

An Analysis of Healthcare Measures in India

Jeesa Joy.C¹ and Prof. Dr. K.V.Ramachandran²

¹Research Scholar, Department of Economics, Dr. John Matthai center, University of Calicut, Thrissur-680618.

²Rtd. Professor, Department of Economics, Dr. John Matthai center, University of Calicut, Thrissur-680618.

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ABSTRACT

At present each country gives much importance to the process of human development. The human development is determined by both socio-economic status as well as the health status of an individual in the society. By giving the health status as an indicator of development, which is identified albeit, morbidity and mortality rate. High morbidity and mortality mean low health which arises due to inefficient implementation of health schemes. Also, huge morbidity and mortality rates negatively affect human development and impede the economic development of a country. The inter-state disparities in human development had widened in the decade of the 1990s (Singh and Nauriyac, 2006) In India, the major health-related problems are high malnutrition, poverty, illiteracy and poor sanitation (Sandya,2005). So proper health schemes and programs are sines- qua -non for assuring better health standard of people(human development). The present study intended to analyze the trend and pattern of morbidity and mortality and examine health care measures and policies in India. The study exclusively relies on NFHS (National Family Health Survey) estimates from the period between 1996- 2016 period, Census Reports of India, RGI (Registrar General of India) Reports, SRS(Sample Registration System). The paper finds that the average Indian remains underserved by the present healthcare system. Because, even though many programs and policies have been started by the government of India, the morbidity and mortality rate are very high.

Keywords: Morbidity, Mortality, Healthcare, Healthcare schemes

INTRODUCTION

The health status of a population is now considered as an important indicator of development. Theoretical, as well as empirical evidence, clearly shows the positive linkages between good

health and economic development. Health has also emerged as a major area of academic interest in the social sciences. Health is a basic need along with food, shelter, and education. Health is a pre-condition for productivity and growth. Health services have a major influence on the well-being of individuals and societies and are an important part of a nation's politics and economy. Health interventions can lead to economic growth and reduce inequality in developing countries.

Health is an important indicator of the socio-economic development of a country. It is also one of the main components of the Human Development Index. Health is a necessity for the nation's progress. Nothing could be greater significant than the health of the people in terms of resources for socio-economic development. In spite of this realization, the people living in have no little or no access to modern medicine and health care. This results in a high rate of morbidity and mortality from diseases.

RELEVANCE OF THE TOPIC

Nowadays, every country gives too much importance to human resource development. The overall human resource development is determined by both socio-economic status as well as the health status of an individual. Accepting the importance of health status as an indicator of development, morbidity and mortality are identified as two important factors that influence health status. Huge morbidity and mortality rate negatively affect human development which impedes the economic development of the country. High morbidity and mortality rate means low health which arises due to inefficient implication of health schemes. So, proper health schemes and programs are sine-qua-non for assuring a better health standard of people. The present study intended to focus upon such schemes and issues associated with their implementation.

REVIEW OF LITERATURE

Hari Kurup (2014) examines "Health policies and Strategies; Role of Access to health care in Kerala" with an object of assessing the spread of public and private health care infrastructure in urban and rural areas in Kerala. By using data on the private health care institutions in Kerala. The results of the analysis reveal that health care services are well supplied in Kerala compared to other states in India. This paper also points out the increasing growth of the private sector in terms of hospitals, beds, and utilization by the people. Rajesh(2011) in his study "Health care services by primary health centers in Madurai District in Tamil Nadu" examined the trend and growth of health indicators and health determinants in the Madurai district and also examine the relationship between the demand for and supply of health care services in Madurai district. By using main data on 13 main PHC and 29 additional PHC's in Madurai district. The results of the analysis reveal that health indicators and health variables were favorable to the Madurai district compared to Tamil Nadu. William Joe and U.S. Mishra (2009) Household out of pocket health

care expenditure in India: levels, patterns and policy concerns according to this study richer sections of people are spending more on health care as compared with the poor. poor sections continue to spend a major share of the OOP expenditure on purchase of drugs and medicines and only a smaller share is allocated on components such as diagnostics, service charges and other institutional and non-institutional expenses. The study notes that OOP spending acts stems the poverty status of the household and pushes several of them below the poverty line, particularly in rural areas of backward states.

