KERALA MODEL FOR HEALTH CARE : FROM SUCCESS TO CRISIS

B. Ekbal

Medical College Hospital, Kottayam
India

Kerala is one of the smaller states in India, comprising about 1.2% of the country's total area and supporting around 3% of its population. Geographically it lies in the South West Coast of India. Kerala has a long sea coast and is therefore connected via trade links to many western influences.

The modern state of Kerala was formed in 1957 by the amalgamation of the princely states of Travancore, Cochin and the Malabar district of the Madras province. The state is generally classified as backward in terms of its poor industrial development and faltering production of food grain. In per capita income, it ranks as one of the poorest cities in India.

In spite of the economic backwardness Kerala has attained remarkable achievements in health, comparable to that of developed countries. This is evidenced by the widely accepted health indicators like Crude Death Rate, Infant Mortality Rate and Life Expectancy (Table 1).

Kerala's achievements in the health field has been seen as something of an enigma by most analysts. Kerala achieved this high health status on par with that of the USA, spending roughly 10 dollar (US) per capita per year (Table 2). Kerala's achievement, in spite of the economic backwardness and very low health spending, has prompted many analysts to talk about the Kerala Model of Health as being worth emulating by other developing parts of the world.

Kerala can be said to have made the transition from a society with a high population growth rate, high crude death rate and high infant mortality rate to one with a moderate population growth rate, low crude death rate and a relatively low infant mortality rate. That this has come about without major economic restructuring of the society, sets it apart as a model of what is possible, within severe constraints of development in the health sphere.

There are many socio-economic conditions unique to Kerala which have made this health model possible. Kerala has a highly literate population (which has crossed 90% by 1990) compared to other Indian states. The high level of female literacy has to be given due credit when we look for explanatory factors. All over the world indices such as infant mortality have shown an inverse relationship with female literacy.

It is also to be noted that Kerala has nurtured a political climate wherein the rights of the poor and under privileged have been upheld and fought for. This was the result of a fairly long period of struggle for social reforms which emphasised the dignity of people who were considered socially 'inferior' and which later found expression in the secular-rationalist movements culminating in nationalist and socialist movements. One common thrust of all such movements was on education and the organisation of the downtrodden people. Government departments in Kerala have also given high priority to social welfare sectors such as education and health.

The popularly elected Communist Government during it's tenure period 1957-1959 implemented agrarian reforms, thereby ending feudal relationships in agriculture and giving land to the tillers. This improved the social and living conditions of the landless poor in the rural areas. This might have contributed to alleviating poverty among the agricultural labourers leading to an improvement in their health status.

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

Apart from the socio-economic factors outlined above, the universally available public health system in Kerala has also contributed to the high health status of the people. Kerala has a three tier system of health care: the primary health care centres; Taluk and District intermediary hospitals and Medical Colleges with tertiary care centres, equally distributed both in the urban and the rural areas. Besides modern medicine, Ayurveda, Homeopathy and other alternative systems are very popular in Kerala.

The Kerala Model for Health, widely acclaimed by health analysts, has started showing a number of disturbing trends recently. Even though the mortality rate is low, the morbidity is high in Kerala compared to other states (Table 3), though there is a data gap in this regard. The NSS (1974) and KSSP (1987) studies confirmed these observations. Hence the KERALA Health situation was described as a 'low mortality high morbidity syndrome' (Panicker and Soman). It can be argued that when the expectancy of life increases there can be a corresponding increase in morbidity in terms of high incidence of cancer, heart disease, etc that affect the aged. However, in this regard the Kerala situation is peculiar in that the so called diseases of poverty like diarrhoea, hepatitis, etc are still prevalent in Kerala (Table 4). Hence the Kerala Health situation can also be described as 'low mortality infectious disease syndrome' since such diseases are not seen in places where the health status quo is as good as that of Kerala. Moreover, many epidemics that were thought to have been eliminated from Kerala, like malaria are definitely staging a comeback. Also contemporary epidemics like Japanese encephalitis which did not occur in Kerala, except sporadically, has also started appearing, as well as the modern killer disease AIDS.

The Public Health System is becoming alienated from the people and only 30% of the people from the lower income group seek medical help from the Government hospitals (Table 5). This is as a result of the decline in the quality of the health care in government hospitals. Lack of political commitment, bureaucratic inefficiency, corruption at various levels and the deterioration of the ethical standard of the medical profession have contributed to the deplorable state of affairs. This environment of the perceived inefficiency of the government medical facilities provided the impetus for the growth of private medical care. The number of beds in the government institutions grew from around 36 000 to 38 000 in the ten year period from 1986 to 1996, whereas in the same period, beds in private institutions grew from 49 000 to 67 500. This amounts to nearly 40% growth in the private sector beds versus nearly 5.5% in the government sector. In the case of doctors about 5 000 doctors work in the government sector whereas double the number work in the private sector (Table 6). More significantly, the private sector have far outpaced the government facilities in the provision of sophisticated modalities of diagnosis and therapy, such as CT Scans, Endoscopy Units, MRI Scans etc.

