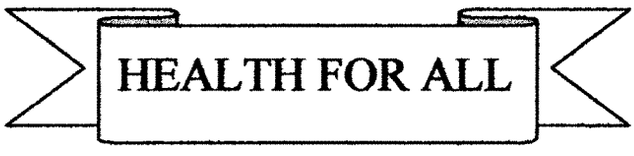
HEALTH FOR ALL

CHAPTER-1

(A) HEALTH FOR ALL

1.1 Physical Dimension

1.2 Social Dimension

1.3 Well – Being

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1.5 Level of Living

1.6 Quality of Life

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A) HEALTH FOR ALL

As the days are passing away it is becoming basic need of an individual to have easily accessible promotive, ~~pre~~-preventive and curative health services. For this, it is essential to have centrally placed, well equipped hospitals and along with that qualified Doctors, and Nurses and other staff.

Health has been viewed differently by different people. Biochemical, Scientists, Ecologists, Sociologists, Anthropologist. They described human health from different angles such as natural condition, as his birth right and as result of living in accordance with the natural laws pertaining to the body, mind and environment. (1)

These natural Laws relate to fresh air, sunlight, good diet, exercise, rest and relaxations, sleep and cleanness, alimination, right attitudes good habits and above all natural life style. People are encouraged to depend on drugs and tonics for maintenance of their health and prevention of disease. Our hospitals are flooded with the sick both.

Physically as well as mentally but still there are very few institution where people are guided towards proper health education.

Our ignorance about health continues to be profound. There is no single criterion which gives a definite measure about health. There is no standard approach towards health and health did not occupies and important place because of their needs. Like wealth, power, prestige, security and were considered more important during the first world war. The world health become the accepted concept at international level. Now during the past few decades, there has been reawaking that health is a basic human right and quality of life that is to be attained by all people. So in 1977, 30th World Health Assembly decided that the main social target of government and world health organisation in the coming decades should be.

"The attainment by all citizens in the world by the year 2000 A.D. of level of health that will permit them to lead a socially & economically productive life".

Health has been traditionally defined as absence of disease as deviation from normal things. The medical profession quence of the breakdown of such machine and it is one of the doctors task to repair of this machine.

The widely accepted definition of health is that given by the World Health Organization, 1948 [WHO]. [2]

"Health is a state of complete physical, mental and social well-being and not merely an absence of disease."

In recent years, we have acquired a new philosophy of health, which may be stated as below:

1) Health is a fundamental human right.
2) Health is the essence of productive life and not the result of ever increasing expenditure on medical care.
3) Health is an integral part of development.
4) Health is central to the concept of quality of life.
5) Health involves individual state and international responsibility.
6) Health and its maintenance is a major social investment.
7) Health is world-wide social goal.

1.1 PHYSICAL DIMENSION :

Physical dimension means a good complexion, a clean skin, bright eyes, not too fat, a sweet breath, a good appetite, sound sleep etc.

Mental health is not merely absence of mental illness, good mental health is the ability to respond to the many varied experiences of life with flexibility and a sense of purpose. More recently mental health has been defined as "a state of balance between the individual and the surrounding world a state of harmony between oneself and others a co-existence between the realities of the self and that of other people and that of the environment.

1.2 SOCIAL DIMENSION :

Social health takes into account that every individual is part of the family and of wider community. It focuses on social and economic conditions and well being of the whole person in the context of his social network.

1.3 WELL – BEING :

The concept of well – being used in the definition of World Health Organization's means standard of living , the level of living & quality of life.

1.4 STANDARD OF LIVING :

The term standard of living refers to the usual scale of our expenditure on food we consume, and the services we enjoy; it includes the level of education employment, dress, house etc.

Definition of standard of living by WHO : → "Income and occupation, standards of housing, sanitation and nutrition, the level of provisions of health, educational, recreational and other services may be used individually as measures of socio–economic status, and collectively as an index of the standard of living."

There are vast inequalities in the standards of living of the people in different countries of the world. The differences are usually measured through the comparison of per capital income on which the standards of living of people primarily depends.

1.5 LEVEL OF LIVING :

The parallel term of standard of living used in united nations documents is "level of living". It consists of Nine Components Health, food consumption, education, occupation and working condition, housing, social security, clothing, recreation and leisure and human rights. These characteristics are believed to influence human well being. It is considered that health is the most important component of the level of living because its impairment always means impairment of the level of living.

