



People's
Health
Assembly

People's Campaign for
Decentralised Planning
and
the Health Sector
in Kerala

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ISSUE PAPER

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In spite of the economic backwardness, Kerala has made remarkable achievements in health almost comparable to that of even developed countries. The widely accepted health indicators like crude death rate, infant mortality rate, and life expectancy evidence this. (Table 1)

Most analysts have seen Kerala's achievements in health as something of an enigma. Kerala achieved the health status as par with that of USA spending roughly 10 US \$ per capita per year while US spends about 3500 \$ per capita per year on health care. The GDP of Kerala is even less than that of the National average. Kerala's achievement in health in spite of its economic backwardness and very low health spending has prompted many analysts to talk about a unique "Kerala Model of Health," worth emulating by other developing parts of the world

Kerala Model of Health

There are many socio-economic conditions unique to Kerala, which have been postulated to make this health model possible. Kerala has a highly literate population compared to other Indian states. This especially the high female literacy, has to be given due credit when we look for explanatory factors. All over, the world indices such as infant mortality have shown an inverse relationship with female literacy.

It is also to be noted that Kerala has nurtured a political climate wherein the rights of the poor and the under privileged have been upheld and fought for. This was the result of a fairly long period of struggle for social reforms emphasising dignity of people who were considered socially 'inferior' which later found expression in secular-democratic movements culminating in nationalist and socialist movements. One common thrust of all such movements was on education and organisation of the downtrodden people. Hence, as has been pointed by many social scientists there is a remarkable reduction in the rate of exploitation of the underprivileged in Kerala compared to other Indian states.

The agrarian reforms that were implemented in the late 1950s ended the feudal relationship in agriculture and giving land to the tillers. This improved the social living conditions of the landless poor in the rural areas. This might have contributed to the alleviation of poverty among the agricultural laborers leading to the improvement of their health status.

The public distribution system of food through fair-priced rations shops distributed throughout Kerala assures minimum food materials at relatively cheap cost to the people. This has assured certain amount of nutritional status to the poor, warding off poverty related diseases.

Apart from the socio-economic factors outlined above the universally available public health, system in Kerala has also contributed to the high health status of the people. Kerala has a three-tier system of health care, the Primary Health Centres (PHC) and the Community Health Centres (CHC), Taluk and District Hospitals and the Medical Colleges evenly distributed both in the urban and the rural areas. Apart from Modern Medicine, Ayurveda, Homeopathy, and other alternative systems are also very popular in Kerala.

However, the widely acclaimed Kerala Model of Health has started showing a number of disturbing trends recently.

Kerala Health from Success to Crisis

Although the mortality is low, the morbidity (those suffering from diseases) is high in Kerala compared to other Indian states. Though there is a data gap in this regard the NSS (1974) and KSSP (1987) studies confirmed these observations (Table 2). Hence the Kerala situation was described as 'Low Mortality High Morbidity Syndrome' (Panicker and Soman 1985). It can be argued that when the expectancy of life increases there can be a corresponding increase in morbidity in terms of the high incidence of diseases like Cancer, Heart diseases etc. that affect old age people more. However, here also the Kerala situation is peculiar in that the infectious diseases like diarrhoea, hepatitis, tuberculosis etc are still prevalent in Kerala. Moreover, many epidemics that were supposed to have been eliminated from Kerala like Malaria are definitely staging a come back. In addition, diseases like Japanese Encephalitis that was sporadic in Kerala has appeared in many parts of the state as epidemic apart from the appearance of the modern scourge like AIDS.



Another disturbing trend is that the Public Health System is getting alienated from the people and only 30% of the people even from the lower income group seek medical help from the Government hospitals (Table 3). This is because of the fall in the quality of services at the Government hospitals. Lack of political commitment, bureaucratic inefficiency, corruption at various levels, lack of proper planning etc has contributed to this sorry state of affairs.

This environment of the perceived inefficiency of the Government medical facilities is one of the factors that provided the impetus for the growth of the private medical care set up in the state. The social milieu of the state is changing and features of a consumer society are visible in all occupations. This has led to the commercialisation and the commodification of health care. Health is no more seen as a right but as a commodity to be purchased by money. The huge remittance of foreign exchange from gulf countries even to the low and middle-income group houses further reinforced this attitude. All these tendencies are leading to a virtual uncontrolled growth of the private medical care facilities in the state.

A comparison of the infrastructure and health manpower development in the private and public sectors confirms the supremacy of the private sector in the state. The number of beds in the government institutions grew from around 36000 to 38000 in the 10-year period from 1986 to 1996, whereas in the same period, beds in private institutions grew from 49000 to 675000. This amounts to nearly 40% growth in the private sector beds in a period of 10 years as against nearly 5.5% in the Government sector. In the case of doctors about 5000 doctors work in the government sector whereas double the number work in the private sector (Table 4). More significantly, private sector has far outpaced the government facilities in the provision of sophisticated modalities of diagnosis and therapy, such as CT Scans, MRI Scans, Endoscopy Units etc. Simultaneously, public sector itself is being subjected to internal privatization. Because of the irregular supply of medicines and other materials patients seeking medical care from the government hospitals are forced to buy them from outside. Also the laboratory facilities are quite inadequate in the government hospitals and patients have to depend upon the private labs for getting investigations done in time.

