CHAPTER-I

SCOPE AND SIGNIFICANCE OF THE STUDY

1.1 INTRODUCTION:

Good health is a crucial part of total well being. Constitution of the World Health Organisation states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic and social conditions." T.W. Schultz on the other hand viewed health as an 'investment in human capital' and included it as one of the factors, 'health facilities and service, on-the-job-training, education, study and extension programme, and migration', responsible for improving human capabilities. To him health had both qualitative and quantitative impact on population and economic growth.

Whether viewed as a 'right' or as an 'investment' the emphasis on health is on the increase in the last fifty years on account of rising comforts and living standards owing to scientific advancements. In both the developed and developing economies there is a constant public interest in health and disease; in deficiencies and defects in health services and in the rising costs of health care. The public is becoming over expectant regarding health standards and the issues of health care therefore have
gone beyond the medical profession and individual family units. In the face of limited resources the world is confronted with the insoluble problem of health care in terms of 'wants', 'needs' and 'available resources'.

The sheer size of the health expenditure has brought 'health' into prominence today. For the world as a whole, public and private expenditure on health services in 1990 was about $1700 billion, i.e., 8% of the total world product. United States alone consumed 41% of this which amounted to 12% of her GNP. Spending so much on health is justified on purely economic grounds, for improved health status of the population contributes in many ways to economic growth. It reduces production losses caused by workers' illness; permits the use of natural resources that had been totally or nearly inaccessible to many because of disease; improves the enrollment of children in school and makes them physically fit to learn; and frees for alternative uses the resources that would otherwise have to be spent on treating illness.

It is inevitable that politically and economically health care has now become a major concern of all governments. The World Development Report of 1993, clearly stated that governments have to intervene early in the health care system especially in the context of a killer, un-controllable disease like AIDS. The governments have a more specific role to play in the developing economies in the provision of health care on account of
the extent of poverty. The adverse effects of health fall heavily on the poor for they die younger and suffer more from many disabilities. They are exposed to greater risks from unhealthy life styles and unhygienic environment. The economic gains of better health are relatively greater for the poor people on account of its direct impact on the productive capacity of the bread winner of the family. Health improvements, thus, have become an important strategy in the poverty alleviation programmes of the less developed countries. The World Development Report 1993, summed up the role of the government in the provision of health care as given below.

- Government need to foster an economic environment that enables house-holds to improve their own health. This calls for growth policies to ensure income gains to the poor and educational investments with special reference to girls' schooling.

- Government health spending to be restricted to cost effective, pro-poor programmes such as treatment of infectious diseases and malnutrition.

- The government is required to promote greater diversity and competition in the financing and delivery of health services. It should finance public health and regulate private insurance market.

The government has a positive role to play in improving the health status of individuals living in developing countries. A carefully
designed public health policy will contribute towards longer, healthier and more productive lives for the people especially for the more than one billion living in poverty around the world.

Unbelievable as it may seem despite scientific advancement at the end of the 20th century, health problems which are thought to be consigned to the past still persists on this planet. The realities of the health situation in the poorest countries of the world are sure to generate sterile pessimism. Good health is an essential component of human life and this has to be recognised by policy-makers. Irrespective of the level of economic development the governments will have to undertake public-health programmes to promote the health status of the public. It takes more than building health centres, providing medical facilities, arranging cross-country vehicles and running staff refresher courses to create the right conditions for health improvement. So many projects have been lost because they failed to take root after producing results which were spectacular, but short lived. For instance, the 'Health for All by 2000 AD' programme, though based on sound principles did not succeed in many countries as it failed to take into consideration the local constraints and socio-economic parameters.

If public health programmes are to be effective then, more attention has to be paid to the public health systems. This means working towards long-term goals, paying special attention to local needs and
resources and placing emphasis on the eco-human dimensions of health. Health programmes must be planned holistically in the light of social, cultural, political, economic factors that interact to prevent people's access to the benefits of these programmes. The health policy interventions of the government need to be more people-focussed, broad based and multi-pronged.

