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REPORT ON THE STATUS OF

RIGHT TO HEALTH

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RIGHT TO HEALTH

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HEALTH AS A BASIC RIGHT

I. INTRODUCTION

Health is integral to life and right to life cannot be conceived without reference to health. As such, it is common sense to argue that everyone has a right to health. The problem is to ascertain the content of the right, the conditions in which it stands violated, the nature and scope of obligations it imposes and the remedies one can claim if the right is violated.

Does right to health mean that every individual is to be guaranteed good health at all times by the State? Certainly, not. This no State can ever guarantee as it is a condition determined by a combination of factors like heredity, environment, timely health interventions, model of development, personal hygiene etc. This is the reason why even the Covenant on Social and Economic Rights speaks only of "the highest attainable state of health" as the object of the right. The content of this right is thus relative, varying in time and place. Yet there is a core content which is spelt out in public health and medical services law. By improving housing, living conditions, level of nutrition, water supply, sanitation etc. Governments can protect health of the people far more effectively than by opening more hospitals. That is why health rights are emerging by way of specific standards and procedures as found in the Court decisions on Blood Banks, emergency medical services in accident cases, preventive health services in hazardous occupations etc. In short, right to health, like other individual rights entitle citizens to demand certain minimum standards and procedures in the maintenance of public health and to seek remedies through Courts whenever such conditions are not maintained and as a result right to life is endangered.

The World Health Organization, in its programme on Primary Health Care and Health for All by the Year 2000 spelt out in 1978 what is called the Declaration of Alma Alta, certain essential initiatives to achieve the "highest attainable standard of health" as stipulated in the Covenant on ESC Rights.

These are :

(a) Emphasis on preventive health measures (such as immunisation, family planning) more than on curative measures;

(b) Emphasis on participation of individuals and groups in the planning and implementation of health care;

(c) Emphasis on maternal and child health care;

(d) Education concerning health problems;

(e) Priority in health care to vulnerable and high risk groups;

(f) Provision for equal access of individuals and families to health care at a cost the community can afford.

One of the serious problems acknowledged by the Alma Alta Declaration is the gross inequality in the allocation of health care and the health status of different groups in society like women, tribals, slum dwellers. Human rights are indivisible and inter-dependent. Hence the right to health cannot be effectively protected without respect for other human rights like equality and non-discrimination, participatory decision-making, education, housing etc.

Right to health has two basic components, (a) right to an environment involving the minimum of health risks and (b) right to have access to health services that can prevent or alleviate suffering and treat diseases. WHO has moved towards such a definition of the right. In both aspects, States have positive and negative obligations which includes even preventing non-State actors from violating that right. Violation of minimum standards are violations of right to health and, as such, enforceable if necessary through court actions. Other obligations are promotional in nature aimed towards achieving higher standards of health.

Medical ethics also are norms intended to protect health rights of patients and the society at large. With growth of human rights standards, medical ethics evolved new norms of conduct in medical care and delivery of health services and, as such, a lot of human rights violations can be redressed through enforcement of code of ethics.

The Indian Constitution devotes several Articles in directing the State to protect health rights in a variety of situations. They are, of course, part of Directive Principles of State Policy which are declared by the Constitution (Article 37) as fundamental in the governance of the country. Among the relevant Articles are :

Article 38 - State to secure a social order for the promotion of welfare of the people.

Article 39 - The State, in particular, to direct its policy towards securing : "(e)..... that the health and strength of workers and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age and strength".

Article 41 - Right to ..... public assistance in cases of ..... old age, sickness and disablement, and in other cases of undeserved want.

Article 47 - Duty of the State to raise the level of nutrition and the standard of living and to improve public health, and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

Article 48A- Duty of the State to protect the environment.

Article 51A(g) - Duty of every citizen to protect and improve the natural environment – etc.

It is interesting to note that in dealing with the subject of health, the Constitution makers did use the language of both rights and duties (Articles 41,47 and 48-A) though they were reluctant to put it as part of judicially enforceable fundamental rights. It is this reluctance which was overcome by the Supreme Court when it interpreted Article 21 (Right to life and personal liberty) to include right to health. In doing so they did seek support from international human rights instruments as well the relevant provisions in the Directive Principles.