The privatisation of medical care is leading to over medicalisation and escalation of the health care cost. The net result is the marginalisation of the poor and it is roughly estimated that at least 30% of the people in the state are denied health care or find it extremely difficult to meet the growing health expenditure.

The changing health scenario in Kerala has provoked analysts like the present author to comment that the Kerala Model of Health Care is slowly drifting towards an *American Model of Health Care*. The hallmarks of Kerala Model were low cost of health care and its universal accessibility and availability even to the poorer sections of society. This may be changing to the American Model where in spite of the technological supremacy 40 million people are denied health care because of privatisation and the escalation of the health care cost.

In short the important aspects of the present health scenario in Kerala are:

1. The simultaneous presence of the diseases of poverty and the diseases of affluence or life style diseases.
2. The decay of the public health system.
3. The uncontrolled growth of the private sector.
4. Escalation of health care cost.
5. Marginalisation of poor.

Towards a People's Health Policy

Toning up of the health care system in the state and making it capable of taking on the burden of provision of equitable, efficient and good quality health care needs concerted actions from the political parties, social movements and the professional organisations. Taking into consideration the specific problems of the Kerala health scenario a **People's Health Policy for Kerala** should be formulated. Reinstating the primacy of the government health services, with its emphasis on primary health care should form the basis of the health policy for Kerala. There should be some amount of social control and auditing of the private sector.



Decentralisation and Community Involvement in Health

These objectives can be realised only through an administrative and financial decentralisation of the health services department, while ensuring community involvement in formulating and implementing health care programs and reforms. The Panchath Raj now provides the possibility for the people to demand the resources to operate a health service in which the people themselves will play the dominant role and of which they will be the chief beneficiaries. All infrastructure, health manpower development, training, distribution, and production of drugs and equipment must conform to achieve this, and not in reverse as is at present. Only thus can a cost effective, human and accountable health service be provided that is funded and operated by the local bodies with the technical assistance of the health professionals. This system involves the entire community and especially the women in identifying their health problems. The people can be mobilised to improve not only the curative care but even more so in health education as well as in the prevention and control of the diseases that originate in their environment. The people have the greatest interest in improving the conditions that affect them and their children. This would also be an impetus to the overall improvement of the community of which they are a part.

The **World Health Organisation** was advocating Community Involvement in Health(CIH) as a pre-requisite for solving the health problems of the developing countries (*Community Involvement in Health Development: Challenging Health Services-Report of a WHO Study Group WHO Geneva – 1991*). WHO study group reports says that **“A critical step will be the decentralisation of health services and the corresponding strengthening of the local health services that will serve as the basis for CIH” and further “Structural changes in health systems will be necessary to support the CIH process. These changes include: decentralisation of planning, management, and budgeting .”**

The administration of the Primary Health Centres, Community Health Centres and the Taluk and District Hospitals are already handed over to the local bodies. Moreover, thanks to the on going Peoples’ Campaign for Decentralised Planning, there is a tremendous scope for solving the health crisis through which Kerala is passing. And CIH as advocated by WHO has become an achievable objective in our state.

Panchayath Raj and the Health Sector

The possibilities that are opened up with the financial and administrative decentralisation of the health sector and the People’s Campaign for Decentralised Planning are the following:

1. The control of infectious diseases and even the prevention, early detection, and management of the life style diseases can be achieved only by strengthening the primary and secondary level health care facilities. With the local bodies in control, this can be achieved with better community involvement.
2. Once the primary and secondary health care facilities are improved through the local bodies , the tertiary care centers like the medical colleges can entirely concentrate on medical education, research, and tertiary health care.
3. The problem of resource constraint in health sector can be solved with a more need-based reallocation of resources and generating local resources through community participation.
4. A better relationship between the health workers, people’s representatives, and the people at large can be accomplished.
5. Once the public health system is reinforced the poor people who cannot afford the private health services will be benefited social equity in health care will be re- established.
6. There are provisions in the Panchayath Raj Act which can be invoked for the social control of the private sector.

An analysis of the experiences of the campaign so far shows that the we are definitely moving in the correct direction in solving the rural health problems of the state.

Decentralised Planning: Achievements

The concrete achievements realised so far can be summarised as follows:

1. As evidenced by the participation in the Gramasabhas, Development Seminars, Task Forces, Voluntary Technical Corps, and voluntary contributions both in terms of money and labor power, community participation in local development has become a reality in Kerala. More than anything else the sense of optimism



generated among the people by the campaign is the greatest achievement of the decentralisation process.

