>312</td>
<td>230</td>
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<td>3</td>
<td>Percentage of SC Population to Total Population (2001)</td>
<td>30.30</td>
<td>33.84</td>
<td>18.21</td>
<td>28.67</td>
<td>23.95</td>
<td>29.33</td>
<td>26.67</td>
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<td>4</td>
<td>Percentage of Workers to Total Population (2001)</td>
<td>38.87</td>
<td>37.91</td>
<td>42.32</td>
<td>37.63</td>
<td>34.78</td>
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<td>5</td>
<td>Cropping Intensity (2005-06)</td>
<td>191</td>
<td>194</td>
<td>182</td>
<td>191</td>
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<td>6</td>
<td>No. of Tractors per thousand Hectares of Net Sown Area (2005-06)</td>
<td>93</td>
<td>50</td>
<td>36</td>
<td>65</td>
<td>65</td>
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<td>7</td>
<td>Population Served per Medical Institution (2005-06)</td>
<td>7418</td>
<td>7282</td>
<td>7502</td>
<td>6172</td>
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<td>8</td>
<td>Population Served per Bed (2005-06)</td>
<td>994</td>
<td>1154</td>
<td>1372</td>
<td>1629</td>
<td>1410</td>
<td>1500</td>
<td>2263</td>
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<td>9</td>
<td>Population Served per Bank (2005-06)</td>
<td>10116</td>
<td>17211</td>
<td>18755</td>
<td>10661</td>
<td>18123</td>
<td>18490</td>
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<td>10</td>
<td>Population Served per Educational Institution (2005-06)</td>
<td>1002</td>
<td>841</td>
<td>682</td>
<td>888</td>
<td>846</td>
<td>887</td>
<td>863</td>
<td>1192</td>
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<td></td>
<td>Borda Scores</td>
<td>33</td>
<td>35</td>
<td>38</td>
<td>40</td>
<td>43.5</td>
<td>53</td>
<td>54.5</td>
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<td>Final Rank</td>
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<td>4</td>
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Note: 1) For Explanation of the Borda Score, see Appendix A
2) Selected Development Block: Nabha (Rank 2); Patiala (Rank 4); Rajpura (Rank 7)

The sampling design for the urban area consists of following two stages:

1. Selection of Towns/Wards

The next concern of the study has been to select representative town from the urban areas of Patiala. From urban areas of Patiala four towns have been selected namely, Patiala, Shekhpura, Rurki Kasba, Sanour and further data has been collected from two wards of each town.

2. Selection of Households

All households of the selected municipal wards have been listed, and ultimately a proportionate random selection of households has been made to represent each stratum. In this manner, 80 households have been selected from the urban area.

DATA COLLECTION AND CONTENTS OF THE PRIMARY SURVEY

A detailed questionnaire was prepared for collecting the primary data. The respondents were convinced about the purpose of the study and it was also made clear to them that the study was purely academic in nature, thereby clarifying the misconceptions about the investigation, thus ensuring smooth data collection. The questionnaire was divided into five sections and contained information regarding the following:-

Section I- Identification Particulars of Household
Section II- Particulars of Household Members
Section III- Sources of Income and Consumption Expenditure
Section IV- Household Members suffering from Minor Illness
Section V- Household Members suffering from Major Illness
CONCEPTS AND DEFINITIONS

Since the same terms can be used in many different senses, it would be necessary to indicate the meanings that have been given to various concepts and definitions.

(a) **Crude Birth Rate**

Crude Birth Rate (CBR) is the number of live births in a year per 1000 population of the mid-year population.

(b) **Crude Death Rate**

Crude Death Rate (CDR) is the number of deaths in a year per 1000 population of the mid-year population.

(c) **Birth Rate**

The Birth Rate (BR) of a population is the number of births per 1000 persons per year.

(d) **Death Rate**

Death Rate (DR) represents the number of deaths per 1000 population per year.

(e) **Infant Mortality Rate**

Infant Mortality Rate (IMR) is the number of newborns dying under a year of age, per 1000 live births per year.

(f) **Life Expectancy**

Life expectancy of an individual is the number of years a person is expected to live given the prevailing age-specific mortality rates of the population to which he/she belongs.

(g) **Total Fertility Rate**

Total Fertility Rate (TFR) of a population is the average number of children that would be born to a woman over a lifetime if she were to experience the exact current Age-Specific Fertility Rates
(ASFRs) through her lifetime, and she were to survive from birth through the end of her reproductive life.

**(h) Household**

The term household includes all persons normally living together and taking food from common kitchen. It also includes those who are temporarily away because of some work or holiday or illness etc., but excludes those who are visiting the household temporarily and the guests.

**(i) Head of the Household**

Normally, the eldest male member of the household is the head but where for some reasons he is not in a position to take decisions, on behalf of the household any member of the household who functions as the decision maker has been taken as the head of the household.

**(j) Consumption Expenditure**

It consists of expenditure on non-durable and durable consumption items, services (education, health care, conveyance and entertainment) and marriages and other social ceremonies.

**(k) Minor Illness**

It mainly refers to seasonal and communicable diseases like fever, cough, cold or any other kind of infection, ache in any part of body or even a minor injury which does not extend more than three or four days.

**(l) Major Illness**

It includes physical disability, chronic illness or any other major illness.

1. Physical Disability:-It refers to a physical impairment which has continued from a long time and is expected to continue for an
indefinite duration and substantially impedes an individual’s ability to live independently.

2. Chronic Illness:- Chronic Illness in this study means an impairment of bodily structure and/or function that necessitates a modification of the patient’s normal life and has persisted over an extended period of time.

3. Any other Major Illness:- It refers to that disease or illness which does not come under the heads of physical disability or chronic illness, but has persisted over an extended period of time.