

A STUDY ON HEALTH AND FAMILY WELFARE IN TAMIL NADU

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ABSTRACT:

Health is one of the prime concerns of any nation because of the tremendous impact on the health of the people has on the economic development of a country. Health is an important entitlement that enhances capabilities of the masses. The study objectives are identify the trends in total health expenditure in Tamil Nadu. To examine the trends in health and family welfare. The constitution of the world health organization (WHO) defines health as, “a state of complete physical, mental and social well being and not merely the absence of disease or infirmity”. Tamil Nadu to spending expenditure on health and family welfare Rs. 53,070,158 and 15,935,978. This paper table displays data on total expenditure on health in Tamil Nadu from 2006-2016. The lowest value of Rs.14112.90 million is recorded in the year 2006 and the highest value of Rs.68670.20 millions.

Keywords: Tremendous, enhances, Health Expenditure and Family welfare.

INTRODUCTION:

Health is a state of physical, mental and social well-being. Health is maintained and improved not only through the advancement and application of health science, but also through the efforts and intelligent lifestyle choices of the individual and society. According to the world health organization, the main determinants of health include the social and economic environment, the physical environment and the person's individual characteristics and behaviors. A healthy mind and proper intellectual development will help proper manpower that is suitable for economic growth. On the other hand with greater economic growth, better health facilities are required and also possible environmental implications of development as well as the opportunities created for attaining health through better facilities. The need for health facilities for the growing population has recognized and there has also been a significant infrastructural development in the health sector. However, the high population growth rate has led to constraints and even contributed to the deterioration of the quality of health. Expenditure on health care had very little influence. Aims and objective of the family welfare programme first one to promote the adoption of the small family size norms, on the basis of voluntary acceptance, the second one is to enhance the use of spacing methods, and last but not least to ensure adequate supply of contraceptives to all eligible couples within the easy reach.

India launched the National Family Welfare Programme in 1951 with the objective of reducing the birth rate to the extent necessary to stabilize the population at level consistent with requirement of the National economy. The family welfare programme in India was recognized as a priority area, and being implemented as a 100 percent centrally sponsored programme. According to the tenth five-year plan (2002-2007) of Tamil Nadu, “Health for All” was the main objective of the plan. It focused on the improvement in the general health status of the population, better access to health care services, improved maternal and child health care, effective control, and prevention of communicable and non-communicable disease (tenth five-year plan- Tamil Nadu: 2002-2007). The important objectives of the health and family welfare sector in the state are to implement schemes for the prevention and control of communicable disease and noncommunicable diseases with special focus on newly emerging vector-

borne disease and lifestyle diseases. the programme had to be implemented as an integral part of "Family Welfare" relying solely on mass education and motivation. The name of the programme also was changed to Family Welfare from Family Planning.

One common objection to the WHO definition is, in effect, an assault upon any and all attempts to specify the meaning of very general concepts. Who can possibly define words as vague as "health," a venture as foolish as trying to define "peace," "justice," "happiness," and other systematically, ambiguous To this objection the "pragmatic" clinicians (as they often call themselves) add that, anyway, it is utterly unnecessary to know what "health" means in order to treat a patient running a high temperature. Not only that, but it is also a harmful distraction to clutter medical judgment with philosophical puzzles. Unfortunately for this line of argument, it is impossible to talk or think at all without employing general concepts; without them, cognition and language are impossible. It had been found out that public and private sectors together had spent 3.75 per cent of GDP in 1990-91. (ii) The share of private sector constituted about 56 per cent and the rest 44 per cent was accounted for by the public sector. According to National Family Health Survey 1998-99, there was five states in India, namely Goa, Himachal Pradesh, Karnataka, Kerala and Tamil Nadu those have achieved the below replacement level . of fertility. So these states were selected for detailed analysis in this study. The primary survey was also conducted among 386 currently married males between 20-39 age group to clarify some of the questions the secondary data analysis was able to answer, such as why certain sections are more among the acceptors, why the utilization of private health services are increasing, how the education levels influences the utilization. Of family welfare services across religion and different economic strata, etc

STATEMENT OF THE PROBLEM:

Health has been identified and accepted as an important factor in human development. The constitution of the world health organization (WHO) defines health as, "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity". Thus, the health of the community has to be viewed from a broad perspective than merely in terms of demographic indicators. The basic objective of any health care delivery system, therefore, would be to provide and organize the services in such a way that reaches to everyone and the available resources, knowledge, and technology are optimally utilized. In India, several policy initiatives have been taken into consideration from time to time in this direction to analysed on various aspects of the delivery of healthcare family welfare and accssibility but the present study focused on health and family welfare only.