1.6 QUALITY OF LIFE :

Quality of life means happiness, satisfaction and gratification as it is experienced in such life concerns as health, marriage, family, work financial

situation, educational opportunities, self – esteem, creativity, belongingness and trust in others.

People are now demanding a better quality of life. Therefore governments all over the world are increasingly concerned about improving the quality of life of their people by reducing morbidity and mortality. Providing primary health care and enhancing physical, mental and social well being. Improvement of quality of life must be added.

1.7 HEALTH – SERVICE PHILOSOPHIES :

HEALTH – CARE :

Health care includes medical care. The medical care refers chiefly to those personal services that are provided directly by physicians. Health care has many characteristics :

1. Appropriateness - i.e. whether the service is needed at all in relation to essential human needs.
2. Comprehensiveness – i.e. whether there is an optimum mix of preventive curative and promotional services.
3. Adequacy – i.e. whether the service is proportionate to requirement.
4. Availability – i.e. Doctor population ratio.
5. Accessibility – i.e. this may be geographic accessibility, economic accessibility or cultural accessibility.
6. Affordability – i.e. the cost of health care should be within the means of the individual.
7. Feasibility – i.e. operational efficiency of certain procedures, logistic support, manpower and material resources.

1.8 NUTRITION AND HEALTH :

Nutrition may be defined as the science of food and its relationship to health. It is concerned primarily with the part played by nutrients in the development growth and maintenance of the body. The world food factor is used for specific dietary elements such as proteins, vitamins and minerals. Good nutrition means maintaining a nutritional status that enable us to grow

well and enjoy good health. Our concern with community aspects of nutrition has five sections, dietary constituents, nutritional requirements assessment of nutritional status, nutritional problems in public health and nutritional programmes in India.

There are many nutrition problem which affect the health. These are –

1. Low birth weight
2. Protein energy malnutrition.
3. Xerophthalmia.
4. Nutritional anaemia
5. Iodine deficiency disorders
6. Endemic fluorisis.
7. Lathyrism.

The government of India have large scale supplementary feeding programmes, and programmes aimed at specific deficiency diseases through various Ministries to combat malnutrition.

NUTRITION PROGRAMMES IN INDIA

PROGRAMME	*MINISTRY*
1. Vitamin a Prophylaxis Programme.	Ministry of Health and family welfare.
2. Prophylaxis against Nutritional anaemia.	Ministry of Health and family welfare.
3. Iodine deficiency disorders control programme.	Ministry of Health and family welfare.
4. Special Nutrition Programme	Ministry of social welfare.
5. Balwadi Nutrition programme.	Ministry of social welfare.
6. ICDS Programme	Ministry of social welfare.
7. Midday meal programme	Ministry of Education.

1. **VITAMIN A PROPHYLAXIS PROGRAMMES :**

This is national programme to control blindness.

2. **PROPHYLAXIS AGAINST NUTRITIONAL ANAEMIA :**

The programme consists of distribution of iron and folic acid.

3. **CONTROL OF IODINE DEFICIENCY :**

This programme is national level goitre control programme.

4. **SPECIAL NUTRITIONAL PROGRAMME :**

This programme was started in 1970. For the nutritional benefit of children below 6 years of age, pregnant and lactarating mothers. This programme is in operation in urban slums, tribal areas, and backward rural areas. The supplementary food supplies, about 300 kcal and 10.12 grams of protein per child per day.

5. **BALWADI NUTRITION PROGRAMME :**

The programme is implemented through Balwadi's which also provide prepartory education to children between the age of 3 – 6 years. This programme is operated by Voluntary Organization. Which receive the funds.

6. **INTEGRATED CHILD DEVELOPMENT SERVICE :**

The workers of village who deliver the services are called Anganwadi worker. Each Anganwadi cover a population of about 1000. A network of mahila mandals has been built up in Integrated Child Development Service (ICDS) project areas to help Anganwadi workers in providing health and nutrition.

7. **MID – DAY MEAL PROGRAMME :**

This programme is known as school lunch programme.

