

CHAPTER 2

LITERATURE REVIEW

This chapter presents a review of available literature pertaining to health and health related issues. The first section reviews meaning and changing concepts of health enunciated by different authors. The second section is followed by the review on the nature, meaning and effectiveness of primary health care. Third section reviews socio economic development and health status which will provide a brief description on the impact of various factors on health status. Finally, various problems and policy issues are reviewed so as to have a clear understanding on the various issues.

2.1. Changing Concept of Health

Health is one of those terms which most people find it difficult to define although they are confident of its meaning. Health is a common theme in most culture. Infact all communities have their concept of health as part of their culture (Park, 2002)¹. Health is viewed differently by different people all over the world (Goel, 1984)². Not only are there marked differences in lay man's definition of health, but their perceptions do not always match with those held by health professionals. Consequently, there is much controversy surrounding the conceptualization and measurement of health (Alan Clarke, 1999)³.

The concept of health is going beyond illness –its prevention and cure. Over the centuries, it has evolved as a concept from an individual concern to a

world wide social goal and encompasses the whole quality of life. A brief review on the meaning and changing concept of health is given below.

The most widely accepted definition of health is that given by the WHO (1978)⁴ in the preamble to its constitution which is as follows: “Health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity”. Although this is an attractive definition, it is subjective and hard to assess (Deon Filmer, *et al.* 2000)⁵.

As stated in the first five year plan (1951)⁶, “Health is a positive state of well being in which harmonious development of mental and physical capacities of the individuals lead to the enjoyment of a rich and full life. It implies adjustment of the, individuals to his total environment. WHO (1957)⁷ defined health as a condition or quality of the human organism expressing the adequate functioning of the organism in a given condition, genital and environmental. Seal (1963)⁸ in his presidential address defined health as: “flexible state of body and mind which may be described in terms of a range with in which a person may sway from the condition where in he is at the peak of enjoyment of physical mental and emotional experiences having regard to environment, age, sex, and other biological characteristics due to the operation of internal or external stimuli and can regain that position without outside aid”.

Dubos (1965)⁹ defined health saying: “Health implies the relative absence of pain and discomfort and a continuous adaptation and adjustment to the environment to ensure optimal function”. This is known as ecological concept of health. Holistic concepts corresponds to the view held by the ancients that health implies a sound mind in a sound body in a sound family in sound environment

(WHO 1978)¹⁰. According to Berthet (1979)¹¹, Secretary General of the International Union for Education, Paris, health should not be defined in terms of sickness, but rather in relation to the harmonious development of every individual's personality. It represents a balanced measure of a person's total potential, biological, psychological and social; and to the notion of individual's health we should add the concept of family and community health. Ahmed and Coelho (1979)¹² based on bio-medical concept viewed health as 'absence of disease' and if one was free from disease, then the person was considered healthy. Goel (1984)¹³ stated that "Health is a condition under which an individual is able to mobilize all his resources, intellectual, emotional and physical, for optimum living. Thus, health is not static. On the contrary, it fluctuates on a scale which ranges between optimum healths as defined by WHO to complete lack of health. WHO (1986)¹⁴ revealed that health is not only a bio-medical phenomenon, but one which is influenced by social, psychological, cultural, economic and political factors of the people concerned. These factors must be considered in defining and measuring health. Thus, health is both a biological and social phenomenon. This is known as psychological concept of health. Angela Scriven (1989)¹⁵ viewed health holistically and its positive aspect was acknowledged. In his view, health should not be primarily considered as an end in its own right, but rather as a means to an end. i.e. the achievement of a socially and economically productive life. For Hema *et al.* (1993)¹⁶, health is a multi dimensional phenomenon. It is not only about disease and medical care system but also about environment around us, which influenced the mental and physical state of person. According to Agnihotri (1998)¹⁷, "health is not a medical artifact, nor can it be equated with politics or economics. It is the social system in which we live, our life styles and living conditions at home.

According to Park (2000)¹⁸, “health is not mainly an issue of doctors, social service and hospitals. It is an issue of social justice. Rexford Santerre (2000)¹⁹ stated that “Health is a nebulous concept that defies precise measurement”. In terms of measurement, health depends much on the quantity of life ie the number of life years remaining as it does on the quality of life. But economists take a radically different approach. They view health as a durable good or type of capital, which provides services. The flow of services produced from the stock of health ‘capital ‘is consumed continuously over an individual’s life time (Gross Man, 1972)²⁰.

Thus, a general distinction can be made between negative and positive definitions of health. Health is viewed largely in negative terms as the absence of disease or illness. Positive health could be described as the ability to cope with stressful situations, the maintenance of a strong social support system, integration with community, high morale and life satisfaction, psychological well-being and even levels of physical fitness as well as physical health. (Bowling, 1991)²¹.

2.2. Nature, Meaning and Effectiveness of Primary Health Care

The Alma Ata conference defined primary health care as “essential health care based on scientifically sound and socially acceptable methods and technology made universally acceptable to individuals 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 of in a spirit of self reliance and self determination” (WHO, 1978)²². It forms an integral part both of the country’s health system of which it is the nucleus and of the over all social and economic development of the community (WHO, 1979)²³.

There are different ways of defining primary health care. The 28th World Health Assembly accepted the working definition of primary health care. According to this definition, Primary health care is taken to mean “A health approach which integrates at the community level all the elements necessary to make an impact upon the state of health of the people.” Such an approach should be an integral part of the national health care system which includes preventive promotive curative and rehabilitative health measures and community development activities. (WHO, 1977)²⁴.