This study attempts to examine from the citizen's perspective as to what is available to him in practice in the field of health rights with a view to understand its status as basic human right. What follows are brief reports on the findings of the survey in the four Southern States.

II. STATUS OF HEALTH AND RIGHT TO HEALTH IN KERALA

"Kerala is renowned as a State which has made success for years in the fields of health and education. Kerala's achievements in key areas of human development have been widely appreciated. However, on deeper scrutiny it would appear that the progress is only in the periphery and is not sustainable in the long run. There is food, but most of it is not produced here. There is longevity, but it is tempered by morbidity. There is a semblance of cleanliness all round, but this cleanliness does not stand the test of scrutiny. People are concerned about personal and household cleanliness; but indifferent to public and environmental cleanliness".

This is how the 1998 report of the Task Force appointed by the Government of Kerala begins about status of sanitation and health in Kerala.

1. Sanitation

1.1 The Report characterises environment sanitation in the State as dismal. Sanitation coverage in Kerala is only 51%. According to the Report people living in the coastal belt, urban slums and other problem areas live in extremely miserable conditions because of high density of population and acute poverty and malnutrition. The situation of women is desperately pathetic because they do not have access to toilet facilities and are deprived of the right to privacy. Many years of experience in the water and sanitation sector has revealed that Kerala has completely neglected the elements of community education, mobilisation and informed participation.

1.2 The report stated that 29 lakh families in the State, 32% of the poor households, do not have proper toilet facilities! 1991 Census shows that the households with latrines is just over 50 per cent (44% in rural areas and 72% in the urban areas). Piped sewerage facility exists only in Thiruvananthapuram and Cochin and that too covers only a small section of the population (About 30 per cent in Trivandrum and 10 per cent in Cochin!).

1.3 Public investment in sanitation sector in the State has been very meagre and there are no indications of it being any better in the future unless the Panchayat Raj institutions in different areas take the initiative and mobilise opinion and resources.

2. Drinking Water

2.1 According to Government statistics 37% of the rural and 70% of the urban population have access to piped water supply schemes. However, National Family Health Survey shows that only 19% of the rural households are consuming piped water. Open wells from which bulk of rural people take their water supply are found to have a high degree of bacteriological pollution. One survey showed that there were over 1800 habitations in the State in 1994 which do not have even a single public source for potable water!

2.2 The State faces acute scarcity of water during summer. In the Trivandrum District nearly 60% of households faces severe scarcity of water in summer months.

3. Nutrition

3.1 According to National Sample Survey (1980, 83) Kerala ranks lowest in food intake. The National Nutrition Monitoring Bureau and the Kerala Statistical Institute studies report that the average per capita consumption of nutrients in Kerala is much below the recommended consumption and remains the second lowest amongst eight States studied in 1990 while it was the lowest in 1979. Food intake studies carried out on pregnant and lactating women also reveal the same trends.

3.2 According to a more recent survey (1995) moderate to severe malnutrition is widely prevalent in Kerala, among children under 4 years. The NFHS survey revealed that malnutrition is more common among rural children and among children of Scheduled Tribes.

3.3 Review of the birth weight of children over the last 30 years from the teaching hospitals indicates that birth weight steadily increased during the 1960s, 1970s and early 1980s, but has started to decline from the mid 1980s. Low birth-weight babies (less than 2.5 Kg) comprised 21% of all births in 1989 (Nutrition and Keralites, C.R.Soman, 1998). The mean weight is around 2810 grams.

3.4 Pre-School children in the urban environment suffer on an average, more than 100 days of illness while the number of disease free weeks is less than 26 for the whole year. About

40 to 50 per cent of pre-school children suffer from one or other worm infection. Childhood morbidity is fairly high in the State.

3.5 Childhood malnutrition still remains a problem in Kerala despite significant reduction in child mortality. About 40% children live under the shadow of moderate to severe malnutrition. Any adverse impact on food intake may result in the increase in the prevalence of severe malnutrition. Food consumption being already below the recommended level, any further decline in intake may lead to a serious deterioration of the nutritional situation.

