ISSUES OF ACCESSIBILITY IN PRIMARY HEALTH CARE:

STUDY OF A RURAL HEALTH CENTRE IN PATANCHERU (A.P.)

A Thesis submitted to the University of Hyderabad for the Degree of Master of Philosophy in the School of Social Sciences

BY

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2002

CERTIFICATE

This is to certify that *Ms Madhumita Biswal* worked under my supervision for the degree of master of philosophy in Sociology. Her dissertation entitled *Issues of Accessibility in Primary Health Care: Study of A Rural Health Center in Patancheru (A.P)* is her own work at the University of Hyderabad, and has not been submitted for a degree or diploma elsewhere.

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DECLARATION

I hereby declare that the dissertation entitled *Issues of Accessibility in PrimaryHealth Care: Study of A Rural Health Centre in Patancheru*, is supervised by Dr.N Purendra Prasad, is my original work in the Department of Sociology, University of Hyderabad, and has not been submitted for a degree or diploma or for publication elsewhere.

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ACKNOWLEDGEMENT

I am grateful to Dr Purendra Prasad, my research supervisor for his help, guidance and moral support throughout my dissertation.

I am thankful to all the teachers and office staff of Department of Sociology for their help.

I thank all my respondents for sharing their experiences with me.

I thank the staff of Rural Health Centre, Patancheru and Ghanpur sub centre for their timely help.

I thank staff of NIRD library, IHS and CESS library for allowing me access to their library.

I am thankful to Saswati and Smriti for patiently proofreading my thesis.

I am thankful to all my friends whose constant help enabled me to complete my work.

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Introduction

Social well-being of individuals and communities is the central concern of one and all. At the World Health Assembly in 1977, it was unanimously decided that the main social target of member governments and the World Health Organization (WHO) in the succeeding decades should be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (Basch, 1990). This is clearly enunciated in the goal of "*health for all by the year 2000AD* ". Alma Ata Declaration of 1978 stated that the key to attaining health for all by 2000 is primary health care. India was a signatory to Alma Ata declaration and it pledged its implementation and committed to achieve *health for all* by the year 2000 AD. The National health policy of 1983 also accepted primary health care as main instrument to achieve "*health for all by 2000 AD*". A network of health institutions were set up supposedly to ensure that health services are accessible to the people, available on a continual basis, socially and culturally acceptable and affordable by most of the communities.

Although the year 2000 has already been crossed, *health for all* has not been achieved. It has remained a utopian vision for India, as well as for most of the developing world. Even though the primary health care concept was

established in India thirty years before the Alma Ata declaration, *health for all* remains still an unfinished agenda. Despite the fact that India's national health policy of 1983 was based on primary health care approach, the grand ideas of Alma Ata never became a reality. Though statistics show that the life expectancy at birth has increased all over the world, and particularly in India it has increased from 38.7 years in 1950-55 to 60.5 years in 1990-95, the majority people, however lack the basic health services as well as the basic necessities of life. UNDP in its 1998 human development report (cit in Frambrose, 1999) says that 840 million people in the Third world suffer from malnutrition; 43% people in the world are living below poverty line; this means 400 million people cannot afford two square meals a day. As Garret (2002) points out that in 1997, more than 200 million Indians went to bed hungry every night, officially malnourished, including half of the country's children. So it remains the fact that longevity without quality is a priceless gift. Then the question arises, those people who cannot even afford two decent meals a day, can we expect them to spend on health care services? Is the state obliged to spend on the health care of the poor?

India's first ever-national health policy of 1983 was based on primary health care approach of Alma Ata, however techno-centric approaches dominated the scene. After India's acceptance of World Bank imposed structural adjustment programmes (SAP), investment in the social sector has been drastically curtailed, of which health sector has had an immediate effect.

And the effect of SAP on the poor is direct and subtle. The international agencies, by dictating the policies of the government, have imposed the vertical programmes. But these vertical programmes which treat the diseases as single units, are not going to address the problem as long as the root cause of diseases i.e. poverty has not been taken into consideration. Frambrose (1999) has rightly pointed out:

> "The Directorate General of Health Services has devised a strategy to monitor, dictate and treat malaria. Monitoring is the function of medical officers of primary health centres. But there is hardly any medical officer in health functionaries in states like Bihar, Rajasthan and Orissa. So the government has initiated a new scheme called the enhanced malaria control project with assistance from World Bank. Under this scheme it is proposed to supply biocides, synthetic pyrethroides and medicated bed net. In these areas the population that does not have enough to eat and drink, are required to use bed nets. Then the question arises what happens when they are outside the bed? The history of malaria in India has consistently revealed the relationship between nutritional status and malaria deaths."

As is evident, vertical programmes are intended to treat only the diseases and not persons. It is quite possible that people who might have benefited from certain vertical programmes would fall prey to other diseases due to the poor environmental condition in which they are forced to live. Even if a particular disease is controlled for the time being, one can not rule out that some other diseases owing to poor nutrition will not occur, considering the fact that poverty gives rise to a chain of diseases. It is

certainly a 'no-end' task to treat the diseases one by one. It appears that the WHO World Health Report 1995 has acknowledged this fact, which saw the inclusion of a new category of disease called Z.59.5 in the international classification of diseases. Z.59.5 stands for "extreme poverty". By its own estimate, 170 million children in the world are suffering from malnutrition. It implies that by immunization alone, it is not possible for children to be free from diseases until and unless they are free from poverty. It is necessary to address the causes of disease rather than only the disease.

Various studies (NSS,1996, Duggal and Amin, 1989, George et al, 1992, Kannan et al, 1991) show that private health sector accounts for over 70 percent of all primary care treatment in India. This is not a healthy sign for a country where over two thirds of population live either at or below subsistence level. This fact provokes one to ask series of questions: while the poor does not have enough material resources to survive, why is he/she spending on private treatment for primary health care? Why does the government sponsored health service become inaccessible for the poor? And what are the factors responsible for this inaccessibility of health service?

At this point of time it is necessary to reexamine the primary health care approach and its applicability in the third world context where the diseases are assuming more prominence than the persons and their well being; also where holistic approach has given way to fragmented and selective

approaches. By taking the above factors into consideration, following objectives have been formulated.

Objectives of Study:

- To understand the concept of health, more particularly primary health care in its changing context and assess it within the framework of development.
- To analyse the issues of accessibility in primary health care for the rural communities.

Following methodology has been adopted in conducting the study to meet the specific objectives.

Methodology:

In order to assess the issues of accessibility in primary health care for the rural poor, more particularly in an empirical situation, I focused on one institutional setting, i.e. a Rural health centre which is supposed to be catering to the needs of rural communities. I chose an institutional setting because it provided an opportunity for me to observe the delivery of health care services where health care providers and receivers directly interact. Also the fact that institutional setting is supposed to cater to the health needs of community irrespective of their caste, class, gender and region.

Keeping this in mind I chose a Rural health centre (one of the model health centres in India), which is situated in Patancheru, about 30 kilometers from Hyderabad city. There are three sub centres under this Rural health centre i.e. Ismail Khanpet, Ghanpur and Chitkul. The study was conducted during one-month period, October to November 2002. Data was collected from the main Rural health centre and two of its sub centres, i.e. Ghanpur and Chitkul. For the study of Rural health centre and Ghanpur sub centre data was collected through both primary as well as secondary sources, while for the study of Chitkul sub centre data was collected only through secondary sources.

Techniques of data collection include: Unstructured Interviews, Observation, and Informal Group Discussion. Interviews were conducted randomly with 15 health personnel belonging to the main Rural health centre and Ghanpur sub centre. Interviews were also conducted randomly with 27 people who came to Rural health centre for treatment. Data on Rural health centre and its sub centres were also collected through secondary sources such as official documents.

Limitations of the Study:

One of the shortcomings in my study was limited interaction with the communities as well as medical and paramedical staff, to be able to probe into

several issues related to delivery of primary health care services. I did not know Telugu, hence communication with the communities was also not elaborate as desired. Time factor was also a limiting factor in my study. Within a very short period it was not possible for me to deal with some of the pertinent aspects including caste which would have thrown deeper insights.

Chapterization:

In the second chapter I made an attempt to delineate the concept of 'health' and 'health care' through available literature. Then by addressing health as a basic right, I tried to examine how it is an obligation of the state to provide health care, particularly in the third world context. By situating health within the framework of development, I argued that health cannot be achieved only through economic development, but social factors play an important role for over all development of health. Hence an effort was made to find whether a comprehensive approach to development has been addressed in primary health care approach or not in this chapter.

In the third chapter I looked at the primary health care concept, particularly the social and economic background in which the concept emerged. Then how the primary health care concept did not make inroads into the lives of the poor and subsequently how selective primary health care approach was introduced has been analysed. Also how in 80s due to global

economic recession and structural adjustment programme, the social sector investment shrunk which made it difficult for, the primary health care approach to sustain, was examined. Then how the primary health care approach was translated into Indian context, how far it has been implemented, and if it is not implemented successfully, what are the contributing factors of its failure has been dealt with.

Fourth chapter deals with the case study of a Rural health centre and two of its sub centres. Through the study I tried to understand, why the public health service is not accessible to the rural poor. Several both medical and non-medical factors that contribute to make the health service inaccessible to the rural poor has been looked into.

HEALTH AS A DEVELOPMENT AGENDA

In 1946 WHO defined "health as a state of complete physical, mental and social well-being and not merely absence of disease or infirmity". This implies complex interaction between humans and their environments, more particularly between social and economic factors, physical environments and biological environments. Inspired by the WHO definition similar attempts have been made to clarify the meaning of health. Linda Ewles and Inna Simmel have added further dimensions to WHO definition of health. They suggested that there are emotional, spiritual and societal aspects of health that needs to be considered (cit in Aggleton, 1990). These kinds of definitions encourage one to think of health more holistically, relocating wide range of human capacities and qualities. It makes clear that the concept of health cannot be equated with physical well-being or absence of diseases. This broader definition of health implies, as Ravichandran (2001) says "health is truly part and parcel of societies, cultures and epochs, it makes comparison between and within societal context across time, and, perceive value of health amongst both those demanding better health and those providing it, is called health care". So 'Health care' is not a monolithic concept, it is a heterogeneous product consisting of a variety of services provided by health personnel, hospitals, and public health programmes etc.

Broadly health care can be classified into two categories, such as public health services and personal health services. Public health services include services like clean water supply, safe disposal of sewage, cleaning central sources of infection etc. and confer their might benefits without any discrimination to all inhabitants of an area. Personal health services consist of services provided by hospitals, health personnel etc. directly to specific individuals (Kethineni, 1991). Health is not only a medical issue to be left entirely to medical professionals and health workers. It has more to do with civil society and state and it is a political task depending on the political will of the state. Hence the concept "health care" deals mostly with public health perspective, refuting the idea of hospital as a health-building factory.

Health is classified as one of the social services provided by the state as one of the basic needs. Health status of the people determines the quality and longevity of life. So health is not merely a need, it is a right. It is the most fundamental of all rights, i.e. right to life. In this context the Universal Declaration of Human Rights, adopted by the United Nations, states that every one has the 'right to a standard of living adequate for health and well-being of his family including medical care'. Also the WHO has resolved that 'the right to health is a fundamental right' (Guhan, 2001). So WHO definition of heath as physical, psychological and social well-being can also be taken as a basis for advocating right to health.

For the justification of claiming a right to health care, one has to situate it within the framework of distributive justice, which can answer, what a right to health care might include. If health care is a right, it is because of the kind of social good health care and the kind of needs it meets. Economists unanimously agree that health care, like school education has all characteristics of public good. This calls for public provision of health rather than leaving it to private sector (Report of the independent commission on health in India, 1997). For any claim of right to health care and to situate it within the framework of distributive justice, one has to discuss health care needs. For this one has to concentrate on objective criterion rather than subjective criterion in assessing well-being. Subjective criterion uses the individual's own assessment of how well off she\he is with and without the claimed benefit to determine the importance of her\his preference claim. An objective criterion invokes a measure of importance independent of an individual's own assessment, i.e. independent of individual's preference for the benefit. In the context of distributive justice an appeal is made to objective criterion of well-being, where needs are given importance rather than mere desire (Daniels, 1985).

