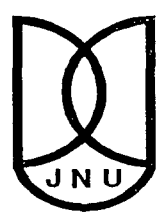
HEALTH CARE PROVIDERS IN DELHI METROPOLITAN CITY: A SOCIOLOGICAL EXPLANATION OF ISSUES AND CONCERNS

Dissertation submitted to Jawaharlal Nehru University in partial fulfillment of the requirements for the award of the Degree of

MASTER OF PHILOSOPHY

NAVIN



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CERTIFICATE

This is to certify that the dissertation entitled, **"HEALTH CARE PROVIDERS IN DELHI METROPOLITAN CITY: A SOCIOLOGICAL EXPLANATION OF ISSUES AND CONCERNS"**, submitted by Navin, in partial fulfillment for the award of the degree of MASTER OF PHILOSOPHY of this university is his original work. This dissertation has not been submitted for any other degree or any other university.

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We recommend this dissertation be placed before the examiners for evaluation.

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Dedicated To My Mother

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If there are any shortcomings in this dissertation, I alone am responsible.

NAVIN

CONTENT

LIST OF TABLE

ABBREVIATION

COPRA	-	Consumer Protection Act
ESI	-	Employee State Insurance
FRCH	-	Fellow of Royal College of Health.
GP	-	General Practitioners
IMF	-	International Monetary Fund
MBBS	-	Bachelor of Medicine And Bachelor of Surgery
MCD	-	Municipal Corporation of Delhi
MCWC	-	Mother and Child Welfare Centre
NDMC	-	New Delhi Municipal Corporation
PHC	-	Primary Health Care
ROME	-	Reorientation of Medical Education
RMP	-	Registered Medical Practitioner
SAP	-	Structural Adjustment Programme
UNESCO	-	United Nation Educational Social and Cultural Organisation
WB	-	World Bank
WHO	-	World Health Organisation

MAP

"There are biologists of various sorts who represent biological man, anthropologists who represent primitive man, sociologists and psychologists who represent social man, and physicians who represent ill and disabled man. But who represents man as a product of the interactions of both biological and social processes in an integrated biosocial system"

Bruce K. Eckland

CHAPTER-I

INTRODUCTION

Problem of poverty and disease haunt a developing country like India, which is plagued by diseases of all kinds, where millions go with scant or without medical care, it is worthwhile to study systematically the sick component of Indian society. The social aspect are indeed much more relevant to the normal functioning of social system. Therefore, sociological analysis of medical system and patient care in the Indian context assume great significance. For an effective application of medical knowledge it is also important to know the cultural and social pressures, which have a bearing on the response of a doctor to patient. Development of medical and social sciences and recognition of the facts that social environment is significant in the etiology of disease and doctor-patient relationship is an important tool. The broader perspective developed by the social scientists and their emphasis on interdisciplinary approach helped to understand human behavior.

The effect of social environment and cultural factors on the occurrence and frequency of disease and the influence of belief system, values, norms, and socio-economic conditions of living on the response of people to the event of sickness has been studied in the sociological research in medicine. Sociologists have explored medical field from various angles. Kendall and Merton (1958), classified the area of sociological research in medicine into I)social etiology and ecology of disease, II)social component of therapy and rehabilitation, III)medicine as social institution and IV)sociology of medical education. Straus (1957), categorized in two broad categories, 'sociology of medicine' and 'sociology in medicine'. Where the first deals with the organizational structure, role relationship,& the functions of medicine as a system of behavior, thus mainly concerned with the study of medical practice. The second is concerned with collaborative research or teaching and the integration of techniques and concepts. The process of socialization of the professional for their institutionalized roles is the matter of 'sociology of medicine'.

1.1 Background of The Study

The patient is recognized as more than a disease entity. The physician of today is reminded that sick person is often an anxious person. That his anxieties and difficulties as well as his potential for recovery may be significantly affected by his social ties, by his situation with the family and workplace and in other groups important to him. In much the same terms, the development of the medical students must be considered in the light of his social and psychological environment, so the medical student must be recognized as more than a passive receptacle into which new knowledge is being poured.

Identification of the individual with his class or status group influences his social reciprocity. The psychologists consider individual feelings of people to be the basis of class. The subjective identification is the basis of class. A man always has a feeling of belongingness to his class. Persons with similar status and role in different spheres develop certain values attitudes and interests which strengthen "class consciousness". An analysis of the correlation of behavior and various status determinants as age ,sex rural/urban residence, religion, caste, education etc has proved useful in the study of social phenomena.(Richard, 1949 cited in Mathur 1975: 36) therefore ,it does not appear to be correct to talk about people and their behavior in general. They should be considered in the context of social categories they belong to.

It is clear with the Indigenous traditional systems of medicines, where Ayurveda and homeopathy with Hindu and Unani with Muslims identified with these religious group, means practitioners from the separate group, which prevent the other religious group to enter in the field and served their people. Theoretically, the allopathic system being modern and a recent entry into Indian Society was open to all religious categories. This suggests that the allopathic system of medicine in India recruits its personnel irrespective of their religious background.

In order to understand the perspective of physicians as a professional group, it is important also to consider the manner in which physicians are selected and trained as medical professions. Family influence seems to be an important variable in encouraging and reinforcing the ambitions of the future recruit to the medical profession. Having a parent or close relative who is a physician also seems to be distinct advantage. The decision to study medicine is largely social in character, that is originates in a social group that is able to generate and nurture the medical ambition (Halls, 1948 Cited in Ventkataratnam, 1979).

Indeed the role expectation and performance of the professional group party depends on how far it has been able to change is professional attitude acquired during the period of primary socialization before entering the professional training. All the member of the professional group might not have freed themselves completely from certain pre-professional attitude which may be antithetical to professional values and expectations. Further the environment that has provided the member opportunities in the profession of medicine has to be understood so that we can find out it there are any relation between a particular social environment and the motivation for choosing medicine as a career. This is to understand how different socio- economic group in the community have availed the opportunity provided to them.

From this standpoint medical students are engaged in learning the professional role of the physician by so combing its component knowledge and skills, attitudes and values as to a professionally and socially acceptable fashion. Socialization includes more then what is ordinarily described as education and training. Most conspicuous in the profess of medicine learning is, of course, the acquisition of a considerable store of knowledge and skills which to some extent occurs even among the least of these students. Beyond this, it is useful to think of the process of role acquisition in two broad classes, direct learning through didactic teaching of one kind or another, indirect learning, in which attitudes, values and behavior patterns are acquired as by products of contact with instructors and peers,

with patients and with members of the health team. It would seem particularly useful to attend systematically to the less conspicuous and more easily neglected processes of indirect learning.

1.2 Research Question

Social scientist had a long enduring interest in studying the process of socialization. It means the process by which individuals are inducted into their culture. It involves the acquisition of attitudes and values, of skill and behavior patterns making up social roles established in the social structure. Although, studies of socialization were largely confined to the early years in the life cycle of the individual, but more recently, increasing attention has been directed to the process as it continues, at varying rates throughout the life cycle. This has given rise to theoretical and empirical analyses of adult socialization. Basically socialization, a process of learning on which the social system depends, is a work of sociology which is concerned with the function, structure and roles of social institution and social processes, and with the social behaviors of persons and groups. The hypothesis of this problem is concerned with the social facets of health and illness, the social function of systems of health care delivery to other social system, and the social behavior of health personnel and those who are consumers of health care.

In other words, how the aspirant, with his characteristic anticipation, fears, hopes and abilities emerges as a socially certified physician, outfitted with a definition of his professional status, with attitudes towards that status, with a self image and with a set of professional values. And how does it happen. In short, to what degree and through what process does the medical school shape the professional self of the students, so that he comes to think, feel and act like a doctor.

Here in this study, the main concern is with the social component of the therapeutic process, in particular with medical practice in social context. There are three ways of dealing with sickness viz. Preventive, therapeutic and rehabilitation.

Health care provider are the main actor in the therapeutic process of health care delivery and solely responsible for the protection of the health of people in order to fulfill their rights and obligations as normal members of society who are a part and parcel of the larger social structure. These men are educated and trained as professional by the society to take care of the sick and cure illness. As a common man of society he bears, and faces several social factors which directly or indirectly affect his behaviour (in broader sense). In short, the socio-economic, political and religious behaviour of the people which affects the making of a ethical professional. Hence any professional might have not freed himself completely from certain pre-professional attitudes and values which he acquired during the period of primary socialization before entering the professional training. Therefore, socialisation of the medical professionals is the area of this study, practiced in different set-up in south of Delhi city.

1.3 Rationale of the study

In order to understand the place of health care providers in social structure, it is necessary to analyse first their social background like –religion, caste, regional-linguistic, rural-urban etc; and also their family background, their parents education, occupation etc. This would us not only to gain a composite picture of the health practitioner but may also be relevant; in helping us to explain more fully his or her professional attitudes and performance. It is also an attempt to gauge the social mobility, these social categories are experiencing, by analysis the difference in occupational background between them and their father. The effort of the study is to understand how open or closed is social terrain from which recruitment to these occupations is taking place. In this attempt to locate the place of any occupational category in social structure, subjective status perceptions that the category has of itself are of vital importance, in addition to the objective attributes. Therefore, the purpose to the analyze is not only the objective attributes of doctors but also the

subjective perception they have of their status in two contexts one is the wider society and within the occupational community of health personnel.

This study, undertaken in South, of the Delhi Metro, which comprised the posh colony as well as middle class colony, with the urbanized village, describes the interpersonal relations between the doctors and their patient in context of social background. To analyze the reciprocal behaviour of the doctor-patients and the effects of age, sex, income, rural and urban communities and educational standards on the interactions and interrelations, in the context of health care providers social backgrounds. Whatever medical services are available, is good but the availability in the context to provider is not same, because of the professionals (as member) is a unit of society which is stratified in account of different level. Hence the available services are still beyond the reach of common man or the quality of service which is provided to them. The concern of this study is that the medical professional comes from the upper status of society (Ramalingaswami, 1985) and their process of socialization and high-tech education is totally different from the common man, to whom they, provide service. The role performance of any professional group partly depend on how far it has been able to change its pre-professional attitudes acquired during the period of primary socialization before entering in the professional training.

Whenever a social scientist analyses a problem his task or interest is mainly to the people who are sick. He deals with then as member of society, as people who are interacting with each other (whether care provider or; seeker) and teaching to their external and internal environment. In this context it is expected to formulate and reformulate the sociological concepts and theory.

1.4 The Conceptual Framework

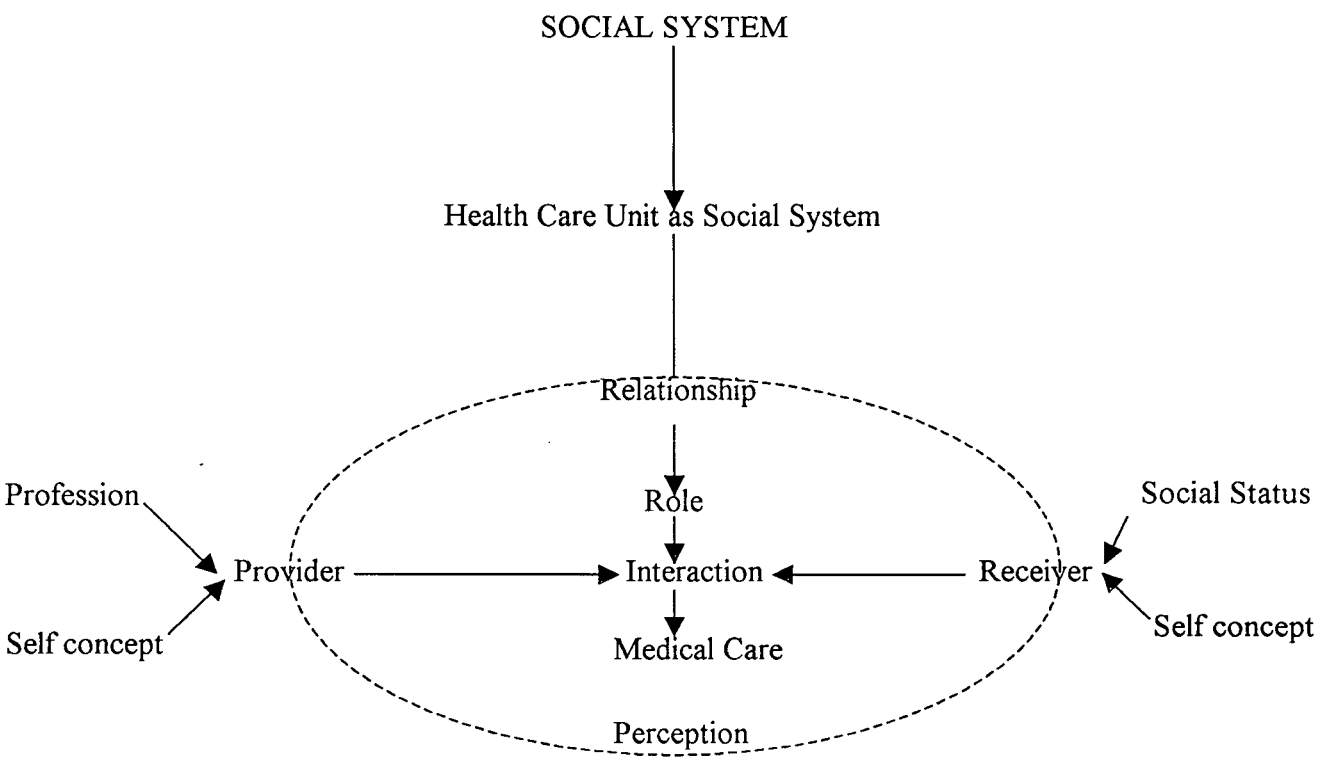
As described earlier that every professional, as a member, is a unit of society. Being a social creature, every man learns some basic norms, values, attitudes and form of interaction to other in the prescribed fashion of particular, group or class he

belongs. There are some factors like status, wealth etc. which construct the personality. Many sociologists have regarded the family as the cornerstone of society. It forms the basic unit of social organization and it is difficult to imagine how human society could function without it. Although the composition of family varies. The external environment and the social structural elements in the community influence the interpersonal relations. The correlation between the status system in the society and the contents and structure of interaction between one unit to another units of society. Many studies reveal that these "latent social identities" as to sex, age, residence rural /urban literacy, income groups etc. influence behaviour.

The medical school is conceived as a social environment in which the professional culture of medicine is vigorously transmitted to novices through distinctive social and psychological processes. The school is regarded as a decisive middle term between the native and previously trained capacities of selected individual and emergence of professional self, the identification of these individuals, by themselves, and by society, as medical doctors. It is plainly in the professional school that the outlook and values, as well as the skill and knowledge, of practitioners are first shaped by the profession. The medical education has been upon matters of what is being taught, what should be taught and how if might most effectively be taught are the emphasis only for educative process in medical school- not for to appraise current medical curricular or to advocate changes in them, upon the ways in which its social structure, like the other organization, largely forms the behavior of its member and so affects the making of the medical man.

The term health care providers will be oprationalised for the purpose of this study as follows – "Those health service providers who are trained and educated by an institution and / or certified, to provide the service, with professional ethics to their client, whosoever."

Provider Seeker Interaction: A Hypothetical Model



1.5 Objectives of The Study

The sociologist in medicine often has to take the role of an applied scientist to solve certain problems of the medical scientists, like, to help in finding out the social causes for an endemic spread of a disease in a locality or to find out why people of a community resist taking immunizations. His help may also be sought to explain why patients refuse certain treatment procedures in the hospital or run away from the hospital during the course of treatment. In this goal identification his sociological interest is relegated to the background. But, in the same context, the study of 'Sociology of medicine' have relatively more theoretical and practical import to the main body of sociology but does not mean that it has no practical use to medical customers. In fact a number of hospital studies have helped to solve practical problems of patient-care and problems of hospitals as complex organisation. Studies on patients their attitudes towards various disease, their notions of health and disease, their behaviour problems and so forth have enabled to build up a substantial theoretical in sociology.

However, a man who maintains his primary identity with his discipline, this professional identity with one's own profession is possible the area of sociology of medicine. Hence the study deals in this sub-area.

With a view to maintain the above identity we have set forth the following objectives for the present work:

1. To find out the social background of health care providers.
2. To examine their process of socialization and social environment in present context.
3. To find out characteristics of the health care seekers, and their pattern of interaction with providers.

4. To explore the expected and performed role of health care providers, in respect of patients Social background.

1.6 Scope and Limitation of The Study

The study population was not large in terms of numbers. Only nineteenth interview were carried out in one public and 14 private health care centers. Some refused after approach because of lack of interest and time. To meet the respondents, prior appointment one day in advance, was taken.

1.7 Methods of Data Collection

The data have been basically collected through interview and case study. The patients and doctors have been contacted at the selected service set up. They were JNU health centre, and private practitioners, private hospitals / clinic in Munirka.

Interview Schedule

Interviews were conducted by the help of interview schedule which was semi structured. Nineteen interview were held. The schedule was divided into three sections. In the first section general information from the respondents was sought. Second about role of health care providers and the third was concerned with national health services.

Case study

The case study method was used to note the perception of patients. This method revealed the factors responsible for their interaction. For this purpose care receiver were selected on the basis of their living standard and specialization of the doctor they approached.

1.8 Key sociological concept for the study

Social medicine in medical science in relation to groups of human being... it is not merely or mainly concerned with the prevention and elimination of sickness, but is concerned also and especially with the study of all social agencies which promote or impair the fullest realization of biologically and socially valuable human capacities. It includes the application to problems of health and discuss of sociological concepts and methods (Crew, 1944 cited in Mathur, 1975:25).

1.8.1 Social Mobility

Social mobility refers to movement (or lack of movement) by individuals or groups from one social role or social status to another. Mobility is an important element of social interaction and an indicator of the strength of stratification and the potential for social change in society. Social mobility is the movement of individuals, families, and groups from one social position to another. The theory of social mobility attempts to accounts for frequencies with which these moment occur. The study of social mobility relates a present to a past social position. It thus forms part of the more general study of social selection, i.e. of how people get distributed into different social positions. (International Encyclopaedia of social science, 1972: 429).

Social mobility has been defined as movement through "social space": from one status category (the origin) to another status category (the destination). It is reflected as changes in relative social standing or status. Social status has been defined as one's community standing (e.g. one's position of power of influence), organizational membership, kinship relations, property, ownership, education, and wealth of income among other criteria. It is a particularly useful measure in that it is linked to economic status and educational background and is therefore, correlated with the "pattern of living" of an individual. These exists a stable relationship between occupations and prestige that is attached to the position. Occupations have

been shown to be strongly related to a class concept. (Encyclopaedia of Sociology, 1992: 1973).

Status is attached with social position many sociologists have assumed that social position is gained by individual *achievement* rather than by birth at least for the majority of the population. Inequality is attached to *positions*, and therefore, it is important to understand how one gets into these positions and how much movement there is across generations. Social mobility thus becomes the focus of attention. First individual positions are unequally rewarded, and differ in access and opportunity. Capitalist societies do not claim to be equal, they do claim to offer equal opportunity to all in the competition for unequal positions. That is, they claim to be *meritocratic*. (Bilton, 1981: 114). The inheritance of wealth and educational advantage make this ideology of 'free competition for unequal reward' a very dubious claim. Despite with the ideal of totally free movement through totally equal opportunity, most mobility occurs on the basis of social position of his family of origin. As claimed the individual does not mere often than not move up or down according to merit.

There are two aspects of mobility:

(I) **Intergenerational Mobility:** That is, son or daughter has a different social position, (higher or low) than that of the parents.

(II) **Intragenerational Mobility:** That is, where an individual changes his social position during his career.

Social mobility is, closely related to questions concerning social achievement and more particularly, concern to the role of the parental social position in determining filial status.

Determinants of Social Mobility

Parental occupations or status is related to the probability of filial entry into an occupation in two principal ways-

a) The father's occupational status may be correlated with a variety of filial attributes, such as education, intelligence, and race/caste, that affect the son's occupational locus.

b) The parental occupational status may affect filial occupational locus more directly, the father's occupational experience may influence his son's occupational interests and may provide him with special knowledge experience, incentives, and opportunities for access to it or other occupations.

Educational Level

Educational level is dependent upon the status level of parents. This dependence is lessened by society's investment in educational facilities and the degree to which these make educational opportunities available with out respect to social origin. (International Encyclopaedia of social science, 1972: 435).

Intelligence and Mobility

In the process of status selection, variations in intelligence operate to influence the achieved level of social status; both by leading to variations in educational level and by facilitating the advancement of those greater intelligence. Thus part of the effect of education on status achievement is due to the correlation of education with intelligence.

Intelligence also depends on environmental circumstances. The dependence of filial on parental status is due to two sources of correlation between parental and filial intelligence – social and genetic.

Discrimination

In some societies the existence of sizable racial / caste or other groups subject to various modes of discrimination increases the dependence of filial status on parental status. The common obstacle shared by father and son tends to show up as a correlation between their status positions. Since status position as defined by social mobility studies does not usually include the criterion of discrimination, this necessarily inflates the degree of dependence of filial status on paternal status.

Other social handicaps

Relatively little attention has been paid to the role of special deficits that are not severe enough to exclude persons from the labour force and yet act as powerful handicaps to occupational achievement. High –grade mental deficiency, physical disabilities, chronic disease, mental disorders, alcoholism etc, taken together, have a sufficiently high incidence and a sufficiently decided effects on occupational achievement to influence mobility. It is possible that a substantial part of the cases of extreme downward mobility can be accounted for in this way.

The reeducation of parental status to a series of more specific and often independently operating factors may lead to a neglect of those sources of influence in the parental occupational situation that exercise a direct influence on the son's occupational destiny by giving him special knowledge, incentives, and opportunities with respect to particular occupations. In dealing with son's who are professional / white collared workers it is fairly easy to account for their occupational status with out making an appeal to the specific occupational locus of their parents.

Behind the propensity of some classes of fathers to produce sons who follow in their occupational footsteps appear to lie certain relationships that, however, can be stated only very tentatively. Sons seem to be more likely to pursue their fathers' occupations under certain conditions:

1. If the fathers are self-employed.

2. If the self-employed fathers utilize a substantial capital in the pursuit of their self-employed occupations.

3. If entry into the fathers' occupation is regulated by licensing, examinations, union control, apprenticeship, or other obstacles that the parental status may aid the son to overcome.

4. If the parental occupation requires special training or education.

Naturally these relationships operate more effectively if the occupation involved provides satisfactory rewards relative to alternatives open to the sons. There are numerous other individual and family attributes that effect the probability that a child will attain a given status position. The number of children in the family and the birth order of child may in some institutional settings be particularly important. The motivations and aspirations of young people in different sectors of society obviously play an important role in determining the manner in which various individual and family assets and handicaps exercise their influence. (Ibid 436)

The highest groups can protect their sons from downward mobility through devices such as public schools. The oxford groups concludes that the sons of higher professionals are three times more likely to follow their fathers, given equality of opportunity. Whereas three out of four manual workers come from manual backgrounds, and that sons of manual workers have only half the chance of entering the professions which they have, given equality of opportunity.

The reality of social mobility is still for removed form such "meritocratic" an ideal model. There have been changes in the opportunities for long-rang mobility, but the middle class have usually been the first to size new opportunities (such as state owned education) to avoid downward mobility. It is generally assumed that the rise of more widespread educational opportunities has given children of working-class parents the chance to study for the qualifications necessary to enter middle – class occupations. At the same time, it is argued the increasing demand for

competitively gained qualifications means that children from middle – class families cannot assume that they will avoid downward mobility. Hence, those who enter an occupation holding few qualifications are, it is argued less likely to achieve work-life mobility (i.e. intergenerational mobility), because qualified trainees will be recruited directly to these higher positions (Biton, 1981: 118). Thus, these trends towards a greater stress or educational qualifications imply that intergenerational mobility with in work caused through promotion becomes much less important as a route for advancement.

