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# PROBLEMS AND CHALLENGES OF PUBLIC HEALTH IN INDIA: A SOCIOLOGICAL ANALYSIS

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## ABSTRACT

*Health is a complex phenomenon, and it can be approached from many wings. Public health aims to understand and influence the social, cultural and economic determinants of health as well as to study and structure health systems as efficient channels for health services delivery. Public health is thus, a discipline built on the academic tradition of inquiry involving research, teaching and professional practice to prevent disease and promote health in populations. Poor people usually have the worst health outcomes and people are pushed further into poverty due to ill health. Health services fail poor people because health systems are often caught in a web of failed accountability.*

*This paper seeks to make explicit a shared understanding conceptual frame-work of public health, and to analyze the Public Health status in India, particularly in Karnataka (state) with empirical evidence with 250 respondents to judge the demographical, Public Health status and factors which are mainly concern with the public health. Finally, researchers mainly highlight to draw suitable findings and suggestions to improvement of public health in India, Particularly in Karnataka.*

**KEYWORDS:** *Health, Public, Population, disease, poor people*

## INTRODUCTION

Public health aims to understand and influence the social, cultural and economic determinants of health as well as to study and structure health systems as efficient channels for health services delivery. Public health is thus, a discipline built on the academic tradition of inquiry involving research, teaching and professional practice to prevent disease and promote health in populations. Public health is a dynamic field of medicine that is concerned primarily with improving the health of population rather than just the health of individuals. Post independence Government of India through several ministries has started centrally sponsored urban and rural sanitation as well as many other programs for adequate supply of safe water and sanitation.[1] Accordingly, to updated estimation of 24 percent of whole diseases burden in India is due to environmental hazard, this risk is arisen into two categories are as traditional hazards concerning with poverty and lack of improvement such as water supply and basic necessities of life to survival.

Poor people usually have the worst health outcomes and people are pushed further into poverty due to ill health. Health services fail poor people because health systems are often caught in a web of failed accountability.

## REVIEW OF LITERATURE:

Review of literature is a key step in research process. Literature reviewed refers to an extensive, exhaustive and systematic examination and publications relevant to the research study. The gathered literature is reviewed as under –

**A. Major Committee Reports:**

| Name of the Committee | Member | Year | Outcome of the Committees |
|---|---|---|---|
| **Bhore Committe[2]** | Sir Joseph William Bhore | 1946 | The committee has observed that if the nation's health is to be built, the health programme should be developed on a foundation of preventive health work and that such activities should proceed side by side with those concerned with the treatment of patients and The recommendations of BC and the availability of preventive and curative medical technology resulted in the evolution of hospital-based public health system in India |
| **Sokhey Committee[3]** | S.S. Sokhey | 1948 | India should adopt a form of health organization, in which both curative and preventive functions are suitably integrated and administered through one agency. The preservation and maintenance of the health of the people would be state responsibility. |
| **Health Survey &Planning Committee[4]** | Dr.ALakshmanswamy Mudaliar | 1961 | The committee has recommended that the increased the number of the PHCs as noticed in the third five year plan rather than consolidating the existing ones. |
| **Chadha Committee[5]** | Dr. M.S. Chadha | 1963 | It recommended the integration of health and family planning services and its delivery through one male and female multipurpose worker per 10,000 population. Further, it recommended that the services of the extension educator should be utilized for all the national health programmes. |
| **Mukherjee Committee[6]** | Shri. Mukherjee | 1965 and 1966 | The recommendations of the committee were as follows:<br>• The camp approach had failed to give the family planning program a mass character and hence Intra Uterine Contraceptive Device (IUCD) was a great opportunity.<br>• Introduction of target fixation, payment for motivation and incentives to acceptors.<br>• Reorganization of the FP program into a vertical program like Malaria. |
| **Name of the Committee** | **Member** | **Year** | **Outcome of the Committees** |
| **JungalwallCommittee[7]** | **Jungalwalla Committee** | 1967 | The major recommendations of the committee were as follows:<br>• Integration from highest to lower level in services.<br>• Integration of preventive and curative services.<br>• Integration of medical services and public health (rotation of personnel).<br>• Integration of health services with 3 main components<br>- Health services of functions and methods of delivery<br>- Their organisation<br>- The personnel providing these services and their administration |
| **Mehta Committee[8]** | Dr. Shantilal J.Mehta, | 1983 | Training and development of auxiliary personnel and paraprofessional personnel.<br>• Basic and induction training in public health management.<br>• Establishment of Universities of Medical Sciences and Medical and health Education Commission |
| **Bajaj Committee[9]** | Prof. J. S Bajaj | 1987 | To formulate a national policy on education in Health services.<br>• Prepare curriculum for school teachers.<br>• Utilize the services of Indian System of Medicine.<br>• Continuing education programme for the health personnel. |

