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Is Kerala Model of Health Care Moving Towards an American Model of Health Care: An Analysis

Sunitha.L.F
Research Scholar, Dept. of Economics, University College, Trivandrum

Abstract

The present paper is an attempt to analyze health care scenario in Kerala and to find out the reasons for the present crisis it faces in the modern era. In many respects, Kerala state has succeeded in increasing life expectancy as well as reducing infant and maternal mortalities. Kerala's achievements in health are almost comparable to any developed country despite state's economic backwardness. India's first ever human development report published in 2002, placed Kerala on top of all states. Over the years, Kerala underwent through a transition from a society with high population growth rate, high death rate and high infant mortality rate to one with moderate population growth rate, low crude death rate and relatively low infant mortality rate. The implementation of land reforms improved the standard of living of the rural poor.Kerala has made remarkable achievements in health almost comparable to that of even developed countries. But all the evidence we have shows that neoliberal policies have adversely affected them. The present paper looks at these issues and suggests remedial measures.

Key words: Health care, demographic transition, American model.

Introduction: Kerala has gained international acclaim in the field of health and development. It has been lauded for its remarkable achievements in health in spite of a poor per capita income and a lack of agricultural and economic growth. It was described as a "good health at low cost" model and was considered a development model for several years. There is nothing accidental or mysterious about the Kerala model development. It was the outcome of a development paradigm, which led to far sighted investments by the state on social sectors like education, food security and health. The focus on female education, public distribution of subsidised food items through a state-wide network, universal access to health services, provision of safe drinking water and sanitation paved the way for its high achievements in health.

The remarkable gains made by Kerala have however been under severe stress in recent years. In the face of growing budgetary deficit and fiscal crisis, Kerala has been witnessing a steady decrease in budget allocation to social sectors like health and education. This has led to a steady decline of the public health system. The mounting demand for health care in

the state, growing consumerism and the increasing capacity among people to spend money have simultaneously led to burgeoning of an almost unregulated private health sector in the state.

There seems to be growing perception among the public on the erosion in quality and creeping inefficiency in the public health sector. The decline of the public health system, the falling morale of the health care functionaries, the failure to live up to the expectations of the people and lack of flexibility in governance may be some of the reasons. The increased demand created by public awareness and education could not be met by a proportionate upgrading of infrastructure by the government. This gap was filled by the private sector resulting in an increase in private health facilities, which remain highly unregulated with ever escalating health care costs. In advanced developed countries, health is predominantly provided by the government; for example, in the United Kingdom and most other European Countries more than 85 per cent of health expenditure is from the public sector. In India and Kerala.

Purpose of the Study: The goal is to better understand this social health issue within the context of a rural community and to identify influential factors useful in developing a praxis theory of rural health that addresses the problem of health and health issues in the marginalised community. The purpose of this research is to conduct an ethnography in to relevant contextual factors in rural community in the study area. Ethnography is like a mirror, providing a reflection of what is observed. In this way, the researcher obtain a vivid portrait, but the community also has the opportunity to view themselves premise of participatory action research. It is time to gather the knowledge learned through living relative to these concepts and put that knowledge in to a new round of action; it is time to affirm Praxis for professionals and community members.la, public health expenditure is less than 20 percent. Because of this low allocation to health care in the public sector, Kerala is now facing shortage of manpower particularly doctors, drugs, supplies and other services.

Review of Literature: Devi *et al.*, 2005**;**The paper proposes Multi Agent System (MAS) technology which can help doctors in rural area to acquire timely consultation of experts working in hospitals like Postgraduate Institute of Medical Research, Chandigarh or the All India Institute of Medical Sciences, New Delhi. The software is designed to bring the knowledge together to serve the underserved rural population. The effective implementation of MAS requires physical computing, networking infrastructure and proper training to doctors. Proper implementation of the technology can potentially deliver quality health care to rural population at par with developed nation.

Kunhikannan and Aravindan highlight the changes in health status of Kerala 1987 to 1997.The study links the socio-economic and health status of Kerala state. It confirmed the findings of other studies that Kerala has made advance in basic health indicators of health status. The study concludes that as long as poverty induced diseases dominate the pattern of illness; Government intervention both in health sector as well as the non-health sectors

would be required. This study is to examine the relationship between health status and consumption expenditure. The study is based on the data obtained from Kannur district.