4. Health

4.1 As per the conventional health indicators like birth and death rates, infant and maternal mortality rates and life expectancy, Kerala claims to have achieved the "Health for All" targets set for India for 2000 AD, even as early as by 1986! Though Keralites live longer (across 70 years) compared to other States, Keralite is dogged by more episodes of diseases. Many of these diseases arise out of poverty and deprivation which calls for education, employment, better sanitation, nutrition etc.

4.2 Presently 10% of the population is in the age group of 60+ which is bound to increase with mortality reduction and fertility regulation. A third of health resources are consumed by this group which may soon go up to 50%. The Health System has not adequately addressed this phenomenon.

4.3 Compared to the rest of the country, diseases associated with circulatory and respiratory systems, cancers of different kinds and nervous disorders are much more in Kerala. The brunt of psychosomatic illness (one that is caused or aggravated by mental stress) outweigh that of physical illness in terms of numbers as well as in terms of the disability and loss of mandays it engenders. Nearly 20 persons in every 1000 reportedly suffer from chronic schizophrenia, recurrent affective disorders, severe psychomotor epilepsy, gross personality disorders as well as profound mental retardation. The suicidal rate also is reportedly very high – as high as 17 per lakh of population per year! In short, mental health is a very serious problem inadequately addressed in the State. There are only 3 mental health centres under the

Government with a bed strength of 1342. The manpower resources available is also totally inadequate with just 78 M.D. degree holders and 164 Diploma holders registered in the State.

4.4 Another health problem in the State is said to be the high prevalence of dental diseases. According to Kerala Dental Association study 33% of the teeth of an average Keralite is out of gear marring not only the physical quality of life but the mental state and personality of the individual. Government facilities for dental care are limited to the dental OPs of the two State Dental Colleges and some dental units attached to few district and other hospitals.

4.5 The threat from emerging diseases like HIV/AIDS is said to be real and imminent to Kerala in view of the transmigration of the people of the State. Mosquito borne viral encephalitis and rat-borne leptospirosis are said to be other emerging threats for the State. Rabies is another significant source of danger in the State.

4.6 The extent of fatal or serious accidents on roads and work places is increasing in the State. There is very little preparedness for appropriate responses in times of natural disasters and man-made calamities.

4.7 The health position of people with disabilities whose number may exceed 4 per 1000 is indeed pitiable. The available facilities are far too inadequate to the tasks in hand.

4.8 Finally, it is interesting to note that a large section of people in the State do not invoke the health services available and manage their health themselves. Furthermore, 43% of the poor seek private treatment at enormous cost while free public treatment facilities are open to them in government hospitals. In fact, the government health services are being used only by one-fourth of the population, three-fourths depending upon private health services.

5. Health Infrastructure

5.1 The following table gives the general picture of the health facilities available under government and private sectors in the State (Source : State Planning Board, 1995) :

Health Infrastructure in Kerala, 1995

SYSTEM	PUBLIC/GOVT.			PRIVATE		
	Facilities	Beds	Doctors	Facilities	Beds	Doctors
ALLOPATHY	1,249	42,438	2,998	1,846	49,030	6,335
AYURVEDA	686	2,309	621	3,925	1,301	4,130
HOMEOPATHY	405	950	421	2,078	296	2,168
OTHERS	-	-	-	95	139	100
TOTAL	**2,340**	**45,697**	**4,040**	**9,063**	**50,766**	**12,733**

The Table conveys some interesting statistics such as :-

(a) there is one Govt. Doctor for every 10,000 people (Allopathy).

(b) there is 1.4 Govt. Hospital beds for every 1000 people and 3 per 1000 when combined with private hospitals.

(c) in hospitals, beds and doctors, the private sector is larger than that of the Government.

(d) the non-allopathic systems in private sector is five times bigger in terms of facilities though they have the same number of doctors. They cater mostly to outpatients as their bed strength is just 2% of the allopathic system.

(e) the doctors working with Government are less than half of those working with private hospitals.

5.2 Kerala's problem is not so much in not having enough doctors but in not having them where they are needed most, namely in rural locations. There is however, acute shortage of nurses and four-fold increase of the existing number is recommended to match the norms set by the Indian Nursing Council.

5.3 During 1998 a total of 11 lakhs in-patients and 2.3 crores out-patients were reportedly treated in allopathic medical centres of the Government. In the Ayurveda and Homeo centres of the Govt. during the same year a total of 50,000 in-patients and nearly 2 crores of out-patients were reportedly given treatment.