Sagya D.Doss (2008) examined "The economic analysis of health care services ". In his study, he analyzed the socio-economic status of the people and their demand for health care services. He also analyzed the availability and adequacy of health care facilities in the study area. The study was carried out in Tirupattur town of Vellore district in Tamil Nadu. 300 samples were selected from 15 wards by using simple random sampling. The study reveals that income played a major role in determining the level of demand for health care services. Dilip (2008) "Role of private hospitals in Kerala an exploration shows that private hospitals did not expand in number but strong consolidation by large hospitals has taken place in Kerala. There are no regional variations in the availability of hospitals. Northern districts were having a high concentration of private hospitals than southern districts. Without any rich-poor division, people approach private hospitals than public hospitals. But when it comes to the matter of utilization, there is a division. This is because the private hospitals tax the poor for providing health care and restrict them to assess the same.

K.Gangadhran (2007) examines "Morbidity and Health care in Kerala; a distributional profile and implications". This study examines the issues connected with health care investments and morbidity prevails in Kerala. By using data on center and state governments' statistical reports. The results of the analysis reveal the health status of Kerala is far better compared to other Indian states. This paper also points out huge morbidity reported both from urban and rural Kerala. S.P.Singh and D.K.Nauriyac (2006) examine "Human development disparities in India; Interstate scenario" This paper examines the interstate disparities in human development. By using data on 15 major Indian states for the two decades 1981- 1991. The results of the analysis reveal the inter-state disparities in economic growth had widened in the decade of the 1990s. This paper also points out that inter-state disparities in human development and HD related indicators had narrowed down thus providing evidence of slight divergence in economic growth and convergence of HD among states. M.H.Suryanarayana (2005)" Morbidity and Health care in Kerala: a distributional profile and implications" this study points that in Kerala that stands out is the high level of morbidity existing with low levels of mortality and high life expectancy. The human development report 2005, for Kerala highlights the fact that morbidity estimates was 71/1000 persons for acute illness and 83/1000 persons for chronic illness in the year 1973-

74.S.Sandya (2005)studies health financing reforms in India; Lessons from other countries" The study reveals that major health-related problems in India are high malnutrition, poverty, illiteracy, and poor water quality and poor sanitation. This paper also points out that India had a double burden of both communicable and chronic diseases.

P.Sivaram, S.Sreenivasan, Prasad Rao, Mj.Mohan Rao (2004) in their study "Decentralized Rural Health care services in Kollam district of Kerala state India –A field inquiry" examined the role of panchayats in the delivery of rural health services. By 120 samples health users representing various socio-economic groups in Kollam district. The study reveals that the involvement by panchayats would always help to improve the health care services in rural areas particularly benefited to BPL groups. The study also suggests that there is an improvement in the regular attendance of medical officers and para-medical staff at the concerned medical center. George and Nair (2004)"An overview of the health scenario of Kerala". According to this study, Kerala has achieved a low birth rate, low death rate, low MMR, and high sex ratio. But the reported morbidity rates have been very high in Kerala compared to the other states in India. But the problems like high morbidity, high health care cost and unregulated gratitude of private-sector health care services questioned the efficiency in providing health care services and the health in Kerala. Kahn (2004) measures the inter-state variations in human development in India. Unlike UNDP, the HDI constructed in their present study is based on four elements; life expectancy, educational attainment, real per capita SDP, and urbanization. The study finds that though India in the category of low human development as per the human development report of UNDP, there are states in India, viz, Kerala, Maharashtra, and Punjab which are in the category of medium human development. However, there are many states in India whose HDI is less than 0.30, which means a very low level of human development. The study concludes that the level of human development is low in many states of India and there is widespread interstate variation in it.