According to Coleking (1981)²⁵, “Primary Health Care is both a philosophy and a strategy”. Its philosophical merits derived from the principles it espouses, while its strategy consists of broad based activities within and beyond the health sector aimed at the improvement of health.

In the words of Segall (1983)²⁶ “Primary Health Care incorporates certain democratic principles such as community involvement, individual and collective responsibility for health and self reliance. These imply that implementation of health policy cannot be left to the mechanization of the state to formulate programs.

Abel Smith (1983)²⁷ while analyzing health care expenditure in terms of primary , secondary and tertiary levels stated that “Primary Health Care covers all health Variables that influence health such as education, nutrition, safe drinking water and sanitation.” A practical definition of primary health care was suggested which includes “All health care from the village or urban community level up to the health center or first line hospital.”

In the opinion of Biswanath Roy (1996)²⁸ Primary Health Care implies the development of socio economic condition which leads to general improvement of health: Primary health care is more social in nature than personnel. So the primary health care is basically a public good. Though primary health care strategy was introduced to provide acceptability and affordability to all, study observed that the goal of health for all is receding more distant and the poor is deprived of the basic health needs as earlier. Primary health care at the global institutional level should be the focal point to attain health for all.

2.3. Effectiveness of Primary Health Care at the National and Local Levels

There should be empirical regularities at both the national and local levels to make inferences regarding the impact of public spending on primary health to promote good health. It might seem odd that we do not review the literature evaluating primary health care .As one recent review of that literature highlights, however, the literature does not permit such an evaluation. Fox (1995)²⁹ analysed 87 articles published in four health journals (Health policy, Health Policy and Planning, International Journal of health Services, and social science and Medicines) that included the word “Primary Health care”stated that “While there are questions about parts of primary health care, there was no serious questioning in the literature of primary health care as a desirable way of Ministries of Health to spend their money. Most of the program evaluations or topic evaluations don’t show great technical expertise in evaluation methodology being applied to primary health care, but a fair number of articles discuss how such an evaluation would be done, or why it would be difficult.”

2.4. Comparison at the National Level

Cross national studies of health status have come to fair consensus on two points. First, socio economic characteristics explain nearly all of the variation in mortality rates across countries, (Filmer, *et al.* 1999). Second, total public spending on health has had much less impact on average health status than one could have hoped for. (Musgrave 1996).³⁰

Using instrumental variables to account for data and endogeneity problems, Filmer *et al.* (1999)³¹ found that public expenditure on health as a share of GDP is a small and statistically insignificant determinant of child mortality and the doubling of public spending from 3 to 6 % of GDP would improve mortality by only 9.13 %. Bidani and Ravallion (1997)³² show that public spending has a large impact on the health status of the poor, but they estimate the effect of public spending on aggregate health status (to the poor and non poor taken together) to be quite small. There are some exceptions to the above. Anand and Ravallion (1993)³³ stated that the very high correlation between average income and poverty explains that a country's average income explains most of the variations in health status.

An influential study (Preston 1980)³⁴, based on data from 1940 to 1970, emphasized the low explanatory power of socio economic variables. The cross national evidence has always been absent or ambivalent on whether health status is improved by a greater commitment to or greater spending on primary health care or both (Deon Filmer, *et al.*, 2000)³⁵. Kunstadter (1985)³⁶ participating at a seminar conference that affirmed support for primary health care on the basis of case studies of China, Costa Rica, Kerala and Sri Lanka committed: "The four

case studies involve societies in which low mortality has been reached without per capita income. Situations in which low income continues to be associated with high mortality were not considered, nor have searches systematically for other societies in which relevant social characteristics of the four successful cases are repeated, to see what happened to mortality. Thus policy prescriptions are weak.”

More over, although China’s bare foot doctors are famous, it is not obvious that their success can be attributed to a primary health care strategy- nor even that it was related to medical care. The largest decline in infant mortality occurred in the 1950s and the first half of the 1960s, before the introduction of the bare foot doctors in late 1965. Further, when the program was abandoned, health status did not deteriorate(Liu *et al.*, 1995)³⁷. These are weak evidence against primary health care. “We know of no published cross national evidence that lends support to primary health care” (Filmer *et al.*, 1998)³⁸.

2.5. Outcomes at the Local Level

A second empirical regularity that would support primary health care would be evidence that the availability of primary health care facilities or community health workers had a demonstrable impact on the local health status of individuals and communities. Frankenberg (1995)³⁹ by comparing randomly matched births from two different age cohorts in a village in Indonesia finds that the presence of a maternity clinic or a doctor reduced mortality but that the presence of a health worker other than a doctor reduced mortality but that the

presence of a health worker other than a doctor increased the probability of death.