Proponents of right to health care are more concerned with social, economic and political arrangements that sustain the condition for health security. The right to health is an obligation of the state to fulfill; it is a "social security". The idea of social security is of using social means to prevent

deprivation and vulnerability (Sen, 1981). There are two different aspects of social security, viz. protection and promotion. The former is concerned with the task of preventing a decline in living standards; the latter refers to the enhancement of general living standards and the expansion of basic capabilities of population and will have to be seen primarily as a long run challenge. As per International Forum for Defense of People (2002), health is an essential human right, and it is a prime right of citizenship and public good. Hence this forum says that health is the duty of the state, and state should provide and protect health. While providing service to the masses, the state also has the responsibility to maintain equity. Equity is an ethical concept. Inequality refers not to all inequalities, but to those inequalities that are considered unfair and avoidable. Equity has to do with fairness and justice.

As pointed out by Gish, health is an invaluable asset for the human well-being of individuals and nations. Therefore some of the key indicators for the measure of development have been health-related. Access to appropriate food, shelter, education and a productive social, cultural and spiritual life have remained the pillars of health and well-being (cit in Bruycker, 2001). Health is a part of social and economic development process. Seers (1969) sees development as necessarily increasing aspects of human dignity, which means access to basic needs: foods, shelter, job and also political freedom. Development is therefore generally understood as the process of improving the quality of all aspects of human life. There exists a

complex relationship between health and development. According to Narayana (1997), "development implies improved nutrition, hygienic living and working conditions, greater awareness of health problems and wider accessibility to health care services which have favorable effect on the health status of the people". There exist a great relationship between social surrounding and health status of the population. Though ill health appears at a biological level, it has social origin.

The development of such a social approach to health can be found in the work of Engels. He did a pioneering work in the tracing social origin of illness. In his work he addresses how different casual factors such as occupational hazards in the form of exposure to dust, chemicals etc, environmental pollution, bad housing conditions and malnutrition were held responsible for the wide spread disability and early death of English workers in 19th century. The origin of ill health was traced to be the capitalist production process where primary consideration was profit, not safety of the workers. Rudolf Virchow in his theory of multifactorial etiology, emphasized on poverty, unemployment, malnutrition, illiteracy and inadequate medical facilities as main sources of ill health among the working class population. These theorists tried to show that although the causes of disease appear to be at biological level, their social determination is easily discerned at a collective level (Narayana, 1997).

There exists a reciprocal relationship between health and development. To explain the importance of health in overall development, Amartya Sen narrates a conversation, drawn from the very old Sanskrit text "Brihadaranyaka Upanishad" between Maitreyee and her husband Yanjavalka. The conversation focused on the ways and means of becoming wealthier and how far wealth serves to achieve what they want. Maitreyee wonders whether she could achieve immortality through wealth, on which Yajnavalka clarifies that there is no hope of immortality by wealth. Upon this Maitreyee remarks "what should I do with that, which doesn't make me immortal". This concerns the relation between income and achievements, between commodities and capabilities, between economic wealth and our ability to live, as we like (Sen, 1999). The ultimate goal of development is to improve and enhance human well-being and the quality of life of all people. The gap between two perspectives, i.e. between an exclusive concentration and economic wealth and a broader focus on quality of life is a major issue of conceptualization of development. It is important to recognize the crucial role of wealth on living conditions and quality of life, but one has to look beyond economic growth. For development, economic growth is not an end in itself. Development has to be primarily concerned with enhancing the lives we lead and freedom we enjoy. The most important freedom is freedom from avoidable ill health and escape from mortality (ibid). From this discussion it becomes evident that health is an integral part of development and for a proper conceptualization of development, health and economic growth has to be conflated.

Economic growth is a necessary condition but not a sufficient condition for achieving good health. There is a considerable evidence to show that income enhancement *per se* doesn't lead to better health outcomes. For example in both India and Pakistan, GNP per capita grew at an annual average rate of 3.1 per cent between 1980 – 92. The annual rate of reduction in mortality rate under the age of 5 years over this period was 0.7 per cent in Pakistan and 2.9 per cent in India. Where as GNP per capita in Costa Rica grew at an annual rate of only 0.8 percent between 1980- 92, its annual rate of reduction under the age of 5 years mortality was 4.5 per cent over the period. Within India itself, Punjab with a percapita income, that is twice the Kerala's level, reports infant mortality rate of 55 deaths per 1000 live births, more than four times higher than Kerala's infant mortality rate of 13 per 1000 live births. Income is channeled by the state for provisioning of better health services and also used by individuals to acquire better health care. Also health outcomes are influenced by a number of other factors, such as freedom that women enjoy, the levels of environmental cleanliness, extent of political support, the efficiency of government administration, dietry and child caring practices etc. (Shiva Kumar 1994).

Though poverty has to be addressed as a condition of economic backwardness, it is important to point out that poverty cannot be seen in isolation only as an economic condition independent of social dimensions.

Amartya Sen (1981) in his book "*poverty and famines*" says, the measurement of poverty can be split into two distinct operations, viz. the identification of the poor, and the aggregation of their poverty characteristics into an overall measure. The identification exercise is clearly prior to aggregation. The most common route to identification is through specifying a set of "basic or minimum" needs and regarding the inability to fulfill these needs as the test of poverty. "Basic" or "minimum" needs are often specified in terms of hybrid vector- e.g. amounts of calories, proteins, housing, schools, hospital beds etc. The poor generally lack a number of elements, such as education, access to land, health and longevity, justice, family and community support, credit and other productive resources, a voice in institutions and access to opportunity.

So poverty is not one-dimensional phenomena, it has many dimensions, and health is one among them. At the same time while defining health, the physical aspect of well-being cannot be over emphasized. There should be equal footing to social and psychological aspects of health. The connections between different types of deprivation are not biological (e.g. between illness and under nutrition) but also economic and social (e.g. unemployment and illness), (Sen, 1981). Health is a complex expression of economic and social determination of life conditions. Health is not an independent fact in itself; it is an aggregation of facts. As Dreze and Sen (1993) wrote, a person's capacity to avoid undernourishment may depend not

merely on his/her intake of food, but also on the person's access to facilities like health care, medical facilities, elementary education, drinking water and sanitation. For example, suppose the success in the rapid reduction of mortality takes place through "support led" process. This "support led" process does not operate through first economic growth, but through a programme of skillful social support of health care, education, and other relevant social arrangements. This process is well exemplified by the experiences of economies of pre-reform China, Costa Rica, Srilanka, and Kerala in India, which have had very rapid reductions in mortality rates and enhancement of living conditions without economic growth. "Support led" process works through priority being given to provide services (particularly health and education) that reduces mortality and enhances life quality. Despite their very low levels of income, the people of Kerla, China, or Srilanka enjoy higher level of life expectancy than much richer population of Brazil or South Africa.

Another study on British civilian life expectancy trends across the decades of two world wars showed an unprecedented rise of seven years. This was, inspite of tremendous increase in urban crowding (greater exposure to air-borne infections) during the wars and reduction in medical services (half of all doctors and nurses in Britain during world war I being recruited into military service). These were periods marked by dramatic increase in many forms of government support, including public employment, food price

control, and food rationing, which ensured access to basic food (Zurbrigg, 2001).

It is historically evident that the quality of life and acquisition of good health for population was not solely due to medical technology. The holistic approach of health was addressed in the Chadwickian view of public health. This view encompassed the full range of social and economic factors affecting human survival: living and working conditions, unemployment, poverty, and hunger. Since the beginning of the 18th century a crucial factor in the mortality decline in Europe was improvement in supply of food and diet. While the improvement in food supply and diet played main role in the earliest mortality decline, sanitary reforms and public health movements made significant contribution to further decline in the mortality rates after the middle of 19th century. The modern concern of public policy with the public health measures was an outcome of the sanitary reform movement, which came as a reaction to the evils of the industrial revolution in 19th century England (Briscoe et al., 1986, Narayana, 1997, Shah, 1997).

From the above discussion it becomes clear that, health is not only biological well-being, it is social as well as psychological well-being. It is a means to achieve the quality of life. It is one of the basic needs of the individual. It is also one of the basic rights, which becomes the obligation of the state to fulfill. The state is required to give social security against

deprivation. In the Indian constitution, this obligation is placed on the state in a number of articles, which deals with 'Directive principles of state policy'. Article 47 stipulates that 'the state shall regard the raising level of nutrition and the standard of living of its people and improvement of public health as among primary duties'. Article 39 calls on the state to protect the health and strength of workers, men and women, and to prevent the abuse of the 'tender age children'. Article 41 and 42 calls upon the state to make effective provision for public assistance in case of old age, sickness and disability, and for maternity relief (Guhan, 2001). Though these obligations are not enforceable by law, the state takes up the responsibility of providing basic health services to people.

Health is not an independent fact by itself, it is an aggregation of facts; it is a complex expression of social and economic life conditions, so treating health in isolation is not going to help in achieving good health, as is shown by the past experiences. For achieving good health it is necessary to fulfill the basic social and economic conditions of life. Such a holistic approach to health is advocated in a comprehensive way by primary health care approach. This approach addresses the health needs of people through basic needs approach. It advocates for an intersectoral approach for the development of health, which needs coordination of health sector with other social and economic sectors. The approach addresses the root cause of ill health, i.e. poverty. It takes up the WHO definition of health as a measure to

assess health. It is concerned with active health promotion and development activities. The primary health care approach addresses health as an issue of social justice, so calls for a right to health, which the state is required to fulfill. The responsibility of achieving lies in the hand of the state; it is an obligation of the state.

COMPREHENSIVE vs SELECTIVE PRIMARY HEALTH CARE

The concept primary health care was defined for the first time in Alma Ata conference in 1978. The conference defined primary health care as "essential health care based on scientifically sound and socially acceptable methods and technology made accessible to individuals and families in the community, through their full participation at a low cost that the community and country can afford to maintain at every stage of their development in a spirit of self reliance and self determination" (Alma Ata, 1978). The Alma Ata conference was jointly organized and sponsored by WHO and UNICEF, which was held in Alma Ata, the capital of Kazakh socialist republic. The primary health care approach made it clear that the attainment of health is not only an individual human aspiration but also a social goal. The conference affirmed that primary health care approach is an integral part of social development in the spirit of social justice. The conference also stressed that health is a fundamental human right.

Taking into consideration the unacceptability of health status of millions of people the conference called for an integration of all systems of medicine, and an integration of other social and economic sectors with health sector through primary health care approach. It was argued that health service delivery need to be considered as a part of whole social and economic

development of a nation and any improvement in services need to take account of whole question of national structures, priorities and goals. It called for decentralization of the activities of health sector through community participation. It calls for a comprehensive approach to health care. The conference fixed the goal for attainment of *health for all by the year 2000.* The translation of primary health care principles into action was required to be made through certain activities, which were considered as the main elements of primary health care approach. These activities include education concerning prevailing health problems and methods of identifying, preventing and controlling them, promotion of food supply and proper nutrition, adequate supply of safe water and basic sanitation, maternal and child health care including family planning, immunization against the major infectious diseases, appropriate treatment of common diseases and injuries, promotion of maternal health and provision of essential drugs (ibid.). The Alma Ata declaration made it clear that the governments have the responsibility for the health of their people. This was no less than a redefinition of the norms and the expectation of the state role with regard to health. This was particularly important for the newly created states, which were challenged to provide health care for their population after the collapse of the colonial system (Kickbush, 2000)

Every social event takes place within the historical and social context. And to have a thorough understanding of the event it is necessary to address

the historical and social forces that determined that particular event. So Alma Ata declaration cannot be seen independent of the social forces that determined it. The health situation of the developing countries and the economic and political context of that particular period had a major bearing upon Alma Ata declaration.