The primary form of mobility is intergenerational, through the education system. This means that inequalities in educational; opportunities are crucial. These trends also mean that, given the occupants' lack of educational qualifications, as Thrope et al. (1971: 120) put it, 'a manual job is now, more than ever a life sentence'. Similarly, the opportunities for advancement out of routine clerical work are also significantly diminished because managerial positions are often filled directly by external candidates with graduate or professional qualifications. If selection were purely on merit, then a fairly high level of social mobility would be expected. Those from higher backgrounds would only secure their continued position by showing talent – for example, through educational qualifications. However, this would not lead to purely open mobility as long as those from higher backgrounds gained significant advantages in the educational system, whether through private schooling or through their more successful use of the state sector. Achievement based systems are not necessarily open. Additionally however, there are definite biases in recruitment which systematically favour those from higher-class backgrounds. (Giddens, 1973: 107) emphasizes this idea with his concept of "structuration", the greater the degree of "closure" of mobility chances the more this facilitates the formation of identifiable classes. For the effect of closure in terms of intergenerational movement is to provide for the reproduction of common life experiences over the generation. The qualities demanded in competitors for a position may effectively produce social closure, so that only those with a certain class back ground or a certain degree of wealth, are considered suitable. Data shows

how a public school educations, followed by top institution/university, is the primary route into many positions of power. Thus it would seem that *ascription* rather than achievement is more important for those in the upper class. The inheritance of wealth, and the gaining of accent and demeanour through a distinct and expensive education, are 'qualifications' for power holding in many social institutions. The 'self-made millionaire' is a rare and peripheral member of this propertied class, overall it makes more sense to refer to the social closer of the upper class to mobility whether upward into it, or downward out of it (Bilton, 1981).

1.8.2 Socialization

Socialization refers to the process of interaction through which an individual acquires the norms, values, beliefs, attitudes, and language characteristics of his or her group. In the course of acquiring these cultural elements, the in individual self and personality are created and shaped. (Encyclopaedia Of sociology, 1992: 1863). In other words the process by which we acquire the culture of society into which we are born – the process by which we acquire our social characteristics and learn the ways of thought and behaviour considered appropriate in our society. When individuals, through socialization, accept the rules and expectations of their society that make up its culture and use them to determine how they should act, means interlined society's cultural rules. (Bilton, 1981: 10). In its application to the medical students, socialization refers to the process though which he develops his professional self, with its characteristic, values, attitudes, knowledge, and skills, fusing these into a more or less consistent set of dispositions which govern his behaviour in a wide variety of professional (and extra professional) situations.

Since the socialization undergone by a human being in the early years of its life will obviously be of crucial influence in affecting the attitudes and behaviour of the social adult, then the family, as the first human group an individual in any society usually belongs to, is clearly a socializing agency of major importance. Most of the influence of the family in this initial stage during the socialization process is

unintended, and takes place informally, as a product of social interaction between people in extremely close physical and emotional proximity to one another. As the child gets older, other agencies get in on the act. for example, other children with whom a child comes into contact – friends, playmates and so on can have a significant socializing influence, called peer group, is probably the first means by which children encounter ideas and ways of behaving different from those at home (Dubey, 1989: 225).

The process of formal education too is crucial socializing agency.

Rose and Glazer (1930) have defined socialization as the process of learning of beliefs, values, patterns and social roles of society and culture. Besides learning it is a process of reception and internalisation. Goode (1977) holds that socialization includes all those processes through which an individual internalises social skills, roles, patterns, values and personality types. The process of internalising social values to social needs and making these part of the personality is called internalisation of social values. The process of internalisation of values through socialization is fulfilled by society. Socialization also includes the knowledge of cultural system, social relationship and skills. Thus socialization enables us to carry out work. Socialization also makes us emotionally sensitive. In binds us with our "environment and neighbours" (cited in Dubey, 1989: 227).

The process of socialization has two aspects-(i) The individual internalises the social values under the social and cultural influence. (ii) Socialisation develop his personality. Thus, through socialization the aims of social responsibility and individual autonomy are achieved. The role of socialization is very important is the individual's life from two points of view. The individual's 'self' develops through socialization. Socialization develops his personality and the process of mental interaction. The unification of individual's socio-psychological behaviour is reflected in personality. It is expressed through the habits, its devices and thinking of the individual. Linton (1936) statement that society, culture and personality are so interdependent that their differentiation poses many problems.

Theoretical Frame Work of Socialisation and Development of Self

The theories related to the socialization and the development of 'self' may be divided into the following categories.

1. Structural
2. socio-psychological

Structural Theory

According to one view, individual's socialization depends on the class he belongs to. The members of a class have a distinctive and life-style. Emiel Durkheim (1895) the profounder of this theory explains the individual's socialization through social facts. The social fact is a special system of working, thinking and feeling that is beyond and above the individual. Morality, law, religion and the division of labour are social facts. The individual has to behave according to these facts..

Cooley's Theory of Looking-Glass Self: A Socio-Psychological Theory

An important aspect of the development of personality and socialization is the development of self. For Cooley 'self' means 'I'. And 'Me'. Self is determined by the individual's thinking about himself. The infant has no 'self'. It has no interest in 'self'. It's interest in itself awakens only when it becomes conscious of itself. Cooley believes that the idea of 'self' is a social product. So it is also called 'social self' Cooley calls his theory the theory of 'looking-glass self'. The ideas, feelings and tendencies concerning 'self' are a process of imagination by which we try to know what other think about us. In the development of 'self', it is important to know not only how people face each other or what they think of each other or what conclusions they arrive at but also to see one self in the mirror of other's conclusion. Thus the development of self is the product of society and it is produced by the individual's interaction with other.

1.8.3 Role Theory

Role theory concerns the tendency of human behaviour to form characteristics patterns that may be predicated if one knows the social context in which those behaviours appear. It explains those behaviour patterns (or roles) by assuming that persons within a context appear as members of recognized social identities (or positions) and that they and other hold ideas (expectations) about behaviours in that setting (Encyclopaedia Sociology, 1992: 1681) Ralph Linton (1936), role theory was a means for analysing social system, and roles were conceived as "the dynamic aspects" of society recognized social positions. (or statuses). 'Status' according to Linton is a polar position in a reciprocal social interaction. This polar position which he calls 'Status' is a "collection of rights and duties". 'Role' according to him is the dynamic aspect of status or giving effect to its right and duties through behavioural enacting. (Cited in Ventatratnam 1979: 96).

Mead (1934) viewed roles as the coping strategies that individuals evolve as they interact with other persons and spoke of the need for under standing others' perspective (role taking) as a requisite for effective social interaction. (Encyclopaedia of sociology, 1992: 1681).

Goffman (1969) introduced further sophistication in role analysis. To him status is a position and role consists of the *activity* the incumbent would engage in, were he to act solely in terms of the normative demands upon someone in his position. Role in this normative sense is to be distinguished from role performance or role enactment, which is the actual conduct of a particular individual while on duty in his position. (cited in Oomen 1978:15).

Moreover, additional insights for role theory were generated by other early authors, particularly Muzafer Sherif's studies of the effects of social norms, Talcott Parson's functionalist theory, which stressed the importance of norms, consensus, sanctioning, and socialization, Robert Merton's analysis of role structure and processes, the works of Neal Gross, Robert Kahn and their colleagues, who

discussed role conflict and applied role concepts to organisations, Everett Hughis's papers on occupational roles. Theodore Newcomb's text for social psychology, which made extensive use of role concept and the seminal monographs of Michael Banon, Annie – Merrie Rocheblave, and Raghar Rommet as well as Ralf Dahremdorf's essay "Homo sociologicus". (Encyclopaedia of Sociology, 1992: 1682).

There are contrasting definitions for concepts, that are basic role theory. For some authors the term role refers only to the concept of social position, for others it designates the behaviour characteristic of social position members, and for still others it denotes shared expectations held for the behaviours of position members. Role theorists may disagree about substantive issues. For example, some authors use role concepts to describe the social system, whereas others apply it to the conduct of the individuals.

Despite these differences, role theorists tend to share a basic vocabulary, interest in the fact that human behaviour is contextually differentiated and is associated with the social position of the actor, and the assumption that behaviour is generated in part by expectations that are held by the actor and others. Moreover it also means that role theory may be contrasted with alternative theoretical positions that give stronger emphasis to unconscious motives or behaviour inducing forces of which the actor may be unaware. Such as unobvious mechanisms that serve to maintain structured inequalities of power, wealth or status. (Encyclopaedia of sociology, 1992 :1682).

Functionalist Role Theory

One early perspective in role theory reflected functionalism, arose from the contributions of Talcott Parsons, this theory made use of role concepts. Functionalist theory was concerned with the problem of explaining social order. Stable but differentiated behaviours were thought to persist with in social systems because they accomplished functions and because actors in those systems shared expectations for

behaviours. Such consensual expectations (or 'roles') constituted norms for conduct, and actor conformity to norms was induced either because others in the system imposed sanctions on the actor or because the actor internalised them. In addition, those in the system were thought to be aware of the norms they held and could be counted on to teach them to (i.e. to socialize) neophytes as the latter entered the system.

Functionalist thought has been attacked and many of its basic assumption have been challenged, critics have pointed out that persisting behaviours may or may not be functional for social systems, that norms for conduct are often in conflict, that actor conformity need not be generated by norms alone but can also reflect other modes of thought (such as beliefs and preferences), that norms might or might not be supported by explicit sanctions that norms that are internalised by the actor may be at odds with those that are supported by external forces and that processes of socialization are problematic. Above all, critics have noted that social systems are not the static entities that functionalist thought portrayed and that human conduct often responds to power and conflicts of interest in ways that were ignored by functionalists.

The Structural Perspective

This third perspective reflects the early contributions of anthropologists such as of. Nadel and Michael Benton. Sociologist such as Marion Levey, and social psychologists ranging from Dorwin Cartwright and Frank Harary to Oscar Oeser rule as a structuralists, Concern themselves with the logical implications of ways for organizing social systems (conceived as social positions and roles) and eschew any discussion of norms or other expectation concepts (Encyclopaedia of sociology, 1992).

Cognitive Perspectives in Role Theory

Empirical research in role theory has been carried out by cognitive social psychologists representing several traditions. Some of this work has focused on role playing, some of it has concerned the impact of group norms, some of it has studied the effects of anticipatory role expectations, and some of it has examined role taking.

In addition, cognitive social psychologists have studied conformity to many forms of expectations including instrumental norms moral norms, norms attributed to others, self—fulfilling prophecies, beliefs about the self, beliefs about others and preferences or "attitudes" these latter studies suggests that roles are often generated by two or more mode of expositional thought, and several models have also appeared from cognitive theorists reflecting this insight.

Unfortunately, much of this effort ignores expectations for social positions and concentrates. Instead, on expectations for individual actors, cognitive role theory also tends to ignore the implications of this findings for structural analysis and thus appears to be atheoretical from a sociological perspective. (Encyclopaedia of sociology,1992: 1684).

Role Conflict and Organizational Analysis

Interest in organizational role theory began with the works of Neal Gross, Robert Kahn, and their associates, who questioned the assumption that consensual norms were required for social stability. Instead, they suggested that formal organisations were often characterised by role conflict (i.e., opposing norms that were held for actors by powerful others, that such conflicts posed problems for both the actors and the organisations is which they appeared, and that strategies for coping with or "resolving" role conflict could be studied.

The concept of role conflict has proven attractive for those who wanted to conceptualise or study problems that are faced by dis-empowered persons.

Role Theory Among Symbolic Interactionists

Interest in role theory has also appeared among symbolic means social actors are continually engaged in 'negotiating' the meaning reality with one another. In general, symbolic integrationists think of a role as a line of action that is pursued by the individual with in a given context. Roles are affected by various forces including pre-existing norms applying to the social position of the actor, beliefs and attitudes that the actor holds, the actor's conception and portrayal of self, and the "definition of the situation" that evolves as the actor and others interact. Roles need not have common elements, but they are likely to become quite similar among actors who face common problems in similar circumstances.

In addition, symbolic interactionism has attracted its share of criticism – among other things, for its tendencies to use fuzzy definitions, and ignore structural constraints that affect behaviours.

1.8.4 Social Stratification

A hierarchical ranking system often represented as a "ladder" in which there are differences in access to social resources, individuals at the top ranks have more access, while those at the bottom lack social resources also called structured inequality. (International Encyclopaedia of sociology, 1972: 1267).

The gradation such as age, sex, and mentality influence specialization and the various roles are the graduation of people and is called stratification. The term has been used to refer both the process by which people are arranged along a scale, or to the institution or condition that results from such grading. Stratification is that the form of interaction by which status or standing becomes more or less definitely linked to some association or grouping of people rather than to specific individuals as such. That is as a process it has to do with the formation class or caste. Stratification deals with the social myths, symbols, rules, codes, functions and structures which have grown up around a class or caste organization of society.

Social stratifications , in its most general sense is a sociological concept that refers to the fact that both individual and group of individual are conceived of as constituting higher and lower differentiated strata, or classes in terms so some specific or generalized characteristic or set of characteristic. Thus is all about social inequality why it exists how it affects our everyday life, and why it is tolerated in a society dedicated to the ideal of equality. Obviously, inequalities of wealth and power underline many of the world's problems. Inequalities in education and class/caste, are important only because they are the basis for social distinctions. Sociologists agree that the nature of society not the nature of human beings, largely determines whether some people are richer or more powerful than other. (Coser, 1983: 158).

Systems of Stratification

Social ranking is a system for distributing things that are scarce and valuable in every society not only the food, shelter and other goods produced by the economy but also such intangibles as honour and power. Social rank awards on the basis of both ascribed at birth according to sex, race, or other characteristics over which the individuals has little or no control. Other are achieved through individual failure or accomplishment. Depending on what kinds of characteristics are considered most important, stratification systems fall into three categories: caste, estate and class.

Caste System

In caste stratification systems individuals are permanently assigned a social position purely on the basis of caste. Although the Indian government has made caste barriers illegal, India is still the most famous example of caste system. Indian society is broadly divided into four major castes and the lowest ranking group, the "untouchables". The ruling castes were the Brahmans (priests) the Kshatriya (warriors) and the Vaisya (merchants and peasants). The fourth caste, Sudras, served these rulers. The untouchables were considered so inferior that they were forbidden

to mingle with higher castes on streets, and so forth. The basis of this rigid system is the Hindu religion, which assigns believes to social positions:

Estate System

In estate stratification systems social position depends on family membership. Each major social stratum, or estate, has certain right and privileges that are passed on through inheritance.

Estate stratifications is characteristic of feudal societies, in which land is the most important basis for social rank. Each estate had different rights, and each was subject to a different set of laws.

Unlike caste system, estate system permit some change is social rank through intermarriage or achievement. Commoners could be knighted or made members of the nobility, as a reward for service to the king. In most cases, however, one's inherited position continued for life. Estate stratification disappeared in the modern era, but many European societies, retain vestiges of the old system. In Great Britain, for example hereditary titles still lend prestige, and the house of lords has kept a remnant of its former power in parliament.

Class system

In class stratification systems social position is largely determined by achievement, especially the economic achievement of individuals. Virtually every industrial society has class stratification systems. Socialized education and occupational skills are more important than family background. (Coser,1983: 170).

The Professions in the Class Structure

During this century, one of the most significant changes in the occupational structure of advanced industrial societies has been the growth of white collar sector, includes clerical, technical and scientific, administrative managerial and professional

occupational. In recent years, the professions have been the fastest growing sections of the occupational structure. The increasing complexity of trade and commerce are the reasons have been given for the rapid growth of the professions. The growth of industry requires increasingly specialized scientific and technical knowledge which results in the development of professions such as science and engineering. The creation of the welfare state and the expansion of local and national government has produced a range of "welfare professions" and has resulted in the growth of the medical and teaching professions and the increasing employment of professionals in govt. bureaucracies. Professionals have been seen both as process and products of industrialization. Their skill and knowledge one regarded as essential for the development and expansion of industrial economies. In term, the wealth produced by this development has provided the means to pay for the specialized services which the professionals supply.

Various explanations have been advanced to account for the occupational rewards of professionals. These explanations are influenced by the sociologist's theoretical perspective and his evaluation of the services provided by professionals. He argues that professionalism involves 'four essential attributes".

Firstly, a body of systematic and generalised knowledge which can be applied to a variety of problems. Thus doctors have a body of medical knowledge which they apply to diagnose and threat a range of illness. Secondly, professionalism involves a concern for the interests of the community rather than self – interest. Thus the primary motivation of professionals is public service rather than personal gain. For example, doctors are concerned primarily with the health of their patient rather than with living their own pockets.

Thirdly, the behaviour of professionals is strictly controlled by a code of ethics which is established and maintained by professional associations and learned as part of the training required to quality as a professional. Thus doctors take the Hippocratic oath which lays down the obligations and proper conduct of their

profession. Should they break this code of conduct, their association can take them from the register and ban them from practicing medicine.

Finally, the high rewards received by professionals, which includes the prestige accorded to professional status as well as earnings, are symbols of their achievements. They donate the high regard in which professionals are held and reflect the value of their contribution to society.

Perspectives

There are three basic perspective of social stratifications.

1. **A functionalist Perspective:** Talcott Parsons, Kingsley Davis and Eva Rosenfeld are the some who believe in functionalist perspective of stratification. They assumes that there are certain basic needs or functional prerequisites which must be met if society is to survive. They therefore look to social stratification to see how for it meets these functional prerequisites. They assume that the parts of society form an integrated whole and thus examine the ways in which the social stratification system is integrated with other part of society.

Talcott Parson's believes that order, stability and cooperation of society are based on value consensus, that is a gave general agreement by members of society concerning what is good and worthwhile.

Kingsley Davis and Moore, the American sociologist in 1945, on functionalist theory of stratification observes that stratification exist in every known human society. One such functional prerequisite is effective role allocation and performance. This means that all roles must be filled. Secondly that they be filled by those best able to perform them, thirdly that the necessary training for them be under taken and fourthly that the roles be performed conscientiously.

Melvin M. Tumin the most famous opponent of Davis and Moor's views suggests that in general, the lower an individual's class position, the More likely he

is to leave school at the minimum leaving age and the less likely he is the aspire to and strive for a highly rewarded position. Hence stratification systems are apparently inherently antagonistic to the development of such full equality of opportunity."

Michael Young says that research has also indicated that many members of the upper strata owe their position primarily to the effect that they have been born into those strata and have capitalized on the advantages provided by their social background. In *The Rise of The Meritocracy* uses of the term meritocracy, as a system of role allocation. In a meritocracy, talent and ability are efficiently siphoned out of the lower strata. As a result these groups are in a particularly vulnerable position because they have no able members to represent their interests.

Marxian Perspective

Perspectives provide a radical alternative to Marxian functionalist views of the nature of social stratification. They regard stratification as divisive rather than an integrative structure. They see it as a mechanism where by some exploit others rather than a means of furthering collective goals.

In all stratified societies, there are two major social groups a ruling class and a subject class. The power of the ruling class derives from its ownership and control of the forces of production. The various institutions of society such as the legal and political systems are instruments of ruling class domination and serve to further its interests. From a Marxian perspective, systems of stratification derive from the relationships of social groups to the forces of production. Marx used the term class to refer to the main strata in all stratification systems, though most modern sociologists would reserve the term for strata in capitalist society. From a Marxian view, a class is a social group whose members share the same relationship to the forces of production.

Marx distinguished between a "class in itself" and "class for itself". A class in itself is simply a social group whose members share the same relationship to the

forces of production. Marx argues that a social grouping fully becomes a class when it becomes a class for itself. At this stage its members have class consciousness and class solidarity. Class consciousness means that false class consciousness has been replace by a full awareness of the true situation, by a realization of the nature of exploitation. Members of a class develop a common identity, recognize their shared interests and unite, so producing class solidarity. The final stage of class consciousness and class solidarity is reached when members realize that only by collective action can they overthrow the ruling class and when they take positive steps to do so.

There are some reason for that the Marx's work on class.

1. Many socialists claim that his theory still provides the best explanation of the nature of class in capitalist society.

2. Much of the research on class has been inspired by ideas and questions raised by Marx.

3. Many of the concepts of class analysis introduced by Marx have proved useful to Marxists and non-Marxist alike.

Weberian Perspective

Max Weber (1864-1920) German Sociologist represent one of the most important development in stratification theory since Marx. Like Marx, Weber sees class in economic terms. He argues that classes develop in market economies in which individuals compete for economic gain. He defines a class as a group of individuals who share a similar position in a market economy and by virtue of that fact receive similar economic reward. Thus in Weber's terminology, a person's 'class situation' is basically his 'market situation'. Those who share a similar class situation also share similar life chances. Their economic position will directly affect their chances of obtaining those things defined as desirable in their society, for example access to higher education and good quality housing. Those who have

substantial property holdings will receive the highest economic rewards and enjoy superior life chances.

Whereas class refers to the unequal distribution of economic rewards, status refers to the unequal distribution of 'social honour'. Occupations, ethnic and religious groups and most importantly styles of life are accorded differing degrees of prestige or esteem by members society. A status group is made up of individuals who are awarded a similar amount of social honour and therefore share the same status situation. Unlike classes, members of status groups are almost always aware of their common status situation. They share a similar life style, identify with and feel they belong to their status group and often place restrictions on the ways in which outsiders may interact with them. Weber argues that status groups reach their most developed form in the caste system of traditional Hindu society in India.

1.8.5 Sociology of Education

Much of the research in the sociology of education has been directed to the question of why members of some social groups reach higher levels of educational attainment than members of other. A large array of statistical evidence shows that, in general attainment rises from the bottom to the top of the class system. Thus, the children of managers and professional usually obtain higher qualification than those of manual workers. Statistics also show that the educational attainment of ethnic or class groups varies.

This issues is primarily concerned with formal education with two main question – the role of education in society, which is examined in terms of functionalist and Marxian perspective, and the question of differential educational attainment, the fact that the attainment levels of different social groups vary. This variation can be explained in terms of a number of theoretical framework.

The French sociologist Emile Durkheim saws the major function of education as the transmission of society's norms and values.

Approaches

There are following approaches to understand the sociology of education:

A Functionalist Approach

From this perspective, the expansion of formal schooling is seen as a precondition for efficient economic growth and for the development of a Meritocratic society. Changes connected with industrialism give rise to specific 'functional imperatives' needs which must be met if society is to survive and prosper. The education system plays a crucial part in meeting at least three of these needs, performing three vital functions on behalf of society.

1. A vehicle for developing the human resource.

2. A sophisticated mechanism to select individuals, according to their talent, and train them for the jobs they can most effectively fill.

3. Schooling contributes to the cohesion of society, core value of that society.

The transmission of a core culture through the education system is to promote consensus on the basic values of the society, to ensure a fundamental level of agreement despite the diversity of individuals' life experiences.

This approach has some limitation:

1. The degree of 'fit' is far from the clear, requirements of efficient production. Hence educational certificates may be necessary to make you eligible for certain jobs, but is unclear whether they make you proficient is those jobs.

2. It is not clear whether the selection and allocation is related to some intrinsic merit of the pupils themselves. Or to as creative characteristics such as their social class back-grounds. Some argues that schools confirm pupils in the status to which they were born rather than acting as 'neutral' selection agents

indifferent to the background of pupils. In practice, many aspects of the education system (whether intentionally or not) seem to dampen down the aspirations of particular groups of pupils, persuading them that they have set their sights realistically high.

3. The notion of a core curriculum is difficult to sustain. Studies indicates many content- analyses of curricular materials show racist, ethnic social class or sexist biases. It can be argued that the values and knowledge selected for transmission within schools will be more familiar, more compatible and more beneficial to some groups in society than to others.

Marxist Approach

Conflict perspectives in search of a more adequate account of the relationship between education, economy and society. Bowles and Gintis in schooling in capitalist America, see an intimate link between schooling and the economy, it is the specific requirements of industrial capitalism, rather than the general needs of industrialism, which in their view shape the nature of educational systems. Rigid hierarchies of authority an increasing fragmentation of tasks, apart from a small proportion of professional and executive personnel, the majority of the labour force are increasingly required to perform mundane tasks allowing small scope for initiative, responsibility or judgment. Most people have minimal control over what they do and how they do it. Schooling operates with in the 'long shadow of work', the education system reflects the organisation of production in capitalist society. The fragmentation of most work processes is mirrored in the breaking up of the curriculum into tiny 'packages' of knowledge, each subject divorced form all others, lack of control over work processes is reflected in the powerlessness of pupils with regards to what they will learn in school or how they will learn it, and the necessity of working for pay when jobs seem pointless and unfulfilling in themselves is paralleled by the emphasis in schools on learning in order to gain good grades, rather than learning for its own sake there is a correspondence between the

nature of work in capitalist societies, and the nature of schooling. Schools are not uniform in their patters of organisation and instruction. Schools for working-class children, emphasis may be on docility, obedience, rule-following. Where as wealthy backgrounds, encouraging the leadership abilities considered suitable for a future elite. The emphasis in Bowles and Gintis's account is on the personality characteristics- particularly patterns of authority and control that the schools foster and reward.