The role of the government is thus clear. It has to provide the basic health infrastructure and the environment for the households to generate their own health. It should continue to undertake the public health measures particularly the provision of drinking water, sanitation, proper housing and food regulation. It should reduce the barriers and ensure equitable access to the available health care.

Health systems of the present day face several problems. In many countries the health system is characterised by mis-allocation of funds against the highly cost-effective communicable diseases control programmes apart from being inequitable and inefficient. The increasing reliance on new technology has resulted in cost-escalations of medical care. The changing morbidity and mortality patterns have posed a greater challenge to the medical technology in terms of the 'new' killer diseases like AIDS and cancer. Health improvements on the other hand have increased the proportion of the 'old' in the population causing concern over the care of the old. Another problem is the reappearance of the some of the
conventional killer diseases like malaria and pneumonia on account of discontinuation of malaria eradication programme and bacterial-drug-resistance.

In spite of these major problems the present health systems are marked by three main characteristics:

(i) Current knowledge in the field of health is adequate to provide an efficient response to priority health problems of people in the less developed countries. They may be grouped as parasitic, infectious and nutritional.

(ii) There is an increasing availability of health manpower in terms of doctors, nurses and paramedical staff. Even the poorest countries have crossed the threshold of one doctor per 10,000 persons.

(iii) As for funding, there is an acceptance among the public of the idea that treatment should be paid for by them. This thought, however, is not new to countries like India where traditionally health and education are always received only on payment in either cash or kind. One of the consequences of this realisation is that the public health policy need not depend entirely on the government source for its funding. With careful utilisation of the services of public, private and newly emerging community sectors it should be
possible to promote a harmonious, realistic health service that would provide a positive response to the demand for a wide range of health care.

This shows that health planners should abandon the well-wornout paths and re-conceptualise the health systems as the existing system is unable to adjust to the resources and demands of the modern world. This calls for research in the direction of health and health care services.

1.2 Health Care in India:

Recognising the importance of health care, developing economies like India, as signatories to the Alma Ata Declaration of 'Health for All by 2000 AD', have incorporated a policy of public health to provide primary health care to promote the health status of the vast majority of the underserved rural and urban poor. As a democratic polity and a welfare state India is committed to universal well being. The Directive Principles of State Policy as enshrined in the constitution treats public health as among the "primary duties" of the state. Thus health services, medical education and medical research form part of the socio-economic development strategy of the country. The committees headed by Bhore (1946) and Dr. A.L. Mudaliar (1961) were chiefly responsible for shaping the health policy of India. The plans laid emphasis on preventive and public health services through a network of Primary Health Centers
The plan investment increased from Rs. 65.20 Cr. in the first plan to Rs. 3,292.90 Cr. in the seventh plan. However, the percentage of total plan expenditure allotted to health sector declined from 3.3% to 1.91% during the same period indicating a need for enhancing the resources provided for health. The guiding principles for the first two and a half decades of planned development of health in India included measures to make health services more accessible to the population, to develop the much needed human resources and to provide services for health, including maternal and child health and family planning. Over the course of time, the need to interact more closely with people was felt and more emphasis was given to preventive and promotive aspects of health care.

The basic strategies of health planning in India

(i) Expansion of physical infrastructure for health including Maternal and Child Health (MCH) Centers.

(ii) Initiating family planning programme.

(iii) Control of communicable diseases like malaria, filaria, T.B., leprosy and venereal diseases.

(iv) Establishing facilities for training of health personnel including female health personnel, like nurses, auxiliary nurse midwives, health workers and Dais.
(v) Recognition of the need to establish a 'co-ordinated hospital system' at different levels and correlate their functions with those of clinics, domiciliary care services and public health activities.

