International Journal of Applied Home Science
Volume 8 (1 & 2), January & February (2021) : 7-11
Received : 03.12.2020; Revised : 18.12.2020; Accepted : 03.01.2021

RESEARCH PAPER
ISSN : 2394-1413

An Assessment of Health Accessibility and Delivery in Uttarakhand

ANITA SATI
Associate Professor
Department of Home Science,
HNB Garhwal University Srinagar, Garhwal (Uttarakhand) India

ABSTRACT

The paper deals with the concept and analysis of health care delivery taking Uttarakhand as the area of study. The concept part is explained using the key characteristics given by World Health Report 2008 and the data regarding health personnel, health infrastructure, institutional deliveries, availability of health schemes and geographical differences in availability of schemes are taken from HDR of Uttarakhand 2018, and fertility rate and mortality rate are taken from various NFHS reports. The paper is an attempt to understand the condition of health care delivery in Uttarakhand state.

Key Words : Public Health Centre, Community Health Centre, Sub Centre, District hospital, Per Capita Income, Geographical difficulties, Polished lifestyle

INTRODUCTION

Strengthening service delivery is crucial to the achievement of the Sustainable Development Goals of United Nations, which include the delivery of interventions to reduce global maternal mortality ratio, to end preventable deaths of new-borns and children under five years of age, to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, achieve universal health coverage, substantial increase in health financing and recruitment, and so on. Service provision or delivery is an immediate output of the inputs in to the health system, such as the health workforce, procurement and supplies, and financing. Increased inputs should lead to improved service delivery and enhanced access to services. Ensuring availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system. To monitor progress in strengthening health service delivery, World Health Organisation has given eight key characteristics of good service delivery in a health system (World Health Report, 2008). These ideal characteristics describe the nature of the health services that would exist in a strong health system based on primary health care. Good service delivery is a vital element of any health system. Service delivery is a fundamental input to population health status, along with other factors, including social determinants of health. The precise organization and content of health services will differ from one country to another, but in any well-functioning health system, the network of service delivery should have the eight key characteristics. First is comprehensiveness. A comprehensive range of health services is provided, appropriate to the needs of the target population, including preventive, curative and rehabilitative services and health promotion activities. Second is accessibility Services are directly and permanently accessible with no undue barriers of cost, language, culture and geography. Health services are close to the people, with a routine point of entry to the service network at primary care level. Services may be provided in the home, the community, the workplace, or health facilities as appropriate.

Coverage:

Service delivery is designed so that all people in a

How to cite this Article: Sati, Anita (2021). An Assessment of Health Accessibility and Delivery in Uttarakhand. *Internat. J. Appl. Home Sci.,* **8** (1 & 2) : 7-11.

defined target population are covered, i.e. the sick and the healthy, all income groups and all social groups.

Continuity:

Service delivery is organised to provide an individual with continuity of care across the network of services, health conditions, levels of care, and over the life-cycle.

Quality:

Health services are of high quality, *i.e.* they are effective, safe, centred on the patient's needs and given in a timely fashion.

Person-centeredness:

Services are organized around the person, not the disease or the financing. Users perceive health services to be responsible and acceptable to them. There is participation from the target population in service delivery design and assessment. People are partners in their own health care.

Coordination:

Local area health service networks are actively coordinated, across types of provider, types of care, levels of service delivery, and for both routine and emergency preparedness. The patient's primary care provider facilitates the route through the needed services, and works in collaboration with other levels and types of provider. Coordination also takes place with other sectors (e.g. social services) and partners (e.g. community organizations).

Accountability and efficiency:

Health services are well managed so far as to achieve the core elements described above with a minimum wastage of resources. Managers are allocated the necessary authority to achieve planned objectives and held accountable for overall performance and results. Assessment includes appropriate mechanisms for the participations of the target population and civil society.

For health sector leaders, policy-makers and research scholars, these above mentioned characteristics are very important to consider. Some concepts that have frequently been used to measure health services remain extremely relevant and are part of the key characteristics. For example, terms like access, availability, utilization and coverage have often been used interchangeably to reveal whether people are receiving the services they need (2, 3). Access is a broad term with varied dimensions: the comprehensive measurement of access requires a systematic assessment of the physical, economic, and socio-psychological aspects of people's ability to make use of health services. Availability is an aspect of comprehensiveness and refers to the physical presence or delivery of services that meet a minimum standard. Utilization is often defined as the quantity of health care services used. Coverage of interventions is defined as the proportion of people who receive a specific intervention or service among those who need it.