Capitalist societies are class societies, characterized by great and persistent inequality and relationship of subordination and domination between social classes. Inequalities are the inheritable result of capitalist relations of production, in which the means of production are privately owned and all other people must compete in the market-place for rewards in the form of income. Schools play an important part in transmitting inequality between generations. The occupations of future members of the labour force are to a large extent predetermined by the social class from which they come. Schools play apart in ensuring that this comes about, by assigning pupils to a school, or tracks or stream that is appropriate to their future position in the labour force. There they will be socialized into the habits of thought and practice that will be required of them in their future work. In this way, schools take an active part in 'reproducing' people who have been muddled in order to slot into their place in a labour force that is divided along lives of social class, sex and ethnicity.

At the same time, it helps to legitimate that inequality. That is education helps to justify in people's minds a system of inequality, and to reconcile them to their own position with in it. As long as most people believe that education gives everyone a fair chance to prove their worth and as long as their privilege and disadvantage are widely believed to stem from fair competition in the educational arena, then inequality appears to be justified by different levels of educational achievement (Bilton, 1981: 387).

Contemporary Approach

A meritocracy society is one in which social reward are allocated not according to "accidents of Birth" but according to talent, where there are no social barriers to the translation of talent into educational achievement, and thereby into occupational success.

Ramond Boudon is his publication. *Education opportunity and social inequality*, presents the relationship between social class and educational attainment. The inequality of educational opportunity is produced by a two – component process". (a) The primary effects of stratification has been dealt with in the previous section. It involves sub cultural differences between social classes which are produced by the stratification system. The differences in values and attitudes between social classes produce inequality of educational opportunity. (b) The secondary effects stem simply from a person's actual position in the class structure. Even if there were no sub cultural differences between classes, the very fact that people start at different positions in the class system will produce inequality of educational opportunity. (cited in haralambos,1988: 205). A.H. Hasley writes, the social background has an increasing effect on educational attainment at the vary time when the bonds between educational and occupation are tightening. The education is increasingly the mediator of the transmission of status between generations. Privilege is passed on more and more from father to son via the educational system (Haralambos, 1988:222)

The myth of meritocracy – the view that our schools stimulate individual talents and, without regard for ascribed characteristics such as social class or gender reshuffle children according to ability – is one of the most cherished myth of our time. The overwhelming evidence is that the education favours those who are already privileged and puts further obstacles in the path of those who are disadvantaged.

CHAPTER- II

LITERATURE REVIEW

Disease is a universal phenomenon and therefore affects all people every where. However it does not always affect everyone to the same degree or in the same way. The relationship between social conditions and factors that influence health and development of disease has long a major interest of human kind. Throughout history people have to viewed health problems from the perceptive of their own particular societies and culture. As a result they have usually responded to the threat of disease in predictable ways. Knowledge about norms, values, beliefs, social structures, and life style has provided insight not only about the social organisation of human resources, designed to cope with health hazards, but also about the nature and causes of illness.

The study of how diseases attack human groups and the way they react to diseases provide important substantive for the application of sociological knowledge and research techniques. As an academic discipline, sociology is concerned with the function, structure and roles of social institution and social process and with the social behaviour of persons and groups. Thus, medical sociology is concerned with the social facets of health and illness, the social functions of health institutions and organizations and relationship of systems of health care delivery to other social system. It is also concerned with the social behaviour of health personnel and consumers of health care.

In 1960, the Medical Care Research Centre, Washington University, worked out the four broad areas of research interest are,

1. Organizational analysis of health facilities and programs concerning medical behaviour in the institutional context of hospital, and nursing homes, extended care facilities, and similar agencies.
2. Utilization of community health resources, in which various socio-cultural and psychological factors associated with the individual's perception of and response to illness are studied in relation to the community's medical care resources.
3. Studies of health professions which focus on professional socialization of students in the health occupation and organizational context in which this learning process takes place.
4. Cost and financing of medical care, involving studies of how much various programs cost not only to the users but also the purveyors (Coe 1978:24).

2.1 Social Science and Emergence of Medicine

Throughout history man lived in the social group, which gave him security against enemy and natural calamities. This association with other group members for survival, makes him a social animal. Hence man developed the dependency on other members for food, Shelter and in case of other mal function of his body.

The history of dynamic between medical science and society reveals a strange contradiction. Health represents the degree to which an individual can operate with effectiveness within the particular circumstances of his heredity and his physical and cultural environment. Classical epidemiological studies of seventeenth to twentieth century observed that, there are links between human health and total environment-social, economic, political, physical, and biological. These classical studies has the origins of primary heath care, which consider health in totality (Qadeer, 2001 : 119).

Knowledge, as it grows, deeply influences the thinking processes of those who have access to it. People strive constantly to improve their lot some with formal knowledge and some without it, but perhaps with greater wisdom. The former may pursue knowledge with the assumption that it is objective and universal, or they may choose to acknowledge their biases. Either way they claim to seek answer for society as a whole to establish certain ways of thinking(Qadeer, 2001).

The first to examine the evolution of the concept of public health and the intellectual efforts to undermine it. The exercise between the two, in solely responsible for the emergence of medicine from the social science.

In approaching the question of emergence of medicine it has been helpful to consider both the historic sequence of disease patterns and the different systems for using medical knowledge as a single stepwise evolutionary process punctuated by a certain stages from the primitive of traditional or the modern.

The first stage of biomedical growth in the change away from the most primitive society is the introduction of impersonal measures that are not customarily regarded as being related to disease at all. This initial steps consist of such things as the innovation of eating off a table instead of from a dirt floor, along with this come the beginning of the economic infrastructure. The second stage consists of attempt to affect disease by introducing a change in the non personal environment. Example of this are the provision of a safe water supply and sanitation (Macdermott, 1969 :8). During the 1800s, century, Louis Pasteur, Robert Koch, and other in bacteriological research that led to the conceptualisation of the germ theory of disease. The germ theory along with the development of internal Medicine (Anaesthesiology, Pathology, immunology, and surgical techniques.) convinced physicians to focus exclusive upon a clinical medicine grounded in exact scientific laboratory procedures. The practice of medicine in the twentieth century thus rested solidly upon the premise that every disease had a specific pathogenic cause whose treatment could best be accomplished by removing or controlling that cause within a biomedical framework (Cokerhem, 1978: 9). In other words, the holistic view of

disease (Social science perspective) was over shadowed, first by the sanitary approach of the Chadwickian model and later by germ theory both undermining the "predisposing" host factors and promoting "external" causality (Hamlin, 1992 cited in Qadeer, 2001: 119).

The ahistorical progression of the science of health divested of its social-and economic moorings reveals a commitment to a science characterised by positivism, and extreme rationalism. Above all, it reveals a manifest commitment to methodological individualism which continue to dominate the understanding of epidemiology up to the present. Social science as a discipline interact with health a similar reification of the quantitative method is seen, at the expense of the development of a theory of a society which contours the occurrence of disease. To move closer still, pathology and medicine do have their own paradigm, but like those imposed by Social Science; beg the substantive issue of "health" itself (Yadavendu, 2001).

Thomas Kohn (1962), argues that the principal characteristic of any field of scientific enquiry, during any particular epoch in its development, is the fundamental paradigm that organises the practice of "normal science" during the epoch. Hence astronomy, some 500 year ago passed from the paradigm of geocentricism to that of helio-centralism and beyond (Ibid).

The fundamental paradigm currently in practice, in the study of health, is still not well defined. The social scientist, whose primary orientation is disciplinary (e.g economics, sociology, psychology) rather than substantive issue/area (e.g health) would respond with paradigms from their respective disciplines, moral hazard, (sick) role, pluralism, and so forth. (Ibid).....if medicine is the science of the healthy as well as of the ill human being (which in what it ought to be), what other science is better suited to propose laws as the basic of the social structure, is order to make effective those which are inherent in man himself! Once medicine is established as anthropology, and once the interests of the privileged no longer determine the course of public events, the physiologists and the practitioner will be counted among the

elder statesmen who support the social structure. Medicine is a social science in its very bone and marrow (Virchow cited in Coe, 1978: 1).

2.2 The Convergence of Sociology and Medicine.

Through the history of medicine, there has been an intimate connection between disease and the social environment. The treatment of disease involves more than the mere application of medical knowledge through medical institution. In our society, the institutions which purvey medical care are supported by many other organisation such as, health care agencies, public health department, pharmaceutical companies and heath insurance firms, which have emerged to provide physicians with, necessities for effective therapy. All these medical institutions are further related to, and partly controlled by, other social institutions. Similarly, in simpler societies, the force of religious ritual and presence of both kinsmen and neighbours usually combine to support the " Medical" efforts of healers (Coe, 1978: 2).

For all these reasons, social sciences, and particularly sociology, has much to contribute to the field of medicine. The study of the distribution of diseases in society, of cultural perspectives on disease (and on ways of staying healthy); of the roles, attitudes and values emerging from the social organisation of treatment centres, and of the relationship of treatment and support facilities are all subjects well within the preview of sociology. In a word, to study medicine as a system of behaviour (Ibid: 3). Medicine in now faced with two distinct alternatives. It can either redefine disease and restrict its treatment to specifically medical conditions or it can accept a broad concept of disease (which includes problems in living) and change medical education programs to deal effectively with the wider spectrum of illness (Cokerhem, 1978). White (1972) explains that, in the past, medical schools selected students who were motivated primarily by curiosity about disease, instead of students motivated by humanistic concern for people. Combs and Powers (1975) found that physicians would intellectually dissect their patient into physical parts and concentrate upon treating only the pathological part. Reader (1953) has argued

that medical schools should require a background in sociology of all students who apply for admission on the grounds that sociological principle are basic to understanding how to be a better medical student and a better practising physician. Mckinley (1971) has ventured to suggest that the time may come when the research contribution of medical sociology will stand in the same relation to medicine as do those of physiology, endocrinology and biology as a body of knowledge explaining human functioning in the medical sphere. Knowles (1972) is correct when he states that medicine is a social science as well as biological science and that it needs the social sciences as never before.

Something of the same perception governed much of ancient medicine. The Hippocratic, Corpus both pays explicit attention to the social environment as an etiological factor in disease and deals specifically with the doctor- patient relationship as a therapeutic tool. Great renaissance physicians and surgeons, such as Pare or Paracelsus, often exhibited greater perception of the patients' psychological situation than physiological processes. In the seventeenth century, too, men like Sydenham emphasized observation of the natural history of disease in individual and groups as prerequisite to medical understanding.

During the past century and a half, while medicine has become scientific in the modern sense of the word, it has never really lost the social insight of previous generations. However, for the first time a conscious distinction has been made between the "science" and the "art" of medicine and except within modern psychiatry *formal* instruction and academic interest alike have centred almost wholly on science. Because medical science has been defined almost entirely in biological terms, this distinction has pushed interest in the social aspects of medicine to the periphery of medical consciousness with the development of the germ theory of disease and the concurrent progress in physiological medicine-the "medicine of internal environment"- it seemed that the theory of pathology had been reduced to analysis of the response of the organism to deleterious physical and chemical stimuli. The tremendous successes in the management of disease which this theory won reinforced the tendency to think of medicine as an exclusively biological

science. Even its social organization was conceived as ideally determined by criteria of efficiency in implementing technical, diagnostic, therapeutic, and preventive operations. (Coe, 1978: 8) In the late nineteenth and early twentieth centuries medicine tended both to breaks with the past and to place its essential hopes upon the laboratory. As Merton has noted, their attitude has become the "great tradition" of modern medicine. (Merton, 1957)

Thus in many respects, it would seem that sociology and medicine more or less ignored each other during their respective periods of development as scientific disciplines. Paradoxically although, the respective quests of sociology and medicine for scientific development tended to lead them in separate directions prior to the mid-twentieth century, the fruits of these efforts have led in recent years to converging interest among the disciplines. As we shall see, the changes brought about by sociological and especially medical discoveries have created a favourable situation for productive collaborative efforts.

2.3 Difference between Social Medicine and Medical Sociology

"Social medicine" is a product of France, Germany, Belgium and other European Countries. Firmly based in the medical profession, it reflected a concern with the role of social factors in the etiology of disease, and the need for government. action in the areas of disease prevention and medical care. The term was widely adopted in Great Britain in the 1940s (Editorial, 1985).

In 1848, Jules Guèrin introduced the term and concept of "social medicine", at a time when revolutionary hopes were still running high. Guèrin appealed to the French medical profession to act for the public good, to help create the new society for which, the February Revolution had opened the way. He divided social medicine into four parts: social physiology, social pathology, social hygiene and social therapy. In this sense Guerin saw social medicine as " the key to the most important issues of our period of regeneration" and the medical profession as the most appropriate group to use this tool. (George, 1972)

Medical sociology is concerned with the social causes and consequences of health and illness. Medical sociologist. Study the social facets of health and disease, the social functions of health organizations and institutions, the relationship of system of the health care delivery to other social systems, the social behaviour of health personnel and those people who are consumers of health care and interchangeable patters of health services.

2.4 International Definition of Health

WHO defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or injury. This definition calls attention to the fact that being healthy involves much more than simply determining if a person is ill or injured. To be healthy means also to experience a sense of well being. Evans and Stoddart (1990) point out, health not only means an absence of disease or injury, but also an absence of distress or and impaired capacity to carry out one's daily activity. Several European studies conducted in France (d'Houtaud and Field 1984, Herzlich 1973) and the Netherlands (Joosten 1989) report, for example; that many individuals view health primarily as a state of functional fitness and apply this definition to every day social circumstances.

Good health is a prerequisite for the adequate functioning of any individual or society. If our health is sound, we can engage in numerous types of activities. As Rene Dubos (1981) explains, *health can be defined as the ability to function*. This does not mean that healthy people are free from all health problems, it means that they can function to the point that they can do what they want to do (Cokerhem, 1978 :2).

As McKeown (1979) explains, we know from personal experience that the feeling of well-being is more than the perceived absence of disease and disability. Many influences-social, religious, economic, personal, and medical-contribute to such a state. The role of medicine is health promotion in the prevention of illness and premature death and care of the sick and disabled. Thus McKeown conclude

that medicine's task is not to create happiness, but to remove a major source of un happiness- disease and disability –from people's live.

In every medical action there are always two parties involved, the physician and the patient or, in a broader sense, the medical corps and society. Medicine in nothing else than the manifold relations between these two groups. The history of medicine, therefore cannot limit itself to the history science, institutions and characters of medicine, but must include the history of the patient in the society, that of the physician, and the history of the relations between physician and patient(Bloom, 1972:315).

Sigerist's (1960) assertion that health care is essentially a social relationship deserves special emphasis today because our era is distinguished by its focus on the technology of medicine. In the dense web of machinery, technique, testing and computer processing that enfolds modern medicine, it often is easy to forget that the nub of the health system is found in the interplay between helper and helped. Thus, Sigerist's admonition about the centrality of the doctor- patient relationship has been largely unheeded by historians of medicine they have chosen instead, as Friedson, "to pass through the centuries picking out the 'valid' elements of medical knowledge and assembling a chronology of truths that add up to become present-day scientific medicine.

Henderson (1935) an outstanding biochemist, became fascinated with the idea of adapting Pareto's theory of sentiments to the Gibbs model of physiochemical systems, a large sociological literature has accumulated in which the relation between the medical profession and his client are treated as the crux of medicine.

Henderson's system analysis focused on the internal processes of interaction between doctor and patient. Parsons expanded the perspective to view medicine as "an important sub system of modern western society".

2.5 Indian Scenario

Indian social scientists tend to study the health profession in India. Systematic study of medical profession began in the 1970s. Some notable contribution have appeared both on health professional and on organizational aspect of heath professionals. One of the initial works to appear examined the health professional in a northern Indian city of Gaziabad. (Madan, 1972). Another study entitled "Doctors and society' which was at All India Institute of Medical Science, Delhi research conducted during 1975- 77 as a part of UNESCO sponsored study of doctors in India, Malaysia and Sri Lanka. Another prominent work of the decade on health professional entitled 'doctors and nurses' by Oomen (1978) which is the study of health professionals in organization, covering both doctors and nurses with focus on occupation role structure. Venkatratnam (1979) in Tamilnadu studied the medical services and social background of doctors and nurses in hospitals, organization, structure and role-perception, role expectations and role-performance. A great deal has also been published in the 70's by Rao (1966) on doctors in making- that is on medical student, their background, characteristics, professional socialization, work value and professional aspirations.

During 70s there were important studies conduct by Ramalingaswami (1985) on "Social background of medical students, and cost of Estimation of medical Education made a relevant contribution. Chandani's (1985) works on sociological exploration of medical profession examined social background of doctors etc. Nagla's (1988) dealt with the socio-cultural background of doctors, their attitudes towards their profession and measures of satisfaction.

In the study of Tamilnadu, Venkataratnam (1979) examined castes and group which have access to medical education.

Among the doctors the largest representation is from high caste non-Brahmin with 40% and the lowest representation is from SC with 6%, the low caste non-Brahmin groups having more or less equal representation of 25% each. In his Gaziabad study Madan (1972) found that the clean middle castes (81.8%) mainly

Jats, Kurmis, Yadavs, Kayasthas, Khajris, Banias dominated the medical profession. Chandani's (1985) study of Jodhpur found that more than half of the doctors belonged to the clean middle castes (53.3%) followed by the clean upper castes (36-8). It is interesting to find that Brahmans were the largest single caste 34% in the profession of medicine in Jodhpur while scheduled castes doctors is quite low (2.6%). The actual performance of roles is not in accordance with prescriptions, it means practitioners are not properly socialized. They have not acquired the professional qualities of 'effective-neutrality' knowledge by research, and the rules of bureaucracy. Ramaligaswami (1985) found that in spite of the reservation all students belong to middle and upper-classes. So health service has upper class and urban oriented character. While studying the 'Estimation of cost of medical education" in 14 medical colleges in India. Ramaligaswami found that the high recurring costs of medical education determined the nature of this elite oriented profession. Medical education is one of the most expensive forms of higher education. It has to be highly subsidized by the state. So the question of expenditure incurred by the state in educating a medical graduate is very high and the question is raised as to whether the returns for the investment are commensurate with their functioning in various institutions.

Career motivation is another area in which the studies have yielded some insights. According to Banerji (1994) 'service to suffering humanity' is the platitudinous reply which most medical students and doctors make to question about why they become doctors. But Oomen (1978) found that self orientation rather than humanitarian orientation is the predominant motivation behind doctors choice for medical profession. Chandani (1985) found that 'altruism' and note individual-aggrandizement' was considered an impelling factor in joining this profession. Courtesy, dedication, expertise and humanism were the other attributes of doctors. She found that they, however, did not seem to possess these qualities in real life situations. Madan (1972) reported that there are mixed motives. But Rao (1966) revealed significant differences in the work values, professional aspirations and perceptions of campus climate of first year and final year students. The increase in

years of exposure to medical education is accompanied by rise in students interest in the economic and status dimensions of the job, but decline in their academic and service orientation. He further reports that medical students attach great value to 'service to others' but little value to work in rural areas.

Abidi (1993) studied different aspects of social and professional roles of working women. Professionals stand out better in arranging alternative service for children and house hold chores. Role conflict is reported to be closely related to motivation to seek employment. Physicians being professionals show more career commitment and their professional productivity is less affected by their social roles. Double role of women is still, not fully recognized by society. The situation of role-conflict may persist according to the type of family motivation to seek employment as well as own commitment consistency towards dual roles, their personal and social satisfaction and autonomy in managing their two different sets of obligations.

Madan (1972) explained that doctors harbour a 'patient and disease oriented' rather than a person and health oriented. He finds a big gap between the normative model of doctors role which in largely of western extraction. Madan observes that doctors usually look upon their profession basically 'interns of making a livings' rather than in terms of some notion of social responsibility. The practice of medicine emerges as a kind of business and the first concern of doctor is to enhance his earning. He further explained that colleaguial relations among doctors are not always of professional accord. They see each other as competitors, more so the private practitioners who avoid discussing their patients' illness with each other. In fact, they depend more on the medical representatives than on their colleagues for learning the latest development in medicine. Assessing the role of doctors as a modernizing elite, Madan (1972) found that not to speak of having a general modernizing influence in society, the doctors did not always operate in terms of latest developments of knowledge and technique. To that extent, they did not represent a modernizing element among the professionals. They are more modernists than modernizers.

Oomen's (1978) focussed on doctors role in relations to their patients, nurses and colleagues. Regarding doctors attitude towards patients, he finds that most of the doctors' tend to view patient not as a person but as a 'bundle of clinical symptoms. He observed that the majority of doctors in public hospitals do not consider the welfare of patients as their most important role-obligation. However nurses attitudes towards patients' care, reveals their humanitarian perspective in contrast to doctors who betray an instrumental orientation. Nurses' relation with doctors are marked by an undercurrent of hostility, primarily due to authoritarian and overbearing attitudes of doctors, which the former resent. As regards role commitment, doctors are found to be committed to their profession more than the nurses. Doctors role commitment is also positively related to the length of experience, but not so of the nurses. Relations among doctors in hospitals as 'hostile and suspicion prone'. (Madan 1972, Oomen 1978).

Banerji (1994) draw attention towards the manifestation of and crisis is in the form of strikes by physicians and junior doctors in teaching hospitals for higher emoluments. The demands are usually of the increased emoluments, better promotional avenues and better status of physicians in government hospitals.

Another study of the attitude of interns towards rural health services and towards their training in rural health care. In seven medical colleges all over India, Taylor (1976) suggested that most medical students receive a western oriented scientific clinical education. Such training pays little attention to indigenous, social and cultural factors. Inadequate provision of drugs supplies and equipment, lack of opportunity for professional advancement and post graduate education, poor access to libraries were identified by the interns as the most important deterrents for effective rural work. Interns with rural background and from lower socio-economic strata expressed greater interest in rural health centre work than the others.

The most informative and explorative study in post-independent India is conducted by Banerji (1981) in 19 villages in 8 states of India. He explained that PHC has lack of doctors and medicine and basic infrastructure. People have to travel

to the nearest town to buy the medicine. Banerji found that highly expensive, urban and curative oriented medical education actively encourage the physician to look down on existing facilities with in the country particularly in rural India. Thus physicians looked for jobs abroad, causing the so-called 'Brain-Drains'. Foreign trained physicians often demand high salaries, sophisticated and well-equipped medical institutions as the price for returning home. They create conditions under which the younger physicians try to follow their footsteps and a spire to go abroad and become super-specialists.

The social, cultural background of physicians, lack of basic amenities and infrastructure in rural areas discourage doctors from working in rural areas. About 80% of the population live in rural areas, while only 20% doctors are there and 20% population is in urban area than 80% doctors are there.

In the Reorientation of Medical Education Programme (GOI, 1975) it was found that a high degree of reluctance from the teacher to move into rural areas and 80% did not agree that rural education would help them in making knowledge more comprehensive. About 72% of teachers involving in ROME programme were not keen in staying in villages for more than overnight. So, as a result of which the ROME programme could not bring out the expected result in developing the skill and calibre of the fresh medical graduate posted to the rural areas.

In some of the studies conducted in the tribal areas, it has been brought out very often that physicians posted at PHC located in the tribal areas are ill motivated and more ignorant about life-patterns of tribal as well as their health problems. In one of the study Sahu (1991) found out that the doctors, working in the Oraon villages were not in a position to meet the felt needs of Oraon patients in a rural industrial area of Rourkela. He further concludes that the doctors were more often ignorant about the cultural life process of Oraon as well as their health practices. As a result of these, the doctors working in tribal areas could not provide the health delivery package through the PHC and other health institutions to the vulnerable tribal populations.

Another indication of the crisis of the medical profession in India is manifested in the form of sharp decline in the ethical standards in the practice of medicine. Practice of medicine is now becoming a commercial fields, physicians are now getting away with gross professional misconduct and negligence, even when they are held responsible for avoidable deaths, deformities and sufferings to the patient who have literally entrusted their lives to them.

The picture is indeed very grim. The political leadership must be responsible for bringing about such a decay and degeneration in the medical profession. Exercise of patronage and nepotism, corrupt practices and grossly unjustifiable interferences in the day to day working of health institutions and organisations have been the hallmark of their activities. However, the network of medical personnel to the political leadership is increasing the power of doctors. It further create stratification, among physicians. Physicians those who have FRCS degree and also political backing joined the teaching as well as private practices thereby they create medicine as an industry. Even those physicians who have only MBBS degree with political backing are in the best position than those who are posted in Talula and Tehsil level hospitals.