BALANCED DIETS CHARTS

[The quantities are given in grams]

	Food Item	Adult Man			Adult Women			Children		Boys	Girls
		Sedentary	Moderate work	Heavy work	Sedentary	Moderate work	Heavy work	1-3 years	4-6 years	10-12 years	10-12 years
1.	Cereals	460	520	670	410	440	575	175	270	420	380
2.	Pulses	40	50	60	40	45	50	35	35	45	45
3.	Leafy Vegetables	40	40	40	10	100	50	40	50	50	50
4.	Other Vegetables	60	70	80	40	40	100	20	30	50	50
5.	Roots and Tubers	50	60	80	50	50	60	10	20	30	30
6.	Milk	150	200	250	100	150	200	300	250	250	250
7.	Oils and fats	10	15	65	20	25	40	15	25	40	35
8.	Sugar or Juggery	30	35	55	20	20	40	30	40	45	45

1.9 ENVIRONMENT AND HEALTH :

A number of factors in the environment e.g. food, water, housing, clothing, sanitation affect the health. These controllable factors are those included in the standard of living. It is control at these factors that has been responsible for considerable improvement in the health of the people during the past century in the developed countries. However man's mastery over his environment is not complete. As old problems are being solved new problems are arising. Air pollution is of growing concern in many urban centre. Industrial growth has given rise to the problem of environment pollution by industrials wasters. Advance in nuclear technology have produced the problem of radio – active pollution of the environment. The demographic growth and fast urbanization all over the world are bring profound social and environmental changes. Proper environmental health now requires the services of the public health qualified doctors, the public health engineers, the town planners, the sociologists, the economists and the health inspectors. A purely Medical or Engineering approach by itself is no longer sufficient. A combined multi – disciplinary programme of action is needed to achieve a healthy environment.

India is still much of in the ill health among the underdeveloped countries. It is largely due to lack of safe drinking water. In India 80% of population in rural areas had no adequate access to potable water and 20% of the urban population had reasonable access to safe water. There is shortage of funds and trained manpower, weakness in national programmes, difficulties in system operation and maintenance and insufficient involvement of users. The W.H.O today is committed to participating in the global effort to attain the target adopted in the 1976 U.N. conference on Human Settlements that is to have "Water for All" by 1990.

1.10 VENTILATION :

The modern concept of ventilation implies not only the replacement of vitiated air by a supply of fresh outdoor air, but also control of the quality

of incoming air with regard to its temperature, humidity and purity with a view to provide a thermal environments, that is comfortable and free from risk of infection.

1.11 HOUSING :

Housing in the modern concept includes not only the physical structure providing shelter, but also the immediate surroundings and the related community services and facilities.

'Human Settlement' is defined as all places in which a group of people reside and pursue their life goals. The size of the settlement may very from a single family to millions of people.

The basic principles of healthful housing published by the American public Health Association are

1. Healthful Housing provides physical protection and shelter.
2. Provides adequately for cooking eating, washing and excretory function.
3. Provides for protection from hazards of exposure to noise and pollution.
4. It is free from unsafe physical arrangements due to construction or maintenance and from toxic or harmful materials.
5. It is designed, constructed, maintained and used in a manner such as to prevent the spread of communicable diseases.
6. Encourages personal and community development, promotes social relationships, reflects a regard for ecological principals and by these means promotes mental health. Housing is part of the total environment of man and being a part it is responsible for the status of man's health and wellbeing.

1.12 HEALTH CARE OF THE COMMUNITY :

Health is fundamental human right. The state of resposibility for the health of the people. The health service is that –

a. Predominately urban oriented.
b. Mostly curative in nature
c. Accessible mainly to a small part of the population.

Developed countries and developing countries have not yet reached the whole

population with adequate health care services they are also yet to secure an acceptable level of health for all by the year 2000 A.D. through the application of primary health care programmes.

PRIMARY HEALTH CARE IN INDIA :

In 1977 the Government of India launched Rural Health Scheme based on the principle of placing people's health in people's hands. It is three tier system of health care. It is based on the recommendations of the Shrivastav Committee of 1975. The brief details of the scheme are as follow.

1. **Village Level :**

At the village level three schemes are in operation.

A) Village health Guides scheme: This scheme was introduced on 2nd october, 1977. The scheme was launched in all states except Kerala, Karnataka, Tamil Nadu, Arunachal Pradesh, and Jammu & Kashmir, which was alternative system that is mini – health centres in Tamil Nadu of providing health services at the village level.