5.4 It is stated that though Kerala has only 3 per cent of India's population, it consumes 10 to 12 per cent of the drugs and medicines produced in the country. More than 20 per cent of the total Government expenditure for health programmes, is spent for purchasing medicines. Over 750 crores worth of medicines are sold out every year in the State. Government alone spends 50 crores for purchasing medicines a year and still hospitals do not have adequate supplies.

5.5 The State spends around 14-15 per cent of the total budget for health. More than 50 per cent of health care needs of the people of Kerala are met by private sector hospitals. There is practically no control over the private sector health system. With increasing flow of patients to the private sector, the role of State medical institutions and the health policy itself requires re-examination.

III. RIGHT TO HEALTH : THE KARNATAKA SCENE

Introduction

The causes for poor health in India may be grouped under five different heads :

(a) Population increase and consequent pressures
(b) Environmental sanitation problems
(c) Communicable diseases
(d) Nutritional problems
(e) Inadequacies of medical care and health services

Added to these are the poverty, ignorance and illiteracy of the masses and the uneven development of health care services.

Organization of Health Care Services

Medical care in urban centres is organized through District level hospitals of which there are 176 in the 20 Districts of the State (16 District hospitals, 9 teaching hospitals, 8 major hospitals, 16 specialised hospitals and 127 General/Maternity hospitals). In all these District level hospitals combined there is provision for 22,000 beds. All these hospitals have specialised units for a variety of diseases. They cater to patients referred to them from mofussil hospitals as well as those who directly report to them for treatment. Psychiatric clinics are in Shimoga, Hassan, Bidar and Bangalore. The Emergency and Casualty Department work round the clock. Blood Bank services are available in most of the District level hospitals.

In conformity with the Government of India guidelines in the implementation of the Minimum Needs Programme (Rural Health), Karnataka has provided a three-tier health infra-structure; Sub-Centre, Primary Health Centre and Community Health Centres. The Primary Health Centre is to cater health services for every 30,000 population in plain areas and for every 20,000 population in hilly and tribal areas. Every PHC is supplied with drugs worth Rs.30,000 annually. Each PHC is intended to provide all the basic health services including curative,

preventive and promotive health services. Karnataka's Primary Health Units have been upgraded into PHCs.

The Community Health Centre is to provide all national and State sponsored health programmes for a lakh of population covering roughly four PHCs. It will have 30 bedded hospitals located at sub-divisional headquarters having at least four specialities – General Medicine, General Surgery, Obstetrics and Gynaecology and Dental Surgery.

Health Sub-Centres are intended to serve every 5,000 population in plain areas and 3,000 in hilly and tribal areas. One Junior Health Assistant (female) and one JHA (male) manage each Sub-Centre and drugs worth Rs.2,000/- per annum are supplied for treatment of minor ailments.

The following rural health care centres reportedly functioned between 1990-'92 in Karnataka :

	1990-'91	1991-'92
Community Health Centres	160	179
Primary Health Centres	1198	1236
Primary Health Units	626	621
Sub-Centres	7793	7793
Beds	9264	10192

Health Administration

The health services administration is organized broadly at four levels – National, State, District and local. The Union Health Ministry has two Departments – Health and Family Welfare. The functions assigned to it under the Constitution (Seventh Schedule, Union List and Concurrent List) include (a) administration of port and inter-State quarantine; (b) administration of central health institutes; (c) drugs control; (d) prevention and spread of communicable diseases; (e) prevention of food adulteration; (f) control of drugs and poisons;

(g) social planning, vital statistics and co-ordination; and (h) medical education, medical profession etc.

The Central Council of Health was set up in order to promote a co-ordinated effort between the Centre and the States in the planning and implementation of health programmes. There is a similar Council for Family Welfare.

The States are totally independent in matters pertaining to the provision of health services and consequently there are variations in the pattern of health administration within each State. Broadly speaking there is a Ministry of Health and Family Welfare under a Minister having several Departments and Directorates to look after specific functions. Under them at the Sub-divisional and District levels there are officers responsible for supervision and effective implementation of various health-services in their assigned areas. The District Medical Officer and Medical Officers in PHCs are people who actually deliver the services to people in need.