Karl Taylor's (1976) work on doctors for villages emphasised that the rapid expansion of rural health services left the primary Health Centres doctors and their staff with tremendous responsibility.

Nagla (1988) showed that doctors have preferred to be in urban areas for professional progress, social benefits and monetary gains. Social and cultural background of doctors separates them from General masses.

To understanding the cost of medical education, Ramalingaswami (1980) conducted the study of final year MBBS students in selected 14 medical colleges to assess the awareness of students regarding the poverty and its relation to illness and rural health infrastructure. She found out that the majority of medical students who are about to complete the course of MBBS are not aware of the relation between poverty and illness. Neither do they students have clear idea about rural service network in different states. Present medical education is not equipped for generating this sensitivity. As a result of which the doctors who are coming out from their

medical college are not suitable for rural posting. Their elitist background as well as poor understanding of rural areas, and poverty hinder them.

Benerji (1994) has argued how the health policies of the government of India have let down medical profession, as they have landed it into a situation where it is the drug industry which dictates the profession what to prescribe. Jeffery (1978) characterize allopathic medicine is undergoing a process of deprofessionalization, than to state involvement in it.

The corporate sectors made significant investments into health care industry because of which deprofessionalization took place and also doctors lost their economic and autonomy. (Banerji 1989) they are dictated by the corporate managers, whose primary concerns is profit. McKinley (1985) pointed out that with the growing of communication of health by private sector, physicians become proletariat in this sector. They become labourer who produce profit. But on the contrary of it, with the growing of commodification and increasing corporate sectors, not only physicians become proleterised but also they gain power in country like India. Due to lack of basic facilities and crude belief of the people, people rush to the private institutions and thereby doctors monopolized the population. This lead to the breakdown of public institutions. Economic power percolating the power of medical professionals. State also supported it. Drug industry supported this power to medical profession because of market forces.

The WHO is its inter-regional conference (1957) for establishment of basic principles of medical education in any developing countries laid down the following objectives:

1. That, every practitioner in a developing country should be as familiar as possible with all aspects and their implications, preventive and curative, of the prevalent medical problems of his country.
2. That he should be competent to contribute effectively to their solution.
3. That the should be so imbued with the principles of learning and skilled in the methods, that he will be able to continue further education in medicine for the whole of his professional life.

CHAPTER-III

SOCIAL BACKGROUND OF HEALTH CARE PROVIDERS

3.1 The Study Area

Munirka located in South West District of Delhi, surrounded by Hauz Khas, IIT, R. K. Puram and JNU. Earlier it was an village but after the expansion of DDA it became an residential colony. Nearby Rind road added its importance, moreover the residents of the village avail the facilities of two major hospital of Delhi viz. AIIMS, Safdarjung hospital. Earlier the area was mainly inhabited by villagers' but, now many are occupied by tenants. While the DDA part comprising of SFS, MIG, LIG. Where most are them are occupied by Government and service sector business man.

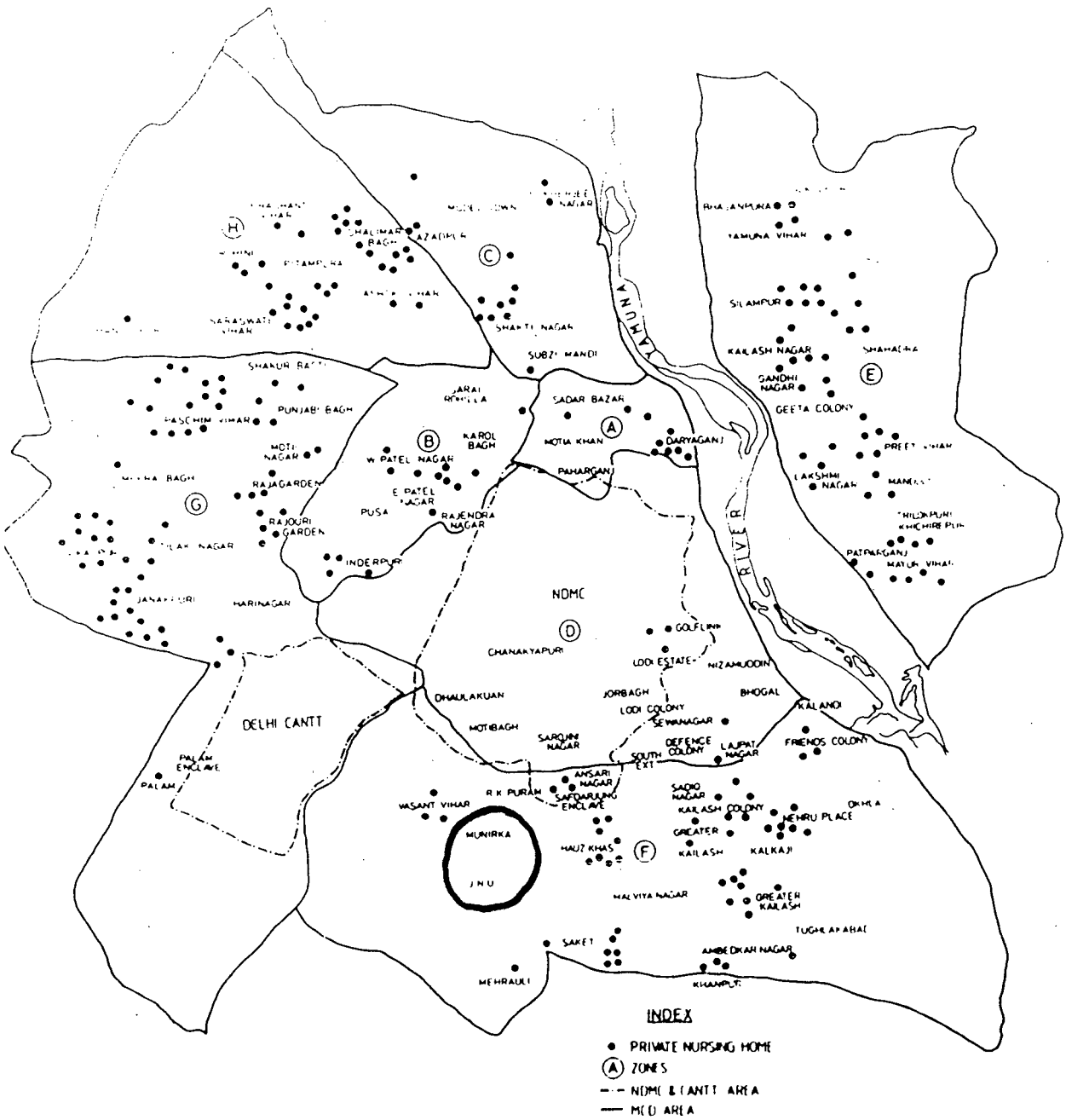
It comes under the MCD (Administrative division of Delhi) and zone F (DDA plan). Delhi has 3 administrative division, and 15 zone made by the DDA. The zones are divided according to DDA on the basis of:

(a) Density of population

(b) Availability of facilities like roadways, railways that is mainly transportation lines.

The "F zone" covers the South Delhi where the zone is over served, large no. of private nursing homes have also come up in this zone (Map 1).

Map of Study Area



Source: Medical Directory 1992, National capital territory of Delhi-state intelligence bureau, Directorate of health services, Saraswati Bhavan, New Delhi.

Data Interpretation:

Table -1

Distribution of respondents by age-group

Age-group	Frequency
<30	4
30-35	6
36-40	2
41-45	1
46+	6
Total	19

There were 4 doctor below the age of 30. The youngest respondent age was 25, two were more than 45 years. The highest number of respondents, six were in the age group of 30-35(table 1).

Table-2

Distribution of sex and marital status

Marital status	Sex		
	Male	Female	Total
Married	5	8	13
Unmarried	4	2	6
Total	9	10	19

Nine of our respondents were male and ten female. Four male out of nine and two out of ten female were unmarried. This shows the traditional perception of family regarding the marriage. The number of female respondent were quite high because of two reason:

1. They were easily convinced to interview.
2. Female were more in private practice.

We find higher proportion of upper caste Hindu women taking to gainful employment. Women education and, the process of westernization which initiated among the women, after the independence has gained sufficient momentum and Hindu women have reconciled to taking jobs on equal footing with men. Men too have realized that-they can no longer keep them in the kitchen and women's emancipation is a necessary condition for personal and social progress.

Table-3

Caste and religion wise distribution of respondents (alphabetical)

Caste	Religion	Frequency
Arora	Hindu	1
Brahmin	"	2
Gupta	"	3
Jain	"	2
Jatav	"	1
Kayast	"	1
Khandayat	"	1
Khatri	"	1
Kurmi	"	1
Kshatriya	"	1
Shia	Muslim	1
Not respond		3
Not believe		1
Total		19

The close association between caste and occupation in the traditional social system of India is widely known. Thus it is interesting to know the defying traditional association between caste and occupation. Out of the 18 doctors, only one belonged to the schedule caste and other back-ward caste. An examination of the surnames of Hindu respondents, except one, mentioned Khandayat who belongs to Orisa. Of these only one is from outside the Brahmin-Vaishya-Kayastha cluster of clean (upper and middle) castes. It is necessary, on the one hand, to attain the basic minimum level of socio-economic development which is pre-requisite to enter in any profession. On the other hand India's hierarchically organized society which resist the chances of upward social mobility. Generally, the spread of education is very limited among schedule castes as compared with its spread among the upper castes. Even when schedule castes respond to education it is the male who gains precedence over the female , hence no female SC respondent was found in study. In a study of doctors in Delhi and private practitioners in the city of Gaziabad (Madan, 1972) have found very shocking figure. Oomen (1978) in his study found only 2 SC out of three hundred 337 regularly employed doctors and none of the 140 house surgeons. While Madan (1972), found none to schedule caste. It may be noted that, to establish private clinic, one must be well-off.

All the respondents, except one were Hindus. Due to the migrating character of Delhi city, it is quite possible that the respondent come from other religion. Traditionally indigenous traditional system of medicines, Ayurveda and Siddha was followed by Hindu religion and unani by Muslims. Whereas Allopathy being a modern and recent entry into Indian society is open to recruits its personnel irrespective of their religious background. However there is only one Muslim respondents in this study. In the course of interviews with respondents, we found that the attitude toward religion was positive.

Table 4

Parents education level of respondents

Lat qualification	Father	Mother
Below Matric	Nil	5
Higher secondary	3	2
Graduation	3	5
Post Graduation	9	3
Medical Education	2	1
Non-response	2	3
Total	19	19

The family background play an important part, to obtain and provide the chances of higher education. The significance of the role of father's education must also be reckoned to be important in this regard. In what ways may education have reinforced or counteracted the particularistic outlook imbibed at home. This is not an easy question to answer, but some clues may be obtained by inquiring the father's education, income and occupation.

Based on our categorization of educational levels, nearly half, 9 out of 19 of the father's had obtained post graduate degree followed by graduation, and higher secondary, 3 each. Two had medical education and no one was educated below matric. While in the mother's education, 3 had post graduation, 5 were graduate, 2 were higher secondary, 1 was medical education, and 5 were below metric.

Table 5

Respondents' father's occupation

Occupation	Frequency
Business	3
Govt. Service	11
Professional	2
Medical professional	2
Not respond	1
Total	19

Occupation was classified into the following categories. Business, Govt. Service, professional (which included lawyers, engineers etc.), high administrative, medical professional. On this basis 11 in no. of the fathers of doctors were government servant, 3 were business man 2 were professionals 2 were medical professional, and 1 did not respond because the respondents himself was fifty five year old and father had been expired long before.

Regarding the income of the fathers, only two respondents reported but in light of other factors (such as type of job qualification and education etc) clearly showed they belong to higher middle class i.e. Rs. 15000 and above.

Table 6

Nativity, rural-urban origins of respondents and their fathers

Nativity	Self	Father
Urban	17	15
Rural	2	4
Total	19	19

Infact modern higher education attracts the urbanites first as they are close to the influence of the institutions of higher learning. Ashok Parthasarthy and Surjit Sinha in their studies independently have found that there is a strong urban-bias in the social back-ground of most of our scientists working in various institutions. Similarly, Jones by found as urban and western educated bias among IAS officers. Beteille also discusses the existing social background of business executives, military personnel, IAS and other professional intellectuals (cited in Venkataratnam, 1979). According to his analysis the background needed for an individual, to enter these services as it exists today, is a course of study in a public school in India or abroad, a nearer perfect English accent and a kind of polish, manners and social poise. Hence 17 respondents were from urban background ad only 2 from rural, while 15 respondents father were from urban background and only 4 from rural.

Table 7

Age of decision and source of motivation to study medicine

Age of decision/motivator	Age >15	Age <15	Total
Parents	4	4	8
Significant Relatives	2	1	3
Self motivated	1	6	7
Not respond	-	1	1
Total	7	12	19

It may be interesting to note the sources which influenced the doctors to pursue their profession at which age. This may have an indirect bearing on their entry into the profession. The response of doctors indicates that there were only three sources of influence Viz. parents, significant relatives and self motivated. 8 were influenced by parents, 3 were significant relatives, 7 were self motivated. If, to club the both first and second category as a environment factors, to shape your

career, were the no. reaches eleven, which is the significant indicator in terms of choosing a career.

Environment factor and age of decision, to pursue particular profession has very close relation which is indicated in the above table(7), that two had decided to opt medicine as a career before the age of ten.

Table 8

Motivational orientations of doctors in choosing their career

Reason	Top three rank			Total
	1	2	3	
1. Always wanted to be a doctor	5	1	-	6
2. Wanted to help people/work people	7	2	-	9
3. Better career prospects	3	1	2	6
4. Good at science subject	-	6	2	8
5. Influenced by relatives/friends	2	2	1	5
6. Suggested by school	1	-	-	1
6. Experience of illness	-	1	1	2

When asked, if they wanted to become a doctor, nearly all, 17 out of 19, answered that 'Yes'. Only 1 doctor who practice homeopathy said 'No' and 1 not responded. during the conversation she said that after the graduation, my maternal uncle suggested that to study, homeopathy as career which is better interims of money, rather then doing master in arts. Most of doctors (7) were motivated to chose this profession because they wanted to help people. Following, was the desire to become a doctor which motivated them. These two were the top most reasons among all listed. the sound ranking was a good score in science stream. The doctors are interviewed quite a few year after their entry into their professions.

Table 9

Future plan of respondent after medical education

Where to work	Frequency
Own practice	11
Government service	5
Go abroad	2
No plan	1
Total	19

Regarding the future plans after medical education more then half, 11 of the total respondents decided to establish his own practice, while 5 wished to join government service and 2 had plan go abroad. This is important to note that more doctors plan to establish unit clinic and fewer want to join government services. This reflects the possibility of better returns from the unit than public services but also on the privatization of health sector. It also reflects the diminishing concern to 'return' the expenses incurred on preparing a doctor, considering than many of them became doctor because they wanted to serve people.

Table 10

Medium of instruction and location of school from which respondents matriculated

School	Frequency
Location	
Rural	Nil
Urban	19
Medium	
English	18
Regional language	1

Education plays an important role as an agency of socialization. To begin with the schools medium of instruction from which the respondents matriculated is important. It was found that all the respondents had received their schooling from urban (located) school.

The exclusive character of the schools through which the majority of the respondents, passed is brought out by the language through the medium of which they received instruction. Thus it was found that 18 received their high school education through the medium of English, and only one in regional language (Marathi).

Turning to college-level premedical education we found that all 19 respondents studied in an urban centre. Medical studies were, of course, pursued in colleges in large or metropolitan cities with the instruction medium in English.

Table 11

Considering factors for performance

Factors	Rank
Money	3
Professional ethics	8
Patient suffering	4
Social responsibility	4
Total	19

The term performance here refer to a set of attributes which is considered as a motivational factor to provide service. Professional commitment means, commitment to internalization of a body of generalized knowledge and its conscientious application for community welfare. Commitment to a self-imposed professional code of ethics and commitment to work achievement and rewards. But the logical (may be) implication is that commitment to an occupation is to a large

extent dependent on the amount of pre-entry investment one makes to acquire the prescribed level of skills. Three doctors consider money as a performance factor while 8 out of 19 consider professional ethics as their considering factors.

Table 12

Doctors perception: users' health care utilization considering

Factor	Rank
Educational status	12
Income	3
Occupation	2
Caste	Nil
Sex	2
Native place	Nil

Table (12) shows, the determining factors to utilization of health care. Twelve out of nineteen respondents consider educational status as first rank, 3 considered income at first rank, 2 considered occupation at first. It is noteworthy that educational status, income, occupation has very high co-relation.

Among 19 doctors, 12 rank educational status as highest in rank order as compared to others for the health care utilization by users.

Table 13

Perception of self as a doctor

Perception	Yes	No	Total
Perform your duty as expected	18	1	19
Satisfied with your expected and performed role.	17	2	19

If we analyze the self-perceptions of a category we are likely to get at its *ideal role image*, if we discuss the expectations the role incumbents think others hold of them we may arrive at the *actual role-image* and an analysis of expectations by outsiders are likely to provide us with stereotypes. Extending this discussion we may suggest that the role expectation may have different aspects, viz. expectation the role incumbents uphold about themselves that is, self-perception of their roles, expectations, the role incumbents think, which are held by significant others, and expectations held by outsides.

In this table (13) we are concerned with ideal as well as actual role-images of professionals. The ideal role image was measured through responses such as sympathetic to the patient, willingness to give more time to a patient if he or she needs it, ability to understand and identify with patients. Eighteen out of 19, were performing their duty as expected, and only one said 'no', in-terms of time, professional ethics etc. where as, 17 out of 19 were satisfied with their performance and expected role.

Table 14

Dependency on technology and cost of cure

	Yes	No	Don't know	Not response	Total
Technology intervention and it impact on doctor's ability	9	8	1	1	19
Intervention increase the cost of cure	12	3	-	4	19

Technological development in past 2-3 decades has also an impact on the health care services. A good number of high-tech equipments have come into existence. A new generation of techno-centric doctors is resulted in the increased cost of cure. Doctor's dependence on technology for diagnosis has increased. More

than half the respondents think so and, 12 out of 19, believe that technology intervention increase cost of health care.

It is quite clear the burden will be more on the marginalized person and doctor's service as business.

Table 15

Social interaction

	Yes	No	Not respond	NA	Total
Medical study kept you away from family responsibility	10	7	2	-	19
Did you miss any important social evident	14	3	2	-	19
Family/Social expected their presence	2	12	2	3	19

This is the indicator which is used in this study as a process of de-socialization and or expectation of society from the medical professional for the socially accepted norms. Why they are exempted from social obligation. These indicator may be not adequate in sketching the full picture, but they definitely give some idea. Ten out of 19 respondents said, medical study kept them away from family responsibility, 7 said no and only 2 respondent not respond the question. When asked whether they missed any important social event, in the family 14 out of 19 responsed positively. Only 2 out of 19 faced confrontation, for not attending the social events. However most of them 12, did not face such confrontation.

Table 16

Respondents perception towards RMPs

	Yes	No	Don't know	Not respond	Total
RMPs service should be banned	14	1	2	2	19
	Govt.			**Nursing home**	
Where do you refer your patients	15			4	

Despite the acceptance that technology increase cost of cure, almost all of them wish that RMPs who deliver cheap care should be banned.

It is very interesting that, for the tertiary level health care service/referral service most of the respondents refer to govt. hospital like Safadarjung hospital, AIIMs, and other nearest govt. hospital because of these hospital has infrastructure and more competent health personnel. It is clear that at primary levels, they make money by diagnosis, treatment.....etc. Moreover they argue that RMPs should be banned as they can't give complete service to all the population.

3.2 Perception of Self as Doctor

Professionally, every doctor is responsible for their patients health. In an individual practice setting there are external controls and the doctors have personal responsibility regarding the patient.

The concept of 'role' cannot be properly understood unless its complementary concept 'status'. According to Ralph Linton (1936) 'status' is a polar position in a reciprocal social interaction, which constitutes 'a collection of rights and duties', whereas 'role' is the dynamic aspects of status or giving effect to

its right and duties through behavioral enacting. Thus he linked through these concepts the culturally defined expectations with the patterned behaviour and relationships which constitute social structure.

Doctors acceptance of various tasks as ideal ones for carrying out the duties, does not mean that all members of the profession have a homogenous model uniformity upheld by all or most of the members of the professions. This only means that within the professional dimension some of the expected professional activitities to be carried out are accepted by most respondants as the relevant duties of doctors.

The profession of medicine has its own normative subculture a body of shared and transmitted ideas, values and standard towards which members of profession are expected to orient their behaviour. The norms and standards define technically and morally allowable patterns of behaviour indicating what is prescribed, preferred, permitted or proscribed. The subculture, then, refers to more than habitual behaviour, its norms codify the values of the profession.

3.3 Values Governing the Physician's Self Image

1. The physician should continue his self-education throughout his career in order to keep pace with the rapidly advancing frontiers to medical knowledge.

   But: he also has a primary obligation to make as much time as possible available for the care of his patients.

2. The physical must maintain a self-critical attitude and be disciplined in the scientific appraisal of evidence.

   But: he must be decisive and not postpone decisions beyond what the situation requires, even when the scientific evidence is inadequate.

3. The physician must have a sense of autonomy, he must take the burden of responsibility and act as the situation, in his best judgment. requires.

   But: autonomy must not be allowed to become complacency or smug self assurance, autonomy must be coupled with a due sense of humility.

4. The physician must have the kind of detailed knowledge which often requires specialized education.

   But: he must not become a narrowly specialized man, he should be a well-rounded and broadly-educated man.

5. The physician should have a strong moral character with abiding commitments to basic moral values.

   But: he must avoid passing moral judgments on patients.

6. The physician should attach great value to doing what he can to advance medical knowledge, such accomplishments deserve full recognition.

   But: he should not express a competitive spirit towards his follows.

3.4 Values Governing the Physician Relationship with Health Care Seekers

1. The physician must be emotionally detached in his attitudes toward patients, keeping "his emotions on ice" and not becoming "overly identified" with patients.

   But: he must avoid becoming callous through excessive detachment, and should have compassionate concern for the patient.

2. The physician must not prefer one type of patient over another, and must curb hostilities toward patients (even those who prove to be uncooperative or who do not respond to his therapeutic efforts).

   But: the most rewarding experience for the physician is the effective solution of a patient's health problems.

3. Physician must gain and maintain the confidence of the patient.

   But: he must avoid the mere bedside manner which can quickly degenerate into expedient and self-interested salesmanship.

4. The physician must recognize that diagnosis is after provisional.

   But: he must have the merited confidence of the patient who wants to know what is really working with him.

5. The physician must provide adequate and unhurried medical care for the each patient.

   But: he should not allow any patient to usurp so much of his limited time as to have this be at the expense of other patients.

6. The physician should come to know patients person and give substantial attention to their psychological and social circumstances.

   But: this too should not be so time consuming a matter as to interfare with the provision of suitable care for other patients.

7. The physician should institute all the scientific tests needed to reach a sound diagnosis.

   But: he should be discriminating in the use of these tests, since these are often costly and may impose a sizable financial burden on patients.

8. The physician has a right to expect a "reasonable fee" depending upon the care he has given and the economic circumstances of the patient.

   But: he must not 'soak the rich' in order to provide for the poor.

9. The physician should see to it that medical care is available for his patients whenever it is required.

   But: he too has a right to a "normal life" which he shares with his family.

3.5 Social Background of Clientele

A majority of their clientele are from the Munirka locality, and very small proportion are from surrounding locality. The wealthy and middle classes form the bulk of their clientele. An attempt was made to find out the income level of patients.

But the doctors said that they were not interested in that kind of information. they were only concerned with whether the patient could pay for the services used or not..

The following interviews with patients could pay fore the services setup taken after the consulting the doctors reveal they are not bother about the patients background but education and economic status make difference to education and economic status make difference to establish the relationship with the doctors. During my repeated visits to collect information I identified the following cases who had come for treatment.