Health situation:

The conceptual background of Alma Ata can be understood from the time of World War II. People of the world in the decade following World War II from mid 1940's – 50's were war weary and disease ridden. They were suffering from life threatening diseases. Most of the disease producing conditions were rooted in adverse environmental conditions and associated with poor hygiene and sanitation, the manifestations of poverty and illiteracy. Many developing countries looked up to the newly formed WHO to fight the diseases. The burdens of tropical diseases were addressed through medical and scientific intervention. In 1970's efforts were made to eradicate small pox and it is claimed to be eradicated. According to official reports the last human being that fell victim to small pox was identified in Somalia on October 26th 1977. With the success of small pox eradication campaigning, other programmes were introduced which came to be identified as "vertical programmes" attacking disease problems as single units. Vertical programmes like malaria, schistosomiasis, African sleeping sickness, and leprosy were

started. With the same euphoria in 1974 the extended programme of immunization to vaccinate children under the age one was started in developing countries.

Despite enormous efforts made by national and international agencies to improve people's health, it was realized by mid 1970's, that nearly 1 billion people were trapped into vicious circle of poverty, malnutrition and disease (Partow and Bekele, 1989) One third of all deaths was occurring to children under 5 years old. In the developing countries approximately 11 million children less than 5 years of age were dying every year out of hunger, malnutrition and infectious diseases. Infant mortality rate at this period was so high that Michanek in 1975 used the term "the passing generation" to emphasize the scale of death among young children in developing countries (Macpherson, 1986). In these countries mortality rate of children aged 1- 5 years were twelve to fifteen times more than children born in developed countries. Morbidity rate was high; there was widespread suffering from neo-fatal diseases. There were wide regional differences in life expectancy at birth. While it was about 70 years in developed countries, it was 50 years or less than that in developing countries. Infant mortality rate was 10 –20 per thousand live births in developed countries against the range of 70 –300 per 1000 in developing countries (Bekele & Partow, 1989). These disparities could be observed between countries, within countries, between city and country, between rich and poor and between male and female.

It has long been recognized that the diseases of developing countries are diseases of poverty, poor environment conditions, lack of clean water, inadequate nutrition, and population growth. Malnutrition was identified as the biggest single contributor to child mortality in developing countries by Food and Agriculture organization in 1970. It was accepted that despite considerable variation within and between developing countries both in patterns of disease and levels of ill health, the conditions of the poor in developing countries are basically similar everywhere in the world. Diseases were brought under control in most areas by 1950s, but since the 1960s it again became a serious problem. There was success in malaria eradication during the 1960s, but it increased dramatically i.e., the number of cases increased by over 230 percent between 1972 and 1976 (Macpherson, 1986). This has cast doubt on the ability of vertical disease control programmes. Then the question raised, why vertical programmes weren't able to solve the health problems? It was realized that disease is not the production of single causal factor, but multiple factors, the social, economic and the environmental conditions have equal bearing on diseases. But the vertical programmes were based on the techno centric view of health, which believes that medical interventions have the ability to solve the disease problem (Phillips, 1990), so it treated diseases as single units. It was realized during this period that areas dominated by poverty and malnutrition are not likely to respond to the narrow vertical programmes, because most of the diseases of the third world are

manifestations of poverty. As long as the root cause of disease is not addressed, the disease is not going to disappear. But vertical programmes were fragmented and competitive, it was only addressing the disease problem, instead of addressing the cause of it. There was a need for paradigm shift in the treatment of diseases, i.e. a shift from bio-medical model which believes that disease is a production of single cause, to a holistic model, which focuses on the relationship between human health and the total socio-economic and environmental conditions.

It was also necessary to redress the imbalance between rural and urban health care coverage. Most of the time the health care system was biased against rural areas. Health care system of most of the developing countries was a continuity of the colonial health system. In the 1960s there was a rush for independence particularly in Africa. Health services in the developing countries, the majority of which were former colonial territories, have grown out of colonial medical care systems. The patterns of underdevelopment have their roots in colonialism. The pattern of medical care during colonial era had three major components: urban hospital, the rural dispensary, and public health or hygiene. While hospitals were initially to meet the needs of the Europeans, the rural dispensaries were essentially curative institutions, dispensing drugs to outpatients. In terms of public health, the essential objective of colonial policy was to provide safe environment for the Europeans. The legacy of colonialism was irrelevant to the needs of the

majority. Political independence made little difference to health policies in most of the developing countries. Most newly independent states tried to expand their health care system, but in the form it developed under colonialism. The health care provision was almost in urban areas, which widened the gap between rural and urban population (ibid.)

In such a discouraging situation it was noticed that significant progress in health was achieved by China, Philippines, Kerala in India and many small initiatives were taken up in different parts of world by employing community based health care mixed with basic needs approach. With this experience, community-based health care approaches were widely recognized by 1970s. However, the global economic situation in the post 70s influenced different set of priorities for the developing countries.

Economic situation:

The 1940's and 50's spelled the end of colonial period and European political and economic domination of the developing world. Post war re-construction was dominated by economic concepts with scarce resources allocated primarily to increasing productivity in industry and agriculture. The development planners maintained that though initially the wealth would be concentrated with a small section of population, gradually it would trickle down to the poor. This sector required a relatively high degree of skill formation on the part of the work force. A great emphasis was given to

population control and food production. Population growth was considered as the major contributing cause of poverty. There was dissatisfaction with the employment creation and distributional record of the growth strategy. Research findings also revealed that many preconditions for this strategy were lacking. These factors resulted in looking for alternative strategies. First reaction to this was employment strategy, it emphasized on programmes to increase employment in the modern sector but it was soon realized that the size of modern sector is too small and it doesn't include urban informal sectors and rural sectors. Because the concept of employment is not clearly defined in these sectors, so attention was shifted from employment strategy to anti poverty strategy. This strategy was required to incorporate programmes for small-scale rural households, redistribution of lands, and programmes for rural infrastructural works. The disadvantage of the anti poverty strategy was that attention was prominently given to income, which often resulted in over emphasis on the demand side as compared to the supply side. A major lacunae of the anti poverty strategy was that some essential elements of 'well being' of a household were not included (Hoven, 1988). It was pointed out by a few studies (Wood, 1982) that infant mortality rate had grown drastically during the period of Brazilian economic miracle. The largest growth in GNP per capita took place in late 60s and early 70s in Brazil. But it was realized that GNP per capita is not an indicator of individual consumption. The miracle was based on an overwhelming exploitation of the working class, which

determined a substantial decline of standard of living of the majority of population (Navarro, 1984).

The oil and raw materials crisis in the developed countries in early 70s showed that, if less developed countries are poor; it was not because they lacked resources. It was during this period, it appeared within the political and intellectual centers of developing countries that their poverty was an outcome of the pattern of world wide relations in which the few control quite a lot and the many control very few. The problem was perceived to be structural (ibid.). So out of energy crisis of seventies and the inability of the developing countries to maintain a level of 'quality of life', a type of global interdependency was felt. Research was undertaken into issues of unemployment and underemployment by International Labour Office (ILO) in early 70s to conceptualize and measure the social needs of the third world. Various ILO studies concluded that the employment problems of the developing countries were not consequence of ineffective labour utilization but a manifestation of poverty. Due to poverty their basic necessities of life is not fulfilled and this gives rise to further problems, like disease and ill health. So in 1976, at the world employment conference the "basic needs approach" was introduced (Macpheron & Midgley, 1987). It linked the concept of need directly to the provision of public services. And this approach became dominant in health policies, more particularly in developing countries. Here it

was to replace the state sector in public services or to reduce its role to a minimum. Structural adjustment policies have involved sharp cuts in public spending on health, education and other social services, phased removal of subsidies on basic commodities, shift from production of food and goods for domestic consumption to production for export, liberalization of trade policies, privatization of public services and state enterprises, devaluation of local currency (Sen Kasturi, 2001).

The 'enforced' application of the standard economic reform strategies of International Monetary Fund \ World Bank has become the routine in many developing countries. This structural adjustment programme had a severe impact on the essential public goods such as health and education, the way they were handled. Privatization, liberalization, and free market became dominant slogans from which the already weakened health sector could not escape (Bruycker, 2001). Several studies highlighted reduction in the consumption of nutritional staple foods as a result of these changes, especially among vulnerable groups, such as children and elderly people. This has occurred in the early adjusting countries of Africa and Latin America, such as Mexico and Brazil (Watson, 1994, Werner & Sanders 1997). By early nineties a clear correlation had been established between the introduction of user fees for health care and a marked fall in women's attendance at antenatal clinics in Zimbabwe, one of the first African country to experience reforms. Adverse health trends were beginning to emerge in infant mortality and maternal

mortality levels at Harare General Hospital. Here mortality rate among children due to mothers who did not attend antenatal clinics was almost five times greater than that of registered counterparts (Sen, 2001). Many developing countries implemented adjustment policies since 1980s. As a result of the adjustment policies, many developing countries had drastically reduced resource allocation in public sector. UNICEF echoed the danger signals from these countries. UNICEF report of 1990 and 1992 on "the state of the world's children" describes that "for the first time in the modern era, a subcontinent is sliding back into poverty. The number of families in Sub-Saharan Africa who are unable to meet their basic needs have doubled in a decade. The proportion of children who are malnourished has risen". It further blames such conditions on the debt burdens imposed by world bank's policies on these countries, noting that "the total inhumanity of what is now happening is reflected in the single fact that even small proportion of interest which does manage to pay is absorbing a quarter of all its export earnings and costing the continent, each year, more than its total spending on health and education of its people" (ibid).

UNICEF report further comments "great change is in as the 1990s begin. And great change is needed if a country of unprecedented progress is not to end in decade of decline and despair for half the nations in the world. In many countries poverty, child malnutrition and ill health are advancing again after decades of steady retreat. And although the reasons are many and

complex, over shadowing all is the fact that the governments of the developing world as a whole have now reached the point of devoting half of their total annual expenditure to the maintenance of the military and servicing of debt (Sengupta, 1994).

By eighties, the International Monetary Fund and World Bank were freely using the debt trap of third world countries to compel them to accept a set of new economic deals, of which health sector was a part. By early 90s, South Asian countries were made to agree to plans which were convinced for them, but not necessarily by them. They adopted bank driven, narrow, techno-centric interventive strategies in the area of population control, reproductive child health, and treatment of communicable diseases. They opened up medical care to private sector and introduced a slow dismantling public sector, first by depriving it of funds and second by taking advantage of people's dissatisfaction with it (Qadeer, 2001).

The world development report, 1993: *Investing in Health* is designed to keep state support to health to a bare minimum. It advocates the policy of further promoting vertical programmes, which destroyed the entire primary health care concept. Since the world development report 1993, the debate on public health, or on public interest considerations has been becoming dominated by economic aspects, with a focus on specific disease and risk factors, leading to a fragmented picture of health (Bruycker, 2001). The report

has a series of recommendations designed to operate the withdrawal of the state, like reduction in support to medical education, research activities and tertiary care. In order to keep the state support to health at a minimum, the report compartmentalizes health into a series of 'nuggets' to which it assigns scores with a novel computing system called "DALY"(Disability Adjusted Life Years). The whole exercise is to reduce health to a series of mathematical calculations to determine which intervention 'optimizes' returns. The fragmentation of health into discrete components facilitates the calculation of DALY. This reinforces a model of health care that has its roots in technological determinism, which is based on the belief that technological solutions can be applied to all health problems of a community, in the name of cost effective analysis. The issue of cost has been pushed to the center stage, but the questions regarding the nature of development and cost to whom are sidelined. DALY is a composite index quantitatively representing "burden of disease", incorporating into one figure morbidity, disability, and mortality, expressed in terms of estimated years of human life affected. Each disease is quantified in terms of number of deaths caused and age of death converted into standard numbers of years of human life lost "prematurely" and weighted for value of human life at different ages. The value choices made by the proponents of DALY include considerations of only those social variables "that are general to all communities and households, namely age and sex". Other variables such as occupation, income, educational attainment, religion, and ethnicity have been excluded. Equality as a value is catered to by making

no difference in quantifying death or disability of individuals, except age and sex. For example, the premature death of 40-year-old woman should contribute equally to estimates of the global burden of disease irrespective of whether she lives in slum or wealthy suburb (Ritu Priya, 2001).