According to Ramachandran (1982) the factors responsible for Kerala' s achievements can be attributed to: meaningful land reforms; ` food for all' schemes through fair-price shops and feeding programmes for school children, infants and mothers; providing easy access to primary and preventative healthcare; promoting high literacy, particularly among women, through free and universal primary and secondary education; high mandated agricultural and farm wages; cost effective transportation facilities; rural electrification; engaging the poor and working people in democratic processes, such as in labor and civic organizations; fostering public dialogue on environmental conservation issues; and developing social movements through the establishment of a civil society to promote environmental conservation and other grassroots projects.

V. Raman Kutty (2000) point out that Kerala 'model' in health is currently dominated by privatized health care, where services of doubtful quality are offered to an unsuspecting public through advertising and other inducements, many of them unethical, purely as a profit making Venture. Private hospitals now surpass government facilities in the density of beds and employment of personnel. He concluded that if the political leadership has the courage to develop a vision for Kerala's health, a new Kerala 'model' can emerge for ensuring a healthy society.

Kerala Model of Health care: An Analysis: Kerala's healthcare system has garnered international acclaim. The state has a very good medical facility. The United Nations Children's Fund (UNICEF) and the World Health Organization designated Kerala the world's first "baby-friendly state" because of its effective promotion of breastfeeding over formulas. For example, more than 95percentage of Keralite births are hospital-delivered. Aside from Ayurveda (both elite and popular forms), siddha, and unani many endangered and endemic modes of traditional medicine, including kalari, marmachikitsa and vishavaidyam, are practiced.

These propagate via gurukula discipline ship and comprise a fusion of both medical and supernatural treatments, and are partly responsible for drawing increasing numbers of medical tourists. A steadily aging population (11.2percentage of Keralites are over age 60) and low birthrate (18 per 1,000) make Kerala one of the few regions of the Third World to have undergone the "demographic transition" characteristic of such developed nations as Canada, Japan, and Norway.

Kerala's remarkable achievements in health care were to a large extend based on its vast network of public health institutions which enabled her to earn the fame of "Kerala Model of Health" worth emulating even by advanced countries. The hall mark of this model was the low cost of health care, universal accessibility and availability to the poor sections of the society. This health model was made possible by many socio–economic conditions, important among which was the high female literacy rate in the state. Apart from these, the extensive network of medical institutions in modern medicine has also made this possible.

Despite all these, Kerala faces some major problems in the health sector at the beginning of the 21st century.

Challenges of Kerala model of Health care: During the past few years, Kerala's health care sector has been facing serious crises. Return of the eradicated infectious diseases and the emergence of new ones, increase in lifestyle diseases, prevalence of health problems for women and aged, constraints and quality of government hospitals, excessive privatization of health care sector, increasing health care costs, entry of self –financing medical education etc.Kerala's health sector had begun to face crisis by early 80's.Doubts regarding existence of cracks in Kerala health model emerged with the return of epidemics which were once considered as completely eradicated. Inspite of this new epidemics appreared in Kerala(Dengue Fever, Chickenguniya, Japanese Encephalitis and H1N1).In this time incidence of lifestyle diseases like diabetics, hypertension and cancer cases increased at an alarming rate.

By the beginning of 90's, Kerala society started to bear the double burden of epidemics and emergence of life style diseases. High incidence of suicides indicating a low mental health status and causalities due to motor accidents are also the signs of the crisis faced by Kerala Model of Health. The severity of health crisis faced by the marginalized groups dependent on traditional health care facilities lead to the problem of rising morbidity. Government medical colleges and other hospitals are failed to transform according to quantitative and qualitative change in the morbidity pattern of people in Kerala. The vacuum is exploited by the profiteering private investors. As a result, big private hospitals mushroomed in Kerala. Health care became an attractive avenue for profit-motivated investors where anyone can invest their funds without any hesitation. Many of the medium and small sized private hospitals who provided affordable health care facilities at affordable rates to people who cannot afford high expenditure. Apart from the financial implications the current super specialty culture completely neglects preventive health care and health education.