Case-I

P is a 40 year old man from the DDA, SFS type residence suffering from minor ailment for the last week. he works as an executive in an MNC and has monthly income of Rs. 35000. Since he has been suffering and consulted directly to this doctor. During the conversation he told that doctor took five minute for diagnosis, which is by the first visit, and alter the diagnosis he prescribed the medicine and told me come after a week. This is mine second visit he said. After the initial check-up, we exchanged the view on my job related field and current news and indian polity over there for 10 miniute. On the question of patients background he admits that the economic status and education makes the difference in every sphere of life. He said, they charged more but I can't queue-up for the minor ailments like this, in big Government Hospitals.

Case-II

R. is a 35 year old woman from the Munirka village, she is tenants there. Her husband works in a private firm and has monthly income about Rs. 5000. She is suffering from Jaundice and taking treatment for last one month. Since then she almost spend Rs. 3500 on her diagnosis and treatment. She said, that doctor does not know about my residential status and never asked about it and not also suggest me anything about the drinking water. He usually continued/changed some drugs. She said, that private practitioners provide the best service. Definitely! they charged

more but what we can do. It is not the grocery shop, to buy the things if you do realise, that they are charging more.

Case-III

This was a young man of around 25 years old and visit clinic while I was having conversation with one doctor respondent, who was chest specialist and his wife also runs a diagnostic centre in same premises. This fellow came along with another doctor's prescription to this doctor and asked about necessity and charges of prescribed diagnosis. It is noteworthy that prescription for his pregnant wife. But doctor neglected the main issues of patients quarry and asked, is this your first child. Yes- you should go for all test and all are necessary and don't be clever to avoid these test. It is important to notice that doctor did not provide any suitable reason for reply. At last he said, you can earn money but not wife. Come with the patient, I will do something for you.

CHAPTER-IV

HEALTH CARE DELIVERY SYSTEM

In the proceeding chapters, the organizational structure and the programmes for the provision of health care service and along with their availability at the national and state/union territory levels have been analysed. The present chapter in focused on some specific issues considering the available manpower, and service delivery system.

4.1 Health Care Delivery System

After independence the Government, of India implemented recommendations of the Bhore Committee with the resources that were available During the subsequent decades a vast network of health institution has been developed covering the entire county and the planning process through the Five Years plan as well as large number of committee were established to review periodically Various component of public heath system.

In the context of medical manpower in health care delivery system, since the post independence period, may be divided into four distinct phases 1947-65, 1965-73, 1975-85.

During the period 1947-65, there was almost 5 times increase in the number of medical institution from 17 in 1947 to 87 in 1965, with the corresponding increase in the annual turn out of medical graduates.

Table 1

Education in India

Period	No. of Medical college	Annual Turnout
1947-1965	17-87	1400-5387
1965-1975	87-105	5387-11911
1975-1985	105-106	11911-12278

Source: Medical Education in India, Dr. H , Helen, in Health and family welfare Department in independent India, vol. II 1999, PP-226

There has been an additional 15-20 medical college beings managed privately in different State and unrecognised by the Medical Council of India (1986) (Table 1).

Table 2

Health Manpower Position In India

Category	Existing No.	Training Instts. No.
Medical Graduates	474270	160
Dental Surgeons	19525	67
Nurses		
a) General	512595	487
b) ANMs/FHW	229304	494
Health Workers		
a) Lab. Technicians	23617	97
b) Dental Mechanics	1903	18
c) Dental Hygienists	6800	17
d) Physiotherapists	6800	8
e) Occupational-Therapist	800	4
f) X-Ray Technicians	4872	33
g) Pharmacists	175000	290
h) Ophthalmic Assistant	4390	7

Source: Medical Education in India, Health and family welfare department in Independent India, Vol. II, 1999 pp. 227

4.2 Administrative Structure

The health care delivery system in India administratively has three tiers, Federal, State and district.

(a) Federal set-up: The official organs of the health system at the National level consist primarily of Ministry of Health and Family welfare, the Directorate General of Health services with a network of supporting subordinate offices and attached institutions providing health care services and the central council of health and family welfare. The planning commission and ministry of planning and plan implementation provide over arching mechanisms for policy planning, co-ordination and implementation.

The union ministry of Health and Family Welfare in generally headed by a cabinet minister who is assisted by a minister of state. In addition to the above, planning commission chaired by the prime minister has a member (Health) of the rank of a Minister of State.

The union Ministry of Health and Family Welfare had two department earlier, viz the Department of health and Department of family welfare, recently department of Indian system of Medicine also have been created.

The Department of health is headed by the secretary to the Government of India who is assisted by two Additional Secretaries, three joint Secretaries and several Directors/ Deputy Secretaries and other Administrative staff. In addition, a joint secretary (F A) caters to all the three department.

The Department of family welfare was created in 1966 and is headed by Union secretary who is assisted by the three joint secretaries, Several Directors/ deputy Secretaries and a large number of supporting staff. The department of family welfare also has three Deputy Commissioners holding similar position of a Joint secretary and are from the technical sides. These deputy commissioners are also assisted by several assistant commissioners and other technical and administrative staff. Recently on 30th August 1995, the ministry has issued order stating that the

work of the Department of Family Welfare will be also through Director General Health services.

Functions of Federal Government

The following functions are the responsibilities of the federal Government.

I. International Health relation and administration of port-quarantine.

II. Administration of institutes for scientific and technical education financed by the Govt of India only or in the part or declared by the parliament as institutes of national importance.

III. Co-ordination with states and other ministries for promotion of health.

(b) State Level:- The state government have full authority and responsibility for all the health service in their territory. The state ministry of health and family welfare is headed of a cabinet rank or a minister of state. A Deputy minister depending upon the political situation assists him. The health secretary is the official organ of the state ministry and is headed by health secretary/Principal secretary/ commissioner as the case may be. A technical wing called the state health directorate assists state health secretary.

(c) District Level:- The principle unit of administration in India is the district which is under a collector/ District Magistrate/ Deputy commissioner . The district health system in headed by the chief medical and health officer/district health officer.

There were certain functions which were the responsibility of both the union and state government these here:

I. Regulation and development of medical pharmacy, dental, and nursing provision through their respective councils.

II. Establishment and maintenance of drug standards.

III. National health programmes implementation.

IV. Population Control and family planning .

V. Vital Statistics including registration of births and deaths.

VI. Adulteration of food stuffs and other goods.

VII. Lunacy and Mental deficiencies

Otherwise state government were responsible for provision of health care service through public health and sanitation hospital and dispensaries.

Quantitatively, there has been significant increase in the number of medical and para-medical personnel in PHCs. Qualitatively, these had been four major changes. First many special mass campaign have been integrated with staff and functions of the primary health centre. Secondly there has been a functional integration of work of the personnel of PHCs in relation with components of various national health programme. There has led to the development of categories of male and female multipurpose worker. Third ,a twenty five bed hospital has been developed for every four PHCs in the country. Finally, a perhaps most importantly, a decision was taken by the government of India in 1997 to entrust peoples " Health" in peoples hand by offering opportunities to village communities to choose from among themselves a person who would work as a community health volunteer. The Govt. authorities also arranged for the training of CHVs paying them as honorarium and supplying some drug and equipments.

After the Alma-Ata declaration the health care delivery system in India is intended to deliver health care services which operates in the context of the socio-economic and political frame-work of the country. In India, there are five major sectors or agencies which are delivering health care services.

(1) Public Health Sector:

(i) Primary Health Care

(a) Primary health centres

(b) Sub-Centres

(ii) Hospitals / Health Centres

(a) Community Health Centre

(b) Rural Hospital

(c) Specialist Hospitals

(d) Specialist Hospitals

(e) Teaching Hospitals

(iii) Health Insurance

(a) Employees State Insurance (ESI Hospital)

(b) Central Government Health Scheme (CGHS dispensaries)

(iv) Other Agencies

(a) Defence Service

(b) Railways Medical Services

(2) Private Sector:

(a) Private Hospital, Polyclinic, Nursing Homes, and Dispensaries

(b) General Practioners and Clinics

(3) Indigenous System of Medicine and Services:

(a) Ayurveda and Siddha

(b) Unani and Tibbitian

(c) Homeopathy

(d) Unregistered Medical Practitioners

(4) Voluntary health Agencies: These are providing health services or health education or advancing research or legislation for health or by combination of these activities during the past years many voluntary health agencies are providing health services by establishing projects to improve the health services in the country. They rendered two type of services:

(a) Supplementing the work of govt. health agencies, and or strengthen the work of government agencies lending personal or by contributing funds for special equipment, supplies or services.

(b) There are some voluntary agencies, which are conducting research to explore the new way of benefit and felt need oriented community base programme. And sometimes government take over these projects. The family planning in India is an example of pioneering by a voluntary agencies which first spearheaded the movement, in spite of much opposition (NIHFW, Vol. II, 1999, pp. 186). There agencies also run the dispensaries and hospital in a much cheaper price. Some of these organisation are functioning on basis of no profit no loss.

(5) National Health Programmes

4.3 Types of Hospital and Management

The directory of hospitals in India 1988 lists the various types of hospitals and the types of management.

(a) General Hospital: all establishments permanently staffed by at least two or more medical officers, which can offer in-patient accommodation and provide active medical and nursing care for more than one category of medical and nursing care for more than one category of medical discipline. (e.g. general medicine, general surgery, obstetrics, paediatrics etc).

(b) Rural Hospital: Hospital located in rural areas (classified by registrar general of India) permanently staffed by at least one or more physicians, which offer in-patient accommodation and provide medical and nursing care for move than one category of medical discipline (e.g. general; medicine, general surgery, obstetrics and paediatrics).

(c) Specialised Hospital: Hospitals providing medical and nursing care primarily for only one discipline or a specific disease/affection of one system (e.g.

tuberculosis, ENT, eye, leprosy, orthopaedic, paediatric, cardiac, mental, cancer, infections disease, venereal diseases, maternity etc.). The specialized departments, administratively attached to a general hospital and some times located in an annexe or separate ward, may be excluded and their beds should not be considered in this category of specialized hospitals.

(d) **Teaching Hospital:** A hospital to which a college is attached for medical education.

(e) **Isolation Hospital:** This is a hospital for the care of persons suffering from infections diseases requiring isolation of the patients.

Types of Management

(a) **Central Government/Government of India:** All hospitals administered by the government of India, viz. hospitals run by the railways, military/defence, mining/ESI/post and telegraphs, or public sector undertaking of the central government

(b) **State Government:** All hospitals administration by the state / UT government authorities and public sector undertaking operated buy states / UTs including the police, tail, canal department and others.

(c) **Local Bodies:** All hospitals administered by local bodies, viz. the municipal corporation, municipality, zila parishad, and panchayat.

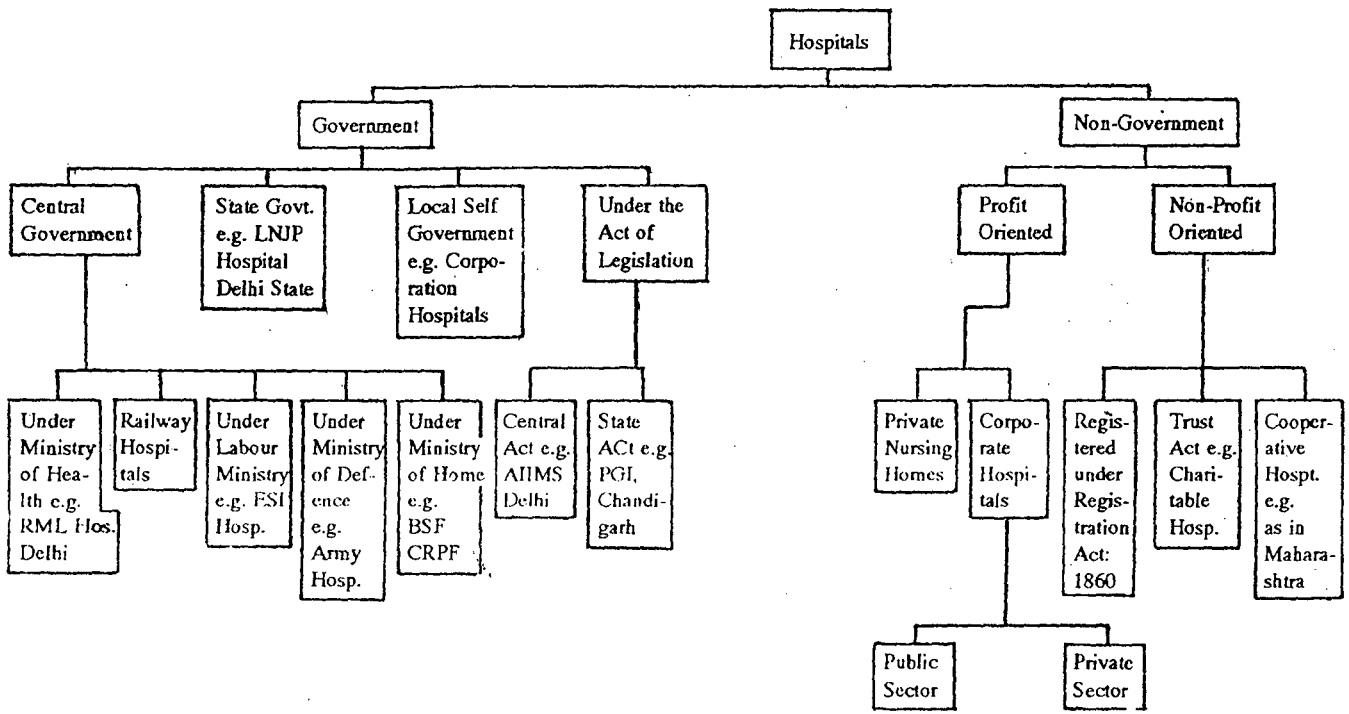
(d) **Private:** All private hospitals owned by an individual or by a private organisation.

(e) **Autonomous Body:** All hospitals established under a special act of parliaments/state legislation and funded by the central / state govt. / UT, e.g. AIIMS (New Delhi, PGI Chandigarh etc).

(f) **Voluntary Organisation:** All hospitals operated by a voluntary body / a trust / charitable society registered or recognised by the appropriate authority under central/state govt. laws. This includes hospitals run by missionary bodies and cooperatives. (Figure 1)

Figure 1

Classification of Hospitals on Ownership Control Basis



Source: Health and Family Welfare Department in India, Vol. II, 1999.

Delhi

Delhi is an old city and has slowly expanded over the years to acquire its present status of a big metropolis. Delhi ranks sixteenth amongst the world's 34 largest cities and from population point of view, it is the third largest city in the country. As per the 1991 census, the total population of Delhi is 9.421 millions out of which 8.472 millions reside in urban and .949 millions reside in villages. The density of population, at 6532 persons per sq. km., is the highest in India. About 35% of Delhi's population reside in slums.

In Delhi, health care facilities are being provided by both government and non-government organisation.

4.4 Department of Health and Family Welfare, and its Institution

Health and family welfare department of government of NCT of Delhi has a tremendous health care responsibility. The department caters to health needs of nearly 130 lakh population of the ever growing metropolis and also has to share the burden of migratory as well as floating population from neighbouring states which constitute nearly 33% of total intake at major hospitals in Delhi.

Health and family welfare department, government of NCT of Delhi plays a significant role and is committed to provide health care facilities to the people of Delhi and it does so through a network of existing primary, secondary, and tertiary hospitals, dispensaries/health centres, school health clinics, polyclinics, mobile health clinic, by implementation of various state and national programmes under medical and public health sector for prevention and eradication of various diseases, dovetailing of India system of medicine and homeopathy (ISM & H) in the main system and by opening new hospitals and dispensaries / health centres. Under the health and famiiy welfare department, following institution and a number of hospitals are functioning:

(1) **Directorate of health Services:** DHS is one of the government organisations. The department participates in deliver of health care facilities and also co-ordinates with other government and non-government organisation. DHS deals with both medical and public health.

(2) **Directorate of family welfare:** DFW was established in Delhi under Delhi Administration in October 1966 to provide legal-ship, provision and co-ordination of family welfare activity implemented by various agencies. The responsibility of directorate of family welfare is to generate the demand for family welfare services.

(3) **Office of drug controller:** The drug control organisation till January 1996, was functioning as a subordinate office under directorate of health services and director health services was the Ex-officio drugs controller. Thereafter, the drugs control organisation became an independent department with drugs controller as head of department.

(4) **Department of prevention of food adulteration:** The prevention of food adulteration department was set-up in 1977 by the government of Delhi. The objective of the prevention of food adulteration department is to eradicate adulteration in food articles in the entire area of Delhi.

(5) **Directorate of India system of medicine and homeopathy:** Directorate of ISM & NHMC was established in 1996,Indian system of Medicine, namely Ayurveda, Urani, Yoga, and Naturopathy have been serving the Mankind since many-many years. For the convenience of administration Homeopathy has been added along with these systems.

(6) **Maulana Azad Medical College:-** Delhi Govt. has two Medical Colleges namely Maulana Azad medical colleges and university college of Medical science. Maulana Azad medical college was established 22 years after the commission of the Irwin Hospital in, 1958. The university college of medical

science, established in 1971, a medical college of the university of Delhi. Duo for degrees of MBBS, MD/MS and PH.D in medical subjects.

(7) **Centralised Accident of Trauma Services (CATS):** - CATS was conceptualised as a plan scheme in 1984 during the 6th five years plan, and CATS was formed by Delhi Administration as a registered society in June 1989. The Primary Objectives of CATS are to reach the site of the accident as quickly as possible, to give first- aid to the accident victim.

(8) **Institute of Human Behaviour and Allied Science (IHBAS):-** IHBAS was established in compliance with the directives of the Hon'ble supreme court in response to a public interest litigation. The institute is an autonomous body. Hospitals have traditionally been providing medical care to the sick people since long time. They are an integral part of health care delivery system. After the Alma- Ata declaration in 1978 one of the its recommendation is, to highlight primary health care as the key for achieving goal of Health For All. Honovring the recommendations, Govt. of India decided to extend the role of hospitals from traditional medical care to their rolein providing primaryhealth care as well. Now hospitals all over India are expected to be the partners and supporters of health care delivery system rather than limiting their role to medical care only registered under the societies Act 1860, funded jointly by ministry of health and family welfare, Govt, of India and Govt, of NCT of Delhi.

(9) Nehru Homeopathic Medical College and Hospital

(10) Dr. B.R Sur Homepathic Medical college and Hospital

(11) A & U Tibbia College and Hospital

(12) Indraprasta Vyabsaik & Paryavarniya Swasthya samiti (IVPSS)

(13) Delhi State Aids Control Society (DSACS)

(14) Delhi Tapedik Unmulan Samiti

4.5 Agency For the Health Services of Government of NCT of Delhi

There are some agency in Delhi territory are solely provider of health service like, DHS, DFHS, MCD, NDMC, Delhi cantonment area, statutory body. collaborative body, central Government Hospital's (Safdarjung) C.G.H.S.

(1) Directorate of Health Services: Directorate of health services is the nodal agency among the health care providers of government of NCT of Delhi in the matter of establishment of hospitals and dispensaries, implementation of various national and state programmes related to medical and public health for health care and prevention, control and eradication of major disease.

Hospitals have traditionally been providing medical care to the sick people since log time. They are an integral part of health care delivery system. After the Alma-Ala declaration in 1978, one of the its recommendation is, to highlight primary health care as the key for achieving goal of health for all. Honouring the recommendations, government of India decided, to extend the role of hospitals from traditional medical care to their role in providing primary health care as well. Now hospitals all over India are expected to be the partners and supporters of health care delivery system rather than limiting their role to medical care only. Hospitals and other health care delivery institution under health and family welfare department directorate of health services are as under:

(A)Hospital under health & family welfare department:

(1) Aruna Asaf Ali Govt. Hospital, Rajpur Road.

(2) Central Jail Hospital, Tihar Jail

(3) Deen Dayal Upadhyay Hospital, Hari Nagar

(4) Guru Nanak Eye Hopstial, Maharaja Ranjit Singh Marg

(5) Guru Teg Bahadur Hospital, Shahadara

(6) G.B. Pant Hospital, Jawaharlal Nehru Marg

(7) Lok Nayak Hospital, J.N. Marg

(8) Sanjay Gandhi Memorial Hospital, Mangol Puri

(9) Surusta Trauma Centre (first of its type), Metkalf House

(B)Hospitals under directorate of health service:

In the year 1993, directorate of health services had only 5 hospitals under its control. In the year 1995, one more hospital started functioning under DHS and in addition to this, seven colony hospitals were taken over by DHS form MCD on 1.10. 96. At present, thirteen hospitals are functioning under DHS. These hospitals are providing primary, secondary and tertiary level care in different specialities like- medicine, surgery, obstetrics and gynaecology, ENT, ophthalmology, Skin/VD, orthopaedics etc. These hospitals are also acting as referral centres for various dispensaries / health centres functioning in the area. Out of these 13 functioning hospitals, 6 are the peripheral hospitals and other of are colony hospitals. The names of all 13 functioning hospitals are as follow:

(I) Peripheral Hospital:

(1) Babu Jagjiwan Ram Memorial Hospital, Jahangir Puri

(2) Guru Gobind Singh Govt. Hosptial, Raghuvir Nagar

(3) Lal Bahadur Shastri Hospital, Khicripur

(4) Rao Tula Ram Hospital Jaffarpur

(5) Dr. N.C. Joshi Memorial Hospital, Puth Khurd

(6) Dr. N.C. Joshi Memorial Hospital, Karol Bagh

(7) Maharishi Valimik Hospital, Puth Khurd

(8) Physiotherapy Centre at Atarsen Jain Charitable Trust Building, (donated to Govt. of Delhi) at keshavpuram.

(II) Colony Hospitals:

(1) Balak Ram Hospital, Timarpur

(2) Kalkaji Hospital

(3) Lajpat Nagar Hospital

(4) Malviya Nagar Hospital

(5) Moti Nagar Hospital

(6) Patel Nagar Hospital

(7) Tilak Nagar Hospital

These colony hospitals have been taken over by DHS with a view to upgrade these hospitals to 100 bedded.

(III) Other New Peripheral Hospital Coming up and which are under Different Stages of Construction:

(1) 200 bedded Dr. Hadgevar Arogya Sansthan at Karkardooma

(2) 200 bedded Hospital at Narela.

(3) 500 bedded Dr. B.R. Ambedkar Hospitalat Rohini.

(4) 500 bedded hospital at South Delhi (site to be identified)

(5) Super speciality hospital at Jankpuri.

Further DHS also provider health care facilities through 244 dispensaries/health centre, 8 family welfare centres, 65 school health centres along with 5 referral centres, 5 special clinics and 60 mobile dispensaries.

(IV) Other state and National health programmes under medical and public health sector undertaken by govt. of NCT of Delhi.

(a) State health programme:

(1) Matri Suraksha Abiyan

(2) Delhi Arogya Nidhi

(3) Centralised Accident and Trauma Services (CATS)

(4) Trauma Centres

(5) Srawan Shakti Abhiyan

(6) Vector 6 born disease control programme like malaria, dengue.

(7) Water born disease control programme

(8) Special immunisation programme

(9) Pulse polio immunization programme

(10) Motiabind Mukti Abhiyan

(11) Thalassemia screening programme.

(12) Health city project

(13) Health scheme for employees of Delhi govt.

(14) Compulsory testing of blood by blood banks for hepatitis B and C.

(b) National Health Programme:

(1) AIDs control programme

(2) Revised National Tuberclosis programme

(3) Blindness control programme

(4) National leprosy control programme

(5) Cardio vascular control programme

(6) National iodine deficiency disease control programme

(7) Cancer control programme.

(V) The speciality centre:

(1) Cardio Thoracic sciences centre

(2) Neurosciences centre

(3) Dr. R.P. centre for ophthalmic sciences

(4) Institute rotary cancer hospital

(5) De- addiction centre

(6) National poisons information centre

Health Services Provided by Municipal Corporation of Delhi

The health services of the Municipal Corporation of Delhi operate under the charge of a health officer. The area of the corporation has been subordinated into eight zones placed under the charge of zonal health officers who exercise complete control off all health activities in their respective zones and look after environmental sanitations, prevention of food adulteration and maintenance of adequate standard of food hygiene, control of epidemics, management of slaughter houses, maternity and child welfare centres, vital statistics, burial and cremation grounds and dispensaries etc.

The corporation is providing diagnostic and treatment facilities in all the systems of medicine viz. Allopathy, Ayurvedic, Unani and Homoeopathy. There are 19 hospitals under MCD. Hospitals like Hindu Rao, infections disease hospital etc. There are 58. Allopathic, 81 Ayurvedic, 14 Homeo and 14 Unani dispensaries. There are around 130 MCWC followed by 50 subcentres. There are 10 TB, 3VD/STD and 3 leprosy special clinics.