The privatisation of medical care is leading to over medicalisation and escalation of health care costs (Table 7). A case in point is the growing tendency for submitting patients of the higher income groups for Caesarean Surgery (Table 8). The net result is the marginalisation of the poor and it is estimated that at least 30% of the people are denied health care or find it extremely difficult to meet the health expenditure.

The changing health scenario in Kerala has prompted analysts like the present author to comment that the Kerala Model of Health Care is slowly drifting towards an American Model of health care. The hallmarks of the Kerala Model were the low cost and universally accessible health care. This is changing to an American Model where the poor are denied health care in the face of escalation of health care cost because of privatisation.

The implementation of New Economic Policy by the government of India is further deepening the crisis in all fields of life including health care. As per the recommendation of the World Bank, user fees were introduced in government hospitals ostensibly to charge the rich in order to help the poor. This system of private practice has resulted in the internal privatisation of the public sector. Also, the

private sector is encouraged to enter into curative care and diagnostics with tax exemption. The public sector drug industry in Kerala is now earmarked for disinvestment and privatisation.

It should be understood that the crisis in the health sphere is not confined to that field alone. Even though the multifaceted character of the crisis encountering the state is widely noted, the focus of attention of the relevant debate and studies has rightly been on the sustained poor performance growth of the productive sectors of the economy. The crisis in the productive sector is manifested in the virtual stagnation of the agricultural sector, deplorable lower levels of productivity of important crops, growing apathy among cultivators, structural decay of the industrial sector dominated by the ailing traditional industries, rapid deterioration of the power situation over burdening the fragile ecosystem etc. The threats faced by other aspects of social life are also equally severe. For instance, the deterioration in the quality services offered by the crucial service sector, such as education, public distribution and transport along with public health has emerged as a major problem. Incidentally, free or subsidised provision of such basic necessities was instrumental in raising the standard of living of the people of the state to levels comparable to those of even developed countries. It needs to be added that the stagnation of the productive sectors has worsened the fiscal position of the state and made it incapable of making any effective intervention. More importantly the crisis has also tended to strengthen the neo-liberal arguments which blame the people and their organisations. The contemporary crisis has already started affecting the redistributive gains of the past, the standard of living of the people and the very ideology of the unique democratic project of modernisation.

The silver lining in this situation is the demands of the People's Science Movements like KSSP (Kerala Sastra Sahithya Parashad) for a People's Health Policy for Kerala and the initiatives taken by the State Planning Board for decentralised Planning involving the local bodies. KSSP feels that the toning up of the health care system in the state and making it capable of taking on the burden of providing equitable, efficient and good quality health care needs concerted action from the political parties and other social movements. Re-instating the primacy of the government health services, with its emphasis on primary health care should form the basis of the health policy for Kerala. There should be some amount of social control of the private sector.

While the modern medical system dominates both in terms of supply and demand as well as in terms of the government expenditure, people seem to prefer in some measure the indigenous systems of medicine (mainly Ayurvedic) for certain types of ailments. While the indigenous system of medicine of homeopathy cannot be expected to replace medicine as the dominant mode of care in any contemporary society, the fact that these are demanded by the people at some time or other, point to certain felt needs in health care which cannot be adequately addressed by modern medicine. Thus, there is a need to support and nurture alternate systems.

There is a growing demand for the effective administrative and financial decentralisation of the health sector to tide over the bureaucratic inefficiency of the system. It is in this context that the newly constituted Kerala State planning board, of which the author is a member, resolved in its first meeting to initiate a People's campaign to empower the Panchayats (local bodies) and the municipal bodies to draw up the Ninth Plan (1997-2002) schemes within their respective areas of responsibility. It is hoped that 35 to 40% of Ninth Plan will consist of schemes formulated and implemented from below. Based on the total literacy movement, the campaign seeks to motivate and bring together elected representatives, officials, experts and the voluntary activists together local level development activities. The campaign is systematically organised starting with the Gramasabhas (ward conventions) in which people's aspirations are aired. This is followed by development seminars where solutions are on offer to people's problems which are later projected and prioritised with the help of the experts and people's representatives. Finally preparation of the five year plan is undertaken.