In Karnataka, there are several externally-funded health projects now under implementation. These include the World Bank and Germany assisted Karnataka Health Systems Development Project, India Population Project and OPEC Project for strengthening District hospitals in backward areas of Northern Karnataka.

The schemes and programmes being implemented are many. These include National Leprosy Eradication Programme, National Tuberculosis Control Programme, National Programme for Control of Blindness, National Malaria Eradication Programme, Health Education and Training Programme, Nutrition Programme etc.

Health Status Indicators and Performance

The rate of population growth in the State has declined to 26% during 1971-81 to 21% during 1981-'91. The crude birth rate is said to be 24 in 1995. In 1991, infant mortality rate was 77. About 12 lakh children are born in Karnataka every year. Around one lakh of them die before completing the first birth anniversary and 0.15 lakh die by the age of 5 years. Half of these 1.15 lakhs of child deaths are said to be due to the six preventable childhood diseases. Under the Universal Immunization Programme a substantial control of infant mortality is

expected to be achieved. Another scheme called Child Survival and Safe Motherhood Programme is also launched since 1992-'93 under which reduction of infant mortality rate from 65 to 60 per thousand live births, reduction of child mortality from 41 to 10 and reduction of maternal mortality from 4 to 2 per 1000 live births are expected to be achieved by 2000 AD.

Crash programmes of training of various types of medical and health personnel are also under way.

The estimated leprosy cases in Karnataka in 1991 are about 56,000 cases. The prevalence rate is 1.6 per thousand population. Eight Districts are endemic having prevalence rate of 2.5 and above.

Another serious disease in the State is TB for the control of which Centre and State Governments have a cost sharing on 50:50 basis; however, it was pointed out that State had diverted its share of costs. Because of administrative corruption, the actual services available to patients is very minimal. Nearly a lakh of people are victims of this disease.

The incidence of malaria has been on the increase since 1991. It rose from about 50,000 to nearly 3 lakhs in 1996.

Health Statistics are reported to be outrageously misleading. Statistics only reflect the efficiency of the process of reporting and documentation system. It does not reflect the ground reality.

In analyzing health situation one must have multiple approaches because of definition of health can be a political - cultural statement conditioned by several parameters. As such the analysis should at least have three approaches :

(a) Health providers' approach;

(b) Welfare approach from the perspective of economic capacity and development priorities of State; and

(c) A basic right approach from the point of view of recipient of services.

All the three approaches may not coincide though they do occupy common spaces. If commitment is not there at the providers' level, whatever be the inputs, health status cannot be improved. Though the State has responsibilities, it is not always clear as to how in a system in which health is the cumulative result of roles played by individual, community, Government and the providers of services, right to health can be ensured. If the State is undermining the right by shirking its responsibility, it can be restrained. Thus if the Government succumbs to the liquor or tobacco lobby which engenders health, State and the industry can be made accountable. State can be asked to standardize services and enforce quality control though punitive strategies are not always effective. State can do promotional work by health education. State is to invest in preventive health care and public health services. The State can be asked to correct regional imbalances and ensure equal accessibility of health care services. If health care is to be privatised, State can be asked to ensure access to poorer sections of the community through subsidy or special schemes (like public distribution system for essential commodities) to ensure equity in health care.

Thus in assessing status of health as a basic right of all persons, there has to be agreement on indicators of assessment and the role and responsibilities of the various players in the system.

For a population of 4.5 crores of people, Karnataka has a total bed strength (public and private combined) of a little over 52,000. This makes a ratio of one bed for about 1000 people. It becomes still less when the rural sector alone is taken where 70% of the people live.

Health expenditure by the State is said to be declining over the years while it is increasing for the citizens who are forced to seek services from the private sector. The annual per capita expenditure is said to be as low as Rs.103 in 1994-'95. The Health Budget has declined from 6.6% to 6.3% in 1994-'95.

There are serious problems in medical education in the State despite having the largest number of teaching institutions of the country. There are cases of unqualified medical practitioners reported in the State causing untold suffering to ignorant village people.

IV. RIGHT TO HEALTH IN ANDHRA PRADESH

Introduction

Right to health may be viewed from two angles – one, preventive which emphasises reduction of risks in the physical and social environment through public health measures, and second, provision for easy access to medical services for treatment of diseases. It is in this context, the Indian Constitution discussed health both in terms of rights and duties.