Health services provided by NDMC

The NDMC function in a small area, which is approximately 16.50 sq. miles. It has 2 hospitals, 14 Allopathic, 9 Ayurvedic, and 9 homeopathic dispensaries. There are around 13 MCWC and 1 polyclinic and 1 T.B. special clinic.

Health services provided by cantonment board

The Delhi contonment or defence services have their own system of medical care under banner "Armed Forces Medical services". The contonment General Hospital, Delhi Cantt was established in 1935. Now there is 1 hospital, 1 MCWC and 2 poly clinics.

Statutory body

The statutory bodies are autonomous institutes run by central government which provide health care to people as part o the programme of medical education and research. There are 8 hospitals among the statutory bodies which includes 2 ESI hospital, AIIMS, IIT, V.B. Patel chest. There are 117 allopathic, 6 Ayurvedic and 3 homeopathic hospitals. Apart form the following facilities there are ITB, 1 Leprosy, and 2 Cancer special clinics. While talking about statutory a special characteristics of its own. It has research centres and education is imparted to various department, functioning under oncology

Voluntary organisation

Voluntary organisation under the relevant act, constitute on extremely heterogeneous category. There are hospitals run by churches missionaries and charitable organisations. While the hospitals like Batra, Escorts, Jivodaya and Holy Family are also registered under these organisation which do not fulfil the criterion or even function in such a manner to be included under this category as they function like corporate or 'five star' hospitals.

Under this category there around 24 hospitals, 8 Allopathic, 1 Ayurvedic, 13 Homeopathic and 1 Unani Dispensaries, 5 TB, 2 VD/STD, 5 cancer special clinics.

Railways hospitals and dispensaries

The medical department of the Northern Railway is under the administrative control of chief Medical officer assisted by a divisional medical officer and two senior medical officers. There are 2 hospitals and 12 Allopathic dispensaries under the railways to cater to the need of its Employee.

Employee State insurance Scheme (ESI)

The ESI scheme (hospital) have been established under the ESI Act of 1948, to provide health care facilities to workers in the organised sector. The scheme of covers only social security the insured industrial workers and their family. The scheme provides a full range of medical benefits through a network of dispensaries, specialist centres and its hospital. At the national level, the ESI scheme is administrate by a statutory body called employees state Insurance Corporation, which consists of representatives of employees, employers, of the central as well as state government comprehensive medical care is provided in the form of medical attendance, treatment, drugs specialist consultation and hospitalisation.

The ESI scheme is mainly financed by contributions from employees and employers. Employers contribute 5% of the wages payable to insured employees and employees contribute 2.25%. The state government share $1/8^{th}$ of the expenditure on health care.

There are 2 ESI hospitals in Delhi are in Basai Darapur and other in Shahadra. There are 42 Allopathic and 6 Auyurvedic dispensaries functioningin Delhi.

Private health care facilities

Apart form all these agencies there are almost more than 1000 units of private health care facilities available in Delhi in the form of private nursing home, private clinic etc. Delhi Medical Association XXXVII Medical conference 1993 published a nursing home directory of a souvenir committee which gives the telephone number of 454 nursing home address this directory helped in locating these private nursing homes on the map of Delhi in the next part of this chapter.

Distribution of Health Care Facilities in Delhi:

Table 3

MEDICAL INSTITUTIONS IN DELHI (1991)				
Institutions	Govt.	Local Bodies	Others	Total
Hospitals	27	22	32	81
Dispensaries	305	199	143	653
MCH Cenres	3	193	7	203
Pimary Health Centres	3	5	-	8
Poly Clinics	9	1	-	10
Private Nursing Homes	-	-	107	107
Special Institutions	13	17	15	45
Total				1107
Source: Directorate of Health Services, Delhi Administration, Delhi				

The above table (3) gives an idea about the availability of various institutions imparting with health care facilities in whole Delhi (Urban + Rural). There are 81 hospitals, 653 dispensaries, 203 MCH centre, 8 PHC, 10 poly clinics, 107 private nursing homes and 45 special institutions. Altogether there are 1107 institutions.

Table 4 shows the number of hospital and nursing home in Delhi and the health financing (Figure 2).

Table 3

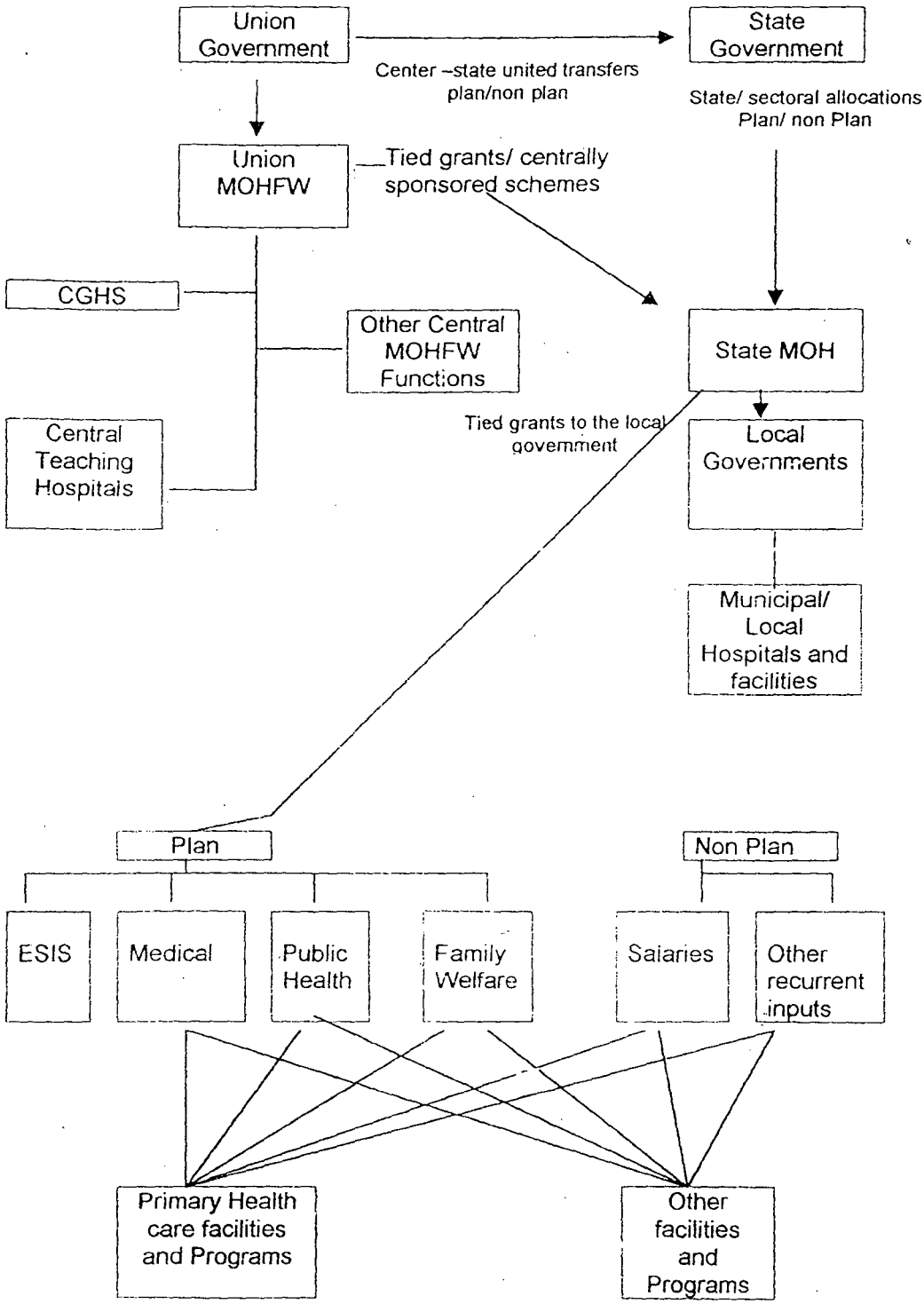
Number of Hospitals and Nursing Homes in Delhi (1991)

Zones	No. of Hospitals	No. of Beds	No. of Pvt. Nursing Home	No. of Beds & Nursing Home	Total No. of Hospitals Hospital/Nursing Homes	Total No. of Beds per 1000 population	Population per	NO. of Beds	Population per bed
MCD	70	13175	105	2113	175	15306	51326	1.70	587
NDMC	9	4424	2	3	11	4427	26740	115.05	66
CANTT	2	903	-	-	2	903	47136	10.26	104
NDMC & CANTT	11	5327	2	3	13	5330	29883	13.72	73
COMBINED									
Total	81	18502	107	2134	188	10636	49843	2.20	454*

Source: Directorate of Health Service, Delhi Administration (For Basic Statistic) One of the Highest in the Country (Kerala 427, Andaman & Nicobar 399, Goa 383).

Figure 2

The Structure of Government Health Financing



Source: Health and Family Department of India, Vol. 1, 1999

CHAPTER-V

SOCIOLOGY OF PRIVATISATION OF HEALTH CARE IN INDIA

Sociology is the systematic study of human society, it provides us with evidence and explanations of how society works, of the actions of individuals and groups, of patterns of similarity and difference between people within a single society and between societies, of the distribution of social resources and economic and political power. Sociology is concerned both with studying individuals-social actors and agents, operating in the social world and with trying to understand how the social world 'works' by investing how social structures and relationship develop, persist and change.

A sociological explanation of inequalities in health, for example emphasizes the impact of economic, social and cultural structures and relationships with in the wider society on people's health chances as well as the actions and attitudes of individuals. Before 1930, health and illness were recognized as being appropriate topics for sociological study. It was the impact of social structure on people's health that was noted rather than how a person's physical and mental state might influence their actions. (Jones, 1994:40). The science of health has been characterized by positivism and extreme rationalism, divested from its social and economic context. Medicine is not a science but a learned profession deeply rooted in a number of sciences and charged with the obligation to apply them for man's benefit (George, 1972: 9).

5.1 Social, Political and Economic Background:

Social and cultural factors play a critical role in the dynamics of economic and political systems. The Hindu social order – is universally recognized as a uniquely Indian approach to metaphysical and worldly affairs. Its complexity and

various inflexibilities have caused backward, rigid and unchanging stereotypes. Considerations of caste, community, and blood relationship persist at all levels and in all spheres of activity, whether it be industry, public service or politics (Srinivasan, 1964 cited in Veit, 1976) .

The colonial period and the nationalist struggle substantially altered Indian conception of how society should be organized. The congress party, later recognized as the party of independence, began its life in 1885 as an organization of upper-class, urban Indians who sought greater privileges from the British with in the then existing order of colonial rule. Congress's diversity and its long-standing dominance in Indian politics are largely explained by its pre-independence heritage. Because of the preeminence of independence as apolitical issue, the congress attracted member with a wide diversity of economic views. It owed its strength to the combinations of (1) mass support in rural India (2) the political and organizing role of its intellectual elite and (3) the financial contributions of nationalist – inclined industrialists and wealthy landowners. Thus, when the congress became India's ruling power, its choice of economic policies was affected by commitments to various factions of the party and a strong desire not to alienate any of its supporters. (Veit, 1976: 25). Nonetheless, although almost all the diverse interests within the congress have symbolic representation, real power has generally been kept in the hands of the politically active – the urban petty bourgeoisies and the newly emergent rural upper-middle class.

The first effort at a collective working out of a planned economy for India was the formation of the national Planning Committee by the Indian national Congress in 1938. The committee succeeded bringing together representatives of the political and business field. But the effort did not lead to conclusion because the second world war broke out and the arrest of the chairman Jawaharlal Nehru, and several other members of the committee and sub committee followed by the unsettled political conditions in the country , put an end to its activities.

'Bombay Plan' or the 'Tata-Birla Plan' in 1944 was the first collective effort made by the bourgeoisie proper-big business- to outline the path of advance for India when she attained an independent status. They wanted a 'National Government' to come into existence at the centre on the termination of the world war II, 'which will be vested with full freedom in economic matters. It was clear to them that no plan would succeed if the destinies of the nation were in the hands of foreign rulers. The Bombay plan on perspective of internal development, setout the general idea was, state intervention and control was to be used in the interest of capitalist development and not to curb or control the development of capitalism. Three methods of state intervention in the economic activities were discussed, the nation-ownership, control and management.

State control is recommended in the case of public utilities' basic industries, monopolies industries, using or producing scarce natural resources and industries receiving state aid, such control however, should be exercised with out unduly hampering the initiative of the management. It was suggested that even those industries which are under state ownership may be handed over to private capitalists for their management.

State intervention is thus envisaged as the method through which private enterprise is enabled to grow- by receiving financial aid and other forms of assistance to start new undertakings or buying from the state those enterprises which in the beginning are built up by the state through its own investment, or again securing the right of management of enterprises which are state-owned. There is obviously nothing socialistic about it. The publication of the Bombay Plan, however, turned out to be a landmark in the history of Indian planning.

All over the country, intellectuals started to prepare their own alternative plans. The Indian federation of Labour (IFL) headed by M.N. Roy drew up what was called the 'people's plan' and Sriman Narayan Agrawal who prepared a 'Gandhian Plan'.

The 'people's plan' based itself on the experience of planning in the Soviet Union. The main contribution of this to Indian planning are, the land as well ass the underground riches are collective property of the nation, heavy industries and banks are subject to state control small agricultural producers to be free from all other taxation, except local rates, large scale cooperative agriculture, minimum scale of wages etc. The policies advocated by them were far too 'radical' for the authors of the Bombay Plan and other representatives of the bourgeoisies.

The 'Gandian Plan' worked out by Shriman Narayan Agrawal was different from both these plans, as well as from the general stand taken by the national planning committee. The author of Gandhian plan said. "I feel that these plans have not taken into account the special cultural and sociological foundations on which our economic planning in India must be based. Merely copying western plans, whether of the capitalist or the socialist type, will not do. We must evolve an indigenous plan with its roots firm in the India soil".

The decade before the attainment of independence by the country was thus a decade of intense discussion on the necessity, possibility and general direction of planning the post-independence economic setup of the country. These discussions led to the emergence of three distinct groups of thinkers on the question of planning the left radical, the frankly capitalistic and the Gandhian. The conflict of trends represented by these three groups has left its clear imprint on post-independence planning. (Namboodiripad, 1974: 32).

The conclusion toward which this discussion lead is that, except for democracy, which modern India has never challenged as an objective, there have been so many ideological differences in India as to prevent any one approach from becoming dominant. In practice, for each policy objective (democracy, egalitarianism, nationalism, and centralization) there are one or several counter objectives (authoritarianism, elitism, internationalism, and decentralization).

The genesis of capitalism in India proceeded under the impact of three main factors- (1) the historically constituted backwardness of the social environment

exacerbated by colonialism, (2) involvement of India in world capitalist market (3) the policy of the colonial administration which strengthened the impact of the other two factors, while at the same time hindering the development of national capitalism (Pavllov et. al 1975: 90). When in 1948 India announced its first Industrial Policy Resolution was regarded as a retreat from socialism, Nehru defended it on grounds that the economy was weak and the achievement of India's economic development required full participation of the private sector.

In 1957, to quell mounting business anxiety and encourage investment, both the public and private sectors would advanced swiftly. In 1966, owing to devastating drought, foreign exchange shortage and industrial bottlenecks, a retreat was made from socialist policies. Greater reliance was placed on the free play of supply and demand, import restrictions were liberalized, and investment decisions were redirected toward productivity at the expense of egalitarianism. While in 1974, Agricultural and industrial reverses caused mounting disaffection with leftist sloganeering and led India to de-emphasize socialist policies. After a one year trail, the wheat trade was denationalized and, in many areas, private enterprise was accorded greater scope for its operations. Budget constraints restricted social programs. (Viet, 1976: 26)

The recent course of free enterprises in India has proceeded at two quite different levels, rural and urban. The place of the wealthy landowners, known as Kulaks, as Rajni Kothari in her writing in 1970 put it this way, the newest power group in Indian politics is that of the Kulaks, the class of independent owner-cultivators drawn from a variety of social groups, who are making agriculture a thriving business proposition and one that provides them with a base for effective political bargaining at higher level was paralleled in the cities and town by a rising upper middle-class bourgeoisie. Wealthy families such as Tatas and Birla, with industrial empires comparable to those of the Carnegies and Vanderbilt's, stand at the apex of Indian capitalism. Because of its importance in both rural and urban structures, Indian capitalism has retained considerable political power, but it has been subject to unremitting attack and has gradually lost some of its authority.

5.2 Colonial Approach Towards Private Health Care Service:

Political forces play a dominant role. The health problems and the health practices both of community are deeply embedded with in this ecological, social, economic and political systems. These have a profound influence on the size, extent and nature of community health problems. They are also of critical importance in the formulation of policies, plans and programmes for dealing with them. Obviously then, health services are but one of the many factors that influence the health status of a population. Furthermore, as in the case of the other factors which influence the health status of a community, its health services are a function of its political system. Decisions concerning resource allocation, man power policy, choice of technology and the degree to which health services are made available and accessible to different segments of the society are examples of the manner in which the political system shapes community health services. indeed, each pattern of approach to health care emerges as a logical outcome of a given political, social and economic system. These forces generate an unwritten policy frame which influence the health of a population.

The British conquest of India in the mid-eighteenth century. In 1764 the East India Medical Service and the European doctors were bought to India to provide medical care to the company personnel (Jesani, 1989: 11). The British had introduced western medicine in India in the second half of the 18th century mainly to serve their colonial aims and objectives, medical services were needed to support the British army and British civilian personnel living in India. And later on, medical services were made available to a selected segment of the "native" population. (Benerji, 1973: 485). After 1857, (Ramasubban 1982, 1985) the main factors which shaped colonial health policy in India were its concern for the troops and the European civil population. The genuine public health measures remained confined to the well planned cantonment areas housing British people. But for the general population the sanitary measures were started in ad-hoc fashion for pilgrim centres, but the realization that they would be very expensive made the colonial government

shelve the programme under various pretexts. And contends that as the era of sanitary reform was superceded by the professionalisation of medicine in England, the colonial government shifted the focus from the sanitary reforms to public health research in India.

As regards rural health care a study of Madras Presidency (Muraleedharn, 1987), revealed that the colonial state had established dispensaries and hospitals for the people, more in the urban areas but less in the rural area. In 1924 it introduced a scheme called subsidise private practitioners who agreed to settle down in villages. Such private practitioners were not considered government servants, were required to settle down in the villages specified by the local boards and were asked to treat the "necessitous poor" free of charge. The subsidy offered was Rs. 600 and Rs. 400 per annum to graduates and licentiates respectively an additional amount of Rs. 100 per annum if a qualified midwife was employed and each such dispensary was given medicines worth Rs. 360 per annum to treat patients free. However this scheme was only partially implemented as out of 3000 such institutions planned in 1919, only 1150 were setup by 1935 and their number actually decreased to 1050 in 1938. The reason for such implementation, as formulated by Murleedharan, was government's reluctance to spend money and in 1932s, the government actually started shifting burden of this rural scheme to the local bodies. Not only that, even in the hospital set-up in order to affect economy, the government started allowing more role to private practitioners and thus in this period, it reintroduced honorary system in the Madras Presidency. (Jesani, 1989: 112).

5.3 Social History of Indigenous Medicine:

The European doctors who were brought to India, were not found so useful for treating certain local diseases and thus, the British personnel often sought help of local healers. For example, the surgeons of the East India company learned the art of rhinoplasty from their Indian counterparts (Basham 1954, cited Benerji, 1985: 8). It is noteworthy that during the early period of British rule in India (the late 1700), the

western system of medicine was still dominated by such procedures as purging, leeching, scarification, and blood letting, and therefore could not be considered superior to the prevailing Indian system (Rosen 1958, cited Benerji,1985: 8). Jeffery (1988: 51) mentions that between Years 1814 and 1835 some processes of mutual involvement between local healers and European medicine took place. He says that in 1814 under the instruction of the court of the Directors in London, some attempts were made to investigate the value of local medicines and medical texts. He also mentions that the informal training scheme at Calcutta was established on such more substantial grounds in 1822, as a Native Medical Institute (NMI), teaching indigenous and European Medicine. The Muslim Madrassa and the Hindu Sanskrit college (both established with European patronage) had already in corporated some European medicine and anatomy into their courses. However, a change in policy in 1835 abruptly ended this interaction as it was decided to cease teaching Ayurveda and Unani in those institutions. However, as a result of the colonial policy of shifting state patronage from indigenous systems to the western system, the already stagnant indigenous systems were caught in a vicious circle. The very neglect accentuated their decline, and the decline in turn made it increasingly difficult for indigenous systems to complete with the highly favoured and rapidly flouring western system for the support of the newly emerging Indian elites educated in the western style. (Banerji 1975b: 8)

Colonial exploitation of the Indian people, caused complete disruption of their traditional way of life, including the indigenous health practices which different strata of society had developed over the millennia. They were denied the benefits of western medical science. Thus at a time when spectacular developments were taking place in different branches of the western system of medicine, the indigenous systems of medicine came to be dominated by person with very limited competence, sometimes even by quacks and impostors and the very scientific bases of these system was almost totally eroded. Hence the resulting vacuum was filled by a variety of superstitions practices and beliefs in supernatural practices and beliefs in supernatural powers and deities (Benerji 1975b). It is unfortunate that the most

social scientist who have studied the health culture of rural populations in India have over-stressed the prevalence of superstitions beliefs and practices. (Paul 1955 cited in Banerji, 1985: 9)

5.4 Process of Privatisation of Health Care Service:

The private sector is not new to Indian health services. It was a predominant mode of service for the well off until the end of the colonial period. During the pre-independence period the private sector was restricted to individual practitioners. The Bhore Committee, setup prior to independence, prepared the blueprint for health services development in the country. This committee made a penetrating assessment of the then health situation and health services in the country and recommended measures for their improvement. The Committee conducted a survey on medical institution which revealed that 92 percent of the institutions were maintained on public funds and the remaining 8 percent wholly maintained by private agencies. The proportion of allopathic doctors in private practice was as high as 73 percent and the remaining 27 percent were employed in Govt. service (GOI 1946, vol. I, cited in Baru 1998: 48).

When the recommendations of the committee were adopted, there seemed to be reservations regarding private practice by doctors in government service. As far as individual private practitioners were concerned, the committee assured them that their interests would not be affected. Although the committee had categorically stated that private practice by government doctors must be prohibited. It did not visualize a role of independent private practitioners in government hospitals. A shift in policy could be seen as early as 1961 in the report of the Mudaliar Committee. This committee took note the fact that nearly 40-70 percent of doctors in different states were private practitioners. Thus the committee visualized a role for them in government services because of inadequate manpower. It was important that they were given opportunities to serve in government hospitals on a part-time or honorary basis, and hospital authorities could encourage them to admit their patients

needing 'in-patient care'. It further stated that: 'Independent practitioners have to be considered as a separate entity whose legitimate interests must be protected (Govt. of India 1961).

Thus even as early as 1961, the demarcation between the public and private sectors had become clear, especially with individual private practitioners being encouraged to use government hospitals to treat their patients. During this period there was also no serious effort to prevent government doctors from having private practice. The Bhore Committee had strongly recommended a ban on private practice by government doctors and the second five-year plan also reinforced this need due to the negative impact of private practice on teaching and research in medical colleges. However, there recommendations proved to be difficult to implement because effort banning private practice were short-lived due to the lobbying power of the doctors.

In 1967, the Jungalwala Committee report did not mention individual practitioners but it observed that a large percentage of doctors in government service were practicing privately.