Mandal(2003) generates an overall ranking of major Indian states in terms of the level of human development as indicated by certain indicators like per capita net state domestic product, life expectancy at birth, literacy rate, female-male ratio. The study based on sixteen major Indian states concluded that human development requires much more than the growth of income. The progress in human development in India marked by unevenness and stagnation. There are wide disparities in achievements and improvements among northern and southern states. Kohali and Kothari (2003) analyze characteristics of human resources in Gujarat, Haryana, Madhya Pradesh, Punjab, Rajasthan and Uttar Pradesh of western India individually and comparatively to identify the backward states based on human development index. The study also suggests that there is a need to develop human resources. It is necessary to integrate human resource development and development planning. Ramankutty(1999); A primary of health systems economics- In earlier

days health is provided as a service but none because of the high cost in health care infrastructure the dimension changed into a business. Thus it promotes the unregulated growth of the private sector in the health care system. Even though Kerala's public health care systems were far better than other states of India and also have a more equitable distribution of health care facilities whether it is private or public. But the no –availability of medicines, less care and infrastructure facilities make people opt for private hospitals. Deshpande (1998) studied “morbidity differentials in Rural Karnataka”. The researcher selected 1600 households from selected villages in Karnataka state by random sampling method. The study revealed that the children below four years of age, elderly people with 60 and above years of age had higher levels of morbidity as compared to other age groups. The study also pointed out the morbidity rate of women was higher than that of males. Kurusu (1998) in his unpublished thesis entitled " the effects of socio-economic demographics and health Infrastructural variables on health status in major states of India " had viewed that health status is not directly related to health variables alone- but there are number of other intervening variables like education, income, employment, health expenditure, and health facilities, etc. This study also revealed that Kerala had low mortality but high morbidity whereas Gujarat had high mortality and low morbidity rate. Gumber's (1997) analysis across states found that reliance by the people on the public sector was more in less developed states as compared to more developed states. The reason in the former could be the non-availability of private sector service providers. It was further found that among the nine major states, the lower socio-economic groups and scheduled caste population used the public facility more often than the high socioeconomic groups.

Soumitra Ghosh and P.Arokiasamy “Morbidity in India; Trends, Patterns, and Differentials". This study presenting the evidence on levels differentials and determinants of morbidity prevalence in India. This study found that the burden of the ailments is reported to be higher among better-off sections than the poor. Seasonal variations are observed with being highest between January and March. The rural-urban differences in reporting illness indicate that the health conditions of the rural people are poorer than their urban counterparts. This study suggests that health budgets are necessary to target these populations with a very different pattern of disease profile and health care access. Panikar and Soman (1984) studied “ the developments in health and non-health sectors leading to the improvement in Kerala's health status". They viewed that the health status of the populations was 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 facility. Kerala achievements in the health sector had attracted wide attention particularly in the context of global efforts to attain Health for all by 2000 A.D

RESEARCH QUESTIONS

- How much extent morbidity and mortality prevails in India?
- What are the major health care services and provisions in India for effectively curbing their morbidity and mortality?

RESEARCH PROBLEM

At present each country gives much importance to the process of human development. The human development is determined by both socio-economic status as well as the health status of an individual in the society. By giving the health status as an indicator of development, which is identified albeit, morbidity and mortality rate. High morbidity and mortality mean low health which arises due to inefficient implementation of health schemes. Also, huge morbidity and mortality rates negatively affect human development and impede the economic development of a country. The inter-state disparities in human development had widened in the decade of the 1990s (Singh and Nauriyac, 2006) In India, the major health-related problems are high malnutrition, poverty, illiteracy and poor sanitation (Sandya,2005). So proper health schemes and programs are *sines- qua -non* for assuring better health standard of people(human development).. Therefore an attempt has been made to understand the relationship with health care programs and Morbidity and Mortality status in India.

OBJECTIVES

- To understand the trend and pattern of morbidity and mortality prevails in India
- To examine various health measures and schemes in India for effectively curbing their morbidity and mortality.

DATA SOURCE AND METHODOLOGY

The study exclusively relies on secondary data. The required data and information collected from the sources such as NFHS surveys from 1996- 2016 period along with Census Reports of India, Registrar General of India Reports. NSSO Reports, Central Bureau of Health Intelligence, Govt. Of India and as such. Health care provisions and services calculated in terms of thousand units because they have huge differences in population and area. Data analyzed by taking the Life Expectancy at birth, Infant Mortality Rate, Maternal Mortality rate, and Crude Death Rate. Morbidity data is collected by pertaining to the disease-wise. The Tables and graphs also have been used.