Due to structural adjustment policy the public sector investment is shrinking, and this condition is not a favorable condition for PHC approach to survive. So the survival of PHC approach is questioned, at the same time SPHC approach is further supported and promoted. As a result of which it is seen that in 1980s, a disturbing trend emerged, while child mortality rates dropped, malnutrition and morbidity rates rose. In the late 1980s and early 1990s, the decline in child mortality rates slowed or halted and in many countries, especially in Africa, the child mortality rate is rising (Kelly, online). The SPHC approach does not give importance to individual disease problems; it clusters individuals into certain age and sex groups and tries to treat their disease problem in isolation of their social context. Because of all these factors along with selective elimination of PHC approach *"health for all by 2000"* became an unrealized dream.

The failure in achieving ***"health for all by 2000"*** in an international scenario leads us to ask the question, whether *"health for all by 2000"* has been achieved by India? So an attempt is made in the following pages to understand the Primary Health Care situation in India.

Primary Health Care in India:

During colonial period Indian medical science declined rapidly. Ayurveda along with Unnani, Siddha and all kinds of indigenous medicines suffered. Indian medical service was established mainly to cater to the needs of British population and armed forces. The medical facilities had a distinct racial and urban bias. Government of India Act of 1919 and 1935 led to some rural health care expansion in a limited way (Duggal, 2000, Banerjee, 1991). The British who formed health boards and built up sewage, and piped water supply and medical facilities in England during 19th century, did not take a similar step as rulers of India. Indians were blamed for their resistance to sanitary programmes. It was forgotten that the attitude of British people towards sanitation in the last century had been in no way different from that of Indians. H. A. D. Phillips wrote in 1880s that "those who know anything of the progress of sanitary reforms in England are aware that sanitation was to a great extent forced on the people. Even at the present day there are villages in England where sanitary arrangements shock the tourists, and sanitary education is no more advanced than in a Bengal village". Indifference to sanitary conditions in British society in the 19th century, as noted by John Bristowe, produces in many persons state of ill health, which makes life irksome, but do not necessarily end in death. In India, neither the State nor the elite social reformers launched sanitation campaigning before Independence (Shah, 1997).

Indian national movement compelled the British Government to set up committees on health situations. The Health Survey Development Committee, well known as Bhore committee, was appointed by the Government of India and it submitted its report in 1946. The committee found that the state of public health was very poor, environmental sanitation extremely unsatisfactory, inadequate nutrition, protected water supply and drainage reached to a very small section of population. The gap between the ratio between people and health personnel was very wide. The majority of the health personnel served the urban population. There was shortage of women doctors. Very little attention was given to the general health problems of women. Bhore committee plan was biased in favour of rural areas with the intention of correcting the wide rural-urban disparity in the shortest possible time. It emphasized on an equal footing to the preventive, promotive and curative services. So, the presence of primary health care approach can be seen in India 30 years before the recommendations of the '*health for all*' was accepted in 1978. And independent India had the fortune of having well studied health policy document and national health plan in the Bhore committee report. After independence, the Bhore committee report provided a framework for the development of health services in India. The constitution of India in its directive principles of state policy provided in the article 47 states that the "state shall regard the rising of the level of nutrition and standard of living of its people and the improvement of public health as among its primary duties"(cit Guhan, 2001).

While the first health ministers' conference in 1948 accepted in principle the recommendations of the Bhore committee, the subsequent conferences and committees, conferences and Five-year plans picked up only pieces of the recommendations of Bhore committee recommendation (Duggal, 2001). In the First and Second Five-Year Plans, priority was given to building infrastructure, water supply, and sanitation, maternity and child health. Health sector planning was visualized as a technical and managerial exercise. The central problem of poverty was left for the economic planners after recognizing the link between poverty and disease. This separation led to a disjunction between nutritional planning, agricultural policies, sanitation, control of communicable and occupational diseases and welfare sector planning (Quadeer, 2001). The percentage of funds allocated in the Five-Year Plans for health have been inadequate and nowhere commensurate to the recommendations of Bhore committee. Third Five-Year Plan onwards greater focus was on the urban based curative infrastructure like, medical colleges, hospitals and the training of doctors even though the rural primary health centers suffered due to the unwillingness of the urban trained doctors to serve the rural areas. There was massive increase in manpower, infrastructure and financial inputs in the field of curative medicines. During this period, the health planning indirectly supported private sectors by diverting attention from the holistic approach of preventive, promotive and curative aspect and people's participation as recommended by Bhore Committee especially for

rural areas. Private sector not only grew at fast pace, it also received government subsidies. During this period health policy was guided by planning commission and few committees on specific issues, this process diluted the comprehensive character of health policy. All these factors resulted in primary health center concept being relegated to a centralized health bureaucracy to help achieve the national targets of a variety of vertical programmes such as family planning, devised by international experts. Force and coercion became the hallmarks of family planning programmes. The height of arrogance was reached during the Emergency when officially inflicted atrocities became the main reason for the downfall of the Congress Government in 1977 (Antia et al, 2000, Qadeer, 2001).

India was a signatory to primary health care declaration of Alma Ata in 1978. But Sixth Five-Year plan did not find a mention about it. The programmes of immunization and later the child survival strategies were promoted, and selective primary health care became a part of health sector planning. Later in 1982, the Government of India came out with a document sharply criticizing the pattern of health service development since the country attained Independence. Within the over all framework of the Alma Ata declaration, India had accepted primary health care as the basis of planning for its health services. In 1983 a comprehensive, all embracing national health policy was formulated. India's national health policy was mainly influenced by the preamble of the constitution of India, envisaging the establishment of

new social order based on equity, freedom, justice and dignity of the individual. The primary objective of the national health policy was to attain the goal of *health for all by 2000 AD.* But the implementation of comprehensive primary health care continued to be weak. Despite the advantage of having started the programme earlier, Indian government has chosen to put on a number of independent programmes and call them as its PHC strategy, while the PHC strategy should have been more comprehensive. The acceptance of primary health care policy and formulation of national health policy was in fact a political move by the government of India to regain its democratic image that had sullied by the emergency and it's excess (Qadeer, 2001).

Though the PHC strategy advocated for decentralization of health services, in India, the health care service continues to be centralized in its form. Health care system in India is operationalized on a three-tire system, the central, the state and the district. Though constitutionally the responsibility of health lies with the government of each state, health policies are defined by central government, which allocates grants from the plan budget. So the responsibility of the central level of administration consists mainly of policy making and planning, guiding, assisting, evaluating and coordinating the work of state health ministries. And the primary health centers are the principal institutions for providing integrated service to the rural population. Planning is made at the central level, which needs to be implemented in the grass root

level. In other words, while there has been a great deal of macro planning at the secretariat armchair level, there has been very little of micro planning at field level. Programme related information, guidelines, technology and resources have to pass through a series of steps before they reach the people. Large parts of potential of the given medical technology is lost in multistage transfer process. The bureaucratic set up is highly centralized organization. The highest level of organization is far removed from the ground level situation (Shiva Raju, 1991, Srinivasan, 1987, Cruz and Bharat, 2001, Kochar,1991)

Though Alma Ata accepted community participation as central to primary health care approach, but while translating the ideology into action India systematically ignored it. A vast gap can be noticed between programme and implementation. The national health policy is against 'vertical' programmes and advocates that existing vertical programmes like the national malaria eradication programme, family welfare etc. be merged into the general health services. But in practice new vertical programmes such as AIDS and separate organizations, like national AIDS control organizations were formed outside the ministry of health (Report of the independent commission on health in India, 1997). During the Ninth Five-Year Plan India had already received the World Bank policies for structural adjustment. The entry of international agencies like World Bank has meant an attempt to dictate the development policies, plans and programmes of the country. After India

accepted the conditionality laid down by the World Bank/IMF, there was a 20 percent reduction in the allocation for the health services compared to its previous year. The World Bank seems to be promoting vertical programmes, which destroys the concept of primary health care. The World Bank package on communicable diseases focuses primarily on AIDS, malaria, tuberculosis and blindness. Between 1990 and 1993, World Bank funding for AIDS went up, while there was a cut for programmes, which is critical to the poor. There was 40 percent cut in the malaria programme and 20 percent cut in the eradication of tuberculosis (Report of the independent commission on health in India, 1997, Banerjee, 2001,Cruz and Bharat, 2001). The key to successful implementation lies in cultural affinity, constant availability and accountability to the people of whom they are a part. This is a social than a medical function which vertical programmes formulated by World Bank can never hope to achieve. Since our own bureaucracy in Delhi and state capitals cannot understand this problem due to their physical and cultural distance from the people, it is less likely for those organizations that dictate policy from the opposite side of the globe (Antia, 1994).

Much emphasis is given to vertical disease oriented programmes rather than comprehensive programmes. Again the public spending on health remains low in priority in most of the developing countries, including India, which makes it difficult to carry out comprehensive programmes. Only 1.7% of India's total public expenditure is devoted to health care, in sharp contrast with 16.9% in US or 14% in UK. It is even lower than that in some less

developed countries like Brazil (5.9%), Malaysia and Kenya 5.6% (World Development Report, 1997). Debabar Banerjee (2001) also highlights that in Europe and Japan the percentage of public expenditure on health is over 80%, while in India it is only 23%. Even in USA it is over 50%. And after India submitted to the conditionalities laid down by World Bank there is further 20 percent reduction in the allocation for health services. The fund allocation on health care is very less out of which a large amount goes on the payment of staff.

Due to this poor central government expenditure on health, health service system is affected. A keen observation on India's health situation was made by Amartya Sen, he states "illness is, obviously enough, one of the most widespread cause of human deprivation and economic insecurity in India. It affects not only the actual patients and those who depend on them for their subsistence, but also the other members of the society, in so far as the threat of disease arising from morbidity reduces the quality of life. A well developed public health system is an essential contribution to the fulfillment of social security objectives"(Dreze and Sen, 1995). The public investment on health in India has been miniscule compared to the demand for health care in the country. So the quality of health care suffers.

For the low quality health care provision by primary health centers, primary health care becomes inaccessible to the masses. Jayaram (1977) and

Madan (1980) in their studies made it prominent that the inequality becomes manifest whenever any disease acquires epidemic or massive proportions. In all these cases it is the poor who get hit hardest as they have the least access to information, doctors, hospital care, transport, life support systems.

From the above discussion it becomes clear that, Alma Ata declaration represented the liberation of people through the promotion of self-reliance and democratization of health services. Though the primary health care approach was advocated enthusiastically by the world community in 1978, the grand ideas were not translated into practice. The SPHC approach has been accepted by the international agencies as a better alternative. And the SPHC approach is further promoted through structural adjustment programme, while primary health care strategy is suffering a natural death due to cut down in public spending. In Indian context the primary health care approach has not been implemented successfully. Though India signed Alma Ata declaration in 1978, it only tried to implement the programme in 1983, by that time the global economic recession had already started. So the climate did not favor the primary health care approach, which needed large amount of social sector spending. And India's acceptance to structural adjustment policy further made it difficult for the primary health care approach to sustain successfully. Though the selective primary health care approach has been adopted by the state, the past experiences with vertical programmes have already shown that such programmes do not have an impact because it tries to treat the disease

independent of its social surrounding. In such a situation the question always remains, how far the state will be able to solve the disease problem of its population. Given this scenario, to what extent the existing institutional health care delivery is approachable, accessible and affordable to the rural poor is examined in the next chapter.