The health scenario in the present period in India is a complex one. Impressive achievements and intolerable shortcomings characterise the health performance. The IMR has declined from 137 in 1970 to 90 in 1991 and the life expectancy at birth has gone up from 49 to 60 for females and 50 to 60 for males during the same period. Under-five mortality rates on the other-hand remained as high as 125 for female and 123 for male children. The total fertility rate is still high at 3.9. Inspite of the massive investments that have gone into the infrastructural development, millions of Indians still lack access to primary health care and safe drinking water. Observation across the states reveal high inequality in the health performance. While states like Kerala have emerged as the global example of 'health-model' against the background of low per capita income and low degree of industrialisation, states like Bihar lie far behind the target fixed for 2000 A.D. making it appear almost an impossible dream. China has made impressive break-through in the health field mainly by proper allocation of resources. India, however, failed to do this. To day, the Indian health system is characterised by an urban-biased, pro-rich, doctor-based, cure-oriented medical model. This has almost replaced the indigenous system resulting in a 'pill-culture' even in the rural areas. The success
stories of the corporate sector is encouraging the market friendly system to take deeper roots which are already beyond the reach of the common man. The Indian health system appears as dualistic as the other sectors of the economy with two extreme states of health care access and availability. While one section of the population has access to the latest medical technology, the other major section lacks easy access to even primary health facilities. With the 'return' of the drug-resistant malarial epidemic, the task before the planners seem stupendous.

The structural adjustment programme has raised doubts in the minds of academicians and health economists as to the continuance of governmental support for the health programmes in the country. The present health scenario very clearly warrants a positive role for the government in the health planning of India. The efforts of the government so far have not gone wasted. India is one of the first countries to have introduced an official family planning in 1951. It has had its own effect in terms of creating awareness in the minds of the people. The catalytic role of the government agencies cannot be forgotten in this. Gowriker is convinced that 'some thing very positive' has happened on account of the four decades of health planning in India hence India's population is not likely to cross that of China's. According to him the health programmes in India have created access to primary health care even though the quality
and quantity of health care received varied from region to region. Health awareness created by these programmes along with improvements in literary levels, energy consumption, health generation, and food availability according to the author have taken India to the fifth stage of demographic transition.

It may seem paradoxical but it is true that it is the illiterate farmer of India who has adopted the green revolution. Therefore, the health awareness present among the Indian masses is not surprising. Health information can effectively be disseminated through the mass media of T.V. and Radio. The power of T.V. to reach out to the illiterate masses is yet to be fully exploited. Innovative health communicators could enhance the health awareness. Community-oriented, community-based health system built up on the support of governmental and non-governmental agencies of health is the need of the hour. An important issue that calls for immediate attention is the inequalities in the distribution of health care. Increased utilisation of indigenous system of medicine would increase the rural coverage of health care. The role of government is clear in India. While the government continues to support the primary health care programmes, a careful regulation of the functioning of the private sector is called for.
1.3 **Significance of the Study:**

India is currently experiencing demographic, epidemiologic and health transitions simultaneously and differentially. The direction of this change is not clear. While mortality has been declining in the past sixty years, fertility decline has begun only twenty years ago. We have the co-existence of chronic and degenerational and poverty related health problems. Diseases of affluent life styles such as cardiac problems and AIDS are slowly emerging as major killers. Malaria and Tuberculosis are striking back as drug-resistant diseases. In the midst of this chaotic health scene, successful planning and management of health service require knowledge about the frequency and pattern of morbidity in a population as well as the utilisation of preventive and curative services. In addition, information is needed on people's preference and attitude towards alternative forms of health care.

Health behaviour of the population need to be studied and health interview surveys at the household level are one of the best means of obtaining this information. The data thus obtained can fill up the gaps in the health information available through the official sources. The official statistics on morbidity, mortality and health infrastructure is available periodically from various sources such as Census of India, Ministry of Health and Civil Registration System. Reviewing the existing health
statistics in India Bhatia & Roy reported the data base as very deficient and suffered from inadequate coverage and unrepresentative character.

Realising the need for strengthening the basis of research in health economics in India, both theoretically and empirically, this work is directed towards the household health behavior. The study is based on rural Tamil Nadu.