Though health is a subject in the State List, in actual practice, the policy, the priorities, budgetary allocations are all influenced by the Central Government.

The status of health care administration is charcterised by emphasis on programme management rather than identification and analysis of problems, integrating policy and programmes, monitoring, evaluation and feed-back. Co-ordination and correction based on past mistakes hardly take place in health administration with the result the system consumes more resources on establishment rather than on delivery of services. The medical personnel in the Health Ministry are far removed from the ground realities which reflects on policy as well as on implementation. With the appearance in the scene of Panchayat Raj institutions there is need for greater fine-tuning of the system to make it not only accessible, but affordable.

About 8,000 corporates are producing over 30,000 drug formulations under different brand names; yet there is shortage of life saving drugs and profuse supply of avoidable and non-essential medicines. The drug control enforcement is so soft and erratic that it is easy for anyone to market some spurious drugs, make quick money and disappear from the market. Doctors prescribing drugs (a) have inadequate continuing education on the range of drugs and their relative efficacy; (b) are influenced by the manufacturers and advertisement agencies and (c) occasionally over-prescribe for various reasons.

Health-Care System in A.P.

The Primary Health Centres have not been quite successful in A.P. because of the

absence of any supportive role from tertiary and secondary health care services. People have no faith in PHCs. As a result there is a tendency to depend more on private sector and flock to the tertiary hospitals even for minor ailments. This, in turn, results in unnecessary overburdening and consequent dilution of the quality of tertiary facilities and services. Tertiary health care facilities are not only expensive to establish and maintain but are not easily accessible to people from rural areas. In addition, the providers at the tertiary level are often not familiar with the cultural and social practices of the patients of remote areas. This results in a mismatch between expectations of consumers and approaches of providers.

Medicare in A.P. is characterised by high cost and low return. About 80 per cent of the population in rural areas are catered by about 20 per cent of medical professionals. Only 1/3rd of professionals are in the service of Government and 2/3rd are in private practice who are relatively untouched by public interest concerns of the medicare system. The public health institutions are still in high demand; so much so, every doctor may have to examine about 600 patients every day.

Recognising the need for an efficient secondary health care system, the Government set up the Andhra Pradesh Vaidya Vidhana Parishad (APVVP) which did initiate lot of reforms to improve the quality of services provided by hospitals.

In A.P. the tertiary health care facilities are co-ordinated by the Directorate of Medical Education, while the primary health care and implementation of disease control programmes are looked after by the Directorate of Health.

The Seventh Five Year Plan has proposed a norm of one bed for every 1000 population of which 15% beds to be available at primary care institutions, 70% at secondary level and 15 per cent at tertiary level. Out of nearly 32,000 hospital beds now available in the public sector, 41% are in tertiary hospitals, 43% in secondary institutions and 16% in primary care institutions.

During recent years there has been a spurt in the growth of health service in the private and voluntary sectors in the State. They together hold over 53,000 beds though the facilities are not evenly spread and are concentrated in urban centres.

The number of out-patients handled between 9 AM and 12 Noon by each district hospital ranged between 600 and 1300 per day. Maintenance of hospital buildings and staff quarters was poor. In summer most hospitals face acute water scarcity. Most hospitals do not have facilities for scientific disposal of waste. Nurses spend more time on record keeping than on patient care. Important diagnostic equipments often are out of order for weeks together. The budget allocation of Rs.5/- per day for providing diet for in-patients is highly inadequate.

Utilisation of Treatment Facilities

The National Sample Survey data for the State on the use of medical care services revealed that in rural households the self-employed and casual labour constituted the bulk of users, while in urban areas the salaried groups were predominant. An overwhelming majority of households utilised the Allopathic system of medicine both for hospitalisation as well as for other types of care. Preference for allopathy was universal and not influenced by household characteristics such as income, social class or literacy.

Despite the presence of extensive health infra-structure in the public sector, there is a distinct preference for private hospitals particularly in rural areas. This may be because of poor access, non-availability of staff and drugs, inhospitable attitudes and poor quality care of the public hospitals. A high percentage of S.Cs and S.Ts used the public health care institutions. Utilisation of free wards in public hospitals is very high and some of the users belonged to high income groups. In both urban and rural areas, more than two-thirds of the medical expenditure was on doctors' fee and on drugs.