A RURAL HEALTH CENTRE IN PATANCHERU: STUDY FINDINGS

The primary health care approach of 1978 was not new for India. Presence of the approach could be felt since the 1946 Bhore committee report. Again the primary health care approach was redirected in the first-ever national health policy of 1983. The primary objective of national health policy was to attain *"health for all by the year 2000"*. But the implementation of primary health care programme continued to be weak. The selective programmes took over the primary health care approach. Selective programmes were promoted through the health care system, which was meant for implementing primary health care approach. The selective disease oriented programmes do not treat people as a whole; rather it clusters people into certain age or sex groups and tries to treat only the problem of disease independent of their social surrounding. This approach is in exact opposition to the primary health care approach. So it diluted the primary healthcare programme by being implemented through same organizational structure. After India's acceptance to structural adjustment programme, there is a reduction in the public spending on health. Again this makes it difficult for the primary health care approach to sustain. The World Bank through structural adjustment policy further stresses on vertical disease control programmes. So in the Indian context the primary health care approach has never been implemented fully, though India had the potential to implement this primary

health care programme successfully. In such a situation, the question arises that the existing primary health care model that was formulated and implemented from time to time, to what extent, health services are available, accessible and affordable to the rural communities? Although the aim of primary health care is to bring health care as close as possible to where people live and work, it leads one to ask how accessible are health care services to communities and what are the constraints in accessing health services for the rural poor?

In order to assess some of these issues, I conducted a study on a Rural health centre (RHC), located in Patancheru, and two of is sub centres. This study was expected to give clues about the health care system in India and how far the health care centres are able to meet the health needs of rural communities. The health centre is located on a national highway, about 30 kilometers from Hyderabad city. It is a model health centre for field training unit of social and preventive medicine department of Osmania medical college. The main objective of the health centre is to give hands-on training to house surgeons and paramedical students regarding comprehensive health services and make the services available to the community.

Organizational structure of Rural health centre and it's sub centres:

The rural health centre is under the administrative control of the Principal, Osmania Medical College, but the health targets are fixed by district level administration and hence, a kind of dual administration operates at the health centre. The rural health centre covers 42 villages consisting of about one lakh twenty thousand population. There are three sub centres under this rural health centre, i.e. Ismail khanpet, Ghanpur and Chitkul. Ismail khanpet sub centre exists at a distance of 17 kilometers on the western side of Patancheru, the sub centre covers 7500-8000 population. Ghanpur sub centre is located in the southern side, about 7 kilometers away from Patancheru and covers 4000-5000 population. And Chitkul sub centre exists 7 kilometers away in the western side of Patancheru and covers 4000-5000 population.

In the Rural health centre, health officer is the supervisor of the health team, under him two medical officers, one assistant woman surgeon and one assistant dental surgeon and other paramedical personnel work. In the sub centres the medical officer is the leader of the health team, along with other paramedical personnel. For the purpose of study data was collected randomly from 15 medical, paramedical personnel and house surgeons who came for training. The age-sex composition of the respondents is given below.

Table –1: Age-sex composition of the respondents (Medical Personnel)

Age group	Male	Female	Total
21-30	4	1	5
31-40	0	0	0
41-50	1	1	2
51-60	1	0	1
Total	6	2	8

In the age group of 21-30, 4 out of 5 respondents are house surgeons who were appointed in rural health centre for training, and one lady health officer belongs to this age group. In the 41-50 age group the respondents were one health officer of Ghanpur sub centre and one assistant woman surgeon of RHC. And in the age group 51-60, the respondent was the health officer of RHC.

Table –2: Age-sex composition of respondents (Paramedical Personnel)

Age group	Male	Female	Total
21-30	0	1	1
31-40	1	1	2
41-50	0	1	1
51-60	2	1	3
Total	3	4	7

In the 21-30 age group the respondent was a multipurpose health assistant, in the 31-40 age group the respondents were pharmacist and dresser. In the 41-50 age group the respondent was a pharmacist and in the 51-60 age group one public health nurse and one health supervisor of RHC and one health supervisor from Ghanpur sub centre were the respondents.

Socio-economic profile of the community respondents:

Data was also collected randomly from 27 respondents who came to access health service from the Rural health centre. Their socio-economic profile is given below.

Table-3: Age-sex composition of the respondents (community)

Age group	Male	Female	Total
17-45	10	15	25
46-60	0	1	1
61 and above	1	0	1
Total	11	16	27

Among the community respondents, 16 of them are females and 11 are males. Majority of them belong to 17-45 age group. However the age profile of the randomly selected respondents in this study does not reflect the actual profile of different communities accessing the health services at RHC, Patancheru.

The findings of my study are presented along with other studies in order to compare as well as analyze the issues of accessibility in health care in a more comprehensive manner. Although several factors limit people's access to health care, in this study, it is found that most of the people are not given proper attention by the health personnel, and there is a clear bias in favor of educated and economically well-off people and known people of health personnel. Casual approach of dispensing medicine was noticed in the dresser of RHC. Although some particular medicines were prescribed, due to shortage of medicines, whatever medicine was available was being dispensed to people. Some unhygienic way of dispensing medicines to the poor and uneducated people was also found. For example- two bottles of medicines were kept on a table in the corner of the dispensary, which were kept open all the time. And a stick to which cotton was tied on one end kept in each bottle of medicine. When people (especially poor and uneducated) come for dressing, the medicine from the bottle is applied, without even cleaning the wound, even though the cotton touches the person's wound every time while applying the medicine. And this stick is kept back inside the bottle. Sometimes when three to four persons are in a queue, the medicine is applied at a stretch without even adding more medicine into it. But differential treatment is found when educated, rich and known people come and approach for dressing. The dresser used to take out medicines from new stock to apply medicine to these people.

It was revealed by one of the paramedical personnel that when penicillin injection is not available in the health centre poor are dispensed with vitamin 'B' complex injection, though they are prescribed for the former one. It was also revealed that with the shortage of government supply of disposable syringe and needles, the recycled ones are required to be sterilized for a particular time period, but because of over flow of patients, and their attitude towards poor clients, they are not sterilized as required. Most of the time people are asked to buy needles from outside, with some exception to the aged patients from buying the needles. In this study it is observed that while dispensing injection to the poor, the same syringe is used to dispense different kinds of injections, without even sterilizing or cleaning it with water. Similar kind of finding is also drawn in Rai and Bhaduri 's study (2001). In their study it was found that most of the people feel that there is a clear bias in favor of high caste, educated and powerful (socially, economically and politically) people. The rural poor felt that the PHC doctor often maintains distance; the doctor does not encourage dialogue. So this kind of bias against the rural poor limits their access to health care.

It was also observed that people while seeking health service most of the time prefer to consult doctors belonging to their own social group. In my study it was found that in OPD (out patient department) though two to three house surgeons are there, but when a Muslim house surgeon is available

(identified by his beard, dress and looks) the Muslim patients consulted him, though there used to be less crowd near other house surgeons. So cultural sensitivity is as important as any other medical intervention for the successful primary health care approach in India.

The vacancy of staff in the health centre also makes the health service inaccessible to the rural poor. Urban orientation and private practice orientation of the medical personnel results in lack of staff in the health centers situated in rural areas. In my study it is found that, in one of the sub centres, Chitkul, the medical officer post is vacant for four months, so doctors from RHC Patancheru go for health check up and immunization only once in a week. It implies that this sub centre is being run by para-medical staff except occasional visits by the doctors from RHC. In another sub centre, Ghanpur, though the post is filled, the doctor goes to the sub- centre once or twice in a week depending on his convenience. That too for the purpose of immunization, the doctor goes to the sub- centre regularly on every wednesday. Here it is important to point out that the immunization programme and other vertical programmes are given much importance by the health professionals, and there is a clear negligence towards delivering other curative services, which is the felt need of people. From the study on these two sub centres, it is clear that the filling up of the post of medical officers or the vacancy of post does not make much difference. Even though the post is filled, most of the time the doctor is not available in the health centre, because

the doctor is not willing to stay in the rural area. The reluctance to stay with the rural communities is justified with the targets that need to be fulfilled as part of vertical health programmes. The 'vacancy' in health centres is often pointed out for inordinate delay and work pressure on part of the medical officers, in not discharging health services to the people. However, it is the target-oriented approach that is mainly responsible for not attending to people with sickness, although insufficient staff issue cannot be brushed aside. In both the sub centres, in the absence of doctors the paramedical staff try to run the OPD. But in the absence of doctors, people are reluctant to visit sub centres, because they think that the paramedical personnel are not trained enough to prescribe medicines. People's expectation from the doctors may not match with the presence of only paramedical personnel at sub-centre. Hence most of the time they come directly to RHC for treatment. Similar finding is also drawn by Rai and Bhaduri (2001). They point out that in the absence of doctors, the number of patients visiting the PHC is appealingly low.

From the study conducted by Ray and Bhaduri (2001) it is prominent that the shortage of doctors severely limits the extent of curative health services that can be offered by primary health care network. In UP, where doctors posted in primary health centre are never present there, in West Bengal, the government health services fail to attract new doctors and therefore posts of medical officers at primary health centre remain vacant. In primary health centres some doctors deliberately neglect OPD patients,

thereby indirectly compelling them to visit their private clinics. They often use local 'quacks' and agents of different modes of transport (like rickshaw pullers) and other middlemen as commission agents to lure patients to their clinics. It is often found that the medical officer of the PHC is demotivated and somebody who is more interested in illegal curative medical practice, can hardly serve as a role model for rest of the team. In the absence of supportive leadership, the lower cadre staff are required to carry out their responsibilities.

Selective concentration of health care providers, such as urban concentration and preference for private practice becomes a major concern in making the health service inaccessible to the rural poor. As per 1981 census, 59 percent of the country's medical practitioners are located in cities out of which 73% of the allopathic practitioners are located in cities, and especially metropolitan ones. For instance, of all allopathic medical graduates in Maharashtra 60% are located in Bombay city alone which has only11% of the state's population (Duggal, 2000). In the Ahmednagar study conducted by Foundation for Research in Community Health (FRCH) in 1992, it was found that 77% of allopaths were in urban areas and 23% in rural areas. Not only is there an urban bias, but also most of the health professionals are interested in private practice. In 1996 it was found that 68% of the hospitals were private hospitals where as 31.9% were public. And in 1986 while there were 73.4% private allopathic doctors, only 26.6% were in public services. In 1997-98 it

was found that while 77.1% of all allopathic doctors were in private sector, only 22.9% of them were in government sector (Duggal, 2000).

From the above studies it is found that most of the medical professionals are urban oriented and private practice oriented. All these factors limit access to health service to the rural people and particularly the rural poor. The urban orientation and the preference of private practice among the medical professionals gives rise to shortage of doctors in public sector in general and the rural area health centres in particular. For this factor the rural poor, who cannot afford to spend on traveling and private treatment, has the least access to health service. As Banerjee (1983) points out that the policy with regard to the education and training of medical professionals at various levels has resulted in the cultural gap between the people and personnel providing health care. Studies show that the urban educated health personnel are unwilling to stay in rural area and serve the rural communities. This results in urban concentration of doctors and shortage of doctors in rural areas.

Health service becomes inaccessible to rural masses not only due to the urban orientation of the medical personnel, but the gap between macro level planning and micro level implementation of health services also makes the service equally inaccessible to the people. Health planning is made at the central government level, which is required to be implemented at grass root level. Rural community's health needs and their culture of acceptance or

rejection of particular health behaviour is not taken into consideration in the health programme, although it is intended for the people. For example: in my study it is found that certain food taboos are practiced by women during and after pregnancy. After pregnancy women are restricted to take certain foods like potato, brinjal, fish etc., though they are advised by the health personnel to eat all kinds of food. It is not accepted by the rural people, because they see the health personnel as someone who does not know about their customs, practices and values. The traditional folk cultures of village, their pattern of behaviour and perceptions, may not always match with the assumptions of modern health technology. So there is some tension and misfit between the assumptions of medical technology and rural life style. The plans for providing health service are drawn at macro level, which has little understanding of rural people's attitude of acceptance and rejection towards particular health behaviour. So as long as the health programmes are not made with the people, and it is only made for the people, the problems are not going to be addressed. The involvement of the community is required to implement health policy successfully. The community has to be made aware of every health activity. So the process of implementation of health programme deserves closer attention, i.e. the manner in which the health workers carry out specific programme interventions and activities, the manner in which the rural communities and individuals interact with or respond to the health worker and how they act in relation to the information and tasks entrusted to them.