Paris and Lillard (1994)⁴⁰ found that delivering a baby with in a health care institution in Malaysia reduced the probability that the baby would subsequently die. In Malaysia, Da Vanza (1984)⁴¹ found that the distance to medical care was related to infant mortality rate, but that low birth weight was correlated with the distance to care. Hammer *et al.* (1995)⁴² found that public medical facilities in Malaysia were unrelated to mortality, where as Hossain (1989)⁴³ reported that the pressure of a dispensary and family planning clinics lowered mortality in Bangladesh. Rosenzweig and Schultz (1982)⁴⁴ showed that rural health posts, municipal, public and private clinics dispensaries and mobile care units were not significantly related to child mortality in rural Colombia. In urban areas, hospitals, clinics and family planning centers tended to reduce mortality. Rosenzweig and Wolpin (1982)⁴⁵ used data from rural India to find that villages in a district with a family planning clinic and those with a dispensary were associated with lower child mortality but that villages with any other health facility (health centers, nursing homes etc,) were associated with higher mortality. The large National Family Health Survey of India showed no relation between health center or sub center and child mortality (World Bank, 1998)⁴⁶

Based on the empirical results Deon Filmer *et al.* (2000)⁴⁷ suggested that enhancing health out comes is not simply a matter of providing additional funds or increasing access to primary health care services and facilities. These provide two likely explanations for the negligible impact of public spending: First, the impact of primary health care provision depends on the effectiveness of the

service produced. The solution is an improvement in the quality of the services. Second, the impact of the service depends on individual choice and the market for health. Primary health care may have little impact on health status not because such case is unimportant but because, in practice, the efficacy of government health interventions may be low. Study argued that increase in public spending in primary health care are effective in improving aggregate measures of health status, while curative services at secondary and tertiary levels are not. This view can rationalize an increase in funds for primary health care as well as reallocation of the health budget toward primary health care activities.

Kenneth Lee and Annee Mills (1983)⁴⁸, based on a number of demonstrations stated that the provision of primary health care can do much to improve health, especially of mother and children. Yet the health services of most developing countries still concentrate their resources and efforts on hospitals which are not accessible for the majority of the population in rural areas and urban slums. Djukanovic and March (1975)⁴⁹ stated that primary health care aims to improve the basis of health, implying the distribution of resources to maintain health. This distributive aspect makes primary health care a profoundly political issue. The five case studies in India, Thailand, Jamaica, Sri Lanka indicate that primary health care strategy need to be combined to prevent the emergence of problems associated with the development strategies and life styles that foster conditions of ill health (WHO, 1984)⁵⁰. Santhosh Mehrotra and Richard Jolly (1997)⁵¹ by studying the experiences of ten developing countries that have achieved high health status with low income stated that these countries achieved major reductions in mortality of mother and children by focusing their primary health care activities on maternal and child health. If primary health care is properly focused on preventive and educative medicines, and if cases are

caught before they become serious, and if expanded services are brought closer to the people, primary health care will be superior to hospital care in three ways. It will reduce pain, it will reduce waiting and it will reduce cost. Panchamukhi ⁵² in her study concluded that emphasis in planning will have to be based on the provision of clean water supply, environmental sanitation, and at least the minimum of medical facilities in the villages of the backward health status, for there is a tendency for the available health facilities to concentrate these also in the urban areas. The role of the primary health center will have to be activated in this direction. According to the Ninth plan document (1997-2002)⁵³, two important areas which need closer scrutiny in a perspective on health are its approach to primary health care and to disease control program. The existing primary health care institution, according to the document are functioning sub-optimally because of inappropriate location, poor access, lack of maintenance, lack of funds, drugs etc. The primary health care units have been in a shamble as revealed in the plan document.

Finding of a study about leptospirosis epidemic in Gujarat by Purendra Prasad (2000)⁵⁴ showed that strategies and efforts undertaken by the government to fight against epidemics were directed towards curative rather than preventive which led to the failure of the health delivery system at different levels. Reputation of primary health centers and community health centers was at the lowest ebb. Efforts should be made to improve the health services in all the government institution rather than attempt a few changes here and there during epidemics. Alan Ghosh (1996)⁵⁵ stated that practically no drugs are available in any one of the lakhs of primary health centers which have been set up by the government over the years. There is thus an infrastructure lying unused merely because of the sharp cut back in public expenditure on health.

2.6. Socio Economic Development and Health Status

Improvement in the health status of people requires an integrated approach to deal with various socio economic problems like poverty, unemployment, illiteracy and ill health. Isolated attempt at dealing with any one of these problems are not likely to be very fruitful (Narayanan, 1997)⁵⁶.

Since the beginning of the eighteenth century, a crucial factor in mortality decline in Europe was improvement in the supply of food and diet (United Nations, 1975)⁵⁷. Further decline in the mortality rate after the middle of the nineteenth century was contributed significantly by sanitary reforms and public health movements (McKeown and Record, 1962)⁵⁸. Looking at the infant mortality decline experienced by Stonlnitz (1965)⁵⁹ considered socio economic factors of lesser importance than public health measures and health facilities. Preston (1975)⁶⁰ attempted to prove that 9% of the mortality decline was caused by the socio economic development, as reflected in the changes in nutrition, water system, housing and sanitation. The decline in the prevalence of other disease was ascribed to the public health measures, consisting of immunization and vector control measures. Debabar Banerjee (2001)⁶¹ stated that relatively recent improvement in the health status of people in countries like Japan, South Korea, Taiwan, Hong Kong and Singapore can be attributed more to socio economic development than to specific actions of the health service systems. Implementation of health for all is a complex process involving socio cultural political, economic and technological process.

The main focus of development versus public health debate is however centered around the so- called paradox of high status of health at a relatively low

level of development in Sri Lanka and Kerala. In Sri Lanka, mortality decline after the second world war, was attributed exclusively to the public health programs in general and the malaria eradication program in particular (Magg, 1967⁶²).