About a third of the sampled women in the National Family Health Survey in the State had institutionalised delivery. Among those who had institutional deliveries, a higher proportion preferred the private hospitals. Among home deliveries, about 17 per cent made use of the services of health staff while the rest got assistance of relatives or neighbours. The utilisation of institutional facilities for confinement was directly proportionate to the literacy status.

About a third of the children had immunization cards. 43% of all children had all primary vaccinations before the completion of first year. The immunization coverage was better among male children and residents of urban areas.

There are some tribes and few others who still believe that illness is caused by supernatural forces, sorcery and evil eye. They adopt violent and customary practices to cure illness sometimes resulting in death of patients.

The Health Budget of the State is in the range of 500 to 600 crores per year (6% of total State Budget) with a per capita expenditure of roughly Rs.34/-. While expenditure on health did increase, the quality of services declined. It is revealing to note that less than 3% of expenditure was on water, sanitation and nutrition.

There is a move in A.P. to have the management of Primary Health Centres either entrusted to NGOs or for a partnership with them as well as with Panchayat Raj institutions.

A.P. has increasing incidence of snake-bites resulting in death. Snake-bite venom is available only in urban areas whereas the incidence are in rural areas.

Evaluation

In spite of impressive progress in several spheres, the demographic and health picture of A.P. still raises several issues of concern. Infant mortality is about 127 per 1000 live births. Malnutrition among children is exceptionally high. Only 31 per cent of the rural population has access to potable water supply and less than one per cent enjoy basic sanitation facilities. Communicable diseases still take a heavy toll of life. The diseases oriented approach in medicare has given benefits to the upper layers of society living in urban areas. The emphasis is on curative approach almost to the near total exclusion of preventive strategies. The system of medical education has built up a cultural gap between Doctors and patients. It is demonstrated that more investment in primary health care can produce dramatic results. There is also need for a reversal of the budget allocation between curative and preventive services and between the peripheral services and the ever-growing urban hospitals.

V. STATUS OF HEALTH RIGHTS IN TAMIL NADU

Introduction

In the context of modern life and patterns of consumption, the issue of Health cannot be discussed in isolation. Environment, Education and Economy influence the status of health in many ways, directly and indirectly. Economic growth leads to social and ecological disruption including spread of diseases some of which unknown in the past. Unplanned urbanisation and the resulting deterioration in basic services has increased respiratory and gastro-intestinal infections in urban areas. The plague-like epidemic in Surat and the dengue fever outbreak in Delhi are examples of the outcome of urban neglect. Deforestation and dam building have been shown to be related to a rise in malaria and different new types of fever. Poor water supply and sanitation have promoted the resurgence of a whole range of gastro-intestinal syndromes. Modern transport and communication systems and greater mobility of populations have spread diseases more rapidly than before. Land degradation due to over use of chemicals and fertilizers is a growing health hazard.

Tamil Nadu has an impressive record of progress on the health front with significant reduction of maternal mortality, infant mortality, polio, malaria and malnutrition deaths. Nonetheless the situation is far from satisfactory. Public health is the most dismal factor. There are plenty of legislations intended to achieve sanitation of the environment, control of infections, educating people on personal hygiene and provision of medical and nursing services. The Tamil Nadu Public Health Act, 1939 is a comprehensive law enabling health officers the power to secure the above goals. Local bodies working in co-operation of health officials can possibly secure public health if there is political will and informed action.

Health Indicators and Performance

A serious distortion has taken place in policy formation process relating to the health sector in Tamil Nadu and perhaps in other States as well. This is the displacement of medical professionals by bureaucrats of the Administrative Services. There has been a near total abdication of responsibility. Even heads of departments who continued to be professionals

became ineffective against the combined strength of the bureaucracy headed by the Health Secretary who is a passing bird in civil services. At the same time influential lobbies of the pharmaceutical companies, private hospitals and associations of competing professional groups have hijacked the health administration to serve narrow sectarian ends. Doctors have found it easy to toe the official line as they were to lose otherwise in terms of transfers, private practice, foreign visits and attractive deputations outside.