## B. Research Articles:

| Researcher | Year | Outcome of the research articles |
|---|---|---|
| **Jehani**[10] | 2012 | It explores the reported size of the Indian healthcare delivery market as Rs.2.6 lakh crore in 2011-12 which is expected to almost double to Rs.4.7 lakh crore in 2016-17. Further, he listed the major reasons for the immense potential of the healthcare market in the long-term, such as a shift in demographics (an increase in population and rise in life expectancy) and a higher purchasing power (due to rising income levels and rising literacy levels). |
| **Buckley & Cuff**[11] | 2012 | Presented the results of a revealed choice experiment testing the theoretical predictions of a model of a mixed system of public and private finance. |
| **Duggal**[12] | 2012 | It is denoted that the reproduced the discussion that had taken place in Third People's Health Assembly, organized by the People's Health Movement in July, 2012 in Cape Town, South Africa. A wide range of discussion were held in health and related issues, including the political and economic context of health, comprehensive primary health care, social determinants of health, universal coverage, mobilising for health, etc. It also highlighted the issue of creating fiscal space in public budget to make adequate budgetary commitments for health care. |
| **Gayathri**[13] | 2011 | It attempts to develop a defined set of financial indicators to track the health budget and expenditure at the national and at the state level and to review the healthcare financing trends in Karnataka using the indicators developed for the purpose (i.e., Gross State Development Product, Revenue expenditure, capital Expenditure, Per capita real expenditure.etc). |
| **Chakraborty G.**[14] | 2010 | It observed the patterns of public health expenditure in India. The main objective of his analysis is to examine the size, distribution, trends, composition and rate of growth of union and state health expenditure during the period of 2001 - 2002 to 2008-2009. |
| **Researcher** | **Year** | **Outcome of the research articles** |
| **Claeson et al.,**[15] | 2009 | States that the MDGs to be achieved by 2015, of which nearly half concern with health: eradicating extreme poverty and hunger, reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria, and other diseases. While some goals have been met, for example, the poorest quintile of the population within countries is on target to reach the nutrition goal; the child mortality goal is unlikely to be achieved in most low-income countries. All countries can make progress- the ability to scale up by 2015 will depend on a combination of sound policies and additional funding. |
| **Bhat and Jain**[16] | 2004 | It made an analysis of public expenditures on health using state level public health expenditure data |
| **Chauhan**[17] | 2001 | opined that health is determined not only by medical care but also by determinants outside the medical sector such as environment, socio-economic factors, information and communication, availability of health services, utilisation of health services, age structure of the population etc., |
| **Rahman and Smith**[18] | 2000 | Have reviewed the use of location-allocation models in health service development planning in the developing nations. The purpose of their review is to examine the suitability of these methods for designing health care systems and their relevance to overall development problems in Developing countries. |

## OBJECTIVES OF THE STUDY

As discussed above the present paper is to analyze the **Problems and Challenges of Public Health in India: A Sociological Analysis**, the main specific objectives of the present paper are as under:

1. To know the conceptual frame-work of Public Health in Indian Context.
2. To analyze the Public Health status in India, particularly in Karnataka (state) with empirical evidence.
3. To draw suitable findings and suggestion to improvement of Public Health status in Karnataka.

## METHODOLOGY

The present paper have used both theoretical and empirical. Hence, both primary and secondary sources of data are used for the present paper. The sources of data are as under –

### i. Primary Data: –

The present paper is mainly dependent on primary data collected from the diseased patient across Karnataka. Hence, survey made on Government Hospital (250 respondents) patients in whole, Karnataka state.

### ii. Secondary Data: –

The present work is also based on secondary sources of data pertaining to Public Health in India, particularly in Karnataka (State). The researchers was collected and gathered secondary literature published in books, research journals, research articles, newspapers, magazines, web based sources are as secondary sources of data used for the present paper.

## TOOLS AND TECHNIQUES

The data for the present study has been gathered from both the primary and secondary sources. Though the study is mainly based on primary data, the secondary data has also been used. Both, descriptive and explanatory methods of data analysis have been used in the research paper. The research used percentage; as a technique to interpret the data and in analyzing the data with tables have been used to make the study more effectively.

## The Study

## Public Health - The Concept:

- The state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (The World Health Organization, 2003)[19].