Similarly improvement in the health status of Kerala is generally attributed to the widespread network of health care system in rural areas and its higher utilization rate and/or the public health programs undertaken by the state (Narayanan, 1997)⁶³. Nair (1974)⁶⁴, suggested that the extension of primary health centers and public health measures in the state led to the decline in infant and child mortality rates in the 1950s and subsequently to fertility decline in 1960s.

On the other hand, Panikar (1975)⁶⁵, pointed out that mortality rates had already declined substantially prior to the 1950s and proposed that main factors behind the mortality decline in Kerala were the high priority given to preventive and promotive measures in the health care system, female literacy, better utilization of health care services and the success of public health measures which were introduced on a large scale by the princely States of Cochin and Travancore. He argued that the relative contribution of modern health facilities was small.

A United Nations (1975)⁶⁶ study on Kerala's health development concludes that "..... the achievement of Kerala in lowering mortality rate and rising life expectancy to almost the levels of more developed countries must be attributed largely to the widespread net work of health services and the scales on which they are used.

An all encompassing hypothesis was provided by Ratcliff (1977)⁶⁷ who saw changes in Kerala's demography as a result of broader socio- economic and political development. Paniker and Soman (1984)⁶⁸, laid equal emphasis on public health and medical care services. While the first phase of health status improvement was attributed to preventive health measures against infectious diseases, in the second phase, the stress was on the expansion of medical care system with low rural urban disparities and small size of the catchment areas. They recognized the contribution of land reforms, public distribution system, literacy and housing to the reduction in socio- economic inequalities and better utilization of health care services but attributed health improvement mainly to the health care services. The role of social factors in Kerala's mortality and fertility decline is highlighted in Nag's comparison of that state with West Bengal (Moni Nag, 1983)⁶⁹. Nag drew attention to the early introduction of public health measures, including sanitation and immunization in Travancore-Cochin during the nineteenth century and to the absence of such measure in West Bengal. Nag attributed the high health status to the social development in terms of wider distribution of health care services in the rural areas and their greater utilization, better transportation facilities, higher living especially among women and political awareness all resulting from the public policy.

Zachariah and Patel (1983)⁷⁰ compared infant mortality in three districts of Kerala and found that infant survival was mostly influenced by mother's education. Kabir and Krishnan (1992)⁷¹ analysed the social, institutional and economic forces that aided the health transition in Kerala, role of government in initiating and sustaining these processes and the lessons they provide for other states. Based on various studies it has been proved the critical role of the government in providing access to health and the importance of social and

political changes in bringing about the health transition in Kerala. Another major indirect finding is the importance of preventive and public health measures in reducing morbidity and mortality. Krishnan (1976)⁷² found literacy an important variable for explaining interstate differences in mortality rate in 11 state of the country. Again, while he found literacy to be the most significant factor, the health service ratios also had some explanatory power. On the other hand, health expenditure was not a particularly significant explanatory power. Again Krishnan (1976) showed that infant mortality rate of different regions of Kerala were positively correlated with the size of the “catchment area” of health centers. These approaches concluded that economic development is the means to reduce mortality and improve health and the resources spent on health measures are wasted resources and they should be channeled into development from which health will automatically ensue. Dreeze and Sen (1995)⁷³ states that the political consciousness of the people to demand what they are entitled to, had the effect of making health care much more rapidly available for the poor in Kerala. This account is in sharp contrast with the corresponding state of affairs in UP where widespread absenteeism of government doctors is passively accepted as a normal state of affairs. The role of social and political factors in generating the effective performance of government agencies in Kerala is well described in Heller (1996)⁷⁴. Earlier, Cald Well (1986)⁷⁵ described instances in which Kerala’s held health workers accountable through armed means.

Ramankutty and Paniker (1995)⁷⁶ conducted an in depth study on the pattern and intensity of the reaction of the government health sector in Kerala to the current fiscal crisis. This study reports that public sector health services played an important role to have an exemplary health status attained by Kerala in the early period. But of late, the importance of public sector in the health

services in the state has waned greatly due to fiscal crisis. Performance of the health sector is directly dependent upon the state of its finances

2.7. Problems and Policy Perspectives

Amar Jesani (2002)⁷⁷ in his study on 'social objectives of health care services regulating the private sector' had stated that since all the eight elements embodied in the primary health care cannot be provided at a time due to resource constraints, prioritization of elements are needed. Based on previous experience author suggest that minimum health services that should be provided to all will include 1. Maternal and Child Health, 2. Immunization, 3. Treatment of common illness and 4. Provision of essential drugs.

As per this study, quantitative development rather than qualitative development is to be given preference. Study concluded that it is better to have lower quality care for every one and upgrade it gradually than to set up pockets of high technology hospital based on curative services inaccessible to the vast majority of people. Study conducted by Zacharia, Nair, and Irudaya Rajan indicate that more than 70 % of women in Kerala are protected by various family planning methods and among 80 % of them are sterilized. Since Kerala has reached below replacement level of fertility, role of family planning in the state in the near future is insignificant. In this ground, the government can divert money from family planning to social security. Some important issues related to health policy revealed that interventions in the health sector may have to focus on the preventive aspect of health care especially in the areas of safe drinking water and provision of sanitary facilities. (Kannan *et al.*, 1991)⁷⁸. Sen and Dreeze (1995)⁷⁹ have noted massive displacement of health care activities by family planning programs. While family planning programs are definitely

important, it should never be at the cost of general health care particularly where the general health care help a lot in progress towards family planning (Biswanath Roy, 1996).⁸⁰