THE HEALTH STATUS OF PEOPLE IN INDIA : TRENDS AND INTER-STATE COMPARISONS

The health status of a population is reflected in the levels of morbidity and the treatment seeking behaviours of its members. The given table shows the number of women and men age 15-49 per 100,000 who have diabetes, asthma, or goitre or any other thyroid disorders by background characteristics. The overall prevalence of diabetes, asthma, and goitre is substantial for women, and the prevalence of diabetes and asthma is substantial for men.

Table 1 : The distribution of women and men who have diabetes, asthma, or goitre/other thyroid disorders by state, India 2005-06

State by region	Diabetes	Number of women per 100,000			Number of men per 100,000		
		Asthma	Goitre or other thyroid disorder	Diabetes	Asthma	Goitre or other thyroid disorder	
All-India	881	1,696	949	1,051	1,627	383	
South India							
Kerala	2,549	4,037	5,744	3,078	2,984	1,888	
Tamil Nadu	2,188	1,126	1,568	1,351	687	170	
East India							
Assam	402	1,411	760	601	1,105	1,371	
Orissa	556	2,533	362	1,179	1,592	122	
Central and West Asia							
Gujarat	968	1,530	484	524	1,844	72	
Rajasthan	282	1,565	376	362	1,739	246	
North India							

Haryana	1,169	1,552	388	608	1,266	739
Punjab	849	945	601	802	802	241

Source: National Family Health Survey-3rd round 2005-06

Diabetes

The number of women who have diabetes ranges from 282 per 100,000 women in Rajasthan to 5,744 per 100,000 women in Kerala. Rajasthan and Assam have diabetes prevalence levels below 500 per 100,000 women. although prevalence of diabetes among men exceeds that of women in states: Kerala (3,078 per 100,000), Only one states have diabetes prevalence levels below 500 per 100,000 men, namely Rajasthan (362 per 100,000) have the lowest prevalence levels among women as well.

Asthma

The prevalence of asthma ranges from 945 per 100,000 in Punjab to 4,037 per 100,000 in Kerala among women and from 687 per 100,000 in Tamil Nadu to 2,984 in Kerala among men. The number of women with asthma exceeds 3,000 per 100,000 in Kerala (4,037), with the highest prevalence. Prevalence exceeds 1,000 per 100,000 men in 6 states and is exceptionally high (above 2,000 per 100,000) in Kerala(2984). The lowest prevalence levels (below 1,000 per 100,000) are seen among women in Punjab (945). Prevalence levels fall below 1,000 per 100,000 men in 687 (Tamil Nadu).