## The Empirical Evidence:-

**Table – 1:**
**Respondents' opinion about Demographical factors affected towards Health**

| Factors | Opinion | Number of Respondents | |
|---|---|---|---|
| | | Frequency | Percent |
| Sex | Female | 178 | 71.20 |
| | Male | 72 | 28.80 |
| | **Total** | **250** | **100** |
| Place of Residence | Urban area | 198 | 79.20 |
| | Rural area | 52 | 20.80 |
| | **Total** | **250** | **100** |
| Family Type | Nuclear | 141 | 56.40 |
| | Joint | 109 | 43.60 |
| | **Total** | **250** | **100** |
| Qualification of the respondents | Literate | 107 | 42.80 |
| | Illiterate | 143 | 57.20 |
| | **Total** | **250** | **100** |
| Do you have health coverage | Yes | 168 | 67.20 |
| | No | 82 | 32.80 |
| | **Total** | **250** | **100** |

*Source: Field Survey.*

The above table - 1 deals with demographical factors of the respondents which are mainly concerned with the health prospective of the study area. Researchers categorized the factors of demographic which are as sex, place of residence, family type, qualification and health coverage of the family. It is evident from the table that the female are more in number is 178 (71.20 percent) of the respondents are responding about the health factors and

place of residence majority of urban area respondents are responding towards health variables are 198 (79.20 percent) of the respondents and a very less responses from the rural area. 141 (56.40 percent) Family type of respondents is nuclear and joint have equally share the health matters. Majority 143 (57.20 percent) of the respondents are mainly dependent that they are illiterate people more suffering consent health problems. Finally, more number of respondents are suffering huge number of health problems and need to be solved for that reason they are go for health coverage scheme which are provide by the government and private.

**Table – 2:**
**Respondents' opinion about Public Health Status**

| Factors | Opinion | Number of Respondents | |
|---|---|---|---|
| | | Frequency | Percent |
| Present Public Health status of the respondent | Good | 37 | 14.80 |
| | Normal | 97 | 38.80 |
| | Poor | 116 | 46.40 |
| | **Total** | **250** | **100** |
| Did he or she suffering from any of the constant disease | Yes | 203 | 81.20 |
| | No | 47 | 18.80 |
| | **Total** | **250** | **100** |

***Source**: Field Survey.*

Table - 2 reveals that the respondents' opinion regarding public health status. Majority 116 (46.40 percent) of the respondents are feel that the present public health status is not satisfied and it encourages to sick the public and 97 (38.80 percent) of the respondents have opined that they are normal. Only 37 (14.80 percent) of the respondents are responses that the good respondents from the hospital. More number of 203 (81.20 percent) of the respondents belonging to that he/she suffering from any types of the constant disease in the study area and only 47 (18.80 percent) of the respondents are not suffering constant disease.