B) Local Dais : Most deliveries in rural areas are still handled by untrained dais, who are often the only people immediately available to woman during the delivery period. This programme has been undertaken under the Rural Health Scheme, to train all categories of local dais to improve their knowledge about taking care mother and child. The training is for 30 working Days. Each Day is paid stipend of Rs. 300/- during the training

worker is selected from the community, she is expected to serve. She undergoes training in various aspects of health, nutrition and child development for 4 months, she is part time workers and is paid 250 per month.

2. **SUB CENTRE LEVEL :**

The sub – centre is the outpost of the existing health delivery system in rural areas. This level is established in 5000 / 3000 population in hilly, tribal and backward area. In this centre, one male and one female workers are provided.

3. **PRIMARY HEALTH CENTRE LEVEL :**

In January 1953, the establishment of primary health centre in community development was undertaken to provide adequate health care to the rural population. Hospital, apart from the primary health centre the present organization of health services by the government sector consists of rural hospitals, sub-divisional/ tehisil / taluka hospitals, district hospital specialist and teaching institution.

4. **COMMUNITY HEALTH CENTRE :**

The community health centre covering a population of 1,00,000 with 30 beds and specialists in surgery, medicine obstetrics and Gynecology and pediatrics with x-ray and laboratory facilities, for preventive and promotive health care.

VOLUNTARY HEALTH AGENCIES IN INDIA :

1) <u>INDIAN RED – CROSS SOCIETY</u> :

The Red-Cross Society was established in 1920. It has a network of over 400 branches all over India. The programmes are undertaken for the promotion of health, prevention of disease and mitigation of suffering the people. Its activities are :-

(1) Relief Work –

(a) Milk and Medical supplies.

(b) Armed forces.

(c) Maternal and Child Welfare Services.

(d) Family Planning.

(e) Blood Bank and First – Aid.

(f) When disaster strikes any part of country like earth-quake, floods drought epidemics etc. The Red-Cross Society immediately mobilises all its resources and goes to the rescue of the affected people.

In additional to the above agency, there are few other agencies who also engage in giving health services to the people. They are listed below.

1. The Hind Kust Nivaran Sangh.
2. Indian Council for Child Welfare.
3. Tuberculosis Association of India.
4. Bharat Sevak Samaj.
5. Central Social Welfare Board.
6. The Kasturba Memorial Fund.
7. Family Planning Association of India.
8. All India Women's Conference.
9. The All India Blind Relief Society.
10. International Agencies →

The Rockfeler Foundation Ford, Foundation and Care.

(Cooperative for American Relief everywhere) are examples of voluntary international health agencies.

(B) RESEARCH DESIGN :

The medical services are one of the basic requirements of the people. Health services constitute basic needs of the society. In our country medical and health services are not provided adequately and regularly. This causes prolonging of illness many a times calamiting into death. Even dietary aspects of health care is neglected to the extent of causing malnutrition. Health care needs to be practised from the very beginning of pregnancy and due care must be taken of the newly born ones. This alone is the key to the healthy citizens and healthy society. Environmental hygine, personal hygine must be the integral part of the life of the people.

With galloping increases in population and inadequate number of medicine the medical services that people receive are not only less in quantity but also poor in quality. Quantum of medical services can be augmented by increasing the number of centre training medical people and paramedical people. That is being taken care of by planning medical education, quality of medical services depends upon education training, devotion and attitude of the persons professing medical services. Skills that are acquired during the course of education and improved by training and sharpened by experience determine the level of quality of services rendered to the patients in particular and society in general. Medical skills of the doctors and of nursing and supporting staff determine the quality of medical services rendered at the centre. On this backdrop, the present study attempts to examine the occupational proficiency of doctors and of personnel and its impact on the patients.

1.13 STATEMENT OF THE PROBLEM :

The study attempts to assess the occupational proficiency of medical Personnel. In the other part an effort is made, to assess the quality of medical services as felt by the patients.

1.14 AREA AND SCOPE OF THE STUDY :

Present study is exploratory in nature. It is a case study of a maternity hospital – "MATRU MANDIR HOSPITAL, MIRAJ". The study covers all doctors, nurses, technicians in the said hospital. this particular hospital was chosen because it is owned and managed by my uncle and brother of researcher. This facilities may getting all information open heartily.

The first dimensional deals with assessing the occupational proficiency of doctor, nurses, and the technicians of the hospital. For this purpose an attempt is made to investigate the skill and the ability of the person.

The second dimensional study covers the sample of patients who were in the hospital during five years period between 1989-90 and 1994-95 were interviewed to assess the impact of the skill of hospital staff on them.