Present Status of Kerala Model of Health Care: Though Kerala has registered a significant improvement in key health care indicators, the health situation in the state reflects a paradox. It is a paradox of high morbidity and low mortality, which resulted in the crucial social problem of ageing. Kerala has made significant progress in improving the key healthy statistics: death rates, birth rates, infant mortality rates and life expectancy at birth. The state performance in the health sector has been better compared to the rests of the states in India. Still there is a long way to go in for improving the key health care indicators, new dimension of health status are emerging which need attention now. These are environmental issues causing for bad health, chronic morbidity in urban and rural areas, and shattered health status in urban slums, new contagious disease such as AIDS and diseases of poverty and prosperity. Also much needs to be done to improve the health of women and children especially among the dalits, marginal and deprived sections of the community.

Despite all the achievements, as mentioned, the major challenges in the present health scenario of Kerala are the simultaneous presence of widespread infectious diseases and the life style diseases, escalation of health care cost and marginalization of the poor. Uncontrolled growth of the private sector is also a major challenge. The morbidity rates are higher in Kerala than other Indian states though the mortality is comparatively low. Kerala's prevalence of LBW is substantially higher than the developed nations (13.3%). The maternal mortality rate is slowly showing an increasing trend and the immunization coverage, a declining trend.

Impact of the Policies of Globalisation: The policies of privatization and liberalization implemented from 1991 onwards by the central government had its impact all over India and in Kerala. An important recommendation of the World Bank was that public funding to the service sectors like education and health shall be reduced. Accordingly the central government is reducing investment in the health sector. Though health is a subject under the state list, the central government has cut short the share of the several centrally sponsored health care and preventive programmes.

The Indian health care system is predominantly privatized. The government has set apart only 0.9% of GDP to this sector. Government spends only 17% of the total expenditure on health. But even in America it is 40%. In European countries it is more than 80%. As a result of the intervention of the Left, in the Common Minimum Programme the UPA government had agreed to set apart 2 to 3% for health care.

Government had opened up the scope for great strides in health sector along with others. The local body governments had intervened to improve the efficiency of hospitals from the primary health centres to the district hospitals. Priority was given for local health problems, the planning for solving the problem was done at the local level and the mobilization of fund with the help of local support had enabled to cover come various difficulties. Out of the total plan fund given to the local bodies, 30% was set apart for the projects in the fields of education and health. By exploiting this congenial situation steps were taken to solve the local health problems with the co-operation of doctors, health workers and the public.

Steps are also being taken to enhance the standards of the Medical Colleges and to develop them as Super Speciality Centres. A committee consisting of six members was constituted to study the possibilities of the same and suggest recommendations. In order to solve the problem of the shortage of doctors in hospitals from rural dispensaries up to Medical Colleges, the government has adopted certain measures to declare rural service as compulsory to the young graduates in medicine.

Towards an American Model of Healthcare?

Excessive privatization and commercialization of health sector lead to an escalation in health care expenses especially in the case of Kerala. According to a study conducted by KSSP, per capita annual out-of-pocket health care expenditure increased from Rs.88 in 1987 to Rs 5,029 in 2011.Kerala state Planning board Report, Kerala has the highest out-of-pocket health expenditure in India and that 12% of rural households and 8 % urban

households were pushed below poverty line due to increasing health expenditure. This trend is still continuing without any change. Kerala model of health care seems to be following American Model of Health care, characterized by the co-existence of cutting edge modern facilities for treatment and lack of accessibility of health care to the poor.

Suggestions: Condition of hospitals in the grass root level began to improve in the present century. Enhancement in the availability of drinking water and sanitation facilities helped a lot to control the outbreak of epidemics. The very first years of implementation of People's planning witnessed significant increase in the number of people who uses Government or Public hospitals fot their health care. Conditions of Government hospitals improved in government hospitals because of the effective implementation of the schemes introduced by the NRHM.LSGs are now implementing more schemes especially on preventive health care and health education rather than curative cure. Joint efforts of Doctors, Patients and health care volunteers have led to the emergence of Palliative care movement in Kerala. There is no need for effective coordination of the activities of health related activities of LSGs. By the united efforts of health department, LSG, people's representatives, doctors and hospital staff can establish a new participatory Health care Model for Kerala.

Conclusion: Thus the study concluded that the development of healthcare facilities of the selected hospitals is varying but their role in the health care sector in Kerala is very significant. Kerala's achievements in health care are the outcome of peoples 'interventions and the implementation of public health provisions by various governmental agencies. But Kerala is moving away from success to severe crisis in health sector and possibly from social equity to social exclusion. Comprehensive efforts to tackle these problems must form an integral part of the struggle for a new Model of Health care in Kerala.

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