Goiter or other thyroid disorders

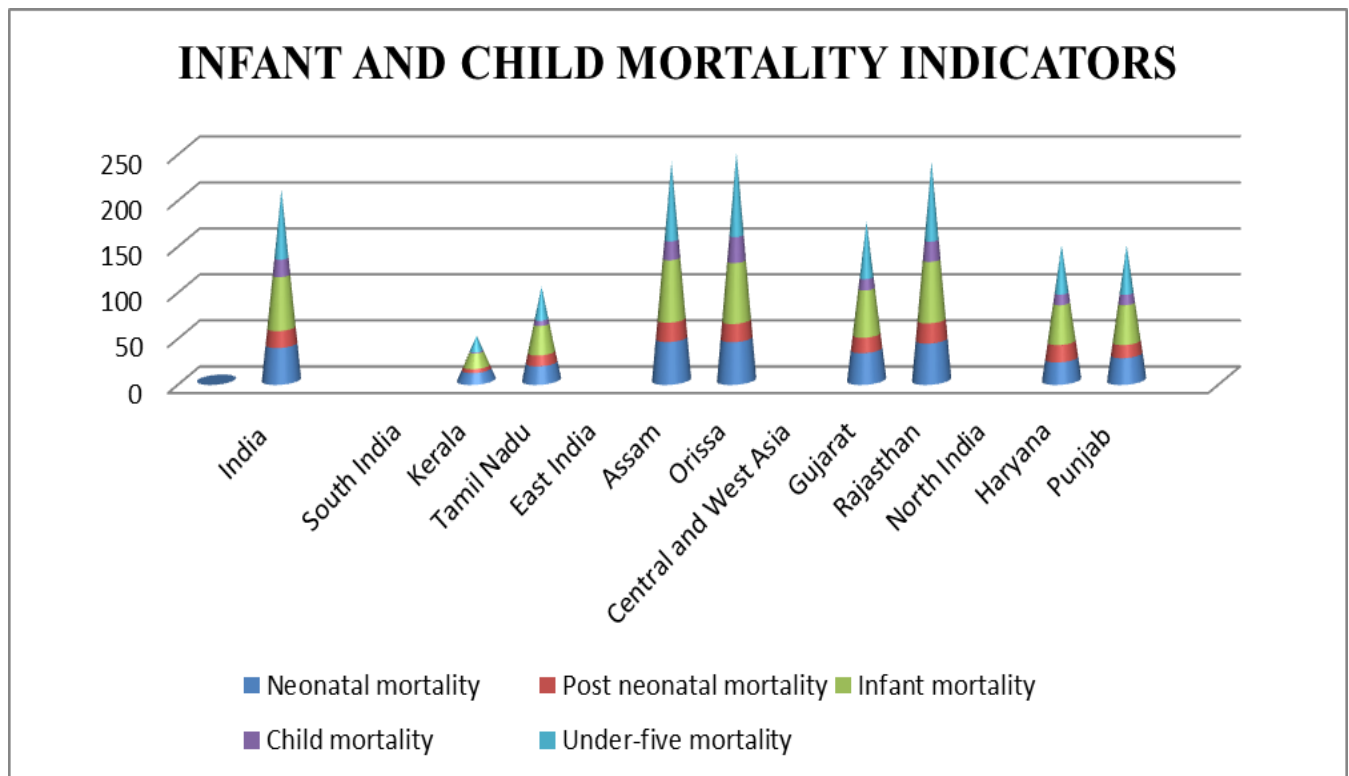
The number of persons who report goiter or other thyroid disorders varies widely across states, especially among women, and shows some tendency toward geographic clustering. Prevalence of goiter or other thyroid disorders is lowest in Orissa(362 per100,000) among women and Gujarat(72 per 100,000) among men and highest in Kerala among both women and men (5,744 per 100,000 women and 1,888 per 100,000 men). The prevalence of thyroid disorders exceeds 1,000 per 100,000 among women in 10 states and men in four states. The Northeast Region exhibits the highest prevalence levels of goiter or other thyroid disorders, followed by the South Region.

INFANT MORTALITY AND CHILD MORTALITY IN INDIA AND SELECTED STATES

Figure 1: presents estimates of Infant and child mortality rates for the five-year period. According to these estimates, Infant mortality is highest in Assam (67) and lowest in Kerala (15). With respect to under-five mortality, Orissa also has the highest rate (67) and Kerala has the

lowest rate (16). In contrast, all states in the southern and western regions have lower levels of infant and child mortality. Favourable for low IMR and child mortality appear to be a high female literacy rate, good medical and educational facilities close to the place of residence, and an excellent transportation and communication system.