The highly centralized administration with vertical programmes as their strategy is unable to address the felt health care needs of the rural masses. This is one of the major limiting factors in terms of accessibility to health services. Out of 27 respondents who came to seek health service from Rural health centre, 15 of them said that the health workers don't visit their houses, and 10 respondents said that they visit their houses either for survey, immunization or for the purpose of persuading people to accept family planning. Though at the planning level they are required to carry other activities like health education, most of the health workers do not see it as their primary duty. They only give importance in meeting the health targets. Several studies have observed that family planning and immunization programmes get a disproportionately large share of the health workers' effective work-time (NIRD, 1989, Duggal and Amin, 1989, Duggal, 2000). An overriding priority is given to the family planning. While the plan allocation for it was Rs 6.5 million in the first plan (1950-55), it increased 10,000 fold and became Rs 65000 million in the eighth plan (1991-1995). But the plan allocation for other programmes did not rise on par with the family planning allocation (Banerjee, 2001). The family planning targets are fixed at the central level and each level of bureaucracy is required to fulfill the assigned target. Entry of target achievement in service records of the health bureaucrats is the motive behind this kind of action (Banerjee, 1992).

In case of RHC patancheru, the target of family planning is fixed by District level authority. The target for family planning for the year 2000-2001 was 1280, and it is 1300 for the year 2001-2002. Auxiliary nurse midwives and their field supervisors and lady health supervisors are required to generate a prescribed number of family planning cases. If they fail to meet required number of targets their fixed tour allowance and increment are stopped by the authorities. As it is pointed out in Jairam's study (1977) that a majority of ANMs and basic health workers are from lower middle class background and so when their increment or allowance is stopped they are hit hard. For this reason they desperately want to meet the family planning target. Because of this sometimes they try to convince the poor widows and people who have crossed the reproductive age through offering government spcnsored entice.

In my study, one of the respondent who is a widow belonging to Lambda tribe, had come for tubectomy operation said that the health worker convinced her to go for tubectomy operation, because of Rs. 500 incentive being offered. While action is taken against the health workers for not fulfilling certain targets for family planning, similar kind of action is not taken against them for not delivering some of the most essential health services, like health education. Hence health workers give top priority for fulfilling the targets of family planning and immunization, where as the other health care activities are given least importance.

In the monthly health centre meetings, most of the time is devoted to review case motivations by individual staff members. Auxiliary nurse midwives, the field supervisors and lady health visitors are required to generate a prescribed number of family planning cases from scheduled areas. Mark Nichter (1986) in his study focuses on how this target for health workers introduces organizational conflict and provokes tension and competition between the cadres. This affects the health service delivery.

It was found in my study that when the family planning programme is resisted by a particular community, different types of coercive and pressure techniques are used, which is antithetical to the primary health care ideology. It was revealed by one of the paramedical staff that when people in a particular village don't accept family planning, pressure is built on the community through Mandal office, by which it stops giving loans to the rural poor for buying seeds. So the family planning targets not only makes health service inaccessible to the poor, but the rural poor's non-cooperation in achieving the targets affects them badly, by making other services inaccessible to them.

It has been observed in various studies that family planning and more recently immunization gets a disproportionately large share of health worker's effective work time. In my study it is also found that the other services in the health centre gets affected badly because of the over emphasis on family

planning. In the RHC most of the health centre staff are engaged in family planning programme for which other programmes suffer. The two medical officers and the woman assistant surgeon concentrate on the operation theatre, where only family planning operations are done, although one of the medical officers is supposed to look after OPD and the health officer is in charge of the inpatient ward. But a greater importance is given to meet the family planning target; so the two medical officers spend their effective time in doing family planning operations, while OPD is left to the house surgeons who are on training. By implication, patients at OPD suffer as the house surgeons run OPD, instead of any experienced medical officers.

A batch of 20-30 house surgeons is posted for one month in RHC for training. They are required to work under the supervision of medical officers and health officer. The batch is divided into four groups. Each group is posted in OPD for a week and they work on rotation basis. So everyday two to three house surgeons are on OPD duty. In the absence of medical officer and with frequent change of house surgeons, the laypersons face a lot of problems. They complain that when one house surgeon prescribes certain medicine and asks the person to revisit for follow-up, the same house surgeon is not found. And in the absence of that particular house surgeon, no attention is given to the prescription written by her/ him, by the other house surgeons. Hence the diagnosis for follow-up cases starts from the beginning again. The rural clients complain that most of the time in the nearest sub centres, the doctors are not

available. When these people are in dire need of health service and cannot afford to pay private practioners, they come to approach this RHC to fulfill their health needs, but here also they don't get satisfactory treatment.

The over emphasis on family planning leads to neglect of other patients in various ways. In RHC, for instance tubectomy cases are given more importance compared to delivery cases by the health centre staff. When more number of tubectomy operation patients get admitted in the health centre, the delivered women are asked to shift from the ward to the corridor. The delivered women complain that enough care is not provided by doctors and nurses. Dayas only help with deliveries, but they feel that dayas in the health centre are less skilled than doctors and nurses. Even after the delivery the patients are not attended by doctors. This is another evidence of health personnel attending to those cases that meets their targets at the cost of other serious cases. Cruz and Bharat (2001), also point out that pregnant women are treated badly in addition to being pressurized for contraception. As a result only 13 percent pregnant women register for antenatal care and 8-10 percent deliveries are attended by government personnel.

The family planning programme itself is discriminated and programmed against women. The ground level health workers who are employed to meet the targets are also women. So they always feel comfortable to convince women. In state health policy, the family planning programme is

formulated in such a way that, it only attracts women to accept it. The entice, given by the government for receivers of family planning is more in case of women. A family gets more monetary benefit, in case of a woman recipient than a male recipient. So there is pressure on woman to go for it. At the same time the health personnel get more monetary benefit for convincing women, than a man, so they pressurize women. The programme acts as a kind of oppressive mechanism against women. Due to this programme women are pressurized by the health workers and the family members to go for the tubectomy operation. Women are subjected to emotional harassment and forced to go for the tubectomy operation. One of my woman respondents told how her husband insisted her to go for tubectomy operation, instead of him going for vasectomy operation. And gave the justification that she should go for operation, because he is the wage earner and if he goes for the operation he will be weak, which will affect his work. At the same time, the domestic work, that she is engaged does not get counted as work. Though the woman also felt that she will be very weak after the operation and was as scared of the operation, she was forced to go for it. So the target oriented family planning programme not only affects the health service delivery in the health centres, but it also pushes women into further subordination.

It is not only the family planning programme that discriminates against women, the primary health care approach also does not address the needs of women as a marginalized category, who has least access to health care in the

society. Women's health needs are given less importance in the society as well as in the family because, most of the time they don't contribute directly to the economy of the family. So in a family where there is lack of resources the health needs of a male member is given much importance because of his direct economic contribution. There is reluctance to invest money on women's health. Primary health care approach views women only in terms of their childbearing roles. So for the women who fall outside the category of motherhood, their health needs are not addressed. These factors reinforce discrimination against women and further worsen their health status. Cruz and Bharat (2001) point out that, in the Indian context while only two percent of national health budget is spent on women through MCH programme, family planning programme gets a respectable share, which is targeted against women. In Indian the context women and adolescent girls face various social and cultural constraints in acquiring health services and expressing their health needs. One of my woman respondents who is a Muslim said "there are many restrictions on our movement, we don't come to the health centre until and unless the illness is unbearable". So there are lots of restrictions on the movement of women. Due to social norms women as a category have the least access to health services. So when the sickness becomes unbearable and affects their work, they come to approach the health centre.

There is an urgent need to structure the health services to respond to gynecological and obstetric conditions that women experience, and to take

into consideration the social, cultural and the economic constraints that women face in expressing them. In my study, most of the women respondents said that they don't feel comfortable to tell their gynecological problems to a doctor, who is a male, due to social distance. Though in OPD most of the time only male house surgeons are available, in the absence of any lady doctor, they are compelled to consult male doctors, but they feel that there is always a cultural constraint in expressing their problems. One of the women respondent said that a woman doctor gives better treatment for gynecological problems, because she experiences these. There is also a need to address factors underlying infertility. Women's poor health and nutritional status, which can lead to, repeated miscarriage and foetal wastage. Infertility can have serious consequences for female well-being in a culture like ours, which prizes reproduction. It leads to various kinds of emotional harassment or marital disharmony. Adolescent girls, most of whom are out of school, constitute a sizeable proportion of female population. They are particularly vulnerable and neglected, coming under the purview of government programme only once they are pregnant. . The majority are out of school and are neither served by educational or school health programmes nor by child health nutritional services. While poor quality of health care can inhibit women from seeking health care, women's lack of autonomy in decision making or freedom of movement and time can restrict visits to health centres even where a health problem has been recognized. Health workers themselves are poorly informed about reproductive morbidity and can be insensitive in

probing and recognizing symptoms (Jejeebhoy, 1997). The present health care system focuses largely on women sterilization rather than women's health in general, which limits women's accessibility to health service. To cater women's health needs there is a need for health service, which can be available to them at their doorstep.

Health programmes are aimed at providing some services to the people, thereby expecting them to accept, collaborate and comply. The expectations from health programmes can be described in terms of appropriate patterns of participation, acceptance and compliance by the target population. All health programmes to be effective require people to do certain things in a particular manner, which is different from the customary behaviour. This means health programmes are in effect the programmes of social change (Kochar, 1991). So to bring change in the health behaviour, the community cannot be seen as passive receivers of service; for making it successful, active participation of the community is required. In India, while translating the primary health care approach, the community participation was selectively ignored. So health service is more centralized, instead of being decentralized. A particular community's felt needs for specific health behaviour is not given importance in the centralized planning. And health-seeking behaviour differs from community to community, so a universally applicable health programme is not going to solve the problem. As Imrana Qadeer (1985) defines health as a social concept, which is determined by the perceptions of a group or

community and therefore differs from community to community. So to identify different community's health needs, it is important to understand the social and cultural context of people's lives to identify their health needs. A comprehensive concept of health should have an inbuilt social dimension, reflecting upon the available knowledge and consciousness of people and culture and power relations within the society. The health programmes are drawn at the central level, and the rural people don't necessarily share the perceptions of health planners and their priority of health needs. As the perceptions about the health behaviour differs, the acceptance of a particular health programme becomes difficult.

Based on the field data and observation, it can be said that the poorer sections of population, i.e. Muslims, migrants and S.Ts are the ones who predominantly access health services at RHC, Patancheru (see table- 4). This is because all of them with their meager income could not afford private practitioners and hence consulted RHC. In the West Bengal case study Ray and Bhaduri (2001), found that the hospital OPD is used either by the very poor who have no access to credit to make an immediate payment for private medical care or by the rich and politically influential who can extract preferential treatment from the OPD services

Table – 4: Caste and disease wise distribution of the respondents who consulted RHC

Caste	Febrile		Skin disease		Minor ailments		Gynecological problems	Total
	Male	Female	Male	Female	Male	Female	Female	
Muslims	1	2	1	1	1	2	5	13
S.Ts		1					1	2
S.Cs	1				1			2
B.Cs	1			1	1			3
U.Cs			1					1
Others		1	3	1			1	6
Total	3	4	5	3	3	2	7	27

ST–Lambadas, S.C–Madiga, B.C.-Munuru kapu, Padmasali, Mudiraj, U.C- Reddy

Others- include migrants from Maharashtra, Bihar, Nepal, so their castes were difficult to be classified.

In my study it was found that in five cases while women came to the government health centre for treatment, the male members of the house went for private treatment. It was also found in another case that while the earning member of the house went for private treatment, the non-earning members of the house visited government health care, and in most cases where there is frequent recurrence of disease, the government doctor was consulted. The rich and educated people come to RHC for health care when they knew the doctor

personally and for simple BP check up, other simple checkups and to get specific medicines from the health centre which were not available outside.