METHODOLOGY

The paper is an analytical one using the available details from the secondary sources of data regarding health infrastructure and facilities. Simple tabulation and percentage method is used for the analysis of data. The secondary data in the paper are collected from various sources like the website of Uttarakhand Health and Family Welfare Society, Human Development Report of Uttarakhand (2018), NFHS-14 (2015-16) and National Health Accounts (2018).

RESULTS AND DISCUSSION

Uttarakhand geographical setup is such that far-flung villages and habitats, more so in the hills, lead to difficulties in the provisioning of as well as access to basic health infrastructure facilities and services for the population which hinder the overall well-being of the people. The rural-urban as well as hills versus plains disparities are one of the major issues in state's health care delivery.

Status of Health Personnel :

As regards to health personnel is concern the health personnel are the men and women working in the provision of health services, whether as individual practitioners or employees of health institutions and programs, whether or not professionally trained, and whether or not subject to public regulation. They play an important role in reaching medical aid to the people. The availability of general physicians, doctors, surgeons and various health specialists, especially in the rural and far flung hill areas is an important determinant of the health and longevity of the people living there. Data given below (HDR 2017 Survey Report) clearly highlights the acute shortage of various health related personnel in the state run Primary Health Centres (PHCs). Primary Health

Table 1 : Availability of health personnel by population (in lakhs) – 2018

Health Personnel	2016
No. of doctors per lakh population (hills and plains)	13.91
No. of paramedical per lakh population (hills and plains)	38.57
No. of hospitals beds per lakh population (hills and plains)	1032
No. of PHC per lakh population (hills and plains)	2.58
No. of maternity and child care centre per lakh population (hills and plains)	18.97
No. of other health centres per lakh population (hills and plains)	3.44
Number of persons covered under health insurance(R)	24,28,275
Number of persons covered under health insurance(U)	33,53,350
Number of persons covered under health insurance (T)	57,81,625

Source: HDR, Uttarakhand, 2018

Table 2 : Current Availability of Health Personnel in Uttarakhand-2018

Cadre	Sanctioned	In Position	Vacant	Vacant as a Share of Sanctioned Posts (%)
Allopathic Doctors at PHC	147	65	82	55.78
Surgeon at CHC	83	6	77	92.77
OBG at CHC	79	7	72	91.00
Physician at CHC	79	5	74	93.67
Paediatrician at CHC	80	14	66	82.50
Total Specialists at CHC	321	32	289	91.00

Source: HDR, Uttarakhand, 2018

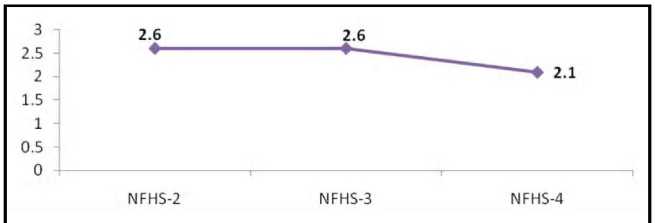
Centres are important in a way that it is the first and biggest point contact between the surrounding community and they provide an integrated system of curative and preventive health care.

The data suggests that for the hills and the plains, there are around two PHCs per lakh population which is dismally lesser than the norm, as per the Indian Public Health System there should be one PHC per 20,000 populations in a Hilly or Tribal region. The number of doctors and paramedics per lakh population is approximately 13 and 39, respectively. And there is minimally small number of other health centres (3 %) for a lakh population which further worsens the health facilities. While the number of maternity and child care centres are low at around 19 per lakh population, the number of hospital beds is also low at 1032 per lakh population. The Table 1 shows the current availability of health personnel in the state of Uttarakhand.

The percentage of sanctioned posts in the health sector that are lying is also worrying. More than half the posts (55.78 %) for allopathic doctors at PHCs, 82.5 % of posts for paediatricians at Community Health Centres CHCs), 93.67 % posts of physicians at CHCs, 91 % posts of OBGs and 92.77 % of sanctioned posts for surgeons are vacant in the state reflecting a very dismal scenario in the public health sector which caters to a large proportion of specially the poor and underprivileged population in Uttarakhand (Table 2).