Figure 2: Infant and Child Mortality Indicators, India 2017

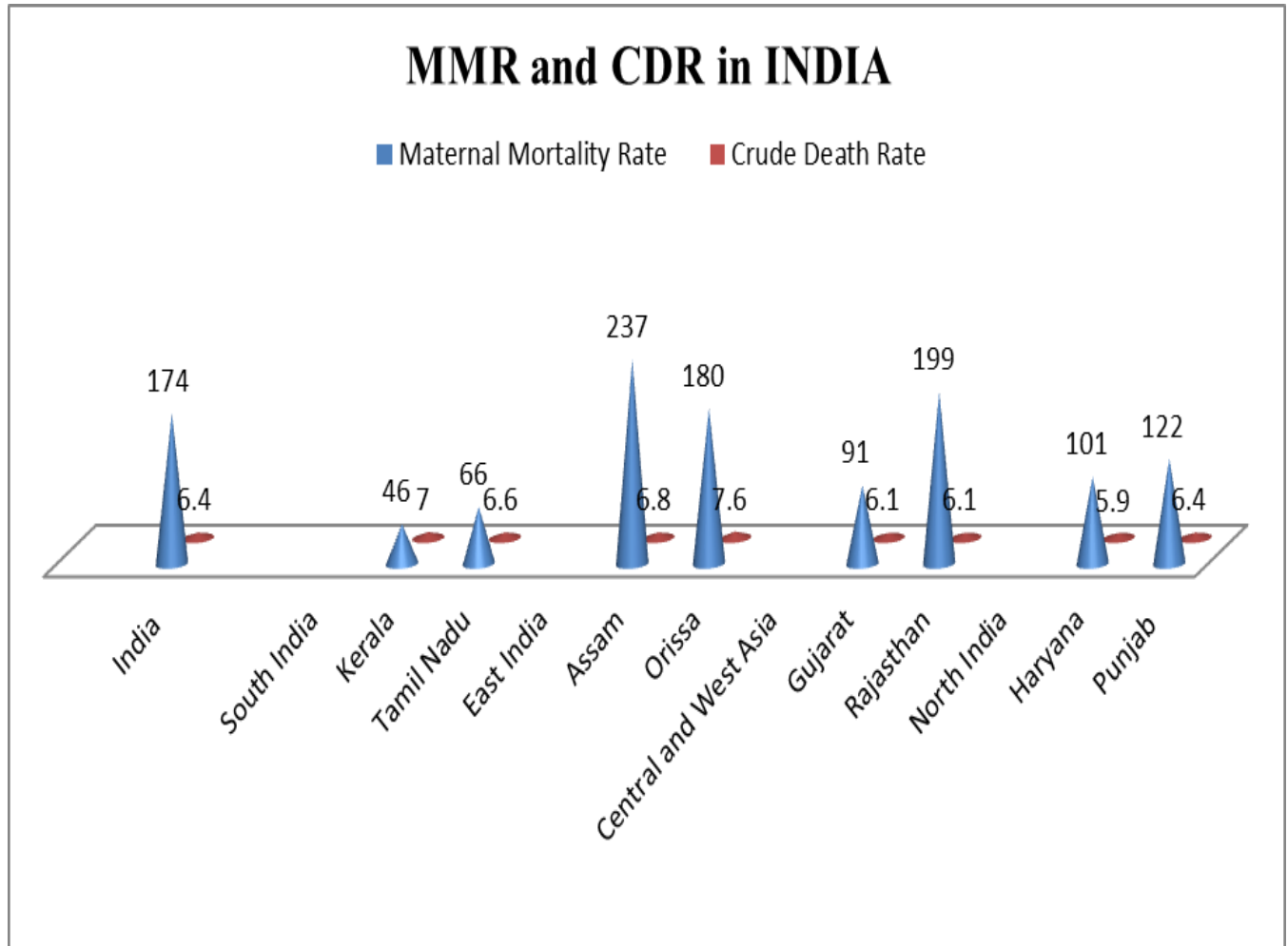


Source: Registrar General of India

MATERNAL MORTALITY RATE AND CRUDE DEATH RATE IN INDIA AND SELECTED STATES , 2015-2017

Figure 2 : shows the Maternal Mortality Rate and Crude Death Rate In India for the period 2015-2017. Maternal Mortality ratio provides a measure of safe deliveries and maternal care. Among the southern states, the decline is from 93 to 77 and in other states from 115 to 93. Kerala had best performance because of a robust public health system as well as high levels of education and awareness, with the lowest MMR of 46 . The CDR at national level is 6.3. The states having death rate higher than or equal to national average are Assam6.5, Tamil Nadu 6.7, Kerala 6.8 and Punjab 7.0 .

Figure 2: Maternal Mortality Rate and Crude Death Rate in India , 2015-2017



Source: Office of Registrar General Of India

LIFE EXPECTANCY AT BIRTH AND IMR IN INDIA AND SELECTED STATES,1970-2014

Table 2; represents trends in LEB in 15 major Indian States over the period from 1970 to 2014. Data reveal increases in LEB over time in all Indian States, a positive and expected sign. However, data also reveal that all-India averages show significant inter-state variations in LEB. In general, states in south India (especially Kerala), and Haryana, and Punjab have a much higher life expectancy while Orissa, Bihar, Rajasthan, and Uttar Pradesh fall below the all India average.