For a population of 62 million, Tamil Nadu has 1420 primary health centres each supposed to be serving a population exceeding 30,000. There are health workers whose numbers may vary between 8 to 32 in each PHC. There are over 200 dispensaries. Each PHC serves an area between 2 to 15 KMs. Some of the PHCs are provided with ambulances which are used more to transport doctors and health staff between their houses and hospitals rather than patients.

The total number of doctors registered with the Medical Council in the State is over 42,000 of whom 2/3rd may be in actual practice within the State.

There are 48 teaching hospitals, 29 District headquarters hospitals and another 300 taluk and other hospitals. The number of doctors serving the public sector hospitals may be about 10,000. There are ESI hospitals, railway hospital, hospitals of Madras Corporation which are independently managed and are outside the Health System under State control. Public Sector beds in these hospitals exceed 50,000. Private hospitals and nursing homes have increased in the recent past. Their bed strength may exceed that of Government. There are nearly 30,000 private doctors in the State.

Health sector receives 8% of the Plan budget which is around 700 crores per year. The investment in drinking water and sanitation is outside this because it is under different departments of the Government.

Status of Medicare Services

Admittedly health policy is not formulated keeping in mind the demands of human rights of people in relation to health. As such evaluation of health care services in terms of human rights will be misleading. The concept is not clear either to medical personnel or Government

officials. They do recognize the duty of Government to provide medicare and public health services to poor and needy people. Beyond that, the conception of health as a result of clean air, water, nutrition, food and exercise is outside their calculations. Consequently people fail to see the difference between health care and medicare. They are used interchangeably.

From the point of view of health, the right should include clean air, clean potable water, minimum staple food with minimum micro-nutrients and basic knowledge of health services.

The average infant mortality rate is 57 per thousand. It is more in rural areas than in cities. Pre-natal deaths are 2 per 1000 live births. Nearly 100% of children born in the State do get immunization services.

Communicable diseases affect 15% of the population of which T.B. alone affects 2 to 3% of the people and one per cent each of malaria and hepatitis B. HIV is found among 0.5% to 0.8% people. 10% suffer from parasitic diseases.

More than 85% of available beds in public sector hospitals are occupied at any point of time round the year which is an indicator of the prevalence of morbidity. T.B., malaria, asthma, ischaemic heart diseases, pneumonia, diarrhoea, strokes, worms in children, peptic ulcer, anaemia and cancer are the common diseases of admission cases. The quality of care and treatment depends on the status and income levels of patients. Women get lesser attention than men. Urban folks have better chances of attention then rural people. Over 90% of patients are given free treatment, food and drugs.

The utilization of resources in the health sector is as follows. About 55% of the allocation is spent for administrative expenses. About 80 crores per year (8 to 10%) is spent on medicines. This is done through a fairly efficient arrangement managed by the Tamil Nadu Medical Services Corporation. The system of accountability to patients in the whole system is very weak.

Private sector in medicare is expanding fast with Government patronage. 65 to 70% of services are now routed through the private sector. Each Government servant is entitled to

Rs.75,000 worth of private medicare through contributory health fund of the State Government. People prefer private hospitals and clinics.

Health rights of children get no priority. Mental patients do not get even the minimum attention they deserve. Violation of health rights may be happening in many cases; but they do not end up in litigation as yet. Drug control is not efficient. Frequently sub-standard drugs reach the market and get distributed. Prohibited drugs are often sold.

Preventive health care is a low priority area. Smoking is prohibited in most public places and transport. Alcoholism is widely prevalent. Health education is poor.

25% of children born are those with less than 2.5 Kg of birth weight. Nearly 15% of children die before they reach the age of five years in the State. Malnutrition of children is as high as 56%.

Only 25% of people of Tamil Nadu have access to safe drinking water and sanitation.

10 to 15% of annual income of the average person in the State is spent on medical treatment. It is said that if the health situation remains steady in 2000 AD it will be a big achievement. Health for All by 2000 AD is a mere slogan and a far cry.

Tamil Nadu gives special importance to Indian systems of medicine of which the Siddha system occupies the pride of place. There are Siddha units in majority of District/Taluk hospitals and even in PHCs. Some of the PHCs are now being managed by local industries which is said to be a welcome development for quality improvement and greater accountability in administration.