Fertility and Mortality Trends in Uttarakhand:

Demographic indicators like fertility and mortality have a direct bearing on maternal and child health outcomes. The data given below (NFHS) indicates that in Uttarakhand, the Total Fertility Rate (TFR) remained constant at a value of 2.6 over the period 1998-99 (NFHS 2) to 2005-06 (NFHS 3) and then reported a decline to a value of 2.1 in 2015-16 (NFHS 4). A decline in TFR over two decades indicates that families are choosing to have a small family size (Fig. 1).



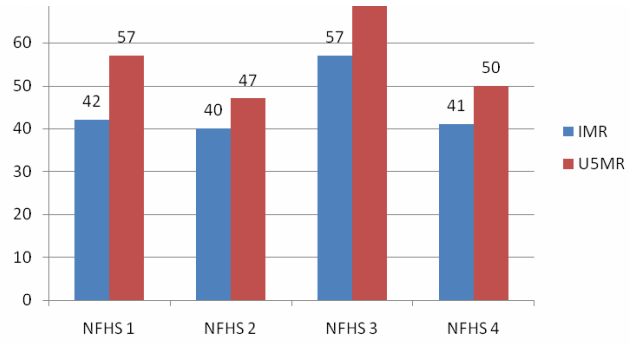
Source: NFHS reports

Fig. 1 : Fertility Trends- Total Fertility Rate (Children per Women)

Infant and Under 5 Mortality Rates:

The NFHS 1 and NFHS 2 estimates for infant

mortality rate (IMR) show decline in this indicator from 42 to 40 over the ten year period under consideration, which is not really much of a decrease. The under-five mortality rate (U5MR) has shown a larger decline from 56 to 47 over the same decade. Although the state is faring better than the all India figures for the U5MR over the period under consideration, there is a lot more to be done to bring down the infant and under five mortality rates (Fig. 2).



Source: NFHS reports

Fig. 2 : Fertility Trends- Total Fertility Rate (Children per Women)

Maternal and Child Health:

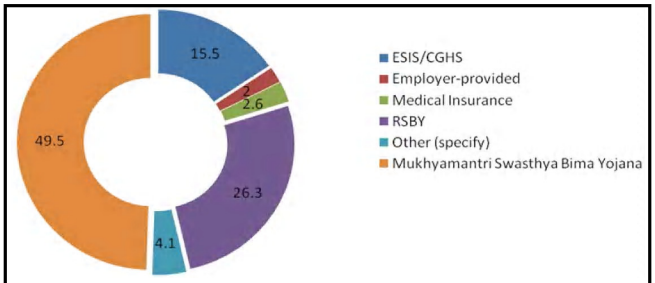
Improving the health and well-being of mother and children is a development imperative for any state or nation striving for human development. A child also needs a healthy mother as a mother is the primary care giver for her children. Maternal and child health parameters are governed by factors such as access, availability and utilization of health care services, especially during pregnancy, at the time of birth and immunization.

Institutional Deliveries in Uttarakhand:

The map of Uttarakhand given below shows the per cent of institutional delivery in the state. Chamoli had the lowest proportion of institutional deliveries in the state and it comes in the third category that is between 48-61 per cent. Tehri Garhwal, Haridwar, Amora, Champawat and Pithoragarh are the districts which come under the category of 62-74 per cent of institutional deliveries. Uttarkashi, Dehradun, Rudraprayag, PauriGrhwal, Bageshwar, Nainital and Udham Singh Nagar are the better districts which have the percentage of between 75 and 87.

Availability and Accessibility of Health Schemes in Uttarakhand:

The data related to accessibility an health schemes is taken from HDR survey, 2017 report, which gives the availability of insurance schemes. Approximately half of the households are covered under the Mukhyamantri Swasthya Bima Yojana (MSBY) that is 49.5 %, 26.3 % having been covered by Rashtriya Swasthya Bima Yojana (RSBY) and 15.5 % by the ESIS/CGHS. The detail is given in Fig. 3.