TABLE 2: LEB in India and Selected States, 1970-2014

State by region	1970-75	1981-85	1991-95	1995-99	2002 -06	2010-2014
All-India	49.7	55.5	60.3	61.7	63.5	67.9
South India						
Kerala	62.0	68.4	72.9	73.5	74.0	74.9
Tamil Nadu	49.6	56.9	63.3	64.6	66.2	70.6
East India						
Assam	45.5	51.9	55.7	57.2	58.9	63.9
Orissa	45.7	53.0	56.5	57.7	59.6	65.8
Central and West Asia						
Gujarat	47.4	57.6	61.4	62.8	64.1	68.7
Rajasthan	48.4	53.5	59.1	60.5	62.0	67.7
North India						
Haryana	57.5	60.3	63.4	64.5	66.2	68.6
Punjab	57.9	63.1	67.2	68.1	69.4	71.6

Source: Registrar General of India

AN OVERVIEW OF HEALTH AND NUTRITION PROGRAMMES

The initial years after independence were characterized by a host of initiatives that attempted to address nutritional deficiencies, especially among women and children. Thus, on the basis of numerous studies which noted the existence of acute malnutrition in India, the 1st Five Year Plan pro-posed a feeding programme besides setting up public health departments to take care of the needs of infants, children and mothers. The manufacture of synthetic vitamins and shark liver oil to mitigate the problem of malnutrition was also decided upon. While continuing with this, the second plan also provided for the distribution of milk powder, cod liver oil and vitamins to vulnerable groups, as well midday meals to school –going children.

The trend of integrating specific initiatives into larger and more comprehensive programmes began with Forth plan. Maternal child health(MCH) services were integrated and an integrated nutrition programme was proposed. . In addition, a new scheme for pre- school children in the form of *balawadies* was initiated. In 1970-1971,the social welfare department also started special feeding programmes for children below the age of 3 years in tribal areas and slums in

metropolitan cities. This scheme was extended to children up to 6 years, pregnant women and lactating mothers. Vitamin A doses were also administered to over 1 million children in the age group of 1-5 years.

As it was becoming increasingly apparent that India needed to make a more holistic approach to addressing the problem of child and maternal health, the fifth plan saw the adoption of the National policy for children and the launch of the Integrated Child Development Services (ICDS) Scheme , both in 1975 . The latter covers the main components of holistic and sustainable child development, namely health, nutrition and education. It provides a package of essential services which includes supplementary feeding and growth promotion, immunization, health checks, early childhood care and pre-school education, nutritional and health education to children below 6 years of age, expectant women and nursing mothers. Rightly maternal health was seen as an essential component of child development, and hence both pre-and post natal services were included in this initiative.

By the time of the Sixth Plan it was apparent that health had to be seen from an even larger perspective. The plan consequently attempted to shift away from supplementary feeding programmes to the creation of adequate employment opportunities and undertaking rural development programmes. Nutritious programmes , however were continued in backward and rural areas for severely malnourished children . Hence, in addition to the on –going mid-day meals schemes introduced in 1962-63 for children in the age of 6-11 years , a special nutrition programme was introduced as part of the Minimum Needs Programme ; this included the provision of 300 calories and 8-12 grams of protein for children in the age range of 0-6 years for 300 days, and 500 calories and 25 grams of protein for pregnant women and nursing mothers for 300 days. During sixth plan , and following National Health Policy 1983, interventions on child health became part of MCH goals set by the MoHFW. Subsequently a new programme ,Child Survival and Safe Motherhood (CSSM), was launched , and it included essential new born care, immunization , appropriate management of diarrhea and acute respiratory infections , and iron and vitamin A prophylaxis.