Santhosh Mehrotra and Richard Jolly (1997)⁸¹ presented retrospective studies of ten developing countries that managed to exceed the scope and pace of social achievement of the majority of other developing countries, many of their social indicators being comparable with those of industrialized countries. The study concludes that it is possible to achieve a high level economy, if the government sector sets the right priority. Blerman (1998)⁸², in his study 'Rethinking health care system' stated that service priorities such as family planning under public delivery system reduced real access to other services and popular perceptions of quality. Kunnikannan and Aravindan (2000)⁸³, critically analysed the achievement and future prospects of the most discussed Kerala Model of health development and has revealed that major proportion of resources allotted for health sector are spent on family planning, but not as per the requirements of the community. His study points out the need for developing and prospering the working of primary health care in these areas so as to promote the efficiency of public health sector. According to Sucha Singh Gill (2000)⁸⁴, prioritizing rural health care in the state policy by allocating additional investment for sanitary infrastructure and medical personnel in rural areas is essential for redressing the growing disparity in health care facilities between rural and urban Punjab.

Imrana Quadeer (2002)⁸⁵, stated that the network of primary health health centers do not provide comprehensive primary health care but only family planning service, selected immunization service and selected disease

surveillance. Various studies have observed that family planning and more recently immunisation get only a large share of public resources but also take a disproportionately large share of health worker's effective work time. Ravi Duggal (2002)⁸⁶, observed that re-organising resource allocation in a meaningful way is only the first step to improve the health status of population.

2.8. Public Vs Private : Need for Government Intervention

Although health is recognised as fundamental human right, the responsibility of state in providing health care services are grossly neglected in many of the world countries (Subramanian, 1997)⁸⁷, Jowet (1990)⁸⁸ suggested that government health spending is being increasingly substituted by private spending even where economies are growing. No program of social service can be effective without public support and co- operation. This is perhaps more true in case of health services and also the sanitation and cleanliness program may fail to yield desired results for want of public support and co- operation.

Usha Banerjee (1970)⁸⁹ stated that, in the absence of public financing, there will not be a socially optimum supply of hospital. Ramamani Sunder (1992)⁹⁰, conducted a household survey of health care utilization and expenditure in India in 1993. The results of the survey revealed that the people's dependence on public health facilities is higher for natal, intra natal and preventive care. More than 60 % of the deliveries in both rural and urban areas have taken place in the government health facilities. Dileep (2002)⁹¹, in his paper on 'Reproductive and Child Health Care Service' attempted to understand the role of private sector in providing reproductive and child health care service in India. Study concluded that majority of services that come under the

reproductive and child health care is relatively cheaper, which in most cases do not involve hospitalization. Therefore, at a policy level, the public sector should consider the potential of private sector in delivering reproductive and child health services at least in places where knowledge and use of these services have been universal.

Brain Abel Smith (1999)⁹², in his study about how to improve health in a cost effective and politically acceptable way stated that private sector is the long term answer to the provision of health care since public services are bound to be inefficient, bureaucratic and impersonal. Because the private sector has to respond to market forces, it will be more efficient and user friendly. But in many countries, private sector is generally regarded by the public sector as a dangerous predator, robbing the public sector of trained workers, distracting doctors by its higher earnings from their main work which ought to be in the public sector.

NSSO (1998)⁹³, stated that rise in the role of private sector providers is expected to decrease burden on the government. The profit oriented private sector is not only a major contributor of both inpatient and out patient care services, but their perception in the delivery of health services in India is showing an increasing trend as well. Based on the experiences from different states, Nair *et al.* (1999)⁹⁴, stated that even though rise in the role of the private sector in family planning services is not a pre- requisite for the fertility decline, it can relieve the public sector from the burden of reproductive and child health care. Pillai (1999)⁹⁵, traced out the development of Kerala economy from 1951-1991 and investigates into the role of 'Kerala Model'. According to him, the role played by the private sector in the medicare system is quite significant and its

contribution to Kerala's health status is much more than that of the government sector. While looking for explanations for the high level health status of the state, usually the big role played by the private sector in this area does not get recognized. Krishnan (1999)⁹⁶, in his study stated that private sector has played a major role in the health care delivery since 1975 in Kerala. Provision of financial incentives for the private sector to establish and operate educational institutions played an important role to reduce the disparity and to promote health. Immunisation survey indicates that nearly 1/3rd of the total number of child immunisation and over half the number of TT immunization was given by the private physician in 1991. Ravi Duggal (2002)⁹⁷, stated that private sector cannot be left to its own means and ways. It needs to be integrated under a common umbrella along with the public health system. Based on the world wide experience, author concludes that to attain universal access to health, an organized public private mix health care system has to evolve.

According to Mavalankar (1996)⁹⁸, Quality of service is a major factor that influences the client in choosing a health care provider. Researches in family planning services assume that women may be preferring the private sector because of superior quality of services when compared to the public sector. Kannan *et al.* (1991)⁹⁹, stated that public health care institutions have played a crucial role in the health care in the early decades but since 1980's there has been rapid expansion in the health care facilities in the private sector. Low rate of utilization of public health care even among the poor shows poor performance of public health institutions and the preventive health care aspects in the public institutions does not seem to get the attention they warranted.