5.5 Emergence of Private Health Care Institutions:

The private sector has been expanding since the past three decades in India earlier during the fifties and sixties, the presence of private sector institutions was small but over the years this sector has grown and diversified to include commercial-based institutions like-nursing home and corporate hospitals. With the increasing penetration of high-tech investigative equipment, investing in medical care has become a profitable proposition and has been an important reason for fuelling the growth of private institutions. The private sector has been largely involved in the provision of curative services while the public sector has provided both preventive and curative services. Stagnation of public expenditures during the seventies and the eighties, which has created space for the growth of the private sector. An added reason has been the profitability of private enterprises which resulted in their

proliferation. The government has also played a supportive role to the private sector by offering a number of concessions and subsidies. Government policies have been in the form of concessional loans, custom duty exemptions and reduction of import duties on high technology medical equipment. The indirect benefits are the accommodation of private interests in the government sector. These interest are served through liaison with the private sector for purchase of drugs and equipment, encouraging the private sector to fill gaps where there is inadequate investment by the government, allowing private practice by government doctors and handing over hospitals to the private sector to be run privately. Another reason for the private medical sector in urban area is the lack of expansion of public services in urban areas. It has given rise to a peculiar situation. There are very few opportunities for medical graduates in urban areas while a large number of posts are lying vacant in rural areas. In 1963-64, 39.6 percent of allopathic doctors were in government service and this proportion declined to 26.6 percent by 1986-87. The proportion of doctors in government service has continued to decline (Nanda, 1993).

5.6 Policy of Liberalisation and Business in Medical Care:

Since the mid-seventies there have been two important development in the world. The decline of Soviet system and the ascendancy of capital at the expense of labour. The rise of Thacherism and Reaganism in the west accompanied by the rise of the service sector and the emergence of new labour displacing technologies weakened labour considerably. Trade Union membership has been constantly on the decline in most countries around the globe.

These two developments weakened the developing world. The space that existed for them to manoeuvre in the international sphere and ward-off economic and political pressures from the western powers narrowed. This has been coterminous with the IMF and World Bank applying greater economic pressures on the developing world. During this period, pressures for opening up their economies mounted on the developing world. New issues were introduced precisely in this

period with the Uruguay Round of negotiations starting in 1986. The advanced nations found an opportunity to get the market of the developing world opened and integrated into the world markets dominated by their interests. Hence the pressure to open up trade in agriculture and services mounted on developing countries and get a tighter control over capital and technology and obtain freedom for mobility of capital. All this has enabled capital to aggregate itself in larger and larger size and also made the developing countries compete with each other to obtain more and more concessions for itself.

Since the 1980's, pressures for change have come from different quarters. As for as the public sector health services were concerned, the govt. cutback in fund and promote the medical care as an industry. Private sector practitioners, who had enjoyed the privilege of state protection since independence in India's mixed economy of service provision, aspired to influence policy and create move advantages for themselves. The private sector grew from polyclinics to nursing homes, private hospitals and finally, to the development of corporate hospital (Qadeer, 2002: 26) this is because of the govt. has offered a number of concessions for the growth of the private sector. First, government encouraged the growth of large private hospitals by reducing import duties on high technology, medical equipment and special concessions are given for NRIs. Second, it has recognised medical care as an industry thereby making it eligible for loans from several public finance companies like the Industrial Development Bank of India (IDBI) (Baru, 1998: 54).

Interestingly, the emerging middle class, with the result of globalisation, succeeded in acquiring a reasonably adequate standard of living lobbied for "high tech hospital", which conformed to their concepts of international standards of health care".

The growth in imports of medical technology has made health care a profitable business venture. The absence of a public sector in the manufacture of medical equipment, India has relied on imports, which have increased over the

years. The first corporate hospital in India was setup at Chennai in 1987 by Apollo group. The establishment of Apollo marked the entry of non-resident India doctors into medical care and signalled a recognition of a hospital as a corporate enterprises. Several big business groups like Tata, Hinduja, Modis, and Escorts have floated multi specialty hospitals in Delhi and Bombay that are mainly registered as Trusts. In Calcutta, the G.P. Birla Group has promoted as Rs. 15 crores B.M. Birla Heart Institute in 1989 as a research cum treatment centre. Chabbarias' Shaw Wallace is planning to promote a hospital a Rs. 30 crore hospital and Goeankas are also floating a Rs. 50 crore hospital project. Similarly the Singhanias of the JK group who are managing hospitals in Kanpur, Kota and Jaipur are now, planning to start one in Delhi. The Nandas of Escorts floated the Escort heart Institute during the later half of 1980 which is a specialist hospital cum research centre for heart disease. It was established with an outlay of Rs. 25 crores of which five crores was spent on importing equipment from USA, UK and Germany. The idea to set up such a hospital was mooted by a non resident Indians based in New York and subsequently several specialists from the US have associated themselves as consultants or regular employees of this hospital. A few year back regional business groups like Apollo hospital Ltd have entered into joint sector collaboration with the municipal corporation of Delhi with an estimated cost of Rs. 70 crores. In Bombay, the Hindus have renovated their 100 bed National Hospital to a 300 bed modern general with the latest diagnostic equipment. The regional business groups like Standard Organics Ltd, Apollo Hospital Ltd, C Dayakar Reddy Hospitals Ltd. and a few others like Tamilnadu Hospitals and Malar Hospitals are running their venture successfully. Indeed, the rise of corporately owned hospitals is essentially a southern phenomenon with cities like Hyderabad and Madras having the largest numbers. These enterprises have been promoted by business groups and doctor entrepreneurs, some of whom are non resident Indians based in the United States (Baru, 2000).

Baru in her study on private medical institutions in Hyderabad, observed that the large multi specialty are floated by business groups and are managed as private limited, public limited or as trusts. The private limited hospital is organised like any

other company and does not issue public shares in the market. The public limited hospital, on the other hand, issues public shares in the market while the trusts are essentially supposed to be 'non-profit' concerns. Section 35 of the Income Tax Act offers tax exemptions in respect of expenditure on scientific research, therefore the groups have setup many of these multi specialty hospitals as a research centre and therefore can be registered as a non-profits enterprises. (Baru, 1994)

5.7 SAP and Health Sector Reforms:

Any analysis of privatisation of the health sector would be incomplete if it did not include the impact of this development on the public sector. The decade of the 90's saw several state governments restructure their secondary level hospitals with loans from the World Bank.

The impact of SAPs that has begun to emerge during the past five years reveals that they have led to an overall chaos in the public sector, in addition to the impact on employment, food, and transport, judged even by conventional economic standards, they have generated impoverishment and reduced considerably the capacity for the reconstruction of economies- a stated aim of the policy itself (Emengwali 1995, UNRISD 1995, 94, Cited in Sen, 2001: 142).

In 1991 when SAP was formally accepted, there were two basic responses to this official acceptance. One lauded the step as bold, desirable, and necessary to successful entry into the twenty-first century and its globlised modernity. The other saw it as a step backward in state's effort at independence, self-sufficiency, and building a less iniquitous society. Both viewpoints accepted the innumerable problems of the present system of promoting private initiatives and removing the bottlenecks of government rules, the letter asserted the importance of regulatory mechanism of the state, which required reforms not rejection. This second view not only upheld the primacy of the state in protecting the interests of the under-privileged in the process of development, but also put at centre-stage the unfinished task of social and structural reforms initiated during the early phases of national

reconstruction. On the other hand, the proponents of SAP placed their faith in the process of globalisation, mechanisms of free market, and international co-operation. They argued that only these would encourage the "quality" and 'efficiency" of technological growth, which was the basis for long-term economic growth and development.

The meaning of term "reform" and the relevance of the term "efficiency", as used under reforms have escaped clear thinking and evaluation. The very use of the word "reforms" which was forced to accept as the uniforms model, is misleading because in recent social memory rooted in historical experience, reforms meant measures for the welfare of the majority of the people (Qadeer, et al. 2001).

The world bank and IMF took advantage of this social perception and never made it explicit for whom their "reforms" were meant! It was argued that in the long run the poor would benefit even if they carried the burden of reforms on their shoulders initially. Reforms were projected as the only answer to the problems of the third world countries. Therefore, this was an inevitability that had to be tackled with security nets. The justification for the world bank reforms was provided by highlighting the existing state structures and failures of the promises made by the nation-states, such as democratic governance, individual rights and choices, and efficient and participatory local self-government. The efficiencies of governments, particularly of the third world, thus became a key justification for the rolling back of the states. Other than the impatient middle class, hoping to acquiring international living standard, and the private sector both played a crucial role in justifying the reforms. The supporters of the reforms argued that there were not enough resources to invest in public provision and that the only way forward was to privatise as the quality of public services could never be improvised. If middle class or elite backgrounds have created the illusion that their privileges are exclusive, then the case of Britain should be a lesson, where the rising costs of health care and failures of protective insurance systems have severally struck at there classes (Pollock, Brannign, and Liss 1995, cited in Qadeer et al.2001, 31). This was to only further

distort access and enhance existing inequalities in the provision of health services, despite the fact that their non-affordability remains to be proven.

SAP led to the introduction of health sector reform in India. Instead of learning from past experiences and contradictions with in the Indian health care system and enhancing an efficient and integrated approach to improving its working, the entire exercise was dominated by unquestioning acceptance of the prescribed reforms. The main aspects of the IMF-world Bank-inspired reforms were- cuts in health sector investment, opening up of medical care to private sector. Introduction of user fees and private investments in public hospitals and purely technocentric public health intervention. PHC suffered a lot due to the cutbacks in the welfare sector and the proposed health sector reforms had a direct impact on PHC because:

1. Intersectional strategies for PHC were already being undermined by a weakening food security system, massive unemployment and loss of subsistence for many Indians.
2. Infections disease control programmes were disrupted by a reduction in investment.
3. Medical care was handed over to the private sector with out any mechanism to ensure the quality and standards of treatment, as well as access to services.

5.8 Issues in Health:

State policy towards the private sector has to be addressed within a systemic perspective covering not just providers of health care services but also other related components in the health care system. Within this perspective it is essential to delineate the extent of private sector involvement in provisioning and financing, medical technology, medical / paramedical education, research and pharmaceuticals.

5.8.1 Introduction of Market Principles:

Market are the new buzz word. They are to be left free to operate. This means freedom to capital, labour laws that have evolved have long periods of time to check the extreme forms of exploitation by capital are now being diluted.

Economic globalization represents the structure of the economy and society. Market are an institution to exchange goods and services and governed by the purchasing power of the individuals in society. They are not democratic institution, in effect, left to themselves, they lead to the marginalization of the marginal. In that sense the market are value less.

Markets are governed by the principles 'more is better' and 'consumer sovereignty'. Individual's welfare is supposed to increase as s/he consumes more. Consumer sovereignty means that the consumer knows her/his interest best so whatever s/he wishes to consume should be made available in the market. There should be no interface with this from any quarter (government). 'Efficiency' is defined as the achieving of the wished of the consumers. This may be iniquitous in the extreme with one person having all and the others having nothing. But as long as this is consistent with the initial endowments, it is 'efficient' and in that sense the notion of market 'efficiency' is status quoist.

Since 'more is better' consuming less is not desirable as it lowers the individual's welfare. Restraint is then meaningless. Sacrifice is outright stupidity in this framework. The notion of 'consumer sovereignty' means that the focus is on self as opposed to the collective,. So both these market principles weaken the idea of community and of working towards a common goal. The idea of the nation based on a shared common goal itself weakens. In brief, growing emphasis on market lead to a narrowing of the individuals horizons and undermining of the idea of the nation.

Market do not decide which goods are socially good or bad. They have no social value. Judgment about the nature of goods is made and imposed by society from outside the markets. For instance, markets do not decide that smoking is bad or that cigarette advertising should not be allowed. Society decides that children should

not be targeted by advertising or that sex and violence should not be beamed at them. Penetration of the markets into the social realm is undermining social values.

In the market there is no distinction between essential and inessential goods. All goods are alike except that their elasticity of demand differs. Hence in economic theory, there is no need to curb the import of luxury goods or to tax them heavily. So whether the poor get their food or not. One can have one's Mercedes Benz and one need not feel bad about it.

Dominant western values are being imposed on the developing nations through the media, with the help of power of money and politics but above all because of the dominance over ideas. The desire of the elite of the developing world to integrate with the global one has made this process voluntary. These elites hardly empathise with their people. Progress for them means copying the dominant western model and success is also defined in these terms. This is clearly visible at the level of thinking and in the institutions of higher learning in the developing countries.

In such a situation there could be only two reason for the increasing pressure or privatisation, the first could be the failure to support public sector personnel to perform their duties in the skeleton comprehensive programs inevitably created a very big "market" for the private sector. This was an increasing burden on the poor who were at the receiving end in this scheme of things. Two recent nation wide surveys (NSSO, 1992, NCAER, 1992) on the pattern of utilization of medical institutions reveal that expenditure for getting treatment for diseases was the second most cause for rural indebtedness (after dowry) among these impoverished people (Qadeer et. Al. 2001: 47). The second could be ideological because it is easy to play along with the popular belief that public sector health care is inferior to that provided in the private sector.

5.8.2 Quality of Care: A Myth

Much of the debate on privatisation of health care has been based on the assumption that the private sector provides a better quality services than the public sector. Efforts are on to restructure public institutions on market principle to

promote efficiency. This assumption does not stand up to empirical scrutiny, because of the difference in stated goals, it is evident that the private sector attracts and treats persons who can pay and are non-emergency situations hence there is already a selecting out of patients. The public sector, on the other hand, seeks to provide universal access and therefore the patient load is always higher than the intended capacity. These differential goals set reflected in the case mix, social background of patient and rate of patient turn over in the private and public hospitals. These differences make comparisons of efficiencies of the public and private sectors difficult and therefore generalisations are also not possible. There are difficulties in arriving at any generalisation based on studies which tend to be unit specific in their comparisons. As Barker states:- "There is a real problem in comparing public enterprises with private enterprises. This is because efficiency can only be assessed in relation to stated goals. In private business these goals are clear. They are to maximise profits or and/or economic growth. In the public sector, however, these goals are not so clear. It may not be important for a government department to make a profit, provided it performs functions defined as essential for the community or for another department" (Barker 1996, cited in Baru et al., 2000: 154). A comparison of private and public providers in Trivadrum raises some of the methodological problems in doing such an exercise (Homan and Thankappan 1997, cited in Baru et. al., 2000).

The quality of care of any service organisation highly depends on the providers skills (qualification), working conditions, attitude and wages of staff, and other social factor which is related to providers. Hospitals are labour intensive organisations which are not only merely dependent on medical expertise but require the co-ordination of different level of staff to provide quality patient care. It is not enough to have well qualified specialist alone, it is equally important to have well trained paramedical and supportive staff for ensuring good quality patient care.

Studies on private nursing homes in Bombay (Nandraj, 1994) Delhi (Nanda and Baru 1993) and Hydrabad (Baru 1998) have shown that paramedical and supportive staff often work for very low wages and are not qualified for the work

that they do. Hence there is a great deal of turnover of staff at these levels and they work under abysmal conditions which is bound to have a direct impact on patient care. "Critical condition: a report on workers in Delhi's private hospitals" conducted by workers solidarity states that 50 percent of the expenditure is incurred for equipment and drugs, 30 percent for wages and that 30 percent of that to consultant and 20 percent for maintenance and sundry expenses. Economic efficiency justifies paying low wages to the paramedical and supporting staff in order to make profits. Hospital management keep their expenditure on wages low through the contractualisation of fourth class employee viz ayahs, ward boys, sweeper, security guards and also among canteen workers, laundry workers and pharmacy workers. The report shows that the contract workers are overworked in terms of long hours of work often without even a weekly break (a volition of section 17 of the Delhi shops and establishment Act, 1954). When there is a shortage of labour the available workers are made to work overtime with out adequate break or rest from their earlier shift. These kinds of conditions will definitely affect the productivity of these workers and infect reduce their efficiency.

The job insecurity and poor working conditions of this class of workers is bound to affect the quality of care provided to patients. In any hospital it is the paramedical and supportive staff who interact closely with patients by attending to their physical and emotional needs while the medical personnel look after the clinical aspect of treatment. Therefore a hospital that is responsive to patient needs, requires well trained personnel at various levels who interact together as a team coordinating and complimenting each others role. The problem of contractualising the support staff means it does not generate a sense of belonging and loyalty among the workers, towards the institution in which they are employed. This is definitely not conducive for building commitment among the workers towards the hospital that employs them. Infect over worked, ill trained and insecure workers are likely to make more mistakes and hide them too!. In short, the reputation of the consultant alone supported by a shaky and overstretched staff at different levels is responsible for whatever quality of service that is provided. (Baru et al, 2000).

5.8.3 Culture of Practice:

The doctor is undoubtedly a professional and this status is due to his or her acquired knowledge special skill and the position, he or she occupies in society. Therefore the society's dependency on doctors and that realization create a gap, for unethical practice or a culture of practice driven by the hiding information.

In the private practice, desire to earn more money is undoubtedly a significant reason for irrational practice, rising cost of health care, commercialisation of health, over medicalisation, unethical practice, increasing usage of technology etc. the health care as a commodity is sold by the health care provider in the market.

As a pretty commodity producer, the doctor does own his or her skill and certain instrument for providing service. The relationship between the customer (patient) the trade person (doctor) and the technology used for curing (drugs) is no longer of old type in the sense that the industry has almost thoroughly penetrated this relationship. Since the doctor as a professional is essential for the sale and the use of goods produced by the health care industry, he or she while acting as a small commodity producer simultaneously works as an 'agent' (or a sales person) of the industry in the market for the realisation of profit. This new role of doctor is almost universal because he or she no longer gather herbs and chemical, and compounds drugs. The increasing technological use in diagnosis and the treatment has, therefore changed the practice of medicine from caring to mere curing. Thus the changes in he organisational set up of individual medical practice are not limited to the change in the doctor-doctor relationship and doctor-patient relationship but the very social position of the doctor as a health care provider has changed the doctor has indeed become an essential part of the market strategy of the health care industry. The convergence of the interests of the industry and the practicing doctor takes place most visibly in the for-profit medical care.

In our country the private sector almost exclusively works on user changes. Intensive use of high-tech equipment, irrational diagnosis, diagnosis for money, and

technology for earning how become a culture of practice. The issues of over-medicalisation and atrogenesis were forcefully raised by Ivan Illich (1975) and Ian Kennedy (1981). Such issues have equal relevance in our country. ICSSR/ICMR committee (1981), expressed serious concern about of 50,000 drugs and formulations available in our country are hazardous, useless, unnecessary and irrational. Such products not only harm the interests of the consumes and inculcate irrational medical practice, but are also causing waste if resource and increasing cost of medical care.

The role of increasing usage of various technologies and specifically the new ho-tech instruments, in medical care is well documented. Nearly 80 percent of private health practice is based on this nexus of commission and cuts between the GP and the consultant. They go to any lengths to earn their bread, butter and jam. The alliance may be as part of the so called 'Arab practice Clique' or the 'Kidney transplant mob'. Such doctors admit patients to their 'ICCU' with a (mis) diagnosis of an infarct. They even have an understanding with medical representatives who give them cuts for prescribing specific drugs, although they are spurious or banned (like EP Forte) (Murlidher, 1994: 29).

The doctors prior to technological revolution were independent healers. They examined, diagnosed, investigated and treated the patients under one roof. They could be compared to the artisans of medieval times. In modern times large-scale capital-intensive diagnostic and therapeutic centres like the CT and MR scan units and the shock-wave lithography units-have been set-up by businessmen. For these centre the doctor is just a pawn in their endeavour to increase profit margins. The doctor, consciously or unconsciously, falls pracy to industry. Studies from both developed and developing countries have shown that private hospitals often discharge patients even before they are ready for it in order to maximise patient turnover and increase interventions. According to a promoter of a corporate hospital makes profits on beds after which the profit margins tend to fall. It is during the first few days of hospitalization that all the procedures, both surgical and non-surgical are completed, there is little scope for charging patients more than bed charges that the

hospital is likely to derive profits from during the recovery phase are on drugs and nursing care. This is an important reason why private hospitals tend to discharge patients much earlier than public hospitals (Baru et al. 2000). "Much of a private hospital's profits are derived form the usually steep charges for inpatient services and diagnostic tests. It is also extracted from exorbitant bed charges" (Workers solidarity 2000).

The health care insurance is also introduced in Indian market. The insurance schemes have actually helped in the increasing usage of hi-tech high cost Medical care in the private sector. In her study of technology use in hospitals, Lovise Russell (1979) argues that the growth of third party payment system has also diminished cost consciousness amongst the health care providers and the patients to leading the excessive usage of the technology.

The value system of private sector medical care have come to dominate the practice of medicine. Hence the curative care component of public sector is also greatly influenced by this value system of the private sector. As a result, one witnesses increasing illegal or unofficial private medical practice by government doctors in PHCs and hospitals. There are even agitations by doctors to make their private practice official. It is also not unusual to see government doctor doing private practice, some times even using PHC's medicine for the practice while sitting in the OPD of the PHC. We also find the government doctors in same way and for the same purpose as they do for doctors in the private sector.

Some scholars have written that the public sector's malfunctioning is providing scope for the expansion of the private sector. It is also necessary to assess how the private sector oriented policies of the state and the actual existence of an unnecessarily large big private sector with its dominant value system have contributed to the malfunctioning of the public sector. (Jesani, 1989: 59).

5.8.4 Consumer Concerns and Empowerment in Health Care:

Decades of unregulated growth in the health care market have led to a situations, wherein a vocal and powerful section of health care professionals are

shamelessly and assertively declaring that the medical profession is acceptable only to itself and not to society. They defend unfair market and trade practices under the garb of professional independence. They have interpreted the new economic policy as being one which promotes market forces with out enforcing any regulations and allows private providers to practice without obligations to ethics or patients / users. On the one hand they demand the status of an industry for financial support include the granting of status of infrastructure, providing a level field for health care, giving nursing homes the status of small-scale industry, loans and further reduction of import duties on medical equipment, and on the other hand, they want to retain the privileges of a welfare institution. This is the outcome of a Delhi Government Committee Report. This committee must not only take stock of the performance of the private sector and its adherence to conditional-ties but also define the role of the state in monitoring these hospitals like any other industries, health care enterprises must also adhere to rules and regulations regarding employment conditions, and minimum wages for all levels of staff certain minimum procedures regarding pricing, billing, maintenance of medical records, financial and medical audit which become requirements for ensuring transparency and accountability to the consumer and state.

In this era of consumerism, free market economy and information explosion, how can one empower the consumer to utilise health care services more effectively without endangering doctor-patient relationship which is based on trust? The consumer rights, consumer responsibility gains an equal importance. An irresponsible use of the rights may lead to a distorted an expensive health care delivery as seen in USA today. The current Indian scenario, despite great technological advances and specialization in medicine, health care still depended greatly on trust, care and compassion. Unfortunately, in the blind present of scientific knowledge, the human side of doctor-patient relationship is often forgotten the doctors should find time to listen to their patients and allay their anxieties. This would humanise medicine. The piece meal and de-humanised health care that is

available today causes a lot of consumer dissatisfaction and in largely responsible for the litigations in consumer protection councils.

The passing of the Consumer Protection Act, in 1986 to protect the interest and rights of the consumers. But the effectiveness of COPRA is in doubt also because of the number of cases pending with the courts (Bhat Ramesh, 1999).

The chapter identifies certain broader issues like commercialisation, corporatisation, use of expensive technologies and so on, which are so fundamental to the rising cost of health care that the cost-containment cannot be successfully attempted without tackling them. In any case it should be noted that these factors are at the root of certain commercialised irrational use and over use of medicine.

CHAPTER-VI

DISCUSSION AND SUMMARY

Discussion

Sociology in medicine refers to study that help to solve problems in medical science or to provide knowledge, about a practical problem in medical practice, the allocation of health resources, operation of health facilities and services, and the use of medical settings and health and illness to study such sociological phenomena as organizational role, relationship, attitudes and values of persons involved in medicine. The institutional setting, in which professional socialization of young recruits to the profession takes place. Medical settings and provider's social behaviour, which could be subjected to such a study and to enable to elaborate, refine and test general proposition of social behaviour.

Medicine as a profession has a measure of public esteem in every society. The medicine man who within their own limitations in terms of tradition contribute to the physical welfare of their people. From the beginning in all societies men of medicine were held in; high esteem. In fact a career in medicine profession is considered as a highly prestigious one and ranks one of the top professions in almost all these contemporary society of the world. Its is necessary to take a holistic view of all the cultural dimensions of the health and to relate such a holistic perspective to the concerned people. The conceptualisation an measurement of health and the quality of life gaining increasing attention in the health services. Since the concept of health has different meanings in different social systems, the health problems of a person cannot be studied in isolation from the social network of the concerned givers.

Wide spread poverty, illiteracy and malnutrition, lack of personal hygiene, absence of safe drinking water, sanitary, living conditions, health education, maternal and child health services and inadequate and ineffective coverage by national health and other supportive services have been delineated in several studies as the possible contributing factors for the dismal health condition prevailing in India.