After the implementation of the seventh plan (1984-89) , the family welfare programmes evolved with dual focus :one, on the health needs of women in the reproductive age group and of children below the age of 5 years and two, to provide contraceptives and family planning services . The universal immunization programme (UIP) aimed at reducing mortality and morbidity among infants and young children through vaccine against pre-ventable diseases programme started in 1985-86. Oral Rehydration Therapy (ORT) was also started in view of the fact that diarrhoea was a leading cause of death among children , Various other schemes under MCH wre also implemented during this period

While these programmes did have beneficial impact, the discrete and separate identities of each programme led to problems of effective management, besides also reducing the outcomes to some extent. Therefore, during 1992-93, these programmes were integrated under the CSSM programme. The adoption of the National Nutrition policy in 1993 also led to an expansion of direct interventions (namely, ICDS, UIP and ORT). Doubtless there has been considerable improvement in the indicators, but this improvement has not been uniform across states

GOVERNMENT PROGRAMMES

There are a host of programs and schemes that directly come under the ambit of the MoHFW, and the ministry website lists 42 centrally –sponsored programs and schemes for which expenditure was allocated. National Aids Control Program, National Leprosy Eradication Programme,, Vector Borne Disease Control Programme, National T B Control Programme, National Programme for Control of Blindness, National Cancer Control Programme, National Iodine Deficiency Disorder Control Programme, Diseases Surveillance Programme for Communicable Diseases, Mental Health Programme, Drug De-addiction Programme, Rashtriya Arogya Nidhi, Central Government Health Scheme, National Cardio-Vascular Disease Control Programme, Scheme for Improvement of Medical Services Health, National Family Welfare Programme, Scheme for the upgradation of departments of ISM&H(Indian systems of medicine and homeopathy),International exchange programme /seminar/ conferences /workshop on Indian systems of medicine and homeopathy, Reorientation Training Programme of ISM&H Personnel, Grant in-aid under the scheme for strengthening of the existing undergraduate colleges of ISM&H during the 9th Five Year Plan,Scheme for standardization of *ayurvedic*, *siddha*. *Unani* drugs, Scheme for providing central assistance for development and cultivation of medicinal plants used in *Ayurveda*, *siddha*, *unani* and homeopathy, Scheme for providing central assistance for development of agro techniques of medicinal plants used in *Ayurveda*, *siddha*, *unani* and homeopathy

While it is evident that there are a whole range of initiatives in the central government's expenditure list – narrowly defined (disease –specific. Input specific and facility specific) broadly defined (spanning multiple ailments, facilities and inputs) – there has been a perceptible move in recent years away from those that are narrowly defined. A limited set –generally referred to as 'flagship' programmes and schemes –now accounts for the bulk of allocations and efforts. The NRHM and the newly announced NUHM are arguably key programmes in the government arsenal that have a direct relevance to the future of health care delivery for the masses. The NRHM builds on more than five decades of experience with many programmes and schemes aimed at improving maternal and child health.

FINDINGS AND CONCLUSIONS

Maternal and child mortality and Morbidity are considered key health indicators as they reflect the state of female health care. Over the years, the government has taken initiatives to improve these health indicators. The trends in LEB in 15 major Indian States increases over the period from 1970-2006. Not surprisingly, there is substantial inter-state variation in IMR as well. The groups of states with above-average life expectancy are also the ones with much lower than average IMR. At other extreme and except for Bihar have high IMR. Inter-state Inequality is also high in India.

This analysis reveals that the average Indian remains underserved by the present healthcare system. This has been observed in many aspects. The important findings of the study are:

- Indians have inadequate access to quality healthcare, and this is particularly true for the poor, those residing in rural areas
- Private health care providers predominate in both institutional and non-institutional services
- Public health services are not always free. Often, they do not even have medicines or diagnostic equipment, making it necessary for the patient to purchase the product/service from the market.

This analysis indicates that healthcare basics need to be addressed first and foremost. It also defines these basics by borrowing from the World Bank's definition of the main objectives of a health system:

- Lower mortality and morbidity rates
- Protection against the financial risks of health problems
- Healthcare that is responsive to the population demands and needs
- Maintain services at affordable and socially Sustainable levels

It would not be an exaggeration to state that the healthcare sector in India is under a tremendous burden.

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