Irudaya Rajan (1995)¹⁰⁰, in his study on major issues in the health status of Kerala pointed out that utilization as well as the development of private sector has become a vital factor in Kerala especially in 1980s. Another amazing finding is the utilization of private institutions by the socio-economically poor sections of the population which indicate the health consciousness among Keralites and the poor performance of public health care institutions. United Nations (1992)¹⁰¹, while analyzing ageing problems of Kerala and its implications for policy making showed that employment opportunities for physicians in the government sector may not increase proportionately with the increase in number of physician. Many doctors may have to look for employment in the private sector. This may widen the already existing gap in perceived quality of care between the government and private sector, with the government facilities seen to over crowded and under staffed compared to private hospitals.

Ravi Duggal (2002)¹⁰², in a critical study on draft national health policy of 2000 emphasised high correlation between decline in the share of public sector utilization and the reduction seen in expenditure on the non salary components of health budgets. He concluded that in order to increase rate of utilization of public health facilities from current level of less than 20%, expenditure on non- salary components of the health budget is to be increased.

References

1. Park K. (2002). "*Preventive and Social Medicine*". Seventeenth edition. M/S Banarsidas Bhanot Publishers.
2. Goel, S.L. (1984). "*Public Health Administration*". Sterling Publishers. Pvt Ltd.
3. Alancark (1999). "*Evaluation Research: An Introduction to Principles, Methods and Practices*". Sage Publication
4. WHO (1978). "*Alma-Ata 1978. Primary Health Care: Health For All*". Sr. No; 1. World Health Organisation. Geneva
5. Deon Filmer, Jeffrey S.H. and Lant H.P. (2000). "Weak Links in The Chain A Diagnosis of Health Policy in Poor countries". *Research Observer* Vol. 15.
6. Government of India (1951). "*First Five Year Plan*"; Government of India: Planning Commission. New Delhi. P.488.
7. WHO (1957). Tech: Report Series No; 37. World Health Organisation. Geneva.
8. Seal, S.C. (1963). "Presidential Address: 50th Science Congress". In: S.L Goel (1984). *Public Health Administration*. Sterling Publishers. Pvt Ltd.
9. Dubos, R. (1968). "*Man, Medicine and Environment*". Harmondsworth, Pelican.
10. WHO. (1978). *Op. cit.*
11. Berthet (1979). "*World Health*". May 1979 WHO Geneva. p.23.
12. Ahmed and Coelho (1979). "*Toward a New Definition of Health*". Pleum. New York.

13. Goel, S.L. (1984). *Op. cit.*
14. WHO 1986. "*Evaluation of the strategy for Health for All*". *Seventh Report, World Health Situation*. Vol: 4. WHO. SEARO.
15. Angela Scriven (1989). Angela Scriven and Judy Orme (ed) (1989): "*Health Promotion: Professional Perspectives*", Open University. Macmillan.
16. Hema *et al.* (1993). "Health and Human Resource Development": *Economic and Political Weekly*. Vol. XXV111. No; 43. p-2328.
17. Agnihotri (1998). "*Random Thoughts on Safe Motherhood*". *Health Education in South East Asia.*, Vol: X111. No. 293. April-July. P-29.
18. Park. (2002). *Op. cit.*
19. Rexford, E.S. and Stephen, P.N. (2000). "*Health Economics: Theories, Insights and Industry Studies*". Dryden Press.
20. Gross Man. (1972). "*The Demand for Health: A Theoretical and Empirical investigation*". National Bureau of Economic research. New York.
21. Bowling (1991). "*Measuring health, A review of quality of life measurement scale*". Milton Keynes, Open University
22. WHO (1978). *Op. cit.*
23. WHO (1979). "*World Health: Primary Health Care*". World Health Organisation. Geneva. May. 1979. p-6.
24. WHO (1977). SEARO 30th September p-38 world Health organization Geneva.
25. Coleking (1981). "*Primary Health Care: A look at its Current Meanin*"g. Mimeo Publication.

26. Segall, M.M. (1983). "Planning and Policies of resource Allocation for Primary Health care: Promotion of Meaningful National Policy". *Social science and Medicines*. Vol; XV11. p.1947-1960.
27. Brain Abel Smith (1999): "*An Introduction to Health: Policy, Planning and Financing*". Longman, Newyork.
28. Biswanath Roy. (1996). "*Welfare, Choice and Development: Essays*". In: Honor of Amartyasen. Kanishka Publishers. New Delhi
29. Fox (1995). "*Primary Health Care: Notes on the literature and Annotated Bibiliography*". Paper Prepared for the World Bank, Latin America and Human Development Group. Washington, D.C. Publication.
30. Mus Grave. Philip (1996). "*Public and Private Roles in Health: Theory and Financing pattern*". World Bank Discussion Paper No: 339. Washington D.C.
31. Deon Filmer, Jeffrey S. Hammer, Lant H. Pritchett (1999). "The impact of Public Spending on Health: does it Matter?" *Social Science and Medicines*. Vol: 49. No. 1. p.1309-23.
32. Bidani and Ravillion. (1997). "Decomposing Social Indicators Using Distributional Data". *Journal of Econometrics*. Vol; 77,p-125-139.
33. Anand and Ravillion. (1993). "Human Development in Poor Countries. *Journal of Economic Perspectives*". Vol.V11. No; 1. p-133-150.
34. Preston, Samuel. H. (1980). "*Causes and Consequences of Mortality Decline in Less Developed Countries during the twentieth Century*". In: Richard Easterlin (ed). Population and Economic Change in Developing Countries. University of Chicago Press for the National Bureau of Economic Research.