1.15 OBJECTIVES OF THE STUDY :

The survey is undertaken to study –

1. The organization and working of MATRU MANDIR HOSPITAL to understand the quantity and quality dimensions of the staff of the hospital.
2. The various categories of hospital staff, and profile of the staff to prepare an inventory of skill acquired during education and enhanced by attending seminars, conferences , workshop etc.
3. The opinions of patients about the standard of medical services received by them and general impressions about the hospital.

1.16 METHODOLOGY :

The study is carried out with the help of surveys. Data regarding hospital, number of patients is collected from records of the hospital and therefore, it is secondary in nature. This data is supportive.

Main data is generated by conducting surveys. With a view to understand the skills acquired by doctors a questionnaire was prepared and

canvassed personally. The skills of nursing and technical staff are likewise enumerated by administering a different schedule prepared for the purpose. A third schedule was structured to collect the opinions, and impressions of the patients. Copies of all the three questionnaires are collected at the end. All the three surveys were conducted personally, observation of surrounding facts has also helped in data collection.

There are three doctors attending the hospital and all the three are included in the first survey. Hospital is manned by four nurses, one compounder and one technician. And staff for sanitation purpose.

Names and address of patients who took treatment in the hospital during the span of five years between 1989-90 and 1994-95 were taken from the record of the hospital.

The responses in interviews – doctors, nurses, technician and patients are reproduced in chapter IV respectively with view to maintain authenticity and favour of the information.

Information regarding number of patients and fees charged to them in January, 1989.in the second part a summary of number of patients treated in hospital during 1989-90 and 1993-94 is also given. Hospital schedule is also given.

1.17 OBSTRETICS AND GYANECOLOGY :

Patients enumerated as below:

In January, 1989/

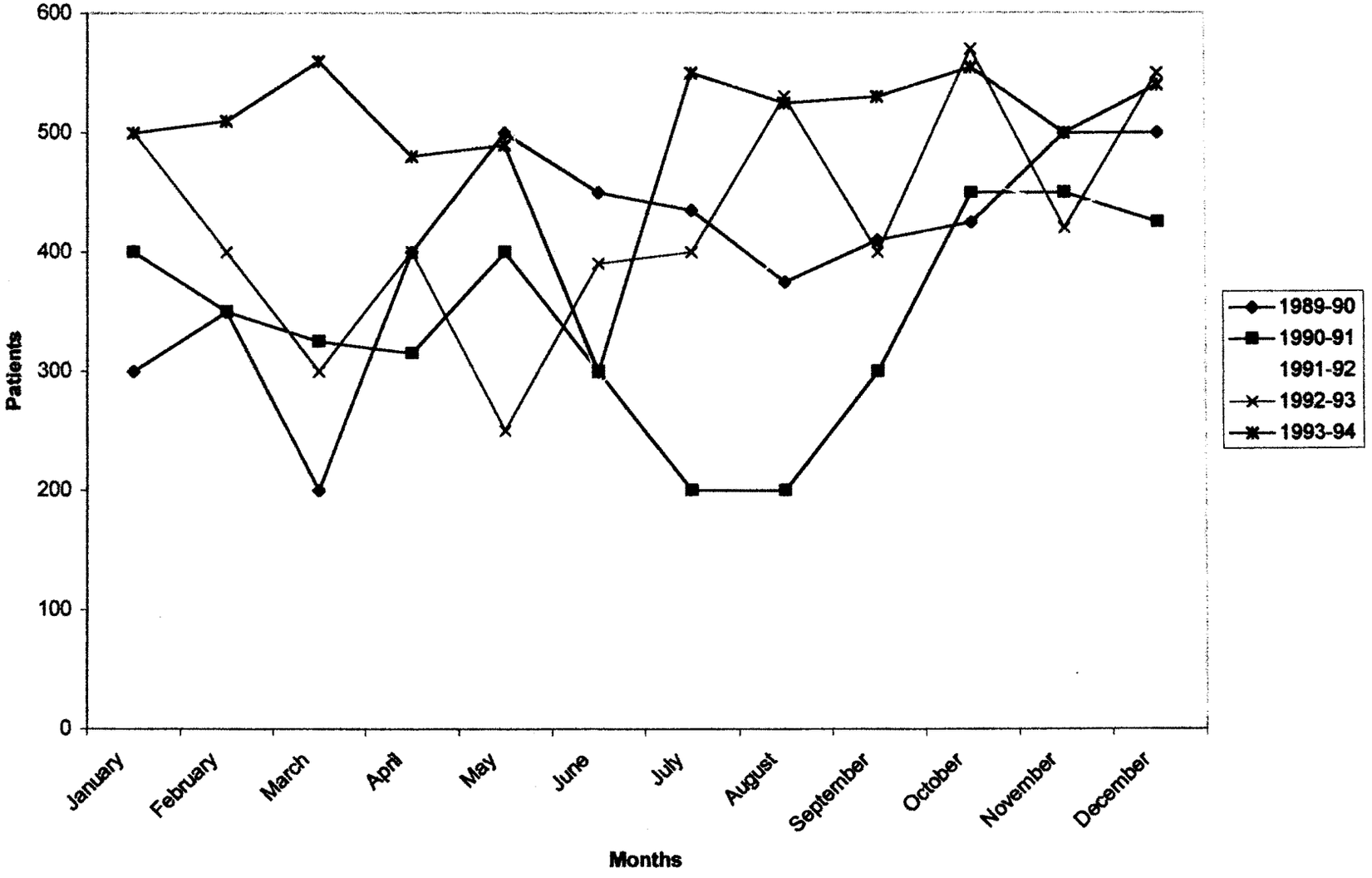
Patient	Day cases	Charges RS.
O.P.D.	30 patients	60
	Indoor	
	10 patients	
Sonography	3	100
Delivery	2	500 to 1,000
caeserian		