**Chart – 1:**
**Respondents' opinion about Public Health Status**

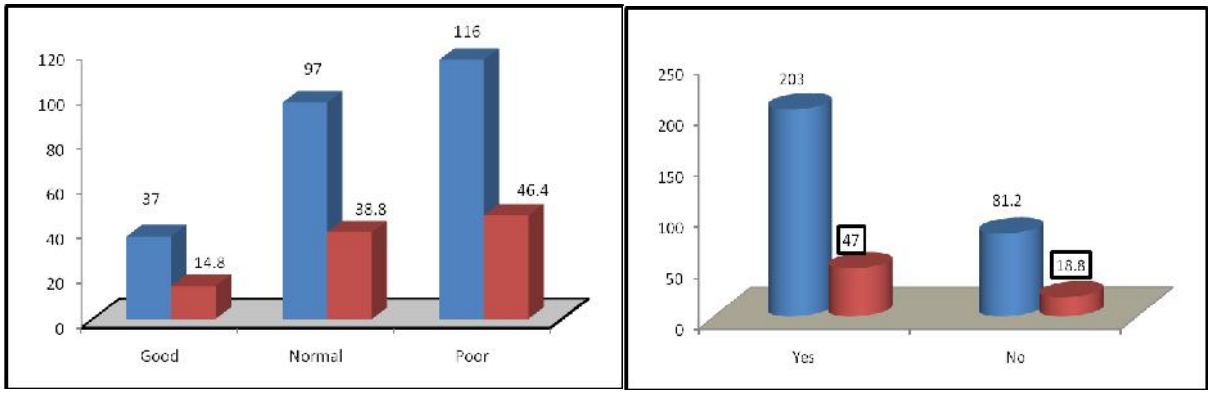

**Table – 3:**
**Satisfaction Level of Respondents about the Health Issues Regarding Hospital Facilities**

| Factors | | Respondents Opinion | | | | | Number of Respondents |
|---|---|---|---|---|---|---|---|
| | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | |
| Drugs /medicine availability | Frequency | 57 | 21 | 15 | 84 | 73 | 250 (100) |
| | Percent | 22.80 | 8.40 | 06 | 33.60 | 29.20 | |
| Doctor availability | Frequency | 47 | 23 | 12 | 99 | 69 | 250 (100) |
| | Percent | 18.80 | 9.20 | 4.80 | 39.60 | 27.60 | |
| Waiting timings | Frequency | 21 | 30 | 20 | 78 | 101 | 250 (100) |
| | Percent | 8.40 | 12 | 08 | 31.20 | 40.40 | |
| Treatment Quality | Frequency | 69 | 34 | 23 | 73 | 51 | 250 (100) |
| | Percent | 27.60 | 13.60 | 09.20 | 29.20 | 20.40 | |
| Response from medical personnel and staff | Frequency | 23 | 41 | 19 | 92 | 75 | 250 (100) |
| | Percent | 9.20 | 16.40 | 07.60 | 36.80 | 30.00 | |
| Cleanliness | Frequency | 61 | 53 | 37 | 47 | 52 | 250 (100) |
| | Percent | 24.40 | 21.20 | 14.80 | 18.80 | 20.80 | |
| Infrastructure (bath room, water supply, building etc) | Frequency | 36 | 42 | 39 | 87 | 46 | 250 (100) |
| | Percent | 14.40 | 16.80 | 15.60 | 34.80 | 18.40 | |

***Source**: Field Survey.*

Table – 3 explores that the satisfaction level of respondents concerned with the issues pertaining to facilities provide by the hospitals in study area. The factors are drugs/medicine availability; doctors are availability, waiting timings, treatment quality, response from medical personnel and staff, cleanliness and infrastructure. Majority is 84 (33.60 percent), 99 (39.60 percent), 101 (40.40 percent), 73 (29.20 percent), 92 (36.80 percent), 61 (24.40 percent) and finally, 87 (34.80 percent) respectively. Respondents level of satisfactions are as 'disagree', 'strongly disagree', strongly agree', above six factors responses are mixture in nature by the respondents.

## FINDINGS

1. Majority of 71.20 percent of the respondents are female and 28.80 percent of the respondents are male respondents.
2. 198 (79.20 percent) of the respondents are belonging to urban area of the respondents and 52 (20.80 percent) of respondents are from rural area.
3. The study shows that the more number of 141 (56.40 percent) of the respondents are nuclear family type and slight number of 109 (43.60 percent) of the respondents have opined that they are from joint family type.
4. Qualification of the respondents majority 143 (57.20 percent) of the respondents are illiterate it indicates that huge number of respondents are not take much care about the health matters. About 107 (42.80 percent) of the respondents are literate only.
5. Out of 250 (100 percent) of the respondents regarding the health coverage scheme majority 168 (67.20 percent) of the respondents are take much care towards the coverage scheme provide by the government and private organizations. Only 82 (32.80 percent) of the respondents are take any health coverage scheme.
6. The study indicates that the present public health status of the area that more number 116 (46.40 percent) of the respondents have opined that the poor responses and 97 (38.80 percent) of the respondents responses in terms of normal regarding public health status. Only 37 (14.80 percent) of the respondents are agreed about the present public health status in study area.
7. Total 250 (100 percent) of the respondents out of which 203 (81.20 percent) of the respondents are suffering from more number of constant disease. About 47 (18.80 percent) of the respondents are opined that they are not feel constant disease.

8. The study find out that the drugs/medicine availability factor responses from the respondents that the 33.60 percent are disagree and 29.20 percent are strongly disagree about the availability medicine.
9. Out of 250 (100 percent) respondents 99 (39.60 percent) are opined that they are disagree with said variable of doctor availability in the hospital and 69 (27.60 percent) of the respondents are indicate that strongly disagree stated variable.
10. The study reveals that the waiting timings, treatment quality and responses from the medical personnel and staff, cleanliness and infrastructure majority of the respondents are responding mixture responses are as disagree, strongly disagree and agree for the stated variables.

## SUGGESTIONS

1. There is a quick observation need to strengthen and systematically locate the public hospital to maximize and to provide good services in constant diseases not only in rural and urban areas.
2. Government of India is to provide some essential physical and social infrastructure facilities to facilities to patients like building, power, running water, ambulance, telecommunication and other required perquisites in health issues.
3. The government should take a serious note of the conspicuous shortage of human resources in the public primary health institutions. Because they provide primary health care services to maximum population living in rural areas and vulnerable and poor sections of the society in urban areas.
4. Government take keen eye on the behavior of medical personnel in public hospital influences service utilisation, the government should arrange recurrent behavioral trainings to medical personnel.
5. Government of India and private people how are wish to run the hospital they must to provide advanced technology For the preservation of drugs, each PHC should be supplied with refrigerator along with a generator.
6. As the community confidence on public health system is weakening day by day, there is urgent need to strengthen the public health system at all levels of care by improving its service quality standards.

The above suggestions are successfully implemented for the improvement of public health in India, particularly in Karnataka and to facilitate good number of medical treatment to constant and deadly diseases. If we are honestly and promptly doing our duty without fail to public and to reach the words of Winston Churchill, '***Healthy citizens are the greatest asset any country can have'.***

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