It was found that most of the time the patients were not satisfied with the interaction they had with the doctors. Often it is found that the duration of consultancy is very less, and no physical examination was being done by the doctors at RHC. The rural people have their own perception of doctor and expect the doctor to do physical examination by pulse check-up, examination by stethoscope etc. But when their expectation is not met, they become suspicious about the effectiveness of the treatment and it restrains them from repeated consultation of RHC. When the poor villagers expectations from the health centre is not met, they simply don't want to access the health centre at the cost of losing wage and spending on transport. Rhode and Viswanathan (1995) in their study point out that rural people prefer private practitioner because the duration of consultancy is more and in case of government clinics the consultancy period appear to be small and waiting time prior to consultancy is longer. And the private practitioners give much importance to physical examinations. Often primary health centre is seen as a poor man's place. When all other options of getting health care are closed, they seek the government health care.

The OPD timing is also one of the important factors in terms of accessibility to health services. It is found that the OPD timing does not match

with the poor wage earners timing. In RHC though the OPD timing is from 9 am to 1 pm, it is actually open from 10 to 12. As this is the time people engage in wage labour, they have to lose one day's wage if they decide to consult RHC. Hence when the disease becomes unbearable to the extent that it affects their work and also in most cases as they cannot afford private practitioners, they come for health service at RHC. And they also expect quick relief, so that they can get back to work soon. Hence there is always a great demand for injections, which is to save their wage earning. In their study Rhode and Viswanathan (1995) point out that average rural persons prefer to go to private practitioners for medical care because of their preoccupation with quick care. Because an average rural person loses wages if daily work is interrupted. So they cannot afford the luxury of prolonged cure and periods of rest. For the relatively poor wage earner and tillers, the treatment at the OPD often proves to be quite costly in terms of lost working days and wages since it involves regular visits and long delays every time. Often the OPD patients have to pay for diagnostics and medication due to lack of adequate supplies. Thus effectively the cost of private care is not perceived to be significantly higher. So the poor comes and approaches the government health centre when the option for accessing the private care is closed due to lack of money. But here also the poor does not find the health service to be accessible.

Non-availability of drugs further curtails people's accessibility to health services. This assumes much importance because the people who come to government health centres are needy and all the other options of accessing health care are closed. It is found that there is shortage of drugs in RHC, for which the poorer sections of the society and women are affected badly. Women are affected because there is reluctance for spending on the health care of women in the family. So most of the time the women members of the house come to access health service from government health centre while the other members of the house exercise the option of consulting private treatment. In the RHC, knowing well the shortage of drugs and institutional lacunae, employees of RHC took advantage in establishing their entrepreneurial activity. For example one pharmacist's husband has established his medical store right in front of RHC, while no other medical stores exist in the near vicinity. The discussion with pharmacist, other paramedical personnel and community persons revealed that some important medicines like penicillin also does not get utilized (subsequently may also get expired) in RHC, while people were asked to buy those injections from outside to be administered in the dispensary. So most of the time people will have to buy the injections from outside medical shop and come to the dispensary to take it. On the other hand, medical personnel take advantage of institutional weaknesses and make profits; while on the other hand; rural communities have to make hard choice even in consulting government health centres as they have to buy injections and certain medicines.

Due to the casual approach of the doctors and paramedical staff, and lack of satisfaction and the interaction with the health personnel, people are often suspicious about the quality of medicines given in RHC. Most of the people complain that the same medicine is dispensed for different kinds of diseases (perceived by the size and colour of the medicine). And they feel that though medicines are available in the health centre not all of them are dispensed to people. One woman respondent showed two sets of medicines and told "see, my child and myself are given the same medicine for different diseases, and the doctor has asked to give the full dosage to the child. How can a child and an elderly person have same medicine with the same dosage, either the medicine won't be effective for the elderly person, or it will be harmful for the child". Similar findings have been drawn by Rai and Bhaduri (2001) in their study, where they discuss that some people complain about ineffectiveness of PHC medicines, when it is available. The same medicine is dispensed to all patients irrespective of the ailment. They suspect that good quality medicines are given to 'known' and 'privileged' patients.

In addition to the above factors, professional hierarchy of health centre staff also affects the delivery of health service in health centre. In the RHC, it was found that there is an over utilization of the services of the sub-ordinate staff by the upper cadre. For example, while there are two pharmacists in RHC, one is in charge of dispensing medicines and the other pharmacist takes

care of the store. The person, who is in charge of the store, is required to take the medicines out of the stock room only once in three to four days and rest of the time, she was free. Though it is the duty of a pharmacist to dispense injections, the multi-purpose health assistant was required to dispense injections at the dispensary, at the same time she was required to be in the operation theatre when tubectomy operation was going on, also attend the deliveries. This additional burden and irregular shifts (day and night) demotivates the lower cadre staff. This affects the service delivery. For instance, in the absence of multi-purpose health assistant the dresser used to give injections, for which job he was not skilled. Mark Nichter (1986) also focuses on the generic difficulties in implementing primary health care ideology at the health centre level. He argues that the ideology of the primary health care needs to be considered from the vantage point of health centre staff and in relation to issues involving professional status and personal motivation. In the health centre workers are keenly aware of each other's status, which is in part determined by salary, specialized knowledge and access to sources of power and symbols of authority. The professional jealousy between the health centre staff affects the health delivery system. In the South Karnataka health centre study, Mark Nichter found that two out of three medical officers observed, restricted their auxiliary nurse-midwife field staff from administering even the simplest curative medication, though they have been trained to attend medical emergencies. The rationale of those medical officers was that if field staff were allowed to dispense medicines,

they would aspire to become 'quacks' and would pay less attention to their preventive and promotive health duties. At the same time the doctors were engaged in private practice. The ANMs recognized that their inability to provide even the most basic curative services reduced not only their status, but also people's receptivity to their promotive, preventive health advice.

From the above discussion it is clear that the rural poor has least access to healthcare service. As Antia (2000) rightly points out poorly functioning public health care system in rural areas has in some states reduced to a collection of deserted and chaotic primary health centres, filthy dispensaries and unmotivated doctors. Imbalance is also reflected in the quality of service provided to the rural people by primary health centres which has failed in providing an integrated service and also adequate preventive and promotive care while neglecting curative services which is the felt need of people. Though health service infrastructure is there in rural areas, it is of little use for the rural poor in the absence of health professionals and adequate services. The rural poor is worst affected, because they lack resources even to spend on transport to access health service in urban areas. Besides, the cultural gap between health personnel and rural masses makes the health service inaccessible to the rural people. Women as a marginalized section have least access to health service. Their subordinate position in society along with social norms and restrictions on their movement makes the service inaccessible to them. The needs of women are not addressed in the primary

health care service. Women are only addressed in terms of their motherhood roles, through mother and child health programme and family planning programmes. The family planning programme acts as an oppressive mechanism against women. Due to target-oriented approach of family planning, the poor in general and women in particular are worst affected. The selective programmes, which are carried through primary health centres, are given prime importance by the health personnel, which affects the delivery of most essential services. As the medical personnel spend all their effective work time on carrying out the selective programmes, the delivery of curative health service is affected. The casual approach of the health centre staff along with shortage of drugs and OPD timings further curtails the accessibility of health service to the rural poor. People's expectation in terms of physical examination by the health personnel do not meet. In addition the casual approach of treatment of health personnel gives rise to suspicion about the service made available by the health centre as it forces the poor to choose the RHC as the last option for accessing health service. Distance is also one of the critical factors in terms of accessibility to health service. For instance, some of my respondents who came from more than 5 kilometers, from the places like Chitkul and Isnapur, to access health care from RHC said that for coming to RHC each time they had to spend 20 rupees on traveling, so it becomes difficult to access RHC as soon as they fall sick. Only when the sickness becomes intolerable they come to consult doctors in RHC. So the availability of medicine, long waiting time, money and time spent on traveling influences

or rather hinders the accessibility to health service. It is quite evident that, whatever health services are available to the rural poor, these services are not even accessible to them because of the top-down and vertical programmes that are designed and implemented without any concern for the local needs of the communities.

SUMMARY AND CONCLUSION

WHO defines health as a state of physical, mental and social well-being. The health status of people determines the quality and longevity of life. Thus health is not merely a need; it is the most fundamental of all rights that is, the right to life. As it is a right, it is an obligation of the state to fulfill this need. The concept of health connects well with the development thinking, which emphasizes that the purpose of development is human well-being. Therefore some key indicators of development are health related. Development does not mean only economic growth. Though economic growth is a necessary condition for the achievement of good health, but other factors like environment, education, status of women, dietary/health practices, culture equally influence health.

The primary health care approach addresses health as an issue of development and right of the individual. The primary health care approach was first defined in the Alma Ata declaration. It emphasizes on a comprehensive view of health, giving equal importance to curative, preventive and promotive aspects of health. It addresses health in terms of three measures such as: health as a basic human right, a social goal and necessary for developing strong economies. Alma Ata declaration made it clear that governments have the responsibility for the health of their people. This was a

redefinition of the norms and expectations of the state's role with regard to health. This was particularly important for newly created states, which were challenged to provide health care for their population after the collapse of the colonial system.

Within a year of the introduction of the primary health care approach, it was criticized, and an alternative to primary health care approach emerged. Primary health care approach was ignored on the basis of the amount of money required to be invested. As an alternative to primary health care approach, Walsh and Warren presented selective primary health care approach to a joint FORD/ Rockfeller foundation symposium on health services in Bellagio, Italy, which was well received. This approach was required to institute health care directed at preventing or treating few diseases that are responsible for greatest morbidity and mortality. It was justified on the basis of cost effectiveness. This approach is based on techno centric approach, which subordinates people into technological packages.

SPHC defines health as absence of disease rather than well-being. This definition implies that medical intervention can restore health. However, by emphasizing a biological body-machine model, it undermines dynamic interaction between mind and body. The interplay of three factors of mind, body and environment, which is responsible for manifestation of disease, has not been given importance in selective primary health care approach. Where

as the primary health care approach gave equal importance to curative, preventive and promotive health care service, the preventive aspect of it became the most favored approach of many developing countries and that of international agencies. The interventions were aimed at the disease rather than its cause. By ignoring malnutrition as the mother of morbidity, health interventions based on selective approach gradually developed independent of its social matrix. Limitations of technology in the context of health of children can be addressed if we focus on the larger issue of role of public health technologies and emphasize that the health improvements brought about by immunization and Oral Rehydration Therapy can only be sustained by availability of food, water, shelter and political and economic power.

The selective primary health care approach became the most favored approach of international agencies. Due to global economic recession, World Bank and International Monetary Fund emerged as major funding agencies and tried to dictate the policy of the developing countries. They tried to impose their economic policy on developing countries in the name of structural adjustment programme. Through structural adjustment programme, budgets for so-called non-productive government activities such as health, education and food subsidies were ruthlessly slashed. Here the real issue is not whether adjustment is necessary but the manner in which it has been put through undermines the issue of social justice. In such a situation the implementation of primary health care became an impossible task. WHO in its

"health for all in 21st century" agenda is reinventing the wheel by emphasizing the selective primary health care approach, and supporting selected disease control programmes. It pushes the commitments to equity and social justice under the carpet. The proposed agenda of *"health for all in 21st century"* targets the year 2020 as the time frame for achieving this vision. But as long as the solution to the disease problem is treated independent of the social context, it may have limited impact, and health for all will remain a distant dream.

In the Indian context the existence of primary health care approach was felt much before India's formal commitment to primary health care strategy through Alma Ata, in Bhore committee Report 1946. The first ever national health policy of India accepted primary health care as the basis of providing health care service. But it has not been implemented successfully. Selective primary health care approach was the preferred strategy and it was implemented through the same health care machinery, which was meant for implementing primary health care approach. And after India's submission to structural adjustment programme, the implementation of primary health care approach became much more difficult. In such a situation, the question arises, to what extent are the health services available, accessible and affordable to the rural communities?