2. It was feared by many that, the health related projects would be confined to building more and more curative centres. It is true that there is a contradiction in health between the felt and real needs of the people. While only through a preventive and promotive approach the basic health problems can be solved, there is a growing demand for more sophisticated curative health facilities from the community. However, the preliminary examination of the health projects show that majority of them are for sanitation, health education and for improving the primary health care infrastructure in the villages. Of course, there are instances of unrealistic and inappropriate demands for hospitals. However, the thrust is on prevention and improvement of the existing health care facilities.

3. With the reallocation of plan funds within the health sector, the problem of financial constraints of the health sector appears to be solved. Of the 6000, Crores of rupees allotted to the local bodies for the Ninth Five Year 30% can be spent on social services sectors like health, education, water supply, sanitation etc. Of this at least 500 crores are available for health sector. In the first year, the projects were mainly on water supply and sanitation. Nevertheless, the estimates from the first year projects shows that the local bodies are likely to spend at least 340 crores exclusively on health and health related projects. It may be interesting to note that the departmental allocation for Ninth Plan amounts to 310 crores. Thus, the primary and secondary health care institutions have been given adequate funding for improvement of the services rendered by these institutions. Once these facilities are better organised, the department can spend the fund allotted to them exclusively for improving the tertiary care facilities. Over all compared to the Eighth Plan, health funding has increased from 2.37 to 4.03 percentage of the total plan allocation.

4. A better working partnership is developing between the doctors, the health workers, the Panchayath functionaries, and the people in the rural areas. The health workers now feel that with out bureaucratic red-tapism and the involvement of the higher authorities improvements can be made at the Panchayath level itself. For the first time in the history of the medical profession, the doctors working at the rural areas have a role in the planning of the health care set up where they are working. This has given them a sense of participation and professional satisfaction.

5. The autonomy with in the decentralised set up has offered the local bodies to formulate and implement a number of imaginative community based health programmes. From organising blood donation camps to issuing health cards to the people of the Panchayats and conducting health surveys to study the health problems of the local community a number of innovative programmes are being accomplished by the local bodies.

It was pointed out that the widely acclaimed Kerala Model of Health that can be described as ‘good health at low cost’ and based on social justice is passing through a period of crisis and if unchecked this may lead to an American Model of Health based on privatisation and the marginalisation of the disadvantaged. The Panchayath Raj system rooted in community involvement is poised to change the health scenario in our state and is likely to conceive a new **Decentralised and Participatory Model of Health Care** in our state. In case this becomes a reality then Kerala will bestow another unique model of health care worth emulating not only by the other Indian states but also by other developing parts of the world.



**TABLE ONE
KERALAM HEALTH STATUS
1996**

Indicators	Keralam	India	USA
Crude Death Rate	6.3	10	7
Infant Mortality Rate	11	79	8
Crude Birth Rate	17.7	29	17
		Life Expectancy	
Male	66.8	57.7	73
Female	72.3	58.1	79

(Sources: 1. Health Services Data Government of Kerala 1996; 2. World Health Report WHO Geneva 1996)

**TABLE TWO
KERALAM MORBIDITY**

	Keralam NSS 1974	India	Keralam KSSP 1987
Acute Diseases	71	22	206
Chronic Diseases	83	21	136

**TABLE THREE
UTILISATION OF HEALTH SECTORS
1987**

Group	Public	%	Private
One	33		43
Two	25		50
Three	16		60
Four	8		66

(Group One - Poorest, Group Four – Richest)

(Source Table 2 to 3 Health and Development in Rural Kerala KP Kannan etal KSSP1991)

**TABLE FOUR
GOVERNMENT AND PRIVATE SECTOR
1995**

	Private	Government
No of Institutions	4288	1249
No of Beds	67517	42432
No of Doctors	10388	4907

(Source: Report on the Survey of Private Medical Institutions in Kerala 1995 Department of Economics and Statistics Government of Kerala 1996)



TABLE FIVE
PLAN ALLOCATION - HEALTH SECTOR
 (in Indian Rupees-Crores-10 Million Rupees)

EIGHTH FIVE YEAR PLAN TOTAL ALLOCATION	HEALTH SECTOR	PERCENTAGE	NINTH FIVE YEAR PLAN ALLOCATION	HEALTH SECTOR	PERCENTAGE
5460	120	2.2	10100	309.4	3.06

TABLE SIX
PLAN ALLOCATION- HEALTH SECTOR
 (LOCAL BODIES)

LOCAL BODIES ALLOCATION	HEALTH SECTOR (EXPECTED)	HEALTH SECTOR TOTAL	TOTAL NINTH PLAN ALLOCATION	HEALTH SEC' PERCENTAGE
6000 Crores	500 Crores	500+309.4 = 809.6 Crores	16100 Crores	<u>5.02</u>

(Source: Planning Board Documents: 1999)