LSCS (Lower segment Caeserian Section)	15 per month	3,000
Hysterectomy	05 per month	4,000
M.T.P. (Medical Termination of Pregnancy)	25 per month	600
Laproscopy	10 per month	3,000
Tubectomy	5	1,500
	300 patient	1,26,200

Number of patients treated in the hospital during 1989-90 to 1993-94 is given below.

Month	1989-90	1990-91	1991-92	1992-93	1993-94
January	300	400	425	500	500
February	350	350	430	400	510
March	200	325	460	300	560
April	400	315	500	400	480
May	500	400	520	250	490
June	450	300	290	390	300
July	435	200	330	400	550
August	315	200	400	530	525
September	410	300	450	400	530
October	425	450	460	470	555
November	500	450	440	420	500
December	500	425	450	550	540
Total	4,845	4,115	5,155	5,010	6,040
Average	404	343	530	418	504

1.18 Patients Chart



Following are fixed days for different categories of patients.

Monday	for new patients priority
Tuesday	routine all patients
Wednesday	operation day
Thursday	for ANC patients
Friday	for family planning programme
Saturday	routine patients
Sunday	holiday + indoor patients

1.19 CHAPTER SCHEME :

First chapter entitled "HEALTH FOR ALL" traces importance of health care in its physical and mental dimensions. Health depends mainly upon nutrition. So nutrient food must provided from the very birth. Environmental aspects of health are also discussed. Maintaining health at individual level is not enough. That does not make the community healthy though community is constituted of individuals. Community as a whole must also take care of its health.

Second chapter presents profile of the hospital on the background of which the presents study is undertaken. Location of the hospital, layout and capacity of the hospital, management of the hospital, organization, communication, hospital information system, materials management, demand forecasting and finance of the hospital are the aspects discussed in detail. Outlines the research methodology of the study. It discusses statement of the problem, area and scope of the study, objectives of the study, methodology, patients intake and chapter scheme.

Third chapter discusses occupational proficiency of the doctor that cover medical, organizational, managerial and financial aspects.

Fourth chapter enumerated the completed question schedules of three doctors that look after the hospital. it gives us the skill inventory of the doctors and the methods adopted by them to update their skills.

The answers to the questionnaires given by three nurses and a technician are reproduced in fourth chapter. It gives us an in-depth understanding that not only occupational proficiency but organisational and managerial skills are imbibed during educational courses.

Reflections of patients are enumerated in the fourth chapter. The tabular representation of more important aspects of their opinions gives us a visual impression about their feelings. The patients covered are from different age group, different ailments so that gives us a cross section analysis of their opinions.

The last chapter draws conclusions from the discussion done in chapter III and V and puts fourth a few pragmatic suggestions to improve skill capabilities of doctors and supporting staff.

Then are given three questionnaires administered to doctors, supporting staff and patients.

At the end is given a bibliography of books referred to in the study.