35. Deon Filmer, Jeffrey, S. Hammer, Lant, H. Pritchett (2000). *Op. cit.*
36. Kunstadter, Peter (1985). "Remarks". *In*: Scott B. Halstead, Kenneth. S. Warren, (ed) *Good Health at Low Cost* New York: Rockefeller Foundation.
37. Lieten G.K. (1977). "Land Reforms. Failure Even in Kerala". *EPW* Vol; X11.March 9 p-415
38. Filmer *et al.* (1998). "*Health Policy in Poor Countries. Weak Links in the chain*". Policy Research Working Paper No: 1874. World Bank Development Research Group, Washington D.C. Processed.
39. Frankenberg, Elizabeth (1995). "The Effects of Access to Health care on Infant Mortality in Indonesia". *Health Transition Review*, 5, p-143-63.
40. Paris W.A and Leo. A. Lillard (1994). "Health Inputs and Child Mortality in Malasia. *Journal of Health economics*". Vol. 13 No: 4. p-455-89.
41. Da, Vanza, Julie (1984). "A household survey of Child Mortality Determinants in Malasia". *Population and Development Review*. 10. p-307-23.
42. Hammer, Jeffrey, S. Ijuz Nabi, and James Cercone. (1995). "Distributional Effects of Social Sector Expenditures in Malasia. 1974-1989". *In*: Dominique van de Walle and Kimberly Neads (eds). *Public Spending and the poor: Theory and Evidence*. Johns Hopkins University Press.
43. Hossain Shaik. (1989). "Effects of Public Program on family size and Child Education on Health". *Journal of Development Economics*. Vol. 30 No; 1. 144-58.

44. Rosenzweig Mark and P. Sschultz. (1982). "Child Mortality and fertility in Colombia. Individual and Community effects". Health Plicy and Education. Vol 2. p.305-48.
45. Rosenzweig Mark and Kenneth and Wolpin (1982). "Government Intervention and Household Behavior in a Developing Country: Anticipating the unanticipated Consequences of Social Programs" *Journal of Development Economics*. Vol: 10. p- 209-225.
46. World Bank (1998). "*Reducing Poverty in India. Options for More Effective Public Services*". *World Bank Country Study*. Washington D.C.
47. Deon Filmer, Jeffrey S. Hammer, Lant H. Pritchett (2000). *Op. cit.*
48. Kenneth Lee and Annee Mills (1985): "*The Economics of Health in Developing Countries*". New York: Torondo: Oxford University Press.
49. Djukanovic, V. and March, E.P. (1975). "*Alternative Approaches to Meeting Basic Health Needs in Developing Countries*". World Health Organisation, Geneva. UNICEF.
50. WHO (1984). "*Intersectoral Action for Health; A Conceptual frame Work*. Part II". WHO Offset Publications No: 8.
51. Santhosh Mehrotra and Richard Jolly (ed) (1997). "*Development with a Human Face: Experiences in Social Achievement and Economic Growth*". Clarendon Press. Oxford.
52. Panchammukhi, P.R. "*Economics of Health: A Trend Report. A Survey of Research Economics*". Vol. Six. A Project Sponsored by the Indian Council of Social Sciences Research. New Delhi. Allied Publisher Private Ltd.

53. Ninth Plan 1997-2002. Government of India. Vol. 11. Planning Commission. New Delhi.
54. Purendra Prasad (2000). "Health Care Access and Marginalised Social Space. Leptospirosis in south Gujarat". *Economic and Political Weekly*. Oct. 7. p-3688.
55. Alan Ghosh. (1996). "Health Care and Globalisation: A case for a Selective Approach". *Economic and Political Weekly*. Feb.24.
56. Narayanan. K.V. (1997). "*Health and Development: Intersectoral Linkages*". Rawat Publications .New Delhi
57. United Nation's (1975). "*Poverty, Unemployment and Development Policy: A case study of Selected issues With Reference to Kerala*", UN New York.
58. Mc Keown, Brown and Record (1972). "*An Interpretation of the Modern Rise of Population in Europe*". *Population studies*. Vol: 26, No; 3. p-345-82.
59. Stonlnitz, G. J. (1565). "*A century of Mortality Trend-1*". *Population studies*. Vol: 9, p-24-35.
60. Prestion (1975). *Op. cit.*
61. Debabar Banerji (2001). "*Sociology and Politics of Health for All*". Bharatiya Samajik Chintan Volume XXIV No.1-4 p- 26
62. Magm (1967). "Determinants and Consequences of Mortality Trends in Ceylon". Public Health Report. Vol: 76.
63. Narayanan, K.V. (1997). "*Health and Development: Intersectoral Linkages*". Rawat Publications .New Delhi

64. Nair, P.R.G. (1974). "Decline in Birth Rate in Kerala: A hypothesis about the Inter-relation ship between Demographic Variables, Health Services and Education". *Economic and Political Weekly*. Vol: IX No; 6, 7 & 8. p.323-336.
65. Panikar P.G.K. (1975). "Fall in Mortality in Kerala: An Explanatory Hypothesis". *Economic and Political Weekly*, No.47. p .1811.
66. United Nation's (1975). *Op. cit.*
67. Ratcliff, E.J. (1977). "*Poverty, Policies and Fertility: The anomaly of Kerala*". Hastings Center Report.
68. Panikar, P.G.K. and Soman. (1984). "*Health Status of Kerala: Paradox of Economic Backwardness and Health Development*". Center for Development Studies Thiruvananthapuram
69. Moni Nag (1983). "Impact of Social and Economic Development on mortality: Comparative Study of Kerala and West Bengal". *Economic and Political Weekly*. Vol: Xx V111. No: 19. 20 & 21. p.877-900.
70. Zacharia K.C. and Patel. S. (1983). "Trends and Determinants of Infant and Child Mortality in Kerala". Discussion Paper No: 82. Washington D. C. World Bank.
71. Kabir, M. and Krishnan, T.N. (1992). "*Health and Development in India Social Intermediation and Health Transition. Lessons from Kerala*". Jan; 2-4. Center For population and Development Studies. .
72. Krishnan, T.N. (1976). "Demographic Transition in Kerala Facts and factors". *Economic and Political Weekly*. Vol: X1. No: 31/33 p-1203.
73. Dreze, Jean and Amartya Sen (1995). "*India: Economic Development and Social Opportunity*", Oxford University Press. New Delhi.