METHODOLOGY:

The data is collected from the secondary data sources like the Reserve Bank of India data source. Simple Linear Regression model and Annual Growth Rate (AGR) are computed for this study.

OBJECTIVES OF THE STUDY:

The aim of this study is to evaluate the health status of the people of Tamil Nadu

1. To identify the trends in total health expenditure in Tamil Nadu
2. To examine the trends in public health and family welfare

REVIEW OF LITERATURE:

Jatinber bajaj (1999) attempted to study the knowledge and utilization of maternal and child health services available to women residing in the slums of south Delhi. Five slums suited near Ramakrishnanapuram in south Delhi were selected. Every tenth household in each slum was selected. The total sample households were 500. The findings of the survey were,

- i. 80 percent of women had availed themselves of care during pregnancy.
- ii. Awareness of free maternal and child health facilities was at 82 percent, but people prefer home delivery.

It is being increasingly realized that unless there is a significant improvement in the quality of maternal and child health (MCH) services, besides the widespread propagation of family planning methods, it is unlikely that there will be a decline in fertility concomitant with the improved health of the woman as well as her child. In recognition of this, the family welfare programme seeks to promote MCH as its primary object in its quest to achieve national demographic goals. Hence under basic maternal and child health care services, the mothers should be provided with ante-natal, natal and postnatal care, and infants and pre-school children should be monitored for their growth and development.

Karpagam1 (1981) examined some aspects of the theory of health economics and their application to the hospital. She stated that hospitals may be divided into two, special and general. Special hospitals deal with specific systems of the body such as eye, ear, nose, throat, etc., or certain special diseases like cancer, tuberculosis etc. General hospitals contain a range of special services. It provides treatment for men, women, and children suffering from many forms of illness except highly infectious and dangerous conditions such as smallpox, etc. For the provision of medical care to a community, the general hospital is a more useful institution. Besides these two, there are also private hospitals. They are managed by different groups, religious communities, societies, industrial undertakings etc. and run on a commercial basis. The Government hospitals provide services at lower costs or free of cost. A greater rush is for general hospitals rather than private ones. Hospital is having an outpatient and inpatient department. Inpatient services are provided in general wards, special wards, A, B, C Class wards. The charges differ based on the ward, where the patient undergoes the treatment.

Panikar and Soman (1984) attempted an analysis of the developments in health and non-health sectors leading to the improvement in Kerala's health status. They viewed that the health studies of a population are shaped by a variety of factors such as the level of income and standard of living, housing, sanitation, water supply, education, health consciousness, personal hygiene, and accessibility of medical care facilities. Kerala's achievements in health had attracted wide attention, particularly in the context of the global efforts to attain "Health for All by 2000 A.D." In the first chapter, authors narrated the history of Kerala right from the formation of Kerala in 1956, social organization and the caste system in Kerala, economic conditions of the people, health infrastructure and political setting in Kerala. The second chapter dealt with nutritional status in Kerala, birth rate, death rate, change in morbidity pattern and trends in mortality rates. The third chapter included development policies in Kerala, health strategy, non-health care sectors, namely agriculture, public distribution system, housing, water supply, sanitation, and education.

Ghai (1985) dealt with management of primary health care. This was the textbook on primary health care. It was useful to the students of preventive and social medicine. In this book, the author had discussed the exigency of increasing the efficiency of the health infrastructure and principles of management and delivery of services. The four components of primary health care were, (i) satisfying the immediate felt health needs of the people, (ii) problems of women and children, (iii) control of communicable diseases and (iv) referral services. At the primary health level, there was one medical officer, who was in charge of Primary Health Centre. There was one health nurse, and also an auxiliary nurse, midwife, health guides, community health worker and paramedical workers. At secondary health levels, referral cases from Primary Health Centres and other immediate cases are attended to by undergraduate basic doctors. At tertiary health level, specialist medical teachers and post-graduate doctors were employed. The medical college is attached to the general hospital.