Source: HDR, 2018

Fig. 3 : Distribution of Beneficiaries by Type of Health Schemes in Uttarakhand

Geographical Differences in access of health insurance and Health Schemes :

The major problem of health delivery in Uttarakhand is the disparity in accessibility of health care and government services. There are definite disparities in the number of people who have any health insurance; in hill region the number is 37.9 % and that of plain is 23.2 %; in rural area the number is 31.8 % but 27.2% in urban area. The number of people covered in ESIS/CGHS are low in rural and hill area (12% and 13.2%, respectively), but that of urban and plain areas are 23.4% and 18.9%, respectively. In terms of RSBY the value of rural a hill area are 28.1% which is higher than the values 22.2% and 23.5% of urban and plain areas (Table 3).

Conclusion:

The paper is all about the concept and analysis of health care delivery. World Health Organization (WHO) considers health care delivery as a vital element of a health system, as health outcomes of a nation or a state is very important for the human development of the region which in turn leads to the overall development. In the case of Uttarakhand state health infrastructure suffers from acute shortage of Primary Health Care Centres which are the first point of contact for those seeking health care. There is the added scarcity of health

Table 3 : Geographical Differentials in Health Care Beneficiaries by Type of Scheme, 2017

Uttarakhand	Family member having health insurance (%)	Scheme Under ESIS/CGH S	Employer-provided	Medical Insurance	RSBY	MSBY
Rural	31.8	12	1.7	2.2	28.1	52.4
Urban	27.2	23.4	2.9	3.5	22.2	43
Hill	37.9	13.2	1.6	1.7	28.1	51.4
Plain	23.2	18.9	2.7	3.9	23.5	46.6

Source: HDR, Uttarakhand, 2018

personnel, with a large proportion of unfilled vacancies in the existing health centres. Insufficient numbers of trained health personnel is an inescapable impediment for the successful provisioning of health care especially to the poor and adversely affects efforts at reducing maternal and child mortality. To have a desirable impact on health outcomes in Uttarakhand it is very important that the availability and accessibility of improved health facilities and services should be considered by improving shortfalls in health infrastructure and health personnel.

Although Uttarakhand has attained replacement levels of fertility (TFR of 2.1), there is still a pressing need for improving maternal health outcomes by raising the rates of institutional deliveries in both rural and urban areas. To achieve this, strengthening health facilities including the availability of health care centers, personnel and equipment would contribute to ensuring safe deliveries and reducing any delivery related complications. Increasing and strengthening the number of delivery facility points that work round the clock, especially in rural areas, would go a long way in reducing maternal and child mortality rates in the state. In some of the health indicators, the state is well ahead compared to All India averages, but for a small state the values are not at all satisfactory.

REFERENCES

Anonymous (2010). *Health Service Delivery.* [Online].

Baru, Rama, Acharya, Arnab, Acharya, Sanghmitra, Shiva Kumar, A.K. and Nagaraj, K. (2010). Inequities in Access to Health Services in India: Caste, Class and Region. *Economic & Political Weekly,* **45** (38) : 49-58

Deogaonkar, M. (2004). Socio-economic inequality and its effect on healthcare delivery in India. *Electronic Journal of Sociology,* **11.**

Government of Uttarakhand (2018). *Human Development Report of the State of Uttarakhan,* Institute of Human Development New Delhi

Narang, R. (2010). Measuring perceived quality of health care services in India. *Internat. J. Health Care Qual. Assur.,* **23**(2):171-186.

Navneetham, K. and Dharmalingam, A (2002). Utilization of maternal health care services in Southern India. *Soc. Sci. Med.,* **55**(10):1849-69

Sharma, J.K. and Narang, Ritu (2011). Quality of Healthcare Services in Rural India: The User Perspective. *Sage Journals.*

Singh, Prashant Kumar, Rai, Rajesh Kumar, Alagarajan, Manoj, and Singh, Lucky (2012). Determinants of Maternity Care Services Utilization among Married Adolescents in Rural India. *PLoS One*, **7**(2):e31666..

Singh, N. (2008). Decentralization And Public Delivery Of Health Care Services In India. *Health Affaires*, **27** (4) : 991-1001.

Srinath Reddy, K., Patel, Vikram, Jha, Prabhat, Paul, Vinod K., Shiva Kumar, A.K. and Dandona, Lalit (2011). Towards achievement of universal health care in India by 2020: a call to action. *Lancet*, **26** : 377(9767):760-768.

****