Family health status depends on family's access to health care which in turn depends on income, and educational status of the family, availability of health care facilities and the status of the women within her family as the provider of health. Studies have shown positive results for health investments in women in terms of improvements in child health, nutrition, education, decreased fertility, and declining population growth. This research, apart from studying the health care expenditure pattern among the rural households of Tamil Nadu, places special emphasis on women's health care behaviour, their preferences for system of medicine, and their attitude towards health and health care. The research attempts to focus on the importance of health care within the budgetary framework of the family and identify the major determinants of health care expenditure.
1.4 **OBJECTIVES:**

The Study proposes:

- To stress the role of women in the demand for health care within the households
- To identify the consumer behavior with reference to health care.
- To make an assessment of the existing health systems in terms of the needs of the households.

In the light of the above the specific objectives are as follows:

1) To study the pattern and frequency of illness in the households and the consequent health-care seeking behavior with special reference to women.

2) To study the nature of demand for health care expressed as expenditure on health care and the variables influencing it.

3) To identify the preferences for alternative systems of medicine and agencies of health care.

4) To identify health status variables and to focus on health care in the Indian rural context and barriers to access.
1.5 **Hypotheses:**

To strengthen the micro foundations for policy issues at the macro level this study attempts to verify the following hypotheses:

(1) Health care expenditure of the household is not significantly dependent on its income.\( (H_1) \)

(2) Health awareness is more significant in the determination of health status compared to the levels of literacy.\( (H_2) \)

(3) There is gender bias in the intra-family resource allocation with reference to health care expenditure.\( (H_3) \)

1.6 **Methodology:**

This research work studies the demand for health care in the context of rural Tamil Nadu. In order to study the health behaviour of the population which governs the demand for health care the research is conducted at two levels. At the State level, Secondary data is used to establish the health care requirements of Tamil Nadu. Data from Economic Appraisal - Tamil Nadu, Census and other government sources are used to study the health status in Tamil Nadu. With this background, a rural household survey is conducted to study the health behaviour in terms of utilisation of existing health infrastructure and preferences for system of
medicine and agency of health care delivery. A simple consumption approach is adopted to study the health expenditure incurred per month by the households and factors influencing it. The details of this primary survey are reported below:

**The Survey:**

The study is based on a survey of sample households with primary data collected through personal interview method. A one-time interview was conducted using a detailed schedule. The schedule includes questions on all variables listed in the objectives.

**Study Area:**

The survey pertains to households in rural Tamil Nadu. As the enquiry relates to the demand side of health status, areas that have easy access to health facilities have been chosen deliberately so as to control the supply-side effects of health status. Given the supply of health infrastructure, the health care behaviour of the households is studied. In Tamil Nadu, as in any other state of India, there is a concentration of health facilities in the urban centres. However the rural areas are well connected by roads to nearby cities and towns. The chosen Places of Study are Thirunageswaram in Thanjavur District and Kuthambakkam in Chingleput district. Both the areas are well connected by bus and have easy access to
primary health facilities within two Kilometers radius, hospital facilities within ten Kilometers and specialised medical centres within forty Kilometers radius.

**Sample Design:**

The sample households were selected systematically from the recent voters list. The sample size was 5% of the total household. To ensure proper representation, proportionate number of households were chosen by random selection from each street. Care was taken to include the marginal groups of Schedule Caste households and religious minorities.

**Respondents:**

The key woman responsible for health care decisions within the family was chosen as the respondent for this survey, who was either the mother or the wife of the head of the family. As providers of health they could answer on behalf of the members of the family on all issues pertaining to health. Though proxy responding had its own limitations, it was assumed that in matters of illness the mother or the wife is best suited for proxy response.
Recall Period:

The illness of the households was recorded with two recall periods. The recall period must be long enough to include a reasonable number of illness episodes or actions and short enough to minimise the problem of recall errors. One recall period was two weeks and the other was one year from the date of interview. (Sept.'94 to Oct.'95). The short period covered all 'illnesses' that necessitated medication and treatment and the longer period covered any major illness that involved an expenditure of Rs.500 and above or hospitalisation or both. Special attention was paid to the self-reported illness of the respondents. 'Illness' in the survey referred to the experiences of the person of being unwell as perceived by him or her. This is an accepted practice in health surveys on the defence that after all the individual is the best judge of his or her own health status.