The campaign assumes importance also from the point of view of the contemporary crisis of Kerala's widely acclaimed development model. The focus of mass movements, which has made the Kerala Model possible, has so far been on the question of equity in distribution of wealth and income. But it is increasingly evident that the pursuit of equity cannot be sustained in the absence of economic growth. The question whether the organised strength of mass movements and the democratic consciousness they have generated can be utilised to accelerate economic growth, therefore, is assuming critical importance in the present juncture. The People's Campaign for the Ninth Plan represents such an initiative to make use of the legacy of collective social intervention and the strength of mass movements to meet contemporary crisis in development including that in health.

Fortunately Panchayati Raj now provides the possibility for the people to demand the resources to operate a health service in which they will play a dominant role and of which they will be the chief beneficiaries. All infrastructure, manpower production, training, distribution, production of drugs and equipment must conform to achieve this, and not in reverse as it is at present. Only thus can a cost effective, human and accountable health service be provided which is funded and operated by Panchayat with technical assistance of the health professionals. The available public health resources can be augmented by those who can obtain far better services of their worth rather than spending on private curative service. This system involves the entire community, and especially women, in their own health, not only curative care, but even more so in health education, as well as the prevention and control of the diseases which originate in their own environment. They have the greatest interest in improving the conditions which affect them and their children. This would also be an impetus to contribute to the overall improvement of their community.

Let us take the example of the most common cause of morbidity, namely water-borne diseases such as diarrhoea, dysentery, worms, cholera, infectious hepatitis and typhoid. Ensuring adequate and safe water supply varies from village to village and is primarily the role of the local community such as cleaning of wells, repairing the hand pumps, drainage of stagnant water and sanitation. This would not only drastically reduce the need for medical attention but the people themselves are also the best functionaries for prompt treatment of conditions like dehydration by oral rehydration therapy (ORT). This would reduce the need and cost of professional medical care which can be restricted to the care of a few difficult problems.

The Planning Board is allocating about 40% of the plan's fund to the local bodies. As far as health is concerned this has opened up tremendous possibilities since the primary health centres and the intermediary hospitals are already handed over to the local bodies. If successful, along with the other fields participating in health, Kerala may be poised for a second revolution in health leading to a Decentralised Model of Health Care.

Table 1: Kerala - Health status

Indicators	Kerala	India	USA
CDR	6.3	10	7
CBR	17.7	29	17
IMR	11	79	8
Life Expectancy			
Male	66.8	57.7	73
Female	72.3	58.1	79

Table 2: Kerala - Government Health Expenditure (40% of Total Health Expenditure - per capita)

1985 -86	Rs. 46.27	(1.3 US$)
1990 -91	Rs. 76.52	(2.5 US$)
1994 -95	Rs. 130.06	(3.7 US$)

** Per Capita Health Expenditure: 10 US$*

Table 3: Kerala - Morbidity

	KERALA 1974	INDIA 1974	KERALA 1987
Acute diseases	71	22	206
Chronic diseases	83	21	136

Table 4: Kerala - Morbidity according to social status

DISEASE	GROUP 1	GROUP2	GROUP3	GROUP 4
Diarrhoea	34	23	18	11
Fever	141	123	108	88
Tuberculosis	11	7	4	2
Asthma	18	17	15	2
Diabetes	1	2	6	11
Heart Disease	3	5	5	6
Hypertension	6	9	16	22

Group 1 - Poorest
Group 4 - Richest

Table 5: Utilisation of health sectors

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

Group 1 - Poorest
Group 4 - Richest

Table 6: Kerala - government and private sector

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

Table 7: Health expenditure

Year	Consumer price index	Health expenditure
1991	100	100
1994	120	141

Table 8: Caesarean surgery

Total Delivery	11.9%
Group 1	9.3%
Group 2	12.0%
Group 3	11.3%
Group 4	19.3%

Group 1 - Poorest
Group 4 - Richest

References

1. Bhat Mari and Rajan. *Demographic Transition Kerala Economic and Political Weekly* September 1-8 and 15, 1990.
2. George KK. *Limits to Kerala Model of Development.* Trivandrum CDS 1993.
3. Government of Kerala. *Government Allopathic Medical Institutions.* Thiruvananthapuram.
4. Government of Kerala. *Health Profile of Kerala.* Trivandrum 1989.
5. Government of Kerala. *Report on the survey of private medical institutions in Kerala.* Thiruvananthapuram 1996.
6. Kannan KP, Ramankutty. *Health and Development in Rural Kerala.* KSSP. Trivandrum, 1991.
7. National Sample Survey. *Twenty Eighth Round.* New Dehli, 1974.
8. Panikar and Soman. *Health Status of Kerala, the Paradox of Economic Backwardness and Health Development.* Trivandrum CDS 1985.
9. Ramankutty. *Socio-economic factors in Child Health Status: A Kerala Village Study.* CDS 1987.