In order to assess some of the issues of accessibility I conducted a study on Rural health centre, Patancheru. In the study I have made an attempt to understand the complex set of factors that determine people's accessibility to public health care system which cater to their health needs. The inaccessibility of government sponsored health care service can be attributed to various reasons. It is found that most of the doctors are urban oriented and private practice oriented. Because of this in most of the health centres situated in rural areas, either the post of doctor is vacant or if it is filled, the doctor is a reluctant service provider. This attitude of doctors seriously affects the delivery of health services. Although the paramedical staff try to deliver the service, it does not meet the expectation of , most of the times. The centralized planning of health care service is also unable to incorporate the felt needs of the rural communities. The vertical programmes in general and family planning programme in particular is given much importance and it is carried out with much sincerity at the cost of the curative and other essential services of the health centre and because of this the curative health service becomes inaccessible to the rural poor. The inadequate supply of drugs also affects people's accessibility to health service. Also the professional hierarchy and subordination of the lower cadre staff affects the health service delivery in the health center. Along with the several factors mentioned above, the casual approach, attitude towards the rural clients, timing of the health centre etc equally restricts people's accessibility towards public health services. As the OPD timing does not match with the poor wage labourer's timing, the public

health service often becomes expensive in terms of loss of wage. And only when all the options of getting health care are closed, the poor often visits the government health centre. But here also the poor do not get proper health care service. So the rural poor in real sense is left with minimal or no option in terms of health care.

As is evident, the rural communities have several factors, which affect their utilisation of services from the public health system. On the other hand, several studies (NSS,1996, Duggal & Amin, 1989, George et al, 1992, Kannan et al 1991) show that the private health sector accounts for over 70 percent of all primary health care treatment, inspite of the fact that over two third of the population live below poverty line. But the poor goes for private treatment not out of choice, but out of compulsion, since services are not available from government machinery. Without understanding complex set of factors, why most of the people access private health sector for primary health care, Draft National health policy 2001 as well as the World Bank prescribes that the government should focus only on preventive and promotive health services leaving curative care for the private sector. If this happens all the options will be closed for the poor to get cured from sickness, and it will leave the poor to be diseased in eternity. Again health, especially the preventive aspects have little significance to the vast majority of people whose main preoccupation is to provide the next day's meal for the family. Even illness and pain is not adequate reason to seek medical aid, unless it interferes with earning their daily bread. Further from my study it is evident that there are

people who solely depend on the health centre for treatment and cannot even afford to pay for a single needle to take injection, although the needles provided by the dispensary are not sterilized properly and there is every possibility of transmission of deadly diseases by taking injection with those needles. Secondly in a society like ours where women are conditioned to cope with and not complain about their sickness and their health needs are given secondary importance, as also there is a reluctance to spend on their health. If the government health sector is not going to provide curative service, women as a marginalized category will be the worst affected category. The goals of achieving social justice, equity, all round development etc becomes rhetoric unless felt needs of the communities gets incorporated into primary health care approach.

References

Aggleton, Peter (1990): "Health", Routledge Publication.

Alma Ata declaration (1978): "Report on International conference of primary health care", World Health Organization.

Antia, N.H, Dutta G.P, and Kabeskar A.B (2000): "Health and medical care: a people's movement", Pune: Foundation for Research in Community Health.

Antia,N.H. (1994): "The world development report 1993: a prescription for health disaster", ***Social Scientist,*** Vol.22, Nos.9-12, Sep-Dec.

Banerji, Debabar (2001): "Landmarks in the development of health services in India", In Qadeer Imrana et al (ed) "Public health and the poverty of reforms", New Delhi: Sage Publications.

Banerji, Debabar (1991): "Trends in health service development in India", In Yesudian, C.A.K. (ed), "Primary health care", Bombay: Tata Institute of Social Sciences.

Banerji, Debabar (1983): "National health policy and its implication", ***Economic and Political Weekly,*** January 22.

Basch, Paul.F (1990): "Text book of international health", Oxford University Press.

Briscoe. J, Feachem. R.G., Rahman. M.M (1986): "Evaluating health impact: water supply, sanitation and hygiene education", UNICEF, ICDDR, IDRC.

Bruycker, Mark.De (2001): "Dilemmas for research in primary health care in the era of reforms", In Imrana Qadeer, Kasturi Sen, K.R. Nayar (ed), "Public health and the poverty of reforms", New Delhi: Sage publications.

Cruz, D and Bharat, Shalini (2001): "Which way to turn? Inadequacies in health care system in India", ***Journal of health Management,*** Vol.3, No.1.

Daniels, Norman (1985): "Just health Care", Cambridge University Press.

Dreze, Jean and Sen, Amartya (ed) (1995): "Indian development: selected regional perspectives" Oxford University Press.

Dreze, Jean and Sen, Amartya (1993): "Hunger and public action", Oxford University Press.

Duggal, Ravi (2001): "Our national health policy: a critique", ***Health Action***, Vol.14, No.11.

Duggal, Ravi (2000): "The private health sector in India: nature, trends and a critique", Voluntary Health Association of India.

Duggal, Ravi and Amin, S (1989): "Cost of health care", Bombay, Foundation for Research in Community Health.

Frambrose, Pintos (1999): "Globalization of health", ***Health Action,*** Vol.12, No.10.

Garrett, Laurie (2002): "The collapse of global public health", ***Health Matters,*** Spring issue-47.

George, Alex et al (1992): "Household health expenditure in Madhya Pradesh", Mumbai, FRCH

Gish, Oskar (1982): "Selective primary health care: old wine in new bottles", ***Social Science and Medicine,*** Vol.16, No.10.

Guhan, S (2001): "Health in India during the period of structural adjustment", In Subramanian.S (ed), "India's development experience", Oxford University Press.

Hoven, Rolph Var Der (1988): "Planning for basic needs: A soft option or solid policy?", Gower Publishing Company.

International forum for the defense of health of people (2002): "Health as an essential human need, a right of citizenship, and public good: health for all is possible and necessary". ***International Journal of Health Services***, Vol.32, No.3.

Jayaram, N. (1977): "Social implications of medical education in India", ***Journal of Higher Education,*** Vol.3, No.2, Autumn-1977.

Jejeebhoy, shireen.J (1997): "Addressing women's reproductive health needs", ***Economic and Political Weekly,*** Vol.32, Nos.9&10.

Kannan, K.P et al (1991): "Health and development in rural Kerala", Thiruvananthapuram: Kerala Sahitya Parishad.

Kelly, Anthony. "Health for all in the year 2000: the unrealized dream?" http:// home.online.no/oneworld/health/health htm.

Kethineni, Veeranarayana: "Political economy of state intervention in health care", ***Economic and Political Weekly,*** october19, 1991.

Kickbush, Ilona (2000): "The development of international health policies, accountability intact", ***Social Science and Medicine,*** Vol.51, No.6.

Kochar, Vijay (1991): "Social techniques for PHC", In C.A.K. Yesudian (ed) "Primary health care", Bombay: Tata Institute of social sciences.

Macpheron, Stewart and Midgley (1987): "Comparative social policy and the third world", Harvester Group Publication.

Macpherson, Stewart (1986): "Social policy in the third world: the social dilemmas of under development", Selected book service syndicate.

Madan. T.N. (1980): "Doctors and society, three Asian case studies", New Delhi: Vikas publishing house.

Narayana, K.V. (1997): "Health and development", Jaipur: Rawat Publications.

Navarro, Vicente (1984): "A critique of the ideological and political positions of the Willy Brandit Report and the WHO and Alma Ata declaration", ***Social Science and Medicine,*** Vol.18, No.6.

Nichter Mark (1986): "Primary health center as a social system: PHC social status and the issue of team work in South Asia". ***Social Science and Medicine,*** Vol.23, No.4.

NIRD (1989): "Health care delivery system in rural areas- A study of MPW scheme", Hyderabad: National Institute of Rural Development.

NSS (1996): Report No.441, 52nd Round, New Delhi: National Sample Survey Organization.

Partow, Farouk & Bekele (1989): "Health for all: primary goal by the year 2000", In Haq, Khadija & Kirdar, Uner (ed): "Development for the people: goals and strategies for the year 2000", North and South Roundtable and UNDP Development Study Programme.

Phillips, David.R (1990): "Health and health care in the third world", Longman group Publication.

Qadeer, Imrana (2001): "Impact of structural adjustment programs on concepts in public health", In Qadeer, Sen, Nayar (ed) "Public health and the poverty of reforms", New Delhi: Sage Publications.

Qadeer, Imrana (1994): "World development report-1993, the brave new world of primary health care", ***Social Scientist***, Vol.22, Nos.9-12.

Qadeer, Imrana (1985): "Health services system in India: An expression of socio-economic inequalities", ***social Action***, Vol.35, July-Sep.

Ravichandran, N. (2002): "Primary health care and globalization: organizing for change", ***Social Action***, Vol.52, January- March.

Ray, Amit.S, Bhaduri, Saradindu (2001): "Political economy of rural health center in India", Voluntary health association of India.

Report of the independent commission on health in India (1997), Voluntary Health Association of India.

Riffkin, Susan .B & Gill, Walt (1986): "Why health improves: defining the issues concerning comprehensive primary health care and selective primary health care", ***Social Science and Medicine***, Vol.16, No.6.

Ritu Priya (2001): "Disability Adjusted life years as a tool for public health policy: a critical assessment" In Qadeer Imrana et al (ed) "public health and the poverty of reforms", Sage Publications.

Rohde, J.E & Viswanathan, H (1995): "Rural private practioner", Oxford University Press.

Seers, D. (1969): "The meaning of development" In Lehmannced's "Development theory: four critical studies", Frank Cass, London.

Sen, Amartya (1999): "Health in development", ***International Journal of Public Health***, Vol.77, No.8.

Sen, Amartya, (1981): "Poverty and famines: an essay on entitlement deprivation", Oxford University Press.

Sen Kasturi (2001): "Health reforms and developing countries- a critique" In Qadeer Imrana et al (ed) "Public health and the poverty of reforms", Sage Publications.

Sengupta, A. (1994): "World development report: implications for infrastructure development in health care and the pharmaceutical industry", ***Social Scientist,*** Vol.22, Nos.9-12.

Shah, Ghanshyam (1997): "Public health and urban development", Sage Publications.

Shiva Raju (1991): "Health care system in India and need for comprehensive evaluation", In Yesudian, C.A.K (ed) "Primary health care", Tata Institute of Social Sciences.

Shivkumar, A.K (1994): "Some considerations in the formulation of India's health policy: a note on equity", ***Social Scientist,*** Vol.22, Nos.9-12.

Srinivasan, S (1987): "Management of rural health care", ***Social Change,*** Vol.17, No.1.

Tarimo, E. & Webster, E.G (1997): "Primary health care concepts and challenges in a changing world: Alma Ata revisited". Division of analysis, research and assessment, WHO.

Unger, Jean Pierre & Killingsworth (1986): "Selective primary health care: a critical review of methods and results", ***Social Science and Medicine,*** Vol.22, No.10.

Venediktov, Dmitry (1998): "Primary health care: Alma Ata and after" ***World Health Forum,*** Vol.19, No.1.

Walsh, J.A, Warren, K.S (1979): "Selective primary health care: an interim strategy for disease control in developing countries", ***New England Journal of Medicine,*** Vol.301, No.18.

Watson, F. (1994): "Human face or human facade? Adjustment and the health of mothers and children", London: Centre for International child health.

Werner, David (2001): "What happened to health for all?" ***New Internationalist,*** Jan-Feb.

Werner, David & Sanders, David (1997): "Questioning the solution: The politics of PHC and child survival", Health Wrights.

Wood, C.H. (1982): "The political economy of infant mortality in So Paulo, Brazil", ***International Journal of Health Services,*** Vol.12, No.2.

World Development Report (1997): "Selected indicators on public finance, World Bank", Oxford University Press.

Zurbrigg, Sheila (2001) "Rethinking public health: food hunger, and mortality decline in South Asian history", In Imrana Qadeer, Kasturi Sen, Nayar,K.R (ed), "Public health and poverty of reforms", Sage Publications.