Validation and Repeatability Checks:

Several methods are available to check the validity and repeatability of health interview surveys. This survey has a combination of tests. To check the validity of the illness-record generated by the survey the doctors in the regions were interviewed. Information was gathered on the nature and type of illnesses reported as well as follow up action taken by their patients and comparison was made between the
two sets of information. The schedule had several built-in cross checks for health expenditure data. As regards repeatability, the survey was conducted simultaneously in two regions which yielded comparable results to indicate repeatability.

**Data Analysis:**

The primary data analysis involved the use of computers. As regards the descriptive statistics, relevant cross tables were formed and percentages were the main basis of comparison. 'Chi Square' has been employed to verify relationships. Scaling technique was used to identify preferences regarding system of medicine, agency of health care and to compile opinion on the functioning of the existing system of health care. The same technique was used to identify variables governing access to health care facilities and health status of the population. It has been attempted to quantify the relationship between health expenditure per month and other independent variables in the form of a multiple regression model. The variables included were family income, years of schooling of the respondent, expenditure on habits per day and size of the family. Based on the questionnaire index was compiled to represent attitude towards health.
1.7 Chapterisation:

This thesis consists of Six Chapters.

Outlining the importance of study of health from the viewpoint of Economics Chapter-I, gives the profile of Indian health system. Significance of the study along with the listing of objectives and hypotheses are included in this Chapter. The methodology is discussed and an outline of the study is given.

Chapter-II reviews the existing literature on health economics in three sections. The first section specifies the research trends in the U.K., U.S.A. and India. The second section provides the theory of health demand and supply and third section includes main empirical works that are relevant to the present research conducted in India and abroad.

Chapter-III discusses the health experience of women and stresses the need for a separate study of illness experience of women and their response to it. Women bear a 'triple burden' of domestic responsibilities, child rearing and bearing and participation in market activities. Irrespective of the economic status of the families this has a negative impact on the health status of women. Moreover, poverty falls more heavily on women than men. The interest in women's health within a household framework has increased in the recent years and several studies have been conducted on women's health status in the
developed and developing countries. Many of the major works in this field are highlighted in this Chapter.

Chapter-IV reviews the health status scenario in Tamil Nadu on the basis of data collected from the Economic Appraisal - Tamil Nadu for the period 1971 - 1991. The health status variables Crude Birth Rate (CBR), Crude Death Rate (CDR), Infant Mortality Rate (IMR) were studied along with per capita income of people and state expenditure on health. The health status of the state is analysed for the pre-independence and post-independence periods.

Chapter-V contains the empirical analysis of the research work which is divided into few sub-sections. The first section has the descriptive statistics namely the sample description in terms of income, education, occupation and family details. Comparisons are made between the two selected areas of study. The second section consists of attitudes of the respondents towards health as an end variable, health practices adopted by them and housing facilities enjoyed by them.

Section three includes the opinions of the respondents covering preferences for system of medicine, agency of health delivery, assessment
of the existing health care system in the respective regions, identification of health status variable and access barriers.

Section four analyses the illness record of the families as per two recall periods and the course of treatment taken with special reference to the health problems of the women.

The last section is an attempt to quantify the relationship between demand for health expressed as average monthly expenditure on health and the independent variables.

The analysis reveals that rural households do not hesitate to spend on health expenditure and consult doctors for all ailments. Women take the initiative and look after the family health especially that of the children. Income is found to have influence on the health expenditure and health awareness is present irrespective of the levels of education of the 'health provider', the woman of the house.

1.8 Conclusion:

The researcher, in presenting this work, is completely aware of the limitations of a single cross-sectional survey. However, this is a venture into an area that has not yet been covered by researchers in India and
hence very few studies are available for cross reference. It is hoped that works of this kind would make their contribution in building up a relevant theoretical base for health economics in India and serve, in no small way, in guiding the direction of health policy of the state.