The medical profession over the ages acquired two major roles in society. The first, the more ancient one is providing medication, treatment and relief for illness and injury. The second role evolved later and gradually. It was that of a mentor to the society on health matters. It carried out this role by organising and instituting measures for prevention of sickness. By advising and suggesting measures for the promotion of health. This role less dramatic and less spectacular has not the glamour associated with the provision of relief from suffering. But it is perhaps more substantive and important as it promotes and preserves the weal, welfare and integrity of the society. However this role are not exclusive but mutually supplementary.

Since health manpower constitutes perhaps the most crucial element in the health system infrastructure, the training and development of health personnel must ensure that they are not appropriately skilled, technically, but are also socially motivated and responsible. The relevance of this training and development to the real health needs of people in community has to be ensured. The concept and practice of health and protection, prevention of diseases and disabilities and education of the public on health matters must form the core of health care.

The concept of developing health manpower in close correlation and co-ordination with the needs of health services has been with us. In reality, however, there are still gaps in this correlation, through some valiant attempts have been made in restructuring the curricula of medical education in recent years. Coordination among universities, medical colleges, and other institutions and organisation , on the other remains weak. There is a mismatch in the numbers and categories of many categories of health manpower, which has led occasionally to the paradoxical situation of surplus admits shortage. A team approach to health personnel mix to deliver integrated health service is also widely accepted. Its implementation, however, remains patchy. Experimental field studies and ad hoc efforts may not be adequate.

Medical education in India must be viewed in the context of health needs of a diverse population phenomenal expansion in the health infrastructure during the post independence era and the concerns expressed on the need to re-orient the kind and the quality of medial education, keeping in mind a large number of Student enrolment and resource constraints. There is imbalance in the production of doctor versus other

health personnel, which affect not only the cost and access to health care but also the quality of training. The doctors are concentrated in hospitals located in Urban areas and metropolitan Cities whereas the village areas, silly and tribal areas are under-served. The demand for opening new Medical Colleges and increasing Specialization has given a boost to high technology and thereby resulted in cost escalation. Presently, there are about five lakhs registered Medical practitioners in the allopathic System of medicine and about 6-7 lakhs in the Indian System of Medicine and Homeopathy where by the ratio of doctor to population is 1: 1800 for allopathic practitioners and 1: 800 for doctors of all systems of medicine.

The period also had a carry over effect from the pre independence days in the sense that most of the medical teachers at that time were those who had received their postgraduate training in Western hemisphere especially in the United Kingdom, and therefore were most concerned about the maintenance of standards of medical education which would meet with international acceptance in real terms, the academic standards were being judged with an international yard stick, and the so called academic excellence meant in reality the approved of the General Medical Council of Great Britain. So, the pre occupation with academic excellence took precedence over the prime need of national relevance. At the end of this period therefore, there was an increasing awareness that the medical graduates who were product of the then prevailing system of medical education in the country were not willing to provide a uniform geographical coverage in the country and that the mal distribution of medical and health care, if anything was increasing, thus creating a wide hiatus between the ' haves', in the cities and towns from the ' have-nots' in the remote rural areas.

The close association between caste and occupation in the traditional social system of India is widely known. Against this background it is instructive to know the caste background of those who take to modern occupations for which none of the castes had any legitimate claiming. Despite of the policy of protective discrimination pursued by the government of India the schedule caste, tribe and other back ward classes are not represented in prestigious professions such as medicine, study shows. Because the primary condition for entry into a prestigious professions such as medicine which calls for substantial economic investment is the economic resource

base of the one's family, as well as an appropriate cultural base for the aspiring individuals. Infect a minimum level of socio-economic development is a prerequisite for even to utilize the special benefits extended to underdevelopment social categories. On the one hand they do not seem to have attained the basic minimum level of social –economic development which is a prerequisite to gain entry into the profession. Generally speaking the spread of education is very limited among schedule caste and tribe as compared with its spread among the total population. On the other hand it seems clear that is a hierarchically organized society, such as India, unless policies are consciously evolved and vigorously implemented to protect the interests of the under developed social categories they are not likely to be represented in prestigious professions. In a society where educations is a private service to be purchased by the consumer based on the strength of his economic resources, the entry into those professions which require large investments of time and funds will be invariable restricted to the rich. Even when steps are initiated through appropriate social polices to facilitate the entry of deprived sections into these occupations, given the persistence of traditional disabilities the erstwhile deprived categories will in all probability be unequipped to avail of these opportunities. This gap between the provision of opportunities and utilization of opportunities is very wide and can be narrowed only through taking drastic measures in favour of the deprived.

The subject of medical education also covers the field of medical ethics and the practices of medicine continually presents ethical dilemmas to doctor. They have to make decisions and choose paths from among conflicting alternatives, which not only should respect the patient's wishes but also respect the dictates of health care managers. Ethics need to be taken into consideration when making decisions regarding the doctor patient relationship, organ transplantation, appropriate use of technology, clinical trails, informed consent and a variety of situation when apportioning of services becomes necessary. It such ethical decisions in the fundamental values of equally and efficiency that we set for ourselves in modern day health care In their regard, the 'Medical council of India has made a detailed code of Medical Ethics for observance by doctors and take action against erring doctors in case of negligence.

The pre-requisite for selection of student to Medical admission in 10+2 or after higher secondary which in now equal to 12th standard a student raw from the school straight enters in to the portals of medical college. The switch over from one system to another has caused grave problems.

So far, the emphasis in the pre-medical knowledge course has been mainly for providing the students sufficient knowledge in Physics, Chemistry, and biology. The type of general education also requires reorientation to make Medical education community oriented according to the special health needs of our country and should include training in various aspects of social sciences humanity and study of behavioural sciences. In order to have premedical training more relevant to medical education, suggestions often have been made that premedical education should also be imparted in the in the medical colleges. But this may not be ideal as exposure of student to an interaction between the different science disciplines and other disciplines of humanity may be lacking in medical colleges. Therefore it is necessary to improve the general education while it is still imported in the universities rather than transfer it to medical campus. At present educational control of premedical courses do not have enough emphasis on sociology, Psychology, humanities which are so important to prepare them for medical education. Because only a fraction of the students who opt for premedical course get selected for admission to medical colleges, it was suggested that to obviate this the selection of student or medical colleges can be made before the premedical stage of their training and then this premedical training while still being imported in the universities can have better oriented students for medical education.

The minimum age of admission to a medical college at present is 17 plus on 1st October, Mudaliar committee, in its recommendation had suggested the minimum age for admission as 18 plus. In developed countries a candidate ordinarily joins a medical college at the age of 20 plus. There have been suggestions to raise the minimum age of admission so that the candidate attains more maturity and gets more time to study the additional subject which have relevance on medical education, in developing so much required doctor patient relationship.

There is a wide disparity between the various methods employed for the selection of the students in many institutions. This is achieved by holding an admission test and selecting student in open competition. Here too, the subjects prescribed for the test differ slightly from place to place but by and large, students are examined in physics, chemistry and biology. Another procedure adopted to select students is on the basis of the marks obtained at the premedical examination. But the students of these examinations very significantly, and the results do not reflect the actual intellectual level and competence of the candidates because they are liable to be influenced by personal and political factors. At most of the institution there is no test to judge the aptitude of the candidates. So it is generally felt that the existing methods of selection are defective placing too much emphasis on scholastic qualifications disregarding completely the candidates personality as a contributing factor to his career as a doctor. The methods of selection of students may be primary screening than a test and final selection after and interview and personal assessment of standardise evaluation factors like motivation, aptitude, personality and psychological tests giving the candidates due credit for participation in community work.

The criteria for admission in private medical college is mainly paying capacity of the capitation fee which they charge, with the result a large number of foreign students who cannot get admission in their own countries and the children of affluent parents find their way into these medical colleges. These capitation colleges not only run on the money they collect but have even became a source of income leading to commercialisation of medical education. More and more of these medical colleges are being started every year. In most of the colleges the fate of teachers depends on the management, the student take studies very lightly and even try to influence to pass the examination through mal practices. In is, therefore necessary that the Medical Council of India should be empowered to assess the feasibility of any new medical college before it in started. The recent judgement of supreme court had given directions for starting of private professional colleges and the fee structure for such colleges etc.. In Maharastra, NDTV news, dated 5/6/2003 exposed the situation of capitation fee, which is as high as 27-32 Lakh, trained in these institution's doctor, How serve the society.

Summary

The medical profession is responsible to deliver the health package at each and every level. The elite physician since their primary education is in English medium schools which creates gap, with the culture masses. The physicians continued to receive their training in large well- equipped hospital where teaching in heavily loaded with study of disease and individual care mainly and/or within the tertiary institution i.e. hospital.

Now the question has been raised why the physicians are not interested to serve the masses (rural 80% population). It is evident with their life style and living culture. Hence physicians are not interested to get posted into PHCs and CHCs. This has resulted serious problems for rural health services in India as well as the Urban basically poor or with the same culture of rural area, whether they live in urban, and near to the physical accessibility of services. They are here also marginalized, why! because the problem is the gap between the provider and receiver's social background.

The physicians role, status, motivation to join the field are key to understand this problem. Lot of social science studies have been carried out on the medical profession by several eminent scholars. But in this context specially provider-receiver ends with their social background in urban Delhi is not found. This study was conceptualised and designed to study the social background of physician in their socialization, in order to generate and explore data as a part of analysis of sociology of health care providers.

In the present study attempt was made to list out all the health care providers (physician) in South West district of Delhi, specially Munirka and JNU campus health centre. In that process all the physicians had to be approached for data collection but 19 physicians out of total 26 practising are posted in this area. With the help of interview schedule the data were collected.

The main findings of this study is that most of the physicians were higher caste and class background, English medium educated, urban born and/or brought up, atleast second generation children, higher status of father, educated mother, small

family size, luxury lifestyle, most of the clinics were in shopping mall and some were in residential locality.

The findings of this study about social background of physicians and their socialization process were very close to the findings of other scholars and studies conducted by other intuitions discussed earlier. Since the health profession, physicians have been moulded and trained as a separate entity of society. Due to their higher class background, hi-tech training, society bestows respect to them. It gives them a push back the position higher than other in society. This makes them "for society" and not "with society".

From the sociological angle it can be finally analysed that the problems has been rooted right from the initial stage of socialisation, medical education as well as Gods' status of physician. Further if a meaningful interdisciplinary study is carried out keeping in view multidimensional problems of the medical profession. Than one can arrive at a conclusion to identify the gaps between community and physician. For this a wider study with a larger sample can provide scope for analytical data.

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APPENDIX-I

INTERVIEW SCHEDULE FOR HEALTH CARE PROVIDERS

(1) Identifying information: -

(1.1) Name of the respondent: -

(1.2) Type of profession: -

Allopathic	1
Ayurvedic	2
Homeopathic	3
Unani	4
Other	5

(1.3) Area of practice: -

(1.4) No. Of Years In Practice: -

(1.5) Religion: -

(1.6) Caste: -

(1.7) Native place, whether: -

Rural	1
Urban	2

(1.8) Marital status: -

Unmarried	1
Married	2
Separated	3
Divorced	4
Widow/er	5

(1.9) Sex: - Male/Female

(1.10) Educational Details of Respondent: -

SL. No.	Grade	Name of the Institution	Passing Year	Nature of School Day/ Boarding	Location of School Rural/Urban	Medium of Education
1	Primary					
2	Middle					
3	High School					
4	Intermediate					
5	Graduation					
6	Post- Graduation					
7	Vocational Course					
8	Others					

(1.11) EDUCATIONAL DETAILS OF SPOUSE: -

Educational qualification	Name of the institution	Place of the institution	Nature of the institution (Day/ Boarding)	Passing year	Location of institution	Medium of education	Kind of institution (co/single)	Type of job	Income	Other

(1.12) Parents details:

	Level of education	Work status	Type of job	Native place	Income	Other source of income
Father's						
Mother's						

(2) ROLE OF HELTH CARE PROVIDERS: -

(2.1) Generally your patients come from which locality: - (Please mark)

Slum	1
SFS	2
MIG	3
LIG	4
Others	5

(2.2) Did you want to become a doctor?

Yes	1
No	2

If no then what you wanted to be?

(2.3) When did you first decide that you wanted to study medicine? (Approximate age when took decision for)

(2.4) What were reasons mainly made you to study medicine? (Please rank the reasons which are applicable to you)

a) Always wanted to be a doctor
b) Wanted to help people / work with people
c) Better career prospect
d) Good at science subject
e) Influenced by relative/ friends

f) Suggested by school
g) Experience of illness
h) Better economic and job prospects

Any other reason/s – specify _____

(2.5) Who motivated you the most to join this field?

Parents	1
Friends	2
Relatives	3
Self motivated	4
Not planed	5
Others specify	6

(2.6) Were there any family members/significant others medically qualified?

Yes	1
No	2

If yes, kindly record the details (who?)

(2.7) Did this influence you in any way in your decision to study medicine?
Record comments: -

(2.8) When you first entered medical school what did you think you would do after qualifying as a doctor?

Own Practice	1
Govt. service	2
Go abroad	3
Other (specify)	4

(2.9) When you qualified as a doctor, did you think same as earlier?

Yes	1
No	2

(2.10) What was the most important factor in your time at medical school, which made you change/stable your mind by the time you qualified?

Always had wanted to do that	1
Parental influence	2
Marriage constraints	3
Wanted to work closely with people	4

Any other reason(s): -

(2.11) What do you perceive as your duty being a doctor:

(2.12) Do you, perform your duty as expected: -

Yes 1
No 2

Reason(s): -

(2.13) Are you satisfied with your expected and performed role_____

Yes 1

No 2

Give details: _____

(2.14) What are the motivating factors to perform your role_____

Money	1
Professional ethics	2
Patients suffering	3
Social Responsibility	4
Other Specify	5

(2.15) What is the most important factor in your opinion in obtaining the health care services:

Factor	Rank
Educational status Income Occupation Caste Sex Native place	

(2.16) Do you think that there is any difference in the treatment of low social class and high social class patients by medical/ professional: -

Yes	1
No	2
Do not Know	3

Reasons:

(2.17) Do you think that there is any difference in the treatment in rural area where caste is more influencing factor?

Yes	1
No	2
Don't know	3

Reasons:

(2.18) When do you recommend Pathological diagnosis for your patient?

After initial medication	1
After poor/no response to prior medication	2
More diagnosis—good treatment	3

(2.19) In which cases do you use diagnosis/pathologic test:-

Very severe	1
Moderate severe	2
Low severe	3
Illness history	4
Other	5

(2.20) What are your considerations about the patient while recommending pathological-diagnosis, other than the ill heath?

Factor	Rank
Economic status	
Occupation	
Sex	
Residential status	
Age	
Caste	
Religion	

(2.21) Do you think technological development and its intervention in the health care under mine the ability of doctors:

Yes	1
No	2
Do not know	3

(2.22) Do you think intervention increased the cost of cure: -
If yes, in what way-

(2.23) What effect do you think it has?

(2.24) Do you think the test you recommend for your patients, are always necessary?
(Can they be done without?)

(2.25) Do you think that studying as resident scholar/a boarder/hostel or during your medical course kept you away from family responsibility

Yes-1
No-2

Reason:

(2.26) Did you miss any family marriage/party or important event during your study?

Yes- 1

No- 2

If yes what was/ were it—

(2.26) Do you face any obligation for not attending such social events
Yes-1
No –2

If no, why (give details)?

(3) NATIONAL HEALH SERVICES:

(3.1) Have you ever-participated in NHP?
Yes-1
No-2

In which programmed, and how many times?

Programs	No. Of times participated	Year
Family planning		
Polio drops		
Eye check-up		
Others (specify)		

(3.2) Why did you participate: -

(3.3) As you may be aware of the debate over the Registered Medical Practitioner, do you think their services should be banned: -

Yes	1
No	2
Don't know	3

(3.4) Why do you think so?

(3.5) Where do you generally refer your patients:-

Safderjung hospital	1
AIIMS	2
Nursing home	3
Nearest govt. hospital	4
Others	5

(3.6) Why do you refer there: -

APPENDIX-II

The Hippocratic Oath

(5th Century BC)

It is not certain that the Hippocratic Oath was written by Hippocrates but it was probably written during his lifetime. The earliest surviving references to this Oath date from the 1st century AD. These suggested that the Oath was seen as an ideal rather than a norm and it was not until the 4th century that it was an obligatory requirement for the doctor to take the oath before practising.

The Hippocratic Oath

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgement this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art - if they desire to learn it - without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgement; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favour of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.

If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

Source: Ethical codes and declarations relevant to the health professionals, Amnesty International, 2001.

APPENDIX-III

DELHI AT A GLANCE

POPULATION			
1.	Population		9,370,475
2.	Decennial Growth Rate (%) 1981-91		50.46
3.	Area (Sq.Kms.)		1,483
4.	Density of Population, 1991(per sq.km.)		6,319
5.	Percentage of urban population to total population (1991)		89.93
6.	Sex ratio (Number of females to 1000 males) 1991		830
VITAL RATES			
7.	Crude birth rate per thousand population 1990		29.48
8.	Crude birth rate per thousand population 1990		6.36
9.	Natural growth rate per thousand population 1990		23.12
10.	Infant Mortality Rate (1990) (per 1000 live births)		32.66
11.	Immigration rate per thousand population (1981-91)		27.52
SOCIO-ECONOMIC			
12.	Per capita income (1989-90)		
i)	At current prices (Rs.)		9,709
ii)	At constant prices,1980-81(Rs.)		4,902
13.	Literacy rates (%)		
		1991	1981
	Persons	76.09	61.09
	Male	82.63	68.40
	Female	68.01	53.07
D. MEDICAL FACILITIES			
14.	No. of medical colleges (Allopathy)		4
15.	No. of hospitals (1991)		81
16.	No. of dispensaries (1991)		653
17.	No. of registered nursing homes (1991)		107
18.	No. of beds (1991)		20,636
19.	No. of doctors (1990)		3,196
20.	Area served per hospital (sq.kms.)		18.30
21.	Area served per dispensary(sq.kms.)		2.27
22.	Population served per hospital		115,700
22a.	Population served per hospital and nursing home		49,843
23.	Population served per dispensary		14,350
24.	Hospital beds per 1000 population		2.20
25.	Population served per doctor		2,833
26.	Total expenditure 1991-92 (Rs. in lakhs)		81,915
27.	Expenditure on health-1991-92 (Rs in lakhs)		4,936
28.	Percentage on health (1991-92)		6.0
29.	Per capita expenditure on health 1991-92(Rs)		50.73

Source: Delhi: A tale of two cities, VHAI, 1993.

APPENDIX-IV

DEMOGRAPHIC INDICATOR

Sl. No.	State/UT	Population (in 000) 1991 Census	Annual Exponential Growth Rate(%)		Literacy Rate % Female (7 yrs & above)		Sex Ratio	C.B.R.	C.D.R.	Natural increase (CBR-CDR)	I.M.R.		T.F.R.	Mean age at effective marriage (female)	Singulate Mean age of marriage (female)	CPR(%) 31.3.97 (Prov.)
			1981-91	1971-81	1991	1981	1991	1996	1996	1996	1996		1994	1994	1981	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)		(12)	(13)	(14)	(15)
					#	$		#	#	#	#		#		$	
	INDIA	846303	2.14	2.22	39.30	29.80	927	27.4	8.9	18.5	72		3.5	19.4	18.33	45.4
I.	MAJOR STATES															
	1 Andhra Pr.	66508	2.17	2.10	32.72	24.16	972	22.7	8.3	14.4	66		2.7	17.8	17.26	46.9
	2 Assam	22414	2.17	2.12	43.03	NA	923	27.7	9.5	18.2	75		3.8	19.4	NA	19.1
	3 Bihar	86374	2.11	2.17	21.89	16.51	911	32.1	10.2	21.9	72		4.6	18.6	16.55	21.1
	4 Gujarat	41310	1.92	2.46	48.64	38.46	934	25.5	7.6	17.9	62		3.1	20.4	19.52	57.4
	5 Haryana	16464	2.42	2.55	40.47	26.8	865	28.8	8.1	20.7	68		3.7	19.2	17.84	53.9
	6 Karnataka	44977	1.92	2.39	44.34	33.16	960	23.0	7.6	15.4	53		2.8	19.4	19.21	55.6
	7 Kerala	29098	1.34	1.77	86.17	75.65	1036	17.8	6.2	11.6	13		1.7	22.3	21.82	46.7
	8 Madhya Pr.	66181	2.38	2.27	28.85	18.99	931	32.4	11.1	21.3	97		4.2	18.8	16.56	47.4
	9 Maharashtra	78937	2.29	2.21	52.32	41.01	934	23.2	7.4	15.8	48		2.9	19.1	18.77	51.0
	10 Orissa	31660	1.83	1.85	34.68	25.14	971	26.8	10.7	16.1	95		3.3	19.5	19.08	39.5
	11 Punjab	20182	1.89	2.16	50.41	39.64	882	23.5	7.5	16	52		2.9	20.3	21.07	76.9
	12 Rajasthan	44006	2.50	2.87	20.44	13.99	910	32.3	9.1	23.2	86		4.5	18.4	16.10	32.6
	13 Tamil Nadu	55859	1.43	1.63	51.33	40.43	974	19.2	7.9	11.3	54		2.1	20.2	20.25	51.7
	14 Uttar Pr.	139112	2.27	2.29	25.31	17.18	879	34.0	10.2	23.8	85		5.1	19.5	16.71	37.2
	15 West Bengal	68078	2.21	2.10	46.56	36.07	917	22.8	7.8	15	55		3.0	19.5	19.23	34.2
II.	SMALLER STATES															
	1 Arunachal Pr.	865	3.14	3.04	29.69	14.01	859	21.9	5.6	16.3	61	**	NA	NA	NA	12.1
	2 Delhi	9421	4.15	4.29	66.99	62.57	827	21.2	5.4	15.8	39	**	NA	NA	NA	33.9
	3 Goa	1170	1.49	2.37	67.09	55.17	967	14.1	5.8	8.3	13	**	NA	NA	NA	32.9
	4 Himachal Pr.	5171	1.89	2.15	52.13	37.72	976	23.0	8.0	15	62		2.9	20.4	** NA	55.3
	5 J&K	7719	2.54	2.58	NA	19.55	NA	NA	NA	NA	NA		NA	NA	NA	17.6
	6 Manipur	1837	2.57	2.83	47.60	34.61	958	19.4	5.7	13.7	27	**	NA	NA	NA	23.7
	7 Meghalaya	1775	2.84	2.80	44.85	37.15	955	30.4	8.9	21.5	45	**	NA	NA	NA	4.0
	8 Mizoram	690	3.34	3.99	78.60	68.60	921	NA	NA	NA	NA		NA	NA	NA	44.2
	9 Nagaland	1209	4.45	4.09	54.75	40.28	886	NA	NA	NA	6	**	NA	NA	NA	8.1
	10 Sikkim	406	2.51	4.14	46.69	27.35	878	29.0	6.5	13.5	47	**	NA	NA	NA	23.7
	11 Tripura	2757	2.95	2.79	49.65	38.01	945	18.3	6.5	11.8	45	**	NA	NA	NA	26.3
III.	UNION TERRITORIES															
	1 A&N Islands	281	3.97	4.98	65.46	53.15	818	17.30	2.6	14.7	32	**	NA	NA	NA	40.9
	2 Chandigarh	642	3.51	5.67	72.34	69.31	790	16.9	4.1	12.8	44	**	NA	NA	NA	38.3
	3 D&N Haveli	138	2.89	3.38	26.98	20.38	952	28.9	9.2	19.7	78	**	NA	NA	NA	35.6
	4 Daman & Diu	102	2.52	2.32	59.40	46.51	969	21.0	9.0	12	36	**	NA	NA	NA	36.8
	5 Lakshadweep	52	2.51	2.37	72.89	55.32	943	23.8	6.3	17.5	36	**	NA	NA	NA	9.6
	6 Pondicherry	808	2.90	2.50	65.63	53.03	979	18.0	6.8	11.2	25	**	NA	NA	NA	65.7

Sex ratio - Females per 1000 males

Source: Col. 2 to 7 - 1991 census: Col. 8 to 13 - SRS Estimates: Col. 14 - 1981 Census: Col.15-Deptt. of FW

#: Excludes J&K and Mizoram $: Excludes Assam: **: for 1993

NA : Not Available *:Three years moving average(1993-95)

Source: Ninth five year plan, India