Arvind Singhal (December 2015) to examined Utilization of health services is a complex behavioral phenomenon affected by multiple factors including availability, distance, cost, and quality of care as well as personal attitudes, cultural beliefs, and socio-economic characteristics. Mothers and children constitute a vulnerable group or special risk group in a community. This is more so with those residing in the slum where the access to and affordability of healthcare is compromised on account of various reasons. These slums have limited access to basic amenities and the same time living conditions are unhygienic. These unhygienic conditions propagate the number of diseases. Most of these causes of maternal deaths are well known and are largely preventable by increasing access to and utilization of available maternal health services. It is essential that all pregnant women have access to high-quality maternal health care throughout their pregnancies.

Table: 1**The growth of Total expenditure on health in Tamil Nadu from 2006-2016**

Year	Total expenditure on health (Rs. in Millions)	Annual growth rate
2006	14112.90	4.32
2007	15163.90	7.45
2008	20191.50	33.16
2009	28736.70	42.32
2010	37203.00	29.46
2011	37144.40	-0.16
2012	43863.80	18.09
2013	50784.90	15.78
2014	56293.00	10.85
2015	62633.20	11.26
2016	68670.20	9.64

Source: A Study of Budgets; Various issues by RBI, India.

Table 1 reveals that the total expenditure on health in Tamil Nadu from 2006-2016. The lowest value of Rs.14112.90 million is recorded in the year 2006 and the highest value of Rs.68670.20 million is registered in 2016 and which shows a continuous increase after the year 2006. The annual growth rate of total expenditure on health indicates the flow of government spending on health between the year 2009 and 2011 was 42.32 per cent and -0.16 per cent respectively. The government of Tamil Nadu had been declined above said period.

The table2**The trend in public health expenditure and family welfare**

Year	Public health expenditure	AGR(Public health expenditure)%	Family welfare	AGR(Family welfare)%
2006	130,972	13097100	24,225	2422400
2007	144,223	14422200	29,482	2948100
2008	189,506	18950500	39,343	3934200

2009	25,205	2520400	4,960	495900
2010	33,955	3395400	6,801	680000
2011	35,390	3538900	6,805	680400
2012	41,340	4133900	8,522	852100
2013	44,865	4486400	9,442	944100
2014	53,070	5306900	15,936	1593500
2015	3,305	330400	2,494	249300
2016	3,322	332100	1,105	110400

Source: State Finances: A Study of Budgets; various issues by RBI, India.

The above table 2 shows that the trend in public health and family welfare in Tamil Nadu during the period from 2006-2016. The lowest value of public health expenditure and family welfare Rs.3, 322 million and Rs.1, 105 is recorded in the year 2016 and the highest value of Rs.189, 506 million and Rs.39,343 million is registered in 2008 and it shows a continuous reduce the after the year 2008 public health expenditure and family welfare. These tables conclude that government of Tamil Nadu did not given more importance of family welfare because the whole amount transferred to census expenses.

CONCLUSION:

Family Welfare Programme is implemented as a people's programme involving the active co-operation of the community at large to improve Maternal and Child Health Services and thereby to stabilize the population growth. Tamil Nadu is the model State in the introduction of "Community Needs Assessment Approach" to all the States in the country. The success of the Family Welfare Programme in the State has been attributed to several factors including strong social and political commitments and good administrative backup. Health being the state subject in Tamil Nadu much depends on the ability of the state governments to allocate higher budgetary support to the health sector. This inter alia depends on what the current levels of spending are, what percent of income the states assume to spend on health and given the fundamental relationship between the income levels and the public expenditures. Family planning is the most important component of reproductive health services that can make the maximum impact over a broad range of reproductive health issues. Contraceptive prevalence is influenced by two factors: demand. For fertility, regulation, and the use of contraception in case of such a demand. The demand would generally be influenced by socio-economic and demographic conditions such as place of residence, age, age at marriage, levels of education, religion, caste, type of family, total number of children and their sex, incidence of abortion and child loss, exposure to mass media messages, access and availability of health services, occupation, income and standard of living.

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