74. Heller, Patrick (1996). "Social Capital as a Product of Class Mobilisation and State Intervention: Industrial Workers in Kerala, India". *World Development*, Vol. 24 (4): p.1055.
75. Caldwell (1986). "Route to Low Mortality in Poor Countries". *Population and Development Review*. Vol: 12. P-171-220.
76. Ramankutty and Panikar, P.G.K. (1995). "*Impact of Fiscal Crisis on Public Sector Health Care system in Kerala*". A Research Report. Achuta Menon Center for Health science studies.
77. Amar Jesani (2002). "*Social Objectives of health care services regulating the private sector*". In: Seetha Prabhu and Sudarshan R. (ed). *Poverty, Nutrition Health and Education*. Social Science Press New Delhi.
78. Kannan, K.P., Thankappan, K.R., Ramankutty, V. and Aravindan, K.P. (1991). "*Health and Development in Rural Kerala: A Study of the Linkages between Socio- Economic Status and Health Status*". Integrated Rural Technology Center of The Kerala Sastra Sahitya Parishad.
79. Dreze, Jean and Amartya Sen (1995): *Op. cit.*
80. Biswanath Roy (1996). *Op. cit.*
81. Santhosh Mehrotra and Richard Jolly (ed) (1997). *Op. cit.*
82. Peter A. Blerman (1998). "Rethinking Health Care System: Private Health Care System in Kerala". *World Development*. Vol: 26. No: 8. p-1463-79.
83. Kunnikannan, T.P. and Aravindan, K.P. (2000). "*Changes in Health Status of Kerala 1987-1997*". Discussion Paper No. 20 Kerala Research Program on Local Level Development. Center for Development Studies. Thiruvananthapuram

84. Sucha Singh Gill, and Ranjith Singh Guhman (2000). "*Rural Health: Proactive Role for the State*". *Economic and Political Weekly*, Dec: 16. p.4474.
85. Imrana Qadeer. (2002). "Debt Payment and Devaluing Elements of Public Health; Draft National Health Policy 2001-1". Commentary. *Economic and Political Weekly*. January 5 p-12
86. Ravi Duggal. (2002). "Resource Generation without Planned Allocation. Draft National Health Policy. 2001-11". *Economic and Political Weekly*. January 5 p-116
87. Subrahmanian. V. (1997). "Quality of Care at Community Hospital". *Economic and Political Weekly*. Sep. 13. p-1997.
88. Jowet, M. (1990). "*Health Resources*". In: WHO. Evaluation of the Implementation of the Global Strategy for Health for All By 2000 A.D. Geneva. World Health Organisation. .
89. Usha Banerjee (1970). "*Health administration in a Metropolis*". Abhinav Publications New Delhi.
90. Ramamani Sundar (1992). "Household Survey of Health and Utilisation and Expenditure". Working Paper 53. NCAER New Delhi.
91. Dilip, T.R. (2000): "Utilization of Reproductive and Child Health Care Services. Some observations from Kerala". *Journal of Health Management*.
92. Brain Abel Smith (1999): *Op. cit.*
93. National Sample Survey Organisation. (1998). "Morbidity and Treatment of Ailments". Report No. 441. NSSO New Delhi.

94. Nair, P.S. *et al.* (1999). "*Factors Affecting Sources of family Planning in India. National Family Health Survey. Report No: 12*". Mumbai. International Institute for Population Sciences: East West Center.
95. Pillai, P.P. (1999). "*Kerala economy: Four Decades of Development*". Institute Planning and Applied Economic Research. John Mathai Foundation University of Calicut.
96. Krishnan, T.N. (1999). "*Access to Health and Burden of Treatment in India: An Inter-State Comparison*". In: Rao Mohan (ed). *Disinvesting in Health: The World bank's Prescription for Health*. Sage Publication p-212-30.
97. Ravi Duggal (2002). *Op. cit.*
98. Mavalankar. D. (1996). "*Quality of Family Welfare Program in India: An Over View of Public and Private Sector*". Population Council New Delhi.
99. RamanKutty, V. and Aravindan, K.P. (1991): "*Health and Development in Rural Kerala: A Study of the Linkages between Socio- Economic Status and Health Status*". Integrated Rural Technology Center of The Kerala Sastra Sahitya Parishad.
100. Irudaya Rajan, S. and Mohana Chandran, P. (1995). "Infant Mortality Estimates Part 1". *Economic and Political Weekly*. Vol: XXX111. No: 19. P-1120.
101. United Nations (1992). "Economic and Social Aspects of Population Ageing in Kerala". United Nations.
102. Ravi Duggal (2002). *Op. cit.*